THE EFFECT OF INSURGENCY IN THE PSYCHOLOGICAL ADJUSTMENT OF THE MIZO

Ms. Zoramhmangaihzuali Khiangte

Thesis Submitted for the Degree of
Doctor of Philosophy in Psychology

DEPARTMENT OF PSYCHOLOGY
MIZORAM UNIVERSITY
AIZAWL : 796012

2011

DEPARTMENT OF PSYCHOLOGY
MIZORAM UNIVERSITY
AIZAWL: 796012

Dated1st Nov, 2011

Certificate

This is to certify that the present piece of Thesis titled, "The Effect of Insurgency in the Psychological Adjustment of the Mizo" is the bonafide research conducted by Ms. Zoramhmangaihzuali Khiangte under my supervision. She worked methodologically for her dissertation being submitted for the Doctor of Philosophy in Psychology under the Mizoram University.

(DR. ZOKAITLUANGI)
Supervisor

DECLARATION

I, Zoramhmangaihzuali Khiangte, hereby declare that the subject matter of this Thesis is the record of work done by me, that the contents of this Thesis did not form basis for the award of any previous degree to me or to the best of my knowledge to anybody else, and that the Thesis has not been submitted by me for any research degree in any other University or Institute.

This is being submitted to Mizoram University for the Degree of Doctor of Philosophy in Psychology.

(ZORAMHMANGAIHZUALI KHIANGTE)

(DR. ZOKAITLUANGI)
Supervisor

(Dr. H.K. LALDINPUII FENTE)
Head
Department of Psychology

ACKNOWLEDGEMENT

This thesis would not have been completed without the direction, support and love from a number of different people.

I would firstly like to acknowledge my Lord and Saviour Jesus Christ. Without Him everything is meaningless.

My deepest gratitude to my Supervisor, Dr. Zokaitluangi. Thank you for your guided direction and your commitment to making this thesis excellent.

I would like to acknowledge and thank my husband. Thank you for your unfailing love and support. You are my rock.

I also wish to thank my children and family, I would not have been able to complete this research without their support and understanding.

I would like to thank the a member of Peace Accord MNF Returnees Association (PAMRA), Ex-Mizoram National Army Association (Ex-MNA), Widow of MNA and Mizoram Elder Association (MUP – Mizoram Upa Pawl) for their support and cooperation.

Thank you also to Dr.H.K.Laldinpuii Fente, Head, Department of Psychology, Mizoram University, for her support.

I would also like to thank Dr. C.Lalfamkima Varte. Thank you for all your help with statistical analyses. Your giving of precious time was greatly appreciated.

I also like to thank Lalbiakzuali Chhakchhuak and C.Lalduhawma, for helping me with my data collection and data entry.

Lastly, but not the least, much thank you to the staffs of the Department of Psychology for all their help.

(ZORAMHMANGAIHZUALI KHIANGTE)

Aizawl : 2nd July, 2010

Table of Contents

List of Tables

List of Figures

List of Appendices

INTRODUCTION

Insurgency began in Mizoram on 1966 when a demand was made by MNF (Mizo National Front) for creating a sovereign state of Greater Mizoram, which would be independent from India. The MNF wanted that Greater Mizoram should include the borderline territories of Tripura, Manipur and Cachar district of Assam. The Government of India sent in many Army battalions and Para-Military forces to Mizoram to counter the insurgency and to restore peace, most of which stayed on till after normalcy returned. Mizoram became a battleground for the MNF and the Indian Army and the sufferings of the innocent and the loyal citizens knew no bounds. Many lost their lives at the hands of both the fighting forces and many people were detained for years together in jails or in bunkers under deplorable conditions. However, after some years, negotiations for restoration of peace were initiated and ultimately a Peace Accord between the MNF and the Government of India was signed on 30th June, 1986, and Mr. Laldenga (the President of MNF), with all of those agreements the MNF were given an interim Government of the Mizoram state. The election of the first Mizoram Legislative Assembly was held on I6th February, 1987 and Mizoram became a full-fledged State from 20th February, 1987 as stated earlier (Lalnithanga, 2005).

Insurgency has become household language today, as media highlighted many countries facing insurgency within their country Insurgency has existed throughout history but ebbed and flowed in strategic significance. Today the world has entered another period when insurgency is common and strategically significant. Current British military doctrine defines insurgency as “an organized movement aimed at the overthrow of constituted government through the use of subversion and armed conflict. It is an armed political struggle, the goals of which may be diverse. Generally, an insurgent group attempts to force political change by a mixture of subversion, propaganda, political and military pressure, aiming to persuade or intimidate the broad mass of the people to support or accept such change.” (Sheryington, 2005). Current events in Iraq have forced the British Army to re-

examine this definition: ‘Insurgency is competition involving at least one non-state movement using means that include violence against an established authority to achieve political change’ (Marston, 2005). The verbosity of the definition tells the practitioner that insurgent movements will use all methods and tactics at its disposal to achieve a political aim. Bard O Neil offers a less prescriptive synopsis: “Insurgency may be defined as a struggle between a non-ruling group and the ruling authorities in which the non-ruling group consciously uses political resources organizational expertise, propaganda and demonstration) and violence to destroy, reformulate, or sustain the basis of legitimacy of one or more aspects of politics.” (O’Neill, Bard E. 2005). In short, the insurgent demonstrates that he is capable of prosecuting a broad tactical battle as part of a politically strategic campaign. Examining the evolution of this capability over the 20th Century is best focused by looking at four issues: the conditions from which revolt appeared; the insurgent leader’s strategy and operational philosophy; the tactics that were employed; the outcome of the campaign and the way that it affected subsequent insurgencies (Sheryington, 2005).

An insurgency is a rebellion against a constituted authority (for example an authority recognised as such by the United Nations) when those taking part in the rebellion are not recognized as belligerents (Sheryington, 2005). Not all rebellions are insurgencies, because a state of belligerency may exist between one or more sovereign states and rebel forces. For example during the American Civil War, the Confederate States of America, was not recognized as a sovereign state, but it was recognized as a belligerent power, and thus Confederate warships were given the same rights as United States warships in foreign ports.

A variety of terms, none precisely defined, all fall under the category of insurgency: rebellion, uprisings, etc. No two insurgencies are identical. The basis of the insurgency can be political, economic, religious, or ethnic, or a combination of factors. Insurgency is a movement - a political effort with a specific aim. An insurgency, or insurrection, is an armed uprising, or revolt against an established civil or political authority (Sheryington, 2005). Persons engaging in insurgency are called insurgents, and typically engage in regular or guerrilla combat against the armed forces of the established regime, or conduct sabotage and harassment in the land in order to undermine the government's position as leader; the government established

by an invading force counts as "collaborators", not "established authority". An insurgency differs from a resistance both in its political overtones and in the nature of the conflict: an insurgency connotes an internal struggle against a standing, established government, whereas a resistance connotes a struggle against invading or occupying foreign forces and their collaborators.

Nationalism appears to be the guiding force that Clausewitz discusses for the insurgency activity that took place in the Napoleonic era. This was as true in his day as it is today. It is true that many of the Communist insurgencies particularly in Cuba and Vietnam also utilized in the concept put down by Communist theorists both publicly and in many cases privately. Nationalism was the driving force behind the rebellion towards an occupying power, such as the French, American or in the Cuban case a puppet régime of the Americans. Tribal conflicts, as seen in the Arab revolt as well as and currently within Iraq today, are examples of nationalism on a smaller scale. People who are invaded by a military power will in the future be likely to resort to a guerrilla style campaign in an attempt to wear down their opponent and make it politically impractical for them to stay on (Lammy, 2005)

In discussing about insurgencies it is necessary to explain the difference between insurgency and terrorism as it is often assumed that insurgency and terrorism are identical.

If no single definition of terrorism produces a precise, unambiguous description, we can approach the question by eliminating similar activities that are not terrorism, but that appear to overlap. For the U.S. military, two such related concepts probably lead to more confusion than others. Guerilla warfare and insurgencies are often assumed synonymous with terrorism. One reason for this is that insurgencies and terrorism often have similar goals. However, if we examine insurgency and guerilla warfare, specific differences emerge.

Terrorism is defined by Title 22 of the U.S Code (2002) as, “politically motivated violence perpetrated against non-combat targets by sub national groups or clandestine agents, usually intended to influence an audience”.

A key difference is that an insurgency is a movement - a political effort with a specific aim. This sets it apart from both guerilla warfare and terrorism, as they are both methods available to pursue the goals of the political movement.

Another difference is the intent of the component activities and operations of insurgencies versus terrorism. There is nothing inherent in either insurgency or guerilla warfare that requires the use of terror. While some of the more successful insurgencies and guerilla campaigns employed terrorism and terror tactics, and some developed into conflicts where terror tactics and terrorism became predominant; there have been others that effectively renounced the use of terrorism. The deliberate choice to use terrorism considers its effectiveness in inspiring further resistance, destroying government efficiency, and mobilizing support. Although there are places where terrorism, guerilla warfare, and criminal behavior all overlap, groups that are exclusively terrorist, or subordinate "wings" of insurgencies formed to specifically employ terror tactics, demonstrate clear differences in their objectives and operations. Disagreement on the costs of using terror tactics, or whether terror operations are to be given primacy within the insurgency campaign, have frequently led to the "urban guerilla" or terrorist wings of an insurgency splintering off to pursue the revolutionary goal by their own methods.

The ultimate goal of an insurgency is to challenge the existing government for control of all or a portion of its territory, or force political concessions in sharing political power. Insurgencies require the active or tacit support of some portion of the population involved. External support, recognition or approval from other countries or political entities can be useful to insurgents, but is not required. A terror group does not require and rarely has the active support or even the sympathy of a large fraction of the population. While insurgents will frequently describe themselves as "insurgents" or "guerillas", terrorists will not refer to themselves as "terrorists" but describe them using military or political terminology ("freedom fighters", "soldiers", "activists"). Terrorism relies on public impact, and is therefore conscious of the advantage of avoiding the negative connotations of the term "terrorists" in identifying themselves (Sheryington, 2005).

Terrorism does not attempt to challenge government forces directly, but acts to change perceptions as to the effectiveness or legitimacy of the government itself. This

is done by ensuring the widest possible knowledge of the acts of terrorist violence among the target audience. Rarely will terrorists attempt to "control" terrain, as it ties them to identifiable locations and reduces their mobility and security. Terrorists as a rule avoid direct confrontations with government forces. A guerilla force may have something to gain from a clash with a government combat force, such as proving that they can effectively challenge the military effectiveness of the government. A terrorist group has nothing to gain from such a clash. This is not to say that they do not target military or security forces, but that they will not engage in anything resembling a "fair fight", or even a "fight" at all. Terrorists use methods that neutralize the strengths of conventional forces. Bombings and mortar attacks on civilian targets where military or security personnel spend off-duty time, ambushes of undefended convoys, and assassinations of poorly protected individuals are common tactics (Walter, 1998).

Insurgency need not require the targeting of non-combatants, although many insurgencies expand the accepted legal definition of combatants to include police and security personnel in addition to the military. Terrorists do not discriminate between combatants and non-combatants, or if they do, they broaden the category of "combatants" so much as to render it meaningless. Defining all members of a nation or ethnic group, plus any citizen of any nation that supports that nation as "combatants" is simply a justification for frightfulness. Deliberate de-humanization and criminalization of the enemy in the terrorists' mind justifies extreme measures against anyone identified as hostile. Terrorists often expand their groups of acceptable targets, and conduct operations against new targets without any warning or notice of hostilities (Sheryington, 2005).

Finally, the difference between insurgency and terrorism comes down to the intent of the actor. Insurgency movements and guerilla forces can adhere to international norms regarding the law of war in achieving their goals, but terrorists are by definition conducting crimes under both civil and military legal codes. Terrorists routinely claim that were they to adhere to any "law of war" or accept any constraints on the scope of their violence, it would place them at a disadvantage vis-à-vis the establishment. Since the nature of the terrorist mindset is absolutist, their goals are of paramount importance, and any limitations on a terrorist's means to prosecute the struggle are unacceptable (Hoffman, 1998).

Guerrilla warfare refers to conflicts in which a small group of combatants including, but not limited to, armed civilians (or "irregulars") use military tactics, such as ambushes, sabotage, raids, the element of surprise, and extraordinary mobility to harass a larger and less-mobile traditional army, or strike a vulnerable target, and withdraw almost immediately, it is a form of irregular warfare (Creveld, 2000).

Fundamentally Guerrilla warfare is a political war. Therefore, its area of operations exceeds the territorial limits of conventional warfare, to penetrate the political entity itself: the "political animal" that Aristotle defined (Mulgan, 1974).

In effect, the human being should be considered the priority objective in a political war. And conceived as the military target of guerrilla war, the human being has his most critical point in his mind. Once his mind has been reached, the"political animal" has been defeated, without necessarily receiving bullets.

Guerrilla warfare is born and grows in the political environment; in the constant combat to dominate that area of political mentality that is inherent to all human beings and which collectively constitutes the "environment" in which guerrilla warfare moves, and which is where precisely its victory or failure is defined.

This conception of guerrilla warfare as political war turns Psychological Operations into the decisive factor of the results. The target, then, is the minds of the population, all the population: our troops, the enemy troops and the civilian population (The official CIA manual).

As discussed above Insuregncy is not identical with terrorism, during Mizoram insurgency the type of combat used was more inclined towards the type of Gorrilla warfare. Since the strategy and tactic used by the Mizo army focus around the use of a small, mobile force competing against a larger, more unwieldy one, as of the Gorrilla warfare which tended focuses on organizing in small units, depending on the support of the local population, as well as taking advantage of terrain more accommodating of small units.

Mizoram Insurgency

Since this research is related to Mizo insurgency it is necessary to highlight some background of the Mizos and Mizo insurgency. Mizoram occupies the southern part of the Northeast India. It is bounded by Assam, Manipur and Tripura on the north and part of western side and Bangladesh on the west and Myanmar (Burma) on the East, having a total boundary length of 630 miles—with Bangladesh and Myanmar. It is geographically situated between 22°20'and 24°27'(N) and 92°20'and 94°29'(E) latitudes. The tropic of cancer runs through the territory. Mizoram is a mountainous region. The climate in Mizoram is pleasant to cool in the upper reaches and humid in the plains but still tolerable. The winter temperature varies from 11 degree Celsius to 24 degrees and in the summer the range is 18 to 29 degrees which makes the state fairly comfortable throughout the year. The average rainfall is 254 centimetres every year. But in the southern part of the state it rains more. Mizoram has hill ranges running from north-south. The state is divided into eight districts:

1) Aizawl
2) Champhai
3) Kolasib
4) Lawngtlai
5) Lunglei
6) Mamit
7) Chhimtuipui
8) Serchhip

With an area of 20,987 sq. km, Mizoram has a population of 891,058 (Eight lakh ninety one thousand and fifty-eight) people according to the 2001 census. The density of population is 42 persons per sq. km. Out of 891,058 population 459,783 are males and 431,275 are females. Mizoram at present is a highly educated state with high literacy levels, and what is more, the level of literacy among the women is also high, which hardly obtains anywhere in India. The main languages spoken are Mizo and English. According to the 2001 census, the percentage of literacy in Mizoram is 88.49. Due to the high literacy rate it attained second position in literacy rates in India next to the state of Kerala. It was already high in the decadal census when the literacy

in the state was 81.23 per cent. About 90.69 per cent of males are literate and 86.13 per cent of women can read and write.

Mizoram or Zoram as it is sometime called is unique in many ways. The dwellers of the state are known commonly as Mizo. The history of the origin and coming of the Mizo to their present habitat is shrouded in mystery. No systematic research has been made so far. There is no recorded history. As per the oral tradition, the Mizo ancestors emerged from a cave or rock known as Chhinlung somewhere in China. They moved through Tibet into the Hukwang valley in Burma over time, following the Chindwin into the Kubaw valley to enter the Lushai Hills in the 18th century. It is accepted that Mizo are of Mongoloid stock and are believed to have immigrated into their present habitat, possibly sometime between 1400 and 1700 or 1800 AD from the upper Burma. However, the Mizo historians such as K. Zawla (1974) and Rev. Liangkhaia (1938, reprint2002), who wrote "Ancient History and Culture of the Mizo People" and "History of Lushai" have argued that the Mizo were in the Chin Hills in Burma from 1400AD to 1700AD and their gradual movements of migration started between 1700 and 1730 or 1740 AD. But in the absence of any written history, more accurate dates about the movement cannot be envisaged. The Mizo, however, migrated from Burma for mainly two reasons— pressure of the Chin or the stronger clans of Burma and the pressure of over population. Thus the Mizo are not only concentrated in the present state of Mizoram, but also in the states of Manipur, Cachar District of Assam, Chittagong hill tracts and Chin Hills (Burma).

The Mizo as a whole possess a unique social system, which although patriarchal, yet the women play a key role in the social affairs and in the process of betterment of the society. But, when looking at the inheritance law of the society the Mizo women lived a lower status, especially in the inheritance of property rights, they have not much inheritance right. The Mizo law of inheritance is simple. As a rule, the property of a father goes to the youngest son. The father may, however, give shares to other sons also. If there is no male issue, the property goes to the next of kin on the male side. The Mizo society did not provide for inheriting any property by the women. In fact the women were confined to the kitchen and the field and had no voice in the day to day affairs of the village. But in the family, the women do exert a lot of influence on their men folk and Mizo men in general are very much attached to

their women. Before the annexation of the Lushai hills, due to fear of attacks from enemies, Mizo selected village sites on top of the hills from where they could observe enemy movements. Stockades used to be constructed for the protection of their village. There are very few springs at higher altitudes and hill tops in Mizo Hills, and as such, Mizo have to depend on rain water for irrigation and drinking purposes.

Traditionally the Mizos (which literally means "hill people") were subject to the authority of the chiefs where chiefs had a preeminent position. The chiefs were the supreme ruler of each of their own jurisdiction. The chief enjoyed various privileges, such as the allotment of land to the people for cultivation and the exaction of taxes. The chief was the father and protector of the Mizo society. The Mizos were a migratory tribe and the various clans and sub clans moved from one place to another in search of subsistence, that is, Jhum land, along with the chiefs. They got settled in places which were selected by the chiefs. The chiefs created the boundary pillars to enforce their jurisdictions. The land *(ram)* belonged to the chief who was the absolute ruler of his *ram.* In the beginning the selection for a chief was based on the power and ability of a person who had a capacity to command a large number of people and to repeal any attack by other chiefs or enemies as the early Mizo society lived a life of inter-clan clashes. Safety was need of the common people from the invasion of the neighbouring villages. The chieftainship thus, originated in the physical and intellectual power of any person. The strength of a person and his ability to protect the people from the dangerous threats of the opponents is a necessary criterion to become a chief of any village. It thus appears that the institution of chieftainship emerged out of the collective needs of group life which characterized tribal living. There is no definite record regarding when the institution took concrete shape. But it is asserted that it happened at an early stage of evolution in their group life. Most of the historians of Mizo origin traced back the origin of chieftainship to the days of Zahmuaka who had six well-built sons. One of his descendants was Sailova from whom the Sailos of today trace their descent. In the long run, the Sailos became the most powerful chiefs and they ruled practically over the entire Mizoram at the time of the advent of the British.

The Mizo form a close-knit society; they are classless and casteless. The society is cohesive and in times of crisis they have the capacity to rise as one

community to safeguard and protect their identity and their social and cultural life. The notable feature of the Mizo society is of the so-called 'tlawmngaihna' which means 'service above self or 'to sacrifice oneself for the good of others'. It is a value system which is very old, yet promoted in such a way that the society absorbs within its fold the modern social impact without sacrificing the core value of the custom. P.R. Kyndiah, the ex-Governor of Mizoram state in his statement about this system observed that "the core element which constitute the base and thrust of the society lies in the observance of tlawmngaihna an ancient code of ethic and conduct in which even today the Mizo of the present generation are ardent believers". One writer remarked, "All voluntary services are rendered by the Mizo people under this useful custom of tlawmngaihna, which is continuing till now in Mizo society." This value system is one of the important factors which safeguarded Mizo society from class distinction (Patnaik, 2000).

The social life of the Mizo since the advent of Christianity experienced a constructive changes. The society is decorated by the church, which has an imminent influence on the life of the people. Before the advent of Christianity, the Mizo who then considered themselves as powerful militant people took great pride in subduing their rival tribes and raiding their neighbours. Apart from the inter-clan clashes, raids were directed towards the people in the plains of Cachar, Manipur, Sylhet, Tripura and the Chittagong Hill Tracts. It was one of such attacks on 27th January 1871. The Mizo killed a British named James Winchester at Alexandrapore and abducted his daughter Mary. The abduction of Mary Winchester heralded a new era in the history of the Mizo people. A millionaire in London, Robert Arthington having heard about the incident organized a missionary society called 'Arthington Aborigines Mission'. On the 11 January 1894 two missionaries, F. W. Savidge and J.H. Lorraine sponsored by the society arrived at Sairang near Aizawl to start the work of spreading the gospel among the Mizo. Special revivals brought about phenomenal success of the gospel preaching in Mizoram and by the end of the Second World War in 1945, the whole land comprising Mizoram embraced Christianity and the percentage of Christian religion has come up to 95 per cent as of now (Lalthangliana, 2001).

The history of the Mizos can be divided into three broad periods; the Pre-British Period begins with the origin of the Mizos shrouded in mystery and culminates

with the 'Chin-Lushai expedition' of 1889-1890; the British Period (1890 – 1947) begins with the annexation of Mizoram by the British Authority in 1890 and comes to its end along with Independence of India in 1947; and the Post-Independence Period (1947 – till date) witness the vast array of development in the social, political, economic and religious sphere at both the individual and population level, since the Indian Independence of 1947 perturbed by the period of insurgency.

The Anglo-Mizo interaction was recorded as early as 1822 (Lloyd, 1991). The Mizos frequently raid the plain area adjacent to their settlement that was under the British Administration. The earliest record of such raid within the British Territory took place in 1826, and was against the wood-cutters who failed to pay the price of safety to the chief in whose territory they conducted the operation (Mackenzie, 1979).

The first British Expeditionary Force went into the Lushai Hills in December 1844, as a retaliatory measure against a Lushai raid in British territory**.** The advent of the British into Mizoram brought about many changes into the political lives of the Mizo. As a result of the second military expedition of the government of British India by 1889-90, the whole Mizoram was annexed to British for administrative purpose. (The Government of British-India on the 11th September, 1889 decided to send expeditionary operation against the Mizos with the objectives: to punish the tribes that raids British Territory, subjugate the neutral tribes in the region, and to establish semi-permanent posts to ensure pacification as well as recognition of the British regime (Reid, 1978). The expeditionary operation was named 'Chin-Lushai expedition 1889-1890' and this resulted in the subjugation of the Mizo chiefs and the annexation of Mizoram in 1890.) The Lushai (Mizo) Hills were formally included in British India under the proclamation by the Governor General of India-in-Council on September 6, 1895" divided into two parts, viz. North Lushai Hills as a part of Assam and South Lushai Hills as a part of Bengal for administrative purpose. A political officer was in-charge of North Lushai Hills District whereas the South Lushai Hills District was under the charge of the superintendent. The District administrators, therefore, carried out administrative work but did not interfere much in the internal affairs of the Lushai. The Lushai chiefs carried on their rule in their villages under the guidance and instruction of the District administrators. For more convenience the South and North

Lushai Hills were amalgamated as one Lushai Hills District of Assam on 1 April, 1898.

During the British Rule, chiefs were retained, but the chiefs are heavily burdened with taxes, forced labour and punishment (The Tribal Research Institute, 1980). The people became critical of the existence of chieftainship; that gained impetus with the political activities in 1946 (Sangkima, 1992). In 1947, Mizos became free from the clutches of the British and Mizoram became an integral part of India. The formations of the Mizo District Council (1952) abolished chieftainship and its replacement in the form of Village Council revived the hope in the Mizo to regain the administration of Mizoram in their hands that was not imminent.

The Mizo National Famine Front dropped the word 'famine' and a new political organization, the Mizo National Front (MNF) was born on 22 October 1961 under the leadership of Laldenga Mizo with the specified goal of achieving sovereign independence of Greater Mizoram. The Mizo National Front was outlawed in 1967. The demand for statehood gained fresh momentum. A Mizo District Council delegation, which met prime minister Indira Gandhi in May 1971 demanded full fledged statehood for the Mizos. The union government on its own offered the proposal of turning Mizo Hills into a Union Territory (U.T.) in July 1971. The Mizo leaders were ready to accept the offer on the condition that the status of U.T. would be upgraded to statehood sooner rather than later. The Union Territory of Mizoram came into being on 21 January, 1972. Mizoram has two seats in Parliament, one each in the Lok Sabha and in the Rajya Sabha

Statehood was a prerequisite to the implementation of the accord signed between the Mizo National Front and the Union Government on 30 June 1986. The document was signed by Pu Laldenga on behalf of the Mizo National Front, and the Union Home Secretary R.D. Pradhan on behalf of the government. Lalkhama, Chief Secretary of Mizoram, also signed the agreement. The formalization of the state of Mizoram took place on 20 February 1987.

In 1955 Mautam (famine) broke out in Mizoram, the famine was caused by the profuse flowering of a thorny bamboo which occurs at intervals of 40 to 50 years. When the bamboo flowers, the rats gorge themselves on the bamboo seeds, multiply

and then destroy all crops, thus causing famine. The Mizo National Famine Front (MNFF), a political party with the objective to help the famine stricken was established in 1959 by Laldenga. ". He and his youthful followers went from village to village, providing food to the hungry, winning their confidence and telling them of the mis-rule that had brought nothing but misery to the people. The famine was over. Laldenga converted the "Mizo Famine Relief Front" into the "Mizo National Front" (MNF) with the objective to strive for the 'Sovereign Independence of Mizoram' in 1961, with Laldenga as its first President. The MNF soon covered the whole of Mizoram and became a formidable force. The MNF submitted a memorandum to the Government of India seeking to represent the case of the Mizo for freedom and independence. The Government of India sends Pataskar Commission to Mizoram in 1966, met by the MNF with a memorandum, but the visit was perturbed by the outbreak of disturbance on 28 February, 1966 leading to the declaration of Mizoram as 'disturbed area' under the Assam Disturbed Area Act, 1955 and the Armed Forces (Assam and Manipur) Special Power Act, 1958. On February 28,1966, the MNF in one sweep it killed all it thought were working against the movement and wiped out the rudimentary police force. The insurgency had started with a bang. The only place where the government held out was the Assam Rifles headquarters in Aizawl town. The very next day on March 1, 1966— Laldenga declared independence and an underground Government of the MNF was formed. Immediately, the Government of India rushed security forces to Mizoram and by June, 1967, the backbone of the armed revolt had been broken. The insurgents took to the jungles and kept ambushing and killing men of the armed forces, started collecting taxes at the point of gun and ran a parallel government (Lalnithanga, 2005).

Since then the Indian troop moved into the district and the MNF volunteers with their leaders went underground. In the wake of MNF insurgency, political parties including the Indian Nation Congress which was set up in 1961 and headed by A. Thanglura could not make much headway. On 1st March 1966, the government was in for the unkind surprise to find the MNF insurgents launching raids on almost all the Security Posts simultaneously all over the Mizo Hills. "That was the Operation Jericho in action." And thus began one of the series of longest negotiations in the history of the country. They dragged on for more than ten years and witnessed a

number of failures in between. The ban of MNF under the Unlawful Activities (Prevention) Act of 1967 came sooner than expected.

The security forces met the challenge efficiently. Ironically, they were operating in their own country against their own countrymen. As such they had to use force with discretion. They had to distinguish friend from foe and this was a difficult task. Even those Mizos who were sick of the hostiles and their methods of extorting taxes dared not divulge information about the insurgents for fear of reprisal. It was under such circumstances that the system of grouping of the villages was resorted to. The population of Mizoram, which was scattered over the countryside, was shifted to Group Centres set up near the main roads and the inhabitants of these centres were supplied with identity cards. Thus every man in the village was accounted for. A dawn-to-dusk curfew was imposed and all were expected to come back to their centres from work by evening. The new faces had to establish their credentials by producing identity cards. Those who could not were suspected to be "insurgents" and were arrested (Lalnithanga, 2005).

The nation was stunned. It appeared for a while that insurgency had triumphed and Mizoram was in for a period of the law of the jungle.

There was one basic difference between the insurgency of Mizoram and that of other areas of the north-east like Nagaland and Manipur. In these areas, the insurgents were concentrated in the jungles and their activity was confined mostly to ambushes. In Mizoram, while they had their bases in the jungles and did occasionally resort to ambushing their main centre of activity was the capital, Aizawl, itself. It was under such circumstances that the security of the town was entrusted to the CRPF. Soon this force was guarding, not only water supply and other vital installations of the capital, but also the local police headquarters, the Secretariat, the Legislature and residences of top officers of the government and members of the Mizoram Ministry.

During 1966 to 1970, the MNF fought with the Indian Army and hundreds of people lost their lives and thousands of them were imprisoned and may be referred to as the ‘Dark Period’ of Mizoram.

Prime Minister Rajiv Gandhi's election to power following his mother's death signaled the beginning of a new era in Indian politics. Pu Laldenga met the prime

minister on 15 February 1985. Some contentious issues which could not be resolved during previous talks were referred to him for his advice. With Pakistan having lost control of Bangladesh and no support from Pakistan, the Mizo National Front which had evolved from the Mizo National Famine Front after the great famine of 1958 used the opportunity that had now presented itself. New Delhi felt that the Mizo issue had been dragging on for a long time, while the Mizo National Front was convinced that disarming; to live as respectable Indian citizens, was the only way of achieving peace and development. Statehood was a prerequisite to the implementation of the accord signed between the Mizo National Front and the Union Government on 30 June 1986. The document was signed by Pu Laldenga on behalf of the Mizo National Front, and the Union Home Secretary, Mr R.D. Pradhan on behalf of the government. Pu Lalkhama, Chief Secretary of Mizoram, also signed the agreement.

While the MNF kept its part of the bargain, the Centre initiated efforts to raise the status of Mizoram to a full fledged State. A constitution Amendment Bill and another to confer statehood on Mizoram was passes in the Lok Sabha on 5 August 1986.

The formalization of the state of Mizoram took place on 20 February 1987. Chief Secretary Lalkhama read out the proclamation of statehood at a public meeting organized at Aizawl, Assam Rifles' parade ground. Prime Minister Rajiv Gandhi flew in to Aizawl to inaugurate the new state. Mr Hiteshwar Saikia was appointed as Governor of Mizoram.

The Mizo Accord so far remains the only successful accord in the country. Security experts even refer to it as 'the only insurgency in the world which ended with a stroke of pen'. This accord seems to be the longest peace accord that has stood the test of time in the North East India. Contrary to the popular belief in the mainland, Mizoram exudes a semblance of peace and amity in the region. The pace of development in the region is far better than other neighbouring states. Save for a few infinitesimally small segment of population, which is minor aberration, the Mizo Accord serves as a model of Peace in the region. Whatever little pockets of resistance that exist at the moment may be due to slow pace of integration of the people living in the hinterland.

The important groups of the Mizo civil society such as the Church, the YMA and the MZP now play a crucial role in sustaining the peace process that heralded following the signing of the peace accord twenty years ago. It is observed that these organizations work in tandem without contradicting each other's objectives. The transition from tradition to modernity and the process of development have been in progress with minimal tension in the society. This is owing to the cohesive nature of the Mizo community. The homogeneity of Mizo community is also a contributing factor in sustaining peace. The impact of Christianity in providing an identity to the Mizos as an ethnic community provides a fillip to the peace process as well.

Culture difference problem:

Before looking into the psychological impact of the insurgency let's have a brief discussion on acculturation which seem to be the major reason for the ignition of the insurgency. At that time when insurgency began, many government employees were from outside of Mizoram, most of them are Indian whom the Mizo refer to them as 'Vai', many shops and businesses were also run and owned by these 'Vai'. The Mizo feels that these foreigners might eventually obliterate them. So, the Mizo does not want to be in a potpourri with outsider especially the 'Vai' since their culture is extremely different from the Mizo culture, the majority of the Mizo people feel that it was impossible to coexist with the 'Vai'.

Major human activity involves interactions between one individual and another in dyadic or group situation, in which individual stable pattern of behavior (personality) is the centre of all organizational or group behavior. In group behavior interpersonal relations processes as social influence, social motivation, interpersonal attraction, social cognition and so on, that will influence all members who belongs to that group: Individual react to other as in-group or out-group members that would decide type of action to exert differently as a form of acculturation.

Culture refers to "*a set of shared attitudes, values, goals, and practices that characterizes an institution, organization or group*" (Kroeber & Kluckhohn, 1952). Individual behaviour in the process of culture is the interplay of four systems namely: "behavioral system" (biological needs), the "personality system" (an individual's characteristics affecting their functioning in the social world), the "social system"

(units of social interaction, especially social status and role), and the "cultural system" (norms and values that regulate social action symbolically). In which social classification such as 'ethnocentrism" play important role in the process of social and cultural change as individuals often rank one's own group or race superior to those of other group or races (Drever, 1952). The present study was designed to explore the psychological functions of the culture of Mizo, who has experienced 20 years insurgency and also gone through the stages and processes of the acculturation (Kroeber & Kluckhohn, 1952).

The social and cultural change can be explained with cultural appropriation, cultural imperialism, and cultural assimilation are often used in explaining interaction among cultures. Cultural appropriations is the adoption of some specific elements of one culture by other cultural group and may be behavior of other's culture and are typically imported into the existing culture, but can imply a negative view towards acculturation from a minority culture by a dominant culture (Alcoff, 1998). Cultural imperialism is the practice of promoting the dominant culture or language of nation which may be economically or militarily to weaker one. Cultural assimilation is a political response which encourages absorption of the minority into the dominant culture. The Mizo, historically isolated having their distinct culture from the dominant cultures of India, had gone through all of those cultural change processes in becoming the citizens of India. This social cultural change processes would provide bases for psychological, psychosocial and behavioural problems in the project population of study as a process of acculturation in a form of insurgency.

Acculturation is a complex, psychosocial phenomenon that involves individual and group-level changes in cultural patterns for ethnic minorities as a consequence of contact with the ethnic majority (Chun, Organista, & Marin, 2003). Acculturation is often conceptualized in psychological research as an individual-level variable (Graves, 1967).Acculturation is a state in which the amount of culture-related values, beliefs, affects, customs, and behaviors, adapted or endorsed by a minority/immigrant individual that are held by or norms of the majority/host culture (Ward, 1996). It is a process of cultural change that results from repeated direct contact between two distinct cultural groups (Berry, Kim, Minde, & Mok, 1987) in which members of one cultural group adopt the beliefs and behaviors of another group (Birman, 1994), the

hostile groups often acculturate to one another (McGee, 1898). Thus, acculturation is a process of psychological and behavioral adjustment, adaptation, assimilation, individual experience when being confronted with social and cultural changes in their cultural surroundings (Berry, Pootinga, Segall & Dasen, 1992). Cultures are often adaptations to the different types of environment such as the physical environment, social niche, intra-cultural niche and the inter-cultural niche that required different cultural adaptations (Diamond, 1999; Edgerton, 1971; O'Kelly and Carney, 1986; Triandis, 1994; Witkin and Berry, 1975). In the same line, the aim of socialization in all society is to induce individuals to conform to major ways of society where they belong, the maladaptive conformity and independence min interest of cross cultural study (Ash, 1951).

In adapting to new culture, people will select activities which maximize pleasure and minimize pain while ecosystem model begins with the postulates basic ecological-economic factors govern patterns of socialization that in turn determine the level of conformity (Mead, 1961). Cross cultural study may attempt various aspects of group functioning: the nature of pressures imposed by groups on deviant members to elicit adherence to group norms (Coon, 1946); the power of the group of produced behavior attitude and value exchange by means of group decision (Lewin, 1947); and the effects of variations in leadership and communication structure on group productivity and morale (Brehmer, 1970).

The acculturation process can be analyzed two ways, (i) the *unidimensional* (Berry, 1987; Ryder, Alden, & Poulhus, 2000) model views acculturation as cultural transformation along with one continuum with native culture as a starting point and a host culture as destination point with biculturalism as the midpoint of this continuum, (ii) The *bidimensional* model of acculturation allows individuals to select different components of both the host and ethnic cultures in such a way that increasing identification with one culture does not require decreasing identification with the other. Individuals in the process of acculturation face two general issues: whether to maintain the cultural identity and characteristics of the culture of origin, and whether to participate in the "larger society" (Berry, Kim, Minde, & Mok, 1987). While performing acculturation, individuals maintained some aspect of her/his culture of origin as he/she acquires aspects of the dominant culture (Berry, 1994; Szapocznik &

Kurtines, 1979). The forgoing theoretical foundation may laid foundation stone in explaining the causes of insurgency in Mizoram as Mizo standing at the cross road of two cultures, having strong attachment to the heritage culture and geographically distanced from the main Nation, are likely to strengthen their willingness to maintain the heritage culture as reflected in the fight for sovereignty.

Studies may revealed the root causes of insurgency that bicultural individuals are often found to be in-authentic, with insecure self-identity (Nash and Shaw, 1963) and conflicting situation (Fong, 1965); often viewed as a new self-identity that often hostile, and incapable of bicultural integration (Bochner, 1982; Sue & Sue, 1971). The individuals' adaptations involving psychological acculturation had been previously thought to inevitably bring social and psychological problems (Malzberg, & Lee, 1956) reflected with the vulnerability to interpersonal problems (Ryder et al, 2000; Searle & Ward, 1990). The two major factors of Psychological problems among international students are: (i) intrapersonal which have roots within the self and includes personality traits, and (ii) interpersonal which can include environment and cultural milieu or surroundings (Sandhu, 1994).

When an individual encounters a dominant culture and engages in the process of acculturation may experienced tension which is known as 'Acculturative stress' (Berry & Kim, 1988) as individuals' attempts to resolve the differences between their culture of origin and the dominant culture (Rudmin, 2003); that may result in anxiety, depression, psychosomatic symptoms, identity confusion (Williams & Berry, 1991), and negative psychological consequences (Park, 1928). However, researches now agreed that immersion of different culture can have a positive effect on psychological functioning and well being (LaFramboise, Coleman & Gerton, 1993).

An individual psychological adaptation to acculturation included that learning new behavioral repertoire, may refers as (i) 'behavioural shifts' (Berry, 1980b), (ii) 'culture learning' (Brislin, Landis & Brant, 1983) and (iii) 'social skills acquisition' (Furnham & Bochner, 1986). The acculturation process may also involve unlearning of aspects of culture of origin, 'culture shedding' (Berry, 1992) accompanied by moderate 'culture conflict', when incompatible behaviors create difficulties for the individual; the outcome can involve greater conflict and the individual may experience 'culture shock' (Oberg, 1960) or 'acculturative stress' (Berry, 1970; Berry,

Kim, Minde & Mok, 1987). So, taking leads from the available literature, it is obvious that the same process of acculturation stress and cultural conflict is apparent as the may causes of the outbreak of insurgency in Mizoram.

The common agents of acculturation may portrayed in the form of refugees, indigenous people, immigrants, sojourners, students, guest workers, or asylum seekers as acculturation stress resides among them. A biological factors and heritability factor may contribute up to 50% in the variance of attitude, and such relationship are religiosity, job satisfaction and vocational attitude and interest (Averey, Bouchard, Segal, & Dawes, 1982), authoritarianism (Scarr, 1981), liking of jazz, attitudes towards capital punishment and many others. But the present study concentrated on the environmental factors, the individual's interaction with other in his social word and the culture where he belongs play a crucial role in forming the individual's behaviour.

So, Acculturative stress may caused by variation in individual and group levels of acculturation such as "*Reference Group Effect*" (Heine et al, (2002) as the host culture also may compare the minority groups with the host culture norm and find different kind of doubt; '*Ultimate attribution Error*" is when an individual explain the behaviors of their own and other social group is often ethnocentric for example if regarded negative act is performed by an out-group member, may attributed as dispositional factors in comparison to the same act carried out by an in-group member as situational actor, as such the same action is attributed differently depend upon the culture group(Pettigrew,1979; "*Social Identity Theory*" (SIT: Tajfel, &Turner, 1979), derived largely from biased comparisons on salient dimensions that are favorable to the in-group and unfavorable to the out-group; and "*Social Dominance Theory*" (SDT; Pratot et al, 1994) proposed those higher status groups are more egocentric than lower status in trying to maintain their power through a process known as 'Behavioral Asymmetry'. The above models such as "Reference *Group Effect, Social Dominance Theory, Social Identity Theory, Ultimate attribution Error'* provided theoretical foundations for determining the root cause and impact of insurgency in Mizoram as effect in making decision in determining about the Non Mizo that affected their perception, the root cause and impact of insurgency.

Acculturation is an increasingly important topic on these reasons: (a) New technologies for high-speed, high-volume transportation and communication make it increasingly easy for cultures to be in contact worldwide; (b) war, political oppression, economic disparities, and environmental pressures produce millions of new migrants annually; (c) regional and global free-trade arrangements encourage international marketing and international recruitment of skilled personnel; and (d) the liberal political ideologies of the dominant, developed nations cause their governments, their minorities, and their academics to attend to acculturative rights and remediation (Rickard, 1994).

Different cultures have different psychosocial functions,, and individuals differences occur in different cultures (Diamond, 1999; Triandis, 1994; Witkin and Berry, 1975; Perkins, 2000), the essential core of culture consists of traditional ideas and especially their attached value (Kluckhohn, 1951). A value is a concept explicit or implicit, distinctive of individual or characteristics of a group, of the desirable which influences the selection from available modes, means and end of action (Kluckhohn, 1951). Cultural Anthropologists see the individual as a culture carrier and informant who can provide information about a group's values, when speaking about his own (Zavalloni, 1980) and also cultural value may be preservation of native culture and transfer to next generation (Harris & Verven, 1998). Psychologists are trying to understand in detail the basic processes that occur in the living organism: his perception, learning, attitude, value, emotions, motives, and feelings of an individual; and the different individual's social interaction in his social environment.

Attitude is the central core of human actions, if misguided their attitudes such as nationalism, racism or religious fanaticism; and may ready to die for their convictions such as kill, persecuted, inflict suffering. In order to change a particular attitude, one needs to know which function it serves. Even a particular attitudes toward favour of restaurant for food tasty (utilitarian) or you want to cast the impression (social identity) of being one of the people who frequently restaurant (Shavitt, Swan, Lowrey, &Wanke, 1994). The international conflict reflects value differences as Gulf War is mutual miscalculations (Steward, 1991).

A person's attitude toward a particular attitude object may influence his behaviour toward the object. Attitudes do not only influence behaviour and other

attitudes, it also determines how to process information regarding the object (Pratkanis, 1989). Individual often searches for and selects information that confirms their beliefs and attitudes rather than information that may disconfirm them. Moreover, people tend to interprete information in the line of their attitude even if it is unavoidable information (Hastorf & Cantril, 1954). On all these reasons, the psychological importance in determining the root causes of insurgency in Mizoram was very apparent, and also it deserved in-depth study on the psychological effects it build-up among the people of Mizoram by protecting their personal space and territory to preserve their serenity.

Attitudes and Value are the result of early socialization like other behavior such as frustration (Kardiner, 1939) and impulse structure is the outcome of the patterns of child rearing practices. The interaction of individual and culture to which he belongs formed the individual's behaviour and cognition (Bandura, 1978, 1986) effectiveness, biology and the social environment (LaFromboise, Coleman and Gerton (1993). Being a social animal, a person' social and physical environment such as social interaction, social dependence, social influence, social cognition and interpersonal relation with other members who share the same environment and can affect his behaviour, as well as the physical environment where he can have maximum pleasure will determine his bahaviour, that will obviously lead to protect his personal space and territory to retain his contentment.

Personal space *(*Katz (1937) is a boundary regulation mechanism to achieve desired levels of personal and group privacy that regulates how individuals will interact with other member within or outside own culture. It is an evolutionary process to control interspecies aggression to protect against threats to autonomy and thereby to reduce stress (Howard, 1973). Personal space has two primary purposes: (1) protective function and serves as a buffer against potential emotional and physical treats; (2) Communication channel which are employed in different distances with other person that depending upon the quality of relationship. Size of personal space is largely influenced by learning experiences, individual differences, gender, race, culture, and personality (Montagu, 1971). Hall (1966) proposes four zones of interpersonal distances for American people which are intimate distance, personal distance, social distance, and public distance. The optimal personal spaces depend on

situational condition (e.g. attraction) and individual differences (e.g personality). When optimal range of personal space is there, homeostasis is maintained, if not a variety of adverse response may occur but inappropriate distancing often has negative consequences.

Altman's (1975) privacy regulation model implies inadequate personal space will elicit boundary control mechanism, and inadequate personal space leads to an aversive feeling state and coping responses that attempts to reassert freedom; and may evoke fear, discomfort, and feeling of aggression or threat (Evans, et al 1972). Perceived inadequate personal space is due to a combination of objectives physical distance, situational and social conditions (Zakay, Hayduk, & Tsal, 1992) various types of coping are employed which may or may not success (Dabbs, 1971). Degree of friendship and similarity affect interpersonal positioning, and then types of interaction and size of personal space that anger leads to closer distance for retaliation or to farther distances for protection (O'Neal, et al, 1980). Several studies suggest that maintaining inappropriate interpersonal distance is associated with considerable stress, lowering attraction, negative inferences and compensatory behaviour (Dabbs, 1971) if they are not liked culture (person).

The effect of being invaded on flight behaviour was studied by Felippe and Sommer (1966) and found that invaded subject will employ coping behaviour of avoiding the situation (left the place) and more negative inferences (Smith, & Knowles, 1979). The invaded person will experience higher levels of physiological arousal than non invaded person (Evans & Howard, 1972), could lead to aggression (Ryden, Bossenmaier, & McLachlan, 1991), less helping behaviour (Smith and Knowles, 1979), more upsetting to be invaded by a male than female (Kmiecik, et al. 1979), degree of invader action affects the degree of negative inferences, no apparent or inappropriate reasoning of invasion increase negative inference (Smith and Knowles, 1979). Individual are willing to defend their territories from invasion by resorting to aggression as each individual have their own territory.

Territory behaviour is practiced by animal and human, but as it is visible, relatively stationary, visibly bounded and tend to be home centered, regulating who will interact (Sommer, 1969). Territoriality is asset of behaviours and cognitions a person or a group exhibits, based on perceived ownership of physical space (Altman

and Chemers, 1980) which important motives and needs for organism and includes occupying an area, establishing control over it, personalizing thoughts, beliefs, or feelings about it and in some cases defending it (Brown, 1987; Taylor, 1988). As the limited space of the Earth and natural resources were share by all creatures, the instinctive behaviour of human and animal mark off their turf to keep others out and respond with vocal warnings and bodily threat to invaders (Ardrey, 1966; Lorenz, 1965) that driven to defend their territorial claims, and conflicting over it. On the other hand, territoriality is learned behaviour originated from past experiences and also through cultural practices e.g. nomadic is relatively a territorial while others are highly territorial. Protecting territoriality (Carpenter, 1958) among the species is depend on nature of selected functions as mating, food gathering, protecting food supply, shelter, rearing young, social status and social roles, leading to feeling of distinctiveness, privacy, and sense of identity; but human territoriality is rooted in survival needs, and also associated with higher order need (e.g self image recognition; Gold, 1982) as it has higher order of cognition than animal. Human very rarely resort to aggression to defend their turf. They usually deal with territorial invasion with laws that defend territorial rights rather than brute force (Brown, 1987). Human territorial defend may be seen in the form of conflict between nations or the outsiders were greeted with aggression always. Different types of behaviour were often engage to communicate territorial claim if could not preserved dispute aggression is more common (Ley & Cybriwsky, 1974) and the invader of the territory are counteract with verbal adjustment response like warning to leave, threatening him as well as physical ones like putting up a fence “no trespassing”. The Mizo had a historic control over their Mizoram, and the insurgency may an action of prevention of their personal space or territory from invader or who annexed Mizoram to British Empire (British India); and that anger remains in the inner feeling and just finds a time to act out violently their heightened anxiety as they knowledge about modern civilization or strength of Indian government was far off from their ability of understanding. Anxiety is an emotional state in which people feel uneasy, apprehensive, or fearful when they are invaded or constraint in their environment. Sources of anxiety which were perceived as unpredictable and uncontrollable events heightened anxiety reduce toleration, which are usually counted as threatening or dangerous.

Effects of Insurgency:

Continuous or long-term exposure to the lethal combat environment in which the emergency "fight-flight" response is repeatedly invoked eventually results in performance decrements in virtually every combatant. Such repeated physiological arousal gradually has a conditioning effect on voluntary muscles (increased tension, tremors), involuntary or autonomic responses (tachycardia, increased blood pressure, increased perspiration and respiration), and cognitive responses (anxiety, fear). 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 one model of depression, the hormonal regulatory system of the hypothalamus has become disturbed from higher cognitive and limbic (emotional) inputs. The repeated physiological and cognitive arousal invoked by combat exposure would seem appropriate to such a model.

The present study aimed to find out the psychological outcome of insurgency in Mizoram, it was expected that those who participated in the insurgency movement are likely to have experienced higher psychological effects produced by the 20 years long combat or war so to say, such as, anxiety, depression and frustration as compared with the non participants.

Stress: The heterogeneous syndromes found in low intensity wars that have been labeled loneliness and frustration casualties ("nostalgic casualties") should be added acute stress disorders and chronic and delayed post-traumatic stress disorders (chronic and delayed PTSD). PTSD is usually and appropriately thought of in the context of acute overwhelming stress; however, the frequent morale problems of low-intensity, ambiguous wars may carry over into the postwar lives of the former combatants. The current discontents of these war veterans may find expression in the reappearance or new appearance of symptoms associated with combat: anxiety and fears, automatic hyperactivity, reliving of psychologically traumatic events, and a variety of other malaises. Such symptoms often follow service in wars of high intensity as well, particularly when the outcome was unsatisfactory or there is psychological or financial gain from such symptoms. This was seen, for example, in the large numbers of German veterans of World War I who developed chronic war neuroses (many of

whom would now be labeled chronic post-traumatic stress disorder) compared with the small numbers of such cases following World War II. In both cases Germany lost the war, but one difference was that after World War II veterans were not given pensions for neurotic (nonpsychotic or nonorganic) conditions due to the experience of German psychiatrists who knew of the World War I findings, and due to the general opprobrium earned by the military because of Nazi atrocities.

Stress is an unpleasant state of emotional and physiological arousal that people experience in situations that they perceive as dangerous or threatening to their well-being. A stressor is "any condition which an individual judges as requiring some accommodation or readjustment in ongoing lifestyle or behaviour" (Spradley & Phillips, 1972). Some people define stress as events or situations that cause them to feel tension, pressure, or negative emotions such as anxiety and anger. Others view stress as the response to these situations. This response includes physiological changes—such as increased heart rate and muscle tension—as well as emotional and behavioural changes. However, most psychologists regard stress as a process involving a person's interpretation and response to a threatening event.

Stress is a common experience. We may feel stress when we are very busy, have important deadlines to meet, or have too little time to finish all of our tasks. Often people experience stress because of problems at work or in social relationships, such as a poor evaluation by a supervisor or an argument with a friend. Some people may be particularly vulnerable to stress in situations involving the threat of failure or personal humiliation. Others have extreme fears associated with physical threats—such as snakes, illness, storms, or flying in an airplane—and become stressed when they encounter or think about these perceived threats. Major life events, such as the death of a loved one, can cause severe stress.

Stress can have both positive and negative effects. Stress is a normal, adaptive reaction to threat. It signals danger and prepares us to take defensive action. Fear can motivate us to manage or avoid situations that pose threats. Stress can also fuel creativity and motivate us to achieve. Although stress may hinder performance on difficult tasks, moderate stress seems to improve motivation and performance on less complex tasks. In personal relationships, stress often leads to less cooperation and more aggression.

If not managed appropriately, stress can lead to serious problems. Exposure to chronic stress can contribute to both physical illnesses, such as heart disease, and mental illnesses, such as anxiety disorders. The field of health psychology focuses in part on how stress affects bodily functioning and on how people can use stress management techniques to prevent or minimize disease.

Post-traumatic stress disorders (Anxiety disorder) evolved from the Freudian concept of "traumatic neurosis" and technically are part of the combat stress disorders spectrum, of the acute, chronic, or delayed type. The chronic and delayed forms of PTSD (Anxiety disorder) have assumed considerable importance as squealed of combat in Vietnam and in the 1982 Lebanon War. it is important to recognize that PTSD (Anxiety disorder) symptoms can follow any serious psychological trauma, such as exposure to combat, accidents, torture, disasters, criminal assault, and exposure to atrocities or to the squealed of such extraordinary events. POWs exposed to harsh treatment are particularly prone to develop PTSD (Anxiety disorder).

Stress symptoms in wounded and nonwounded soldiers at the 93rd evacuation hospital, Vietnam, January-June 1966 (Not listed in order of prevalence)

A. Stress Symptoms Seen in Wounded Soldiers

The disabling symptoms of wounded soldiers usually developed after hospitalization, or if present when hospitalized, the symptoms persisted or became more severe, requiring neuropsychiatric consultation.

1. Persistent anxiety dreams.

2. Pain in wounded extremity following complete healing.

3. Sensory defects in which the patient claimed hypoesthesia and weakness of an extremity but the neurological examination was negative.

B. Stress Symptoms Seen in Nonwounded Soldiers

1. Somnambulism.

2. Anxiety dreams with talking or shouting.

3. Syncope and vertigo.

4. Narcolepsy-like complaints.

5. Seizures—not proved to be grand mal or petit mal.

6. Musculoskeletal-type complaints, such as low back pain, where the orthopedic examination is negative.

7. Amnesia, especially following exposure to explosions (mortar, artillery, or mines) but having no concussion.

8. Blurred vision—when the ophthalmologist can find no visual defects.

9. Stuttering, especially following exposure to loud noises or automatic weapons fire.

10. Aphonias or other speech disturbances, such as whispering.

11. Persistent nausea or abdominal pain in which no gastrointestinal disease could be demonstrated by the internal medicine service.

12. Headaches, atypical but severe, persistent, and disabling, most often diagnosed as "tension headache."

13. Loss of hearing—in which ear, nose, and throat examination could find no hearing loss.

Stress casualties of low-intensity combat differ substantially from those of mid- to high-intensity combat, which present primarily with anxiety and conversion and dissociative symptoms. In contrast, low-intensity combat casualties tend to present with "nostalgic" symptoms such as alcohol and drug abuse, venereal diseases, and character and behavior problems of indiscipline.

Ranson(1949) has described a spectrum of symptomatology in combat ranging from "the normal battle reaction" to "the pathologic battle reaction." He observes that:

The normal battle reaction is made up of a variable set of symptoms that arise from (1) moderate to extreme physical fatigue; and (2) extreme, repeated, and

continued battle fear, with (a) marked psychosomatic symptoms resulting from this fear and (b) certain psychological symptoms resulting there from.

Ranson(1949) describes normal psychosomatic response patterns to combat stress to include muscular tension, “freezing” or temporary immobility, shaking and tremors, excessive perspiration, anorexia or nausea, occasionally vomiting, abdominal distress, mild diarrhea and urinary frequency including incontinence of feces or urine, tachycardia and palpitation, hyperventilation to the point of giddiness and syncope, weakness and lassitude, and aches and pains. He also described special psychological considerations in the normal battle reaction including combat sensitization with anticipatory anxiety, sensitization to combat noises, insomnia, diminished drive and initiative, irritability and increasing fear, including fear of showing fear.

By observing how individuals and groups respond to sudden, unexpected trauma outside of war, as well as by noting which interventions are helpful to recovery and which are not, we may be better prepared to reduce and prevent combat stress reactions, war-related post-traumatic stress disorders, and other psychiatric problems associated with exposure to combat.

Commitment may be viewed as the extent to which a person has stakes in a given situation. A worker is more likely to appraise a situation as harmful, threatening, or challenging when the situation involves something that is personally significant. Workers who have put little time, effort, or emotional energy into their work would be less likely to appraise work-related events as stressful and less likely to burn out. Sobel (1949) describes the case of a 29-year-old first sergeant of excellent capabilities who was evacuated for exhaustion:

Subsequently it was discovered that he had carelessly left his company records strewn about a command post and that they had been picked up by a British patrol. This sergeant had been extremely careful with secret information and papers. Despite the diminution in efficiency, as shown by this case, there was no loss of motivation, and these men continued, sometimes desperately, in a job they had become incapable of handling. This led to severe conflict and guilt feelings with the result that their anxiety increased progressively to the point where evacuation became imperative. Guilt over letting their buddies down was a constant feature and was directly

proportionate to the state of morale in the unit, as is the incidence of the entire syndrome.

Despite claims that the most committed workers are at greatest risk for burnout, the dominant view of commitment as a risk factor for burnout is incomplete. In fact, commitment can help mitigate burnout. Research suggests that commitment enhances the ability to cope with a stressful work environment and moderates the adverse effects of occupational stress on job performance. Commitment to army values may protect personnel of all ranks from the development of burnout. Taken together, the results suggest that there may be some optimal level of commitment, and deviations in either direction from the optimum increase an individual's susceptibility to burnout.

During World War I, stress casualties presented with hysterical syndromes, psychomotor disturbances, and fear, as well as depressed affect. The high-intensity combat of the 1973 Yom Kippur War produced similar casualties, and the roughly 2-week period of intense warfare during the 1982 Lebanon War also produced these casualties. Except for that 2-week period, which produced most of the "traditional" (anxiety and fear) stress casualties, engagements in Lebanon were more of a low-intensity, insurgency nature with snipers and booby traps accounting for many casualties. In this situation the development of symptom overlap between Vietnam, overall a classic low-intensity conflict, and the 1982 Lebanon War (ie, social estrangement) is seen. In a review of follow-up studies, Belenky (1986) has detected another similarity between Israeli casualties from the 1982 Lebanon War and U.S. casualties from the Vietnam conflict, namely, the development of delayed stress casualties, which are reported as high in both groups of veterans. These low-intensity warfare casualties, who present with problems that suggest a depressive core and depressive symptoms, were the primary presentation of nostalgia in preceding centuries. Unchecked, these casualties can significantly degrade the combat efficiency of a unit as was seen in the latter phases of the Vietnam conflict.

When distress (detrimental stress) develops and continues over a prolonged period, psycho-physiological disorders – previously called psycho somatic disorders – may develop. Indeed the prolonged or intense stress may damage bodily organs. It is argued that when the individual's response to stress is abnormally intense and

prolonged; the damage to organ systems can contribute to the disease process. “Thus the psychosomatic symptom emerges as a physiological concomitant of an emotional state. Psychosomatic disorders may affect almost any part of the body, though they are usually found in systems not under voluntary control ... but it is generally believed that the form a disorder takes is due to individual vulnerabilities.” Encyclopedia Britannica continues that certain forms of hypertension, respiratory ailment s, migraine, Dermatitis and ulcers may occur. Baum et al. observe that illnesses ranging from coronary heart disease to gastro-intestinal disorders and even cancer may develop in such cases.

Hans Selye (1946) claimed that stress could be caused by a vast number of factors, which he named stressors. He furthermore established that stress was related to the increased secretion of hormones by certain glands thereby causing physiological, psychological and behavioural responses. He identified three stages in the process of prolonged stress, which he called the general adaption syndrome theory or GAS theory.

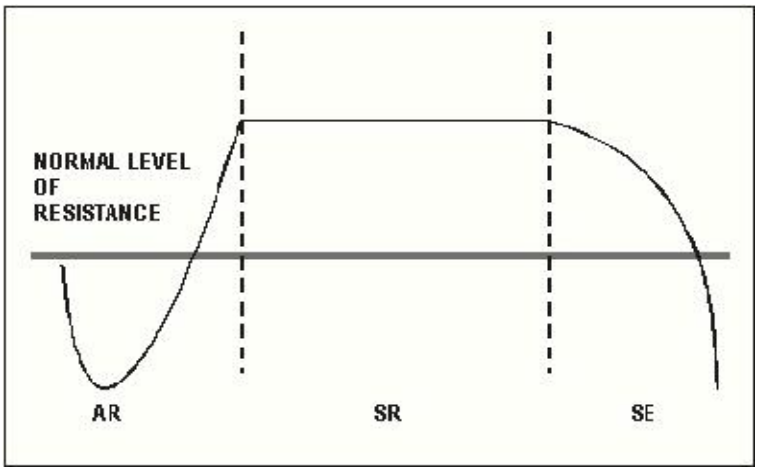


Figure -2: Selye’s GAS theory.(Source: H. Selye, The stress of life, p. 87.)

Figure 2 illustrates the three stages. The first stage Selye called the stage of “alarm reaction” (AR), when the first experience of stress is encountered. Although the normal level of resistance will initially tend to drop when the individual takes fright, he so on recovers and the level of resistance then increases to above the normal. The so-called fight or flight principle then becomes applicable. This stage

may be of a limited duration depending on the type of stressor. As the individual continues to experience the stress he or she moves into a "stage of resistance" (SR), meaning that he is becoming adapted to the stressor. This stage will continue as long as the body can handle or cope with the situation or until the stressor disappears. Additional hormones, primarily the adrenalines and cortisones, are required throughout this period to maintain an adequate level of resistance, so that the prolonged stress can be managed. When the body's capacity of producing the increased levels of hormones eventually becomes exhausted a "stage of exhaustion" (SE) sets in and the level of resistance drops drastically.

According to Lazarus, as quoted in Baum et al. (1997), for an event or a situation to be classified as a stressor it must be appraised as either threatening, harmful or posing an excessive demand. Should the situation be perceived as benign it will not be classified as a stressor and therefore no further demand is made on the individual? Theoretically this is the primary appraisal which automatically takes place. The individual is really asking: "What is it going to cost me?" If the situation appears to be harmful or threatening, it is termed a stressful appraisal which will consequently involve a secondary appraisal or evaluation to determine its magnitude. The question asked is: "How am I going to handle this?" o r "Am I able to deal with this?" In other word s the primary appraisal deals with t he question whether the situation is perceived as a stressor or not, the secondary appraisal whether the individual will be able to cope with it. In practice primary and secondary appraisals of a stressor occur practically simultaneously and the two reciprocally influence one another. The appraisal could perhaps be the assessment of a loss already suffered, or it could signify a threat with possible future dangers; alternatively it might be a challenge which the individual feels he is able to cope with or overcome.

After the stressor has been appraised according to the above outline, the individual moves into coping (or managing) behaviour. The method of coping may vary. Firstly it could change the stressor it se lf, for example by simply closing a door if the stress is a draught in the neck. Secondly more information or clarification might be sought so as to decide on the best course of action. Thirdly it may simply be ignored as some problems tend to solve themselves. However, denial can also lead to

circumstances where the problem is increased. Lastly the decision may be to live with the situation or to try to deal with it – to accept the fact and cope with it accordingly.

Burnout is similar to chronic combat stress reaction in that it is a state of hypo arousal that occurs as a result of chronic exposure to stressors. The signs and symptoms of the two syndromes are similar.

Manifestations of chronic combat reaction include depression, paranoia, decreased tolerance for frustration, excessive complaining, and withdrawal from social interaction, sleep disturbances, weight loss, and abuse of alcohol and drugs. The differences between burnout and chronic combat stress reaction may be more quantitative than qualitative, the two conditions differing in intensity of the stressor (combat versus more mundane peacetime occupational stressors) and intensity of the response (Jones, 2000).

Anxiety: It is obvious those feelings of apprehention will set-in in the presence of intense feeling of stress. War has a heart pounding impact on the effect on everyone, especially to those who are experiencing it up-close. The effect is at most to those who are involved in the war, like those who fought in the war and their family and relatives. War and it related activity, as also in the case of Mizo insurgency which the present study centered on, causes separation of family members, death, injuries, sickness, fright, alarm, panic, worry and so on, that give rise to anxiousness and feeling of apprehension.

The physical symptoms of anxiety reflect a chronic "readiness" to deal with some future threat. These symptoms may include fidgeting, muscle tension, sleeping problems, and headaches. Higher levels of anxiety may produce such symptoms as rapid heartbeat, sweating, increased blood pressure, nausea, and dizziness. Anxiety is a state of fear and apprehension, which is doubtlessly common during war. In contrast anxiety disorders are manifestations of anxiety and distress in situations which would not contrast anxiety disorders are manifestations of anxiety and distress in situations which would not lead to anxiety symptoms at times when no immediate danger exists. Again symptoms may include a faster pulse, increased blood pressure, sweating, intestinal discomfort and muscular tension. Other likely signs are insomnia, forgetfulness, irritability and panic (Smith, 2008).

Weinstein and Drayer (1949) distinguished the anxiety states of combat from those of civilian life by the following characteristics of combat anxiety: (a) the extraordinary precipitating factors in the perils and hardships of the combat environment, (b) symptom plasticity, (c) the importance of hostility and guilt, which is more immediately apparent than in most neuroses in civilians, and (d) the fact that they are in large part group phenomena. The soldier is a member of a closely knit, interdependent group, and group effectiveness and attitudes as well as ability to identify with the group modify significantly the soldier's capacity to withstand the traumas to which he is subjected.

Anxiety is a psychological and physiological state characterized by somatic, emotional, cognitive, and behavioural components. There are three reasons for the motivation of fear and anxiety from the cognitive perspective; loss of control, inability to make a coping response, and state anxiety versus trait anxiety. Loss of control refers to a situation when there are unpredictable or uncontrollable events in one's life which lead to anxiety and/or depression. As a result, feelings of helplessness develop. The unpredictability which may be associated with a task may cause anxiety (Seligman, 1975) The root meaning of the word anxiety is 'to vex or trouble'; in either the absence or presence of psychological stress, anxiety can create feelings of fear, worry, uneasiness and dread (Bouras and Holt, 2007) Anxiety is considered to be a normal reaction to a stressor. It may help a person to deal with a difficult situation by prompting one to cope with it. When anxiety becomes excessive, it may fall under the classification of an anxiety disorder. The intensity and reasoning behind anxiety determines whether it is considered a normal or abnormal reaction (Phil, 2009).

Anxiety is an emotional state in which people feel uneasy, apprehensive, or fearful. People usually experience anxiety about events they cannot control or predict, or about events that seem threatening or dangerous (Ohman, 2000). For example, students taking an important test may feel anxious because they cannot predict the test questions or feel certain of a good grade. People often use the words *fear* and *anxiety* to describe the same thing. Fear also describes a reaction to immediate danger characterized by a strong desire to escape the situation.

Bar-On and colleagues, as cited in Belenky (1986), have reviewed the predominant symptoms described in U.S. and Israeli casualties in World War I, World

War II, Vietnam, and the Arab-Israeli wars of 1973 and 1982. These symptoms were grouped by Jones. These listings are not actual and should be viewed as showing tendencies only. When the anxiety and fear categories are collapsed, these symptoms are found to predominate in all U.S. wars except the Vietnam conflict. Even 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 (1985) found that anxiety and fear symptoms predominated in combat soldiers in Vietnam.

The epidemiology of psychiatric casualties among troops in battle has been examined in numerous studies since World War I. Such studies tended to emphasize the psychiatric casualties that resulted from battlefield stress even though casualties resulting from less dramatic causes had been recognized since World War I. These less dramatic casualties presented with problems of alcohol and drug abuse, disciplinary infractions, venereal diseases, and "self-inflicted" medical disorders (for example, malaria from failure to use prophylaxis). Not until the Vietnam conflict were these casualties recognized as potentially serious causes of ineffectiveness. Although the casualties that occur during actual engagement with the enemy may present the traditional picture of battle fatigue (e.g., anxiety, fatigue, and conversion and dissociative syndromes), the majority of neuropsychiatric cases in low-intensity combat present a picture similar to those that occur among rear-echelon troops in wartime and among garrison troops during peacetime (venereal diseases, alcohol and drug abuse, and disciplinary problems, often related to personality disorders). It is not surprising then that various authors have called such casualties "guerrilla neurosis," "garrison casualties," "disorders of loneliness," and "nostalgic casualties." U.S. Army field manuals refer to them as "misconduct stress behaviors" (Jones, 1977).

One study showed that approximately five decades after the Korean War, surviving male Australian veterans are experiencing markedly worse psychological health, as indicated by excessive levels of anxiety, PTSD and depression, compared with a group of similarly aged Australian men who were residing in Australia at the

time of the Korean War**.** In the Korean conflict, three fairly distinct phases are reflected in the varying types of casualties reported. The mid- to high-intensity combat from June 1950 until November 1951 was reflected in traditional anxiety-fatigue casualties and in the highest rate of combat stress casualties of the war, 209/1,000/y in July 1950. Most of the troops were divisional, with only a small number being less exposed to combat. This was followed by a period of static warfare with maintenance of defensive lines until July 1953 when an armistice was signed. The gradual but progressive buildup of rear-area support troops was associated with increasing numbers of characterological problems. Norbury (1930) reported that during active combat period's anxiety and panic cases were seen, while during quiescent periods with less artillery fire the cases were predominantly characterological. Following the armistice, obviously, few acute combat stress casualties were seen. The major difference in overall casualties other than surgical before and after the armistice was a 50% increase in the rate of venereal disease among divisional troops.

Jones (1985) found that anxiety and fear symptoms predominated in combat soldiers in Vietnam. In contrast, combat-support soldiers were more likely to present with what Jones referred to as "disorders of loneliness," which may be the modern analog of the "nostalgia" of previous centuries.

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. In one model of depression, the hormonal regulatory system of the hypothalamus has become disturbed from higher cognitive and limbic (emotional) inputs. The repeated physiological and cognitive arousal invoked by combat exposure would seem appropriate to such a model.

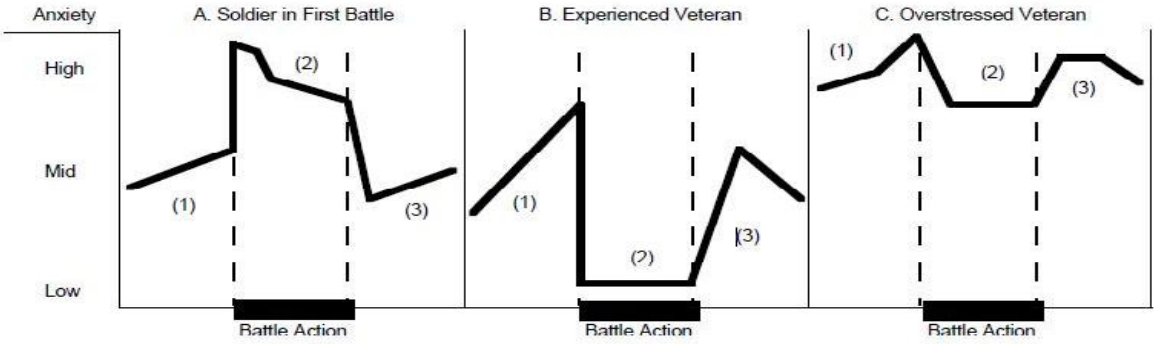


Figure- 1: Anxiety, fear, and arousal at different stages in combat tour. A soldier new to battle is more likely to break down than an experienced soldier; however, a soldier exposed to combat for a long period of time is also likely to be a stress casualty (Reprinted *from US Department of the Army. Leaders' Manual for Combat Stress Control. Washington DC: DA; 1994. Field Manual 22-51: 2-10).*

According to Selye (1946), initial exposure to a stressor is associated with increased resistance as the person tries to overcome the threat associated with the stressor. Prolonged exposure to the stressor eventually leads to the depletion of adaptive resources, to the breakdown of resistance, and finally to a state of exhaustion. The progressive erosion of coping resources is apparent in the following description of soldiers suffering from old sergeant syndrome:

With self-esteem as the mainstay of their personalities, they were able to resist the terrific onslaught of the combat environment. During their early combat careers they proved themselves able to "take it," but once a break in efficiency occurred, self-

confidence became progressively weakened. Yet responsibility was not slackened but often was increased. Forced to carry the same or a heavier load in the face of death and destruction, a cycle between increased responsibility and hesitancy to accept it was set up. This conflict was productive of a progressive and insidious type of anxiety.

Sobel (1949), described the loss of group cohesion in soldiers suffering from old sergeant syndrome. These soldiers had been either original members of their divisions or had been with their divisions for an extended period. These soldiers were survivors in that they were among the few remaining long-term members of their unit. They had close bonds with the few remaining unit old-timers and spent a great deal of time with them relating battle experiences. These discussions made them feel less vulnerable by reminding them that they had survived so many battles. However, as attrition of the long term unit veterans occurred, these soldiers failed to form strong bonds to new soldiers. This failure contributed to the erosion of self-confidence, to weakened defenses against anxiety, and to other manifestations of a severe battle reaction. Sobel noted that "loyalty to the group" was the final defense against anxiety that was weakened before breakdown.

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.

It is one type of anxiety but the symptoms are to the extent to beyond normal level. During and after war or combat PTSD (Anxiety disorder) is commonly suffered by both civilians and combatants alike. It can be said that they are closely related with each other. Therefore, it is required to highlight PTSD (Anxiety disorder) when discussing anxiety during war.

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 (Anxiety disorder) 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 (Anxiety disorder). 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 (Anxiety disorder), VA records show.

In an interesting sociological and psychodynamic analysis of 1,200 U.S. Marine Corps and U.S. Navy personnel serving in the Vietnam combat zone, Renner suggested that the true picture was not one of diminished psychiatric casualties but rather of hidden casualties manifested in various character and behavior disorders. These character and behavior disorders were “hidden” in the sense that they did not present with classical fatigue or anxiety symptoms but rather with substance abuse and disciplinary infractions. Renner (1873) developed evidence supporting an explanation of character and behavior disorders based on a general alienation of the soldier from the goals of the military unit. He contrasted support units with combat units, noting that the former faced less external danger, allowing greater expression of the basic alienation that he regarded as present among virtually all U.S. troops in Vietnam. He attributed this alienation to the lack of group cohesiveness largely resulting from the policy of rotating individuals and disillusionment with the war after 12 months. The result was that the prime motivate behaviors became personal survival, revenge for the deaths of friends, and enjoyment of unleashing aggression. These in turn produced not only disordered behavior reflected in increased character and behavior disorder rates but also feelings of guilt and depression. Alienation from the unit and the U.S. Army led to the formation of regressive alternative groups based on race, alcohol or drug consumption, delinquent and hedonistic behavior, and countercultural life styles.

Depression: For many years, those who joined the Mizo army were separated from their homes and families, not being able to see love ones was stressful enough, not only was that, they were on a constant move all the time as they were hunted by the Indian army and relentlessly battling with them, sometimes they went

on without proper food for days, which was very stressful for them and for some it further led to depression. Same stressful feelings happened with the family and friends of the Mizo army at home, not being able to see their love ones for a long time and not knowing they were death or alive might hugely contributed to the feeling of depression.

Depression is characterized by a dejected mood, a loss of motivation and a disinclination on the par t of the individual to become involved in the events around him. It can furthermore be experienced as tiredness, a feeling of worthlessness and hopelessness, a loss of concentration, appetite, or sexual desire, sleeping problems and a general tendency to withdraw from others. During a guerrilla war, combatants suffering from these adverse symptoms are naturally unable to function as they should and would probably be classified by Hans Binneveld as “psychologically wounded” (Binneveld, 1997).

Major depressive disorder (also known as clinical depression, major depression, unipolar depression, or unipolar disorder) is a mental disorder characterized by a pervasive low mood, low self-esteem, and loss of interest or pleasure in normally enjoyable activities. The term "major depressive disorder" was selected by the American Psychiatric Association for this symptom cluster under mood disorders in the 1980 version of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III) classification, and has become widely used since. The general term depression is often used to describe the disorder, but as it is also used to describe a depressed mood, more precise terminology is preferred in clinical and research use. Major depression is a disabling condition which adversely affects a person's family, work or school life, sleeping and eating habits, and general health. In the United States, approximately 3.4% of people with major depression commit suicide, and up to 60% of all people who commit suicide have depression or another mood disorder.

Major depression is a serious illness that affects a person's family, work or school life, sleeping and eating habits, and general health. Its impact on functioning and well-being has been equated to that of chronic medical conditions such as diabetes.

A person suffering a major depressive episode usually exhibits a very low mood pervading all aspects of life and an inability to experience pleasure in previously enjoyable activities. Depressed people may be preoccupied with, or ruminate over, thoughts and feelings of worthlessness, inappropriate guilt or regret, helplessness, hopelessness, and self hatred. Other symptoms include poor concentration and memory, withdrawal from social situations and activities, reduced sex drive, and thoughts of death or suicide. Insomnia is common: in the typical pattern, a person wakes very early and is unable to get back to sleep. Hypersomnia, or oversleeping, is less common. Appetite often decreases, with resulting weight loss, although increased appetite and weight gain occasionally occur. The person may report multiple physical symptoms such as fatigue, headaches, or digestive problems; physical complaints are the most common presenting problem in developing countries according to the World Health Organization's criteria of depression. Family and friends may notice that the person's behaviour is either agitated or lethargic. Older depressed persons may have cognitive symptoms of recent onset, such as forgetfulness, and a more noticeable slowing of movements. In severe cases, depressed people may have symptoms of psychosis such as delusions or, less commonly, hallucinations, usually of an unpleasant nature.

The following studies indicated how much depression engulfs soldiers during the past wars.

During World War I when the military population in France of U.S. soldiers averaged 200,000 persons, the incidence of hospitalized “psychopathic states” was 5 per 1,000, comparable with the overall rate for “character and behavior disorders” in overseas areas in World War II of about 4 per 1,000. However, because diagnostic practices in World War I and World War II differed markedly, true comparability may not exist. The difference in types of casualties in garrison settings was observed by Salmon and Fenton (1929) who commented that the cessation of hostilities did not reduce the need for psychiatric beds -

A number of more recent cases showed simple depression…An intense longing for home was characteristic of this condition. It resembled a set of reactions to which the term “nostalgia” used to be applied and is common in all military expeditions when a period of intense activity is succeeded by an uneventful one.

Severely disabled soldiers—those with amputations, severe thoracic or abdominal wounds, widespread burns, blindness, and brain or spinal cord injuries—generally cannot be returned to combat; thus early psychiatric treatment is often needed in long-term treatment centers to help the veteran adjust to the disability. A variety of psychological responses similar to those described by Kubler-Ross in the dying patient will be encountered: denial, anger, bargaining, depression, and acceptance.

The symptomatology associated with nostalgia was consistently compatible with modern descriptions of depression, with complaints, for example, of "moroseness, insomnia, anorexia, and asthenia" in a report by Sauvages (1768). Even this early there were observations that nostalgia might be feigned as a method of avoiding duty. A French physician, De Meyserey, who published a treatise on military medicine in 1754, observed that war and its dangers always produced a fruitful crop of malingerers who must be discriminated from soldiers with "true nostalgia."

Frustration: Frustration is an emotional response to circumstances where one is obstructed from arriving at a personal goal. The more important the goal, the greater is the frustration. It is comparable to anger and disappointment. Sources of frustration may be internal or external. Internal sources of frustration involve personal deficiencies such as a lack of confidence or fear of social situations that prevent one from reaching a goal. Conflict can also be an internal source of frustration when one has competing goals that interfere with one another. External causes of frustration involve conditions outside the person such as a blocked road; or conditions linked to the person's actions but not directly such as lack of money, or lack of sexual activity. In psychology, passive-aggressive behavior is a method of dealing with frustration. According to N.E. Miller (1941) "frustration produces instigation to a number of different types of response, one of which is instigation to some form of aggression."

To the individual experiencing frustration, the emotion may more times than not be attributed to external factors, which are beyond their control. Although mild frustration due to internal factors (e.g. laziness, lack of effoert) is often a positive force (inspiring motivation), it is more often than not a perceived uncontrolled problem that instigates more severe, and perhaps pathological, frustration. An

individual suffering from pathological frustration will often feel powerless to change the situation they are in, leading to frustration and, if left uncontrolled, further anger.

Frustration can be a result of blocking motivated behaviour. An individual may react in several different ways. He may repond with rational problem-solving methods to overcome the barrier. Failing in this, he may become frustrated and behave irrationally. An example of blockage of motivational energy would be the case of the worker who wants time off to go fishing but is denied permission by his supervisor. Anotherexample would be the executive who wants a promotion but finds he lacks certain qualifications. If, in these cases, an appeal to reason does not succeed in reducing the barrieer or in developing some reasonable alternative approach, the frustrated individual may resort to less adaptive methods of trying to reach hi goal. He may, for example, attack the barrier physically or verbally or both.

The word frustration is one of the many psychological concepts originating in everyday speech that is all too susceptible to radically different meanings. Even psychologists have used the term in many different ways, sometimes referring to an external instigating condition and sometimes to the organism's reaction to this event. Amsel's (1958) discussion of frustrate no reward used this latter usage, whereas Dollard and his colleagues were careful to speak of frustrations only in the former sense, as external occurrences. For them, a frustration was “an interference with the occurrence of an instigated goal-response at its proper time in the behavior sequence”

Dollard et al. (1939) identified several aspects of the thwarting that presumably affected the strength of the resulting instigation to aggression, giving special attention to (a) the strength of the drive whose gratification was blocked, (b) the degree of interference with this drive satisfaction, and (c) the number of frustrated response sequences. Taking these up in order, the analysis proposed that (a) the greater the satisfaction anticipated on attaining their objective, the more aggressively inclined people will become when kept from reaching their goal; (b) the strength of the resulting instigation to aggression will be reduced by whatever partial gratifications are obtained; and (c) the frustration-generated aggressive inclinations will summate over repeated instances of unsatisfied expectations. In regard to the latter proposition, the Yale group suggested that each thwarting might well leave some residual instigation to aggression, although they also recognized that the leftover

aggressive inclinations probably subside to some degree with the passage of time (Dollard et al., 1939, pp. 31–32). But when these residuals are present, they presumably become added together, so that prior frustrations can intensify the aggressive reaction evoked in the immediate situation. The blockage of a goal reaction generally will not induce interpersonal hostility or aggression unless when they were unexpected (Baron, 1977. The occurrence of aggressive behaviour always presupposes the existence of frustration and the existence of frustration always leads to some form of aggression (Dollard et al., 1939).

Freud (1933) has also suggested frustration- regression hypothesis that frustration could cause an individual to revert to modes of action that had characterized his behaviour to earlier developmental stage, display 'primitive' behaviour patterns (Barker, Dembo & Lewin,1941). A person may revert to an old, usually immature behaviour to ventilate feelings of frustration and causes problems in the individual's life. According to Dembo and Lewin (1956) the character of regressive behaviour is defective speech , homesickness, escapist attitude, lack of self control thinking , excessive day dreaming etc.

Maier (1956) makes it clear that frustration is a terminal responses and not a means to an end, and fixated behaviour deriving from frustration as being Stereotyped and extremely persistent. It is the state in which an individual becomes obsessed with an attachment to another person, being or object (in human psychology): 'A strong attachment to a person or thing, especially such an attachment formed in childhood or infancy and manifested in immature or neurotic behaviour that persists throughout life'.

Frustration has its own system. It has four modes of reactions to a situation - Aggression, Resignation, Fixation, and Regression. Aggression indicates frustration dynamics in hostile situation, resignations the extreme escapism from reality, regression is the condition to go back and fixation is the compulsive type of behaviour (Chauhan & Tiwari, 1972).

In Resignation behavioural, there is extreme elimination of needs, no plans, no future orientation, withdrawal from social contacts, isolation, lack of interest in

surroundings etc. Persons who are severely frustrated in a given situation may try to escape or withdraw from that situation, resigned to the fact that their conditions are more likely to worsen than to improve as one suspects that they are fallen prey to other of the powerful nationalist elites. Resignation may also refer to: state of uncomplaining, utter frustration.

Aggression as a behavioural phenomenon indicates that Aggression Behaviour may stem from learned habits of responding as well as from excessive (Bandura 1965). It may be expressed in terms of irritation; quarrelling and fighting, disrespect to elder's negative reaction to traditional and believes etc. Berkowitz (1965a) proposed: (a) that frustration induces an emotional reaction – anger – that "creates only a readiness for aggressive acts"; and (b) that "aggressive responses will not occur, even given this readiness, unless there are suitable cues, stimuli associated with the present or previous anger instigators. Objects having some connection with aggression generally may also have this cue property". Furthermore, Berkowitz sought to restrict the universal claim that all aggression presupposes frustration by suggesting that in the absence of frustration, exposure to suitable cues can lead to the formation and evocation of aggressive habits.

The most basic precondition for insurgency is frustration and the belief that this cannot be ameliorated through the existing political system. This may be widespread among a population or limited to radical elite which then has to convince the more passive population of the need for violent change. A conspiratorial history and culture are also important. In such societies, insurgents can utilize or take over existing patterns of underground activity, webs of secret societies, or widespread criminal activity. A society already accustomed to conspiratorial activity is a naturally fertile ground for insurgency.

There are several studies in the literature offering evidence that high levels of aggressive drive can be anxiety arousing (Schachter (1957) found a trend in his data indicating that the subjects rated as being moderately angry after frustration manifested a nor-epinephrine-like physiological response, whereas the subjects rated as being either mildly or intensely angry, showed an anxiety type of physiological reaction (epinephrine-like). Along similar lines, Hokanson (1961) demonstrated that the subjects who admit to strong feelings of anger on personality tests manifest more

of an anxiety type of physiological response following frustration than do the subjects who get low aggression scores on the tests. The study provides further evidence in support of the contention that anxiety results in reduced manifestations of overt hostility. There is ample evidence suggesting that increase in systolic blood pressure is a reflection of anxiety (Schachter, 1957); thus the significant negative correlation between systolic increases during frustration and subsequent pressure exerted per shock in the high anxiety condition indicates that the greater the physiological manifestations of anxiety during an instigation to aggression, the less the vigor of post-frustration hostile acts. Another line of indirect evidence pertaining to the reduction in aggressive tendencies, presumably because of the arousal of anxiety, comes from the significant negative correlation between pressure exerted per shock and ratings of anger felt during frustration. It will be recalled that this anger rating was obtained after that subject had an opportunity to administer shocks to the experimenter. The negative relationship thus indicates that the greater the vigour of the subject's response while he was aggressing against the frustrator, the less his subsequent rating of how angry he was during frustration, as if the previous anger were now being denied. This finding conforms to Berkowitz' (1958) contention that high intensity of aggressive behaviour may provoke guilt and/or aggression-anxiety which in turn tends to reduce subsequent manifestations of aggression. Of added interest are the correlations between pressure per shock and systolic changes occurring during and after the expression of aggression towards the experimenter. The pattern of changes indicates that the vigour of response is positively correlated with increase in systolic blood pressure during the actual expression of aggression, but negatively correlated with elevation of blood pressure when the aggressive behavior is completed. These findings suggest that while overt aggression may momentarily increase certain physiological activities, it is also associated with a later reduction in those activity levels. Worchel (1957) suggested a similar cathartic-like reduction in "tension" following the expression of aggression in his study of frustration produced interferences with intellectual performance. The present findings are only suggestive, however, owing to the possible operation of sequence effects and homeostatic controls on the course of blood pressure during the latter part of the experiment. The overall results of this study suggest that both number of aggressive acts and the vigor with which aggressive behavior is carried out may be reliable indicators of hostile motivation.

While neither measure provided entirely consistent data, their potential usefulness in studying the relationship between physiological and behavior processes in the area of aggression is indicated.

Frustration is one among many dynamic factors that influence behavior, and in the flow of life it rarely if ever exists without the blending of other factors. Although the authors of Frustration and Aggression have recognized that "a number of antecedent conditions must sometimes all be present before any instigation occurs", they have not adequately, recognized other complicating factors, and have too largely ignored the correlative complexity of expression of aggression. No aggressive act is the simple atomistic expression of feeling toward another as the catharsis view assumes. Therefore it is not true that the expression of hate or antagonism necessarily releases and dissipates that feeling.

As Dollard pointed out in Social Forces, our hurting others may make us fear them, and therefore cause us to be stirred up further. Perhaps people realize that whatsoever they sow, that shall they also reap. Hate still leads to hate. It is probably not true as Gardner Murphy has claimed that "Most people forget that the gun kicks when fired . . .” The fact is that most people do realize that the gun does kick when fired and that is the reason that the expression of hate makes one hate more. The tension of our feelings may also not be released because we may have a sense of guilt or shame from hurting others. Apparently, in an attempt to be scientifically universal, the aggression hypothesis of the Yale group has been formulated in such an abstract form that it has been stripped of the human variability necessary for it to be psychologically valid. Neither frustration nor aggression is a simple entity to which a specific remedy such as catharsis is applicable in all cases. The theory of catharsis has about as much validity for behavior as castor oil has as a medicine. Because castor oil may be useful for treating certain cases of constipation, we would not be warranted in using it to cure flat feet. Frustration often results in aggression, but frustration does not necessarily cause aggression. Moreover, aggression can occur in the absence of frustration. This conclusion is in agreement with Sargent's view that "Certain kinds of behavior which are definitely aggressive seem to be the socially sanctioned ways of behaving in some communities (e.g., a tough city slum area or a primitive culture).

Such behavior may well be learned and practiced without having its origin, necessarily, in frustration"

The concept that unacceptable aggressive or hostile impulses that may be "displaced" to targets more suitable than the original one has been with us in psychology at least since the writings of Sigmund Freud. However, it is primarily as a result of the explicit formulation of frustration-aggression theory that concerted experimental test of this proposition has been attempted in diverse areas. One specific formulation derived from these conceptualizations is that increasing personal frustration may have, as one consequence, an increase in expression of prejudice. Such a theoretical notion has been referred to as a "scapegoat" theory of prejudice.

There is notable finding in an experiment done by Cowen, Landes and Schaet (1959) that there is the significant increase in anti-Negro feelings following experimental induction of frustration. Such a datum offers additional support for the existence of the scapegoat phenomenon and is quite consistent with earlier findings of Miller and Bugelski (1993). Of incidental interest is the consistent trend observed on three of the subscales for male subjects to show greater prejudice (as well as greater increase in prejudice following frustration on the Anti-Negro scale) than do females. This finding too is in line with empirical evidence and theoretical expectations discussed elsewhere.

According to one view (Geen, 1975), frustration results in aggression when it increases arousal in the presence of cues associated with aggression. Recent reports indicate that the extent to which frustrating events are perceived as aversive and thereby increase arousal is a function of the extent to which such events are perceived as controllable (Glass, et al, 1973). Perception of controllability is related to the characteristics of the particular situation in which frustration occurs. Such perception, however, may have personality as well as situational determinants. Specifically, one's locus of control (Phares, 1976), that is, trans-situational beliefs about one's ability to exercise control over outcomes, may influence the extent to which frustration results in aggression. Those who generally do not believe they can control outcomes (external locus of control) are expected to exhibit greater aggression in response to frustration than those who generally believe they can control outcomes (internal locus of control). Kiran Bhalia and Sanford Golin, University of Pittsburgh experiment

tested this hypothesis. Their experiment was concerned with the cognitive control of frustration-produced aggression. Their finding results showed that generalized expectancies about one's ability to control outcomes can influence aggression in response to frustration in a manner similar to that previously reported for situational induced expectancies about controllability (Donnerstein & Wilson, 1976): The less the believed control, the greater the aggression.

In their now classic monograph, Frustration and Aggression, Dollard, Doob, Miller, Mowrcr, and Sears (1939) hypothesized that the total strength of the "instigation to aggression" within an individual is a positive function of three aspects of the frustrations he had suffered: "1) the strength of the instigation to the frustrated response, 2) the degree of interference with the frustrated response, and 3) the number of frustrated response-sequences". The finding made by Leonard Berkowitz is consistent with the frustration-aggression hypotheses advanced by Dollard, Doob, et al. (1939). The 'Repeated frustration and expectations in hostility arousal' paper by Leonard Berkowitz suggested that unexpected frustrations produce a stronger aggressive reaction than anticipated frustrations because, as a result of the hypothesized contrast effect, the former probably are evaluated as being more severe.

Dollard et Al (1939), argued that *'the occurrence of aggression presupposes frustration [...] Frustration produces instigations to a number of different types of responses, one of which is an instigation to some form of aggression'*.

There was some evidence supporting this hypothesis. Doob and Sears (1939) reported that when participants were asked to imagine frustrating and non-frustrating situations, they generally felt angry in the frustrating situations.

This hypotheses was attacked because it failed to account for justified and unjustified frustration. When Doob and Sear's experiments were redone with justified frustration, then anger decreased significantly.

Other critics pointed to environmental cues to aggression, such as Berkowitz's aggression effect. When participants were electrocuting each other, the presence of a weapon, a symbol associated with aggression and violence, the levels of electrocution increased.

Given these criticisms, Berkowitz reformulated the theory. Berkowitz's "*behaviorist/neo-associationist*" position argues that aggression is a more general example of the relationship between unpleasant stimuli and negative affect. Negative affect is simply unpleasant emotions and feelings, such as anxiety, anger, annoyance, or pain. This negative affect can trigger either "fight or flight", as well as a set of associated thoughts and reactions related to such experiences. Whether fight or flight occurs depends on a number of factors. These can include:

- How the individual examines and controls their feelings
- How the individual analyses the situation

In some instances, this process of deliberation may be rather short or may be avoided altogether. There is a variety of evidence that supports Berkowizt's theory. People have often been seen to attack a target even if they know that attacking a target can not remove the negative affect - for example, when a motorist attacks his/her car out of frustration.

Soldiers less exposed to combat and presenting with personality problems may be called loneliness and frustration casualties. Huffman 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.

Burnout is similar to chronic combat stress reaction in that it is a state of hypo-arousal that occurs as a result of chronic exposure to stressors. The signs and symptoms of the two syndromes are similar. Manifestations of chronic combat reaction include depression, paranoia, decreased tolerance for frustration, excessive complaining, and withdrawal from social interaction, sleep disturbances, weight loss, and abuse of alcohol and drugs. The differences between burnout and chronic combat stress reaction may be more quantitative than qualitative, the two conditions differing in intensity of the stressor (combat versus more mundane peacetime occupational stressors) and intensity of the response.

Empirical study of college student's hypothetical responses to aggression from another nation state examined personality styles in addition to experimental condition -Persons higher in dominance almost always advocated for more aggressive retaliation than those who were more submissive. A similar but less robust or reliable trend was found for greater aggression in more conservative students than those that were more liberal -Anticipated reactions were similar for military and terrorist attacks. -Men and women showed similar levels of conflict in their reactions, unless a peace treaty was in place, in which women were more forgiving and men more aggressive.

Jager (1981), however, found no common pattern in attitudes toward violence, neither ambivalence nor attraction, among the West German terrorists. Some individuals reported a strong prior aversion to aggression.

In the case of the Mizo insurgency, the Mizo army after years of combat with the Indian army did not meet any of their demand and they did not win any of what they were fighting for. It was believed that the Mizo armies were very much frustrated and their frustration further let to aggression which means more violence.

Some psychologists see aggression mainly as the result of the frustration and anger produced in the individual as his desires are thwarted, at first by parents, and later, by others who have more power, by society's customs and laws, and by biological limits.

Many psychologists see aggression as the result of our id's drive for pleasure (the primal motivation). In cases, the ego may realize that it can let the id run free (a powerful nation may, for example, overpower a weaker one). If the ego sees no strategic reason to restrain the id, and if the superego is able to be convinced to step aside (excluding the intended victim from its moral protection, perhaps by accepting a propagandistic, demonized portrait of the enemy), then aggression may be unleashed. Just the same as a child who wants a shiny toy may push away a weaker child who is already playing with that toy, one nation or group of people, may fall upon another.

On the other hand, if the id, with its primal desires, is too tightly repressed by the ego, or superego, in response to external conditions or moral indoctrination, it may seethe within the human psyche, until, unable to bear the pressure of denial any longer, it explodes outwards in rebellion, overpowering the ego's attempts to restrain

it, and launching the individual or nation into irrational and counterproductive forms of aggression, in its desperate effort to attain what is beyond its reach, yet too ardently desired to accept living without. In the process, rationality is lost, or relegated to second place. Unable to stop the madness, reason then attempts to wrap the madness up within a new sense of order and logic, giving an apparently rational form and aim to something that is utterly unreasonable.

Another psychological theory for explaining the manifestation of human aggression that aggression links to the preservation of individual self-esteem. Whereas many scholars and scientists understand the link between aggression and the instinct for physical self-preservation, this theory maintains that it is the individual's quest to love himself - which is a crucial motivational component of his ability to preserve his life - that is the source of much of our aggression. These psychologists believe that when our self-love is threatened, aggressive instincts are awakened within us, as a tool for the defence of the self. The attacks which trigger the rise of this aggression in us could be in the form of criticism, humiliation, indifference, deprivation, abandonment, or betrayal: anything that makes us feel less worthwhile, less valuable, and on some level, less deserving of life. Furthermore, the attacks do not have merely to be against us. These theorists maintain that during the course of our lives, we transfer much of our self-love to others - a form of bonding that also enlarges our identity, fusing us emotionally with others. Thus, we may come to love our family, and our country, as other aspects of our new, enlarged selves. Naturally, if these are threatened or criticized, our aggressive instincts may be unleashed, just as surely as if we, ourselves, were under attack. According to these theorists, although the drive to love the self exists to motivate the drive to preserve the self, the drive to preserve one's self-love is actually stronger than the drive to preserve one's life. Frequently, psychologists have found, aggression may be "displaced", directed not against what has truly provoked it, but against a substitute target. Thus, the man mistreated at work, may vent his anger, not against his boss, but against his wife, his kids, his dog. In the same way, a people essentially enraged by the dynamics of its own society, may have its aggression channelled against another society that has nothing to do with its own dilemma. In fact, this is a way that clever leaders, sitting on top of unjust systems which abuse their own people, have often diverted the

aggression that could have produced rebellions against *them*, against innocent peoples and nations, instead.

According to Sociobiology theory, genetic dynamics, applicable to human beings as well as animals, have rooted aggressiveness deeply into our biological nature. Yet the sociobiologists insist that this aggressiveness is not all-powerful, but only one component of our human nature, a resource that is triggered in certain situations, and one which can, at least, be partially offset by other innate "biological" components of our mind, including our capacity to reason (which also has great "survival value").

In the case of human beings, the sociobiological dynamics which are said to have shaped us are deemed to be even more complex. Being "social animals", our biological resource of aggressiveness inherited from more primitive life forms on the evolutionary ladder, has become adapted to group life. Since the ability of humans to cooperate in social groups was crucial to the survival of our species, the same as with the wolf pack or baboon tribe, we developed ways of managing the manifestations of aggressiveness within the social group, so that it could continue to function coherently and effectively, providing us with its benefits. Rather than fighting against one another for the resources needed to sustain life, members of the group cooperated to procure resources for the entire group, which, therefore, became the unit of survival (this is a development which we are said to have inherited from certain forms of apes, which also lived in social groups). In cases, the "ranges" of particular human groups developed into "territories" (which some forms of "solitary" animals also claim). These "territories" might then be defended against other human groups, in order to guard the resource base of the group.

Certain behavioural propensities, including the capacity for aggression, are common to virtually all humans. This does not mean that they are genetically determined. "Human nature" is a consequence of common genetic factors and of ubiquitous factors in the environment. The combination of genetic endowment and environmental encountered in development that may leads presence of aggression in every individual. But that does not mean that aggressive behaviour stems from an innate "drive" that must be discharged in some way; there is neither psychological (Berkowitz, 1993) nor cross-cultural evidence for such a view. Humans have the

capacity to be aggressive and altruistic, cooperative and cantankerous; the behaviour shown depends on a host of developmental, experiential, social, and circumstantial factors.

Within that framework, aggressive acts are seldom due solely to aggressive motivation; other motivations are usually present. For instance, the behaviour may involve an attempt to acquire an object or situation, which for present purposes we may call acquisitiveness. There may also be a tendency to show off — assertiveness. Furthermore, aggression usually involves risk of injury for the attacker, so that it is combined with self-protective or withdrawal responses. Thus, whether or not aggression actually occurs will depend not only on the individual's aggressiveness, but also on motivations of other types.

Individual aggression is often categorized into a number of types. For instance, one system distinguishes "instrumental aggression," deliberate and concerned primarily with obtaining an object or position or access to a desirable activity; "emotional aggression," hot-headed and angry; "felonious aggression," occurring in the course of a crime: and "dissocial aggression," regarded as appropriate by the reference group or gang, but not so regarded by outsiders (e.g., Tinklenberg & Ochberg, 1981). Such categories, though useful for some purposes, usually turn out to be less clear-cut than they might appear for an obvious reason: a variety of motivations may contribute to a single act, and they may be present in various strengths and combinations. The very fact that such categorization systems can be only partially satisfactory is in itself an indication of the motivational complexity of even apparently simple aggressive acts.

It is convenient to divide the factors contributing to an aggressive act into three categories, with dialectical relations between the levels of social complexity operating in each case. These three categories follow:

Ontogenetic factors. The tendency of an individual to behave aggressively depends in part on genetic factors and in part on experience. Physical aggressiveness tends to be greater in boys than in girls, to increase with age up to adolescence or early adulthood, and then to decline. In our own culture, attention has focused on the roles of classical conditioning, operant conditioning, and observational learning, and

on relationships within the family. These affect both motivational propensities and the acquisition of cognitive capacities, the latter including abilities for conflict resolution. Relationships with individuals outside the family may also be important, including especially those who serve as role models and the peer group with its norms. The behavior of the socializing agent, whether intra- or extra-familial, will be influenced by the norms and values of the group and the society to which the agent belongs, and these norms and values may differ with the nature of the targeted individual. Thus parents may apply different norms for boys and girls, or for firstborns and later looms. Furthermore, the norms and values operating will be influenced by, and will influence, the mass media and other channels of social influence. Thus, the aggressive propensities of individuals can be understood only through the dialectical relations between individuals, their relationships and group membership, and the socio-cultural structure or structures operating.

Predisposing factors. Across societies, violence is more frequent in those that tolerate or extol violent acts by individual or state, do not distribute income or wealth equitably, and lack social and political institutions linking their members in networks of communal obligation (Gartner, 1996). However, the issues here are complex. While political violence may provide a context for increase in criminal violence (e.g. Liddell, Kemp & Moema, 1991; Straker et al., 1996), homicide rates tend to decrease in countries actually at war, probably because of the increased integration (Lester, 1992). After the war, however, homicide rates tend to increase. In addition, the propensity of an individual at any particular time may be influenced also by a variety of contextual factors, including the current social situation and its attendant norms, and the presence and density of other individuals.

Eliciting factors. Whether an aggressive act is actually elicited depends on further factors, including the individual's current motivational state; frustration of current goals; pain, fear, and other aversive factors; and arousal, the nature of the opponent or victim, and the availability of weapons. It depends also on a variety of inhibitory factors, such as fear of punishment and the possibility of alternative courses of action (Goldstein, 1986).

The extreme of the continuum from individual aggression to international war can be distinguished by three criteria:

First, international war involves conflict between societies, each of which is itself complex and consists of many overlapping groups. Any negotiations between potential combatants take place not between unified nation states but between large bureaucracies representing diverse interests (Druckman & Hopmann. 1989). Indeed maintaining the integration of the groups within each side of the conflict may be a major preoccupation for leaders.

Second, the role of leaders is paramount, both political leaders and military leaders at every level.

Third, and most importantly, international war is best seen as an institution. The concept of institution perhaps needs some elaboration here. In our society, marriage is an institution, with husband and wife as constituent roles. Each role has certain rights and duties associated with it. Parliament is an institution; with a large number of constituent roles — prime minister, ministers, members of Parliament, members of the voting public, and so on. Again, the incumbents of each role have certain duties that they are expected to perform, and certain rights consequent upon their roles. In the same way, war must be seen as an institution with a large number of constituent roles, those of politicians, generals, officers, soldiers, munitions workers, transport workers, air raid wardens, doctors, nurses, and many others. Indeed, virtually every member of the civilian population may come to have a role in total war. Each role is associated with its particular rights and duties, and it is the individuals' duties in the roles that they occupy in the institution of war that primarily motivates their behavior. Satisfaction in duty well done contributes to self-esteem.

The motivations that are responsible for individual aggression play little part in total war. Hope of material gain is unimportant, at any rate amongst the combatants. Hope of increasing the status that the institution of war can confer with promotion or decoration may play a minor role. Fear is certainly an issue, and can contribute to defensive aggression, though the excessive arousal associated with fear reduces military efficiency (Marshall, 1947). The issues involved in the formation and dynamics of groups, discussed in the last section, are of course relevant at every level in the complex organization of societies at war. Loyalty to and a tendency to cooperate with comrades may be a major issue, though this is to be seen as part of the combatant's duty. But aggressive motivation is seldom an important issue in

international war, and when it is, as at My Lai, it is often not condoned. It is most likely to be important in short-term interactions, especially in religious and ethnic wars, but the primary motivation stems from duty associated with the role occupied in the institution of war. International war may cause aggression, but aggressiveness does not cause war.

There are people in every society--usually young males--with a propensity for aggression and violence. Insurgency attracts them since it is more prestigious and legitimate than crime, and has a better chance of gaining internal or external support. It offers them a chance to justify imposing their will on others. This is amplified when a nation has a long history of violence or major military demobilization which increases the number of thugs and puts many of them out of work. In many parts of the world, whole generations have never known a time without brutality and bloodshed. Sierra Leone is a perfect example of this.

Wiener and his colleague, (2001), used the "non-moral" framework of evolutionary psychology to explain the occurrence (and non-occurrence) of "coalitional aggression," a term they use to refer to war and other forms of collective aggression.

Stated simply, the male age composition hypothesis claims that "countries with relatively large numbers of young males are more likely to experience episodes of coalitional aggression."

Pointing to war's long history, Christian Mesquida and Neil Wiener (2001) called war a "natural phenomenon, in accord with human nature and part of human nature." He explained that human (especially young male) tendencies to engage in coalitional aggression must be an advantageous trait; if it were not, natural selection would have ensured the trait's extinction by now. Instead, Christian Mesquida and Neil Wiener (2001) suggested that coalitional aggression appears to have evolved over the years, with human physiology and chemistry adapting to maximize capabilities for war. In particular, "sexual selection" accounts for coalitional aggression: young men use the resources available to them to attract a mate and reproduce. Males with a high social status (as judged by their culture) are preferred as mates, and in many cultures men can raise their status through war. In poor countries,

aggression may be the only resource young men possess to gain a spouse. “Advantaged females” mate with “advantaged males,” and consequently the genetic, cognitive, and emotional make-up that supports coalitional aggression is passed on to the next generation. Although war is dangerous, “failure to take risky behaviour leads to a worse consequence—failure to reproduce,” Wiener (2001) explained.

A distinct branch of the psychological theories of war are the arguments based on evolutionary psychology. This school tends to see war as an extension of animal behaviour, such as territoriality and competition. However, while war has a natural cause, the development of technology has accelerated human destructiveness to a level that is irrational and damaging to the species. The earliest advocate of this theory was Konrad Lorenz (1996).

These theories have been criticized by scholars such as John G. Kennedy, who argue that the organized, sustained war of humans differs more than just technologically from the territorial fights between animals. Ashley Montagu strongly denies such universalistic instinctual arguments, pointing out that social factors and childhood socialization are important in determining the nature and presence of warfare. Thus while human aggression may be a universal occurrence, warfare is not and would appear to have been a historical invention, associated with certain types of human societies (Montague, 1979).

Repression by foreign occupation or by colonial powers has given rise to a great many national liberation movements that have sought recourse in terrorist tactics, guerrilla warfare, and other political means. Despite their use of terrorist methods, some liberation movements enjoy considerable support and legitimacy among their own constituencies, and sometimes also from segments of international public opinion.

Terrorism can increase communal identity even when few members of a community consciously support political violence. Ethnic terrorists have an advantage over other terrorists: their agenda usually has some resonance with a preexisting, well defined group of people. Thus, their own acts are often considered retaliation or rebellion against repression rather than acts of random violence.

When repression comes from a rival population, ethnic identity is particularly likely to become defined in opposition to both the state and rival communities. This change can lead to a stronger, more distinct identity among nonmilitant as well as greater support for an insurgency or terrorist group.

There are important controversies over dynamics of terrorism which have not yet been formally addressed in quantitative social research. We suggest a class of stochastic models for social contagion which may help to shed light on theses controversies. Empirical estimates of model parameters were obtained from data on international terrorism in 16 countries over 1968-1978. We find some evidence suggesting that the tendency of acts of terrorism to incite further violence is more easily reversed in less democratic, poorer, and less well educated societies. This suggests that reversal of a terrorism 'epidemic' is more likely under conditions facilitating repression than reform, and that more open societies face particular difficulties in responding to terrorism effectively.

A psychological phenomenon has been observed when traditional values appear threatened by rapid social change; for some there is a hardening of established attitudes, a move to a reactionary posture. Thus there is a polarization of attitudes and a psychological blueprint for deviant, even violent, behavior. The psychology of the group involved in protest, demonstrations, and even rebellion can be traced by some to the humans being's secret love of violence, which is often denied and which they tend to repress, but which becomes manifest in activities as diverse as lynching, boxing, and football. One form of mental illness that seems most applicable to the terroristic character is paranoia. However, middle-class idealistic students are most fascinated by Marxism, especially the words and thoughts of Trotsky, Lenin, and Lao Tse-tung, but by traditional communism, which they perceive as merely another form of bureaucratic repression (Hassela, 1997).

Insights into the mind of the terrorist and the origin of terrorist organizations are also provided by studies of the various defense mechanism that are so basic in our studies of the human psych, particularly the ego defense mechanisms of projection, denial, repression, displacement, rationalization, and reaction formation.

In 1938, P.Eisenberg and P.F.Lazarsfeld published a ‘final’ statement of social psychological theory of unemployment (in Inter-war Britain) and so completed the only systematic analysis of the effects of unemployment on the individual and the family. The theory suggested that men and women went through ‘stages’ in their reaction to unemployment- from optimism to resignation and despair and these stages were accompanied by a progressive deterioration in the individual’s social and intellectual capacities.

After years of violence and war the people of Mizoram were very sick of war which was believed to have led them to feeling of frustration, which may be in the form of resignation, repression, fixation and aggression.

A resignation is the formal act of giving up or quitting one's office or position. Resignation may also refer to: state of uncomplaining, utter frustration. Unprotesting acceptance of something: agreement to something, usually given reluctantly but without protest.

According to the behavior (reactive drive) theory approach frustration- thwarted expectation; the inability to reach a desired state- is the cause of aggression. According to the social learning theory approach, an aversive experience- which leads to a desire to terminate it – produces arousal. Frustration or anger also produces arousal; but – as Bandura shows- not all arousal produces frustration or aggression, yet all frustration produces arousal. The instinct theory – viewing aggression as a primary drive that initiates behavior – would surely also accept that arousal must occur in order to translate the drive state into actual behavior. Aggression with the aim to dominate (described by Lorenz) or the aggressive behavior in the Freudian approach must trigger the same sequence- arousal followed by behavior- regardless of whether the initial stimulus was a signal from another animal or an internal imbalance.

Arousal can be accounted for by accepting the concept of a basic curiosity drive. The need to know – to make sense of the world around us and our position in this world – could in itself account for arousal, whenever incoherent perception of an individual and his environment occurs. As Berlyne (1971) have shown arousal to be high whenever uncertainty is high- especially within a situation perceived to have

marked consequences, such as any combat situation might involve. Thus, signals challenging the territorial imperative, the desire for stability of existing mores, or the thwarting of needs- all trigger the need to reestablish equilibrium to attain a coherent perception.

Taggert, Carruthers and Somerville (1978) have shown that adrenaline exertion- a clear index of arousal- is associated with both aggression and uncertainty. One can assume that such arousal must also be associated with other coping strategies.

If we look at the seven examples of coping behavior listed by Bandura, we see that three of them would be classified as "aggressive" according to the mapping strategies: aggression, performance, and constructive problem solving. Four styles of behavior have in common the avoidance of conflict and aggression: dependency, withdrawal and resignation, psychosomaticization, and self-anesthetization. The first group is aimed at the modification of the aversive stimulus; the second, at adapting to it.

While many are strengthened by the challenges of combat, others return with a changed view of themselves and the world around them. For some, reactions to their experiences may be short-lived (perhaps lasting the first few months of reintegration back into civilian life). For others, healing may require long-term vigilance and care (lasting months, years and even decades).

Typical symptoms of combat-related PTSD (in no particular order, with additional symptoms to follow): Survivor guilt, Cynicism, Frustration, Fear, Negative self-image, Problems with intimacy, Distrust, Loneliness, Suicidal feelings, Preoccupation with thoughts of the enemy, Revenge fantasies, Addiction, Alcoholism, Thinking that feelings are meaningless, Feeling powerless or hopeless, Resignation ("don't care").

In his fascinating book The Last Great War, published a fortnight ago, Adrian Gregory and friends (1979) shows that the notion that Britain was carried to war on a wave of patriotic enthusiasm is false. The crowds that gathered around Buckingham Palace and in Downing Street when war was declared seem to have been more curious than excited. Most people appear to have greeted the war with resignation or dismay.

Nor does voluntary enlistment provide clear evidence of enthusiasm. It is true that some wanted to fight, and others saw war as a more exciting prospect that working in a dead-end office job. But they showed that voluntarism wasn't all that it seemed. For many men fighting was the only employment on offer. The largest numbers volunteered not at the very beginning of war, but after the disaster at Mons on August 24th, when it became clear that there was a genuine threat to national defense.

During and immediately after the experience of intense fear, helplessness, or horror the individual is consumed by the need to cope, and might function effectively or even heroically. For example, during a firefight, the soldier fires back, and may even charge the enemy.

Stress Coping strategies: Coping depends largely on the resources that the individual has at his disposal, which is his general resistance resources (GRRs). When there are not enough resources available coping is not possible and the situation may turn into one of distress. This links with Selye's GAS theory (Figure 2 above). At the stage of alarm reaction (AR) the fight or flight response manifests itself. If the stressor persists and there are sufficient GRRs to deal with the stressor, coping becomes effective. That is when the individual enters into the SR. Resources during this stage may be of a material nature which would include money, clothes, food or goods. Alternatively they may be physical in context such as health, diet or attractiveness. Social position and personal qualities including leadership, self esteem and optimism may also be valuable assets to help an individual to cope with stress. Other factors that are regarded as resistance resources are educational background and a sound general knowledge of affairs and even cultural buttresses such as traditions, customs and rituals. The more GRRs a person has to his disposal the greater his chances become to succeed in coping with stress.

Once coping is successfully accomplished or completed the individual will return to normal physiological and psychological levels, in other words he or she has adjusted to the situation. However, if the individual fails to cope, stress will continue and the individual eventually moves into the stage of exhaustion (SE). The

consequences of prolonged stress will follow. These range from physiological illness to psychological changes in mood such as depression, anxiety and even burnout.

It is generally recognized that while the body responds to a challenge or a threat by, for example, faster heart beat, increased blood-pressure and rapid breathing, an individual may also experience secondary or associated effects, such as irritability or loss of appetite. Baum et al. stated that stress responses go far beyond the activation of the hormonal systems and the organ systems which are subsequently affected. They claimed that in a situation of stress the whole body reacts. Nearly all hormones, most muscle groups, the digestive as well as the immune systems are affected. When a stressful situation demands sudden action, a feeling of excessive fatigue can often be experienced afterwards. These responses are all part of stress. Thus, it is important to note that, while stress may help an individual to perform better when under threat, it may also cause certain adverse secondary effects. Aside from the wear and tear on the body that is generated by repeated or prolonged stress, other less desirable out comes may result . These may range from physiological dysfunctions to tissue damage or may even result in death. Furthermore, physiological stress, the increased body alertness that has been discussed here, may lead to psychological and emotional stress, inducing other cognitive and emotional experiences such as fear, depression, worry, sleeplessness, crying spells and frustration. On the other hand, once a stressful task has been successfully completed, the individual often feels emotionally good about it. The psychological after-effects of distress have been widely researched and include frustration, aggressiveness, helplessness, withdrawal and decreased sensitivity to others. There is additional evidence that anxiety, fear or symptoms of apprehension experienced at high stress levels frequently result in acute episodes of panic. Baum and his friends (1997) added that depressive disorders may also occur. For such an individual the future looks bleak and he believes nothing can be done to change this condition. It has, moreover, been found that in cases where individuals were able to cope successfully with their stress, there were fewer negative after-effects.

According to Sheridan and Radmacher (1992) coping can be either problem focused or emotion-focused depending on the type of stressor involved. If the manner of coping is problem focused it signifies gathering information of the problem,

considering the available resources and planning the use of the resources. If, on the other hand, coping is emotion focused the style of the individual involved may vary. A common coping strategy is simply by avoidance or denial of the stressor. Other emotion focused strategies include exercise, humour, work and hobbies. It is usually adopted when the stressor cannot be changed or eliminated.

The term resistance resources also require some explanation. According to the Merriam Webster dictionary a resource can be a source of supply or of support; it can be a source of wealth; it can be an element to which one has recourse to in difficulty and it can be the ability to meet or deal with a situation. The term resource, in its literal sense, means "to raise again" and is derived from the word "resurrection". Stress resistance resources – also called general resistance resources – refer to those resources which the individual may call upon to help him to deal with the stress he experiences. They are sources from which he can draw, just as water is drawn from a well, when it becomes needed. In this study the term general resistance resources (GRRs) will generally be used.

Sheridan and Radmacher (1992) classify resistance resources in a number of categories: Firstly, there are the material resources which would include items such as money, food, clothing and shelter. For the burghers in the guerrilla phase of the war it would also have included objects such as arms and ammunition, horses and a variety of everyday articles which would have made their life easier for them. Secondly there are the physical resources, which include the positive physical attributes of an individual such as his strength, his health or attractiveness. From the perspective of burghers in the veldt, this would have involved qualities such as their physical endurance and the ability to ride and shoot. Intrapersonal resources are the next category and refer to the inner strength that helps an individual to withstand life's daily onslaughts. These include characteristics such as his self acceptance, ego - integrity and ego -identity, giving the individual a stable yet dynamic and flexible sense of the self. These are partly inborn characteristics, but they mostly develop under specific circumstances. Sheridan and Radmacher (1992) identify educational resources as the fourth category. Knowledge is regarded as a particularly valuable resource, *as* it is often a tool whereby material resources may be obtained. Possessing a wide-ranging knowledge was of great importance during the guerrilla war. Finally

there are cultural resources which include traditions, customs and rituals. These resources frequently help the individual to a better comprehension of the implication of the events taking place. It helps to understand that there are certain details that can be relied upon not to change despite the circumstances. At the time of the Anglo-Boer War religion, and spiritual matters, the importance of the republican flag, the observance of 16 December as Dingaan's Day were all cultural resources which provided important emotional support.

This classification of resistance resources are not necessarily the only correct one, but it does supply a convenient base from which to work. It is however always vital to realize that certain resources may give rise to others. For example, inborn physical strength would probably induce greater self confidence within the individual. This classification should therefore be regarded as flexible and subject to change.

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 (1977) 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.

Coping style means a characteristic or typical manner of approaching or confronting a stressful situation and dealing with it, so it fits nicely with the person-situation approach. There are particular types of situations, such as emergencies, when specific coping behaviours are more likely to be effective and required than other behaviours (i.e., situations where problem-focused responses are more desirable than emotion-focussed responses). If there is a fire in your apartment, it is more effective to try to escape than to screech wildly. In other stressful situations when a variety of coping responses are possible, individual coping styles or preferences may play an important role. Persons may have preferred coping styles, but situational demands may "override" and interact with their preferences. As we shall see shortly both persons and situations affect coping styles. We will focus on three personality styles: task-oriented (or problem focussed) coping, emotion-oriented coping and avoidance-oriented coping.

Task-oriented coping is concerned with purposeful task-oriented efforts focussing on solving the problem, cognitively restructuring it, or attempting to change the situation. *Emotion-oriented* coping is concerned with self-oriented emotion reactions. The goal is to reduce stress, but this is not always accomplished. Responses include emotional reactions, self-preoccupation, and fantasizing. At times, emotion-oriented coping may increase stress. *Avoidance-oriented* coping involves activities and cognitive changes concerned with avoiding the stressful situation, which can occur via *distraction* or *social* diversion.

In order to assess the interaction model of stress, anxiety and coping, it is necessary to have a reliable and valid measure of the key concept of coping, to parallel the reliable and valid anxiety measures. "The Coping Inventory for Stressful Situations" (CISS; Endler & Parker, 1999) is a multidimensional measure of coping that has three 16-item factors: task-oriented coping, emotion-oriented coping; and avoidance coping, with the last factor having two sub-factors, namely distraction and social diversion. Persons are asked to indicate, on five-point intensity scales, how they generally react to difficult, stressful or upsetting situations. Items include "schedule my time better", "become very upset", and "take time off and get away from the situation".

An essential ingredient for adjustment is social support. We all need someone to turn to for assistance and emotional calming. Another important factor is how much control we have over our lives. Can we control situations we encounter and how do we cope with them? How do we cope with situations we cannot control?

In a recent study conducted in Berlin, Germany, by Schröder, Schwarzer and Endler (1997), it is found that recovery from surgery of patients undergoing cardiac bypass surgery was facilitated by personal and social resources such as perceived self-efficacy (Bandura, 1997) and social support. Patients (302 men; 79 women) were surveyed once before and twice after surgery (5-10 days after; and one and one half years later) regarding the quality of life. Their partners (spouses) were surveyed at Time 1. Patients' recovery from surgery at Time 2 and readjustment to normal life one- and one-half years later (Time 3) "could be partly predicted by spouses' perceived self-efficacy and social support as measured at Time 1"

The most efficacious coping style in one situation is not necessarily the most efficacious style in another situation. In a recent study in our laboratory, we examined the effects of experimental and perceived controllability on coping styles and coping efficacy. Forsythe and Compas (1987), and Vitaliano (1990), among others, have discussed the relationships between perceived control of a situation and coping style. In Norman S. Endler's study they examined the congruency ("the goodness of fit hypothesis") between situational and/or perceived control and coping style. They predicted that in situations where participants had control or perceived themselves as having control, task-oriented coping would predominate and coping efficacy would be high. In situations that participants could not control, emotion coping would predominate and coping efficacy would be low.

In their laboratory study (Endler et al., 1997) 80 college students (40 men, 40 women) were asked to solve anagrams of moderate difficulty under conditions of high control (n = 40) and low control (n = 40) of the stressful situation (solving anagrams under pressure). Two different kinds of control were conceptualized as predictor variables: the participants' subjective *perceived control* of the situation (measured via a 6-item scale) and *experimental control*, defined by the assignment of participants to either a high or low control experimental condition. Participants in the *high control* experimental condition were given no restrictions as to how the anagram task was to be completed (e.g., no time constraints, could solve the anagrams in any order, were permitted to jot down notes, etc.) while participants in the *low control* experimental condition were substantially more restricted in how the task was to be performed.

With respect to experimentally manipulated control (*experimental control)*, analysis of variance revealed that participants in the *high control* condition solved more anagrams than participants in the *low control* condition. There were however, no differences between the experimental conditions with respect to A-state, situation-specific task coping, or situation-specific emotion coping. There were also no gender differences. Participants' subjective perceptions of control (*perceived control*) however, had a much stronger impact. In conducting the analyses, participants who scored among the top third on the perception of control scale (n = 27) were compared with participants who scored among the bottom third (n = 26). Analyses of variance revealed that higher perceived control is related to solving more anagrams, lower A-

state, less reliance on situation-specific emotion coping and greater reliance on situation-specific task coping. There were no significant main effects for gender. There was however, a significant gender x perceived control interaction effect. When perceived control was low, women relied more on situation-specific task coping than men. When perceived control is high, men rely on situation-specific task coping more than women.

To sum up for both anxiety and situation-specific coping, perceived control is a better predictor than experimental control. For the number of anagrams solved (a cognitive task) both types of control are equally efficacious.

Studies attempting to find predisposition to psychiatric breakdown in combat have revealed more similarities between psychiatric casualties and their fellow soldiers than differences. For example, in a comparison of the combat records of 100 men who suffered psychiatric breakdowns requiring evacuation to a U.S. Army hospital in the United States and an equivalent group of 100 surgical casualties, Pratt found no significant difference in numbers of awards for bravery. Glass remarked, "Out of these experiences came an awareness that social and situational determinants of behavior were more important than the assets and liabilities of individuals involved in coping with wartime stress and strain;…" The reliance on screening to prevent psychiatric casualties was recognized as a failure when large numbers of these casualties occurred during fighting in North Africa. Because no provision for treatment had been made, they were shipped to distant centers from which they never returned to combat.

A common thread binding present-day civilian victims of war is that, as a group, they have been unjustly persecuted and, as individuals, they have suffered immensely, with few individuals or groups coming to their aid. Their stark awareness of the world communities' apathy and indifference is shocking for them. Generally, their persecution does not happen overnight. Instead, it is progressive, and there are at least three stages to their experience (Bustos, 1990).

Initially, both social and political changes occur in the person's home country, resulting in ever-increasing levels of political repression and persecution (Van der Veer, 1998). These may include limits to freedom of speech and movement within the

country, as well as general intimidation by police, army, or paramilitary groups. The usual response is passive acceptance, even indifference, because they do not understand what is happening. Denial, suppression, and repression are the common social psychological defenses erected to dismiss the unclear situation from concern (Whitaker, 2000).

At some point, psychological defenses no longer work, as the political and social conditions worsen (Horowitz, 1998). The person witnesses friends and/or family members taken at night or even killed. Survivors have vividly described the psychological trauma of being arrested, being detained, and even being jailed for no substantive reason (Van der Veer, 1998). Both psychological and physical tortures are typically brought to bear on these individuals. Some undergo brutal forms of torture immediately; others experience a more selectively applied torture, not only to break their psychological feelings of well- being, but also to humiliate and degrade their personhood. The torture takes place in an environment where the victim is helpless and completely at the mercy of the torturers (Dahl, 1989). Thus, torture can be used to promote and carry out a systematic policy of intimidating and destabilizing an entire ethnic community or group. The physical torture procedures not only are premeditated, but are creatively designed to produce the most pain and torment possible to the victim (Applegate, 1969).

There likely is no universal method in developing extremist ideas that justifies terroristic acts of violence. However, four observable stages appear to frame a process of ideological development common to many individuals and groups of diverse ideological backgrounds. This four-stage process is a model designed as a heuristic (trial and error) to aid investigators and intelligence analysts in assessing the behaviors, experiences, and activities of a group or individual associated with extremist ideas. Begins by framing some unsatisfying event or condition as being unjust, blaming the injustice on a target policy, person, or nation, and then vilifying, often demonizing, the responsible party to facilitate justification for aggression. To begin with, an extremist individual or group identifies some type of undesirable event or condition (“it’s not right”). - While the nature of the condition may vary, those involved perceive the experience as “things are not as they should be.” That is, “it’s not right.” Next, they frame the undesirable condition as an “injustice”; that is, it does

not apply to everyone (“it’s not fair”). - Then, because injustice generally results from transgressive (wrongful) behavior, extremists hold a person or group responsible (“it’s your fault”), identifying a potential target. - Last, they deem the person or group responsible for the injustice as “bad” (“you’re evil”); after all, good people would not intentionally inflict adverse conditions on others. This ascription has three effects that help facilitate violence. First, aggression becomes more justifiable when aimed against “bad” people, particularly those who intentionally cause harm to others. Second, extremists describe the responsible party as “evil”; dehumanizing a target in this regard further facilitates aggression. Third, those suffering adverse conditions at the hands of others do not see themselves as “bad” or “evil”; this further identifies the responsible person or group as different from those affected and, thus, makes justifying aggression even easier.

To deal with stress, people consciously and unconsciously use various methods of coping as essential life-survival techniques (Gottlieb, 1997). Coping is a goal-directed process in which the individual orients thoughts and behaviours toward the goals of resolving the source of stress and managing Emotional reaction to stress (Lazarus, 1993). Coping styles and strategies mediate between antecedent stressful events, and such consequences as anxiety, psychological distress and somatic complaints. There are three basic coping styles: task-oriented coping, emotional-oriented coping, and avoidance-oriented coping (Endler & Parker, 1999; see figure 3). Note that Avoidance-oriented coping further breaks down into social diversion and distraction-oriented coping.

Task–oriented coping is aimed at purposeful efforts to solve problem; emotion-oriented coping is concerned with emotional reactions that are self-oriented; avoidance-oriented coping describes activities and cognitive changes aimed at avoiding the situation via distraction or social diversion. These constructs are assessed via the Coping Inventory for Stressful Situations (CISS; Endler & Parker, 1999)

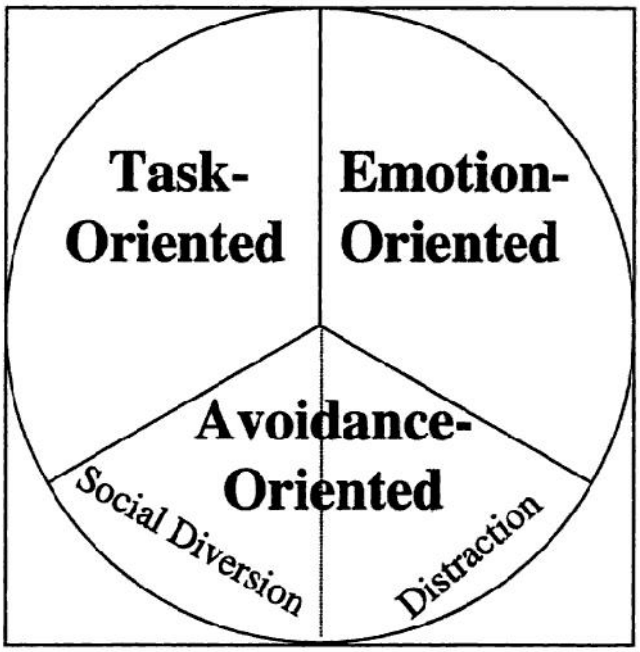


Figure -3 : showing the facets of coping

Task-oriented or problem-focused coping refers to an individual's active efforts to have an impact on, or to deal with, the stressful situation (Endler et al., 1993, 1998; Lazarus **&** Folkman, 1984a). When a person feels competent to handle a stressful situation they typically use a task-oriented response. In other words they take action to meet the requirements of the stressor. This type of response may involve in making changes in one's self, one's surroundings, or both, depending on the situation and circumstances. The action taken could be open (overt) as in showing more affection to a loved one, or it may be hidden (covert) as in lowering your level of expectation or aspiration. The action may involve retreating from, attacking or compromising the problem or situation. If the stressor is a house fire then an appropriate action may be to evacuate (retreat), extinguish the fire (attack), or use a fire extinguisher to clear a path out of the house (compromise). Task-oriented responses tend to deliver positive actions or outcomes, they achieve a goal.

Emotion-oriented or emotion-focused coping involves strategies such as rumination, daydreaming, and efforts to feel differently about the stressful situation (Lazarus & Folkman, 1984a).Emotion-focused strategies involve releasing pent-up emotions, distracting one-self, managing hostile feelings, meditating, using systematic relaxation procedures, etc.

Avoidance-oriented coping has been conceptualized in two different ways. The most common conceptualization of avoidance coping describes it as efforts to avoid, deny, suppress or anesthetize negative feelings (Fleishman & Fogel, 1994). Generally speaking, this form of avoidance coping has been found to be maladaptive, resulting in greater distress (Billings & Moos, 1981; Fleishman & Fogel, *1994).*

Task-oriented coping is most efficacious in a controllable situation, while emotion-oriented coping is most efficacious in an uncontrollable situation. While avoidance oriented coping may be initially appropriate as a reaction to stress, in the long run task-oriented coping is most efficacious. A number of laboratory studies assessing the multidimensional interaction model are reviewed. These studies have both theoretical and practical implications, and contribute to empirical knowledge about stress, coping processes, and personality.

We use coping strategies to solve personal and interpersonal problems, and seeking to master, minimize or tolerate stress, truama or conflict. Some people will try to get back into the routine of life as soon as possible to regain a sense of control, but others will have difficulty focusing for some time. Both reactions are common responses to crisis. Because everybody experiences stress differently, it is not wise to compare ones "progress" with others or judge other people's reactions and emotions. While many people survive major life stressors without developing significant psychological problems, others may need assistance.

The target research problems and the hypotheses set forth for the conduction of the present study were addressed in the succeeding chapter, the 'Statement of the Problem' .

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 conductedto examine the effect of insurgency so far, though human history witneses the adverse effect of war (insugrgency) 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 describe 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 psycho physiological 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 crosssectional multicluster 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 threeyear 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'

METHODS AND PROCEDURE

Sample:

The study was designed to determine the effect of 'Volunteer ('Volunteer' as who joined the MNF personally, and 'Non Volunteer' as who had not joined MNF during Mizoram insurgency) and 'Fatal' ('Fatal as who experienced fatal episode personally and with the family member, and 'Non Fatal' as who did not have experienced fatal episode personally and with the family member) due to insurgency in Mizoram on the behavioural measures.

Based on psychological measures of: anxiety, depression, frustration, and coping test questionnaires were administered to determine the psychological impact of insurgency in Mizoram, which include 200 participants between 50 to 70 years of age experiencing the 'Insurgency in Mizoram'. Purposive sampling technique was adopted in the subject selection with equal proportion of participants under each cell of the design (n=50) for the '2x2, this is because of the nature of the concept and participants under consideration. 'Gender' was not included in the design, as very few members of female volunteers could be recognized, but the background information of the subjects like – birth order, educational qualification, employment status, family structures (joint or Nuclear), size of family, monthly income, space facilities available for each number was recorded for consideration

The participants were randomly selected from different part of Mizoram affected by the MNF movement, with due care of extraneous variables to identify true representation. Lists of people who are a member of Peace Accord MNF Returnees Association (PAMRA), Ex-Mizoram National Army Association (Ex-MNA), Widow of MNA and Mizoram Elder Association (MUP – Mizoram Upa Pawl), Mizoram Civil Pensioners Association who had experienced the Mizoram insurgency were obtained. From these lists the participants were randomly selected. The 'Volunteer' with consideration of 'Suffering' and 'Non-suffering' were selected from the list of Ex-MNF (PAMRA and MNA – Association on Hnam Run, Office of the MNF Party Headquarters.). Following the same procedure of the sample selection, the 'Non-

volunteer' were selected from the list of the members of Mizoram Elder Association (MUP), Mizoram Civil Pensioners Association and Widow of MNA. 'Gender' was not included in the design as very few members of female volunteers could be identified.

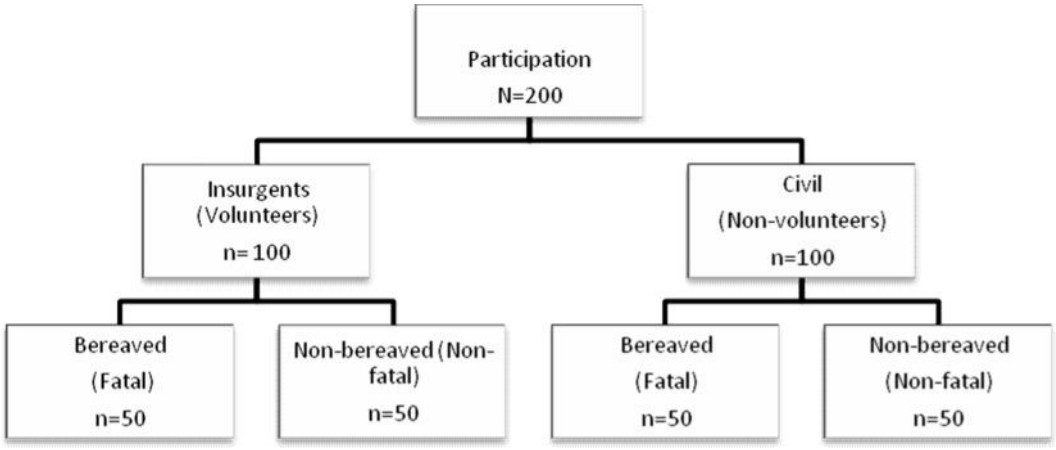


Figure - 4: Showing the 2 x 2 factorial designs of the study.

Psychological tools:

The data collection incorporated the aid of questionnaires tapping 4 psychological constructs namely - anxiety, depression, frustration, and coping styles shall be recorded maintaining anonymity of the participants.

The details of the psychological measures are summarily described to make lucid the behavioral gamut's that are investigated across samples of the study.

1. Symptom Questionnaire (SQ; Kellner, 1987): The Symptom Questionnaire (SQ) is a yes/no questionnaire with brief and simple items. It contains state scales of ***depression, anxiety, anger-hostility, and somatic symptoms***. The psychometric properties of the SQ are somewhat different from those of similar scales. In double-blind, crossover studies, they tended to be more sensitive than other scales in discriminating between the effects of a psychotropic drug and placebo and were found to be highly sensitive in discriminating between distress levels of groups. In studies with small or moderately sized samples in which the sensitivity of scales is important or in populations that include subjects with poor verbal skills, the SQ seems to have

advantages. The SQ is suitable for the measurement of distress and hostility in research and as a checklist in clinical work.

The psychological measure consists of 92 items with four sub-scales of anxiety, depression, somatic concern and anger-hostility; each sub-scale has 17 items tapping the symptom and 6 well-being items. Bi-polar response choice of 1 (one) for each symptom with 0 (zero) representing its absence leads the maximum possible score for each sub scale is 17 (Seventeen) and each well-being sub scale is 6 (Six). This self-rated scale measures distress and well-being. The patient is instructed to read quickly through a list of 92 psychiatric and somatic conditions and choose the response (yes or no, true or false) that best describes how she has been feeling. Respondents are given a rating of 1 for each symptom that is checked "yes" or "true" and for each statement of well-being that is checked "no" or "false." A higher score indicates more distress than a lower score.

2. Frustration Test (Chauhan & Tiwari, 1972): This test consists of 40 items out of which each four modes- ***Regression, fixation, resignation and aggression*** of frustration has 10 items each. Each item having six possible response choice with 0 (zero) representing absence of the corresponding mode of frustration and the intensity to be indicated from 1-very less, 2-less, 3-ordinary, 4-much and 5-very much. The higher scores indicated higher frustration potential, employed to identify the effects of frustration upon the quality of the person's behaviour as a whole.

3.Coping Inventory for stressful situation (CISS, Endler & Parker, 1999): The Adult version of CISS which is consisting of 48 items is a self report measure of coping styles. It has tree sub scales Sixteen items assess ***task oriented***, sixteen items assess ***emotion oriented*** coping, and sixteen items assess ***avoidance oriented coping***. There are two sub-scales in avoidance oriented scales: distraction and social diversion coping styles. Subject rate each items on a 5 points scale ranging from 'not at all' (1) to very much (5).

Individuals who score high on Task Oriented Coping use behavioral or cognitive problem-solving techniques when confronted with stress. Emotion Oriented Capers respond to stressful situations with emotional outbursts, self-preoccupation, or

fantasy. Avoidance Copers rely on social supports or distract themselves with other activities.

The Coping Inventory for Stressful Situations (CISS) is a valuable tool that allows you to effectively measure three major types of coping styles in an individual, including Task-Oriented, Emotion-Oriented, and Avoidance Coping. As well, two types of Avoidance patterns, Distraction and Social Diversion, can also be identified.

The CISS is especially useful in assisting with assessment and placement decisions for psychiatric patients, correctional populations, college counseling centers, employee hiring and counseling situations, medical patients, stress and wellness programs and any other situations where it is useful to assess an individual's coping style and ability.

Demographic Profiles includes subject's name, father name, age, monthly in come of the family, joining age of MNF, duration of serve, nature of suffering, and so on which will supplement and also cross validation of the information.

Procedure:

The selected psychological measures: a) Symptom Questionnaire (SQ; Kellner, 1987), b) Frustration Test (FT; Chauhan & Tiwari, 1972) and Coping Inventory for Stressful Situations (CISS; Endler & Parker, 1999) were originally English, which are translated in to Mizo language as the participants mostly speak in Mizo and then back to English language to confirm the reliability of the translated scale. The original and translated psychological tests were compared by three language experts who were both well verse with English and Mizo, they accepted as not losing the originality. Through pilot study the translated scales are confirmed to be reliable and were found reliable (.83) for the present study. Even though the reliability of the translated scales were previously proved reliable in the same population, it was administered again to confirmed the reliability.

Firstly, the researcher obtained the necessary consents, rapport and careful explanations of instructions for completing the questionnaires were done; subjects required filling out the questionnaire sets anonymously in order to minimize the

potential influence of social desirability response sets. The background demographic sheets will then be distributed and filled up by each subject with assured confidentiality. Each testing session will last for approximately one hour. Then, the researcher asked the subjects to fill up the demographic profile then only administered to the participants The selected participants were carefully given instructions that are required for the conduction of the psychological measurement and request them to complete the questionnaires in a retroactive manner, as they happened during the insurgency. The participants were asking to fill up the demographic profile first. The participants were given the questionnaire sets after cautious preparation and were requested to fill up the questionnaire sets completely and also gave them assurance that confidentiality and anonymity of the subjects should be maintained with that security they should not hesitate to give free and unbiased information.

The subjects were ensured regarding the confidentiality of their response patterns and requested to respond unanimously so as to take care of the components of social desirability, biases in the response mode(s) and Pattern(s) on each measure. After successful completion of all questionnaires, scoring were done separately for Volunteer (Fatal& Non Fatal) and 'Non Volunteer' (Fatal & Non Fatal) and were subjected to close examination for inferential conclusions of the findings.

The participants were both tested under individual and group condition in the presence of the researcher. After completion of the test, the researcher carefully checks the response sheets. From the data collected the researcher carefully checks the response sheets and rejected those that are incomplete and those that were highly differed from other participants. Finally, after screening the responses of of a large participants 200 participants were selected for analyses.

Design of the Study:

Each participant completed a package containing the background demographic sheets and the psychological measures. Comprehensive scores on the scales or sub-scales of the behavioural measures are arranged in order for the project population and the effect of the 'Volunteer' (Volunteer and Non Volunteer) and 'Fatal' (Fatal

and Non Fatal) on the perceived impact as indicated by the psychological measures of : (a) Symptom Questionnaire (SQ; Kellner, 1987), b) Frustration Test (FT; Chauhan & Tiwari, 1972) and Coping Inventory for Stressful Situations (CISS; Endler & Parker, 1999) are determined.

The study incorporated two-way classification of variables: the independent variables are the 'Volunteer' (Volunteer and Non Volunteer) and 'Fatal' (Fatal and Non Fatal), while the dependent variables are the psychological measures of anxiety, depression, frustration and coping styles. Thus, a 2 x 2 Factorial design (2 Volunteer x 2 Fatal) was imposed on the dependent measures with the participants equated and matched for the demographic variables.

Statistical Analyses:

Keeping in view of the problems of the study, the methodological refinements were done in a step-wise manner. Firstly, the preliminary psychometric analyses of the behavioural measures on the sampled equated and/or matched on the demographic variables included the statistical analyses of psychometric adequacy including: item-total coefficient of correlation, Cronbach alpha and split-half reliability coefficient and inter-scale relationships as the psychological of their proven psychometric adequacy cannot be assumed to carry their psychometric properties when transported and applied in any other cultural setting.

The analyses of the preliminary psychometric analyses subscribes to the admonition of researchers in culture specific and cross-cultural studies: that scale constructed and validated for measurement of theoretical construct in a given population when taken to another cultural milieu may not be treated as reliable and valid unless specific checks are made (Berry, 1974; Witkin, et al., 1975); and that cultural researches employing the derived-etic approach assume that each group that occupies an ecological niche is equivalent to that of the other and the study is free of systematic bias (Pootinga, 1989).

Secondly, 2 x 2 factorial design (2 Volunteer x 2 Fatal) with appropriate Post-hoc mean comparison was employed to highlight the independent and interaction

effects of the independent variables on the dependent measures. The analyses incorporated preliminary check of the assumptions underlying the analysis of variance.

Thirdly, Multiple regression analyses were employed for the prediction of the psychological symptoms from the other behavioural measures for clarity and precision.

The responses of the subjects were computerized and analyzed employing statistical software by following the objectives set forth for this study. The overall analyses of results are presented and discuss in the chapter to follow.

RESULTS AND DISCUSSION

Subject-wise scores on the specific items of the behavioural measures of : (i) Symptom Questionnaire (Kellner, 1987); (ii) Frustration Test (Chauhan & Tiwari, 1972); (iii) Coping Inventory for stressful situation (CISS, Endler & Parker, 1999) were prepared for the whole samples – Fatal (Bereaved) Insurgents, NonFatal (Non-Bereaved) Insurgents, Fatal (Bereaved) Civilians, Non-Fatal (Non-Bereaved) Civilians.

Psychometric Properties of the Behavioural Measures

Psychometric analyses of the behavioural measures included the analysis of (i) item-total coefficient of correlation (as an index of internal consistency and item validity) was ascertained for the scales/subscales of the behavioural measures with the criterion of items showing item-total coefficient of correlation $\geq .01$ for the whole sample to be retained for further analysis, (ii) Reliability coefficients (Cronbach alphas & Split-half)of the specific subscales, (iii) inter-scale relationships (in the instances where there were two or more sub-scales/ sub-factors). Following the broad format of analysis, the psychometric properties of the four classes of behaviour measures of (i) anxiety, (ii) depression, (iii) frustration and (iv) coping styles were analyzed by employing PASW Statistics (2009), Statistica 8.0 (2008) and Microsoft Office Excel 2007.

The preliminary psychometric analyses over the level of analyses for each of the specific items and scales/subscales are determined with the objectives to ensure further statistical analyses, and the results are presented in Table - 1 to Table - 4. Results (Tables - 1 to 4) show the means, standard deviations, skewness and kurtosis of the scales/subscales of the behavioural measures of Coping Inventory for Stressful Situations (CISS; Endler & Parker, 1999), Symptom Questionnaire (SQ; Kellner 1987) and Frustration Test (FT; Chauhan & Tiwari, 1972).

The preliminary analyses of the psychometric properties of the behavioural measures was computed in view of the fact that scale constructed and validated for measurement of theoretical construct in a given population when taken to another cultural milieu may not be treated as reliable and valid unless specific checks are made (Eysenck & Eysenck, 1985; Witkin & Berry, 1975). The psychometric adequacies of the scales employed in the present study were already work out and validated in the same population under study (Varte, 2005).

Table - 1 : Mean, Standard Deviation, Skewness and Kurtosis of 'Volunteer' (Fatal) on Behavioural measures for the whole samples.

Variables	**N**	**Mean**	**Std. Deviation**	**Skewness SE=.34**	**Kurtosis SE=.66**
CISS (T)	50	60.30	4.24	-.55	.12
CISS (E)	50	50.58	4.25	-.10	-.51
CISS (A)	50	46.08	4.69	.72	.45
FT (RG)	50	33.16	2.86	-.43	.72
FT (FX)	50	33.16	2.86	-.43	.72
FT (RSG)	50	32.06	2.89	.33	.09
FT (AG)	50	37.88	3.08	-.18	-.54
SQ (A)	50	19.54	1.96	-.67	-.42
SQ (D)	50	18.80	1.61	-.23	-.91
SQ (SC)	50	9.82	1.39	.28	-.87
SQ (AH)	50	19.08	1.99	.06	-.37

Table – 2 : Mean, Standard Deviation, Skewness and Kurtosis of 'Volunteer' (Non Fatal) on Behavioural measures for the whole samples.

Variables	N	Mean	Std. Deviation	Skewness SE=.34	Kurtosis SE=.66
CISS (T)	50	55.36	3.533	.835	2.20
CISS (E)	50	43.58	4.180	.050	-.60
CISS (A)	50	54.54	3.271	.527	-.14
FT (RG)	50	29.76	3.13	.103	.63
FT (FX)	50	29.76	3.16	.100	.49
FT (RSG)	50	38.06	2.316	.551	-.21
FT (AG)	50	31.28	4.62	-.642	.21
SQ (A)	50	16.80	1.87	-1.133	2.46
SQ (D)	50	15.62	1.86	.011	1.74
SQ (SC)	50	12.62	1.62	.472	4.78
SQ (AH)	50	15.90	1.67	-.713	.71

Table - 3 :Mean, Standard Deviation, Skewness and Kurtosis of 'Non Volunteer' (Fatal) on Behavioural measures for the whole samples.

Variables	N	Mean	Std. Deviation	Skewness SE=.34	Kurtosis SE=.66
CISS (T)	50	51.46	3.49	-.1	.22
CISS (E)	50	40.36	3.49	.17	-.33
CISS (A)	50	60.36	3.87	.39	.54
FT (RG)	50	26.46	2.49	1.39	5.48
FT (FX)	50	26.52	2.49	1.29	5.43
FT (RSG)	50	43.18	3.03	.40	-.01
FT (AG)	50	27.62	3.65	-.02	-.99
SQ (A)	50	13.92	1.90	.14	.31
SQ (D)	50	12.68	2.00	-1.20	1.52
SQ (SC)	50	15.70	1.23	.54	.75
SQ (AH)	50	13.50	.95	.00	-.86

Table - 4 :Mean, Standard Deviation, Skewness and Kurtosis of 'Non Volunteer' (Non Fatal) on Behavioural measures for the whole samples.

Variables	N	Mean	Std. Deviation	Skewness SE=.34	Kurtosis SE=.66
CISS (T)	50	44.58	3.34	-.38	-.79
CISS (E)	50	33.62	3.54	.03	-.47
CISS (A)	50	67.38	4.43	-.13	.11
FT (RG)	50	21.26	2.33	-.22	-.99
FT (FX)	50	21.40	2.26	-.38	-.77
FT (RSG)	50	47.48	3.82	-.78	1.02
FT (AG)	50	23.92	4.43	.19	-1.09
SQ (A)	50	11.72	2.11	.69	.07
SQ (D)	50	10.10	1.50	-.10	-.62
SQ (SC)	50	18.66	1	-.64	.11
SQ (AH)	50	9.60	1.73	-.28	-.10

However, the psychometric properties of behavioural measures were computed to confirm to the earlier findings, which further confirmed the adequacies of the psychometric properties of the selected scales for measurement purposes for the present study. The item- Total coefficient of correlation (as an index of internal consistency and item validity) was ascertained for the scales/subscales of the behavioural measures as shown in Table - 5.1. The reliability coefficients (Cronbach Alphas and Spearman Brown Coefficient) of specific scales/subscales of the behavioural gamut were also computerized. The preliminary psychometric analyses for each of the specific items and scales/subscales are determined with the objectives to ensure further statistical analyses, and the results are sequentially presented in Tables - 1 to 4 respectively.

The reliability coefficient (Cronbach Alpha and Spearman Brown coefficient) of the scales/subscales of the behavioural measures of Coping Inventory for Stressful Situations (CISS; Endler & Parker, 1999), Symptom Questionnaire (SQ; Kellner

1987) and Frustration Test (FT; Chauhan & Tiwari, 1972) with reliability ranging from .51 - .86 of alpha reliability and .57 - .85 for Spearman Brown coefficients (Table - 5).

The reliability coefficients emerged to be strong indicating the dependability of the test scales for measurement purposes in the project population (Mizo). In sum, the Item-Total coefficient correlation, the reliability coefficients (Cronbach alpha and Spearman Brown Coefficient), and the Inter-scales/subscales of Coping inventory for stressful situation (CISS), Symptoms Questionnaire (SQ) and Frustration test (FT) are conforming to the findings reported in literature (Kelnner, 1987; Endler & Parker, 1999; Chauhan & Tiwari, 1972; Varte, 2005).

Table – 5.1: Descriptive statistics for the scales and subscales of the behavioural measures (CISS, SQ and Frustration test) with internal consistency and item validity for the whole samples.

Variables	**Variable**	**Cronbach Alpha (α)**	**Spearman-Brown Coefficient**
CISS (T)	16	.51	.57
CISS (E)	16	.80	.77
CISS (A)	16	.86	.85
SQ (A)	23	.63	.72
SQ (D)	23	.63	.64
SQ (SC)	23	.62	.61
SQ (AH)	23	.68	.73
FT (RG)	10	.73	.63
FT (FX)	10	.72	.63
FT (RSG)	10	.86	.83
FT (AG)	10	.86	.85

Relationship of the Behavioural Measures

The bivariate relationships between the scales/subscales of the behavioural measures were computed (Table - 6) and it indicated the relationships among the scales/subscales of the behavioural measures accounting for 'Volunteer' (Volunteer, who joined the MNF personally and Non Volunteer, who does not joined the MNF personally during the insurgency in Mizoram), along with the 'Fatal' (Fatal are those who experienced fatal episode, and Non Fatal, who did not have experienced fatal episode personally.

The results on Table - 6 revealed that there are more significant positive relationship than significant negative relationship amongst the scales/subscales of the behavioural measures. As shown on the table, the Task oriented coping {CISS (T)} shows significant positive relationships with Emotion oriented coping {CISS (E)}, Anxiety, Depression, Anger-Hostility {SQ (A,D&AH)} and Regression, Fixation, Aggression {FT (RG,FX,AG)}; it also shows significant negative relationships with Avoidance oriented coping {CISS (A)}, Somatic concern {SQ (SC)} and Resignation (FT (RSG)}. The Emotion oriented coping {CISS (E)} scale shows significant positive relationship with Task oriented coping {CISS (T)}, Anxiety, Depression and Anger-Hostility{SQ (A,D&AH}, Regression, Fixation and Aggression {FT (RG, FX & AG)}; it also shows significant negative relationship with Avoidance oriented coping {CISS (A)}, Somatic concern {SQ (SC)} and Resignation {FT (RSG)}. The Avoidance oriented coping {CISS (A)} scale shows significant positive relationship with Somatic concern {SQ (SC)} and Resignation {FT (RSG)}; it also shows significant negative relationship with Task oriented coping, Emotion oriented coping {CISS (T&E)}, Anxiety, Depression and Anger-Hostility {SQ (A, D & AH)} and Regression, Fixation and Aggression {FT (RG ,FX & AG)}.

It is also seen that there are significant positive relationship between Anxiety {SQ (A)} scale and Task and Emotion oriented coping {CISS (T&E)}, Depression, Anger-Hostility {SQ (D, AH)}, Reggression, Fixation and Aggression {FT (RG, FX & AG)}, the Anxiety {SQ (A)} scale also shows significant negative relationship with Avoidance {CISS (A)}, Somatic concern {SQ (SC)} and Resignation {FT (RSG)}. Depression {SQ (D)} shows significant positive relationship with Task and Emotion oriented coping {CISS (T & E)}, Anxiety and Anger-Hostility {SQ (A & AH)},

Table – 5.2: Correlation matrix of the behavioural measures (Pearson Correlation)

	CISS (T)	CISS (E)	CISS (A)	SQ (A)	SQ (D)	SQ (SC)	SQ (AH)	FT (RG)	FT (FX)	FT (RSG	FT (AG)
CISS (T)	1	.68**	-.83**	.73**	.76**	-.77**	.79**	.74**	.73**	-.82**	.69**
CISS (E)	.68**	1	-.69**	.69**	.75**	-.74**	.79**	.67**	.67**	-.73**	.66**
CISS (A)	-.83**	-.69**	1	-.74**	-.82**	.85**	-.81**	-.78**	-.78**	.86**	-.75**
SQ (A)	.73**	.69**	-.74**	1	.76**	-.79**	.76**	.72**	.73**	-.79**	.66**
SQ (D)	.76**	.75**	-.82**	.76**	1	-.84**	.80**	.79**	.78**	-.83**	.73**
SQ (SC)	-.77**	-.77**	.85**	-.79**	-.84**	1	-.83**	-.81**	-.82**	.84**	-.76**
SQ (AH)	.79**	.78**	-.81**	.76**	.80**	-.83**	1	.75**	.75**	-.82**	.71**
FT (RG)	.74**	.67**	-.78**	.72**	.79**	-.81**	.75**	1	.94**	-.78**	.65**
FT (FX)	.73**	.67**	-.78**	.73**	.78**	-.82**	.75**	.94**	1	-.77**	.67**
FT (RSG)	-.82**	-.73**	.86**	-.79**	-.83**	.84**	-.82**	-.78**	-.77**	1	-.73**
FT (AG)	.69**	.66**	-.75**	.66**	.73**	-.76**	.71**	.65**	.67**	-.73**	1

** Correlation is significant at the 0.01 level (2-tailed).
Listwise N= 200.

Regression, Fixation and Aggression {FT (RG, FX & AG)}; and shows significant negative relationship with Avoidance {CISS (A)}, Somatic Concern {SQ (SC)} and Resignation {FT (RSG)}. Somatic concern {SQ (SC)} shows significant positive relationship with Avoidance {CISS (A)} and Resignation {FT (RSG)}; it also shows significant negative relationship with Task and Emotion oriented coping {CISS (T & E)}, Anxiety, Depression and Anger-Hostility {SQ (A, D & AH)}, Regression, Fixation and Aggression {FT (RG, FX & AG)}. The significant positive relationship between Anger-Hostility {SQ (AH)} and Task and Emotional oriented coping {CISS (T & E)}, Anxiety, Depression {SQ (A & D)}, Regression, Fixation and Aggression {FT (RG, FX & AG)}; it also shows significant negative relationship with Avoidance {CISS (A)}, Somatic concern {SQ (SC)} and Resignation {FT (RSG)}.

Most mood disorders present as a combination of anxiety and depression. Surveys show that 60-70% of those with depression also have anxiety. And half of those with chronic anxiety also have clinically significant symptoms of depression. (Hara Estroff Marano, 2003). Anxiety and depression share an avoidant coping style. Sufferers avoid what they fear instead of developing the skills to handle the kinds of situations that make them uncomfortable. Often enough a lack of social skills is at the root. Similarly, Jones (1977) found that anxiety and fear symptoms predominated in combat soldiers in Vietnam.

The result (Table - 6) also indicated a significant positive relationship between Regression with Task and Emotion oriented coping {CISS (T & E)}, Anxiety, Depression, Anger-Hostility {SQ (A, D & AH)}, Fixation and Aggression {FT (FX & AG)}; it also shows significant negative relationship with Avoidance {CISS (A)}, Somatic Concern {SQ (SC)} and Resignation {FT (RSG)}. The Fixation {FT (FX)} measure shows a significant positive relationship with Task and Emotional oriented coping {CISS (T & E)}, Anxiety, Depression, Anger-Hostility {SQ (A, D & AH)}, Regression and Aggression {FT (RG & AG)}; also shows significant negative relationship with Avoidance {CISS (A)}, Somatic concern {SQ (SC)} and Resignation {FT (RSG)}. The Resignation {FT (RSG)} measure shows significant positive relationship with Avoidance {CISS (A)} and Somatic Concern {SQ (SC)}; it also shows significant negative relationship with Task and Emotion oriented coping {CISS (T & E)}, Anxiety, Depression, Anger-Hostility {SQ (A, D &AH)},

Regression, Fixation and Aggression {FT (RG, FX & AG)}. Scholte and colleagues (2004) 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.

The Aggression {FT (AG)} measure shows significant positive relationship with Task and Emotion oriented coping {CISS (T & E)}, Anxiety, Depression, Anger-Hostility {SQ (A, D & AH)}, Regression and Fixation {FT (RG & FX)}; it also shows significant negative relationship with Avoidance {CISS (A)}, Somatic concern {SQ (SC)} and Resignation {FT (RSG)}.

Avoidant coping appears the most maladaptive as it is associated with increased distress. (Ben-Zur, 1999).The results regarding emotion-focused coping are more complex as this coping style has been associated with both increased and decreased levels of psychological distress (Network of Relationships Inventory; Ben-Zur, 1999).

Emotion-focused coping incorporates a number of diverse coping styles that have been shown to be both adaptive and maladaptive (Penland, 2000; ; Crockett, 2007). In general, the coping strategies that focus on negative emotions and thoughts appear to increase psychological distress (e.g. venting of emotions and rumination), whereas coping strategies that regulate emotion (e.g. seeking social support, affect regulation and acceptance) appear to reduce distress.

Task oriented coping {CISS (T)}, Emotion oriented coping {CISS (E)}, Anxiety {SQ (A)}, Depression {SQ (D)}, Anger-Hostility {SQ (AH)}, Regression {FT (RG)}, Fixation {FT (FX)} and Aggression { FT (AG)} measures indicated significant positive relationship with each other and they all shows significant negative relationship with Avoidance {CISS (A)}, Somatic concern {SQ (SC)} and Resignation {FT (RSG)}. The reverse is observed with the Avoidance {CISS (A)}, Somatic concern {SQ (SC)} and Resignation {FT (RSG)}, which shows significant positive relationship with each other and significant negative relationship with Task oriented coping {CISS (T)}, Emotion oriented coping {CISS (E)}, Anxiety {SQ (A)}, Depression {SQ (D)}, Anger-Hostility {SQ (AH)}, Regression {FT (RG)}, Fixation {FT (FX)} and Aggression { FT (AG)}.

The mean and standard deviation values for 'Volunteer' and 'Fatal' on the behavioural measures are shown in Tables - 1 to 4. The predictive validity of the test scores was estimated by embedding the independent and interaction effects of 'Volunteer x Fatal' on the test scores.

Univaraite analysis of variance was used for analyzing data on a single variable at a time. The Table – 6 'Tests of Between-Subjects Effects' revealed: one about the main effect of Volunteer, one about the main effect of Fatal, and one about the Volunteer-by-Fatal interaction for different behavioural measures. It is always wise to first look at possible interaction effect, since it does not make sense to talk about main effects if there is significant interaction between the factors.

In the results (Table – 6) indicated *Sig*. = .06 on CISS (T), Sig.= .81 on CISS (E), Sig.= .216 on CISS (A), Sig.= .33 on SQ (A), Sig.= .22 on SQ (D), Sig.= .70 on SQ (SC), Sig.= .12 on SQ (AH), Sig.= .05 on FT (RSG), this validate the null hypotheses that there is no interaction between the two variables 'Volunteer & Fatal). The effect of Volunteer/Non Volunteer, Fatal/Non fatal seem to be different for different behavioural measures. The results also indicated Sig.= .02 on FT (RG), Sig.= .02 on FT (FX), Sig.= .01 on FT (AG) which indicated there exist interaction between the two variables in these three behavioural measures. Significant interaction means the effect is not different for the 'Volunteer and Fatal'.

The *F* statistic for the test of between-subjects effects on dependent variables {CISS (T), (E), (A); SQ (A), (D), (SC), (AH); FT (RG), (FX), (RSG), (AG)} revealed significant difference among the score. This makes sense to test hypotheses. They are further look into in the following analyses. The results in consistance with the earlier finding that the symptoms of PTSD and depression were found to be highly prevalent among Sudanese children living in the refugee camps (Paardekooper, et al, 1999)

Table – 6 : Univariate ANOVA for 2 x 2 factorial design (2 Volunteer x 2 Fatal).

Variables	Tests of Between-Subjects Effects						
	Source	Type III Sum of Squares	df	Mean Square	F	Sig.	Partial Eta Squared
CISS (T)	Volunteer	4811.80	1	4811.80	357.15	.00	.65
	Fatal	1746.40	1	1746.40	129.62	.00	.39
	Volunteer x Fatal	47.04	1	47.04	3.49	.06	.02
CISS (E)	Volunteer	5090.40	1	5090.40	337.33	.00	.63
	Fatal	2359.84	1	2359.84	156.38	.00	.44
	Volunteer x Fatal	.84	1	.84	.05	.81	.00
CISS (A)	Volunteer	9193.68	1	9193.68	546.47	.00	.74
	Fatal	2995.38	1	2995.38	178.04	.00	.47
	Volunteer x Fatal	25.92	1	25.92	1.54	.21	.01
SQ (A)	Volunteer	1431.12	1	1431.12	370.94	.00	.65
	Fatal	305.04	1	305.04	79.06	.00	.28
	Volunteer x Fatal	3.64	1	3.64	.94	.33	.01
SQ (D)	Volunteer	1693.62	1	1693.62	548.53	.00	.73
	Fatal	414.72	1	414.72	134.32	.00	.40
	Volunteer x Fatal	4.50	1	4.50	1.45	.22	.01
SQ (SC)	Volunteer	1776.08	1	1776.08	786.01	.00	.80
	Fatal	414.72	1	414.72	183.53	.00	.48
	Volunteer x Fatal	.32	1	.32	.14	.70	.00
SQ (AH)	Volunteer	1764.18	1	1764.18	656.52	.00	.77
	Fatal	626.58	1	626.58	233.17	.00	.54
	Volunteer x Fatal	6.48	1	6.48	2.41	.12	.01
FT (RG)	Volunteer	2888.00	1	2888.00	389.87	.00	.66
	Fatal	924.50	1	924.50	124.80	.00	.39
	Volunteer x Fatal	40.50	1	40.50	5.46	.02	.03
FT (FX)	Volunteer	2812.50	1	2812.50	381.14	.00	.66
	Fatal	907.38	1	907.38	122.96	.00	.38
	Volunteer x Fatal	36.98	1	36.98	5.01	.02	.02
FT (RSG)	Volunteer	5273.64	1	5273.64	562.52	.00	.74
	Fatal	1326.12	1	1326.12	141.45	.00	.42
	Volunteer x Fatal	36.12	1	36.12	3.85	.05	.02
FT (AG)	Volunteer	3880.80	1	3880.80	243.26	.00	.55
	Fatal	1326.12	1	1326.12	83.12	.00	.29
	Volunteer x Fatal	105.12	1	105.12	6.59	.01	.03

Table – 7.1 :2x2 ANOVA for 'Volunteer x Fatal' on Task oriented coping style {CISS (T)}, Emotion oriented coping style {CISS (E)} and Avoidance oriented coping style {CISS (A) for the whole samples.

Dependent Variable	Sources of Variation	Sum of Squares	df	Mean Square	F	Sig.	Partial Eta Squared
CISS (T)	Volunteer (V)	4811.80	1	4811.80	357.15	.00	.64
	Fatal (F)	1746.40	1	1746.40	129.63	.00	.39
	V X F	47.05	1	47.05	3.49	.06	.02
	Error	2640.62	196	13.47			
CISS (E)	Volunteer (V)	5090.40	1	5090.40	337.33	.00	.63
	Fatal (F)	2359.84	1	2359.84	156.38	.00	.44
	V X F	0.84	1	0.84	0.06	.81	.00
	Error	2957.66	196	15.09			
CISS (A)	Volunteer (V)	9193.68	1	9193.68	546.48	.00	.73
	Fatal (F)	2995.38	1	2995.38	178.05	.00	.47
	V X F	25.92	1	25.92	1.54	.22	.01
	Error	3297.40	196	16.82			

Table - 7.2 : Levene's Test of Equality of Error Variances for CISS

Variable	F	df1	df2	Sig.
CISS (T)	.68	3	196	.56
CISS (E)	1.18	3	196	.31
CISS (A)	1.35	3	196	.25

The 2 x 2 ANOVA was employed to highlight the effects of the independent variables (2 Volunteer x 2 Fatal) on the dependent measures. The 2 x 2 ANOVA {2 Volunteer (Volunteer & Non Volunteer) x 2 Fatal (Fatal x Non Fatal)} test scores of Coping Inventory for Stressful Situation (CISS), Symptom Questionnaire (SQ) and Frustration Test (FT) with Levene's Test of Equality of error Variances for each scales are shown in Tables - 7.1 and 7.2, Tables - 9.1 and 9.2 and Tables - 11.1 and 11.2. The result (Table - 7.1) revealed that there are significant differences among the scores on Task oriented coping style {CISS (T)}, Emotion oriented coping style {CISS (E)} and Avoidance oriented coping style {CISS (A) scores.

The 2x2 ANOVA {2 Volunteer (Volunteer & Non Volunteer) x 2 Fatal (Fatal x Non Fatal)} in Coping styles indicated that there is significant differences among the scores on Task oriented coping style, Emotion oriented coping style and Avoidance oriented coping style. The results (Table - 7.2) further revealed that the effect-size of the 'Volunteer' (64%) on Task oriented coping styles is more than the effect-size of the 'Fatal' (39%) on Task oriented coping styles. On Emotional oriented coping style the 'Volunteer' shows the effect size of 63% while the 'Fatal shows 44% effect size. The effect size of the 'Volunteer' on Avoidance oriented coping style is 73% and the 'Fatal' is 47%.

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 Levene's test results on Table - 7.2 shows non-significance on all the scales that indicated that there is a difference between the variances (heterogeneous variance) in the coping styles (CISS).

Table - 8.1 to Table - 8.3 shows Post-hoc comparisons, Scheffe test was employed for Post-hoc multiple mean comparisons on Coping Inventory for Stressful Situations. The result indicated significant effects among the groups. Figure - 5.1 to 5.3 shows interaction effects of 'Volunteer/Non Volunteer and Fatal/Non Fatal' on

Coping measures. The finding got support of earlier findings that any kind of combat fighting induce higher distress is among the survivors (Carson & MacLeod, 1997).

Table - 8.1: Mean differences for significant two-way interaction effects on CISS (T).

Post Hoc tests :	**Scheffe**				
Volunteer x Fatal		**Mean Diff.**	**SE**	**q**	**Prob.**
Volunteer Fatal	Volunteer- Non-Fatal	4.94	0.62	7.99	0.00
	Non Volunteer- Fatal	8.84	0.62	14.31	0.00
	Non Volunteer-Non Fatal	15.72	0.62	25.45	0.00
Volunteer- Non-Fatal	Non Volunteer- Fatal	3.90	0.50	7.73	0.00
	Non Volunteer-Non Fatal	10.78	0.50	21.38	0.00
Non Volunteer-Fatal	Non Volunteer-Non Fatal	6.88	0.50	13.64	0.00

Table - 8.2: Mean differences for significant two-way interaction effects on CISS (E).

Post Hoc tests:	**Scheffe**				
		Mean Diff.	**SE**	**q**	**Prob.**
Volunteer Fatal	Volunteer- Non-Fatal	7.00	0.77	9.01	0.00
	Non Volunteer- Fatal	10.22	0.77	13.15	0.00
	Non Volunteer-Non Fatal	16.96	0.77	21.83	0.00
Volunteer- Non-Fatal	Non Volunteer- Fatal	3.22	0.77	4.15	0.00
	Non Volunteer-Non Fatal	9.96	0.77	12.82	0.00
Non Volunteer- Fatal	Non Volunteer-Non Fatal	6.74	0.77	8.67	0.00

Table - 8.3: Mean differences for significant two-way interaction effects on CISS (A).

Post Hoc tests:	**Scheffe**				
		Mean Diff.	**SE**	**q**	**Prob.**
Volunteer Fatal	Volunteer- Non-Fatal	-8.46	0.82	10.31	0.00
	Non Volunteer- Fatal	-14.28	0.82	17.41	0.00
	Non Volunteer-Non Fatal	-21.30	0.82	25.96	0.00
Volunteer- Non-Fatal	Non Volunteer- Fatal	-5.82	0.82	7.09	0.00
	Non Volunteer-Non Fatal	-12.84	0.82	15.65	0.00
Non Volunteer- Fatal	Non Volunteer-Non Fatal	-7.02	0.82	8.56	0.00

Figure - 5.1 Line graph showing means of 'Volunteer/Non Volunteer & Fatal/Non Fatal' interaction effects on Task oriented coping {(CISS (T)}

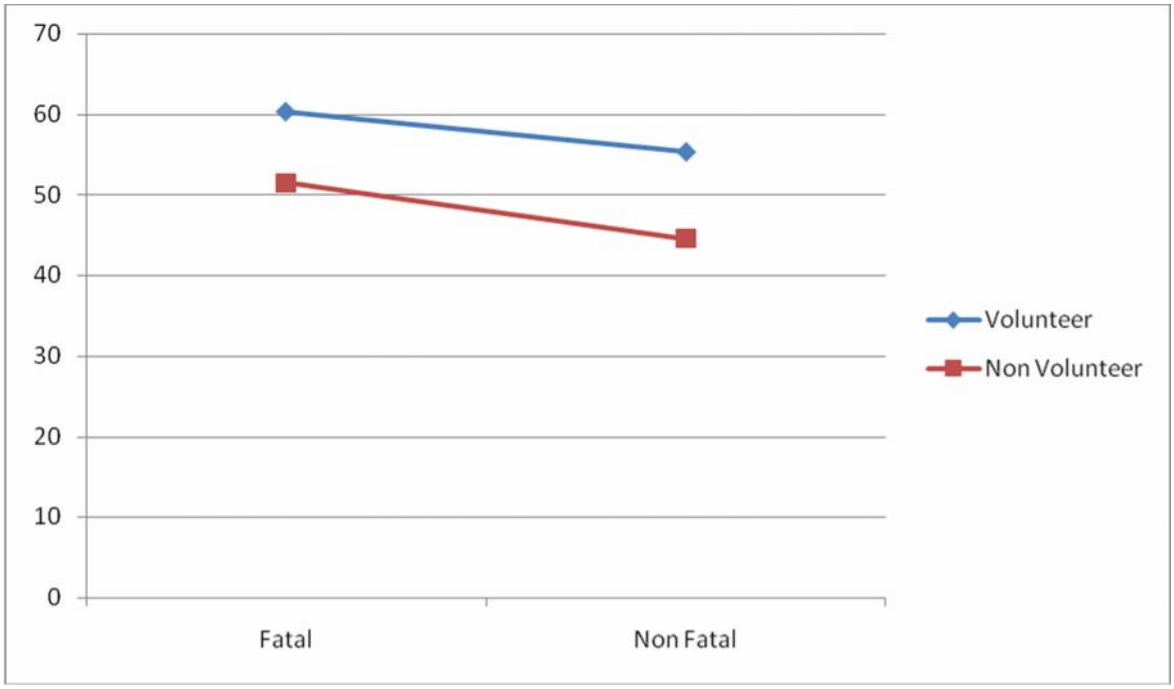


Figure -5.2: Line graph showing means of 'Volunteer/Non Volunteer & Fatal/Non Fatal' interaction effects on Emotion oriented coping {CISS (E)}

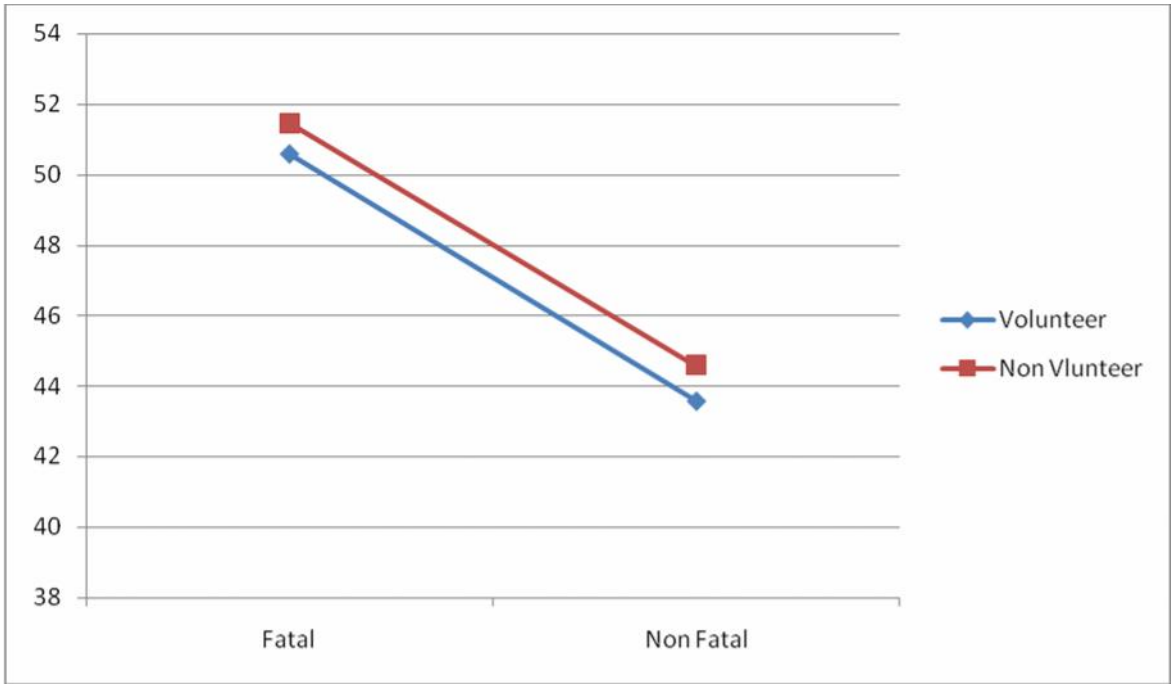
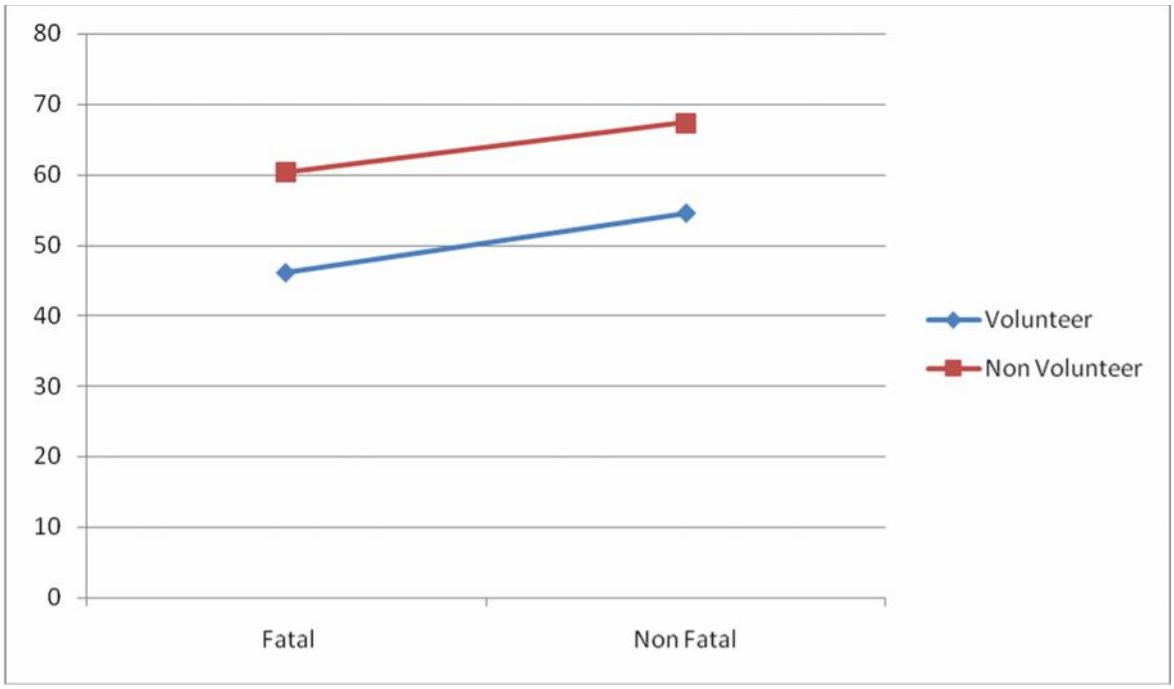


Figure - 5.3 : Line graph showing means of 'Volunteer/Non Volunteer & Fatal/Non Fatal' interaction effects on Avoidance oriented coping {(CISS(A)}.



The Line graph in Figure -5.1 shows that Volunteer, both Fatal and Non Fatal score higher in Task oriented coping style (i.e. $x\bar{}$=60.30 & $x\bar{}$=55.36) than Non Volunteer (Fatal & Non Fatal) (i.e. $x\bar{}$=51.46 & $x\bar{}$=44.58) and it also indicated higher scores by the Fatal (Volunteer & Non Volunteer) than Non Fatal (Volunteer & Non Volunteer). Figure -5.2 shows Line graph of means of 'Volunteer/Non Volunteer & Fatal/Non Fatal' interaction effects on Emotion oriented coping {CISS (E)}, which revealed that Volunteer (Fatal & Non Fatal) scores higher (i.e. $x\bar{}$=50.58 & $x\bar{}$=43.58) than Non Volunteer (Fatal & Non Fatal) (i.e. $x\bar{}$=40.36 & $x\bar{}$=33.62). The result also portrait that Emotion oriented coping style was more prevalent among Fatal participants than Non Fatal participants. The Line graph on Figure -5.3 shows that Non Volunteer (Fatal & Non Fatal) has higher scores (i.e. $x\bar{}$=60.36 & $x\bar{}$=67.38) than Volunteer (Fatal & Non Fatal) (i.e. $x\bar{}$=46.08 & $x\bar{}$=54.54) on Avoidance oriented coping style. It also can be seen that the Non Fatal participants, both Volunteer and Non Volunteer scores higher Avoidance oriented coping style than Fatal participants.

Table - 9.1 shows 2 x 2 ANOVA {2 Volunteer (Volunteer & Non Volunteer) x 2 Fatal (Fatal x Non Fatal)} of Frustration test. The table revealed that there are significant differences among the scores in Regression, Fixation, Resignation and Aggression {FT (RG, FX, RSG & AG)}. In Table 9.1, the effect-size on Frustration Test indicated that on Regression the 'Volunteer' shows 66% and 'Fatal' shows 39%, on Fixation the 'Volunteer' shows effect-size of 66% and 'Fatal' shows 38%. The 'Volunteer' effect-size on Resignation is 74% and the 'Fatal' effect-size is 42%. On Aggression, the 'Volunteer' shows the effect-size of 55% while the 'Fatal' shows 29%.

The Levene's Test the scales of Frustration-Resignation and Frustration-Aggression indicated significant effect (Table 9.2), and other two measures (i.e. Regression and Fixation) in Frustration Test prove heterogeneity of variances. But since these two measures falls under the normal skewness and kurtosis (Tables - 1, 2, 3 & 4) the two measure are considered to be heterogeneous and in support of the ANOVA.

Table - 9.1: 2x2 ANOVA for 'Volunteer x Fatal' on Frustration Test: Regression {FT (RG)}, Fixation {FT (FX)}, Resignation {FT (RSG)}, and Aggression {FT (AG).

Dependent Variable	Sources of Variation	Sum of Squares	df	Mean Square	F	Sig.	Partial Eta Squared
FT (RG)	Volunteer (V)	2888	1	2888	389.87	.00	.66
	Fatal (F)	924.5	1	924.5	124.80	.00	.39
	V X F	40.50	1	40.50	5.46	.02	.03
	Error	1451.88	196	7.40			
FT (FX)	Volunteer (V)	2812.50	1	2812.50	381.15	.00	.66
	Fatal (F)	907.38	1	907.38	122.96	.00	.38
	V X F	36.98	1	36.98	5.01	.02	.02
	Error	1446.32	196	7.38			
FT (RSG)	Volunteer (V)	5273.65	1	5273.65	562.52	.00	.74
	Fatal (F)	1326.12	1	1326.12	141.45	.00	.42
	V X F	36.12	1	36.12	3.85	.05	.01
	Error	1837.50	196	9.37			
FT (AG)	Volunteer (V)	3880.80	1	3880.80	243.26	.00	.55
	Fatal (F)	1326.12	1	1326.12	83.12	.00	.29
	V X F	105.12	1	105.12	6.58	.01	.03
	Error	3126.82	196	15.95			

Table - 9.2: Levene's Test of Equality of Error Variances for Frustration Test

	F	df1	df2	Sig.
FT (RG)	1.234	3	196	.299
FT (FX)	1.789	3	196	.151
FT (RSG)	3.711	3	196	.013
FT (AG)	3.542	3	196	.016

Table - 10.1: Mean differences for significant two-way interaction effects on FT (RG).

Post Hoc tests:	**Scheffe**				
		Mean Diff.	**SE**	**q**	**Prob.**
Volunteer Fatal	Volunteer- Non-Fatal	4.28	0.77	5.54	0.00
	Non Volunteer- Fatal	7.52	0.77	9.74	0.00
	Non Volunteer-Non Fatal	12.72	0.77	16.47	0.00
Volunteer- Non-Fatal	Non Volunteer- Fatal	3.24	0.77	4.19	0.00
	Non Volunteer-Non Fatal	8.44	0.77	10.93	0.00
Non Volunteer- Fatal	Non Volunteer-Non Fatal	5.20	0.77	6.73	0.00

Table - 10.2: Mean differences for significant two-way interaction effects on FT (FX).

Post Hoc tests:	**Scheffe**				
		Mean Diff.	**SE**	**q**	**Prob.**
Volunteer Fatal	Volunteer- Non-Fatal	3.40	0.54	6.29	0.00
	Non Volunteer- Fatal	6.64	0.54	12.22	0.00
	Non Volunteer-Non Fatal	11.76	0.54	21.65	0.00
Volunteer- Non-Fatal	Non Volunteer- Fatal	3.24	0.54	5.96	0.00
	Non Volunteer-Non Fatal	8.36	0.54	15.39	0.00
Non Volunteer- Fatal	Non Volunteer-Non Fatal	5.12	0.54	9.42	0.00

Table - 10.3: Mean differences for significant two-way interaction effects on FT (RSG).

Post Hoc tests:	**Scheffe**				
		Mean Diff.	**SE**	**q**	**Prob.**
Volunteer Fatal	Volunteer- Non-Fatal	-6.00	0.61	9.79	0.00
	Non Volunteer- Fatal	-11.12	0.61	18.16	0.00
	Non Volunteer-Non Fatal	-15.42	0.61	25.18	0.00
Volunteer- Non-Fatal	Non Volunteer- Fatal	-5.12	0.61	8.36	0.00
	Non Volunteer-Non Fatal	-9.42	0.61	15.38	0.00
Non Volunteer- Fatal	Non Volunteer-Non Fatal	-4.30	0.61	7.02	0.00

Table - 10.4 : Mean differences for significant two-way interaction effects on FT (AG).

Post Hoc tests:	**Scheffe**				
		Mean Diff.	**SE**	**q**	**Prob.**
Volunteer Fatal	Volunteer- Non-Fatal	6.60	0.79	8.26	0.00
	Non Volunteer- Fatal	10.26	0.79	12.84	0.00
	Non Volunteer-Non Fatal	13.96	0.79	17.48	0.00
Volunteer- Non-Fatal	Non Volunteer- Fatal	3.66	0.79	4.58	0.00
	Non Volunteer-Non Fatal	7.36	0.79	9.21	0.00
Non Volunteer- Fatal	Non Volunteer-Non Fatal	3.70	0.79	4.63	0.00

The Post-hoc multiple mean comparisons employing Scheffe test was done sequentially on Frustration test measures, which revealed significant effects between all the groups on. Table - 10.1 to Table -10.4 and Figures - 6.1 to 6 .4 shows interaction effects of 'Volunteer/Non Volunteer and Fatal/Non Fatal' on Frustration measures.

Figure -6.1 shows Frustration-Regression graph comparisons for the participants, the graph stated that Volunteer (Fatal & Non Fatal) scores higher (i.e. $x\bar{}$=33.16 & $x\bar{}$=29.76) than Non Volunteer (Fatal & Non Fatal) (i.e. $x\bar{}$=26.46 & $x\bar{}$=21.26). The Fatal participant's scores higher than the Non Fatal participants for both Volunteer and Non Volunteer. The Volunteer (Fatal) scores very high than the rest of the participants.

The Line graph in Figure - 6.2 shows that Volunteer, both Fatal and Non Fatal score higher in Frustration-Fixation measure (i.e. $x\bar{}$=33.16 & $x\bar{}$=29.76) than Non Volunteer (Fatal & Non Fatal) (i.e. $x\bar{}$=26.51 & $x\bar{}$=21.41) and it also indicated higher scores by the Fatal (Volunteer & Non Volunteer) than Non Fatal (Volunteer & Non Volunteer). Figure - 6.3 shows the result of Frustration-Resignation, which revealed that Non Volunteer (Fatal & Non Fatal) scores much higher (i.e. $x\bar{}$=43.18 & $x\bar{}$=47.48) than Volunteer (Fatal & Non Fatal) (i.e. $x\bar{}$=32.06 & $x\bar{}$=38.06), and

Non Fatal are higher on Frustration-Resignation than Fatal. The Line graph on Figure - 6.4 shows that Volunteer (Fatal & Non Fatal) has higher scores (i.e. x□ =37.88 & x□ =31.28) than Non Volunteer (Fatal & Non Fatal) (i.e. x□ =27.62 & x□ =23.92) on Frustration- Aggression. It also can be seen that the Fatal participants, both Volunteer and Non Volunteer scores higher on Frustration-Aggression than Non Fatal participants. Scholte and colleagues (2004) also found that 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. Majority Sinhala and minority Tamil population in Sri Lanka has been ongoing for nearly 30 years, the psychological effects of the conflict on the civilian population was 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%).(Somasundaram and Jamunanatha, 2002),

Figure - 6.1: Line graph showing means of 'Volunteer/Non Volunteer & Fatal/Non Fatal' interaction effects on Regression {(FT (RG)}.

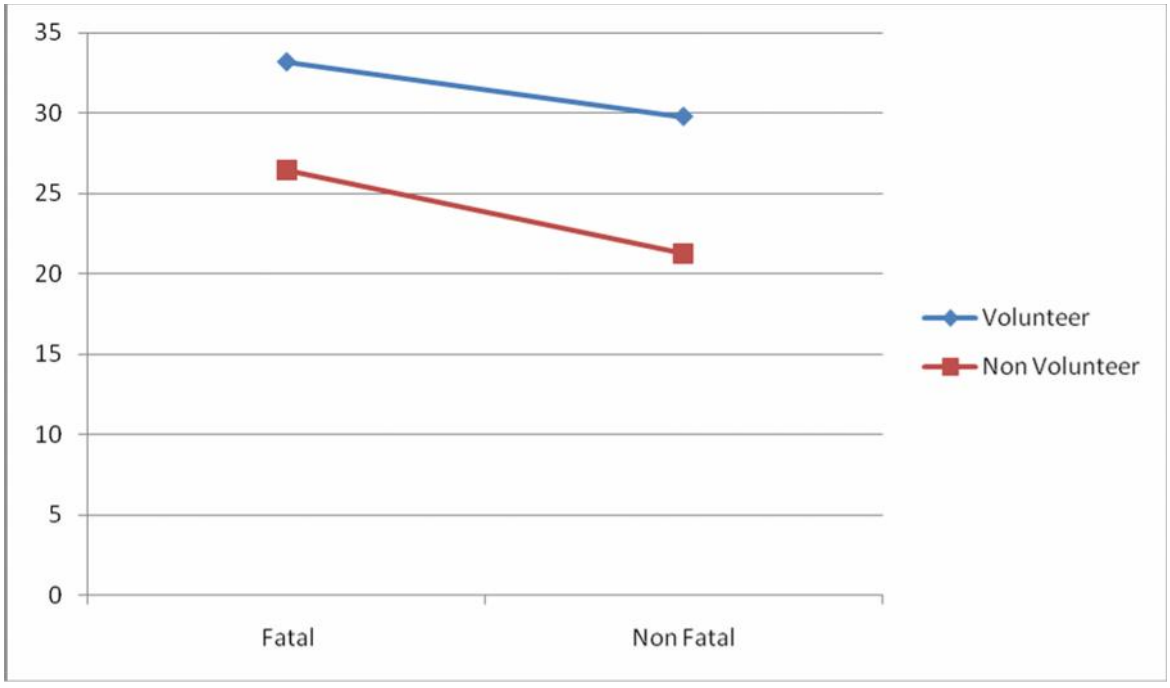


Figure - 6.2: Line graph showing means of 'Volunteer/Non Volunteer & Fatal/Non Fatal' interaction effects on Fixation {(FT (FX)}

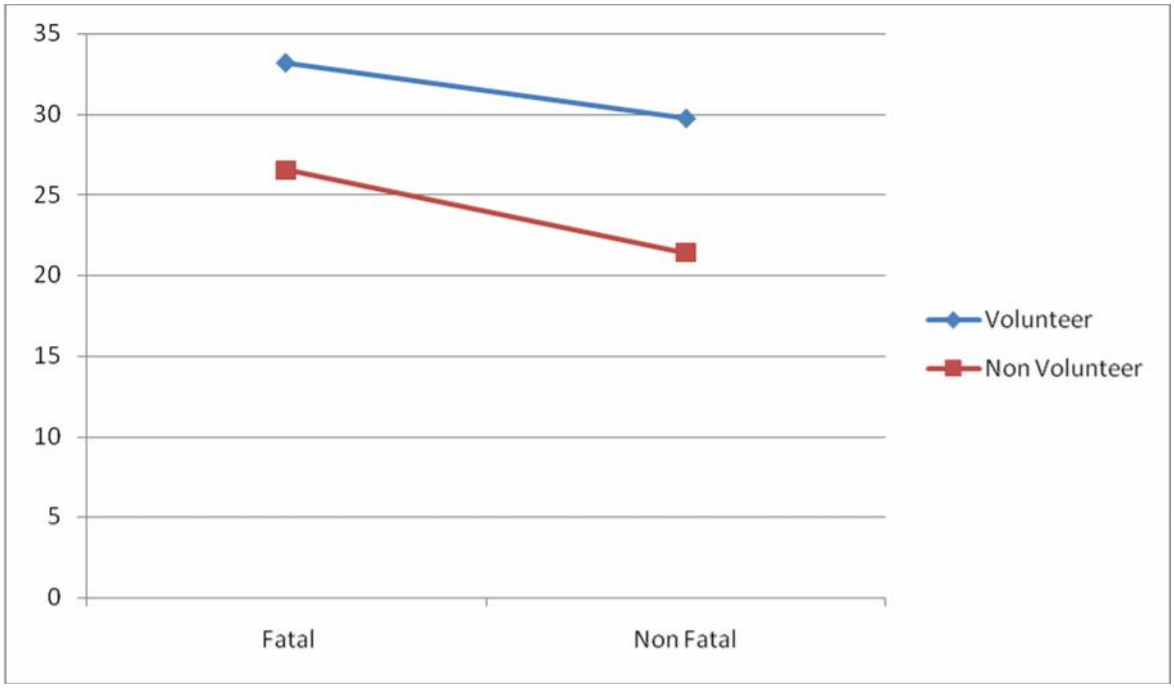


Figure - 6.3: Line graph showing means of 'Volunteer/Non Volunteer & Fatal/Non Fatal' interaction effects on Resignation {(FT (RSG)}

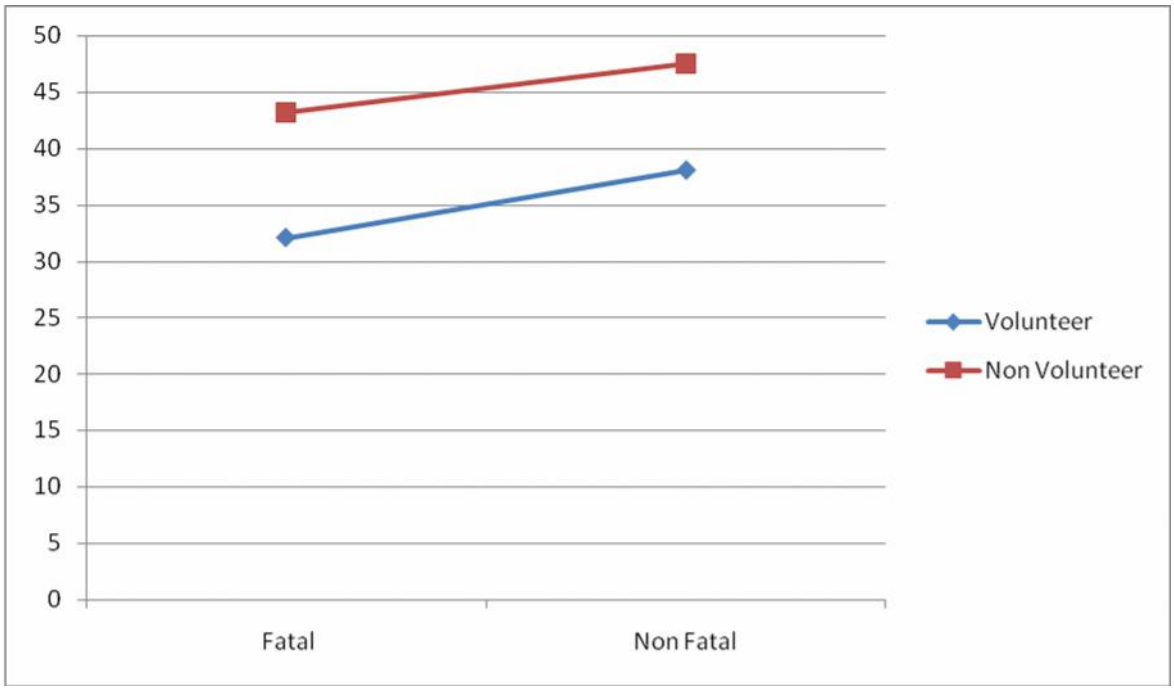


Figure - 6.4: Line graph showing means of 'Volunteer/Non Volunteer & Fatal/Non Fatal' interaction effects on Agression {(FT (AG)}

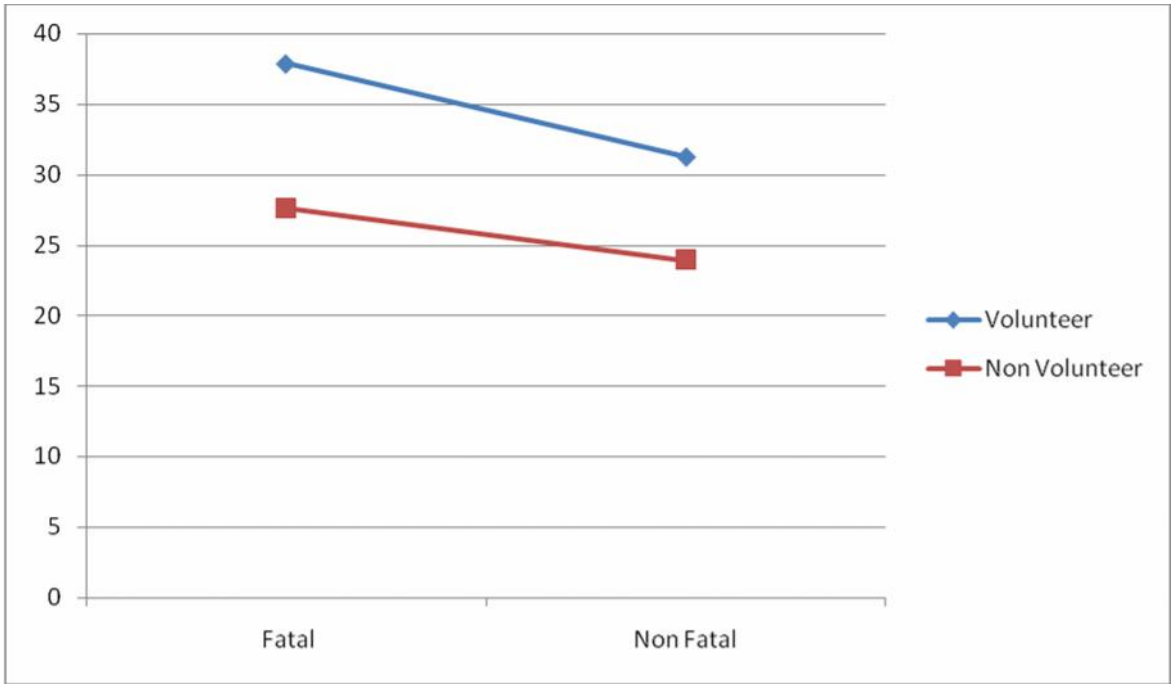


Table - 11.1 shows 2 x 2 ANOVA {2 Volunteer (Volunteer & Non Volunteer) x 2 Fatal (Fatal x Non Fatal)} of Symptom Questionnaire. The table revealed that there are significant differences among the scores on Anxiety, Depression, Somatic Concern and Anger-Hostility {SQ (A, D, SC & AH)}. In Table - 11.1, the effect-size on Symptom Questionnaire indicated that on Anxiety the 'Volunteer' shows 65% and 'Fatal' shows 8%, on Depression the 'Volunteer' shows effect-size of 73% and 'Fatal' shows 40%. The 'Volunteer' effect-size on Somatic Concern is 80% and the 'Fatal' effect-size is 48%. On Anger-Hostility, the 'Volunteer' shows the effect-size of 77% while the 'Fatal' shows 54%. The finding congruent with the work of Spitzer, Kroenke and Williams (1999) that soldiers scoed beyond clinically significant cutoff scores for symptoms of depression, anxiety, and somatic concerns.

Table - 11.1 :2x2 ANOVA for 'Volunteer x Fatal' on Symptom Questionnaire: Anxiety {SQ (A)}, Depression {SQ (D)}, Somatic Concern {SQ (SC)} and Anger-Hostility {SQ (AH)}.

Dependent Variable	Sources of Variation	Sum of Squares	df	Mean Square	F	Sig.	Partial Eta Squared
SQ (A)	Volunteer (V)	1431.12	1	1431.12	370.94	.00	.65
	Fatal (F)	305.045	1	305.045	79.07	.00	.28
	V X F	3.64	1	3.64	0.94	.33	.00
	Error	756.18	196	3.85			
SQ (D)	Volunteer (V)	1693.62	1	1693.62	548.53	.00	.73
	Fatal (F)	414.72	1	414.72	134.32	.00	.40
	V X F	4.50	1	4.50	1.45	.23	.01
	Error	605.16	196	3.08			
SQ (SC)	Volunteer (V)	1776.08	1	1776.08	786.02	.00	.80
	Fatal (F)	414.72	1	414.72	183.54	.00	.48
	V X F	0.32	1	0.32	0.14	.70	.00
	Error	442.88	196	2.26			
SQ (AH)	Volunteer (V)	1764.18	1	1764.18	656.53	.00	.77
	Fatal (F)	626.58	1	626.58	233.17	.00	.54
	V X F	6.48	1	6.48	2.41	.12	.01
	Error	526.68	196	2.68			

Table - 11.2 Levene's Test of Equality of Error Variances for Symptom Questionnaire (SQ)

	F	df1	df2	Sig.
SQ (A)	.71	3	196	.55
SQ (D)	.61	3	196	.61
SQ (SC)	1.71	3	196	.17
SQ (AH)	5.43	3	196	.00

To indicate there is a difference between the variances as assumed by the 2 x 2 ANOVA Levene's test was applied. Levene's test is a Homogeneity test, it show homogeneity of variance for each dependent variable. Table - 11.2 shows non-significant results on all the scale except for Anger-Hostility measures, but on looking at the skewness and kurtosis on the descriptive statistics of Symptoms Questionnaire, measures indicated a normal skewness and kurtosis (Table 1, 2, 3 & 4), which further indicated that there is a difference between the variances (heterogeneous variance) as assumed by the 2 x 2 ANOVA.

The Post-hoc multiple mean comparisons employing Scheffe test was done sequentially on the Symptom Questionnaire measures, which revealed significant effects among the groups. Table - 12.1 to Table - 12.4 and Figure -7.1 to 7.4 shows interaction effects of 'Volunteer/Non Volunteer and Fatal/Non Fatal' on different measures.The finding confirmed the earlier study conducted 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. 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).

Table - 12.1: Mean differences for significant two-way interaction effects on SQ (A).

Post Hoc tests:	**Scheffe**				
		Mean Diff.	SE	q	Prob.
Volunteer Fatal	Volunteer- Non-Fatal	3.40	0.54	6.25	0.00
	Non Volunteer- Fatal	6.70	0.54	12.31	0.00
	Non Volunteer-Non Fatal	11.90	0.54	21.86	0.00
Volunteer- Non-Fatal	Non Volunteer- Fatal	3.30	0.54	6.06	0.00
	Non Volunteer-Non Fatal	8.50	0.54	15.62	0.00
Non Volunteer- Fatal	Non Volunteer-Non Fatal	5.20	0.54	9.55	0.00

Table - 12.2: Mean differences for significant two-way interaction effects on SQ (D).

Post Hoc tests:	**Scheffe**				
		Mean Diff.	SE	q	Prob.
Volunteer Fatal	Volunteer- Non-Fatal	3.18	0.35	9.05	0.00
	Non Volunteer- Fatal	6.12	0.35	17.42	0.00
	Non Volunteer-Non Fatal	8.70	0.35	24.76	0.00
Volunteer- Non-Fatal	Non Volunteer- Fatal	2.94	0.35	8.37	0.00
	Non Volunteer-Non Fatal	5.52	0.35	15.71	0.00
Non Volunteer- Fatal	Non Volunteer-Non Fatal	2.58	0.35	7.34	0.00

Table - 12.3: Mean differences for significant two-way interaction effects on SQ (SC).

Post Hoc tests:	**Scheffe**				
		Mean Diff.	SE	q	Prob.
Volunteer Fatal	Volunteer- Non-Fatal	-2.80	0.30	9.31	0.00
	Non Volunteer- Fatal	-5.88	0.30	19.56	0.00
	Non Volunteer-Non Fatal	-8.84	0.30	29.40	0.00
Volunteer- Non-Fatal	Non Volunteer- Fatal	-3.08	0.30	10.25	0.00
	Non Volunteer-Non Fatal	-6.04	0.30	20.09	0.00
Non Volunteer- Fatal	Non Volunteer-Non Fatal	-2.96	0.30	9.85	0.00

Table - 12.4: Mean differences for significant two-way interaction effects on SQ (AH).

Post Hoc tests:	**Scheffe**				
		Mean Diff.	SE	q	Prob.
Volunteer Fatal	Volunteer- Non-Fatal	3.18	0.33	9.70	0.00
	Non Volunteer- Fatal	5.58	0.33	17.02	0.00
	Non Volunteer-Non Fatal	9.48	0.33	28.92	0.00
Volunteer- Non-Fatal	Non Volunteer- Fatal	2.40	0.33	7.32	0.00
	Non Volunteer-Non Fatal	6.30	0.33	19.22	0.00
Non Volunteer- Fatal	Non Volunteer-Non Fatal	3.90	0.33	11.89	0.00

The Line graph in Figure - 7.1 shows that Volunteer, both Fatal and Non Fatal score higher in Anxiety measure (i.e. $x\square$ =19.54 & $x\square$ =16.80) than Non Volunteer (Fatal & Non Fatal) (i.e. $x\square$ =13.92 & $x\square$ =11-72) and it also indicated higher scores by the

Fatal (Volunteer & Non Volunteer) than Non Fatal (Volunteer & Non Volunteer). Figure -7 .2 shows the result of Depression, which revealed that Volunteer (Fatal & Non Fatal) scores much higher (i.e. x□ =18.80 & x□ =15.62) than Non Volunteer (Fatal & Non Fatal) (i.e. x□ =12.68 & x□ =10.10), and Fatal are higher on Depression than Non Fatal. The Line graph on Figure 3.3 shows that Non Volunteer (Fatal & Non Fatal) has higher scores (i.e. x□ =15.70 & x□ =18.66) than Volunteer (Fatal & Non Fatal) (i.e. x□ =9.82 & x□ =12.62) on somatic concern. It also can be seen that the Non Fatal participants, both Volunteer and Non Volunteer scores higher on Somatic concern than Fatal participants. This finding conform to the earlier finding stating that troops endorsed in high war zone stress exposure, have common symptoms of anxiety, anger, and depression, and multiple health and somatic concerns (Sutker and colleagues (1994).

The Line graph on Figure -7.4 shows scores difference in the Anger-Hostility measure, where the Volunteer (Fatal & Non Fatal) scores much higher (i.e. M =19.08 & M =15.90) than the Non Volunteer (Fatal & Non Fatal) (i.e. M=13.50 & M =9.60). And Fatal (Volunteer & Non Volunteer) scores higher than Non Fatal (Volunteer & Non Volunteer participants.

Figure -7.1: Line graph showing means of 'Volunteer/Non Volunteer & Fatal/Non Fatal' interaction effects on Anxiety {(SQ(A)}

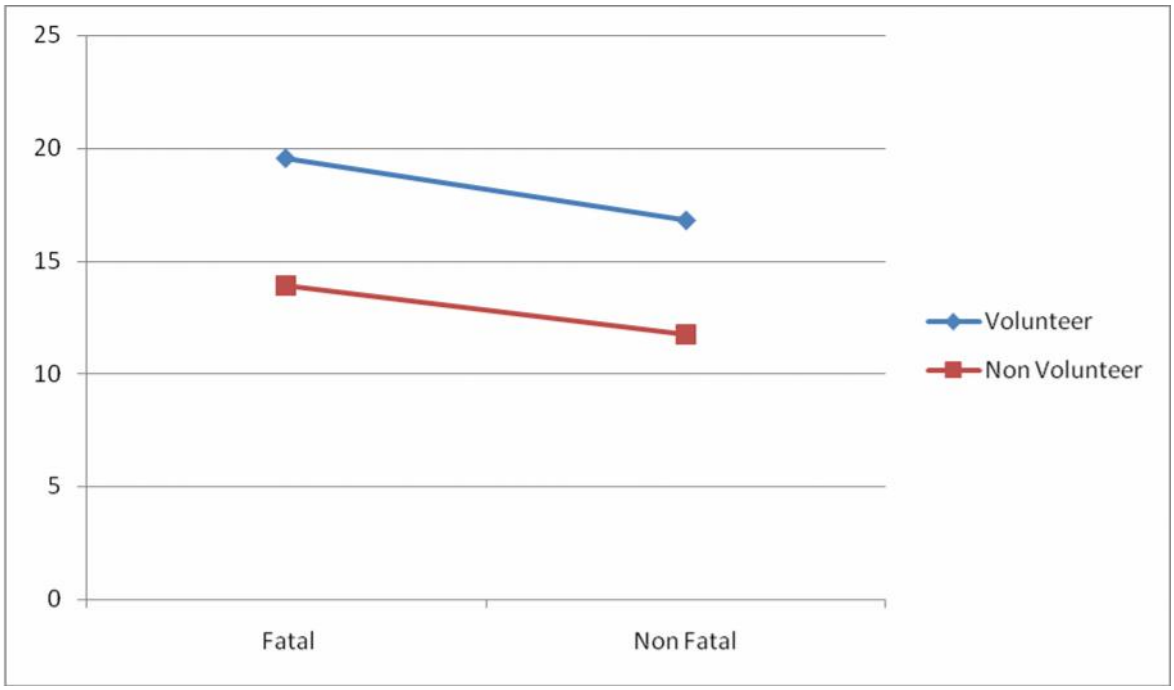


Figure -7.2: Line graph showing means of 'Volunteer/Non Volunteer & Fatal/Non Fatal' interaction effects on Depression {(SQ (D)}

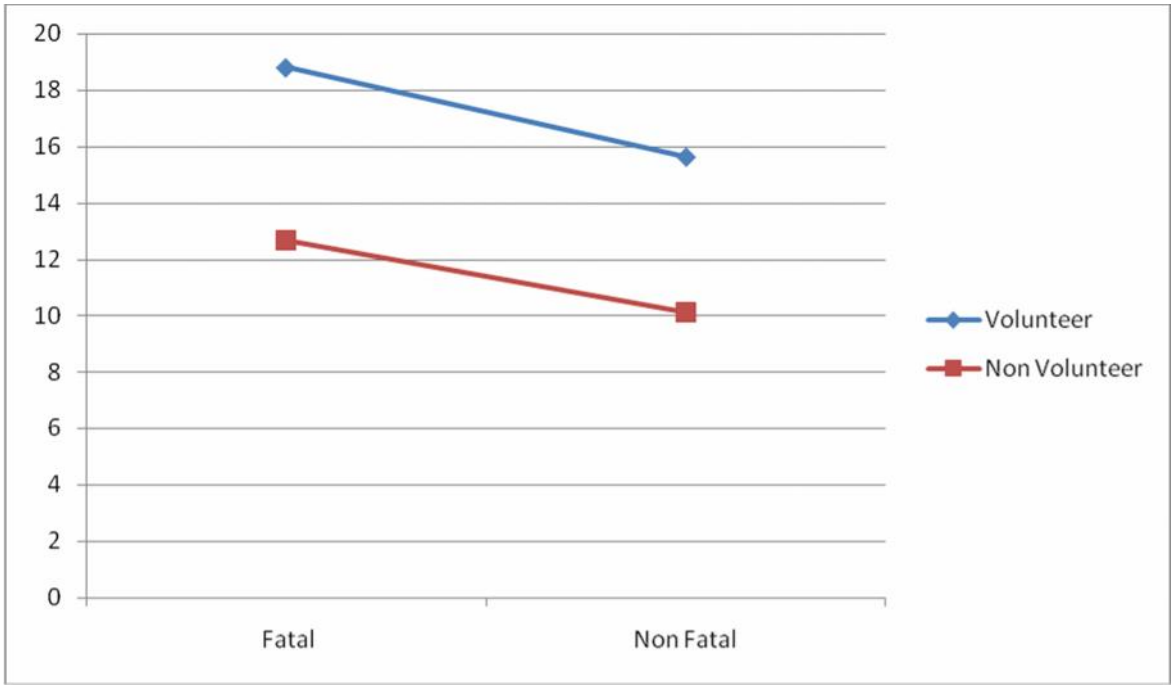


Figure -7.3: Line graph showing means of 'Volunteer/Non Volunteer & Fatal/Non Fatal' interaction effects on Somatic Concern {(SQ (SC)}

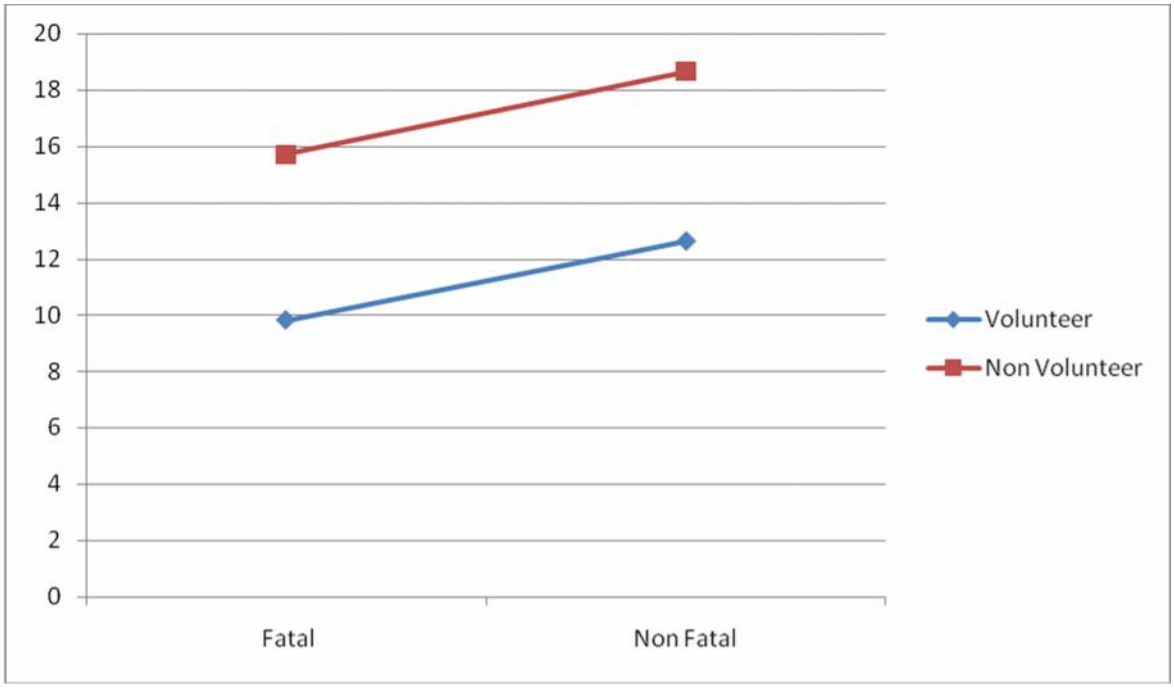


Figure - 7.4: Line graph showing means of 'Volunteer/Non Volunteer & Fatal/Non Fatal' interaction effects on Anger hostility {(SQ (AH)}

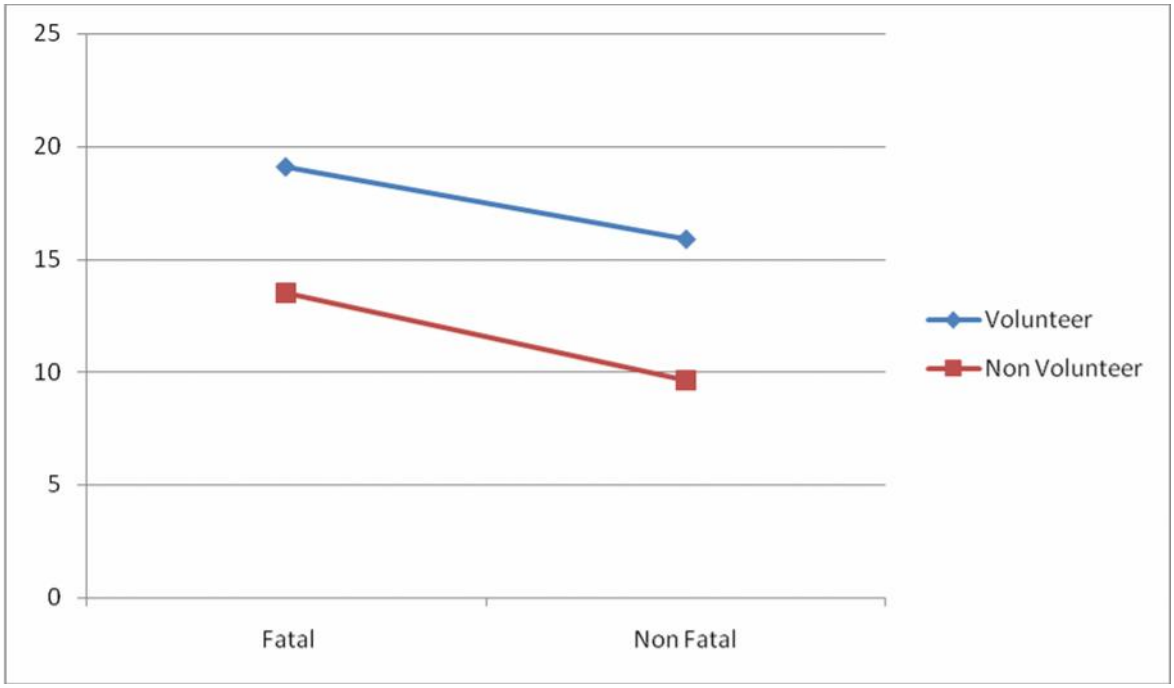
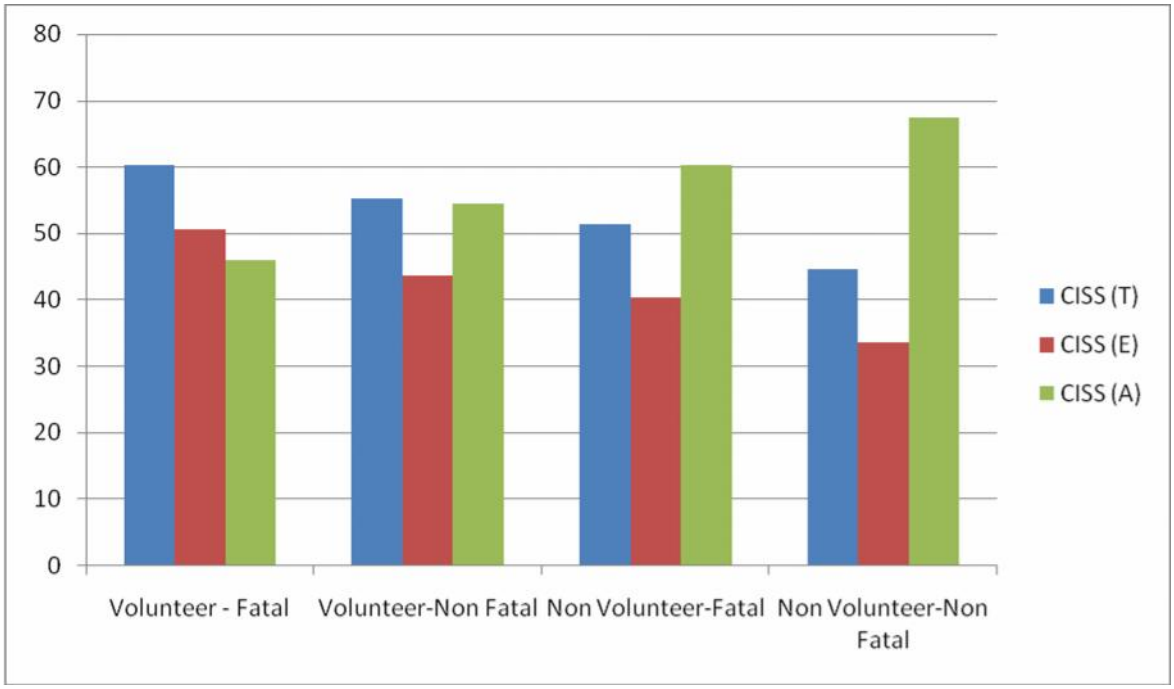


Figure -8 .1: Bar graph showing means for significant 'Volunteer/Non Volunteer' and 'Fatal/Non Fatal' in Task Oriented {CISS (T)}, Emotion Oriented {CISS(E)} and Avoidance Oriented Coping CISS(A)}.



Bar graph comparison of means for significant 'Volunteer/Non Volunteer' and 'Fatal/Non Fatal' in different behavioural measures are presented in Figure -8 .1, Figure -8.2 and Figure - 8.3.

In Figure -8.1, Non Volunteer-Non Fatal depicted highest scores on Avoidance oriented coping followed by Non Volunteer-Fatal then comes Volunteer-Non Fatal and Volunteer-Fatal as such. The reverse is depicted for Task oriented as well as Emotion oriented coping style where Volunteer-Fatal scores highest followed by Volunteer-Non Fatal then Non Volunteer-Fatal and Non Volunteer-Non Fatal.

In Figure -8.2, it can be seen that Volunteer-Fatal scores highest on the measures of Anxiety, Depression and Anger-Hostility and Non Volunteer-Non Fatal score highest on the measure of Somatic Concern. Same is the case in Figure -5.3 where volunteer-Fatal scores the highest on Regression, Fixation and Aggression where Non Volunteer-Non Fatal scores highest on Resignation.

Figure - 8.2 Bar graph showing means for significant 'Volunteer/Non Volunteer' and 'Fatal/Non Fatal' in Anxiety {SQ (A)}, Depression{SQ(D)}, Somatic Concern {SQ(SC)} and Anger Hostility {SQ(AH)}.

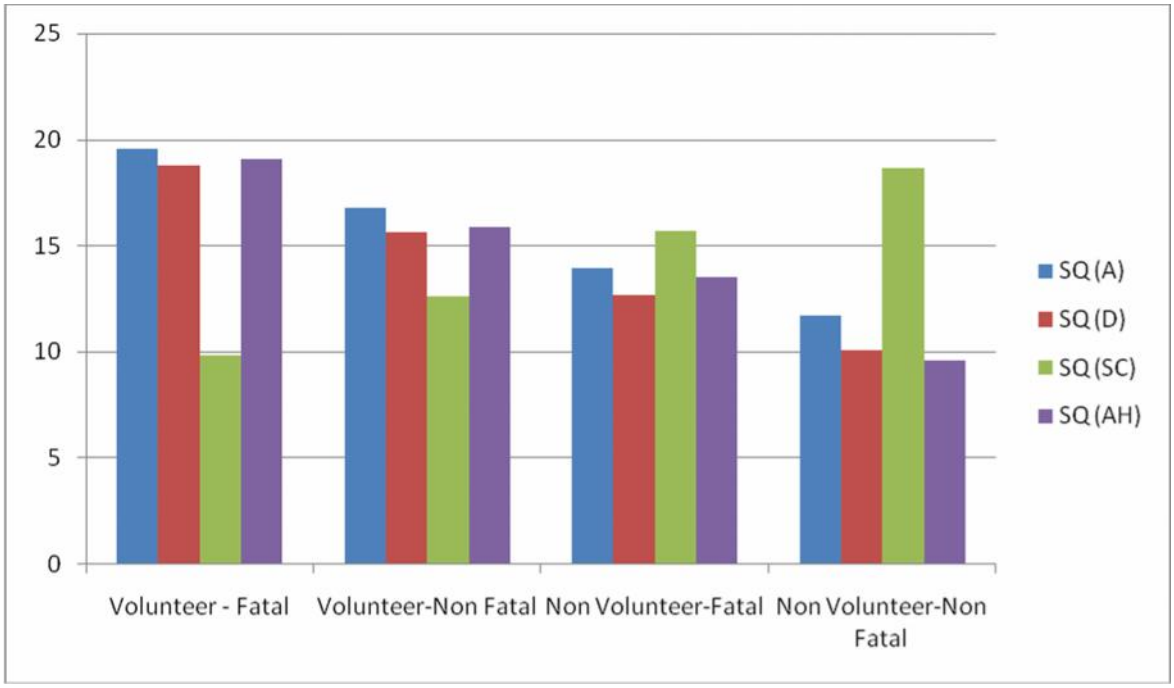


Figure -8 .3 Bar graph showing means for significant 'Volunteer/Non Volunteer' and 'Fatal/Non Fatal' in Regression {FT (RG)}, Fixation {FT (FX)}, Resignation {FT (RSG)} and Aggression {FT (AG)}.

Prediction of the Symptoms of Psychopathology from Frustration test and Coping styles:

For prediction of the symptoms of psychopathology from the behavioural measures of Frustration and coping orientation Multiple regression analyses was employed which attempted to determine the antecedents and the consequences relationship among the behavioural measures of the theoretical construct as envisioned.

The regression model with Task oriented coping ($F=224.67$; $p<.01$), Emotion oriented coping ($F=176.75$; $p<.01$) and Avoidance oriented coping ($F=243.92$; $p<.01$as predictors and Anxiety as the criterion emerged to be statistically significant. The R, R square and the change statistics are presented in Table 13 and the graphs depicting normality and homogeneity of regression slope are presented in Figure - 9.1 to Figure - 11.2 respectively.

Table - 13 :R, R square, change statistics and Durbin-Watson statistics in the prediction of Anxiety {SQ (A)}. { Predictor(s) = CISS (T), CISS (E), CISS (A)}

Predictors	R	R square	Change Statistics					Durbin-Watson
			R square change	F change	df 1	df 2	Sig. F change	
CISS (T)	.73	.53	.53	224.67	1	198	.00	1.28
CISS (E)	.69	.47	.47	176.76	1	198	.00	.96
CISS (A)	.74	.55	.55	243.93	1	198	.00	1.13

Table - 14 :Beta-values and Collinearity Statistics in the prediction of scores on Somatic Concern (Anxiety) { SQ (A)}.

Predictors	Beta	t	Sig.	Collinearity Statistics	
				Tolerance	VIF
CISS (T)	.729	14.989	.000	1.000	1.000
CISS (E)	.687	13.295	.000	1.000	1.000
CISS (A)	-.743	-15.618	.000	1.000	1.000

In Table - 13, the small value of Durbin-Watson statistics on CISS (E) indicated that successive error terms are very close in value to one another, which cause an alarm. But since the Collinearity statistics of Tolerance valued 1.00 (Table - 14), the more likely that it is statistically significant.

The Durbin-Watson statistics and the Collinearity statistics (Table - 14) supported by the normality and the homogeneity of the regression slope (Figure -9.1 to Figure -11.2) revealed that on scores of Anxiety with Task oriented coping as a

predictor explain 53% of variances, Emotion oriented coping explain 47% and Avoidance oriented coping explain 55%. The finding also shows 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).

Figure -9.1 Histogram depicting the distribution of residual scores on Anxiety {SQ (A)}. Predictor = CISS (T)

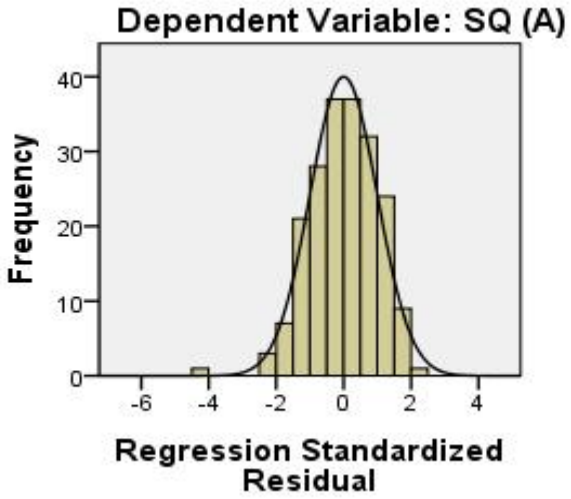


Figure -9.2 Graph depicting the regression slope in the prediction on Anxiety {SQ (A)}. Predictor = CISS (T)

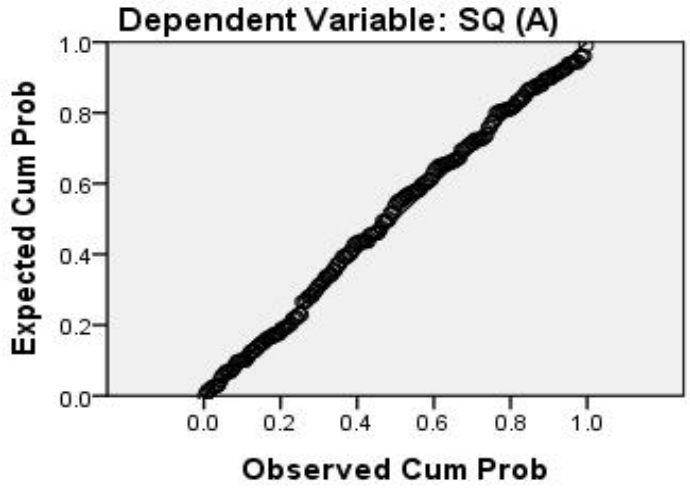


Figure - 10.1 Histogram depicting the distribution of residual scores on Anxiety {SQ (A)}. Predictor = CISS (E)

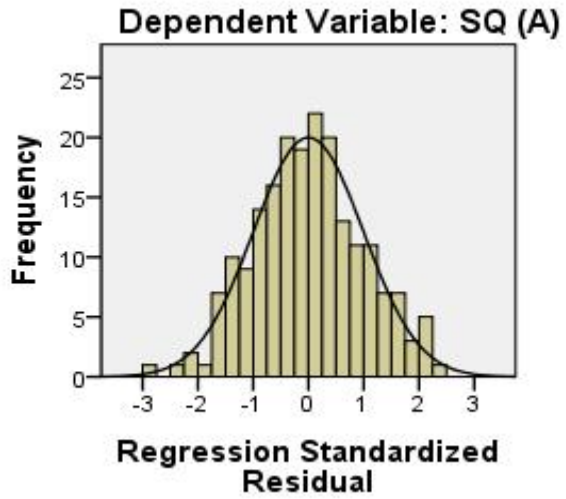


Figure -10 .2 Graph depicting the regression slope in the prediction on Anxiety {SQ (A)}. Predictor = CISS (E)

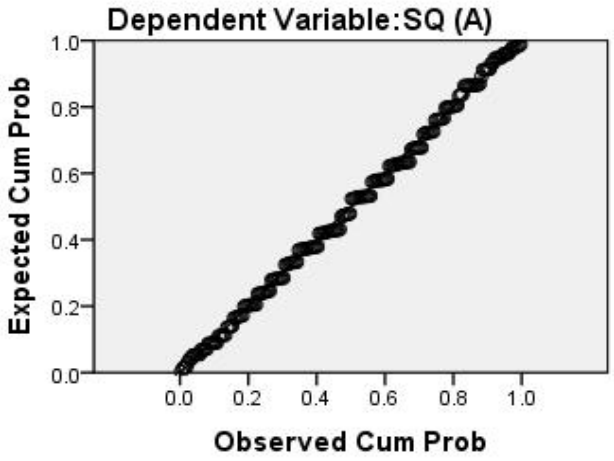


Figure -11.1 Histogram depicting the distribution of residual scores on Anxiety {SQ (A)}. Predictor = CISS (A)

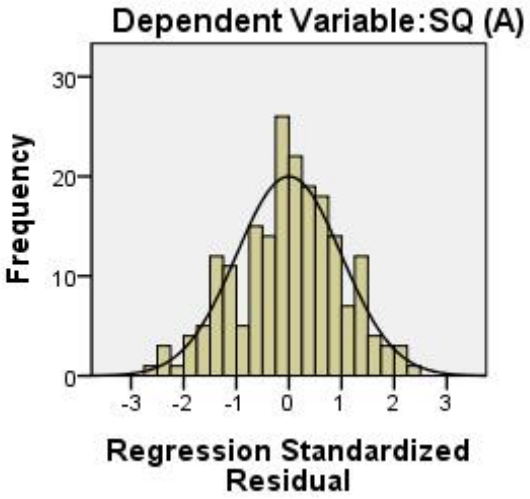
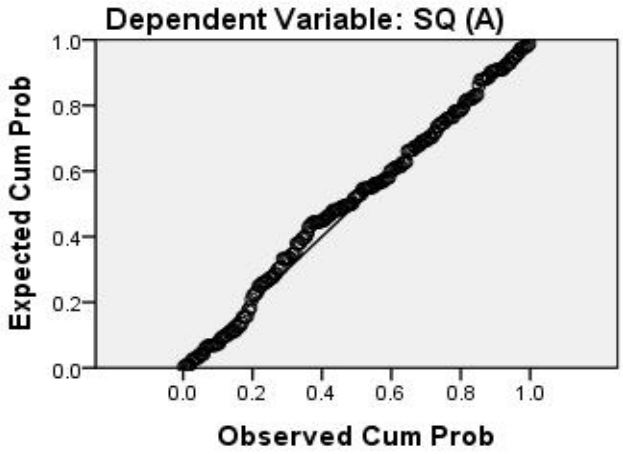


Figure -11.2 Graph depicting the regression slope in the prediction on Anxiety {SQ (A)}. Predictor = CISS (A)



The regression model with Frustration-Regression (F=215.41; p<.01), Frustration-Fixation (F=231.86; p<.01), Frustration-Resignation (F=318.48; p<.01) and Frustration-Aggression (F=150.97; p<.01) as predictors and Anxiety as the criterion emerged to be statistically significant. The R, R square and the change statistics are presented in Table 15 and the graphs depicting normality and

homogeneity of regression slope are presented in Figure - 12.1 to Figure - 16.2 respectively.

The Durbin-Watson statistics and the Collinearity statistics supported by the normality and the homogeneity of the regression slope revealed that on scores of Anxiety with Frustration-Regression as a predictor explain 52% of variances, Frustration-Fixation explain 54%, Frustration-Resignation explain 62% and Frustration-Aggression explain 43%.

Anxiety can arise in several different situations; anxiety can be aroused by mild anger or hostility. Anxiety may be produced as a result of frustration of motives. Frustration produces anxiety in two ways. First, frustration tends to provoke aggression, which leads to fear of punishment for the hostility. Secondly, frustration can cause fear of failure, either in achieving a desirable or positive goal or in avoiding an undesirable or negative goal. 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).

Table - 15 :R, R square, change statistics and Durbin-Watson statistics in the prediction of Anxiety {SQ (A)}. {Predictor(s) = FT (RG), FT (FX), FT (RSG), FT (AG)}.

Predictors	R	R square	Change Statistics					Durbin-Watson
			R square change	F change	df 1	df 2	Sig. F change	
FT (RG)	.72	.52	.52	215.41	1	198	.00	1.32
FT (FX)	.73	.54	.54	231.86	1	198	.00	1.29
FT (RSG)	.78	.62	.62	318.48	1	198	.00	1.41
FT (AG)	.66	.43	.43	150.97	1	198	.00	1.19

Table - 16 :Beta-values and Collinearity Statistics in the prediction of scores on Somatic Concern (Anxiety) { SQ (A)}.

Predictors	Beta	t	Sig.	Collinearity Statistics	
				Tolerance	VIF
FT (RG)	.722	14.677	.000	1.000	1.000
FT (FX)	.734	15.227	.000	1.000	1.000
FT (RSG)	-.785	-17.846	.000	1.000	1.000
FT (AG)	.658	12.287	.000	1.000	1.000

Figure -12.1 Histogram depicting the distribution of residual scores on Anxiety {SQ (A)}. Predictor = FT (RG)

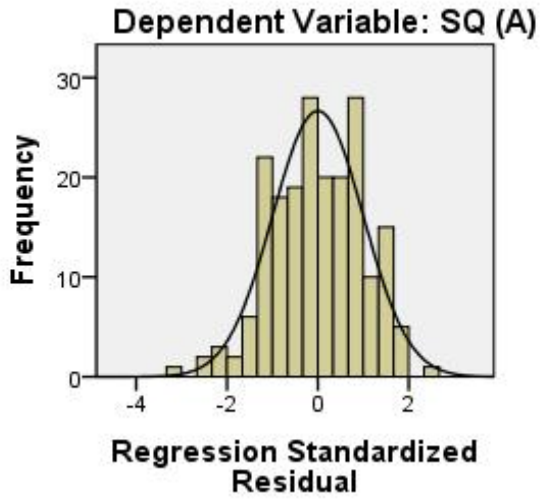


Figure -12.2 Graph depicting the regression slope in the prediction on Anxiety {SQ (A)}. Predictor = FT (RG)

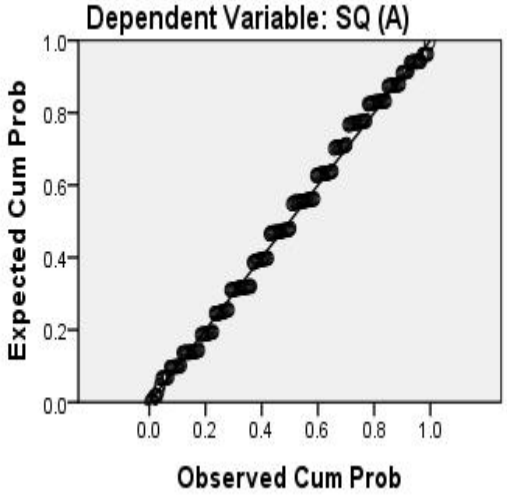


Figure - 13.1 Histogram depicting the distribution of residual scores on Anxiety {SQ (A)}. Predictor = FT (FX)

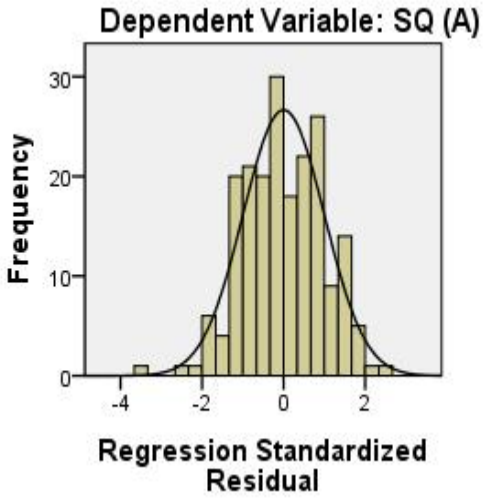


Figure - 13.2 Graph depicting the regression slope in the prediction on Anxiety {SQ (A)}. Predictor = FT (FX)

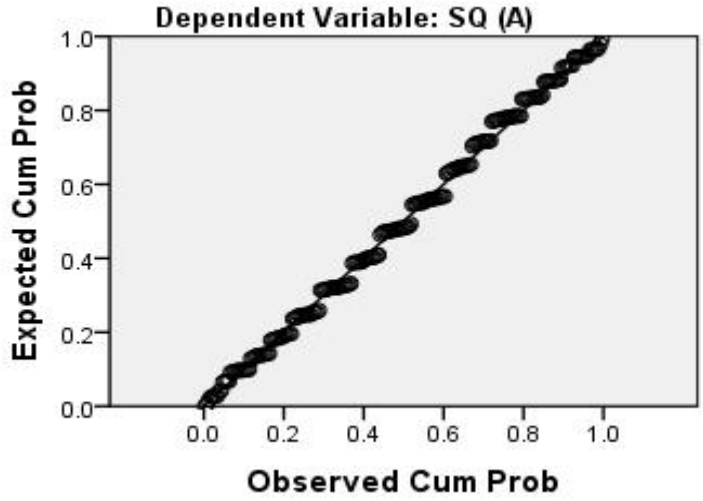


Figure - 14.1 Histogram depicting the distribution of residual scores on Anxiety {SQ (A)}. Predictor = FT (RSG)

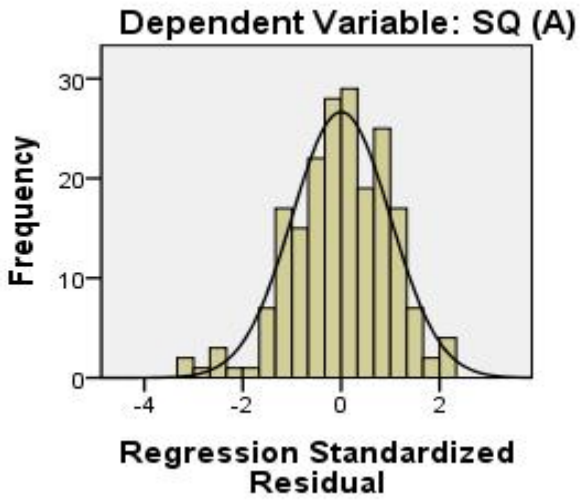


Figure - 14.2 Graph depicting the regression slope in the prediction on Anxiety {SQ (A)}. Predictor = FT (RSG)

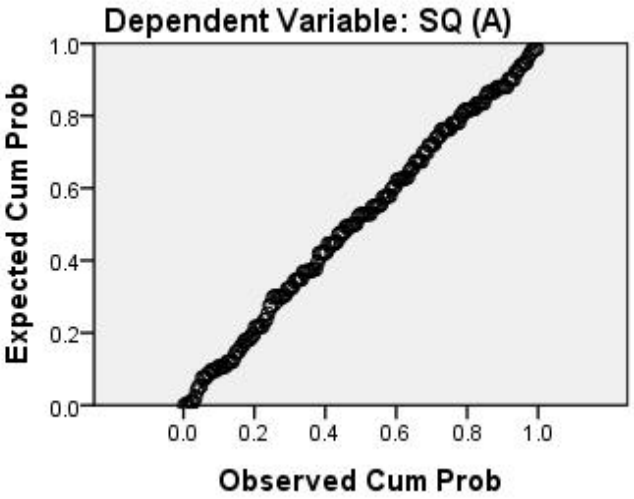


Figure – 15 .1 Histogram depicting the distribution of residual scores on Anxiety {SQ (A)}. Predictor = FT (AG)

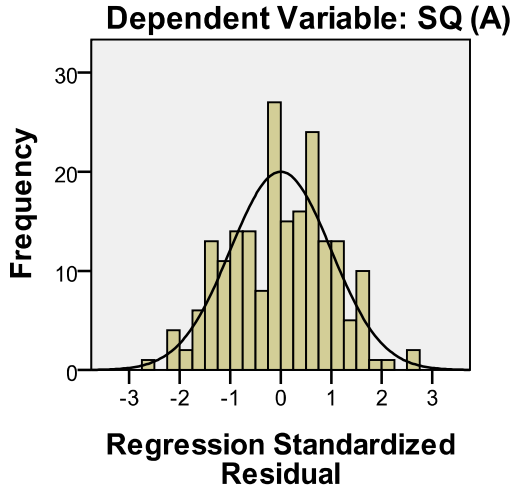
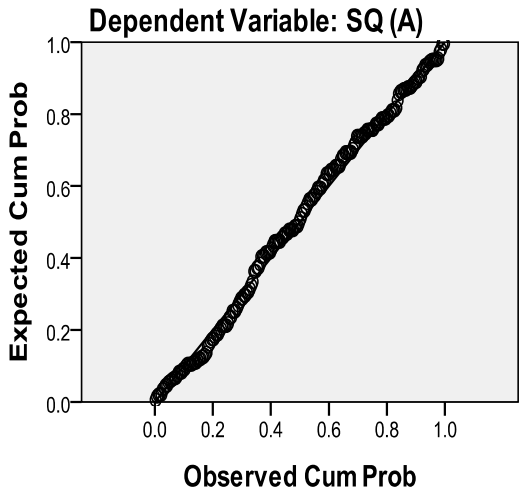


Figure – 15 .2 Graph depicting the regression slope in the prediction on Anxiety {SQ (A)}. Predictor = FT (AG)



The regression model with Task oriented coping (F=268.945; p<.01), Emotion oriented coping (F=250.161; p<.01) and Avoidance oriented coping (F=396.746; p<.01) as predictors and Depression as the criterion emerged to be statistically significant. The R, R square and the change statistics are presented in Table - 17 and the graphs depicting normality and homogeneity of regression slope are presented in Figure - 16.1 to Figure - 16.2 respectively.

Table - 17: R, R square, change statistics and Durbin-Watson statistics in the prediction of Depression {SQ (D)}. { Predictor(s) = CISS (T), CISS (E), CISS (A)}

Predictors	R	R square	Change Statistics					Durbin-Watson
			R square change	F change	df 1	df 2	Sig. F change	
CISS (T)	.76	.58	.58	268.95	1	198	.00	.97
CISS (E)	.75	.56	.56	250.16	1	198	.00	1.24
CISS (A)	.82	.67	.67	396.75	1	198	.00	1.21

Table - 18: Beta-values and Collinearity Statistics in the prediction of scores on Somatic Concern (Depression) {SQ (D)}.

Predictors	**Beta**	**t**	**Sig.**	**Collinearity Statistics**	
				Tolerance	**VIF**
CISS (T)	.759	16.400	.000	1.000	1.000
CISS (E)	.747	15.816	.000	1.000	1.000
CISS (A)	-.817	-19.918	.000	1.000	1.000

In Table - 17, the small value of Durbin-Watson statistics on CISS (T) indicated that successive error terms are very close in value to one another, which cause an alarm. But since the Collinearity statistics of Tolerance valued 1.00 (Table 18), the more likely that it is statistically significant.

The Durbin-Watson statistics and the Collinearity statistics supported by the normality and the homogeneity of the regression slope (Figures - 16.1 to 18.2) revealed that on scores Depression with Task oriented coping as a predictor explain

58% of variances, Emotion oriented coping explain 56% and Avoidance oriented coping explain 67%.

Stress generation, Avoidance coping and Depressive Symptoms: A 10 – year model by Holahan et al (2011), stated that depressive symptoms operate partially through avoidance coping in predicting subsequent life stressors.

In studying people experiencing loss, Susan Nolan-Hoeksema and Judith Larson found that at each interview, people who are engaging in more avoidance coping were more depressed and distressed than those who were not.

Figure - 16.1 Histogram depicting the distribution of residual scores on Depression {SQ (D)}. Predictor = CISS (T)

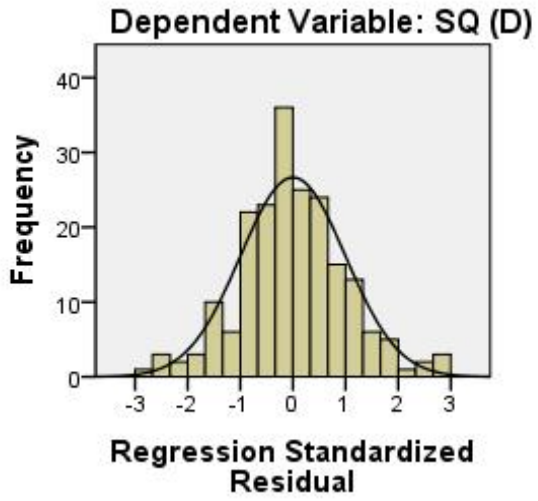


Figure - 16.2 Graph depicting the regression slope in the prediction on Depression {SQ (D)}. Predictor = CISS (T)

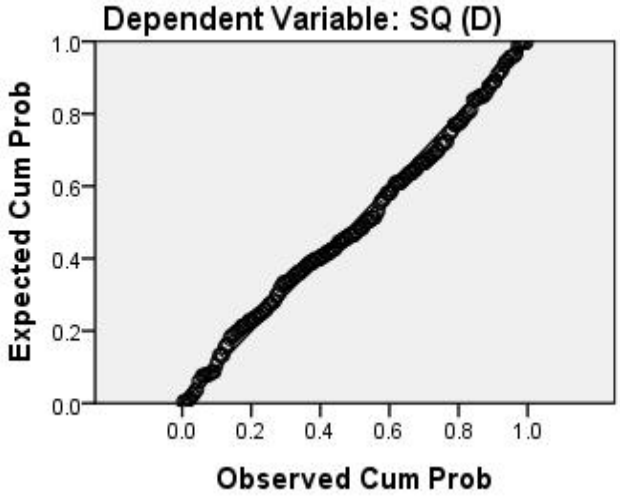


Figure - 17.1 Histogram depicting the distribution of residual scores on Depression {SQ (D)}. Predictor = CISS (E)

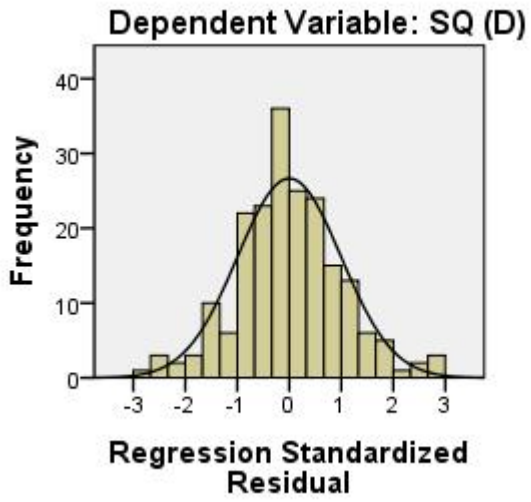


Figure - 17.2 Graph depicting the regression slope in the prediction on Depression {SQ (D)}. Predictor = CISS (E)

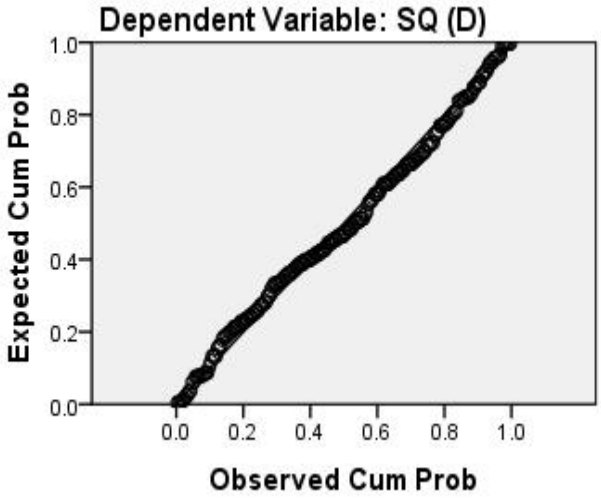


Figure - 18.1 Histogram depicting the distribution of residual scores on Depression {SQ (D)}. Predictor = CISS (A)

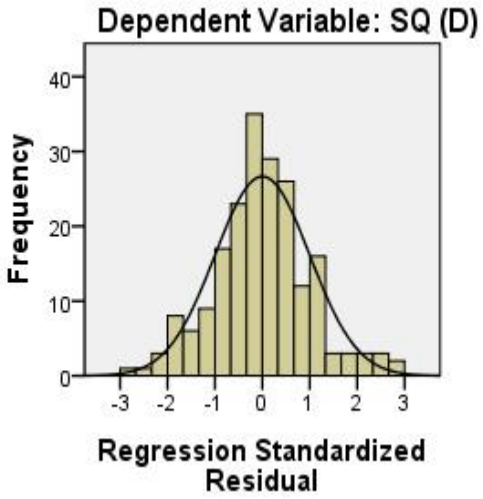
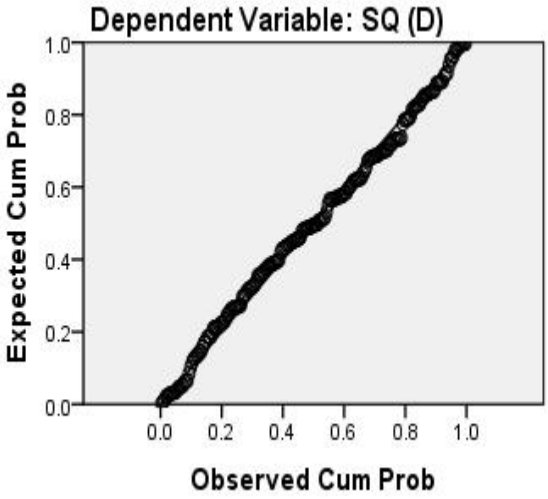


Figure - 18.2 Graph depicting the regression slope in the prediction on Depression {SQ (D)}. Predictor = CISS (A)



Holahan et al. (2005) showed that avoidant coping is positively associated with depressive symptoms in a ten year longitudinal study. Their study examined the coping styles, life stressors and depressive symptoms of 1,211 participants over a ten year period. Penland et al. (2000) found in their university study that participants experienced greater depressive symptoms when they engaged in an avoidant coping style such as wishful thinking. Crockett et al's (2007) study also revealed strong positive associations between avoidant coping and psychological distress. Participants were shown to have increased symptoms of anxiety and depression when they engaged in avoidant coping, as opposed to participants that engaged in problem-focused coping.

Study done by Kathryn Keyes, Betsy Bisno, Jean Richardson and Albert Marston (1987), shows that patients, regardless of age, who used more emotional discharge and more avoidance-coping strategies had higher levels of depression and sickness-related dysfunction.

The regression model with Frustration-Regression ($F=321.06$; $p<.01$), Frustration-Fixation ($F=315.31$; $p<.01$), Frustration-Resignation ($F=437.39$; $p<.01$) and Frustration-Aggression ($F=223.79$; $p<.01$) as predictors and Depression as the criterion emerged to be statistically significant. The R, R square and the change statistics are presented in Table 19 and the graphs depicting normality and homogeneity of regression slope are presented in Figures - 19.1 to Figure -22.2 respectively.

The Durbin-Watson statistics and the Collinearity statistics supported by the normality and the homogeneity of the regression slope (Figure 15.1 to 19.2) revealed that on scores of Depression with Frustration-Regression as a predictor explain 62% of variances, Frustration-Fixation explain 61%, Frustration-Resignation explain 69% and Frustration-Aggression explain 53%. Majority Sinhala and minority Tamil population in Sri Lanka has been ongoing for nearly 30 years, the psychological effects of the conflict on the civilian population was 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%).(Somasundaram and Jamunanatha, 2002),

Table - 19 :R, R square, change statistics and Durbin-Watson statistics in the prediction of Depression {SQ (D)}. { Predictor(s) = FT (RG), FT (FX), FT (RSG), FT (AG)}.

Predictors	R	R square	Change Statistics					Durbin-Watson
			R square change	F change	df 1	df 2	Sig. F change	
FT (RG)	.78	.62	.62	321.06	1	198	.00	1.55
FT (FX)	.78	.61	.61	315.31	1	198	.00	1.57
FT (RSG)	.83	.69	.69	437.39	1	198	.00	1.44
FT (AG)	.73	.53	.53	223.79	1	198	.00	1.15

Table - 20 :Beta-values and Collinearity Statistics in the prediction of scores on Somatic Concern (Depression) { SQ (D)}.

Predictors	**Beta**	**t**	**Sig.**	**Collinearity Statistics**	
				Tolerance	**VIF**
FT (RG)	.786	17.918	.000	1.000	1.000
FT (FX)	.784	17.757	.000	1.000	1.000
FT (RSG)	-.830	-20.914	.000	1.000	1.000
FT (AG)	.728	14.960	.000	1.000	1.000

Figure -19.1 Histogram depicting the distribution of residual scores on Depression {SQ (D)}. Predictor = FT (RG)

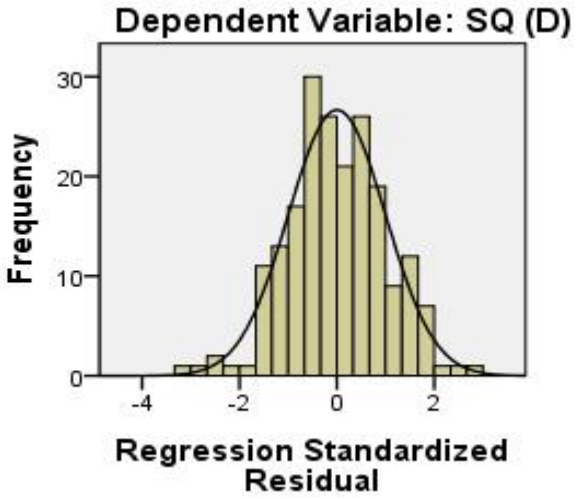


Figure -19.2 Graph depicting the regression slope in the prediction on Depression {SQ (D)}. Predictor = FT (RG)

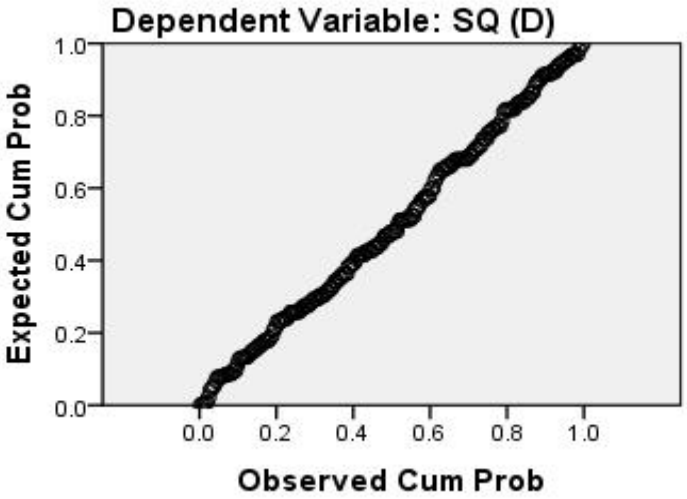


Figure - 20.1 Histogram depicting the distribution of residual scores on Depression {SQ (D)}. Predictor = FT (FX)

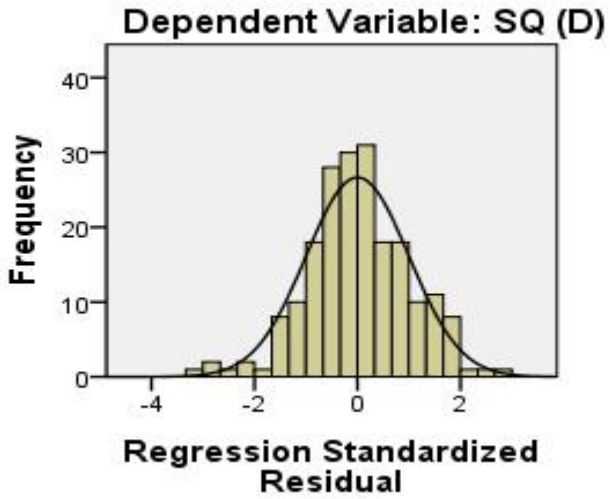


Figure - 20.2 Graph depicting the regression slope in the prediction on Depression {SQ (D)}. Predictor = FT (FX)

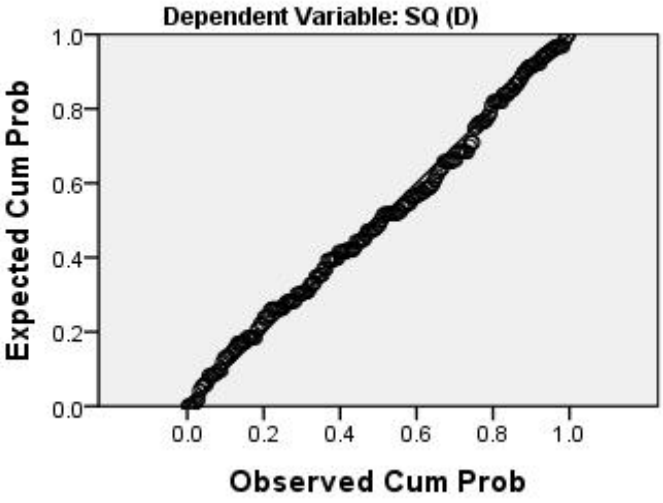


Figure -21.1 Histogram depicting the distribution of residual scores on Depression {SQ (D)}. Predictor = FT (RSG)

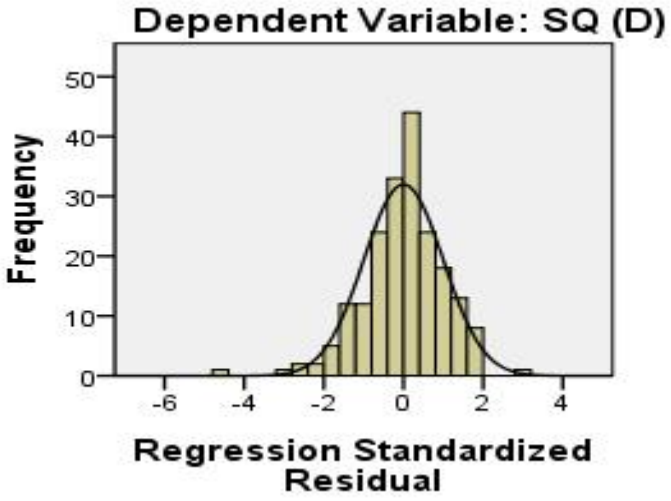


Figure -21.2 Graph depicting the regression slope in the prediction on Depression {SQ (D)}. Predictor = FT (RSG)

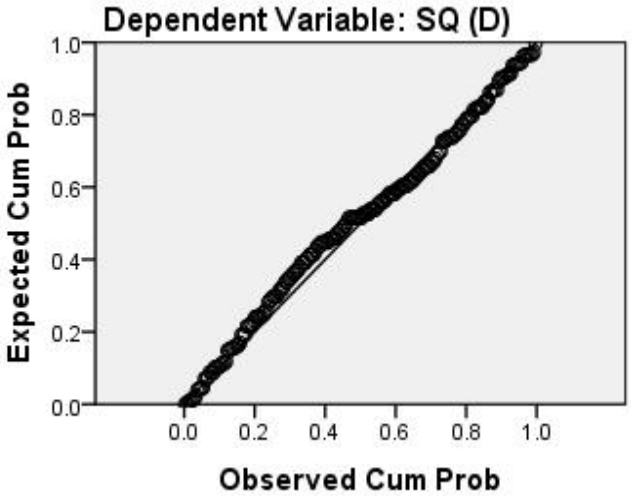


Figure - 22.1 Histogram depicting the distribution of residual scores on Depression {SQ (D)}. Predictor = FT (AG)

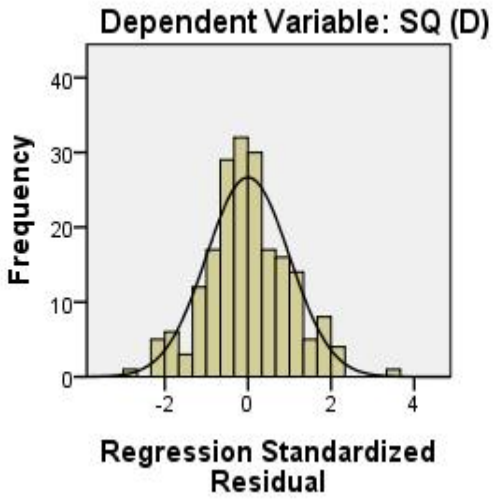
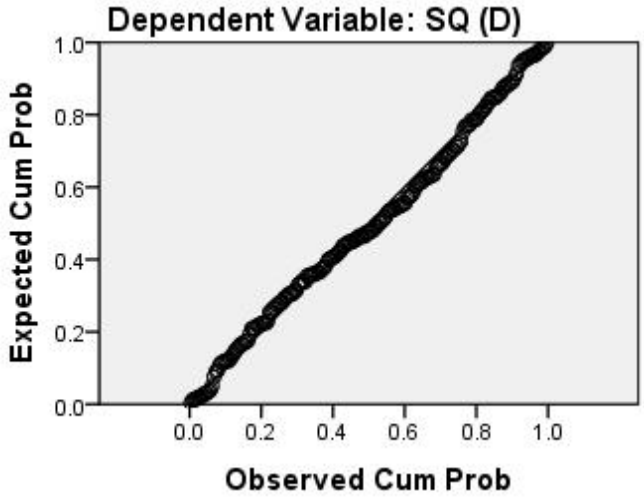


Figure - 22.2 Histogram depicting the distribution of residual scores on Anxiety {SQ (D)}. Predictor = FT (AG)



Depression is closely linked with frustration and anger. The frustrated person becomes more and more angry as he fails to reach his goals. If the anger does not help the person to suceed, then the frustration level goes even higher. A destructive cycle betweeen anger and frustration continues until the person becomes worn down-physically, emotionally and mentally. When a person reaches this point, he starts to give up, and his focus shifta from "What can i do" to "There is nothing i can do." Depression is an expression of this hopeless, helpless feeling. Sorcha Faal (2006)

Table - 21 shows the regression model with Task oriented coping (F=289.900; p<.01), Emotion oriented coping (F=235.528; p<.01) and Avoidance oriented coping (F=504.800; p<.01) as predictors and Somatic Concern as the criterion and the results emerged to be statistically significant. The R, R square and the change statistics are presented in Table - 21 and the graphs depicting normality and homogeneity of regression slope are presented in Figure - 23.1 to 25.2 respectively.

Table - 21 :R, R square, change statistics and Durbin-Watson statistics in the prediction of Somatic Concern {SQ (SC)}. { Predictor(s) = CISS (T), CISS (E), CISS (A)}

Predictors	R	R square	Change Statistics					Durbin-Watson
			R square change	F change	df 1	df 2	Sig. F change	
CISS (T)	.77	.59	.59	289.90	1	198	.00	1.31
CISS (E)	.74	.54	.54	235.53	1	198	.00	1.23
CISS (A)	.85	.72	.72	504.80	1	198	.00	1.41

Table - 22 :Beta-values and Collinearity Statistics in the prediction of scores on Somatic Concern (Somatic Concern) (SQ (SC)}.

Predictors	Beta	t	Sig.	Collinearity Statistics	
				Tolerance	VIF
CISS (T)	-.771	-17.026	.000	1.000	1.000
CISS (E)	-.737	-15.347	.000	1.000	1.000
CISS (A)	.848	22.468	.000	1.000	1.000

The Durbin-Watson statistics and the Collinearity statistics supported by the normality and the homogeneity of the regression slope (Table 21) revealed that on the scale of Somatic Concern, Task oriented coping as a predictor explained 59%, Emotion oriented coping explained 54%, Avoidance oriented coping explained 72%. The histogram and the line graph (Figures - 23.1 & 25.2) shows normal and homogeneous regression slope.

Figure - 23.1 Histogram depicting the distribution of residual scores on Somatic Concern {SQ (SC)}. Predictor = CISS (T)

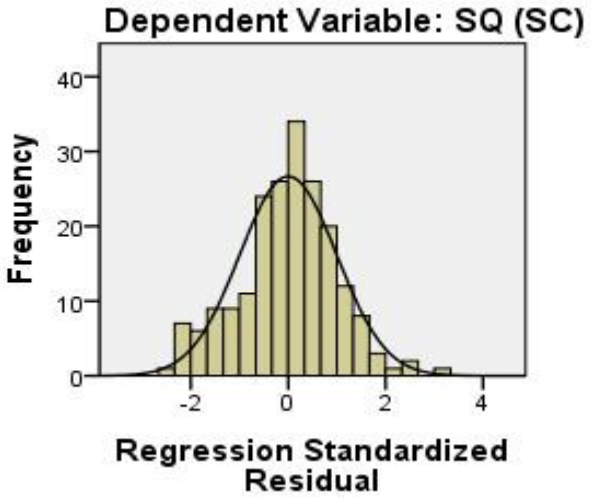


Figure - 23.2 Graph depicting the regression slope in the prediction on Somatic Concern {SQ (SC)}. Predictor = CISS (T)

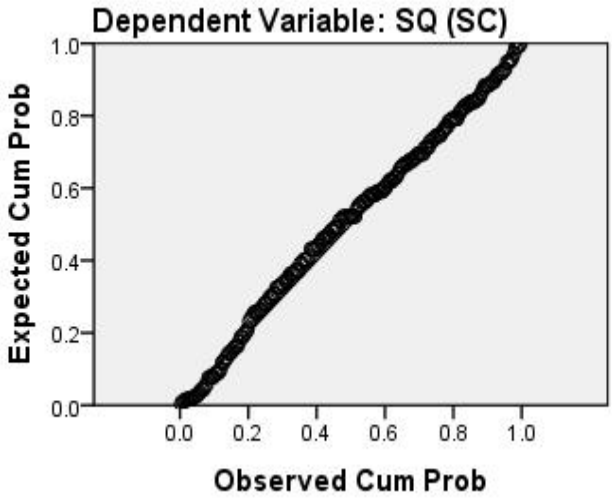


Figure - 24.1 Histogram depicting the distribution of residual scores on Somatic Concern {SQ (SC)}. Predictor = CISS (E)

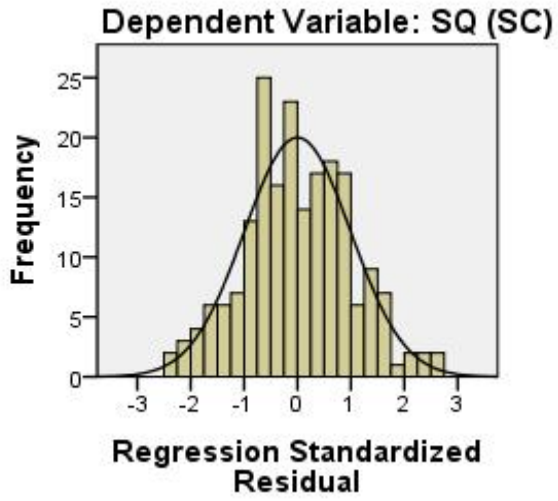


Figure - 24.2 Graph depicting the regression slope in the prediction on Somatic Concern {SQ (SC)}. Predictor = CISS (E)

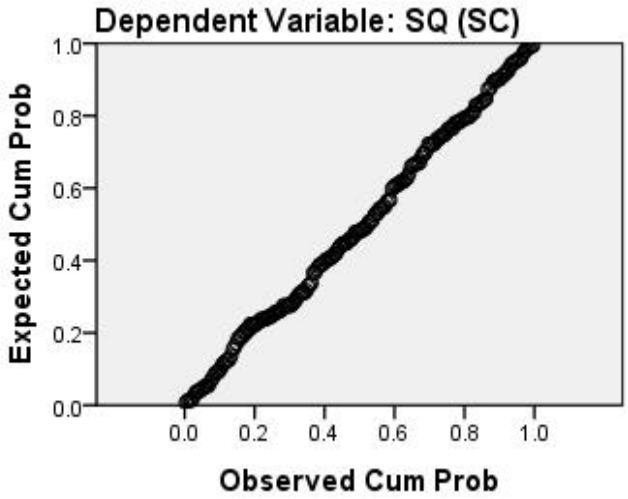


Figure - 25.1 Histogram depicting the distribution of residual scores on Somatic Concern {SQ (SC)}. Predictor = CISS (A)

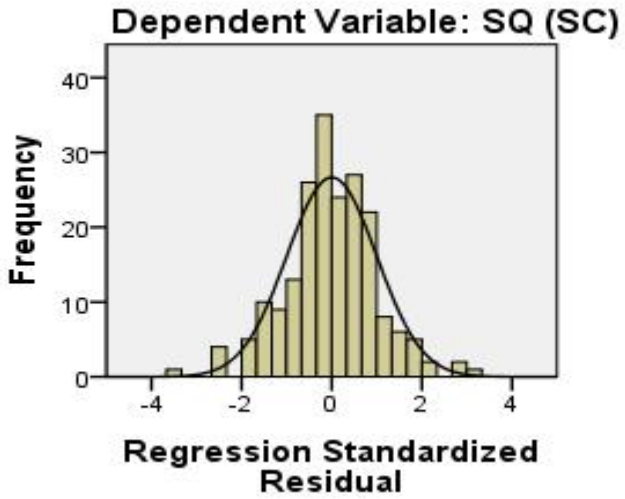
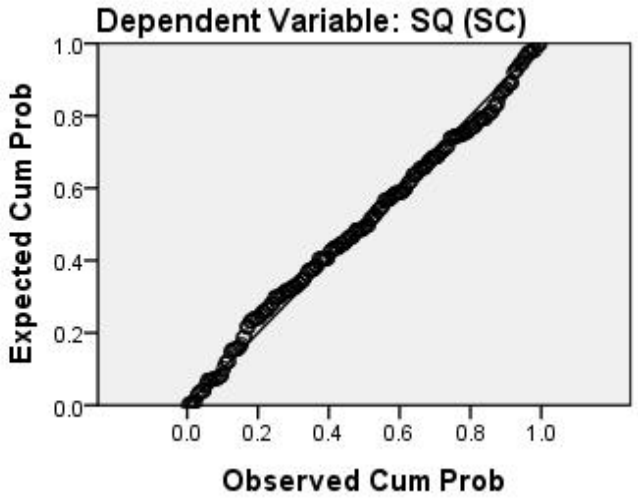


Figure - 25.2 Graph depicting the regression slope in the prediction on Somatic Concern {SQ (SC)}. Predictor = CISS (A)



The regression model with Frustration-Regression (F=380.36; p<.01), Frustration-Fixation (F=393.41; p<.01), Frustration-Resignation (F=472.77; p<.01) and Frustration-Aggression (F=264.02; p<.01) as predictors and Somatic Concern as the criterion emerged to be statistically significant. The R, R square and the change statistics are presented in Table - 23 and the graphs depicting normality and homogeneity of regression slope are presented in Figure - 26.1 to Figure - 29.2 respectively.

Table - 23 R, R square, change statistics and Durbin-Watson statistics in the prediction of Somatic Concern {SQ (SC)}. { Predictor(s) = FT (RG), FT (FX), FT (RSG), FT (AG)}.

Predictors	R	R square	Change Statistics					Durbin-Watson
			R square change	F change	df 1	df 2	Sig. F change	
FT (RG)	.81	.66	.66	380.36	1	198	.00	1.56
FT (FX)	.82	.66	.66	393.41	1	198	.00	1.55
FT (RSG)	.84	.70	.70	472.77	1	198	.00	1.58
FT (AG)	.76	.57	.57	264.02	1	198	.00	1.43

The Durbin-Watson statistics and the Collinearity statistics supported by the normality and the homogeneity of the regression slope revealed that on scores of Somatic Concern with Frustration-Regression as a predictor explain 66% of variances, Frustration-Fixation explain 66%, Frustration-Resignation explain 70% and Frustration-Aggression explain 57%.

Table - 24 Beta-values and Collinearity Statistics in the prediction of scores on Somatic Concern (Somatic Concern) (SQ (SC)}.

Predictors	Beta	t	Sig.	Collinearity Statistics	
				Tolerance	VIF
FT (RG)	-.811	-19.503	.000	1.000	1.000
FT (FX)	-.816	-19.835	.000	1.000	1.000
FT (RSG)	.840	21.743	.000	1.000	1.000
FT (AG)	-.756	-16.249	.000	1.000	1.000

Figure - 26.1 Histogram depicting the distribution of residual scores on Somatic Concern {SQ (SC)}. Predictor = FT (RG)

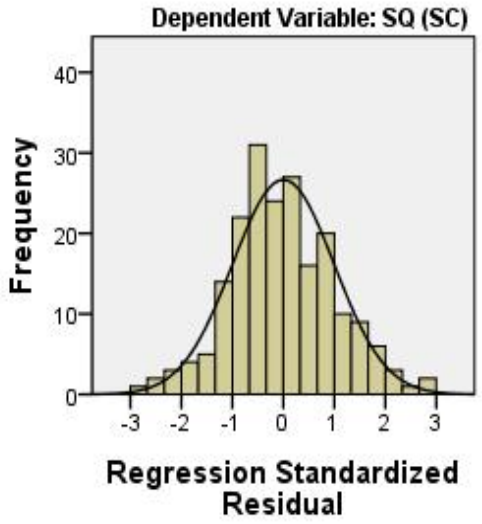


Figure - 26.2 Graph depicting the regression slope in the prediction on Somatic Concern {SQ (SC)}. Predictor = FT (RG)

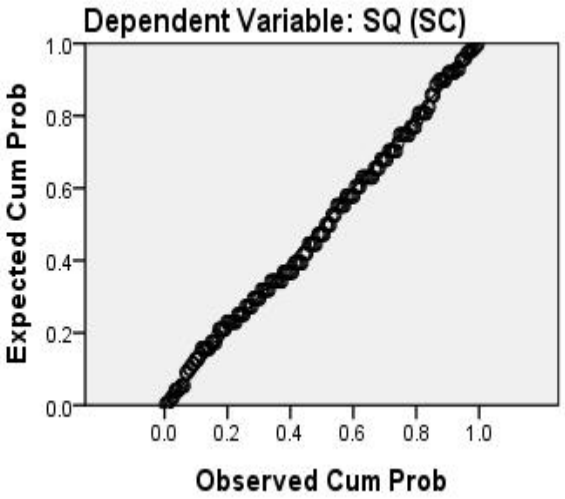


Figure - 27.1 Histogram depicting the distribution of residual scores on Somatic Concern {SQ (SC)}. Predictor = FT (FX)

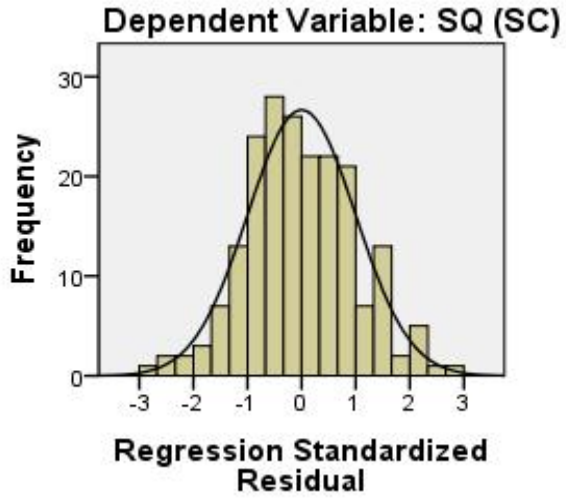


Figure - 27.2 Graph depicting the regression slope in the prediction on Somatic Concern {SQ (SC)}. Predictor = FT (FX)

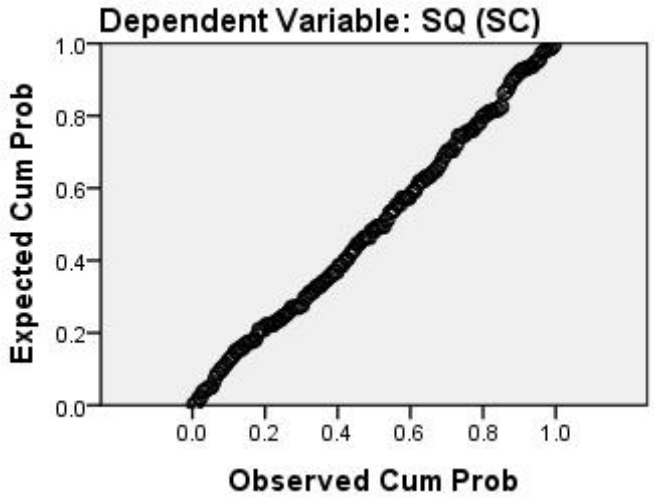


Figure 28.1 Histogram depicting the distribution of residual scores on Somatic Concern {SQ (SC)}. Predictor = FT (RSG)

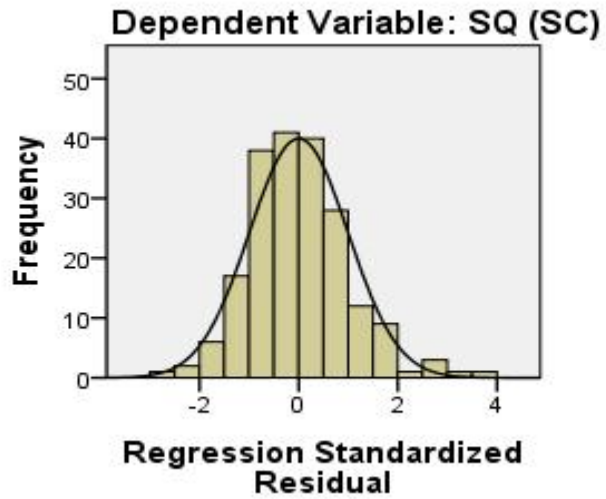


Figure 28.2 Graph depicting the regression slope in the prediction on Somatic Concern {SQ (SC)}. Predictor = FT (RSG)

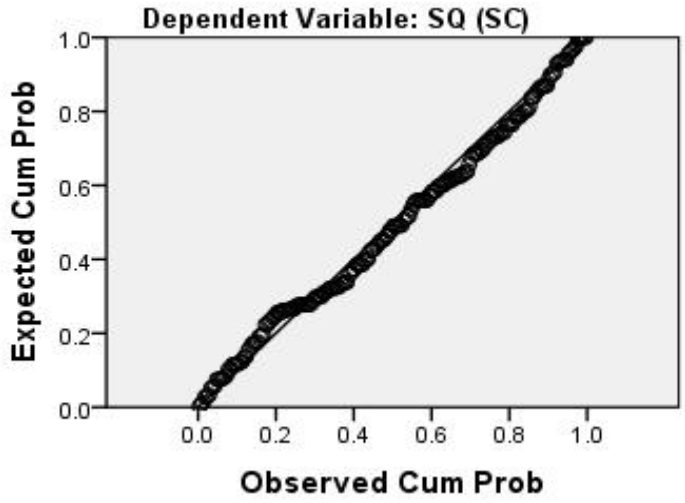


Figure - 29.1 Histogram depicting the distribution of residual scores on Somatic Concern {SQ (SC)}. Predictor = FT (AG)

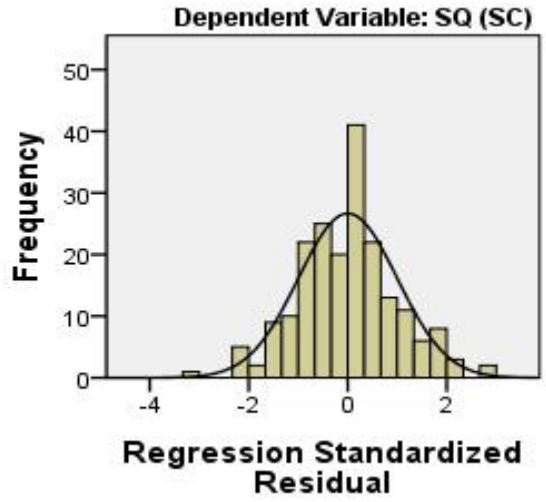


Figure - 29.2 Graph depicting the regression slope in the prediction on Somatic Concern {SQ (SC)}. Predictor = FT (AG)

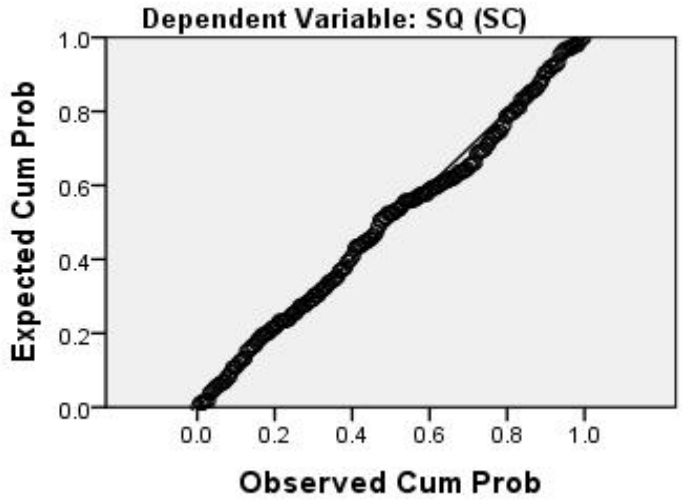


Table - 25 R, R square, change statistics and Durbin-Watson statistics in the prediction of Anger-Hostility {SQ (AH)}. {Predictor(s) = CISS (T), CISS (E), CISS (A)}

Predictors	R	R square	Change Statistics					Durbin-Watson
			R square change	F change	df 1	df 2	Sig. F change	
CISS (T)	.79	.62	.62	319.25	1	198	.000	1.04
CISS (E)	.78	.62	.62	317.44	1	198	.000	1.08
CISS (A)	.81	.66	.66	381.07	1	198	.000	.95

Table - 25 shows the regression model with Task oriented coping (F=319.24; p<.01), Emotion oriented coping (F=317.43; p<.01) and Avoidance oriented coping (F=381.07; p<.01) as predictors and Anger-Hostility as the criterion and the results emerged to be statistically significant. The R, R square and the change statistics are presented in Table - 25 and the graphs depicting normality and homogeneity of regression slope are presented in Figure - 30.1 and Figure 32.2 respectively.

Table - 26 Beta-values and Collinearity Statistics in the prediction of scores on Somatic Concern (Anger-Hostility) (SQ (AH)}

Predictors	Beta	t	Sig.	Collinearity Statistics	
				Tolerance	VIF
CISS (T)	.786	17.867	.000	1.000	1.000
CISS (E)	.785	17.817	.000	1.000	1.000
CISS (A)	-.811	-19.521	.000	1.000	1.000

In Table - 25, the small value of Durbin-Watson statistics on CISS (A) indicated that successive error terms are very close in value to one another, which cause an alarm. But since the Collinearity statistics of Tolerance valued 1.00 (Table - 26), the more likely that it is statistically significant.

The Durbin-Watson statistics and the Collinearity statistics supported by the normality and the homogeneity of the regression slope revealed that on scores of Anger-Hostility with Task oriented coping as a predictor explained 62% of variances, Emotion oriented coping explained 62%, Avoidance oriented coping explain 62%.

Figure - 30.1 Histogram depicting the distribution of residual scores on Anger-Hostility {SQ (AH)}. Predictor = CISS (T)

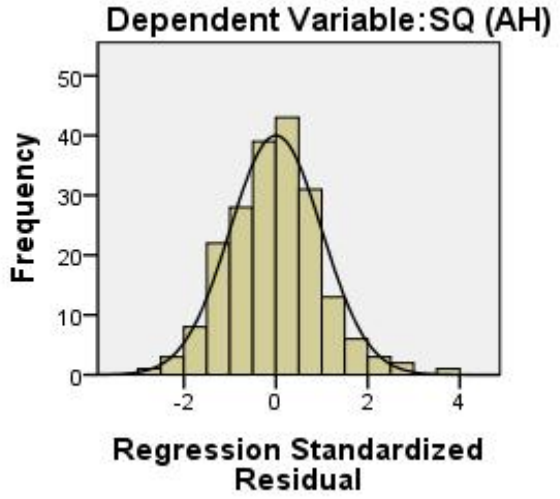


Figure 30.2 Graph depicting the regression slope in the prediction on Anger-Hostility {SQ (AH)}. Predictor = CISS (T)

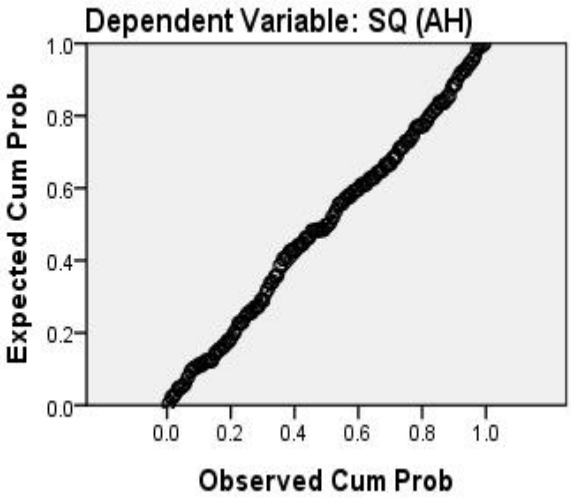


Figure - 31.1 Histogram depicting the distribution of residual scores on Anger-Hostility {SQ (AH)}. Predictor = CISS (E)

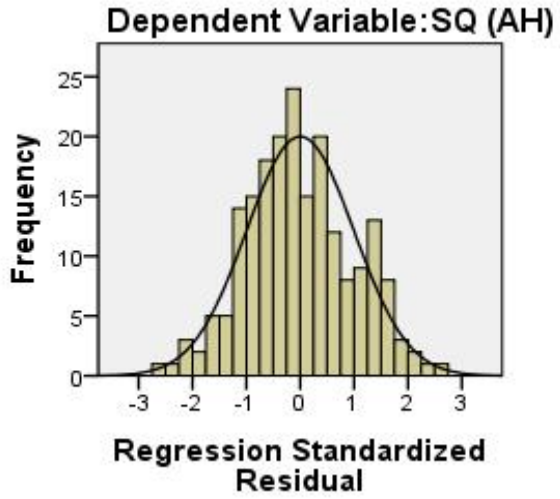


Figure - 31.2 Graph depicting the regression slope in the prediction on Anger-Hostility {SQ (AH)}. Predictor = CISS (E)

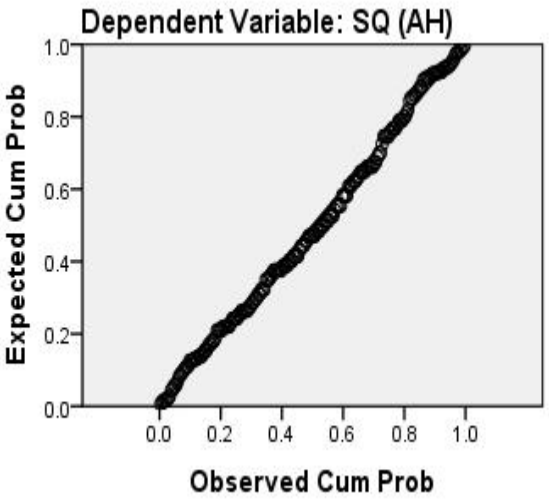


Figure -32.1 Histogram depicting the distribution of residual scores on Anger-Hostility {SQ (AH)}. Predictor = CISS (A)

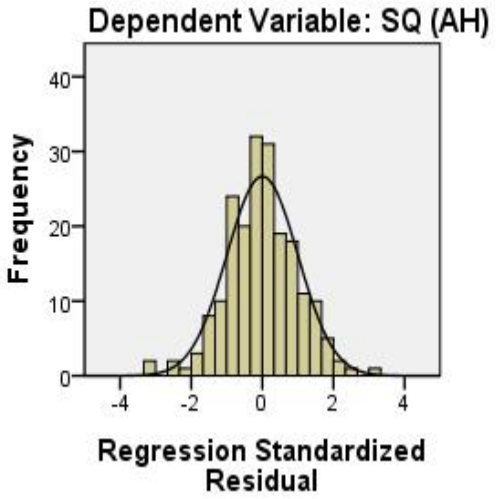


Figure - 32.2 Graph depicting the regression slope in the prediction on Anger-Hostility {SQ (AH)}. Predictor = CISS (A)

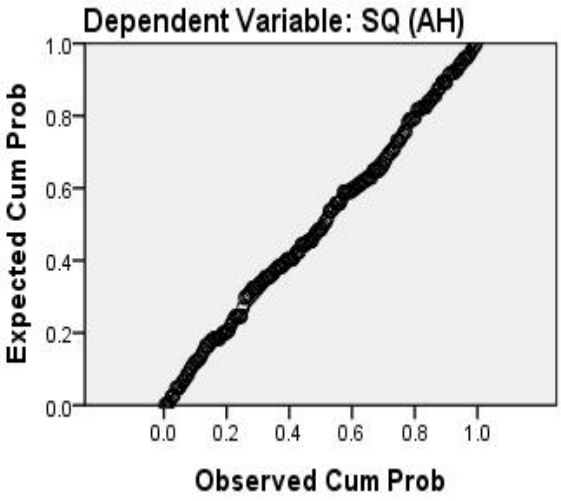


Table - 27 R, R square, change statistics and Durbin-Watson statistics in the prediction of Anger-Hostility {SQ (AH)}. {Predictor(s) = FT (RG), FT (FX), FT (RSG), FT (AG)}

Predictors	R	R square	Change Statistics					Durbin-Watson
			R square change	F change	df 1	df 2	Sig. F change	
FT (RG)	.75	.56	.56	250.12	1	198	.00	1.03
FT (FX)	.75	.56	.56	252.12	1	198	.00	1.03
FT (RSG)	.82	.67	.67	397.86	1	198	.00	.85
FT (AG)	.71	.50	.50	199.89	1	198	.00	.80

Table - 28 Beta-values and Collinearity Statistics in the prediction of scores on Somatic Concern (Anger-Hostility) (SQ (AH)}

Predictors	**Beta**	**t**	**Sig.**	**Collinearity Statistics**	
				Tolerance	**VIF**
FT (RG)	.747	15.815	.000	1.000	1.000
FT (FX)	.748	15.878	.000	1.000	1.000
FT (RSG)	-.817	-19.946	.000	1.000	1.000
FT (AG)	.709	14.138	.000	1.000	1.000

The regression model with Frustration-Regression (F=250.12; p<.01), Frustration-Fixation (F=252.12; p<.01), Frustration-Resignation (F=397.86; p<.01) and Frustration-Agression (F=199.89; p<.01) as predictors and Anger-Hostility as the

criterion emerged to be statistically significant. The R, R square and the change statistics are presented in Table 27 and the graphs depicting normality and homogeneity of regression slope are presented in Figure 33.1 to Figure 35.2 respectively.

In Table -27, the small value of Durbin-Watson statistics on CISS (A) indicated that successive error terms are very close in value to one another, which cause an alarm. However, the Collinearity statistics of Tolerance valued 1.00 (Table 28), which indicated that it is more likely that the value is statistically significant.

The Durbin-Watson statistics supported by the normality and the homogeneity of the regression slope revealed that on scores of Anger-Hostility with Frustration-Regression as a predictor explain 56% of variances, Frustration-Fixation explain 56%, Frustration-Resignation explain 67% and Frustration-Aggression explain 50%.

There is a “disability fatigue”, an inescapable burden that comes from living with a disability and needing to fight for equal opportunity, educate, explain, demand rights and never having a rest from the effects of the disability itself. This fatigue can cause us to become very frustrated, when there is no outlet for the frustration, the fatigue settles in on us like a heavy weight, exacerbating our sense of helplessness. Frustration can cause one to give up hope or turn to violence (McClosky, 1986).

Anger is displayed by aggressive behaviour. When frustration continues, anger blends into a feeling of hostility toward the person causing frustration (S.Dandapani, 2000).

Frustrated person do not always respond with aggressive thoughts, words or deeds. They may show a wide variety of reactions, ranging from resignation, depression, and despair to attempts to overcome the sources of their frustration.

Figure -32.1 Histogram depicting the distribution of residual scores on Anger-Hostility {SQ (AH)}. Predictor = FT (RG)

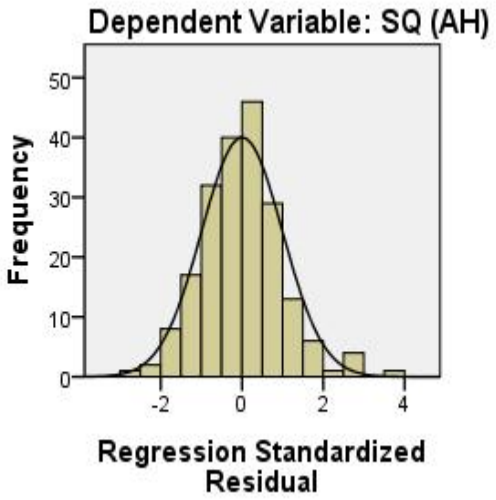


Figure -32.2 Graph depicting the regression slope in the prediction on Anger-Hostility {SQ (AH)}. Predictor = FT (RG)

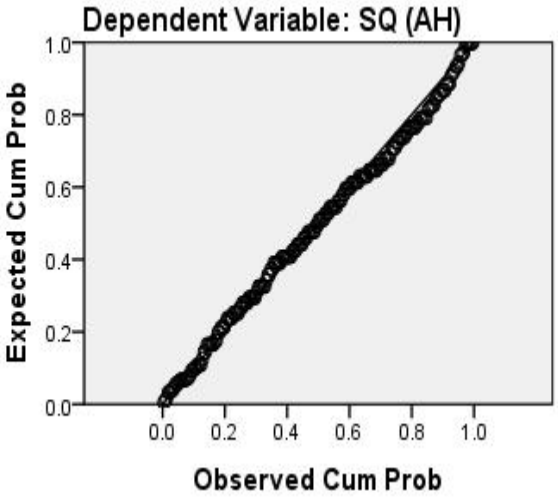


Figure - 33.1 Histogram depicting the distribution of residual scores on Anger-Hostility {SQ (AH)}. Predictor = FT (FX)

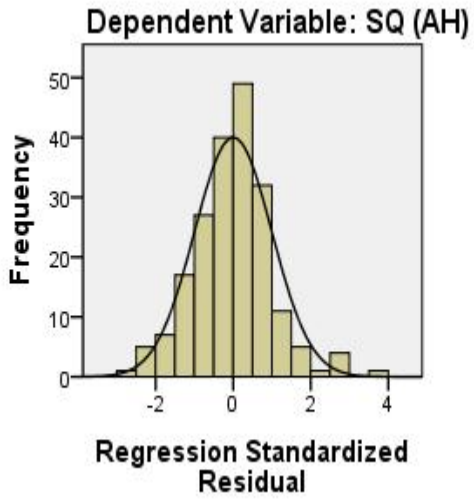


Figure - 33.2 Graph depicting the regression slope in the prediction on Anger-Hostility {SQ (AH)}. Predictor = FT (FX)

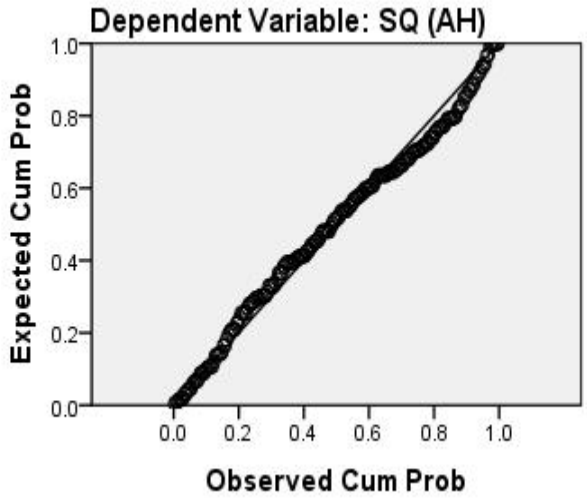


Figure -34.1 Histogram depicting the distribution of residual scores on Anger-Hostility {SQ (AH)}. Predictor = FT (RSG)

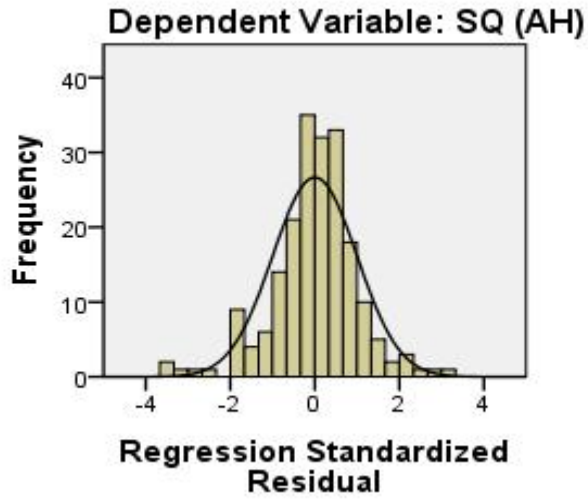


Figure -34.2 Graph depicting the regression slope in the prediction on Anger-Hostility {SQ (AH)}. Predictor = FT (RSG)

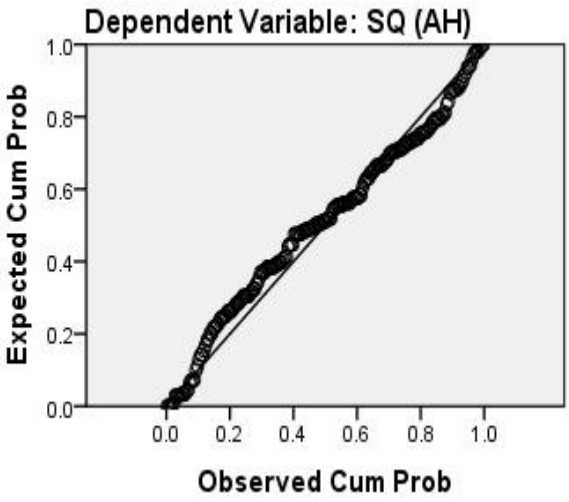


Figure -35.1 Histogram depicting the distribution of residual scores on Anger-Hostilit {SQ (AH)}. Predictor = FT (AG)

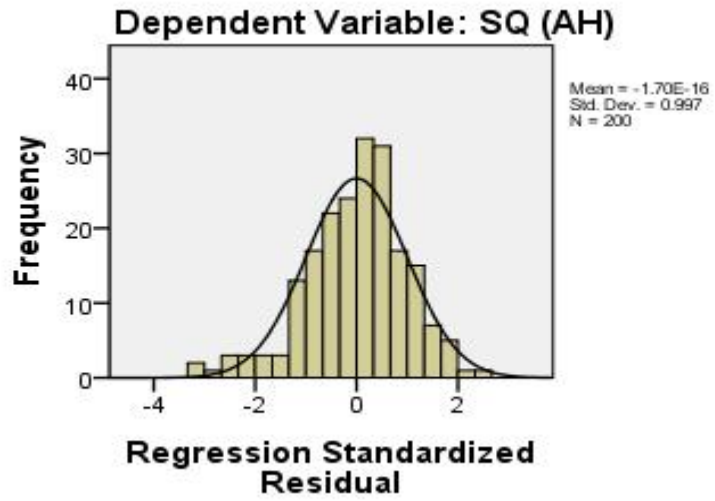
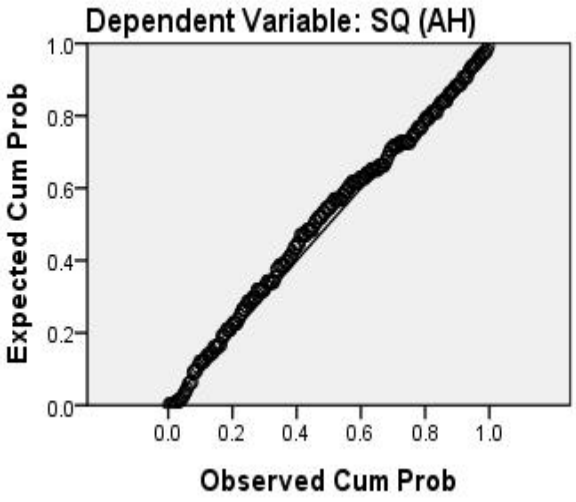


Figure -35.2 Graph depicting the regression slope in the prediction on Anger-Hostility {SQ (AH)}. Predictor = FT (AG)



The invaded person will experience higher levels of physiological arousal than non invaded person (Evans & Howard, 1972), could lead to aggression (Ryden, Bossenmaier, & McLachlan, 1991). degree of invader action affects the degree of negative inferences, no apparent or inappropriate reasoning of invasion increase

negative inference (Smith and Knowles, 1979). 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). People usually experience anxiety about events they cannot control or predict, or about events that seem threatening or dangerous (Ohman, 2000). For example, students taking an important test may feel anxious because they cannot predict the test questions or feel certain of a good grade. People often use the words *fear* and *anxiety* to describe the same thing. Fear also describes a reaction to immediate danger characterized by a strong desire to escape the situation.

Bowman (1967) found predominance of dissociative, anxiety, and conversion symptoms, and in wounded soldiers anxiety dreams and neurological symptoms. Similarly, Jones (1985) found that anxiety and fear symptoms predominated in combat soldiers in Vietnam. During a guerrilla war, combatants suffering from these adverse symptoms are naturally unable to function as they should and would probably be classified by Hans Binneveld as "psychologically wounded" (Binneveld, 1997).

The symptomatology associated with nostalgia was consistently compatible with modern descriptions of depression, with complaints, for example, of "moroseness, insomnia, anorexia, and asthenia" in a report by Sauvages (1768).

The blockage of a goal reaction generally will not induce interpersonal hostility or aggression unless when they were unexpected (Baron, 1977). The occurrence of aggressive behaviour always presupposes the existence of frustration and the existence of frustration always leads to some form of aggression (Dollard et al., 1939).

Berkowitz (1965a) proposed: (a) that frustration induces an emotional reaction – anger – that "creates only a readiness for aggressive acts"; and (b) that "aggressive responses will not occur, even given this readiness, unless there are suitable cues, stimuli associated with the present or previous anger instigators.

Geen (1975), stated that frustration results in aggression when it increases arousal in the presence of cues associated with aggression.

Dollard, Doob, Miller, Mowrcr, and Sears (1939) hypothesized that the total strength of the "instigation to aggression" within an individual is a positive function of three aspects of the frustrations he had suffered: "1) the strength of the instigation to the frustrated response, 2) the degree of interference with the frustrated response, and 3) the number of frustrated response-sequences".

Doob and Sears (1939) reported that when participants were asked to imagine frustrating and non-frustrating situations, they generally felt angry in the frustrating situations.

Survivors have vividly described the psychological trauma of being arrested, being detained, and even being jailed for no substantive reason (Van der Veer, 1998)

To deal with stress, people consciously and unconsciously use various methods of coping as essential life-survival techniques (Gottlieb, 1997).

The most common conceptualization of avoidance coping describes it as efforts to avoid, deny, suppress or anesthetize negative feelings (Fleishman & Fogel, 1994). Generally speaking, this form of avoidance coping has been found to be maladaptive, resulting in greater distress (Billings & Moos, 1981; Fleishman & Fogel, *1994).*

A variety of psychological responses similar to those describe by Kubler-Ross (1969) in the dying patient such as, denial, anger, bargaining, depression and acceptance were found on severely disabled soldiers

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.

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). 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).

Soldiers not only suffered on the battlefield. Veteran often 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. In his study Jones found that anxiety and fear symptoms predominated in combat soldiers in Vietnam (Jones, 1977).

Like wise during the Mizoram Insurgency, high level of anxiety and frustration were demonstated by the Mizo Army (The insurgents) as compared to the civilians (The Non-insurgents).

SUMMARY AND CONCLUSION

The present study was designed to investigate '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.

Insurgency is a struggle between a non-ruling group and the ruling authorities in which the non-ruling group consciously uses political resources (e.g. organizational expertise, propaganda and demonstrations) and violence to destroy, reformulate, or sustain the basis of legitimacy of one or more aspects of politics (Bard O'Neill, 1990). Insurgency is a movement - a political effort with a specific aim. An insurgency, or insurrection, is an armed uprising, or revolt against an established civil or political authority. Persons engaging in insurgency are called insurgents, and typically engage in regular or guerrilla combat against the armed forces of the established regime, or conduct sabotage and harassment in the land in order to undermine the government's position as leader; the government established by an invading force counts as "collaborators", not "established authority". An insurgency differs from a resistance both in its political overtones and in the nature of the conflict: an insurgency connotes an internal struggle against a standing, established government, whereas a resistance connotes a struggle against invading or occupying foreign forces and their collaborators.

War has always taken a toll. Accounts throughout history tell of nightmares and other emotional problems associated with the horrors of war. It seems that we repeatedly discover the effects of trauma on humans every time we go to war. Terms like "combat fatigue" and "shell shock" were used in the past to describe some of the effects of combat.

It is self-evident that stress will play a far more important role during a war-situation, when the demands, which are made on the population in general, and on the combatants in particular, exceed those normally experienced. Moreover, during

guerrilla warfare there will probably be more factors involved causing stress and the impact of these will tend to compound.

The impact of war are terrible, many may suffer immediate pain, horror, destruction and even death. Mental anguish during and after warfare should not be under estimated compared to more visible wounds. The invisible wounds may result from the combat itself, living in or near a combat zone, personal or simply exposure to war from afar as the member of a warring population, etc. Much psychological harm may be suffered by the civilian victims, for they have not been groomed by the expectation of military training to manage the stress, shock, and fright of violence and loss as soldiers have. And prepared or not the deep neural pressure to survive put on soldiers by their own chemical instincts when triggered by circumstances typically exceeds health with its repetition, constancy and force. Adrenaline which promotes survival in the short term fatigues and wears dangerously on people in the long term, as soldiers find. The stress of combat commonly produces psychotropic if not psychopathic effects (Barth, 2003).

Any suffering embedded into the soldier's life (whether or not a soldier dies in war or comes back hurt physically or psychologically) indeed introduces psychological repercussion to the lives of close family members and friends. At the home of soldiers there are presence of instability among the family due to mare absence and worry during absence causing depression and abuse.

Life events are not equally stressful to all people, and it appears that some combination of the environmental stresses or demands that people face and the resources they have available together affect their way of coping.

The present research "The Effects of Insurgency in the Psychological adjustment of the Mizo" was designed to explore how much psychological impact it had upon the Mizo and how did they respond and adjust to it. The participant, i.e. The Mizo, who were selected for the present study experienced the Insurgency from the onset (1966) till the 'Peace Accord' was signed (1986) between the MNF and the Government of India.

The history of the Mizos can be divided into three broad periods; the *Pre-British Period* begins with the origin of the Mizos shrouded in mystery and

culminates with the 'Chin-Lushai expedition' of 1889-1890. Before the advent of Christianity, the Mizo who then considered themselves as powerful militant people took great pride in subduing their rival tribes and raiding their neighbours. Apart from the inter-clan clashes, raids were directed towards the people in the plains of Cachar, Manipur, Sylhet, Tripura and the Chittagong Hill Tracts.; the *British Period* (1890 – 1947) begins with the annexation of Mizoram by the British Authority in 1890 and comes to its end along with Independence of India in 1947; and the *Post-Independence Period* (1947 – till date) witness the vast array of development in the social, political, economic and religious sphere at both the individual and population level, since the Indian Independence of 1947 perturbed by the period of insurgency.

To meet the objectives, 200 Mizo participants between 50-70 years of age experiencing the insurgency in Mizoram were randomly selected from different part of Mizoram to serve as subjects for the present study. The structured interview questionnaire pertaining to the perceived causes and impact of insurgency in Mizoram based on psychological measures of anxiety, depression, frustration and coping were administered to determine the psychological impact of insurgency in Mizoram.

The participants were randomly selected from different part of Mizoram affected by the MNF movement, with due care of extraneous variables to identify true representation. Lists of people who are a member of PAMRA, Ex-MNA, Widow of MNA and Mizoram Elder Association (MUP – Mizoram Upa Pawl), Mizoram Civil Pensioners Association who had experienced the Mizoram insurgency were obtained. From these lists the participants were randomly selected. The 'Volunteer' with consideration of 'Suffering' and 'Non-suffering' were selected from the list of Ex-MNF (PAMRA and MNA – Association on Hnam Run, Office of the MNF Party Headquarters.). Following the same procedure of the sample selection, the 'Non-vulenteer' were selected from the list of the members of Mizoram Elder Association (MUP), Mizoram Civil Pensioners Association and the Widows of MNA(Association of Hnam Run). 'Gender' was not included in the design as very few members of female volunteers could be identified.

The study was design with manifold objectives. The first objective aimed to elucidate the psychometric adequacy of the behavioural measures of (a) Symptom Questionnaire (SQ; Kellner, 1987), (b) Frustration Test (FT; Chauhan & Tiwari,

1972), (c) Coping Inventory for Stressful Situation (CISS; Endler & Parker, 1999). These analyses revealed that specific items of all measures were endorsed within the optimal limits.

Psychometric analyses of the behavioural measures included the analysis of (i) item-total coefficient of correlation (as an index of internal consistency and item validity) was ascertained for the scales/subscales of the behavioural measures with the criterion of items showing item-total coefficient of correlation ≥.01 for the whole sample to be retained for further analysis, (ii) Reliability coefficients (Cronbach alphas & Split-half)of the specific subscales, (iii) inter-scale relationships (in the instances where there were two or more sub-scales/ sub-factors). Following the broad format of analysis, the psychometric properties of the four classes of behaviour measures of (i) anxiety, (ii) depression, (iii) frustration and (iv) coping styles were analyzed by employing PASW Statistics 18 (2009), Statistica 8.0 (2008) and Microsoft Office Excel 2007.

The psychometric properties of behavioural measures were computed which confirmed the adequacies of the psychometric properties of the selected scales for measurement purposes for the present study. The reliability coefficients emerged to be strong indicating the dependability of the test scales for measurement purposes in the project population (Mizo). In sum, the Item-Total coefficient correlation, the reliability coefficients (Cronbach alpha and Spearman Brown Coefficient), and the Inter-scales/subscales of Coping inventory for stressful situation (CISS), Symptoms Questionnaire (SQ) and Frustration test (FT) are conforming to the findings reported in literature (Kelnner, 1987; Endler & Parker, 1999; Chauhan & Tiwari, 1972; Varte, 2005).

The bivariate relationships between the scales/subscales of the behavioural measures were computed and it indicated the relationships among the scales/subscales of the behavioural measures accounting for ‘Volunteer’ (Volunteer, who joined the MNF personally and Non Volunteer, who does not joined the MNF personally during the insurgency in Mizoram), along with the ‘Fatal’ (Fatal are those who experienced fatal episode, and Non Fatal, who did not have experienced fatal episode personally.

Anxiety, Depression, Anger-Hostility, Frustration-Regression, Frustration-Fixation, Frustration-Aggression, Task oriented coping and Emotion oriented coping all showed significant positive relationship with each other, where a very high positive relationship is found between Frustration-Regression and Frustration-Fixation. They all appeared to have significant negative relationship with Somatic Concern, Frustration-Resignation and Avoidance oriented coping, which showed very high positive relationship with each other.

Results of the 2 x 2 ANOVA on Frustration Test measures revealed that there is a significant effect of 'Volunteer' and 'Fatal' in the entire test. The result stated that the Frustration Test measures attributed 84% to 'Volunteer' and 61% to 'Fatal. Volunteer showed greater mean score as compare to Non Volunteer except in Frustration-Resignation measure. The mean scores also showed that 'Fatal' as compare to 'Non Fatal' (Volunteer and Non Volunteer) scores higher than 'Non Fatal' (Volunteer and Non Volunteer) in Frustration Test Measures except for the Resignation measures where the 'Non Fatal' scores higher mean than the 'Fatal'.

The depressed subjects reported greater levels of hostility and anger experience than the normal subjects did (Williams & Wilkins 1989).

Research involving combat veterans has shown that anger and rage are prevalent emotions in post-traumatic stress disorder. Soldiers in a combat zone are subjected to multiple stressors, including threats from enemy combatants, environmental hardships, and lack of physical comforts, which contribute to feelings of anger, frustration, and rage (Reyes and Hicklin, 2005).

Results of the 2x2 ANOVA { 2 Volunteer (Volunteer & Non Volunteer) x 2 Fatal (Fatal x Non Fatal)} in Coping styles indicated that there is significant effect among the scores on Task oriented coping style, Emotion oriented coping style and Avoidance oriented coping style. The results revealed that the attribution to the 'Volunteer' (86%) in the Coping styles is more than the attribution to the 'Fatal' (71%) in Coping styles. In Task oriented coping 'Volunteer' showed greater mean score than the 'Non Volunteer', higher mean scores can also be seen on the scores of 'Fatal' (Volunteer and Non Volunteer) as compared to 'Non Fatal' (Volunteer and Non Volunteer). Similarly, the 'Volunteer' showed higher mean score as compared to

the ‘Non Volunteer’ in Emotion oriented coping measures and the ‘Fatal’ (Volunteer and Non Volunteer) showed higher mean score than ‘Non Fatal’ (Volunteer and Non Volunteer). But in the Avoidance oriented coping measures the ‘Volunteer’ showed lower mean score as compare to ‘Non Volunteer’, it also showed lower mean score for ‘Fatal’ (Volunteer and Non Volunteer) as compared to ‘Non Fatal’ (Volunteer and Non Volunteer).

Results of the 2 x 2 ANOVA on Symptom Questionnaire revealed that there is a significant independent effects among the scores of Anxiety, Depression, Somatic Concern and Anger-Hostility. The results stated that the Symptom Questionnaire measures attributed 90% to ‘Volunteer’ and 72% to ‘Fatal’. The score comparison showed that ‘Volunteer’ showed greater mean score than ‘Non Volunteer’ in Anxiety measures and it also indicated that ‘Fatal’ (Volunteer and Non Volunteer) exhibit higher mean scores than ‘Non Fatal’ (Volunteer and Non Volunteer) in Anxiety measures. Same score comparison can be seen in Depression measures and Anger-Hostility measures where the mean scores of ‘Volunteer’ as well as ‘Fatal’ (Volunteer and Non Volunteer) are greater than the mean scores of ‘Non Volunteer’ and ‘Non Fatal’ (Volunteer and Non Volunteer). In the Somatic Concern measure ‘Non Volunteer’ mean score is higher than ‘Volunteer’ and also higher mean score can be seen on ‘Non Fatal’ (Volunteer and Non Volunteer) as compare to ‘Fatal’ (Volunteer and Non Volunteer).

High anxiety and depression levels of the ‘Volunteer’ is supported by the latest Pentagon survey assessing the mental health of troops in Iraq, which found one-third of the soldiers and marines in high levels of combat report anxiety, depression and acute stress.

Study done by Riley, Treiber and Woods (1989) reported that their study subject depressed group showed greater levels of hostility and anger experience than the normal group.

Post - traumatic stress disorder ((Anxiety disorder) was the most common condition reported, affecting 13 percent of all Iraq or Afghanistan veterans who sought VA (Veteran Administration) services, according to the study. That is slightly less than the 15.2 percent reported in the general population (CNN, 2007)

For many, the cause of anxiety is not just the dangers of being out on combat patrols or missions in enemy-held territory. The loneliness of separation from family and loved ones can be an emotionally draining situation, whether one is in war or not.

Depression and post-traumatic stress disorder (PTSD) are mental conditions that often go hand-in-hand. Many people develop post-traumatic stress disorder after experiencing or witnessing a traumatic event. This can cause them to relive the traumatic event and have nightmares and flashbacks of the event.

In many cases, PTSD (Anxiety disorder) becomes so severe that sufferers retreat remarkably from their everyday activities. They withdraw, isolate themselves and can begin to be depressed.

Symptoms of post-traumatic stress disorder are still reported by a fifth of the heavy combat veterans (Elder & Clipp, 1988) including sleep disturbances, depression and anxiety and flashbacks of combat scenes.

Evidence concerning the long-term effects of war neuroses can be found in the report of a 5-year follow-up study by Futterman and Pumpian-Mindlin. This study of 200 combat veterans seeking treatment at the Veterans Administration Mental Hygiene Clinic in Los Angeles provided evidence of fresh cases of traumatic war neuroses that had not previously sought treatment since the war. Common symptomatology among these veterans included: intense anxiety, recurrent combat-related dreams, startle reactions, depression, guilt, and a tendency to sudden, violent behavior. Secondary symptoms included a tendency to avoid people, fear of criticism, difficulty in making decisions, and various sleep disturbances. Similar findings were reported by Archibald, Long, Miller, and Tuddenham in their 15-year follow-up report on gross stress reactions resulting from combat during World War II. Questionnaire data were obtained from 57 combat veterans and 48 noncombat control subjects. The data indicated that the combat veterans were bothered by problems of tension, irritability, depression, diffuse anxiety symptoms, headaches, startle reactions, dizziness, blackouts, avoidance of activities similar to combat experience, internalization of feelings, insomnia, and nightmares. Eighty-two percent of the combat veterans reported that their psychological symptoms had interfered with their abilities to pro\vide for their families.

The findings are in consistent with the findings done by Robert. H. Stretch (1989) which state that 15.2% of all male Vietnam-theater veterans are currently experiencing symptoms of PTSD (Anxiety disorder). Among female Vietnam-theater veterans, the current PTSD (Anxiety disorder) prevalence is estimated to be 8.5%. These rates are considerably higher than the rates for either Vietnam-era veterans (males = 2.5%, females = 1.1%) or civilian counterparts (males = 1.2%, females = 0.3%). These figures represent individuals with symptoms that qualify for a clinical diagnosis of PTSD (Anxiety disorder).

The present study also showed that subjects who score high on the anxiety scale also scores high on depression, as it can be seen that 'Volunteer' scores are high on anxiety measures as well as depression. One study revealed that, 85 percent of those with major depression were also diagnosed with generalized anxiety disorder while 35 percent had symptoms of a panic disorder. Other anxiety disorders include obsessive-compulsive disorder and post-traumatic stress disorder (PTSD). Because they so often go hand in hand, anxiety and depression are considered the fraternal twins of mood disorders.

The Multiple regression analyses in the prediction of the symptoms of psychopathology from the behavioural measures of Anxiety, Depression, Somatic Concern, Anger-Hostility, Frustration and Coping orientations was employed to determine the anticedents and consequences relationship among the behavioural measures of the theoretical construct as envisioned. Frustration Test (FT) and Coping Inventory for Stressful Situations (CISS) as a predictors and Symptom Questionnaire (SQ) as a criterion in the regression model were computed.

The regression model with Task oriented coping, Emotion oriented coping, and Avoidance oriented coping as predictors and Anxiety as the criterion emerged to be statistically significant. The result supported by the normality and the homogeneity of the regression slope revealed that on scores of Anxiety with Task oriented coping as a predictor explain 53% of variances, Emotion oriented coping explain 47%, and Avoidance oriented coping explain 55%.

Frustration-Regression as a predictor for Anxiety explains 52% of variances, Frustration-Fixation explain 54%, Frustration-Resignation explain 62% and

Frustration-Aggression explain 43%. The result was supported by the normality and the homogeneity of the regression slope.

The regression model with Task oriented coping, Emotion oriented coping, and Avoidance oriented coping as predictors and Depression as the criterion emerged to be statistically significant. The results revealed that on the scale of Depression, Task oriented coping as a predictor explained 58%, Emotion oriented coping explained 56%, Avoidance oriented coping explained 67%.

Frustration-Regression as a predictor for depression explains 62% of variances, Frustration-Fixation explain 61%, Frustration-Resignation explains 69% and Frustration-Aggression explains 53%.

Consistent to the findings with regards to Anxiety and Depression, one study revealed that Avoidant coping may be positively associated with stress, anxiety and depression as it fails to remove minor stressors (Holahan et al. 2003). After a period of time, these stressors may become bigger, leading individuals to experience an enduring pattern of stress and consequently greater psychological distress (Holahan et al., 2003).

Hokanson (1961) also demonstrated that the subjects who admit to strong feelings of anger on personality tests manifest more of an anxiety type of physiological response following frustration.

Coping research has found emotion-focused coping to be both positively and negatively associated with psychological distress (Ben-Zur, 1999; Billings & Moos, 1982c).

The regression model with Task oriented coping, Emotion oriented coping, and Avoidance oriented coping as predictors and Somatic Concern as the criterion and the results emerged to be statistically significant. The results revealed that on the scale of Somatic Concern, Task oriented coping as a predictor explained 59%, Emotion oriented coping explained 54%, Avoidance oriented coping explained 72%.

Frustration-Regression as a predictor for Somatic Concern explains 66% of variances, Frustration-Fixation explains 66%, Frustration-Resignation explains 70%

and Frustration-Aggression explains 57%. The results were supported by the normality and the homogeneity of the regression slope.

The regression model with Task oriented coping, Emotion oriented coping, and Avoidance oriented as predictors and Anger-Hostility as the criterion and the results emerged to be statistically significant. The results supported by the normality and the homogeneity of the regression slope revealed that on scores of Anger-Hostility with Task oriented coping as a predictor explained 62% of variances, Emotion oriented coping explained 62%, Avoidance oriented coping explain 62%.

Frustration-Regression as a predictor for Anger-Hostility explains 56% of variances, Frustration-Fixation explains 56%, Frustration-Resignation explains 67% and Frustration-Aggression explains 50%.

The result findings can be summarized in accordance with the outcome of the quantitative analyses of the perceived impact of the Insurgency. The finding suggested that Frustration and Avoidance oriented coping appeared to be the main predictors of Anxiety, followed by Task oriented coping and then comes Emotional oriented coping as the predictor of Anxiety. Frustration and Avoidance oriented coping, again emerged to be the main predictors of Depression, followed by Task oriented coping and then Emotion oriented coping as the predictor of Depression. Then again, Frustration and Avoidance oriented coping emerged to be the main predictors of Somatic Concern, followed by Task oriented coping and then comes Emotion Oriented coping as the predictor of Somatic Concern. Finally, Frustration and Avoidance oriented coping again appeared to be the main predictors of Anger-Hostility, followed by Task oriented coping and Emotion oriented coping, which equally predicted the Anger-Hostility.

Amongst the participants, Task oriented coping is mostly associated with Anger-Hostility, followed by Depression, then Frustration-Regression, Frustration-Fixation and Frustration-Aggression subsequently. Emotion oriented coping is mostly associated with Anger-Hostility, followed by Depression, and then comes Anxiety, Frustration-Fixation, Frustration-Regression and Frustration-Aggression subsequently. The Avoidance oriented coping is mostly associated with Frustration-Resignation followed by Somatic Concern.

The result findings of this study are summarized in the followings, in relation to the theoretical expectation set forth for the study.

'Volunteer' exhibited greater anxiety scores than 'Non Volunteer'; this finding supported the theoretical expectation (hypothesis) No.1 set forth for the study (Insurgents may exhibit greater anxiety scores than Civilians).

This finding is supported by one study done on male Australian Korean war veterans. The study compared surviving male Australian veterans of Korean war with similar aged Australian civilian men who were residing in Australia at the time of the Korean war. The study found that there exist an excessive level of anxiety, PTSD (Anxiety disorder) and depression aming the veterens as compared to the civilians.

'Volunteer' exhibited greater depression scores as compared to 'Non Volunteer'; this finding is in conformity with the theoretical expectation (hypothesis) No.2 set forth for the study (Insurgents may exhibit greater mean scores than Civilian).

'Volunteer' exhibited greater mean scores on frustration measures as compared with the 'Non Volunteer'; this finding supported the theoretical expectation (hypothesis) No.3 set forth for the study (Insurgents may exhibit greater mean scores on frustration measures than Civilians.

'Volunteer' showed greater mean scores in task oriented and emotion oriented coping styles than the 'Non Volunteer', where as the 'Non Volunteer' showed greater mean scores on avoidance oriented coping style; this shows that the task oriented coping style as well as the emotion oriented coping style are more exercised by the 'Volunteer' as compared to the 'Non Volunteer' and avoidance oriented coping styles is more exercised by the 'Non Volunteer' than the 'Volunteer. This finding supported the theoretical expectation (hypothesis) No.4 set forth for the study (Insurgents are expected to manifest either or both of task and emotion oriented coping styles, while civilians are expected to manifest avoidance oriented coping styles).

Avoidance coping, such as not thinking about the problem, relying on externalization and wishful thinking, and engaging in emotional discharge (e.g., crying, shouting) to vent negative affect (Moos, 1993) is associated with greater PTSD (Anxiety disorder) severity (Bryant & Harvey, 1995; Sutker et al., 1995),

personality disorders (Vollrath, Alnaes, & Torgersen, 1998), violence risk (Kotler et al., 1993), hostility (McCormick & Smith, 1995), suicide (Linehan, Chiles, Egan, Devine, & Laffau, 1986), and comorbid psychopathology among substance use patients (Mezzich, Tarter, Kirisci, Hsieh, & Grimm, 1995). For example, Fairbank, Hansen, and Fitterling (1991) found that former World War II prisoners of war (POWs) with PTSD (Anxiety disorder) reported more coping characterized by self-isolation, wishful thinking, and self-blame than did former WWII POWs without PTSD (Anxiety disorder). Sutker et al. (1995) also noted an association between avoidance coping and PTSD (Anxiety disorder) symptoms among soldiers assessed within one year of their return from Operation Desert Storm.

'Fatal' (Volunteer and Non Volunteer) exhibited greater anxiety scores than 'Non Fatal' (Volunteer and Non Volunteer); this finding supported the theoretical expectation (hypothesis) No.5 set forth for the study (Bereaved insurgents and civilians may exhibit greater anxiety scores than Non bereaved insurgents and civilians counterparts).

'Fatal' (Volunteer and Non Volunteer) exhibited greater depression scores than 'Non Fatal' (Volunteer and Non Volunteer); this finding supported the theoretical expectation (hypothesis) No.6 set forth for the study (Bereaved insurgents and civil may exhibit greater depression scores than non-bereaved insurgents and civilians counterparts).

'Fatal' (Volunteer and Non Volunteer) exhibited greater frustration scores than 'Non Fatal' (Volunteer and Non Volunteer); this finding is in conformity with the theoretical expectation (hypothesis) No.7 set forth for the study (Bereaved insurgents and civilians may exhibit greater mean score on frustration measures than non-bereaved insurgents and civilians).

'Fatal' (Volunteer and Non Volunteer) showed greater mean scores in emotion oriented coping styles than 'Non Fatal' (Volunteer and Non Volunteer), where as the 'Non Fatal' (Volunteer and Non Volunteer) showed greater mean scores on avoidance oriented coping style; this shows that the emotion oriented coping style are more exercised by 'Fatal' (Volunteer and Non Volunteer) as compared to the 'Non Fatal' (Volunteer and Non Volunteer) and avoidance oriented coping styles is more exercised by the 'Non Fatal' (Volunteer and Non Volunteer) than the 'Volunteer. This

finding supported the theoretical expectation (hypothesis) No.8 set forth for the study (Bereaved insurgents and civilians are expected to manifest emotion oriented coping styles, while the non-bereaved insurgents and civilians are expected to manifest avoidance oriented coping styles).

Since the data were obtained in retrospective manner, the level of anxiety, depression and frustration might be not as high as the level during insurgency period which date back to 25 years ago. It is believed that the level of anxiety, depression and frustration during that time to be higher than the recorded data for this study. No abnormally high levels were found in the data, the reason for this is believed to be the nature of the Mizo society. The Mizo society is a closed knit society, they like to do things as a group, so everyone got roles to take part in different activities such as churches and NGOs, etc and so helping and supporting each other. These participation and activities play important means in coping with their war anxiety, depression and frustrations.

Even though the study of the psychological analyses of Insurgency in Mizoram is exploratory in nature, the finding of the present study on the whole provided empirical bases sufficient enough in conformity to the theoretical expectations set forth for conduction of the study and provided empirical background pertaining to the impact of insurgency on 'Insurgents' or 'Volunteer' (Fatal and Non fatal) and 'Civilians' or 'Non Volunteer' (Fatal and Non Fatal) on measures of the dependent variables, and 'Insurgents x Civilians interaction effect.

Although, it was designed to be the systematic and authentic research, the present study is not free from limitations. One limitation is that, since the study try to extract the psychological condition that date back to more than 25 years, psychological changes could happen, as there is a saying that 'time change people change', psychological changes over time would changed the original feeling. Psychological distress such as divorce, illness, unemployment, death of family member etc that came in to existence after the Peace Accord can alter the psychological condition of the participants, which set some limitations on the study. Another possible limitation of the study is that since the self-report questionnaires were used participants' social desirability could have influenced their reporting.

Suggestions for further research: Studies could examine whether coping styles change over time. The coping literature has shown that people seek more social support as they grow older (; Cronkite et al., 1998) however; few studies have conducted longitudinal research to better understand how coping styles change and develop over time.

Another interesting area of research to investigate is whether the association between coping styles and psychological distress are different across different ages.

Future research could also explore whether the presence of external stressors influences the association between coping styles and psychological distress. Research has shown that people experience greater stress at certain points in their life (Adlaf et al., 2001).

REFERENCES

Alcoff, Linda Martin.(1998). "What Should White People Do?" Hypatia, *Summer*, Vol. 13, No. 3: pp. 6-26.

Aldwin, C. M. (1994). *Stress, coping, and development*. New York: Guilford.

Altman, I. (1975). *The Environment and Social Behavior*. Monterey, CA: Brooks/Cole.

Altman, I., & Chemers,M.(1980). *Culture and environment.* Monterey, CA: Brooks/Cole.

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders (4th ed.).* Washington, DC: Author.

Amick-McMullan, A., Kilpatrick, D. G., Veronen, L. J., & Smith, S. (1989). Family survivors of homicide victims: Theoretical perspectives and an exploratory study. Journal of Traumatic Stress, 2(1), 21-35.

Amsel, A. (1958). The role of frustrative nonreward in noncontinuous reward situations. *Psychological Bulletin*, 55, 102-119.

Applegate R.,(1969). *Riot Control Materiel And Techniques*, Stackpole Books, USA.

Archibald, H.C., Long, D.M., Mille,r C., and Tuddenham, R.D.(1962). Gross stress reactions in combat: A 15-year follow-up. *Am J Psychiatry*. 119:317–322.

Ardrey, R.(1966). *The territorial imperative.* New York: Atheneum.

Army Medical Department. 1949;9(Suppl Combat Psychiatry):137–146.

Arvey, R. D., Bouchard, T. J., Segal, N. L., and Abraham, L. M. (1989). Job satisfaction: environmental and genetic components. *Journal of Applied Psychology*, 74, 187–192.

Asch, S, E. (1951). Studies of Independence and Conformity: A Minority of One against a Unanimous Majority. *Psychological Monographs*, 709, Whole No 416.

Askenasy, J. and Lewin, I. (1996). The impact of missile warfare on self-reported sleep quality. Part 1. *Sleep*, 19, 47-51.

Baird, Sarah A (2009). "A Rorschach Investigation of Psychopathy in a Sample of Incarcerated Females" (2009). *School of Professional Psychology*. Paper 83..

Bandura, A. (1965) Influence of models' reinforcement contingencies on the acquisition of imitative response. *Journal of Personality and Social Psychology*, 1, 589-595.

Bandura, A. (1978). The self system in reciprocal determinism. *American Psychologist,* 33, 344-358.

Bandura, A. (1986). *Social foundations of thought and action: A social cognitive theory.* Englewood Cliffs, NJ: Prentice Hall.

Bandura, A. (1997). *Self-efficacy*: The exercise of control. New York: W.H. Freeman

Barker, R., Dembo, T. and Lewin, K. (1941) *Frustration and aggression: An experiment with young children*, University of Iowa Studies in Child Welfare, 18, 1-314

Baron, R. A. (1977). *Human aggression.* New York: Plenum Press.

Barth C.P (2003). The effects of war. Fighting future war, Part two.

Barth, E.F.(2003) The Reintegration of Female Soldiers in Post-Conflict Societies: A Comparative Study from Africa. Oslo: PRIO.

Barth,F.D. (2003). Separate but not alone: Separation-individuation issues in college students with eating disorders. *Clinical Social Work Journal*,31(2), pp. 139-153.

Baum, A., Friedman, A. L., and Zakowski, S. G. (1997). Stress and genetic testing for disease risk. Health Psychology, *American Psychological Attoriuion, Inc*., 16(1), 8-19.

Belenky, G. L.(1986) Military psychiatry in the Israeli Defence Force. In: Gabriel RA, ed. Military Psychiatry: A Comparative Perspective. Westport, Conn: Greenwood Press: 147–179

Ben-Zur, H. (1999). The effectiveness of coping meta-strategies: Perceived efficiency, emotional correlates and cognitive performance. *Personality and ndividual Differences,* 26(5), 923-939.

Berkowitz, L. (1958). The expression and reduction of hostility. Psychological Bulletin. 55, 257-283.

Berkowitz, L. (1965). The concept of aggressive drive: Some additional considerations. in L. Berkowitz. (Ed.), *Advances in ex~erimentasl ocial vsychologv*, vo1.2, (pp. 30 1-329). New York: Academic Press.

Berkowitz, L. (1993). *Aggression: its causes, consequences, and control*. New York: McGraw Hill.

Berlyne, D.E. (1971). *Aesthetics and psychobiology*. New York: Appleton-Century-Crofts.

Berry J. W., and Annis, R. C. (1974). Acculturative stress. *Journal of Cross cultural Psychology,* 5, 382-406.

Berry, J. W. (1970). Marginality, stress and ethnic identification in an acculturated Aboriginal community. *Journal of Cross-cultural Psychology,* 1, 23- 252.

Berry, J. W. (1980b). Social and cultural change: In H. C. Triandis & R Brislin (Eds.), *Handbook of Cross-cultural Psychology,* Vol. 5, Social (pp. 211-279).

Berry, J. W. (1990): Psychology of Acculturation. *Nebraska Symposium on Motivation 1989: Cross-cultural Perspectives* (pp. 201-234). Lincoln: University of Nebraska Press.

Berry, J. W. (1992). Acculturation and adaptation in new society. *International Migration,* 30, 69-85.

Berry, J. W. (1994). Acculturation and psychological adaptation: An overview. (In A.-M. Bouvy, F. J. R. van de Vijver, P. Boski, & P. Schmitz (Eds.), Journeys into cross-cultural psychology (pp. 129–141). Lisse, the Netherlands: Swets & Zeitlinger).

Berry, J. W., and Kim, U. (1988). Acculturation and mental health. In P. R. Dasen, J. W. Berry, & N. Sartorius (Eds.), *Health and cross-cultural psychology* (pp. 207–236). Newbury Park, CA: Sage.

Berry, J. W., Kim, U., Minde, T. and Mok, D. (1987). Comparative studies of acculturative stress. *International Migration Review,* 21, 491-511.

Berry, J. W., Pootinga, Y. H., Segall, M. H., and Dasen, P. R. (1992). *Cross-cultural Psychology: Research and application.* New York: Cambridge University Press.

Billings, A. G., and Moos, R. H. (1981). The role of coping responses and social resources in attenuating the impact of stressful life events. *Journal of Behavior Medicine,* 4, 139-157.

Binneveld ,H. (1997). From shellshock to combat stress, p. 9. Binneveld, From Shell Shock to Combat Stress: A Comparative History of Military ..... Binneveld, Shell Shock (n. 9), p. 202-256..

Birman, D. (1994). *Acculturation and human diversity in a multicultural society*. In E. Trickett, R.Watts, & D. Birman (Eds.). *Human diversity: Perspective on people in context*. (pp. 261-284). San Francisco: Jossey-Bass.

Bochner, S. (1982). *The social psychology of cross-cultural relations*. In S. Bochner (Ed.), *Cultures in contact: Studies in cross-cultural interaction* (pp. 5-44). Oxford, England: Pergamon Press.

Bouras, N. and Holt, G. (2007). *Psychiatric and Behavioural Disorders in Intellectual and Developmental Disabilities* 2nd ed. Cambridge University Press: UK.

Bowman, J.(1967). *Recent experiences in combat psychiatry in Vietnam. Presented at the Social and Preventive Psychiatry Conference*; Walter Reed Army Medical Center. Washington, DC.

Bowman, M. L. (1997). *Individual differences in posttraumatic response*: Problems with the stress-adversity connection. Mahwah, NJ: Erlbaum.

Boyd, R., & Richerson, P. (1985). *Culture and the evolutionary process.* Chicago: University of Chicago Press.

Bramsen, I. and van der Ploeg, H. (1999). Fifty years later: The long term psychological adjustment of ageing World War II survivors. Acta Psychiatrica Scandinavica, 100, 350-358.

Brehmer, B., Azuma, H., Hammond, , K. R., Kostron, L., and Varonos, D.D.(1970). Cross national Comparision, of cognitive conflict, *Journal oc Cross cultural paychology*, 1,5, 5-20.

Brislin, R., Landis, D., and Brant, M. (1983). Conceptualization of intercultural behavior and training. In D. Landis & R. Brislin (Eds.), *Handbook of intercultural training* (Vol. 1, pp. 1-35). New York: Pergamon.

Brown, B.B. (1987). Territoriality. In D.Stokols & I.Altman (Eds.), *Handbook of environmental psychology* (Vol.1,pp.505-531). New York: Wiley-Interscience.

Bryant, R. A., and Harvey, A. G. (1995). Avoidant coping style and post-traumatic stress following motor vehicle accidents. *Behaviour Research and Therapy*, 33, 631–635.

Bryce, J.W., Walker, N., Ghorayeb, F and Kan,j M(1989). School of Public Health, University of Michigan, Ann Arbor.1989. Life experiences, response styles and mental health among mothers and children in Beirut, Lebanon.

Bustos, E. (1990). Dealing with the unbearable. In P. Suedfeld (Ed.), Psychology and torture (pp. 143-164). New York: Hemisphere.

Cardozo, B.L., Bilukha, O.O, Crawford, CA., Shaikh, I., Wolfe, M.I., Gerbe,r M.L and Anderson, M. (2004). *International Emergency and Refugee Health Branch, Division of Emergency and Environmental Health Service*s, National Center for Environmental Health, Centers for Disease Control and Prevention, Atlanta, Ga 30333, USA. Mental health, social functioning, and disability in postwar Afghanistan.

Carpenter,C.R. (1958). *Territoriality: A review of concepts and problems*. In A.Roe & G.G.Simpson (Eds.), Behavior and evolution. New Haven, CT: Yale University Press

Chauhan N.S. and Tiwari G.P.(1972) *Manual for Frustration Test*. Agra psychological research Cell, Tiwari Kothi, Belanganj, Agra -4 (India).

Christian Mesquida and Neil Wiener (2001).Peace Magazine, , page 6. York University, http: //peacemagazine.org

Christian Mesquida,(22June, 2001). *Young Men and War*: Could We Have Predicted the Distribution of Violent Conflicts at the End of the Millennium?.

Chun, K. M., Organista, P. B., and Marin, G. (2003). *Acculturation: Advances in theory, measurement, and applied research*. Washington, DC: American Psychological Association.

CNN World Study, (2007). *Anxiety, depression, acute stress in combat troops*.

Coon, C.S.(1946). The Universality of natural groupings in human societies, *Journal of Education Sociology*, 20, 163-68.

Cowen,E., Landes , J., and Schaet, D. (1959). The effects oof mild Frustration on the expression of Prejudiced attitude, *Journal of Abnormal and Social Psychology*, 58, 33-38.

Creveld, Martin Van (2000). "*Technology and War II:Postmodern War*?". In Charles Townshend. The Oxford History of Modern War. New York, USA: Oxford University Press. pp. 356–358.

Crockett,L.R., Iturbide,M.I., Torres, R.A., McGinley,s.M., Raffaelli,M and Carlo, G. (2007). Acculturative Stress, Social Support, and Coping: Relations to Psychological Adjustment among Mexican American College Students, *Cultural Diversity and Ethnic Minority Psychology*, 13:4, pp. 347–355.

Dabbs.J.M. (1971). Physical closeness and negative feelings. *Psychonomic Science,* 23, 141-143.

Dahl, R.A.(1989). *Democracy and Its Critics,*Yale University Press .

Dandapani S.(2000).Textbook of Educational Psychology.New Delhi :- Anmol Publications Pvt.Ltd,434/4B,Ansari road, Daryaganj,110092

de Jong JT, Komproe IH, Van Ommeren M, El Masri M, Araya M, Khaled N, van De Put W, Somasundaram D., 2001.Transcultural Psychosocial Organisation (TPO), Keizersgracht 329, 1016 EE, Amsterdam, the Netherlands.

de Jong, J., Komproe, I., Van Ommeren, M., El Masri, M., Araya, M., Khaled, N., van de Put, W., and Somasundarum, D. (2001). Lifetime events and

posttraumatic stress disorder in 4 postconflict settings. *Journal of the American Medical Association*, 286, 555-562.

de Jong, J., Scholte, W., Koeter, M., & Hart, A. (2000). *The prevalence of mental health problems in Rwandan and Burundese refugee camps*. Acta Psychiaticar Scandinavica.

Dembo, S. and Lewin, K. (1956): "Psycho-analytic and Topological Psychology. *Bulletin of Menninger Clinic*, 1:202-211.

Diamond, E.L. (1982). The role of anger and hostility in essential hypertension and coronary heart disease. *Psychological Bulletin*, 92, 410-433.

Dollard, J., Doob, L., Miller, N., Mowrer, O., and Sears, R. (1939*). Frustration and aggression*. New Haven, CT: Yale University Press.

Dollard, J., Doob, L., Miller, N., Mowrer, O., & Sears, R. (1939). *Frustration and aggression.* New Haven, CT: Yale University Press.

Donnerstein, D.E & Wilson, D.W. (1976). Effects of noise and perceived control on going and subsequent aggressive behavior, Journal of Personality and Social Psychology, 34, 774-781.

Downs, R.N., and Stea, D. *Cognitive maps and spatial behavior: process and products*. In R.N. Downs & D. Stea (Eds.), Image and environment: cognitive mapping and spatial behavior. Chicago: Aldine, 1973, pp. 8-26.

Drever, J.(1952). *A Dictionery of Psychology*, Harmondworth, Middlesex, Penquine.

Druckman. D. and Hopmann, P.T. (1989). "Behavioral Aspects of Negotiations on Mutual Security." In P.E.Tetlock, J.L.Husbands. R.Jervis, P.C.Stern & C. Tilly (eds.), Behavior, Society, and Nuclear War, Vol 1, pp. 85- 173. New York: Oxford University Press.

Edgerton, R. (1971). *The individual in cultural adaptation*. Los Angeles: University of California Press.

Eisenberg, P and Lazarsfeld, P.F (1938). The Psychological Effectys of Unemployment , *Psycjological Bullettin*, 35, 358-378.

Elder, G.H and Clipp,E. C. (1988). Combat Experience and Emotional Health: Impairment and Resilience in Later Life, *Journal of Personality*, Volume 57, Issue 2, pages 311–341.

Endler, N. S. & Parker, J. D. A. (1999). *Coping inventory for Stressful Situations: Manual*, *Second Edition*, Multi-Health Systems Inc, New York.

Endler, N. S., Denisoff, E., & Rutherford, A. (1998). Anxiety and depression: Evidence for differentiation of commonly co-occurring constructs. *Journal of Psychopathology and Behavioral Assessment*, 20, 149-176.

Endler, N. S., Parker, J. D. A., & Butcher, J. N. (1993). A factor analytic study of coping styles and the MMPI-2 content scales. *Journal of Clinical Psychology*, 49, 523-527

Endler, N.S. (1997). Stress, Anxiety And Coping: The Multidimensional Interaction Model , York University, Toronto, *Canadian Psychology*, 38, 136-153.

Erin P. Finley, (2011). For Soldiers With PTSD, A Profound Daily Struggle - Excerpted from Fields Of Combat. Cornell University.

Evans, G.W.,and Howard, H.R.B. (1972). A methodological investigation of personal space. In W.J.Mitchell (Ed.), *Environmental design*: *Research and practice, Proceedings of EDRA3/Ar8 Conference*. Los Angeles: University of California.

Eysenck, H. J., and Eysenck, M. W. (1985). *Personality and Individual differences: A natural science approach.* Plenum: New York & London.

Fairbank, J. A., Hansen, D. J., and Fitterling, J. M. (1991). Patterns of appraisal and coping across different stressor conditions among former prisoners of war with and without posttraumatic stress disorder.*Journal of Consulting and Clinical Psychology*, 59, 274–281.

Felipe, N.J., and Sommer,R. (1966). Invasions of personal space. *Social Problems*, 14, 206-214.

Fleishman, J., and Fogel, B. (1994). Coping and Depressive Symptoms among people with AIDS, *Health Psychology*, 13, 155-169.

Fong, S. L. M. (1965). Assimilation of Chinese in America: Changes in orientation and social perception. . *American Journal of Sociology*, *71*, 265-273.

Forsythe, C. J., and Compas, B. E. (1987). Interaction of cognitive appraisals of stressful events and coping: Testing the goodness of fit hypothesis. *Cognitive Therapy and Research*, 11, 473–485.

Freud, S.(1933)"*New Introductory Lectures on psycho-analysis*." New York, Norton.

Fuertes, J. N., and Westbrook, F. D. (1996). Using the social, attitudinal, familial, and environmental (S. A. F. E.) acculturation stress scale to assess the adjustment needs of Hispanic college students. *Measurement and Evaluation in Counseling & Development*, *29*, 67–77.

Furnham, A., and Bochner, S. (1986). *Culture shock: Psychological reactions to unfamiliar environments*. London: Methuen.

Futterman S,and Pumpian-Mindlin E. (1951).Traumatic war neuroses five years later. *Am J Psychiatry*. 108:401–408.

Gartner, W. (1996). *Tourism Development*: Principles, Processes, and Policies. New York: John Wiley and Sons.

Geen, R.G. (1975). The meaning of observed violence: Real vs. fictional violence and consequent effects on aggression and emotional arousal. *Journal of Research in Personality*, 9, 270–281.

Glass1,D.C., Singer,J.ER., Leonard, H.K.,Krantz, D., Cohen,S., and Cummings, H. (1973). Perceived control of aversive stimulation and the reduction of stress responses, *Journal of Personality*, Volume 41, Issue 4, pages 577–595.

Goldstein, J. (1986). *Aggression and Crimes of Violence*. New York: Oxford University Press.

Goldstein, M, J. (1973). Individual differences in response to stress. *American Journal of Psychology*, 1, 113,137.

Gottlieb, B. H. (Ed.). (1997). *Coping with chronic, stress*. New York: Plenum Press Graves, T. D. (1967). Psychological acculturation in a tri-ethnic community. *Southwestern Journal of Anthropology*, 337-350.

Gottlieb, B. H. (Ed.). (1997). *Coping with chronic, stress*. New York: Plenum Press

Gourevitch P.(1999). *We wish to inform you that tomorrow we will be killed with our families*: stories from Rwanda. New York: Picador.

Graves, T. D. (1967). Psychological acculturation in a tri-ethnic community. *Southwestern Journal of Anthropology,* 337-350.

Greenbaum, C., Erlich, C., and Toubiana, Y. (1993). *Settler children and the Gulf War*. In N.A. Fox & L.A. Leavitt (Eds.), The psychological effects of war and violence on children (pp. 109-130). Hillsdale, NJ: Erlbaum.

Hall, E.T. (1966). *The hidden dimension*. New York: Doubleday.

Harris, A. C., and Verven, R. (1998). Acculturation as a determinant of Greek-American family values: *Psychological Reports* Vol 83(3, Pt 2)

Hassela, C.V. (1997).error: The crime of the privileged—an examination and prognosis Studies in Conflict & Terrorism, Volume 1, Issue 1, Pages 1 - 16.

Hastorf, A.H., and Cantril, H. (1954). They saw a game: a case study. *Journal of Abnornal and Social Psychology*, 49, 129-134.

Heine, S. J., Lehman, D. R., Peng, K., & Greenholtz, J. (2002). What's wrong with ross- cultural comparisons of subjective Likert scales?: The reference-group effect. *Journal of Personality & Social Psychology*, 82(6), 903-918.

Hoffman, B. (1998).*Inside Terrorism* (New York: Columbia University Press, 29-33.

Hokanson, J.K. (1961). The Effects of Frustration and Anxiety on Overt Aggression. *Journal of Abnormal and Social Psychology*. Vol. 62, No. 2, 346-351.

Holahan, C.J. .,. Moos, R.H .,. Holahan, C.K ., Cronkite, R.C. and Randall, P.K. (2003).Drinking to cope and alcohol use and abuse in unipolar depression: A 10-year model, *Journal of Abnormal Psychology* **112** ,pp. 159–165.

Holzberg, A. D., Robinson, M. E., Geiser, M. E., & Gremillion, H. A. (1996). The effects of depression and chronic pain on psychosocial and physical functioning. *Clinical Journal of Pain*, 12, 118–125.

Horowitz, T. and Leshem, E (1998). *The immigrants from the FSU in the Israeli cultural sphere*. In: M. Sicron and E. Leshem, eds. Profile of an immigration wave: the absorption process of immigrants from the former Soviet Union, 1990–1995. Jerusalem: Magnes Press, pp: 291–333

Howard, R.B., Chase, S.D., and Rothman, M. (1973).An analysis of four measures of cognitive maps. In W.F.E. Prieser(Ed.), *Environmental design research*, Vol. 1. Stroudsburg, Pa.: Dowden, Hutchinson and Ross, pp. 254-64.

Huffman, R.E (1970). Which soldiers break down: A survey of 610 psychiatric patients in Vietnam. *Bull Menninger Clin*. 34:343–351.

Jager, H. (1981).“*Die individuelle Dimension terroristischen Handelns: Annaherungen and Einzelfalle*” [The individual dimension of terrorist actions: Approaches to individual cases.] In H. Jager, G. Schmidtchen, and L. Sullwood, Analysen zum Terrorismus. [Analysis of terrorism.] Vol. 2: Lebenslauf-Analysen [Biographical analysis]. Opladen: Westdeutscher Verlag

Jame,s J.E., and Hardardotti,r D.(2002). Influence of attention focus and trait anxiety on tolerance of acute pain. *Br J Health Psychol*. 2002;7:149–162

Jones, F.D, (2000). *Military Psychiatry: Preparing in Peace for* War. 2000; 35.

Jones, F.D.(1977).*Reactions to stress: Combat versus combat-support psychiatric casualties*. Presented at VI World Congress of Psychiatry; August 28—September 3, 1977; Honolulu, Hawaii.

Jones, F.D.(1985). *Psychiatric lessons of low-intensity wars*. Ann Med Milit Fenn [Finland] 60:128–134.

Jordan, B. K., Marmar, C. R., Fairbank, J. A., Schlenger, W. E., Kulka, R. A., Hough, R. L., and Weiss DS. (1992). Problems in families of male Vietnam veterans with posttraumatic stress disorder. *Journal of Consulting and Clinical Psychology*, 60(6):916-926.

Karam EG, Howard DB, Karam AN, Ashkar A, Shaaya M, Melhem N, El-Khoury N., (1998).Department of Psychiatry and Psychology, St. George Hospital, Beirut, Lebanon. Major depression and external stressors: the Lebanon Wars.

Kardiner, A. (1939). *The individual and his society*. New York: Columbia University Press.

Kathryn, K., Betsy, B., Richardson, J., and Marston,A (1987).*Age Differences in Coping*, Behavioral Dysfunction and Depression Following Colostomy Surgery. *The Gerontologist* ,27 (2): 182-184.

Katz, P. (1937) *Animals and men*. New York: Longmans, Green.

Kellner, R. (1987). A Symptom Questionnaire. *Journal of Clinical Psychiatry, 48, 268-274.*

Kessler, R., Sonnega, A., Bromet, E.,and Nelson, C (1995). Posttraumatic stress disorder in the National Comorbidity Study. *Archives of General Psychiatry*, 52, 1048-1060.

Keyes, K., Bisno, B., Richardson, J.,and Marston, A 91987). Age differences in coping, behavioral dysfunction and depression following colostomy surgery.The Gerontologist, Vol 27(2), , 182-184.

Kiran Bhalia and Sanford Golin,(1978) . *Role of Locus of Control in Frustration-produced Aggression*, 364-365. University of Pittsburgh

Klingman, A. (1995). Israeli children's responses to the stress of the Gulf War. School *Psychology International*, 16, 303-313.

Kluckhohn, C. (1951). 'The study of culture'. In D. Lerner & H. D. Lasswell (Eds.), *The policy Sciences.* Stanford, CA; Stanford University Press.

Kmiecik, C., Mausar,P., & Benziger, G. (1979). Attractiveness and interpersonal space. *Journal of Social Psychology*, 108, 227-278.

Kotler, M., Finkelstein, G., Molcho, A., Botsis, A. J., Plutchik, R., Brown, S.-L., and H.M. van Praag .(1993). Correlates of suicide and violence risk in an inpatient population: Coping styles and social support. *Psychiatry Research*, 47, 281–290.

Kottak, Conrad Phillip .(2005.) *Windows on Humanity*, pages 209, 423. McGraw Hill, New York.

Kroeber, A.L., & Kluckhohn, C.(1952). Culture: a critical review of concepts and definitions. Cambridge, Mass,: *Peabody Museum*, Vol. 47, No. 1.

Kubler-Ross E.(1969). *On Death and Dying*. London: Macmillan.

Labbate LA, Cardeña E, Dimitreva J, Roy M, and Engel CC. (1998). Psychiatric Syndromes in Persian Gulf War Veterans: An Association of Handling Dead Bodies with Somatoform Disorders, *Psychotherapy and Psychosomatics*, Vol. 67, No. 4-5.

LaFromboise, T., Coleman, H.and Gerton, J. (1993). Psychological impact of biculturalism: Evidence and theory. *Psychological Bulletin,* 114, 395-412.

Lalnithanga, P. (2005). *Emergence of Mizoram,* Lengchhawn Press , Khatla, Aizawl-796001.

Lalthakima (2000) Mizoram:A profile; L.T.Pudaite, on Negotiating with Insurgency and Holding on to Peace , in the Patnaik, J.K edited book, *Mirzoram, dimensions and perspectives society, economy, and polity*.

Lalthangliana, B. (2001). *India, Burma, & Bangladesh -a Mizo Chanchin*, The RTM Press, Chhina Veng, Aizawl, Mizoram.

Lammy.J. (2005), University of Calgary. Carl von Clausewitz and Insurgency.

Landau R., Litwin H. (2000). The effects of extreme early stress in very old age. *J Trauma Stress*,;13:473–487.

Lazarus RS, and Folkman S. (1984). *Coping and adaptation*. In: Gentry WD, ed. Handbook of Behavioral Medicine. New York: Guilford; 1984: 282-325.

Lazarus, R. S and Folkman, S. (1984). Stress, *Appraisal, and Coping*. New York: Springer.

Lazarus, R. S. (1993). Coping theory and research: Past, present, and future. *Psychosomatic Medicine,* 55, 2324-2347.

Lazarus, R.S.,and Cohen, J.B. (1977). Environmental stress. In I. Altman & J.F. Wohlwill (Eds.), Human behavior and the environment: *Current theory and research* (Vol. 2,pp. 89-127). New York: Plenum.

Leonard Berkowitz (1960).Repeated Frustrations and Expectations in Hostility Arousal. The *Journal of Abnormal and Social Psychology*. Vol 60(3), May 1960, 422-429.

Lester, D. (1992). "War and Personal Violence." In G. Ausenda (ed.) Effects of War on Society, pp. 211-22. San Marino: AIEP Editore.

Levant, R. F., Barbanel, L and DeLeon, P. H. (2011). Psychology responds to terrorism. In A. J. Marsella, F. Moghaddam, & A. Bandura, A. (Eds.), International terrorism and terrorists: Psychosocial perspectives. Washington, DC: American Psychological Association.

Levant, R.F. (2002) Psychology Response to Terrorism, Professional Psychology: Research and Practice , *American Psychological Association* , Vol. 33, No. 5, 507-50.

Lewin, K.(1947). *Social decision and Social Change.* In T Newcomb & E Hartley (Eds)), Reading in social psychology. New York:Holt, Rinehart and Winson.

Ley, D., and Cybriwsky, R. (1974a). The spatial ecology of striped cars. *Environment and Behavior*, 6, 53-68.

Liddell, C., Kemp, J. and Moema, M. (1991). "*The Young Lions: South African Children and Youth in Political Struggle*." In L.A. Leavitt & N.A.Fox (eds), The Psychological Effects of War and Violence on Children, pp.199-214. Hillsdale, NJ; Erlbaum.

Liddell, C., Kemp, J., and Moema, M. (1991). *'The young lions: South African children and youth in political struggle'*. In Leavitt, L. A., and Fox, N. A. (eds.), The Psychological Effects of War and Violence on Children.

Linehan,M.M., Chiles, J. A., Egan, K. J., Devine, R. H and Laffau, J. A. (1986). Presenting problems of parasuicide versus suicide ideators and nonsuicidal psychiatric patients. *Journal of Consulting and Clinical Psychology*, 54, 880–881.

Lloyd, J.M. (1961). *On Every High Hill*. Hugh Evans and Sons Ltd. Liverpool

Lorenz, Konrad. (1996). The Natural Science of The Human Species: An Introduction to Comparative Research. The "Russian Manuscript" (1944–1948). Edited from the author's posthumous works by Agnes von Cranach. Cambridge, MA: MIT Press.

Mackenzie, A. (1979). *The North East Frontier of India*. Mittal Publications, Delhi

Macksoud and, Abe,r .JL (1996). *National Center for Children in Poverty*, Columbia University School of Public Health, New York, NY 10032, USA.

Maier, Norman R. F.(1956).Frustration theory: restatement and extension. *Psychological Review*, Vol 63(6).

Malzberg, B.and Lee, E. (1956). *Migration and mental disease*. New York: Social Science Research Council.

Marshall, S.L.A. (1947/1978) *Men against Fire*. New York: Morrow.

Marston, D. (2005). War Studies Department at the Royal Military Academy Sandhurst (RMAS).

Masters, R., Friedman, L. N., & Getzel, G. (1988). Helping families of homicide victims: A multidimensional approach. Journal of Traumatic Stress, 1, 109–125

McClosky, P. (1986). *When you are angry with God*. New York: Paulist Press.

McCormick, R. A and Smith, M. (1995). Aggression and hostility in substance abusers—The relationship to abuse patterns, cop-ing style, and relapse triggers. *Addictive Behaviors*, 20, 555–562.

McGee, W. J. (1898). Piratical acculturation. . *American Anthropologist*, *11*, 243-249.

Mead, M. (1961).*Cooperation And Competition among Primitive Peoples*, Boston: Beacon Press.

Meek, C. L. (1990). *Evaluation and assessment of post-traumatic and other stress-related disorders*. In C. L. Meek (Ed.),Post-traumatic stress disorder:

Assessment, differential diagnosis, and forensic evaluation (pp. 9-61). Sarasota, FL: Professional Resource Exchange.

Merskey, H. (1992). Psychiatric aspects of the neurology of trauma. . *Neurologic Clinics*, 10, 895-905.

Mezzich, A. C., Tarter, R. E., Kirisci, L.,Hsieh, Y.-C and Grimm,M. (1995). Coping capacity in female adolescent substance abusers. *Addictive Behaviors*, 20, 181–187.

Milgram, N A and Bar, K (1993). Stress on Wives Due to Husbands' Hazardous Duty or Absence. *Military Psychology*, 5(1): 21-39.

Milgram, N. (1994). Stress and coping in Israel during the Persian Gulf War. *Journal of Social Issue*s, 49, 103-123.

Miller , N.E., and and Bugelsk. R. (1948). Minor stadies of Aggression II, The Influence of Frustration imposed by the in group on attitudes expressed toward out group, *Journal of Psychology*, 25, 437-442.

Miller, L. (1994). Civilian posttraumatic stress disorder: Clinical syndromes and psychotherapeutic strategies. *Psychotherapy*, 31, 655-664.

Miller, L. (1998a). *Psychotherapy of crime victims*: Treating the aftermath of interpersonal Psychotherapy: Theory, Research, Practice, Training, Vol 39(4), 283-296.

Miller, N. E. (1941). The frustration–aggression hypothesis. *Psychological Review, 48,* 337-342.

Miller, N. E. (1941). The frustration–aggression hypothesis. *Psychological Review, 48,* 337-342.

Mitchell D.(2007). *PTSD*, Depression Hurt Soldiers Home From Iraq, Afghanistan

Modlin, H. C. (1983). *Traumatic neurosis and other injuries*. . Psychiatric Clinics of North America, 6, 661-682.

Mollica RF, McInnes K, Poole C, Tor S., 1998. Harvard School of Public Health, Harvard Medical School, Cambridge, MA 02138, USA. Dose-effect relationships of trauma to

symptoms of depression and post-traumatic stress disorder among Cambodian survivors of mass violence.

Mollica, R., McInnes, K., Sarajlic, N., Lavelle, J., Sarajlic, I., and Massagli, M. (1999). Disability associated with psychiatric comorbidity and health status in Bosnian refugees living in Croatia. *Journal of the American Medical Association*, 282, 433-439.

Mollica, R.F., Donelan, K., To,r S., Lavelle, .J, Elias, C., Frankel, M and Blendon, R.J. (1993).Harvard Program in Refugee Trauma, Harvard School of Public Health, Boston, Mass,. The effect of trauma and confinement on functional health and mental health status of Cambodians living in Thailand-Cambodia border camps.

Mollica, R.F., McInnes, K., Sarajlic, N., Lavelle, J., Sarajli,c I., Massagl,i M.P (2001). Harvard Program in Refugee Trauma, Harvard Medical School, Boston, Mass, USA. Disability associated with psychiatric comorbidity and health status in Bosnian refugees living in Croatia.

Montagu, A. (1971). *Touching: The Human significance of the skin*. New York: Columbia University Press.

Montagu, Ashley (1976), "*The Nature of Human Aggression*" (Oxford University Press)

Moos, R.H. (1993). CRI-Youth Form Professional Manual. Psychological Assessment Resources, Inc.

MSNBC.com, 2007. Mental health: Soldiers suffer from stress after coming home.

Mulgan, R.G.(1974). Aristotle's Doctrine That Man Is a Political Animal, Hermes, 102. Bd., H. pp. 438-445.

Nash, D., and Shaw, L. C. (1963). Personality and adaptation in an overseas enclave. . *Human Organization*, *21*, 252-263

Norbury, F. B.(1953). Psychiatric admissions in a combat division. US Army Med Bull Far East. July .130–133.

Norman, M. Camp., Robert, H., Stretch, and William, C. M (1989). *Stress, Strain, and Vietnam*.An Annotated Bibliography of Two Decades of Psychiatric and Social Sciences Literature Reflecting the Effect of the War on the American Soldier.

O'Kelly, C. G., and Carney, L. S. (1986). *Women and men in society* (2nd Ed.). Belmont, CA: Wadsworth.

O'Neal,E.C., Brunault,M.A., Carifio, M.S., Troutwine,R., and Epstein ,J. (1980). Effect of insult upon personal space preferences. *Journal of Nonverbal Behavior*, 5, 56-62.

Oberg, K. (1960). Cultural shock: Adjustment to new cultural environment. *Practical Anthropology*, 7, 170-179.

Ohman, A. (2000). Fear and anxiety: Evolutionary, cognitive, and clinical perspectives. In M. Lewis & J. M. Haviland-Jones (Eds.). *Handbook of emotions*. (pp.573-593). New York: The Guilford Press.

Olaniran, B. A. (1993). International students' network patterns and cultural stress: What really counts. Communication Research Reports, 10, 69-83.

O'Neill, Bard E.(1990). *Insurgency & Terrorism*. New York: Brassey's (US) Inc.,

Ortega, A. N., Rosenheck, R., Alegria, M.,and Desai, R. A. (2000). Acculturation and the lifetime risk of psychiatric and substance use disorders among Hispanics. *The Journal of Nervous and Mental Disease*, 188, 728–735.

Paardekooper, B. de Jong, .J.Tand Hermanns, J.M.(1999). The psychosocial impact of war and the refugee situation on south Sudanese children in refugee camps in northern Uganda: an exploratory study. *J Child Psychol Psychiatry All Discipl.* 40:529–536.

Paardekooper, B., de Jong, J., and Herman, J. (1999). The psychological impact of war and the refugee situation on South Sudanese children in refugee camps in Northern Uganda: An exploratory study. *Journal of Child Psychology and Psychiatry*, 40, 529-536.

Park, R. (1928). Migration and the marginal man. *American journal of Sociology,* 33, 200-206.

Parkes, C. M and Brown, R. (1972). Health after bereavement: A controlled study of young Boston widows and widowers. Psychosomatic Medicine, 34, 449-461.

Parkes, C. M. (1975). *Determinants of outcome following bereavements*. . Omega, 6, 303-323.

PASW Statistics (2009) SPSS Programming and Data Management: A Guide for SPSS and SAS Users, Fourth Edition (2007), SPSS Inc., Chicago Ill.

Penland, E., Masten, W., Zelhart, P., Fournet, G., and Callahan, T. (2000). Possible selves, depression, and coping skills in university students. *Journal of Personality and Individual Differences*, 29, 963-969.

Perkins, D. (2000). Law, family ties, and the East Asian way of business. In L. Harrison & S. Huntington (Eds.), *Culture matters* (pp. 232-243). New York: Basic Books.

Pettigrew, T.F. (1979). The ultimate attributor error: Extending Allport's cognitive analysis of prejudice. *Personality and Social Psychology Bulletin*, 5, 461-476.

Pham, P.N., Weinstein, H.M., and Longman, T. (2004).*Payson Center for International Development and Technology Transfer,* Tulane University, New Orleans, La 70118, USA. Trauma and PTSD symptoms in Rwanda: implications for attitudes toward justice and reconciliation.

Phares, E.J. (1976) . Locus of Control in Personality, Marristown, N.J, General Learning Press.

Phil Barker (8 April 2009). *Psychiatric and Mental Health Nursing*: The Craft of Caring. Oxford University Press, USA. pp. 166–167.

Pootinga, Y. H. (1989). Equivalence of cross-cultural data: An overview of basic issues. *International Journal of Social Psychology*, 24, 737-756

Powell, J. W. (1900). Report of the director. . *Report of the Bureau of American Ethnology*, *19*, xi-xxxiii.

Prasad, M.S and Thakur, G.P. (197). *Manual and Directions for Self Esteem inventory*, Agra Psychological Research Cell. Twari kothi, Belanganj, Agra-282 004.

Pratkaniski, A.R. (1989). *The cognitive representation of attitudes*, In A ,R, Pratkanis, S, J Breakler, & A,G Greenwald (Eds.) Attitude structure and function, Hillsdale, NJ: Lowrence Erlbaum Associates Inc.

Pratto, F., Sidanius, J., Stallworth, L. M., & Malle, B. F. (1994). Social dominance orientation: A personality variable predicting social and political attitudes. Journal of Personality and Social Psychology, 67, 741-763.

Ranson, S.W.(1949). The normal battle reaction: Its relation to pathologic battle reaction. Combat Psychiatry. *Bull US Army Med Dept*.1949;9: 3 – 1 1

Reid, A. S (1978). *Chin - Lushai Land* (A description of the various expeditions into the Chin - Lushai Hills and the final annexation of the country), First edition 1893,Reprinted: 1976, Firma KLM Private Ltd., Tribal Research Institute, Aizawl, Mizoram.

Renner, J.A.(1973). The changing patterns of psychiatric problems in Vietnam. *Compr Psychiatry*. 14(2):165–181.

Ressler, R. K., Burgess, A. W and Douglas, J. E. (1988). *Sexual homicide: Patterns and motives*. New York: Free Press.

Rexresearch.com (2011)"Tuyacan" Central Intelligence Agency. Psychological Operations in Guerrilla Warfare.

Rickard, M. (1994). Liberalism, multiculturalism, and minority protection. *Social Theory and Practice*, 20, 143-170.

Riley, W.T., Treiber, F.A and Woods, M.G.(1989). Anger and hostility in depression. *The Journal of Nervous and Mental Disease*, 177(11):668-674.

Rosen, L., Teitelbaum, J andWesthuis, D. (1993). Children's reactions to the Desert Storm deployment: Initial findings from a survey of Army families. *Military Medicine*, 158, 465–469.

Rudmin, F. W. (2003). Critical history of the acculturation psychology of assimilation, separation, marginalization, and integration. *Review of General Psychology*, *7*, 3–37.

Russ Zajtchuk, (1917) War Psychiatry, *The Military Surgeon*, Vol XLI, No 2.

Ryden, M.B., Bossenmaier, M and McLachlan, C. (1991). Aggressive behavior in cognitively impaired nursing home residents. *Research in Nursing and Health*, 14, 87-95.

Ryden, M.B., Bossenmaier, M., & McLachlan, C. (1991). Aggressive behavior in cognitively impaired nursing home residents. *Research in Nursing and Health*, 14, 87-95.

Ryder, A. G., Alden, L. E and Paulhus, D. L. (2000). Is Acculturation Unidimensional or Bidimensional? A head-to-head comparision in the prediction of Personality, Self-identity, and Adjustment. *Journal of Personality and Social Psychology,* 79(1), 49-65.

Rynearson, E. K. (1988). *The homicide of a child*. In F. M. Ochberg (Ed.),Posttraumatic therapy and victims of violence (pp. 213-224). New York: Brunner/Mazel.

Rynearson, E. K. (1994). Psychotherapy of bereavement after homicide. *Journal of Psychotherapy Practice and Research*, 3, 341-347.

Salama P, Spiegel P, Van Dyke M, Phelps L, and Wilkinson C.(2000). *National Center for Environmental Health, Centers for Disease Control and Prevention*, 4770 Buford Hwy NE, Mailstop F-48, Atlanta, GA 30341, USA.

Salmon, T.Wand Fenton, N.(1994). In the army of occupation. In: Bailey P, Williams FE, Komora PA, Salmon TW, Fenton N, eds. Neuropsychiatry. Vol 10. In: The Medical Department of the United States Army in the World War.Washington, DC: Office of The Surgeon General, US Army; 1929: 423–428.

Sandhu, D. S. (1994). An examination of the psychological needs of the international students: Implications for counseling and psychotherapy. *International Journal for the Advancement of Counseling*, *17*, 229–239.

109-125.

Sangkima. (2002).*The coming and settlement of Myanmares in Mizoram* .Paper presented in the National Seminar on *Cross-border movement of people into Mizoram* by MAKAIAS and Mizo History Association at Aizawl.

Sarra,j E.E and Qouta S.(2005). *The Palestinian experience*. In: Lopez-Ibor JJ, Christodoulou G, Maj M, editors. Disasters and mental health. Chichester: Wiley; pp. 229–238.

Scarr, S. (1998). On Arthur Jensen's integrity. *Intelligence*, 26 (3), 227-232.

Schachter, H. (1957) Pain, fear and anger in hypertensives and normotensives: a psycho-physiological study. *Psychosomatic Medicine*, 19, 17.

Sprang, G., & McNeil, J. (1995). The many faces of bereavement: The nature and treatment of natural, traumatic, and stigmatized grief. New York: Brunner/Mazel.

Schlosser, E. (1997, September). A grief like no other. . Atlantic Monthly, pp., 37-76. pp.

Scholte, W.F., Olff, M., Ventevoge,l P., de Vries, G.J., Jansveld, E., Cardozo, B.L and Crawford, C.A. (2004). *Mental health symptoms following war and repression in eastern Afghanistan.* Academic Medical Center, Department of Psychiatry, University of Amsterdam, Amsterdam, The Netherlands.

Schröder, K., Schwarzer, R and Endler, N. S. (1997). Predicting cardiac patients' quality of life from the characteristics of their spouses. *Journal of Health Psychology*, 2, 231-244.

Schwarzwald, J., Weisenberg, M., Soloman, Z and Waysman, M. (1997). What will he future bring? Thoughts of children after missile bombardment. *Anxiety, Stress, and Coping*, 10, 257-267.

Scurfield, R.M and Tice, S. (1992. Interventions with medical and psychiatric evacuees and their families: from Vietnam through the Gulf War, *Mil Med*;157(2):88-97.

Searle, W and Ward, C. (1990). The prediction of psychological and sociological adjustment during cross-cultural transitions. *International Journal of Intercultural relations,* 14, 449-464.

Seligman, H. E. (1975). *Helplessness: On depression, development,and death*. San Francisco: Freeman.

Selye H.(1946). The General Adaptation Syndrome and the diseases of adaptation. *J Clin Endocrinol Metab*. 6(2):117–230.

Shavitt, S., Swan, S., Lowrey, T.M and Wanke, M. (1994). The interaction of endorser attractiveness and involvement in persustion depends on the goal that guides message processing. *Journal of Consumer Psychology*, 3, 137-162.

Sheridan, C.L. and Radmacher, S.A. (1992) *Health Psychology*: Challenging the Biomedical Model. Chapters 1-3. New York: John Wiley.

Shervington, M.W.(2005).*Small Wars and Counter-Insurgency Warfare*: Lessons from Iraq, Unpublished Dissertation of Master Degree in Defence Administration, Department of Defence Management and Security Analysis. Granfield University.

Sidanius, J and Pratto, F. (1999). *Social Dominance Theory*: A New Synthesis in Social Dominance, New York, Cambridge University Press, 31-57.

Silver, R and Wortman, C. (1980). *Coping with undesirable life events*. In J. Garber & M. E P Seligman (Eds.) Human Helplessness: theory and Applications, 279-340, New York, Academic Press.

Smith P. Perrin S. Yule W, W., Hacam, B., & Stuvland, R.(2002).War exposure and children from Bosnia-Herzegovina: psychological adjustment in a community sample. *J Traum Stress*;15:147–156.

Smith, Melinda (2008, June). *Anxiety attacks and disorders*: Guide to the signs, symptoms, and treatment options. Retrieved March 3, 2009, from Helpguide Web site: http://www.helpguide.org.

Smith, R.J., & Knowles, E.S. (1979). Affective and cognitive mediators of reactions to spatial invasions. *Journal of Experimental Social Psychology, 15, 437-452.*

Smith, R.J., and Knowles, E.S. (1979). Affective and cognitive mediators of reactions to spatial invasions. *Journal of Experimental Social Psychology, 15, 437-452.*

Sobel R.(1949) *Anxiety-depressive reactions after prolonged combat experience: The "old sergeant syndrome." Supplement on combat psychiatry*. Bull US Army Med Dept.; 9:137–146.

Sobel R.(1949) Anxiety-depressive reactions after prolonged combat experience: The"old sergeant syndrome." Supplement on combat psychiatry. *Bull US Army Med Dept*.; 9:137–146.

Solomon Z.(1988). Somatic complaints, stress reaction, and posttraumatic stress disorder: a three-year follow-up study. *Behav Med*; 14: 179–85.

Solomon.Z., Avitzur. E., Mikulincer. M., (1989). *Coping styles and post-war psychopathology among Israeli soldiers.* Department of Mental Health, Israel Defense Forces Medical Corps, Military P.O. Box 02149 Israel, Department of Psychology, Bar-Ilan University, Ramat-Gan, Israel.

Somasundaram DJ, Sivayokan S., (1994) .Department of Psychiatry, Faculty of Medicine, University of Jaffna. War trauma in a civilian population. The British Journal of Psychiatry,165: 524-527.

Somasundaram, D and Jamunanatha, C.S (2002*). Psychosocial consequences of war: northern Sri Lankan experience*. In: De Jong JTVM, editor. Trauma, war and violence: public mental health in socio-cultural context. New York: Plenum; pp. 205–258.

Sommer, R. (1969). *Personal space.* Englewood Cliffs, NJ: Prentice –Hall.

Sorcha Faal (2006), The Partisans Handbook : Essential Survival Guide For Resisting Foreign Military . Occupation,. Escape And Evasion Techniques, Surviving Interrogation EU and US all rights reserved.

Sauvages, D (1768). Disorders of Frustration and Loneliness,War Psychiatry , chapter 3, Office of The Surgeon General United States of America.

Spitzer, R.L., Kroenke, K., andWilliams, J.B.(1999). *Validation and utility of a selfreport version of PRIME-MD*: the PHQ primary care study. Primary Care

Evaluation of Mental Disorders. Patient Health Questionnaire. JAMA,282:1737– 44.

Spradley, J.P. & Phillips, M. (1972). Culture and Stress : A quatitative analysis. *American Anthropologist*, 74, 518-29.

Srinivasa, M. R. and Lakshminarayana R, (2006). Mental health consequences of war: a brief review of research ¢ndings. *World Psychiatry*, 5, 25-31

Statistica 8.0 (2008). U.S. Headquarters: StatSoft, Inc. 2300 E. 14th St. Tulsa, OK 74104 USA.

Steel Z. Silove D. Bird K, et al. Pathways from war trauma to posttraumatic stress symptoms among Tamil asylum seekers, refugees and immigrants. *J Traum Stress.*;12:421–435.

Steward, E. (1991). *An Intercultural Interpretation of the Persian Gulf Crisis*,Tokyo: Kanda University of International Studies, Intercultural Communication Institute. New York: Columbia University Press.

Straker G, Mendelsohn M, Moosa F, and Tudin P (1996) Violent Political Contexts and the Emotional Concerns of Township Youth. *Child Development*, vol 67, n1, pp 46-54.

Sue, S., & Sue, D. W. (1971). Chinese American personality and mental health. . *Amerasia Journal*, *1*(2), 36-50.

Sullivan, M.J.L., Thorn, B., Rodgers, W., and Ward, C. (2004). A path model of psychological antecedents of pain experience: Clinical and experimental findings. *Clinical Journal of Pain*, 20: 164-173.

Sutke,r P.B., Uddo, M., Brailey, K., Allain, A.N and Errera, P.(1994). Psychological symptoms and psychiatric diagnoses in Operation Desert Storm troops serving Graves registration duty. *J Trauma Stress*. 7(2):159-71.

Sutker, P. B., Davis, J. M., Uddo, M and Ditta, S. R. (1995). War zone stress, personal resources, and PTSD in Persian Gulf War returnees. *Journal of Abnormal Psychology*, 104, 444–452.

Szapocznik, J and Kurtines, W. (1979). *Acculturation, biculturalism and adjustment among Cuban Americans*. In A. Padilla (Ed.), Psychological dimensions on the acculturation process: Theory, models, and some new findings (pp. 139–159). Boulder, CO: Westview.

Taggart T, Carruthers M, and Somerville W. (1978*).Emotions,catecholamines and the electrocardiogram*. In: Yu PN, Goodwin JF, eds. Progress in cardiology. Vol 7.Philadelphia: Lee & Febiger, 103-24.

Tajfel, H and Turner, J. C. (1979). *An Integrative Theory of Intergroup Conflict*. In W. G. Austin & S. Worchel (Eds.), The Social Psychology of Intergroup Relations. Monterey, CA: Brooks-Cole .

Taylor, R.B. (1988). *Human territorial functioning* . Cambridge: Cambridge University Press.

The official CIA manual. Psychological operations in Gurilla war.

Thomas, J.L. , Wilk, J.E., Riviere, L.Aand , McGurk D., Carl, A., Castro., Charles, W and Hoge. (2010).Prevalence of mental health problems and functional impairment among active component and National Guard soldiers 3 and 12 months following combat in Iraq.*Arch Gen Psychiatry*.;67:614-23.

Tinklenberg, J. R.; Ochberg, F. M. (1981). *Patterns of violence: a California sample*. In: Hamburg, D. A.; Trudeau, M. B. (eds.). Biobehavioral aspects of aggression. New York, Alan R. Liss.

Triandis, H. C. (1994). *Culture and social behavior.* New York: McGraw-Hill.

Tripp, D. A., Stanish, W. D., Coady, C., & Reardon, G. (2004). The subjective pain experience of athletes following anterior cruciate ligament surgery. *Psychology of Sport and Exercise,* 5, 339–354.

US Department of the Army.(1994). Planning for Health Service Support. Field Manual 8-55, Washington, DC: DA.

Van der Veer G. (1998) Counselling and Therapy with Refugees and Victims of Trauma. Chichester: John Wiley & Sons.

Vandello, J and Cohen, D. (1999). Patterns of individualism and collectivism in the United States. *Journal of Personality and Social Psychology,* 77, 279-292.

Varte, C.L. (2005) . Levels and Strategies of acculturation in Relation to Identity, Attitudes, Values and adjustment: a Study of Mizo.*Unpublished Doctoral Dissertation*. Mizoram University, Aizawl.

Varte, C.L. (2005) . Levels and Strategies of acculturation in Relation to Identity, Attitudes, Values and adjustment: a Study of Mizo.*Unpublished Doctoral Dissertation*. Mizoram University, Aizawl.

Vega, W.A., Khoury, E.L., Zimmerman, R.S., Gil, A.G and Warheit, G.J.(1995). Cultural conflicts and problem behaviors of Latino adolescents in home and school environments. Journal of Community Psychology. 23: 167–179.

victims: A multidimensional approach. *Journal of Traumatic Stress,* 7(1),

Vitaliano, P. P. (1990). Appraised changeability of a stressor as a modifier of the relationship between coping and depression: A test of the hypothesis of fit. *Journal of Personality and Social Psychology*, *59*, 582–592.

Vollrath, M., Alnaes, R and Torgersen, S. (1998). Coping styles predict change in personality disorders. *Journal of Personality Disorders*, 12, 198–209.

Walter R (1998). *Origins of Terrorism*: Psychologies, Ideologies, Theologies, States of Mind, rev. ed.(Washington: Woodrow Wilson Center Press, 17.

Ward, C. (1996). Acculturation. In D, Landis & R. Bhagat (Eds.) *Handbook of Intercultural Training, 2nd Edition* (pp. 124-147). Newbury Park, CA: Sage.

Watson, C.G., Rosenberg, A.M and Petrik, N. (1982). Incidence of wife-battering in male psychiatric hospital patients: are special treatment programs needed? *Psychol Rep*;51:563–566.

Weiner, H. (1992). Perturbing the organism: The biology of stressful experience. Chicago: University of Chicago Press.

Weinstein, E..A and Drayer, C..S.(1949). A dynamic approach to the problem of combat-induced anxiety. Combat psychiatry.*Bull US Army Med Dept*.;9:12–25.

Werner, N. E. and Crick, N. R. (1999). Relational aggression and social-psychological adjustment in a college sample. Journal of Abnormal Psychology 108:615-623.

Whitaker, D. J and Miller, K.S. (August, 2000). *The relationship between mother's and adolescent's attitude about teen sex*. Roundtable discussion presented at the annual conference of the American Psychological Association. Washington, D.C.

Williams, C.L. , Berry, J.W(1991) . Primary prevention of acculturative stress among refugees: application of psychological theory and practice . Am Psychol . 1991;46:632–641

Witkin, H. A and Berry, J. W. (1975). Psychological differentiation in cross-cultural perspective. *Journal of Cross cultural Psychology,* 6, 4-87.

Worchel, P. (1957). Cathersis and the relef of hostility, *Journal of Abnormal and Social Psychology*, 55, 238-243.

Zakay, D., Hayduk, L.A and Tsal, Y. (1992). Personal space and distance misperception: Implications of a novel observation. *Bulletin of the Psychonomic Society*, 30, 33-35.

Zavalloni, M. (1980). Values, in Triandis, H. C./Brislin, R. W. (eds.), Handbook of Cross-cultural Psychology: *Social Psychology*, vol. 5, Boston: Allyn and Bacon, Inc.

Zawla, K. (1974) .Mizo Pi Pute Leh An Thlahte Chanchin(History of Mizo Ancestors and Their Descendants). Aizawl: Hmar Arsi Press.

Appendix -I

Demographic Profiles (MNF/Non MNF)

(ENGLISH)

Name: _____ Age: _____

Education: Below class X/ class X / Above BA

Village/Locality :_____(Before insurgency and after insurgency)

Did you joined the Mizo army during Insurgency — Yes/ No

Rank in the MNF: — Private / Captain / Above Captain

Marital status: — Yes/ No

Owned Radio: — Yes/ No

Government office available in the village — Yes/ No

Number of siblings: — One/ Two/ More than two

Status in the family: — Only child/ only son/ other

Family size: — Below 5/ Above 5

Status in the sibling: — Eldest/ Middle/ Youngest

Owned Vehicle: — Yes/ No

House type: — Mizo house/ Assam type/ RCC

Distance from Post office: — In own village/ neighboring village _____km

Village to village linking road:	No linking road/ Jeep road/ Bus road
Crime committed before:	Yes/ No
Nature of Job:	Government/ self employed/ other
Nature of Parents job:	Government/ Farming/ other
Economic sufficiency of the family:	Self sufficient/ not sufficient
Family type:	Nuclear family/ Joint family
Source of support:	Mother alone/ Father alone/ Parents
Recreational facility available in the village	Hockey ground/ Football ground/ ground for Inkawibah/ No ground
Number of Church in the village:	One/ more than one
Number of different churches:	One/ two/ three/ more
Highest authority in the village:	VC / SDO / AO / DC / LG
Joining age of the MNF	Below 15/ Above 15/ Above 20
Any accompaniment when joined:	Yes/ No/ Don't know
Any invitation from friend or other:	Yes/ No/ Don't know
Family permit you to join:	Yes/ No/ Don't know
Received abandonment from family:	Yes/ No/ Don't know

Any other person joined the movement from same village: Yes/ No/ Don't know

Duration of service as MNF: _____

What kind of problem did you face because of Insurgency / Joining Mizo army?

a) Self _____

b) Family_____ _____

Your Village burned? Yes/ No/ Don't know

Any Village grouping: Yes/ No/ Don't know

Source of information about the independent movement: Friend/ family/ MNF public meeting/ radio/ public information system/ hearsay/ other

Have you ever travelled beyond Silchar before the insurgency: Yes/ No/ Don't know

Do you have any ideas in attaining independence: Yes/ No/ Don't know

Do you consider independence to be most important: Yes/ No/ Don't know

Did you not mind giving your life for the Mizo: Yes/ No/ Don't know

Did you not aware of any other way of protecting the Mizo culture: Yes/ No/ Don't know

Did you fight for God and our land: Yes/ No/ Don't know

Did you think the Indians did not love the Mizo: Yes/ No/ Don't know

Did you think the British love the Mizos than the Indians Yes/ No/ Don't know

Did you think the Indian government employees were bad	Yes/ No/ Don't know
Who told you about the characters of the Indian	Family/ friend/ radio/ one's own eye/ other
Were you against the expansion the Indian religion	Yes/ No/ Don't know
Were you against capitalization of business by Indians	Yes/ No/ Don't know
Were you against others ethnic dress:	Yes/ No/ Don't know
Did you joined just to support them, as a Mizo:	Yes/ No/ Don't know
Did you believe in attaining independence:	Yes/ No/ Don't know
Did you think that you can prohibit the Indian from entering Mizoram?	Yes/ No/ Don't know
Did you believe that Indian will be defeated?	Yes/ No/ Don't know
Did you think that you will receive help from other country?	Yes/ No/ Don't know
Did you believe that Mizoram can stand on its own	Yes/ No/ Don't know
Did society look down upon the MNF participants?	Yes/ No/ Don't know
Did society look up upon the MNF participants?	Yes/ No/ Don't know
Did you have any hatred to Indians before MNF movement?	Yes/ No/ Don't know
Did you personally plan to benefit the Mizo independence	Yes/ No/ Don't know
Did you have any health problem during the onset	Yes/ No/ Don't know

of insurgency?

What problems did the Mizoram faced on the onset of Insurgency:	Famine/ poverty/ bad road condition/ bad link road/ no radio & tv/ epidemic/ no drinking water/ neglect by government/ theft/ murder/ rape/ adultery/ no proper law/ negligence lo religion/ rapid increase of Indians/ no proper school/ no hospital/ no doctor.
When you joined the MNF, did you have habit of taking any of:	Smoking/ Alcohol/ Tobacco/ drug
Did you participate in the church activities during insurgency?	Very much/ Moderate/ No
Did you participate in the Y.M.A activities during insurgency?	Very much/ Moderate/ No
Did the MNF received any help from other country?	Yes/ No/ Don't know
Did anyone from out of Mizoram join the MNF?	Yes/ No/ Don't know
Did any non-Indian join the MNF?	Yes/ No/ Don't know

Appendix -II

Demographic Profiles (MNF/Non MNF)

(MIZO)

Hming: _____ Kum: _____

Lehkha zirthlen: Pawl sawm hnuai/ X / BA chung

Khua/ Veng: _____(Rambuai lai a mi leh tun a mi)

Rambuai lai khan Mizo sipai I zawm ve em	Aw / aih / ka hre lo
Mizo Sipai a nihna chelh:	Private / Capatin / Captain chung
Kawppui meih leh neih loh:	Nei / Nei lo
Mahni in a Radio:	Awm / Awm lo
Veng / Khua a sorkar office:	Awm / Awm lo
Pianpui unau neih zat:	Pakhat / Pahnih / Aia tam
Chhungkuaa din hmun:	Fa neihchhun / Fapa mal/ adang
Chenpui chhungkaw zat:	5 aia tlem / 5 aia tam
Unau zinga nihna:	Upa ber / a lai / naupang ber
Motor neih dan:	Nei / nei lo
In awmdan:	Mizopa in / assam type / cement

In atanga dakin hlat zawng:	Khua a awm / khaw thenawm a awm _____km.
Khua atanga in kal pawhna kawng:	Motor kal theih lohna / Jeep kawng / Bus kal theihna
Sorkar phal loh ti tawh em:	Ti / tilo
Khatih laia hnathawh:	Sorkar hna / mahni hna/ adang
Nu emaw paemaw hnathawh:	Sorkar / lo nei/ adang
Ei leh bar a chhungkaw din hmun:	Intodelh / intodelh lo
Chhungkaw awm dan:	Mahni chung chauha cheng / chhungte dang (pi, pu, ni, etc) nen cheng ho
Tunge enkawl che:	Nu chauh / pa chauh / nu leh pa
Khelmual engnge in neih:	Hockey / football / inkawibahna/ adang
Khuaah Biakin engzat nge awm:	Pakhat / pakhat aia tam
Kohhran hrang engzat nge awm:	Pakhat / pahnih / pathum
In khuaah tu nge thu ber:	VC / SDO / AO / DC / LG
I zawmin kum engzat nge I nih:	15 hnuai / 15 chung / 20 chung

Nangmah chauh in em ni I zawm: Aw / aih / ka hre lo

I thianten an sawm che em ni: Aw / aih / ka hre lo

I chhung ten an phal em: Aw / aih / ka hre lo

I zawm vangin chhungte hnawhchhuah / vuak I tawng em: Aw / aih / ka hre lo

In khua ah midang zawm ve an awm em: Aw / aih / ka hre lo

Kum eng zat nge I tan hman _____

Hnam sipai I tan avangin eng harsatna nge I neih hlen tak:

a) Mahni chunga thleng _____
b) Chhungte chunga thleng _____

In khua an hal sak che u em: Aw / aih / ka hre lo

In khua an sawi khawm em: Aw / aih / ka hre lo

Independence hmuh nan vai do tur tih kha khawi atangin nge I hriat

Thiante / chhungte / MNF vantllang inkhawm / radio/ tlangau / khualthuthang/ adang

Rambuai hma khan Silchar I pel tawh em: Aw / aih / ka hre lo

Independence neih theih dan dang I hre taw hem: Aw / aih / ka hre lo

Independence kha pawimawh ber ah I ngai em: Aw / aih / ka hre lo

Hnamchhan a thih kha pawi I ti lo em ni: Aw / aih / ka hre lo

Hnamchhan dan kawng dang I hre lo em ni Aw / aih / ka hre lo

Pathian leh ram tan em ni I do: Aw / aih / ka hre lo

Vai ho khan Mizo te hmangaih lo in I hria em:	Aw / aih / ka hre lo
Sap khan vaiho aiin Mizo an hmangaih zawkin I hria em	Aw / aih / ka hre lo
Vai sorkar hnathawk te kha sual I ti em:	Aw / aih / ka hre lo
Vai ho chanchin hi tunge hrilh thin che	Chhungte / thiante / radio/ mit a hmu/ adang
Vai pathian bia lian zel tur hi I duhlo em	Aw / aih / ka hre lo
Sumdawnna an thunun tur hi I duh lo em	Aw / aih / ka hre lo
An hnam inchei dan vel hi I duh lo em ni	Aw / aih / ka hre lo
Mizo leh vai indo ta chu Mizo tan vangni tel ve ta mai em ni	Aw / aih / ka hre lo
Independence hi neih I in ring thin em	Aw / aih / ka hre lo
Vaiho kha Mizoram lo lut tur khan dan theih I in ring thin em	Aw / aih / ka hre lo
Thah chimih theih I inring em	Aw / aih / ka hre lo
America emaw ramdang puihna neih theih I inring thin em	Aw / aih / ka hre lo
Mizoram kha mahni in a ding thei in I ring em	Aw / aih / ka hre lo
Hnam sipai kha vantlang in an en hniam em	Aw / aih / ka hre lo
Hnam sipai kha vantlang in an ngaisang em	Aw / aih / ka hre lo
Rambuai hma khan vai huatna I nei sa reng em	Aw / aih / ka hre lo

Independence kha mimalin chhawr I tum em	Aw / aih / ka hre lo
Hnam sipai I zawm hmain natna benvawn eng emaw I vei tawh em	Aw / aih / ka hre lo
Rambuai dawn lai khan Mizoram ah eng harsatna nge thleng	Tam/ retheih / kawngchhia/ kalpawhna chhia/ radio, tv awm lo/ hri leng/ tui harsatna/ sorkar in ngaihsak lo/ ruk ruk/ tualthatna/ pawngsual/ uirena/ dan mumal lo/ sakhaw ngaihsak lohna/ vai pung ta riau/ sikul tha awm lo/ zirtirtu tha awm lo/ khawtlang inzirtirna tha lo/ damdawi awm lo/ hospital tha awm lo/ doctor thiam awm lo
Mizo sipaite I zawm lai khan enge I tih thin:	Mei zial/ zu/ sahdah/ drug
Rambuai lai khan kohhranah I in hmang nasa em:	Nasa/ nasa vak lo/ hmang lo
Rambuai lai khan Y.M.A ah I in hmang nasa em:	Nasa/ nasa vak lo/ hmang lo
Hnam sipai te kha ram dang tanpuitu an awm em:	Aw / aih / ka hre lo
Hnam sipai kha Mizo district huam chhunga mi ni lo zawmtu an awm em:	Aw / aih / ka hre lo
Hnam sipai te kha India mi ni lo, rawn zawm ve an awm em:	Aw / aih / ka hre lo

Appendix- III

COPING INVENTORY FOR STRESSFUL SITUATION (ADULT)

(CISS-Adult; Endler and Parker , 1999)

(ENGLISH)

The following are ways people react to various difficult, stressful, or upsetting situations. Please circle a number from 1 to 5 for each item. Indicate how much you engage in these types of activities when you encounter a difficult, stressful or upsetting situation.						
Like:	Very much = 5 Mostly = 4 Moderately = 3 A little = 2 Not at all = 1					
1	Schedule my time better	5	4	3	2	1
2	Focus on the problem and see how I can solve it.	5	4	3	2	1
3	Think about the good times.	5	4	3	2	1
4	Try to be with other people.	5	4	3	2	1
5	Blame myself for procrastinating.	5	4	3	2	1
6	Do what I think is best.	5	4	3	2	1
7	Become preoccupied with aches and pains.	5	4	3	2	1
8	Blame myself for having gotten into this situation.	5	4	3	2	1
9	Window shop.	5	4	3	2	1
10	Outline my priorities.	5	4	3	2	1
11	Try to go to sleep.	5	4	3	2	1
12	Treat myself to a favorite food or snack.	5	4	3	2	1

13	Feel anxious about not being able to cope.	5	4	3	2	1
14	Become very tense.	5	4	3	2	1
15	Think about how I solve similar problems.	5	4	3	2	1
16	Tell myself that it is really not happening to me.	5	4	3	2	1
17	Blame myself for being too emotional about the situation	5	4	3	2	1
18	Go out for a snack or meal.	5	4	3	2	1
19	Become very upset.	5	4	3	2	1
20	Buy myself something.	5	4	3	2	1
21	Determine a course of action and follow it.	5	4	3	2	1
22	Blame myself for not knowing what to do.	5	4	3	2	1
23	Go to party.	5	4	3	2	1
24	Work to understand the situation	5	4	3	2	1
25	“Freeze” and not know what to do.	5	4	3	2	1
26	Take corrective action immediately.	5	4	3	2	1
27	Think about the event and learn from my mistakes.	5	4	3	2	1
28	Wish that I could change what had happened or how I felt.	5	4	3	2	1
29	Visit a friend.	5	4	3	2	1
30	Worry about what I am going to do.	5	4	3	2	1
31	Spend time with a special person.	5	4	3	2	1
32	Go for a walk.	5	4	3	2	1
33	Tell myself that it will never happen again.	5	4	3	2	1
34	Focus on my general inadequacies.	5	4	3	2	1
35	Talk to someone whose advice I value.	5	4	3	2	1
36	Analyze the problem before reacting.	5	4	3	2	1

37	Phone a friend.	5	4	3	2	1
38	Get angry.	5	4	3	2	1
39	Adjust my priority.	5	4	3	2	1
40	See a movie.	5	4	3	2	1
41	Get control of the situation.	5	4	3	2	1
42	Make an extra effort to get things done.	5	4	3	2	1
43	Come up with several different solutions to the problem.	5	4	3	2	1
44	Take some time off and get away from the situation.	5	4	3	2	1
45	Take it out on other people.	5	4	3	2	1
46	Use the situation to prove that I can do it.	5	4	3	2	1
47	Try to be organized so I can be on top of the situation.	5	4	3	2	1
48	Watch TV.	5	4	3	2	1

Appendix-IV

COPING INVENTORY FOR STRESSFUL SITUATION (ADULT)

(CISS-Adult; Endler and Parker , 1999)

(MIZO)

Hun harsa leh manganthlak I tawh laia I awm thin dan emaw , lo tawng palh ta la, awm a I inrindan mil in a hnuai a zawhna te hi I chhang dawn nia.						
Hetiangin:	ti ziah = 5 ti fo = 4 tih zeuh zeuh = 3 ti ve tawh = 2 ti ngai lo = 1					
1	Ka hun uluk zawkin ka duang	5	4	3	2	1
2	Harsatna chu zirchiangin engtia tihtur nge tih ka hre thin	5	4	3	2	1
3	Hun hlimawm leh nuam ka tawn tawh te ka dawn kir thin	5	4	3	2	1
4	Midangte bulah ka awm tam phah thin	5	4	3	2	1
5	Keiman ka hun hlu khawral nasat vangah ngaiin ka in thiamlo thin	5	4	3	2	1
6	Thaber nia ka hriat ka ti thin	5	4	3	2	1
7	Taksa na leh khamte rilru a luah reng thin	5	4	3	2	1
8	Hetiang hun harsa hi keimah vanga ni	5	4	3	2	1
9	Thillei tak tak lovin dawr ah ka vak kual mai mai thin	5	4	3	2	1
10	Ka ngaih pawimawh te a in dawtin ka rem thin.	5	4	3	2	1
11	Mut bo san ka tum thin	5	4	3	2	1
12	Ka ngaihnat zawng eitur tuhnai ka ei thin	5	4	3	2	1

13	Tawrh harsa ka tih avangin ka rilru a hah thin	5	4	3	2	1
14	Ka rilru a phawklek thin	5	4	3	2	1
15	A anpui harsatna dang ka paltlang tawhdan te ka ngaihtuah let thin	5	4	3	2	1
16	A ni tak tak lo ang tiin keimah leh keimah ka inhrilh thin.	5	4	3	2	1
17	He tiang hunah rilru buai awl tak ka neih avangin ka in dem thin	5	4	3	2	1
18	Chaw leh thingpuite in tur in ka kal chhuak thin	5	4	3	2	1
19	Ka rilru a hahin a beidawng thin	5	4	3	2	1
20	Engemaw thil ka inlei sak thin	5	4	3	2	1
21	Tihtur ka in tuk a ka ti thin	5	4	3	2	1
22	Tihtur ka hriatloh a vangin ka indem hle thin.	5	4	3	2	1
23	Intihhlimna ah ka kal thin	5	4	3	2	1
24	Harsatna hriatchian tumin ka bei thin	5	4	3	2	1
25	A ngaihna hre loin ka khawng tawp thin	5	4	3	2	1
26	Siamthat hna ka thawk nghal vat thin	5	4	3	2	1
27	Thil thleng chu nguntaka ngaihtuah in ka tihdiklohna hmuh ka tum thin	5	4	3	2	1
28	Thil thleng kha tihdanglam emaw , ka tawrhnat dan chu thlakdanglam thei ila ni ila ka ti thin	5	4	3	2	1
29	Thian te ka tlawh thin	5	4	3	2	1
30	Engnge ka tih ang tih ka ngaihtuah hah hle thin	5	4	3	2	1
31	Min hrethiam tute kiangah hun ka hmang thin	5	4	3	2	1
32	Khawi khawi ah emaw kein ka kal thin	5	4	3	2	1
33	A thlengleh tawh lovang tihin ka inhnem thin	5	4	3	2	1
34	Ka tlintawklohna tllangpui te ka bih chiang thin	5	4	3	2	1
35	Thurawn tha nei a ka rin te ka ti ti pui thin	5	4	3	2	1

36	Hma lak hmain harsatna chu ka zirchiang hmasa thin	5	4	3	2	1
37	Thiante ka be kual thin	5	4	3	2	1
38	Ka thinur thin	5	4	3	2	1
39	Ka ngaihhlutte ka thlak thleng thin	5	4	3	2	1
40	Cinema film ka en thin	5	4	3	2	1
41	Ka thuhnuaiah thilthleng chu dah ka tum thin	5	4	3	2	1
42	Nasa leh zuala thawkhah in tihzawh ka tum thin.	5	4	3	2	1
43	Harsatna sut kiandan hrang hrang te ka ngaihtuah chhuak thin	5	4	3	2	1
44	Chawlh la in hmundangah ka kalbosan thin	5	4	3	2	1
45	Midangte vanga thleng ani ka ti thin	5	4	3	2	1
46	Mahni inrintawkna ka neih finfiahnan ka hmachhawn thin	5	4	3	2	1
47	Tha leh zuala ruahmanisiamin harsatna hneh theihloh a awm ka tum thin	5	4	3	2	1
48	TV ka ensan thin	5	4	3	2	1

Appendix-V

SYMPTOM QUESTIONNAIRE

(SQ; Kellner, 1987)

ENGLISH

Please describe how you felt during the past week, and make a check mark on the appropriate response. Do not think long before answering. Work quickly.

1	Nervous	Yes	No		47	Thinking of death of dying	Yes	No
2	Weary	Yes	No		48	Hot tempered	Yes	No
3	Irritable	Yes	No		49	Terrified	Yes	No
4	Cheerful	Yes	No		50	Feeling of courage	Yes	No
5	Tense, tensed up	Yes	No		51	Enjoying yourself	Yes	No
6	Sad, blue	Yes	No		52	Breathing difficult	Yes	No
7	Happy	Yes	No		53	Parts of body feel numb / tingling	Yes	No
8	Frightened	Yes	No		54	Takes a long time to fall asleep	Yes	No
9	Feeling calm	Yes	No		55	Feeling hostile	Yes	No
10	Feeling healthy	Yes	No		56	Infuriated	Yes	No
11	Losing temper easily	Yes	No		57	Heart beating fast or pounding	Yes	No
12	Feeling of not enough air	Yes	No		58	Depressed	Yes	No
13	Feeling kind towards people	Yes	No		59	Jumpy	Yes	No
14*	Feeling of going to faint away	Yes	No		60	Feeling of failure	Yes	No
15	Heavy arms / legs	Yes	No		61	Not interested in things	Yes	No
16	Feeling confident	Yes	No		62	High strung	Yes	No
17	Feeling warm towards people	Yes	No		63	Cannot relax	Yes	No

18	Shaky	Yes	No		64	Panicky	Yes	No
19	No pains anywhere	Yes	No		65	Pressure on head	Yes	No
20	Angry	Yes	No		66	Blaming yourself	Yes	No
21	Arms / legs strong	Yes	No		67	Thoughts of ending your life	Yes	No
22	Appetite poor	Yes	No		68	Frightening thoughts	Yes	No
23	Feeling peaceful	Yes	No		69	Enraged	Yes	No
24	Feeling unworthy	Yes	No		70	Irritated by other people	Yes	No
25	Annoyed	Yes	No		71	Looking forward towards the future	Yes	No
26	Feelings of rage	Yes	No		72	Nauseated, sick to the stomach	Yes	No
27	Cannot enjoy yourself	Yes	No		73	Feeling that life is bad	Yes	No
28	Tight head or neck	Yes	No		74	Upset bowels or stomach	Yes	No
29	Relaxed	Yes	No		75	Feeling inferior to others	Yes	No
30	Restless	Yes	No		76	Feeling useless	Yes	No
31	Feeling friendly	Yes	No		77	Muscle pain	Yes	No
32	Feeling of hate	Yes	No		78	No unpleasant feeling in head or body	Yes	No
33	Choking feeling	Yes	No		79	Headaches	Yes	No
34	Afraid	Yes	No		80	Feeling like attacking people	Yes	No
35	Patient	Yes	No		81	Shaking with anger	Yes	No
36	Scared	Yes	No		82	Mad	Yes	No
37	Furious	Yes	No		83	Feeling of goodwill	Yes	No
38	Feeling charitable, forgiving	Yes	No		84	Feel like crying	Yes	No
39	Feeling guilty	Yes	No		85	Cramps	Yes	No
40	Feeling well	Yes	No		86	Feeling that something bad will happen	Yes	No

41	Feeling of pressure in head or in body	Yes	No		87	Wound up / uptight	Yes	No
42	Worried	Yes	No		88	Get angry quickly	Yes	No
43*	Content	Yes	No		89	Self confident	Yes	No
44	Weak arms / legs	Yes	No		90	Resentful	Yes	No
45	Feeling desperate, terrible	Yes	No		91	Feeling of helplessness	Yes	No
46	No aches anywhere	Yes	No		92	Head pains	Aw	Aih

Appendix-V

SYMPTOM QUESTIONNAIRE

(SQ; Kellner, 1987)

MIZO

I awmdan nia I hriat angin I chhang dawn nia. A dik I tih chuan "Aw" ah thai la, a dikloh chuan "Aih" ah I thai dawn nia.								
1	Hlauthawng	Aw	Aih		47	Thihdan leh thihnate ngaihtuah	Aw	Aih
2	Hah rimtawng	Aw	Aih		48	Thinur sosang nasa tak neih	Aw	Aih
3	Thil nin ngawih ngawih neih	Aw	Aih		49	Rapthlak eltiang ngaihtuah	Aw	Aih
4	Lawm leh lutuk	Aw	Aih		50	Huaisenna neih	Aw	Aih
5	Vei neih vanga tan deuh po	Aw	Aih		51	Mahni leh mahni nihna a lawm	Aw	Aih
6	Ngui reng mai	Aw	Aih		52	Thawk harsa tihna	Aw	Aih
7	Hlim deuh reng	Aw	Aih		53	Taksa peng thenkhat hik lrh mua hriatna	Aw	Aih
8	Hlauhhlawp	Aw	Aih		54	Muthilh lawk theilo	Aw	Aih
9	Buaina awmlo a hriatna	Aw	Aih		55	Mi hmelmakriauna neih	Aw	Aih
10	Hrisel a inhriatna	Aw	Aih		56	Phuba lakchak duhna khawp thinurna	Aw	Aih
11	Thinur hma em em na	Aw	Aih		57	Lungphu rang leh su dup dup	Aw	Aih
12	Boruak duhkhawp neilo a in hriatna	Aw	Aih		58	Nguina leh beidawnna	Aw	Aih
13	Midangte khawngaihna neih	Aw	Aih		59	Hlim leh tha za zar	Aw	Aih
14*	Nikhawhrelova (phungzawl) tlu thut dawn a in hriatna	Aw	Aih		60	Hlawhchhama in hriatna	Aw	Aih
15	Kut leh ke rita ta riau a hriatna	Aw	Aih		61	Thil engmah tihphurna neih loh	Aw	Aih
16	Inrintawkna neih	Aw	Aih		62	Awpbeh tlat ni a in hriatna	Aw	Aih

17	Midang laka in hawn tak riauna	Aw	Aih		63	Hahdam theihlohna	Aw	Aih
18	Rilru thlak deuh thu thutna	Aw	Aih		64	Thlabar leh chiai	Aw	Aih
19	Taksa khawilai mah na loa hriatna	Aw	Aih		65	Lu rit lutuk	Aw	Aih
20	Thinur riauna	Aw	Aih		66	Mahni in thiamlohna	Aw	Aih
21	Kut leh ke te chak thar riaua hriatna	Aw	Aih		67	Mahni nuna tih tawp mai duhna	Aw	Aih
22	Thil eitui tak mang loh	Aw	Aih		68	Hlauhawm lam hlir ngaihtuhna	Aw	Aih
23	Thlamuang riaua inhriatna	Aw	Aih		69	Thisen lum vek khawp a thinurna neih	Aw	Aih
24	Tangkailova inhriatna	Aw	Aih		70	Mi tuemaw ngei neih	Aw	Aih
25	Thil ngaih theihloh riauna	Aw	Aih		71	Hmalam hun thuitak thlirna neih	Aw	Aih
26	Thinur so sang tak neih	Aw	Aih		72	Luakchhuak leh pumpui hnim ruih	Aw	Aih
27	Mahni intihlim theilo	Aw	Aih		73	Nun kawng chho hi a hahthlaka hriatna	Aw	Aih
28	Nghawng leh lu te tawt tun a hriatna	Aw	Aih		74	Ek lam felzan lo leh pum nuamlo	Aw	Aih
29	Hahdam ngawih ngawihna	Aw	Aih		75	Midang tluk phak lova inhriatna	Aw	Aih
30	Hahchawlh theih miahlohna	Aw	Aih		76	Tangkailova in hriatna	Aw	Aih
31	Thiantha tak nia inhriatna	Aw	Aih		77	Tihrawlna	Aw	Aih
32	Mi huat riauna	Aw	Aih		78	Lu ah leh taksa a na awmlo	Aw	Aih
33	Hnawhtawt tlattu nei a inhriatna	Aw	Aih		79	Luna deuh reng	Aw	Aih
34	Engemaw hlauh	Aw	Aih		80	Mite va tihnat chak riauna	Aw	Aih
35	Dawhtheihna nei	Aw	Aih		81	Thinur khur hlwk hlawk	Aw	Aih
36	Hlauh thawn neih	Aw	Aih		82	At riau na	Aw	Aih

37	Thintawt up upna	Aw	Aih		83	Thiltha tih chakna	Aw	Aih
38	Midang puih leh thilpek chakna neih	Aw	Aih		84	Tah vawng vawng chakna	Aw	Aih
39	Inthiamlohna neih	Aw	Aih		85	Taksa peng a aikhirh neih	Aw	Aih
40	Tha a inhriatna	Aw	Aih		86	Thilthalo thlengdawn tlat a hriatna	Aw	Aih
41	Taksa leh lu rit luk delhtu awm a inrhiatna	Aw	Aih		87	Na deuh vung vung leh tawt up up	Aw	Aih
42	Lungkham neih	Aw	Aih		88	Thinur hma na leh chak riauna	Aw	Aih
43*	Thlamuang leh lungawi	Aw	Aih		89	Mahni inrintawkna neih	Aw	Aih
44	Ban leh ke te zawi leh chaklo	Aw	Aih		90	Inchhir vawng vawngna	Aw	Aih
45	Manganthlak khawp a beidawna neih	Aw	Aih		91	Beiseina reng reng neihloh	Aw	Aih
46	Na neihloh	Aw	Aih		92	Lu chhungril na	Aw	Aih

Appendix-VI

FRUSTRATION TEST

(FT; Chauhan and Tiwari, 1972)

(ENGLISH)

	There are fourty interesting questions which you are putting to yourself to answer. Choose answer of your best liking or agreement after a good self-serching. You are to choose only one.						
	Very much = 6 Much = 5 Ordinary = 4 Less = 3 Very less = 2 Not at all = 1						
1	How much hesitation I find in me when I talk to elders?	6	5	4	3	2	1
2	How much difficulty I experience when changes in living and behaviour become necessary?	6	5	4	3	2	1
3	How much useless I think to participate in fairs, shows and social fuctions?	6	5	4	3	2	1
4	How far it is good to break social traditions when need arises?	6	5	4	3	2	1
5	How much liking do I have in taking counseling and help of my family members in every task and doing it accordingly?	6	5	4	3	2	1
6	How much time do I take in revising opinion once formed about a person?	6	5	4	3	2	1
7	How far is it justified to say that happiness does not exist in human life?	6	5	4	3	2	1
8	How much anger do i experience when people do not accept even reasonable things?	6	5	4	3	2	1
9	How much confidence do I lay in others?	6	5	4	3	2	1
10	A man should change his behaviour as a situations change. How much difficulty I experience in changing myself	6	5	4	3	2	1

	according to situations?						
11	How far do I agree with the statement that 'this life is not charming'?	6	5	4	3	2	1
12	How much do I like dashing, and fearless leader?	6	5	4	3	2	1
13	How much do I remember my childhood days?	6	5	4	3	2	1
14	Some incedents of the past life are not forgotten despite efforts.It appears as if they could happen only yesterday.How much do such incident roam in my mind?	6	5	4	3	2	1
15	How far does the idea of suicide is expected in the mind of a person engrossed with miseries and total hopelessness?	6	5	4	3	2	1
16	How much doi like bloody warriors fighting in a pitch battle?	6	5	4	3	2	1
17	How much do I like to play and to have childlike carelessness?	6	5	4	3	2	1
18	I go on tolerating my friend involved in deceiving me over and over again because doing away with friendship is a difficult affair. How far?	6	5	4	3	2	1
19	'Childhood-Youth-Old age, what to say, the whole of life is full of miseries'. How far do I feel about it?	6	5	4	3	2	1
20	How far do I believe in the policy of 'tit for tst'?	6	5	4	3	2	1
21	How far does the feeling 'to become the child again' occur in my mind?	6	5	4	3	2	1
22	How much do I like to continue traditions already operative in the family with making any modification?	6	5	4	3	2	1
23	How far do I agree with the proposition 'the world has peace nowhere and life is pulling on just some how?	6	5	4	3	2	1
24	How much do I find myself possed with incidence of anger in day-to-day life situation?	6	5	4	3	2	1
25	How much do I agree to the fact, 'Carefreeness and enjoyment procured by the childhood days, exist nowhere now'?	6	5	4	3	2	1
26	How far do I agree with the statement, 'it is better to remain fixated to our habits and views than to change oneself with time'?	6	5	4	3	2	1

27	How much can I support the views, 'All efforts have been made to get peace and happiness. They were not seen within the world, may be without'?	6	5	4	3	2	1
28	How much I like to keep in my room, a picture in comparison to others, depicting a warrior soldier with a naked sword?	6	5	4	3	2	1
29	How far do you like to listening or relating stories and incidents after sitting comfortably?	6	5	4	3	2	1
30	How much time do i usually take in forgetting heart-pinching behaviour?	6	5	4	3	2	1
31	How far my life is full of miseries and sorrows?	6	5	4	3	2	1
32	How much do I like to have pitch discussions?	6	5	4	3	2	1
33	How much do I hasitate before superiors in making replies to question I can?	6	5	4	3	2	1
34	'It is good as I am'. How much difficulty I would have in changing myself.	6	5	4	3	2	1
35	How much do I agree with the view, 'What to say, my luck itself is bad?	6	5	4	3	2	1
36	How much would I like to contest elections?	6	5	4	3	2	1
37	How much would I like to keep a picture in a comparison to others, depicting life of children?	6	5	4	3	2	1
38	'Daily change of things and daily a new fashion of life is not a desirable thing'. How far do you feel about it?	6	5	4	3	2	1
39	How far do I remain troubled by the stresses and storms of the time?	6	5	4	3	2	1
40	How much do I like reading biographies of revolutionaries?	6	5	4	3	2	1

Appendix-VII

FRUSTRATION TEST

(FT; Chauhan and Tiwari, 1972)

(MIZO)

	A hnuai a zawhna hrang hrang te hi uluktakin chhiar la I awmdan thin nia I hriat dan in I chhang dawn nia.						
	Nei lutuk = 6 Nei viau = 5 Nei vaklo = 4 Nei tlem = 3 Nei manglo = 2 Nei lo = 1						
1	Aia upa biak huphurhna	6	5	4	3	2	1
2	A tul avanga nungchang leh khawsak dan thlakthleng harsa tihna	6	5	4	3	2	1
3	Kut, ennawm vel a tel tullo tihna	6	5	4	3	2	1
4	A tul vanga hnamdan thlakthleng tha tihna	6	5	4	3	2	1
5	Kawng tinrengah chhungte thurawn lak leh zawm duhna	6	5	4	3	2	1
6	Mi ka ngaihdan tihdanglam harsa tihna	6	5	4	3	2	1
7	Nun hlimna hi a awm lom tih sawi	6	5	4	3	2	1
8	Mi ten thu rintlak an awih duhloh tlat a thinurna	6	5	4	3	2	1
9	MIdangte chunga rinna nghah duhna	6	5	4	3	2	1
10	A tul dan a zira nungchang thlakthleng harsatna	6	5	4	3	2	1
11	Nun hi thlakhleh awmloh tih pawm na	6	5	4	3	2	1
12	Hruaitu huai leh hlauh neilo nih chak na	6	5	4	3	2	1
13	Naupan lai thil thleng hriat reng theihna	6	5	4	3	2	1

14	Nunhlui liam hnu te theihnghilh theih loh na	6	5	4	3	2	1
15	Beidawng leh lungngai te mahni inthah duhna an neih rinna	6	5	4	3	2	1
16	Mi huaisen indo na hmun a thisen chhuak zawih zawih a indo lai hmuh nuam tihna	6	5	4	3	2	1
17	Naupangchhia engmah ngaihtuahlova an awm anga awm chakna	6	5	4	3	2	1
18	Thian ten min bum fo mahse, ban/then har tihna	6	5	4	3	2	1
19	Naupan-tleirawl-puitlin a za vai hian lungngaihna mai nia hriatna	6	5	4	3	2	1
20	“Ha ai ah ha” anga tih ve zel duhna	6	5	4	3	2	1
21	Naupan leh chak thutna	6	5	4	3	2	1
22	Hnamdan te tlem sianthata pawm zel duhna	6	5	4	3	2	1
23	“Khawvelah hian muanna a awm lova, engtin tin emaw kan hmang ve mai mai” tih pawmna	6	5	4	3	2	1
24	Nitin nunah thin ur na	6	5	4	3	2	1
25	“Naupan lai a engmah lungkham lo leh hlimna ang kha upat hnuah kan nei ngai tawh lo” pawmna	6	5	4	3	2	1
26	“Hun tawn a zir a inthlakthleng ai chuan mahni tihdan thin zawm tlat a tha zawk” tih pawmna	6	5	4	3	2	1
27	“Kan theihna zawng zawngin muanna leh hlimna kan zawnga, khawvel ah kan hmulo a, a awmlo aniang?” tih pawmna	6	5	4	3	2	1
28	Sipai huaisen ralthuam famkim nen inthuam lem mahni pindan/room chei nan a tar duhna	6	5	4	3	2	1
29	Hahdam tak a thu chung a mahni nun thawnthu nena hmehbel vel nuam tihna	6	5	4	3	2	1
30	Thinlung kheitu theihnghilh tum a buaina	6	5	4	3	2	1
31	Nun kawngah lungngaihna leh hrehawmna	6	5	4	3	2	1
32	Thu rum tak sawiho nuam tihna	6	5	4	3	2	1
33	Chhanna ka hriat reng hotute hrilh huphurhna	6	5	4	3	2	1
34	“Ka nihna angchiah hi a tha”. Mahni rilru thlak harsatna	6	5	4	3	2	1
35	“Ka vanduai ve reng a ni” tih hi keimah a dik tihna	6	5	4	3	2	1

36	Inthlanna a chuh ve duhna	6	5	4	3	2	1
37	Naupang rilru thianghlimna tilang thei milem tar duhna	6	5	4	3	2	1
38	“Nitin a thildanglam leh nunphung danglam reng a tha lo” tih pawmna	6	5	4	3	2	1
39	Hun harsa leh rilru hanna in engtai rei nge a daih	6	5	4	3	2	1
40	Hun inthlakthleng thlen thei khawp hruaitute chanchin chhiar nuam tihna	6	5	4	3	2	1

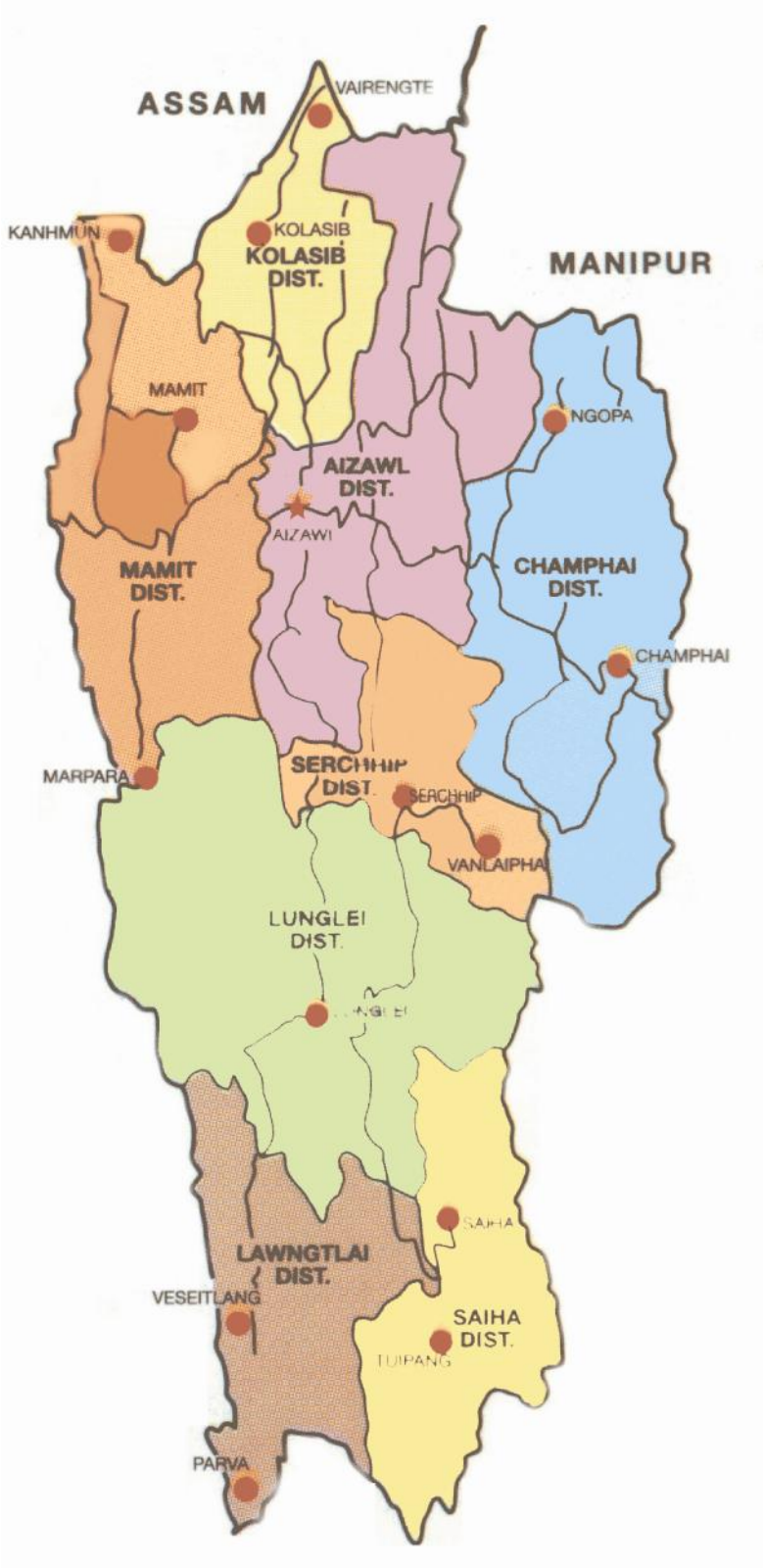
Appendix-VIII

MAP OF INDIA

(Showing the location of Mizoram State)

Appendix-IX

MAP OF MIZORAM STATE



DEPARTMENT OF PSYCHOLOGY
MIZORAM UNIVERSITY
MIZORAM : AIZAWL
Tanhril, Aizawl – 796001, Mizoram

PARTICULARS OF THE CANDIDATE

Name of the Candidate	:	Ms.Zoramhmangaihzuali Khiangte
Degree	:	Doctor of Philosophy
Department	:	Psychology
Title of Dissertation	:	"The Effect of Insurgency in the Psychological Adjustment of the Mizo"
Date of Admission	:	2nd April 2007
Approval of Research Proposal		
1. BPGS	:	31.5.2007
2. School Board		
Registration No. & Date	:	MZU/Ph.D/137 of 2007-2008
3. Academic Council	:	22.6.2007
Extension (If any)	:	Nil

(Dr.H.K.LALDINPUII FENTE)
Head
Department of Psychology