Orphans

(Rising to Rainbow)

Dr Neharshi Srivastava

Dr Neeta Gupta

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Author: Dr. Neharshi Srivastava and Dr. Neeta Gupta

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With Deep Regards

Dr Neharshi Srivastava
Dr Neeta Gupta

PREFACE

The present study has tried to explore the Suicidal Ideation, Depression, and Coping Strategies used by orphan adolescents and the management of their Suicidal Ideation, depression and Coping Strategies through intervention by Group Therapies (PMRT & SMT). In the First Step, the study focused on the present level of Depression, Suicidal Ideation and Coping Strategies used by orphan adolescents and in the Second Step, they were treated by Progressive Muscular Relaxation Training and Self- Management Training. The present study has conducted on adolescents as the most crucial stage of life is "ADOLECENT". Adolescent is the stage which plays a very important role not only in the personality development of mankind but it is much more important for mental health and social identification. Many of the psychologists defined this age as the "**STAGE OF STORM STRESSES".** These stresses can be of many kinds, but the major stresses which found the teenagers are **"How they prove themselves?** To meet all the challenges, overcome depression & lead a normal and healthy life they need the support of their parents and family. They come back again to main stream by their emotional and moral support and spend a normal and smooth life, but unfortunately ORPHAN has no option, no way and no mental or moral support.

Orphan children need more additional support and mental health services as compare to the normal children but in India there are insufficient resources, for this reason The Present study tries to explore the effectiveness of Progressive Muscular Relaxation Training and Self-Management on Suicidal Ideation, Depression and Coping Strategies among Orphans. It is hoped that as a result, the concerned bodies, policy makers, schools, family, governmental and non-governmental organization will work together on orphans or strengthen the existing programs in order to increase the psychological well-being of orphan children. This research is important for those involved in therapy and in counseling to identify children who are at low level of psychological wellbeing and to develop and improve prevention and intervention methods for orphans. The finding of this study will also provide important direction for conducting further research in the areas of Depression, Suicidal Ideation and Coping strategies of orphans in Indian Scenario.

Group Therapy was specially planned for the present study because the study has tried to deal with very vital issues (Depression, Suicidal Ideation & Coping Strategies) of Orphan Adolescents. So it was necessary to get them realize that they are not the only ones who are facing Suicidal Ideation and Depressive thoughts. This feeling of universality makes the respondents relaxed and more comfortable in handling their problems.

CONTENTS

CHAPTER- 1
Introduction

She became more and more quiet. On a December afternoon the 15 year old teenager, Sarita (name changed) from Lucknow decided that she did not want to live anymore. She text-messaged all her friends the following message, "Yesterday a dream. Today's a memory. If you miss me, remember I am only a heartbeat away". She washed her hair and dressed herself in new clothes. Everyone in the house was under the impression that she was going out for the evening. She took her fathers' 22 caliber fire-arm from the safe-box, bent over it and pulled the trigger. A muffled sound of gun-fire was heard. A note written by her was found with these words, "if only you could have known".

Suicidal Ideation

"Each year, between 30 and 40 people per 100,000 Indians aged between 15 and 29 kill themselves. This accounts for about a third of all suicides in the country. After all, India has one of the world's highest rates of suicides among people aged between 15 years and 29 years." (CDC, 2015).

Nature and Definition:-

"Suicidal Ideation" is a medical term for thoughts about or an unusual preoccupation with suicide. Suicide (Latin Suicidium, from sui caedere, "to kill oneself) is the act of intentionally causing one's own death. The word "Suicide" was first coined by Brown (1657). The term has been explained in many ways, as follows: - "Suicide is the human act of Self- Inflicted, Self- Intentioned cessation" (Encyclopedia Britannia, 1973). Death caused by self-directed injurious behavior with intent to die as a result of the behavior. (Center of disease control and prevention, 2015). According to the sociologist Hammerin and Enverstvedt (1988), Suicide is an activity which involves acts with the aim and result of one's own biological death on the basis of social specific historical motives. Suicide is when people direct violence at themselves with the intent to end their lives, and they die as a result of their actions.

Suicide is a leading cause of death in the United States. A suicide attempt is when people harm themselves with the intent to end their lives, but they do not die as a result of their actions. Many more people survive suicide attempts than die, but they often have serious injuries. However, a suicide attempt does not always result in a physical injury. (Fact sheet of National Center for Injury Prevention and Control, Division of Violence Prevention, 2015).

Every 40 seconds a person dies by suicide somewhere in the world. "Preventing suicide: a global imperative" is the first WHO report of its kind. It aims to increase awareness of the public health significance of suicide and suicide attempts, to make suicide

prevention a higher priority on the global public health agenda, and to encourage and support countries to develop or strengthen comprehensive suicide prevention strategies in a multi-sectoral public health approach.

The report provides a global knowledge base on suicide and suicide attempts as well as actionable steps for countries based on their current resources and context to move forward in suicide prevention. Suicide is the act of deliberately killing oneself. Risk factors for suicide include mental disorder (such as depression, personality disorder, alcohol dependence, or schizophrenia), and some physical illnesses, such as neurological disorders, cancer, and HIV infection. There are effective strategies and interventions for the prevention of suicide. (WHO, 2015).

Sign & Symptoms of Suicidal Thoughts

- Having Depression.
- Appearing to have an abnormal preoccupation with violence, dying and / or death.
- Being in a heightened state of anxiety.
- Being very moody.
- Changing personality.
- Changing routine.
- Consuming (more) drugs.
- Consuming (more) alcohol.
- Getting affairs in orders.
- Having panic attack.
- Impaired concentration.
- Increased self- criticism.
- Isolating oneself.
- Psychological states
- Hopelessness
- Loss of pleasure in life
- Anxiousness.
- Poor ability to solve problems

Prevalence of Suicide

Suicidal ideation is the most commonly reported form of suicidality, with lifetime prevalence rates of approximately 12 % among community adolescents aged 13–18 years (15.3 % and 9.1 % for females and males respectively Nock et al. 2013). Notably, about 41 % of adolescent females and 23 % of adolescent males with a lifetime history of suicidal ideation ultimately attempt suicide, in most cases within the first year of onset of suicidal ideation (Nock et al. 2013). Suicide is the third leading cause of death in young people aged 15-24 years. On an average, more than one lakh persons, committing suicide every year in the country during the decadal periods (2003 – 2013).

Table 1.1: Incidence of Suicides During 2009 to 2013

Sl. No.	Year	Total number of Suicides
(1)	(2)	(3)
1	2009	1,27,151
2	2010	1,34,599
3	2011	1,35,585
4	2012	1,35,445
5	2013	1,34,799

The number of suicides in the country during the decade (2003–2013) has recorded an increase of 21.6% (1,34,799 in 2013 from 1,10,851 in 2003). The increase in incidence of suicides was reported each year till 2011 thereafter a declining trend was noticed. The population has increased by 15.0% during the decade while the rate of suicides has increased by 5.7% in 2013 over 2003(from 10.4 in 2003 to 11.0 in 2013), hence showing a mixed trend in incidents of rate of suicides during the decade (2003-2013). National Crime Record bureau (2013), but this is only the tip of the iceberg. Rosenberg et.al (1987) reported that at least ten times this number each year engaged in suicidal behavior which comes to the attention of health professionals and on the basis of community surveys, it was probable that a similar number also risked their lives in some way, but did not seek attention and were thus not treated at all. In addition to this

obvious mortality and morbidity, it has also been estimated that for every person who suicides at least six people are directly affected.

Prevalence of Suicide in different Ages:-

Suicide is the third leading cause of death among persons aged 10-14, the second among persons aged 15-34 years, the fourth among persons aged 35-44 years, the fifth among persons aged 45-54 years, the eighth among person 55-64 years, and the seventeenth among persons 65 years and older. In 2011, middle-aged adults accounted for the largest proportion of suicides (56%) and from 1999-2010, the suicide rate among this group increased by nearly 30% among students in grades 9-12 during 2014. (CDC report, 2015).

Facts of various Report 2015 of Suicide in relation to Age Disparities

- ✔ 1 in 100,000 children ages 10 to 14 die by suicide each year. (NIMH)
- ✔ 7 in 100,000 youth ages 15 to 19 die by suicide each year. (NIMH)
- ✔ 12.7 in 100,000 young adults ages 20-24 die by suicide each year. (NIMH)
- ✔ The prevalence of suicidal thoughts, suicidal planning and suicide attempts is significantly higher among adults aged 18-29 than among adults aged 30+. (CDC)
- ✔ Suicide is the 2nd leading cause of death for 15 to 24 year old Americans. (CDC)
- ✔ Suicide is the 4th leading cause of death for adults ages 18-65. (CDC)
- ✔ The highest increase in suicide is in males 50+ (30 per 100,000). (CDC)
- ✔ Suicide rates for females are highest among those aged 45-54 (9 per 100,000). (CDC)
- ✔ Suicide rates for males are highest among those aged 75+ (36 per 100,000). (CDC)
- ✔ Suicide rates among the elderly are highest for those who are divorced or widowed. (SMH)

Prevalence of Suicide in Worldwide

- ✔ Over 800,000 people die by suicide every year. (WHO)
- ✔ There is one death by suicide in the world every 40 seconds. (WHO)

- ✔ Suicide is the 3rd leading cause of death in the world for those aged 15-44 years. (WHO)
- ✔ Depression is the leading cause of disability worldwide. (WHO)

WHO Report on Suicide, 2015

➢ Key facts

- Over 800 000 people die due to suicide every year.
- For every suicide there are many more people who attempt suicide every year. A prior suicide attempt is the single most important risk factor for suicide in the general population.
- Suicide is the second leading cause of death among 15–29-year-olds.
- 75% of global suicides occur in low- and middle-income countries.
- Ingestion of pesticide, hanging and firearms are among the most common methods of suicide globally.
- Every year more than 800 000 people take their own life and there are many more people who attempt suicide. Every suicide is a tragedy that affects families, communities and entire countries and has long-lasting effects on the people left behind. Suicide occurs throughout the lifespan and was the second leading cause of death among 15–29-year-olds globally in 2012.
- Suicide does not just occur in high-income countries, but is a global phenomenon in all regions of the world. In fact, 75% of global suicides occurred in low- and middle-income countries in 2012.

Types of Suicide

Different psychologists have reported different types of suicides. Some of them are:-

1. **Durkheim (1897) classification of Suicide:-**

➢ **Maniacal Suicide** is most common among those suffering from hallucinations usually schizophrenia.

- **Melancholy Suicide** is characterized by extreme depression, created or imaginary and often unrelated to a person's circumstances.
- **Obsessive Suicide** usually lacks authentic motive and committing suicide becomes an instinctive drive.
- **Impulsive or Automatic Suicide** also frequently lack's motive, and is characterized by an irresistible impulse to commit suicide.

2. <u>Baechler (1975) classification of Suicide:-</u>

- **Escape**:- From intolerable situation such as grief or punishment.
- **Aggressive**:- An attempt to harm others.
- **Oblative**:-As sacrifice, or to attain a desired state in others opinion.
- **Ludic**:- A test to prove oneself.

3. <u>General classification of Suicide:-</u>

a) **<u>Para Suicide or Attempted Suicide:-</u>** A self inflected, life threatening act which does not result in death. Suicide attempt refers to cases in which people unsuccessfully try to kill themselves and in which there is no intention of dying (Stengel, 1964). Enersvedt (1988) defines attempted suicide as an activity which involves acts of intentional self-injury with the object of death, but where the result is not death. WHO (1986) propose that "a non-habitual act with non fatal outcome, that is deliberately initiated and performed by the individual involved, that cause self harm, or without intervention from others will do so or consists of ingesting a substance in excess of its generally recognized therapeutic dosage.

b) **<u>Suicidal Intent:-</u>** Intent is defined as the seriousness or intensity of the wish of a patient to terminate his life. Intent is one component of overall suicidal risk (or Suicidal Potential) that includes, along with other factors such as access to lethal method, and knowledge regarding utilization of these method. Suicidal Intent, in other words is assessed simply by the behavior of the individuals as reported by others and by self reports.

c) **<u>Suicidal Behavior:-</u>** The general term Suicidal Behavior variously includes completed suicide, non-fatal deliberate self harm (Suicide attempts, suicide

gestures, para suicide, self injury, self harm) with or without suicidal intent, suicidal communication including suicide threats and suicidal ideation. Suicidal Behavior is seen as a continuum of intensity with individual ideation at one end and completed suicide at the other. Lester and Bech, (1975) have argued that individuals who deliberately harm themselves are members of a single suicide population. Weiss, (1960) labels those characterized by high medical risk and high intent to die as "Aborted Successful Suicides."

d) **Suicidal Ideation:-** Suicidal ideation, also known as suicidal thoughts, concerns thoughts about or an unusual preoccupation with suicide. (Arkus, 2016). Suicidal Ideation are defined as individuals who admit the thoughts or contemplation of suicide, specially the thoughts of wishing to terminate one's life. (Brown et.al, 2015). The ideation may or may not involve actual planning or mental rehearsal of a suicidal act. Suicidal Ideation may be inferred from over suicidal behavior and communications except for over act. The suicidal ideas category includes behavior that may be directly observed or inferred as that are concerned with or move in the direction of a possible threat to the individuals life, but in which the potentially lethal act has not actually been performed.

Methods of suicide

It is estimated that around 30% of global suicides are due to pesticide self-poisoning, most of which occur in rural agricultural areas in low- and middle-income countries. Other common methods of suicide are hanging and firearms.

Knowledge of the most commonly used suicide methods is important to devise prevention strategies which have shown to be effective, such as restriction of access to means of suicide.

Causes & Risk Factors of Suicidal Ideation

Psychological factors may be related to suicidal behaviors in any of the three ways:-

- ✔ They may be related indirectly either predisposing a person or mediating against suicidal behavior. Under certain conditions, early loss and certain personality characteristics such as neuroticism and impulsivity are generally viewed as predisposing factors. Social support and certain personality characteristics such as restraint and objectives may be viewed as mediating or protective factors.
- ✔ Psychological factors may act as direct casual factors in suicidal behavior.
- ✔ Psycho-social factors may be epiphenomenal or they may be related to phenomenon like depression.

In addition, experiencing conflict, disaster, violence, abuse, or loss and a sense of isolation are strongly associated with suicidal behavior. Suicide rates are also high amongst vulnerable groups who experience discrimination, such as refugees and migrants; indigenous peoples; lesbian, gay, bisexual, transgender, intersex (LGBTI) persons; and prisoners. By far the strongest risk factor for suicide is a previous suicide attempt.

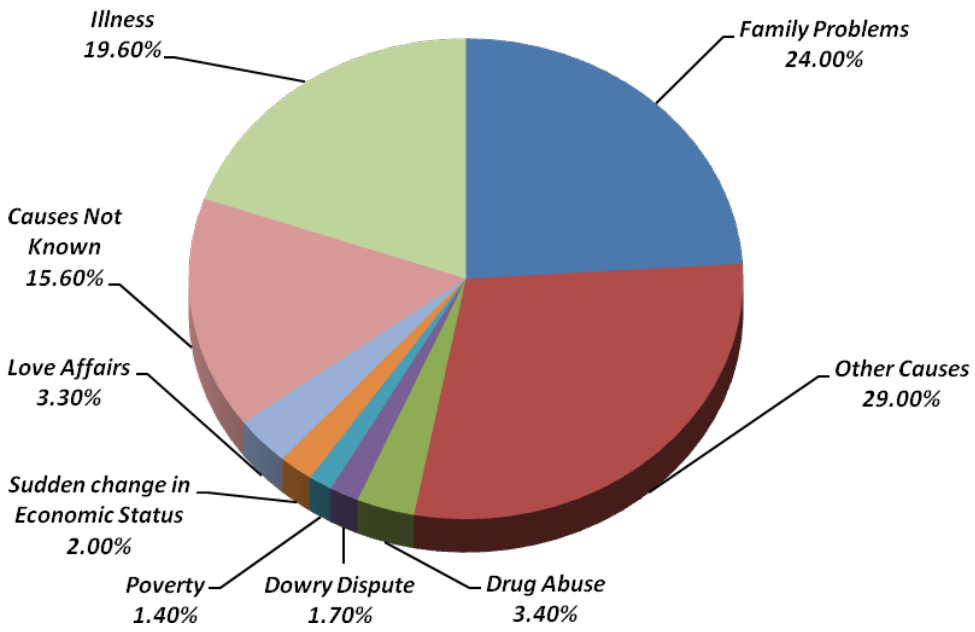
Table 1.2: A summary of risk factors for suicide by adolescents

Demographic	Clinical	Family and environment	Mental state
● Male ● Older adolescence (versus younger) ● Non-heterosexual orientation	● Psychiatric diagnosis ● Recent discharge from psychiatric hospital ● Past suicide attempt ● Family history of suicide ● Child sexual abuse/rape ● Childhood history of trauma ● Severe insomnia ● Poor physical health with functional impairment (eg. epilepsy) ● Personality traits (eg. neuroticism, perfectionism) ● Low self-esteem ● Poor treatment compliance	● Life stresses, particularly unemployment and legal and school problems ● Access to lethal means ● Lack of social supports ● Contagion – exposure to others demonstrating suicidal behaviour (imitation, coping strategy) ● Non-intact families (eg. divorce) ● Parental mental illness ● Impaired relationship with parents ● Poor communication with father ● Perceived excessive control and low care by parents ● Indigenous heritage	● Suicidal thoughts, especially if pervasive and involving planning ● Homicidal ideation ● Alcohol and illicit drug intoxication ● Severe anxiety/agitation, hopelessness ● Impulsivity ● Impaired problem solving skills

When we discuss about the causes of Suicidal Ideation then Family history and biological factors are associated with suicidal behaviors. It is critical to consider the important role of the psycho-social environment and specific life events in refining the understanding of suicidal behaviors. ‘Family Problems’ and ‘Illness’, accounting for 24.0% and 19.6% respectively, were the major causes of suicides among the specified causes. ‘Drug Abuse/Addiction’ (3.4%), ‘Love Affairs’ (3.3%), ‘Bankruptcy or Sudden change in economic Status’ (2.0%), 'Failure in Examination’ (1.8%), ‘Dowry Dispute’ (1.7%) and ‘Unemployment’ (1.6%) were the other causes of suicides. Suicides due to ‘Illegitimate Pregnancy (64.5%), ‘Fall in Social Reputation’ (49.4%), ‘Professional/Career Problem’ (40.8%), ‘Divorce’ (35.7%), and ‘Cancellation/Non-Settlement of Marriage’ (33.5%) have increased in 2013 over 2012, while for poverty and property dispute have declined as compared to previous year. Suicide due to Drug Abuse/Addition and Ideological Causes/Hero Worshipping has shown an increasing trend while in property Dispute has shown a decreasing trend during last 3 years.

Suicide due to Bankruptcy or Sudden change in Economic Status, Divorce, Failure in Examination, Family problems, Illegitimate Pregnancy, Love Affairs, Professional/Career Problem and Unemployment has shown a mixed trend during last 3 years.

Figure 1.1: Percentage Share of Various Causes of Suicides during 2013



Factors affecting Suicidal Ideation:-

If you don't have hope for the future, you may mistakenly think suicide is a solution. You may experience a sort of tunnel vision, where in the middle of a crisis you believe suicide is the only way out. There also may be a genetic link to suicide. People who complete suicide or who have suicidal thoughts or behavior are more likely to have a family history of suicide. There are number of causes associated of Suicidal Ideation like:-

1. **Chronic Medical Conditions** - The presence of a chronic medical illness can have a devastating impact on a person's ability to deal with stress. Individually suffering from psychiatric illness may be more vulnerable to environment stress or to a loss

in social support system. The risk factors for suicidal behaviors are manifold (Gould et.al 2003).

2. **Personal Characteristics/ Conditions**- Among personal characteristics, psychopathology and a previous suicide attempts are the strongest risk factors. Other personal characteristics are aggressive-impulsive behavior (Apter et.al. 1993), Somatic illness, low self esteem and hopelessness (Groholt et.al. 2000). However the last three factors may be closely related to depression, (Gould et.al., 2003). Recent bereavement, separation or divorce, early loss, decreased social support, loss of job and significant humiliations are all potentially important factors that can affect the lethality of a suicidal attempts (Blumenthal, 1984). Depression, hostility, hopelessness and low self- esteem were found to increase the risk for repetition. Another study of 15 to 24 years old orphans with a follow-up period of 5 years found the same risk factors. Beautrais (2007), found that orphnas and sexually abused female also represented risk factors for repeated suicidal attempts. Suicide is a highly complex phenomenon that involves the interaction between genetic, biochemical, psychological, societal and cultural factors

3. **Parenting -** Poor parenting as indicated by childhood physical or sexual abuse also increase the risk for suicidal behavior (Groholt et.al., 2000). On the other hand, mutual positive involvement in the family may have a protective function (Johnson et.al., 2002).

4. **Socioeconomic Status** - It is doubtful that low socioeconomic status has in independent contribution, while school problems or being a school drop-out seem to increase the risk. (Kent & Coffer., 2009).Cross- sectional studies comparing first and second attempts among adolescents have identified the same risk factors (Kotila et.al., 2010). High intent predicted suicide included adolescents admitted to medical wards after a suicide attempts, with a follow-up after 3 to 12 months (Spirito et.al. 2007; Hawton et.al. 1999 and Spirito et.al. 1994). It is observed that social and economic causes have led most of the males to commit suicide whereas emotional and personal causes have mainly driven females to end their lives.

Several other risk factors have been studied in relation to suicide, (Sainbur et.al, 2011), poor interpersonal relationship (Vault,2012), low socio-economic status,

poor physical and mental health, severe depression, family history of suicide (Sonobar,2009), orphans (Bush,2003),affective disorder, Schizophrenia, neurosis, personality disorders (Milak et.al, 1999), generally 40% suicides are due to alcoholism, (Rich et.al,2009). Mass media play an important role in suicide, (Roy, 1988). Available research reports are not commensurate with the magnitude of suicide in the country.

5. **Age -** Suicide rate increases as people grow older. Adolescents Suicide is on the rise, above 45 years of age, there is lower risk. According to National Crime Record Bureau's report (2013), Suicide attempts are relatively common during adolescence, although the rate of completed suicide is lower than in older age group. Thus, in western countries the ratio of suicide attempts to completed suicide was higher among adolescent than in any other age group. (Marthan, 2007). This may imply that the threshold for non fatal suicidal behavior is low during adolescence and that suicide attempts have a less serious outcome in this young age group, but does a suicide attempts during adolescence represent a lower risk for new suicidal acts than in older age group. Around 34.4% suicide victims were youths in the age group of 15-29 years and 33.8% were middle aged persons in the age group 30-44 years. Among the specified causes, 'Failure in Examination' (259), 'Family Problems' (331), , 'Illness' (300), and 'Love affairs' (120) were the main causes of suicides among children (below 14 years of age), However, 3 & 11 children had also committed suicides due to 'Poverty' and 'Drug Abuse/Addicted' respectively during the year. 'Family Problems' have driven 10,722 youths (15-29 years), 12,012 lower middle aged people (30-44 years) and 6,877 upper middle aged persons (45-59 years) to commit suicide. Nearly 38.2% (4,377 out of 11,449) of suicides committed by Senior citizens (60 years & above) were due to 'Illness'. Senior citizens have accounted for 8.5% of the total victims.

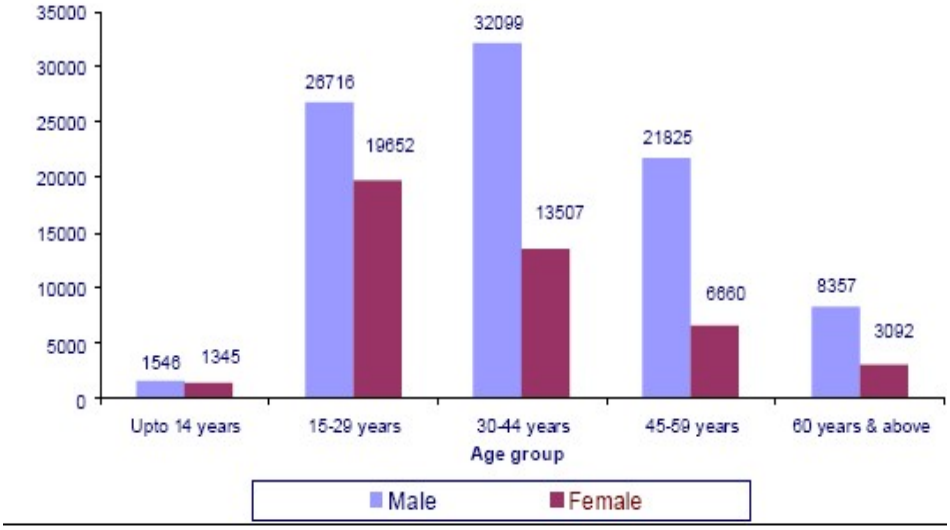
   Compared to those of older people, adolescent's suicide-attempt statistics show two significant differences. First, the fatality rate for boys is hundred times that of girls, a much greater gender difference than with any other age group. The immediate reason is clear enough: most teenage girls use relatively low-lethality methods like drugs and wrist cuts, while a substantial numbers of boys use guns and hanging. The reasons behind these choices are not known. Second the fatality rate among

adolescents, less than 2%, is much lower than that among the elderly, variously reported to be between 25% and 50%. This may be because the young, however miserable, usually have more reason for optimism about the future than do the old, who are too often without friends, family, job and health. Mental health professionals especially clinical psychologist, can assist people in their crises as many of its elements are painful and hard to face. It is not only the persons who attempts suicide but also their family members who have to bear the pain and shame of the act because of the social stigma attached to suicidal behavior . A collective effort of the community is necessary to improve the situation.

6. **Gender-** Gender differences in suicide rates have been shown to be significant; there are highly asymmetric rates of attempted and completed suicides between males and females. The gap, also called the "gender paradox of suicidal behavior", can vary significantly among different countries. Statistics indicate that males die by suicide more frequently than do females; however the prevalence of suicidal thoughts was significantly higher among females than it was among males and there is no statistically significant difference for suicide planning or suicide attempts between the genders.

   According to data from the NCRB for 2013 and a World Health Organisation report for 2012, alcoholism among men between the ages of 15 and 59 years and suicide rates among men of the same age group rise and fall together. However, the data sets do not have an age-wise breakdown, so this covariance could be no more than indicative of other issues.

Figure 1.2: Suicide Victims by Sex & Age-Group during 2013



Many researchers have attempted to find explanations for why gender is such a significant indicator for suicide. In 1981, suicide in men was 1.9 times higher than in women in the UK. In 2012, the male suicide rate increased to over three times higher than the female suicide rate. Male to Female ratio for completed suicide is 3:1. (Bhatt, 2016). Studies suggested that males have appreciably higher risk than females, and those in the older age group have higher risk than younger patients (Myers et.al, 2014). One explanation for this fact is, that since the decline of industrial jobs in the West, men aged over 40 are the segment of population that has been the most affected by job loss, the modification of family structure, and the disappearance of traditionally male-dominated industries. (Bhasin, 2015). According to literature on gender and suicide, male suicide rates are explained in terms of traditional gender roles. Male gender roles tend to emphasize greater levels of strength, independence, and risk-taking behavior. Reinforcement of this gender role often prevents males from seeking help for suicidal feelings and depression. (Annual Survey of Disha's Society, 2015)

Numerous other factors have been put forward as the cause of the gender paradox. Part of the gap may be explained by heightened levels of stress that result from traditional gender roles. For example, the death of a spouse and divorce are risk factors for suicide in both genders, but the effect is somewhat mitigated for females. In the Western world, females are more likely to maintain social and familial connections that they can turn to for support after losing their spouse. Another factor closely tied to gender roles is

employment status. Males' vulnerability may be heightened during times of unemployment because of societal expectations that males should provide for themselves and their families.

Jones et.al (2013) examined the gender and suicide gap by considering how cultural factors impacted suicide rates. The four cultural factors; power-difference, individualism, uncertainty avoidance, and masculinity, were measured for 66 countries using data from the World Health Organization (2015), Cultural beliefs regarding individualism were most closely tied to the gender gap; countries that placed a higher value on individualism showed higher rates of male suicide. Power-difference, defined as the social separation of people based on finances or status, was negatively correlated with suicide. However, countries with high levels of power-difference had higher rates of female suicide. The study ultimately found that stabilizing cultural factors had a stronger effect on suicide rates for women than men. (Sinha et.al, 2014).

Facts of CDC Report 2015 of Suicide in relation to Gender Disparities

- ✔ Males take their own lives at nearly four times the rate of females and represent 77.9% of all suicides.
- ✔ Females are more likely than males to have suicidal thoughts.
- ✔ Suicide is the seventh leading cause of death for males and the fourteenth leading cause for females.
- ✔ Firearms are the most commonly used method of suicide among males (56.9%).
- ✔ Poisoning is the most common method of suicide for females (34.8%).

Suicidal Ideation is generally associated with depression however it seems to have associations with many other psychiatric disorders, life events and family events, all of which may increase the risk of suicidal ideation. The simplest form of suicide is the act of refusing the adventures and challenges that offer themselves to us every day. Yet " Life is Impoverished: it loses interest, when the highest stake in the game of living, life itself, may not be risked. It becomes shallow and empty". Sigmund Freud (1957), It may be nothing more than the steadfast commitment to sameness. People who commit suicide are not necessarily 'sick' or ' sinners', but simply our sisters and brothers, resigned housewives the compulsive playboys, the

despairing priests, the addicted teenagers, the bored bureaucrats, the lonely salesman, the smiling stewardesses, the restless drifters etc.

We might lack the nerve to commit the final act, and we might not recognized our 'sinful' tendencies for what they are, but day in and day out we confront the people of our innate attraction to self destruction. We live in a world that encourage the small daily acts of negation that prepare us for the great one. There are meaning of suicide that neither the courts nor the dictionaries admit, but that make it impossible for us to regard those thousand people a day who do themselves in as very different from us. Thousands of books have tried to answer the question of why people kill themselves. To summarized them in three words: "TO STOP PAIN". (Shneidman1988). Sometimes this pain is physical, as in chronic or terminal illness. More often it is emotional caused by a myriad of problems. In any case, suicide is not a random or senseless act, but an effective, if extreme solution. "Suicide is a permanent solution to a temporary problem". (Hector, 2014).

Prevention and control

Suicides are preventable. There are a number of measures that can be taken at population, sub-population and individual levels to prevent suicide and suicide attempts. These include:

- reducing access to the means of suicide (e.g. pesticides, firearms, certain medications);
- reporting by media in a responsible way;
- introducing alcohol policies to reduce the harmful use of alcohol;
- early identification, treatment and care of people with mental and substance use disorders, chronic pain and acute emotional distress;
- training of non-specialized health workers in the assessment and management of suicidal behaviour;
- follow-up care for people who attempted suicide and provision of community support.

Suicide is a complex issue and therefore suicide prevention efforts require coordination and collaboration among multiple sectors of society, including the health sector and other sectors such as education, labour, agriculture, business, justice, law, defense,

politics, and the media. These efforts must be comprehensive and integrated as no single approach alone can make an impact on an issue as complex as suicide.

Challenges and obstacles

a) Stigma and taboo

Stigma, particularly surrounding mental disorders and suicide, means many people thinking of taking their own life or who have attempted suicide are not seeking help and are therefore not getting the help they need. The prevention of suicide has not been adequately addressed due to a lack of awareness of suicide as a major public health problem and the taboo in many societies to openly discuss it. To date, only a few countries have included suicide prevention among their health priorities and only 28 countries report having a national suicide prevention strategy.

Raising community awareness and breaking down the taboo is important for countries to make progress in preventing suicide.

b) Data quality

Globally, the availability and quality of data on suicide and suicide attempts is poor. Only 60 Member States have good-quality vital registration data that can be used directly to estimate suicide rates. This problem of poor-quality mortality data is not unique to suicide, but given the sensitivity of suicide – and the illegality of suicidal behaviour in some countries – it is likely that under-reporting and misclassification are greater problems for suicide than for most other causes of death.

Improved surveillance and monitoring of suicide and suicide attempts is required for effective suicide prevention strategies. Cross-national differences in the patterns of suicide, and changes in the rates, characteristics and methods of suicide highlight the need for each country to improve the comprehensiveness, quality and timeliness of their suicide-related data. This includes vital registration of suicide, hospital-based registries of suicide attempts and nationally representative surveys collecting information about self-reported suicide attempts.

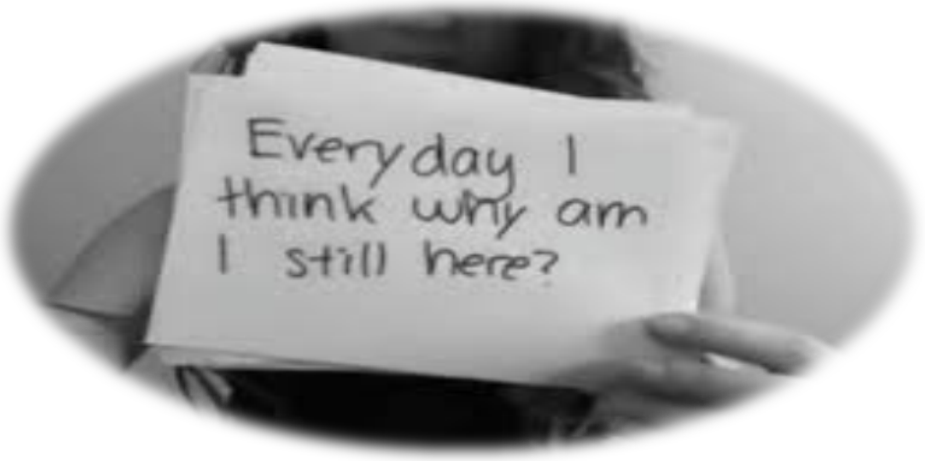
c) WHO response

WHO recognizes suicide as a public health priority. The first WHO World Suicide Report “Preventing suicide: a global imperative” published in 2014, aims to increase

the awareness of the public health significance of suicide and suicide attempts and to make suicide prevention a high priority on the global public health agenda. It also aims to encourage and support countries to develop or strengthen comprehensive suicide prevention strategies in a multisectoral public health approach.

Suicide is one of the priority conditions in the WHO Mental Health Gap Action Programme (mhGAP) launched in 2008, which provides evidence-based technical guidance to scale up service provision and care in countries for mental, neurological and substance use disorders. In the WHO Mental Health Action Plan 2013-2020, WHO Member States have committed themselves to working towards the global target of reducing the suicide rate in countries by 10% by 2020.

Suicidal Ideation and Depression



Although most people who are depressed do not kill themselves, untreated depression can increase the risk of possible suicide. It is not uncommon for depressed individuals to have thoughts about suicide whether or not they intend to act on these thoughts. Severely depressed people often do not have the energy to harm themselves, but it is when their depression lifts and they gain increased energy that they may be more likely to attempt suicide.

According to American Association of Suicidology, 2014

- ✔ Depression is the psychiatric diagnosis most commonly associated with suicide.
- ✔ Lifetime risk of suicide among patients with untreated depression ranges from 2.2% to 15%.

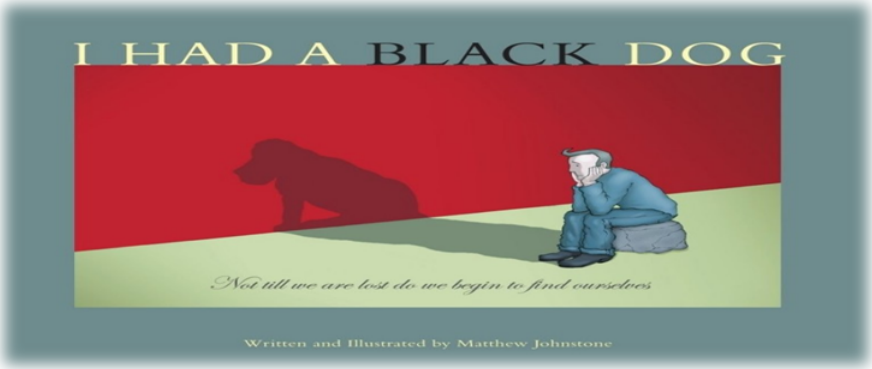
- ✔ Some that 15% of patients with treated depression eventually die by suicide.xiv
- ✔ Depression is present in at least 50 percent of all suicides. 5. 2% to 9 % of people that have been diagnosed with depression in their lifetime will go on to complete suicide.
- ✔ Those suffering from depression are at 25 times greater risk for suicidal than the general population

Depression is the diagnosis most commonly associated with suicide. Patients who need psychiatric treatment for manic depressive psychosis and reactive depression. They have approximately 30 times the risk for the general population of dying by suicide. The life time risk of suicide in depression is 15%. Depth of depression may be an adverse factor, especially when manifested as severe hopelessness and a hedonic. The expression of guilt- feeling and ideas of worthlessness also provide a warning. Painful memories of someone who has already died and fantasies of being reunited with departed relatives are common suicide notes. Bunch (1971) some depressed are unaware of depressive process and they are sometimes to recognize the signs or the association between depressed feelings and actual behavior. They may be unable to attributed any of their problems to depression. The mildly depressed person sometimes suffers from feelings of poor self-image, inadequacy and “The Blue” so, considering the interconnections of Suicidal Ideation & Depression, the present study has also tried to explore depression among the respondents.

Depression

Nature and Definition:- **"Depression"** is more than just sadness. People with depression may experience a lack of interest and pleasure in daily activities, significant weight loss or gain, insomnia or excessive sleeping, lack of energy, inability to concentrate, feelings of worthlessness or excessive guilt and recurrent thoughts of death or suicide. (APA, 2016).

Depression is a common mental disorder, characterized by sadness, loss of interest or pleasure, feelings of guilt or low self-worth, disturbed sleep or appetite, feelings of tiredness, and poor concentration. Depression can be long-lasting or recurrent, substantially impairing an individual's ability to function at work or school or cope with daily life. At its most severe, depression can lead to suicide. When mild, people can be treated without medicines but when depression is moderate or severe they may need medication and professional talking treatments. (WHO, 2015).



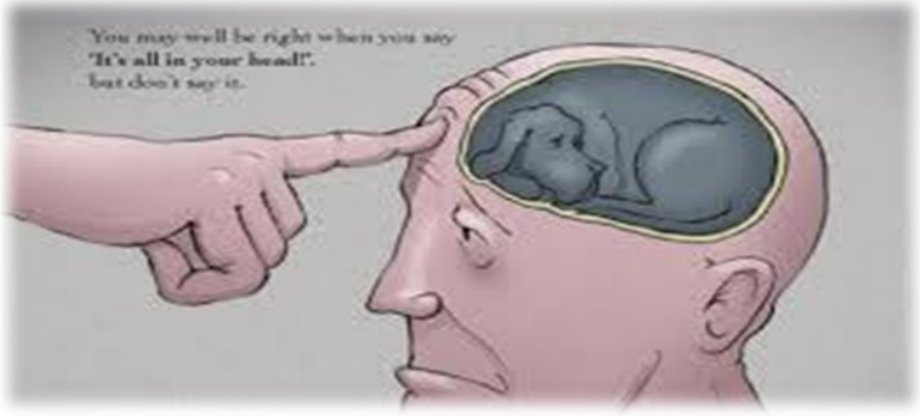
The term '**Depression**' covers a variety of negative moods and behavior changes. The mood change may be temporary or long lasting. It may range from relatively minor feeling of melancholy to a deeply negative view of the world and an inability to function effectively. Depression is a disturbance in mood, thought, and body characterized by varying degrees of sadness, disappointment, loneliness, hopelessness, self-doubt and guilt. Most people tend to feel depressed at one time or another; some people may experience these feelings more frequently or with deeper, more lasting effects. In some cases, depression can last for months or even years. The least intense type of depression, "feeling blue" or "being in a bad mood" is usually brief in duration and has minimal or slight effect on normal, everyday activities. With moderate depression, symptoms are more intense and last for a longer period of time. Daily activities are more difficult but the individual is still able to carry out these activities. In severe depression there may be extreme fluctuations in moods or even a complete withdrawal from daily routine and/or the outside world. Feelings of hopelessness can become so intense that thoughts of death may occur and suicide may seem a viable option. Depression is a state of low mood and aversion to activity that can affect a person's thoughts, behavior, feelings and sense of well-being.

Depression is a mental health disorder that can affect the way you eat and sleep, the way you feel about yourself and the way you think about things. It is not a sign of personal weakness and it can't be willed or wished away. (Lucy et.al, 2015).

Depression is a mood disorder that causes a persistent feeling of sadness and loss of interest. Also called major depressive disorder or clinical depression, it affects how

you feel, think and behave and can lead to a variety of emotional and physical problems. You may have trouble doing normal day-to-day activities, and sometimes you may feel as if life isn't worth living (Roosi, 2015).

Depression is a state of low mood and aversion to activity that can affect a person's thoughts, behavior, feelings and sense of well-being. People with a depressed mood can feel sad, anxious, empty, hopeless, helpless, worthless, guilty, irritable, ashamed or restless. They may lose interest in activities that were once pleasurable, experience loss of appetite or overeating, have problems concentrating, remembering details or making decisions, and may contemplate, attempt or commit suicide. Insomnia, excessive sleeping, fatigue, aches, pains, digestive problems or reduced energy may also be present. (CDC, 2015).



Depressed mood is not always a psychiatric disorder. It may also be a normal reaction to certain life events, a symptom of some medical conditions, or a side effect of some drugs or medical treatments. Depressed mood is also a primary or associated feature of certain psychiatric syndromes such as clinical depression. People who were depressed cannot **"SNAP OUT OF IT"** and get better. Depressed people showed a blunted hormonal response. A number of studies suggested that depression is the major problem of the orphans.

According to Beck's theory (Beck et. al, 1985; Minkoff et. al, 1973), depression was the result of three basic components; the cognitive triad schemas and cognitive errors. The cognitive triad is composed of faculty perceptions. Specially, the person believes he/she has no worth, is defective or is in some other way worthless. In turn, they believe that the world is a black and horrible place and as a result do no believe that the future

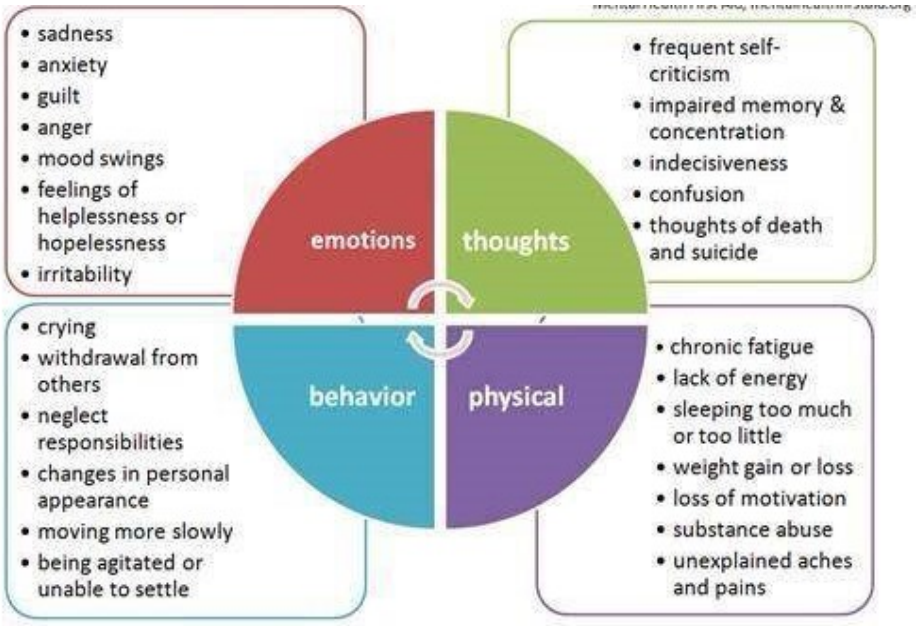
will be any better. All new experiences are filtered through these beliefs (i.e, schemas) and tainted, hence maintaining the depression. Finally, the consistent logical errors committed by the depressed person makes it difficult if not impossible to recognize information which contradicts their beliefs. One potential outcomes therefor, is to view suicide as the only "logical" way to escape what is deemed to be a desperately bad life that can not possibly improve.

As discussed above, research has found that the risk of getting another depressive episode increases with number of previous episodes (Consensus Development Panel, 1985). Furthermore, while the first depressive episode is associated with negative life events, this association is not that strong for recurrent depression (Post, 1992; Zuckerman, 1999), indicating that the depressive episode by itself has been avulnerability factor (Coyne, et al., 1999; Solomon et al., 2000).

Depression has been identified as a strong, consistent correlate and significant predictor of adolescent suicidal ideation and previous suicide attempts (Mazza, 2000). This thing has been very crucial in the context of orphan adolescent. Psychological autopsy studies had revealed a strong likelihood of diagnosable depressive disorder among adolescent suicide victims (Brent et. al, 1988; Shaffer, 1998). Corresponding result had been reported in community- based studies (Lewinsohn, et.al. 1993, Garrison et al, 1991). Depression is the major problem of orphans. (Roy et.al, 2014).

Sign and Symptoms of Depression

Figure 1.3: Symptoms of Depression



Depression is the common cold of mental disorder, most people will be affected by depression in their lives either directly or indirectly, through a friend or family member. Depression is characterized by a number of common symptoms. These include a persistence sad, anxious or empty mood and feeling of hopelessness or pessimism. A person who is depressed also often has feelings of guilt, worthlessness and hopelessness. They no longer take interest or pleasure in hobbies and activities that were once enjoyed this may include things like going out with friends or even sex. Insomnia, early morning awakening and oversleeping are all common. Appetite and or weight loss or overeating and weight gain may be symptoms of depression in some people. Many other experience decreased energy, fatigue and a constant feeling of being 'Slowed down'. Thoughts of death or suicide are not uncommon in those suffering from severe depression. Restlessness and irritability among those who have depression is common. A person who is depressed also had difficulty concentrating remembering and trouble making decisions and sometimes, persistent physical symptoms that do not respond to traditional treatments such as headaches , digestive disorder and chronic pain may be signs of a depressive illness. In conjunction with the

World Health Organization World Mental Health (WMH) Survey, Initiative, researchers from 20 centers collaborated to investigate the prevalence of depression around the globe. To be classified as having had a Major Depressive Episode (MDE) a person was additionally required to fulfill five out of nine criteria including sadness, loss of interest or pleasure, feelings of guilt or low self-worth, disturbed sleep or appetite, low energy and poor concentration.

Ahuja (2002) suggested that depression is characterized by following features:-

Depressed Mood:- The most important feature of depression is sadness of mood, loss of interest or pleasure of almost activities (Pervasive Sadness), present throughout the day (persistence sadness). This sadness of mood is quantitatively as well as qualitatively different from sadness encountered in normal depression on grief. The depressed mood varies little from day to day and is often not responsive to environmental stimuli (Ahuja, 2002).

1. **Depressive Ideation/Cognition:-** Sadness of mood usually associated with pessimism. This result in three common types of depressive ideas, i.e

    - Hopelessness (There is no hope in future due to pessimism)
    - Helplessness (No help is possible)
    - Worthlessness (Felling of inadequacy and inferiority)

    The ideas of worthlessness can lead to guilt feeling. Other features are difficulty in thinking, difficulty in concentration, indecisiveness, slowed thinking, subjective poor memory, lack of initiative and energy. Often there are ruminations (repetitive, intrusive thoughts of pessimistic ideas). Thoughts of death and preoccupation with death are not uncommon. Suicidal ideas may be present. In severe cases, delusion

of nihilism (e.g world is coming to an end or "there is no brain in the skulls") may occur.

2. **Psychomotor Activity:-** In aged patients (e.g post-menopausal women), agitation is common with marked activity, restlessness (inability to sit still, hand-wriggling, picking at body parts or other objects) and subjective feeling of unease. In younger patient (<40 years old), retardation is more common which characterized by slowed thinking and activity.

3. **Physical Symptoms:-** Multiple physical symptoms (Like heaviness of head, vague body aches) are common in elderly depression. Another common symptoms is complaints of reduce energy and easily fatigability.

4. **Biological Functions:-** Disturbance of biological functions is common with insomnia (sometimes hypersomnia), loss of appetite and weight (sometimes weight gain and loss of sexual drive). When the disturbance is severe, it is called as melancholia (somatic syndrome in ICD-10, diagnostic criteriafor research).

5. **Biological Functions:-** Suicidal ideas in depression, if expressed, should be taken seriously. Although there is a risk of suicide in every depressed patient with suicidal ideation, presence of certain factors in increases the risk of suicide.

6. **Absence of underlying organic cause:-** If depressive episode is secondary to an organic cause a diagnosis of organic mood disorder should be made. In ICD-10, the severity of depressive episode is defined as mild, moderate or severe, depending primarily on the number of the symptoms, but also on the severity of symptoms and the degree of impairment.

Causes/Risk Factors

It's not known exactly what causes depression. As with many mental disorders, a variety of factors may be involved, such as:

a) **Biological differences**- People with depression appear to have physical changes in their brains. The significance of these changes is still uncertain, but may eventually help pinpoint causes.

b) **Brain chemistry-** Neurotransmitters are naturally occurring brain chemicals that likely play a role in depression. Recent research indicates that changes in the function and effect of these neurotransmitters and how they interact with neurocircuits involved in maintaining mood stability may play a significant role in depression and its treatment.

c) **Hormones-** Changes in the body's balance of hormones may be involved in causing or triggering depression. Hormone changes can result with pregnancy and during the weeks or months after delivery (postpartum) and from thyroid problems, menopause or a number of other conditions.

d) **Inherited traits**- Depression is more common in people whose blood relatives also have this condition. Researchers are trying to find genes that may be involved in causing depression.

e) Depression often begins in the teens, 20s or 30s, but it can happen at any age. More women are diagnosed with depression than are men, but this may be due in part because women are more likely to seek treatment.

Factors that seem to increase the risk of developing or triggering depression include:

- ✔ Certain personality traits, such as low self-esteem and being too dependent, self-critical or pessimistic
- ✔ Traumatic or stressful events, such as physical or sexual abuse, the death or loss of a loved one, a difficult relationship, or financial problems
- ✔ Childhood trauma or depression that started when you were a teen or child
- ✔ Blood relatives with a history of depression, bipolar disorder, alcoholism or suicide
- ✔ Being lesbian, gay, bisexual or transgender in an unsupportive situation
- ✔ History of other mental health disorders, such as anxiety disorder, eating disorders or post-traumatic stress disorder
- ✔ Abuse of alcohol or illegal drugs

Prevalence of Depression

The 12-month prevalence data for depressive episode presented from the National Survey on Drug Use and Health (NSDUH, 2014).

- ✔ A period of two weeks or longer during which there is either depressed mood or loss of interest or pleasure, and at least four other symptoms that reflect a change in functioning, such as problems with sleep, eating, energy, concentration, and self-image.
- ✔ Unlike the definition in the DSM-IV, no exclusions were made for a major depressive episode caused by medical illness, bereavement, or substance use disorders.

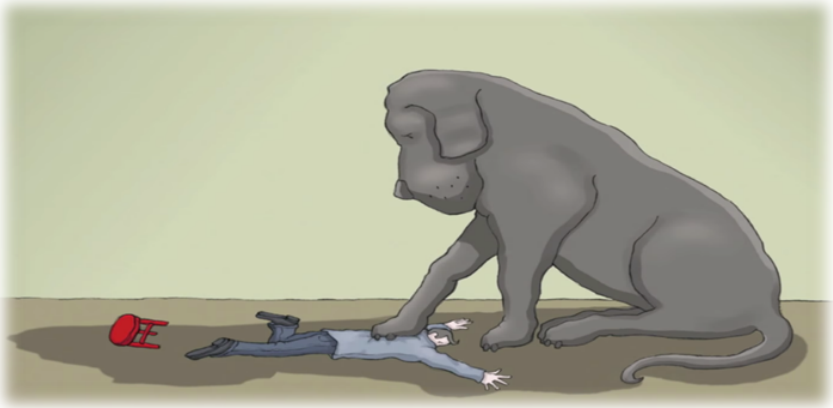
Prof Evelyn Bromet from State University of New York at Stony Brook said, "This is the first study which uses a standardized method to compare depression and MDE across countries and cultures. We have shown that depression is a significant public-health concern across all regions of the world and is strongly linked to social conditions. Understanding the patterns and causes of depression can help global initiatives in reducing the impact of depression on individual lives and in reducing the burden to society."

According to the World Health Organization (WHO; 2010), major depression also carries the heaviest burden of disability among mental and behavioral disorders. Specifically, major depression accounts for:

- **3.7 percent of all U.S. disability-adjusted life years (DALYs); and,**
- **8.3 percent of all U.S. years lived with disability (YLDs).**

Depression is the leading cause of disability for both males & females, the burden of depression is 50% higher for females than males (WHO, 2008). In fact, depression is the leading cause of disease burden for women in both high income and low & middle income countries (WHO, 2008). Research in developing countries suggests that maternal depression may be a risk factor for poor growth in young children (Rahman et.at, 2008). 1/10 people suffer from major depression and almost 1/5 persons has suffered from this disorder during his/her lifetime (one-year prevalence is 10% and lifetime prevalence is 17%). Kessler et.al,1994). By 2020, depression will be the second leading cause of world disability (WHO,2001) and by 2030, it is expected to be the largest contributor to disease burden (WHO, 2008).

The degree of psychic pain of a person with depression can be understood if one considers that many patients prefer death to their suffering. In view of the fact that the overwhelming majority of people who commit suicide are persons with mental illness and especially depression, the need for screening for and early detection of depression in primary care services is unarguable (Patel et al 2010, Araya et al 2003a).



DEPRESSION affects 121 million people worldwide. It can affect a person's ability to work, from relationships and destroy their quality of life. At its most severe depression can lead to suicide and is responsible for 850,000 deaths every year. New research published in BIOMED Central's open access Journal BMC Medicine compares social conditions with depression in 18 countries across the world. According to Zung (1973) depression as an effect or feeling tone is a ubiquitous and universal condition which as

a human experience extends on a continuous from normal mood swings to a pathological state. Thus, depression as a word can be used to describe:-

1. An effect which is a scientific feeling tone of short duration.
2. A mood, which is a state sustained over a longer period of time.
3. And emotional, which is comprised of feeling tones along with objective indicates.
4. A disorder which has characteristic symptoms dusters, complexes or configuration.

Based on detailed interviews with over 89,000 people, the results showed that 15% of the population from high-income countries (compared to 11% for low/middle-income countries) were likely to get depression over their lifetime with 5.5% having had depression in the last year. MDE were elevated in high-income countries (28% compared to 20%) and were especially high (over 30%) in France, the Netherlands, and America. The country with the lowest incidence was China at 12% but, in contrast, MDE were very common in India (at almost 36%).

Depression in relation to Age & Sex

National Institute of Mental Health (NIMH report, 2014), shows that orphan adolescents experienced at least one major depressive episode in the previous 12 months. 17.3% of orphan adolescents that had a major depressive episode in 2014 were female while 5.7% of orphan adolescents that had a major depressive episode in 2014 were male. 5.7% were 12 years old. 8.7% were 13 years old. 10.7% were 14 years old. 13.0% were 15 years old. 14.1% were 16 years old. 15.1% were 17 years old.

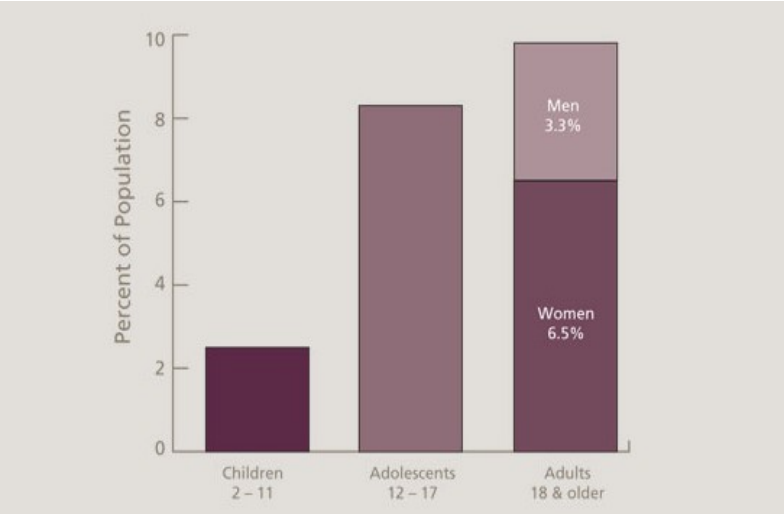
2014 statistics from the National Institute of Mental Health (NIMH)

- ✔ Depression is the most common mental health disorder in the United States among teens and adults.
- ✔ 2.8 million youth age 12-17 had at least one major depressive episode in 2014.
- ✔ Between 10 to 15 percent of teenagers have **some symptoms of teen depression** at any one time.
- ✔ About 5 percent of teens are suffering from major depression at any one time

- ✔ As many as 8.3 percent of teens suffer depression for **at least a year at a time**, compared to about 5.3 percent of the general population.
- ✔ Most teens with depression will suffer from more than one episode. 20 to 40 percent will have more than one episode within two years and 70 percent will have more than one episode before adulthood. Episodes of teen depression generally last about 8 months.
- ✔ **Dysthymia**, a type of mild, long-lasting depression, affects about 2 percent of teens, and about the same percentage of teens develop bipolar disorder in their late teenage years. 15 percent of teens with depression eventually **develop bipolar disorder**.
- ✔ A small percent of teens also suffer from seasonal depression, usually during the winter months in higher latitudes.
- ✔ Teen depression can affect a teen regardless of gender, social background, income level, race, or school or other achievements, though teenage girls report suffering from depression more often than teenage boys.

Teenage boys are also less likely to seek help or recognize that they suffer from depression, probably due to different social expectations for boys and girls – girls are encouraged to express their feelings while boys are not. Teenage girls' somewhat stronger dependence on social ties, however, can increase the chances of teen depression being triggered by social factors, such as loss of friends. Other risk factors that increase the chances of an episode of teen depression include:

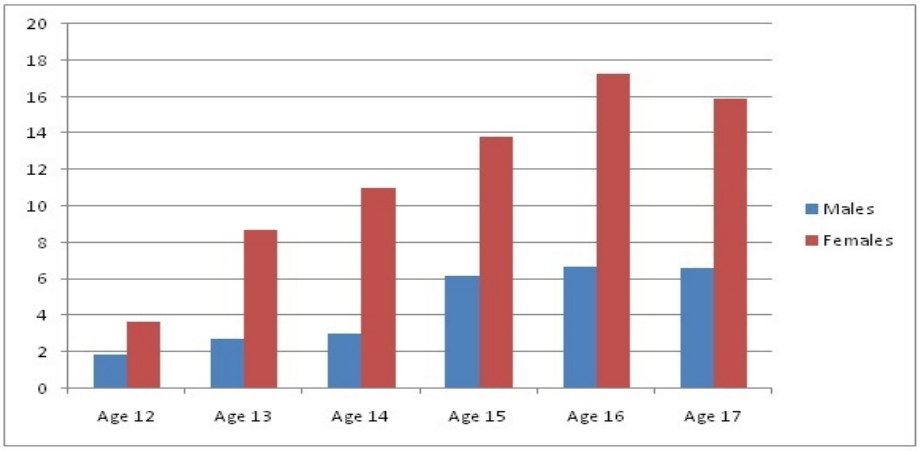
Figure 1.4: Prevalence of Depression by Age & Sex



(Annual Survey of Disha Society, 2014)

Some aspects were cross cultural -- women were twice as likely to suffer depression as men and the loss of a partner, whether from death, divorce or separation, was a main contributing factor. However the contribution of age varied from country to country. Age of onset of depression was almost two years earlier in low income countries and, while the amount of difficulty a person had with aspects of their life increased with depression and how recent their last attack was, it was more apparent in people from high income countries.

Figure 1.5: Depression in relation to Age & Sex



(Annual Survey of Disha Society, 2014)

In the U.S. population, at any one time, 10% had experienced clinical depression in the past year, and between 20-25% of the women and 7-12% of the men would suffer a clinical depression during their lifetime. In the Norwegian study it was found that at any one time 3-5% of the population are experiencing a clinical depression, and that during their life time, 24% of the women and 10% of the men have experienced a major depression (Kringlen et al., 2001). There are a number of symptoms that are used to help diagnose depression. Looking at all instances of depression that can be confirmed (i.e. psychological help is obtained or a suicide occurs from depression-related circumstances), a one-author report states that women have a higher rate of major depression than men, but looking at individual symptoms, the gender divide intensifies in some areas, disappears in some, and reverses in others. While women have a greater proportion of somatic symptoms, such as appetite, sleep disturbances and fatigue accompanied by pain and anxiety, than men, the gender difference is much smaller in other aspects of depression. Female respondents report twice the prevalence of somatic symptoms as male (2.8% vs. 1.4%) versus depression not associated with somatic symptoms (2.3% vs. 1.7%). Depression with somatic symptoms is highly likely to also have an anxiety disorder (31.4% vs. 22.9%), to have pain (60% vs. 48%), and to have chronic depression (49.2% vs. 36.8%). Men with depression with somatic symptoms were more likely than those without to have pain (48.9% vs. 28.6%) but were not more likely to have an anxiety disorder (39.3% vs. 31.9%) or chronic dysphoria (37.8% vs. 33.3%). Instances of suicide in men is much greater than in women. In a report by Lund University in Sweden and Stanford University, it was shown that men commit suicide at a rate almost three times that of women in Sweden, and the (Centers for Disease Control and Prevention and National Center for Injury Prevention and Control report, 2015), that the rate in the US is almost four times as many males as females. However, women have higher rates of suicide ideation and attempts (Khanna et.al, 2014). The difference is attributed to men choosing more effective methods resulting in the higher rate of success.

Types of Depression

Mild depression:- Mild depression usually causes symptoms that are detectable and impact upon our daily activities. We are less interested in doing things we previously

enjoyed, unusual irritability, reduced motivation in work, home or social activities are common however we continue to function – just perhaps not as well as we normally would do when healthy.

Mild depression often goes undiagnosed because the symptoms are not considered to be 'bad enough' for people to think they may have depression and discuss it with their doctors or other people. However accurately diagnosing depression when it is mild, and treating it effectively at this stage can prevent the condition from worsening to become moderate or severe. There are also more treatment options available for mild depression. Lifestyle changes such as regular exercise, relaxation, ensuring sufficient and regular sleep, etc are often sufficient. Natural therapies such as St John's Wart may also be effective treatments for depression if it is diagnosed early – when 'mild'.

Moderate depression:- Moderate depression can cause real difficulties with social, work and domestic activities. The characteristics described for mild depression are worse here – by definition. A reduced interest in normally pleasurable activities becomes no interest – a real lack of interest and motivation. Simple things start to require real effort or just get neglected.

With moderate depression there is usually a detectable reduction in self confidence and/or self esteem which can have a 'snowball' effect as we become less motivated and hence less productive. Often we start to worry about things unnecessarily such as performance at work, even if we are managing to maintain our previous standards, or more sensitive and susceptible to feeling hurt or offended within personal relationships, sometimes they feels suicidal thoughts.

Again, there are more treatment options available and the time it will take to recover from moderate depression will be less than if it is left untreated and develops into major depression. Cognitive Behavioral Therapy (CBT) along with Progressive Muscular Relaxation Technique (PMRT) can be very effective and Self Management Training may still be helpful. This only gives the illness an opportunity to worsen as it is not being effectively treated. Lifestyle improvements always have a positive impact, however can take more effort to actually do as the depression becomes more severe.

Severe depression:- Severe or Major depression causes considerable distress or agitation, loss of self-esteem or feelings of uselessness and guilt. We are unlikely to be

able to continue with work, social and domestic activities. Severe (or Major) depression usually causes severe enough symptoms for a change to be noticeable by those around us even if we try to mask how we are feeling. People with severe depressive episodes may also suffer from delusions, hallucinations or depressive stupor although these are less common. Suicidal ideation with suicidal attempts is also present in Severe depression. While we may be managing one moment, we can plummet very quickly into feelings of hopelessness and despair. It is common for people to feel that they are somehow responsible and 'to blame' for the way they are feeling and believe that others are better off without them.It is vital that professional help and treatment is sought as soon as possible and that treatment is adhered to. As with all major illnesses, during major depression we need additional support on a daily basis both in managing the symptoms and to provide help with treatment.

A hallmark of depression is dangerousness to self—that is, suicide. Depression is a risk factor for suicidal thinking (there are many more attempts at suicide than there are completed acts). Suicidal Ideation and depression my result from the experience of emotional pain out weighing the individual's coping strategies and resources for dealing with that pain or from an individual's unwillingness to impose self discipline and care about more than him or herself. Therefore, the amount of perceived Depression and Suicidal Ideation depends on how a person perceives a situation & how he copes with the multiple demands of situation, so use of Coping Strategies is very important the axis of Depression & Suicidal Ideation. Good Coping Strategies may result in a better life. In the present study also tried to explore Coping Strategies used by the respondents.

Coping Strategies

Nature and Definition:- **"Coping"** has been defined by theorists as "Measure taken to enhance the balance between an individual and his environment." French & Rodgers, 1974 or as "Attempts to meet environments demand to prevent negative consequences" (Mechanic, 1968). The most clear definition among many is the one offered by Lazarus and Folkman (1984) who wrote that "Coping refers to constantly changing cognitive and behavioral efforts to manage specific external and or internal demands that are appraised as taxing or exceeding the resources of the person." This definition implies that coping may consist of a number of adjustments made either

simultaneously or sequentially. It is restricted to instance of perceived stress. It excludes habitual or automatic adjustments to the requirements of daily life, that is, the individual in general is left with the choice of assessing the stress. Based on his assessment, he will have to adopt appropriate coping behavior in order to get rid of the stressful situation. Thus the reduction in stress, depends on the appropriateness of the choice of coping mechanisms adopted by the individual.

Coping is defined as the efforts that people make to manage situations that were appraised as potentially harmful or stressful (Caltabiano et.al.2002).

The term coping generally refers to adaptive or constructive coping strategies can be considered maladaptive. Maladaptive coping can thus be described, in effect, as non-coping. (Loreal et.al 2005).

Coping Strategies are conscious effort to solve a personal or interpersonal problem that will help in overcoming, minimizing, or tolerating stress or conflict. (Giblin, 2015).

Coping strategies are defined as "conscious, rational ways for dealing with the anxieties of life"20 and are often categorized into active (or approach) and passive (or avoidance) strategies. (Merry, 2015).

The coping mechanism in general, have been classified into set patterns for the use of research and clinical purpose. There are many patterns of classification of coping responses (Moos, 1982). Most approaches distinguish between the two:-

1. Strategies are active in nature and oriented towards confronting the problem.
2. Strategies that entail an effort to reduce tension by avoiding the direct dealing with the problems. Many authors in general have adopted similar classification in various dimensions. (Pearlin et.al, 1978, Moos & Billings et.al, 1982).

Strategies of Coping

Coping is expending conscious effort to solve personal and interpersonal problems, and seeking to master, minimizing or tolerate stress or conflicts, the effectiveness of the coping effort depend on the type of stress or conflict the particular individual and the circumstances. Coping is a very complex process that varies according to many variables such as the situation, the evaluation of the situation and the resources available. It refers to the thoughts and actions we use to deal with threatening situations. The term coping generally refers to reactive coping, i.e the coping response follows the stressor. This contrasts with proactive coping, in which a coping response aims to head off a future stressor.

Coping responses are partly controlled by personality (habitual traits), but also partly by the social environment, particularly the nature of the stressful environment. Psychological coping mechanisms are commonly termed coping strategies or coping skills. Subconscious or non conscious strategies (e.g defense mechanism) are generally excluded.

Coping strategies refer to the specific efforts, both behavioral and psychological, that people employ to master, tolerate, reduce, or minimize stressful events. Two general coping strategies have been distinguished: problem-solving strategies are efforts to do something active to alleviate stressful circumstances, whereas emotion-focused coping strategies involve efforts to regulate the emotional consequences of stressful or

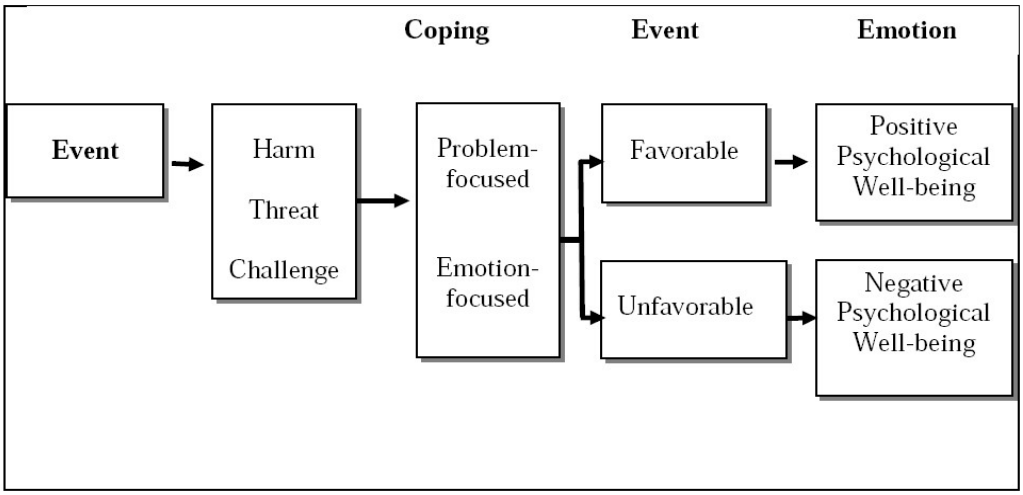
potentially stressful events. Research indicates that people use both types of strategies to combat most stressful events (Folkman & Lazarus, 1984). The predominance of one type of strategy over another is determined, in part, by personal style (e.g., some people cope more actively than others) and also by the type of stressful event; for example, people typically employ problem-focused coping to deal with potential controllable problems such as work-related problems and family-related problems, whereas stressors perceived as less controllable, such as certain kinds of physical health problems, prompt more emotion-focused coping.

An additional distinction that is often made in the coping literature is between active and avoidant coping strategies. Active coping strategies are either behavioral or psychological responses designed to change the nature of the stressor itself or how one thinks about it, whereas avoidant coping strategies lead people into activities (such as alcohol use) or mental states (such as withdrawal) that keep them from directly addressing stressful events. Generally speaking, active coping strategies, whether behavioral or emotional, are thought to be better ways to deal with stressful events, and avoidant coping strategies appear to be a psychological risk factor or marker for adverse responses to stressful life events (Holahan & Moos, 1987).

One factor frequently associated with depression involves the choice of coping strategies for dealing with stress. The use of more passive and less active coping strategies has been shown to be associated with higher levels of depressive symptoms in patients having various chronic illnesses, including depression and anxiety. (Bardwell et al, 2011).

Coping skills are one of the protective factors identified as potentially involved in the suicide process. Against this background, we undertook a study focused specifically on coping to gain a better understanding of its role in depression and suicidal ideation in adolescence.

Figure 1.6: Theoretical Model of the Coping Process (Lazarus & Folkman's, 1984)



This model identifies stress as a transaction between individuals and their environment, where the individuals' perception of the stressful situation is the mediating variable of how they are able to cope with it. Transactions that are perceived as stressful (i.e. harmful, threatening, or challenging) require coping that will manage their level of distress (emotion-focused coping) or manage the problem that is causing their distress (problem-focused coping) (Lazarus & Folkman, 1984). Regardless of the chosen coping mechanism there is an event outcome that is either favorable, unfavorable or there is no resolution. Event outcomes lead to positive or negative emotional responses. The Lazarus and Folkman (1984) model predicts that problem-focused coping will reduce the level of problems that could create stress, and that emotion-focused coping will reduce the level of internal emotional distress.

Classification of Coping Strategies

We need ways to calm our minds and bodies after a stressor has taken its toll. The two main categories of coping strategies are emotion-focused coping and Problem-focused coping.

a) **Problem-focused strategy** -This strategy relies on using active ways to directly tackle the situation that caused the stress: you must concentrate on the problem. Here are some examples:

- ✔ Analyze the situation , e.g. Pay attention, avoid taking on more responsibility than you can manage.
- ✔ Work harder , e.g. Stay up all night to study for an exam
- ✔ Apply what you have already learned to your daily life, e.g. You lose your job for the second time - you now know the steps to apply for a new job
- ✔ Talk to a person that has a direct impact on the situation ,e.g. Talk directly to your boss to ask for an extension to the project that is due in one week.

b) Emotion-focused strategy- Emotion-focused coping strategies are used to handle feelings of distress, rather than the actual problem situation. You focus on your emotions:

- ✔ Brood ,e.g. you accept new tasks instead of saying "no", but you keep complaining and saying it is unfair.
- ✔ Imagine/Magic thinking ,e.g. You dream about a better financial situation.
- ✔ Avoid/Deny, e.g. You avoid everything that is related to this situation or you take drugs and/or alcohol to escape from this situation.
- ✔ Blame, e.g. You blame yourself or others for the situation.
- ✔ Social support, e.g. You talk to your best friend about your concerns.

Common distinctions are often made between various contrasting strategies for example:-

1. Problem focused verses Emotional focused.
2. Engagement verses Disengagement.
3. Cognitive verses Behavioral.

Weiten (1998), identifies three broad types of coping strategies.

1. Appraisal Focused (Directed towards challenging one's own assumptions, adapting cognitive).
2. Problem Focused (Directed towards reducing a stressor, adaptive behavioral).
3. Emotion Focused (Directed towards changing one's own emotional reactions).

1. <u>Appraisal Focused Coping Strategy:-</u> Appraisal Focused Strategy occur when the person modifies the way they think. For example:- Employing denial or

distancing oneself from the problem. People may alter the way they think about a problem by altering their goals and values, such as by seeing the humor in a situation. "Some have suggested that humor may play a greater role as a stress moderator among women than men". On other hand, appraisal focused strategies are appropriate when there is no straight-forward solution to a problem.

2. **Problem Focused Coping Strategy:-** People using problem-focused strategies try to deal with the cause of their problem. They do this by finding out information on the problem and learning new skills to manage the problem. On other hand, problem focused coping strategies are simply solution-oriented approaches to dealing with a situation that causes stress. Problem-focused coping is aimed at changing or eliminating the source of the stress. The three problem-focused coping strategies identified by Folkman and Lazarus are:-

   - **Taking control,**
   - **Information seeking,**
   - **Evaluating the pros and cons**.

If the problem is due to something that can be changed, you can solve it by reducing or eliminating the source of the stress. **For example, you're tense and anxious due to your hectic schedule. You feel like you're running from one meeting to another, while always being afraid that you'll be late to the next one. You would look at how you are managing your appointments to see how you can reduce the problem.**

3. **Emotions Focused Coping Strategy:-** Emotion focused coping strategies involve releasing pent-up emotions, distracting oneself, managing hostile feelings, meditating or using systematic relaxation procedure. Emotion-focused coping "Is oriented towards managing the emotions that accompany the perception of stress". The five Emotion focused coping strategies identified by Folkman & Lazarus (1984) are:-

   - Escape
   - Accepting responsibility or blame
   - Self control
   - Avoidance
   - Positive reappraisal

Emotion focused strategies involve dealing with the feeling that are stirred up as a consequences of the stressor. This can include managing hostile feelings by counting to ten or reducing anxiety by meditating or using relaxation technique. Emotion focused coping is more tactical than strategic since it is aimed at the effects of the stress. Distracting oneself from the urge to binge would be an example that is most relevant to emotional eating. This is what many therapist who work with emotional eating recommend when they encourage people to "surf the urge", meaning, distract yourself from the urge to binge until it passes.

Typically, people use a mixture of all three types of coping strategies and coping skills will usually change over time. All these methods can prove useful, but some claim that those using problem-focused coping strategies will adjust better to life. problem-focused coping mechanism may allow an individual greater perceived control over their problem, whereas emotion focused coping may sometimes lead to a reducing in perceived control (Maladaptive Coping).

Lazarus notes the connection between his idea of "Defensive reappraisal" or cognitive coping and Freud's concept of "Ego-Defenses Coping Strategies" thus overlapping with a person's defense mechanisms.

Other form of coping strategies are:-

1. Positive Techniques (Adaptive or Constructive Coping)
2. Negative Technique (Maladaptive Coping or non coping)

Positive Techniques:- One positive coping strategy, anticipating a problem is known as proactive coping. Anticipation is when one reduce the stress of some difficult challenge by anticipating what it will be like and preparing for how one is going to cope with it. Two others are social coping, such as seeking social support from others and meaning focused coping, in which the person concentration on deriving meaning from the stressful experience. Yet another way of coping is avoiding thoughts or circumstances that cause stress. One of the most positive methods people use to cope with painful situations is humor. You feel things to the full but you master them by turning it all into pleasure and fun.

Negative Techniques:- while adaptive coping methods improve functioning, a maladaptive, coping techniques will just reduce symptoms while maintaining and strategies include dissociation, safety behavior etc. These coping strategies interfere with the person's ability to unlearn or break apart, the paired association between the situation and the associated anxiety symptoms. These are maladaptive stratgies as they serve to maintain the disorder.

Factors affecting Coping Strategies

a) **Personality Characteristics:-** In the transactional model of stress and its coping mechanisms (Lazarus & Folkman, 1984; Lazarus, 1991), stress is the transaction between the person and his environment so both the individual and the environmental factors are taken into account in the perception of stress. In this model, stress is defined as a combination of environmental demands and individual resources, with cognitive processes being a central concept. According to Lazarus (1984) the extent of the environmental demand and the amount of resources that an individual has available to cope with that demand affects the perception of stress, or its appraisal (Aldwin, 2007). Another model was presented by Bolger & Zuckerman (1995) in which a script to help systematize the study of the relationships between the stress processes and the coping strategies with personality dimensions is suggested. These authors state that personality may influence the stress process in three ways: first, in the exposure to the stressor, second, in the reactivity to the stressor, and finally, in both. Similarly, an individual's personality may influence the reactivity to the stressor, thus the resulting in the choice of the coping method, the degree of effectiveness of the chosen coping strategy, or both (Leandro & Castillo, 2010). Therefore, the influence of personality can be noted on the selection and/or modeling of stress producing situations and the kind of coping or interpretation of situation chosen (Vollrath, 2001). In this case, both models function as an attempt or adequate recourse to manage stressful events in order for it to become less stressful or threatening.

b) **Physiological Factors:-** Hormones also play a part in stress management. Cortisol, a stress hormone, was found to be elevated in males during stressful situations. In females, however, cortisol levels were decreased in stressful situations, and instead, an increase in limbic activity was discovered. Many

researchers believe that these results underlie the reasons why men administer a fight-or-flight reaction to stress; whereas, females have a tend-and-befriend reaction. The "fight-or-flight" response activates the sympathetic nervous system in the form of increased focus levels, adrenaline, and epinephrine. Conversely, the "tend-and-befriend" reaction refers to the tendency of women to protect their offspring and relatives. Although these two reactions support a genetic basis to differences in behavior, one should not assume that in general females cannot implement "fight-or-flight" behavior or that males cannot implement "tend-and-befriend" behavior.

c) **Age & Gender :-** Gender differences in coping strategies are the ways in which men and women differ in managing psychological stress. There is evidence that males often develop stress due to their careers, whereas females often encounter stress due to issues in interpersonal relationships. Early studies indicated that "there were gender differences in the sources of stressors, but gender differences in coping were relatively small after controlling for the source of stressors"; and more recent work has similarly revealed "small differences between women's and men's coping strategies when studying individuals in similar situations."

In general, such differences as exist indicate that women tend to employ emotion-focused coping and the "tend-and-befriend" response to stress, whereas men tend to use problem-focused coping and the "fight-or-flight" response, perhaps because societal standards encourage men to be more individualistic, while women are often expected to be interpersonal. An alternative explanation for the aforementioned differences involves genetic factors. The degree to which genetic factors and social conditioning influence behavior, is the subject of ongoing debate.

Differences in coping with mood disorders have been reported as well between the sexes. Li et.al. (2012), showed that girls with depression used more emotion-focused and ruminative coping than boys. In adult populations, studies by Austin,(2015) indicated that men were more likely to engage in distracting behaviors that dampened their depressive mood, whereas women were more likely to amplify their mood by ruminating. According to the literature review by Christensen and Kessing (2014) the general tendency was for men to distract themselves using active coping strategies, whereas women used strategies involving

the expression of emotion. It has been suggested that these factors of a cognitive nature could explain sex differences regarding depression and suicidal behaviors in adolescence. It might be that girls and boys tend to cope differently and that the coping styles adopted by girls put them at greater risk of experiencing depression and suicidal ideation. However, most studies have not taken sex into consideration. Further, few studies have been carried out with clinical adolescent populations, clinical features have not been defined clearly enough, and semi-structured diagnostic interviews have rarely been used.

Adolescents and younger adults used strategies that were outwardly aggressive and psychologically undifferentiated, indicating lower levels of impulse control and self-awareness. Women used more internalizing defenses than men and used coping strategies that flexibly integrated intra-and interpersonal aspects of conflict situations.

About 20 million children, about 4% of their population in India and higher than people living in Delhi, are orphan. Of them, parents of only 0.3% children have died and rest have been abandoned , against this background, we undertook a multisite study to advance our understanding of how coping skills, depression, and suicidal ideation are related among Orphans.

Orphan

Orphan Adolescents Nature and Definition:-

India has the highest population of children below the age of 18 --- 41% of the total population. Although over 4% of them are orphan , around 13% of them live with either of their parent. (National Family Health Survey 3, 2005-06).

The death of a parentis a risk factorfor the development of psychosocial issues in children. Infact , children who experience the death of a parent(s) are at twice the risk of suffering from a various psychological problems such as stress, anxiety, depression and suicidal ideation than children who have to live parents.

Orphaned adolescence, defined here as those who have lost one or both parents, are highly vulnerable, particularly those living outside of family care. In 2009, there were 163 million orphaned youth worldwide (USAID, 2010), and the number continues to increase due to global crises such as poverty, natural disasters, armed conflicts, and HIV/AIDS (UNICEF, 2009, 2011). Orphaned youth often engage in high risk

behaviors, have limited access to material and social resources, and lack adult support (Schenk et.al. 2010), because a child's emotional connection or attachment to an adult caregiver is critical for helping children cope with difficult circumstances and promoting long-term health, well-being, and resiliency (Betancourt & Khan, 2008, Bowlby, 1988; Cicchetti & Rogosch, 2009). Orphaned youth who lack a consistent adult caregiver will likely face developmental challenges. Compared with orphaned youth in family-based or foster care, this maybe even more difficult for orphaned youth in residential institutions with small numbers of staff and high staff turnover that limit opportunities to form relationships to caregivers (Johnson et.al. 2006). It is also likely that orphaned adolescence have high rates of childhood abuse and neglect experiences.

Today the concept of orphan is creating some degree of confusion with regard to defining who is an orphan, how many are there, what are their characteristics , where are they found, what are the trends in orphanhood and most importantly , what are the specific needs of orphans as distinct from other children in their communities. Orphan have existed in all societies and in all times. The pattern of their protection differed from society to society and from time to time and depended on the contemporary social attitudes towards them. Almost all societies had attached some stigma to the orphans. Orphans lost love and care.

“A child whoseparents are dead, having lost one or both parents or to bereave of parent(s) is called an orphan”. (Wagnalls & Funk 1973).

The term **Orphan** is defined as a child whose natural parents are absent or not alive. One legal definition used in the USA is someone bereft through "**death or disappearance of, abandonment or desertion by, or separation or loss from, both parents".**

Some children might not necessary witness effects of missing their parents immediately after their death. The emotional scars for bereaved children may not appear until later in life. In addition, children often experience death of their parents with a sense that it is their fault (Tschudin, 1997). Children like elders expresses feelings of fault and guilty after the death of their parents. Simmons (1992), Cohen (1994), and Heinzer (1995), demonstrated how children can and do survive bereavement and grow into well-adjusted adults. Both Simmons (1992) and Cohen (1994) also stressed the fact that

children need to be heard and given opportunities to express themselves, both at home and in school, when they have been bereaved. The relationship between parents and children is perhaps the most difficult of all relationship to understand. Children and parents cannot choose each other. Children are a part of their parents, but parents have to bring up children in such a way that they will eventually be independent of them and even to a degree reject the parents and their ways.

Children in the first years of life need to trust that the parent will be reliable , available and protective in order to develop a sense of physical and emotional integrity. When an attachment figure dies, the child loses intimate patterns of interaction that organize key developmental domains and constitute the building blocks of the child's sense of self. The loss produces intense long – lasting grief and represents a risk factor for healthy development, unless the child is supported in the protracted process of mourning.

Losing both parents can be a difficult task for both children and adults. It can lead to stress situations that can be very difficult to manage. Anxiety, Depression & Suicidal Ideation is usually greater task for the adolescent ; this is due to the child's limited ability , to test reality and to master anxiety (Furman, 1974). In some cases, however, the stress of the circumstances is so upsetting that even older children and some adults cannot cope with them adequately. Unmetered conflicts and anxieties may result in behavioral difficulties and symptoms at the time of the initial stress or at a later date when additional hardships have produced a cumulative effect on the person's personality (Furman, 1974). Children's responses to loss include cycles of intense distress, mourning, emotional withdrawal, anger, and emotional detachment that may recur at periodic intervals during a prolonged period of time (Lieberman et.al. 2003).

Problems of Orphans

Emotional Problems of orphans

Many of the orphaned children continue to experience emotional problems and little is being done in this area of emotional support. There are several reasons. First, there is a lack of adequate information on the nature and magnitude of the problem; secondly, there is a cultural belief that children do not have emotional problems and therefore there is a lack of attention from adults. Thirdly, since psychological problems are not always obvious, many adults in charge of orphans are not able to identify them.

However, even where the problem may have been identified, there is a lack of knowledge of how to handle it appropriately. In many cases children are punished for showing their negative emotions, thereby adding to their pain. In schools, there is an obvious lack of appropriate training of teachers in identifying psychological and social problems and therefore offering individual or group attention.

Social Problems of orphans

Death of parents introduces a major change in the life of a vulnerable child. This change may involve moving from a middle or upper-class urban home to a poor rural relative's home. It may involve separation from siblings, which is often done arbitrarily when orphaned children are divided among relatives without due considerations of their needs. It may mean the end of a child's opportunity for education because of lack of school fees. Those children who choose not to move or who may not have any other relative to go to, may be forced to live on their own, constituting child-headed families. All these changes can easily affect not only the physical, but also the psychological well-being of a vulnerable child. They can be very stressful as they pose new demands and constraints to children's life.

Psychological Problems of orphans

Anxiety, Depression, Hopelessness, Aggression, Suicidal ideation are the major problem of orphans. A number of studies suggested that depression , hopelessness & suicidal ideation were positively correlated with orphans and specially aged 14-20 years.

The Present Study is an attempt to manage Suicidal Ideation, Depression and Coping strategies among orphans through Group Therapy.

Group Therapy

Group Therapy Nature and Definition:- World Health Organization (2010) reported that Group Therapy might have a moderate effect on depression, The broader concept of **Group Therapy** can be taken to include any helping process that takes place in a group, including support groups, skills training groups (such as anger management, mindfulness, relaxation training or social skills training), and psycho-education groups. Group therapy is sometimes used alone, but it is also commonly integrated into a comprehensive treatment plan that also includes individual therapy and medication. There is clear evidence for the effectiveness of group therapy for depression: a meta-analysis of 48 studies showed an overall effect size of 1.03, which is clinically highly significant.

Group psychotherapy is a therapeutic approach in which a several people meet together under the guidance of a professionally trained therapist to help themselves and one another. The therapy has been widely used and has been a standard treatment option for over half a century.

Group psychotherapy helps people who would like to improve their ability to cope with problems. While in individual therapy the therapist meets with only the client, in group therapy the meeting is with a whole group and one or more therapists. Group therapy helps people learn about themselves and improve their interpersonal relationships.

Group therapy often consists of "talk" therapy, but may also include other therapeutic forms than such as expressive therapy and psychodrama. In group therapy the interactions between the members of the group and the therapists become the material with which the therapy is conducted, along with past experiences and experiences

outside the therapeutic group. Group therapy is not based on a single psychotherapeutic theory, but takes from many different therapies.

Studies have shown that group therapy has been as effective and, depending on the nature of the problem, sometimes even more effective than individual psychotherapy. During the group therapy's sessions each member works to express their own problems, feelings, ideas and reactions as freely and honestly as possible. Accordingly, the group members have an opportunity to learn not only about themselves and their own issues, but also the value of helping other group members.

Features of Group Therapy

Group therapy is very diverse. Psychologists with different theoretical training will use group therapy for many different types of psychological problems and concerns. Group therapy has been effective in addressing many types of problems including, but not limited to:

- ✔ Feelings of isolation
- ✔ Depression and anxiety
- ✔ Difficulties with interpersonal relationships
- ✔ Aging
- ✔ Medical illness and physical problems
- ✔ Addictive disorders
- ✔ Sexual problems
- ✔ Death and other losses
- ✔ Lifestyle issues within a traditional culture

There are two general ways of categorizing group therapy, by the time limits set on the duration of the group, and by the focus of the group and the way group members are selected.

First:- Group therapy can be offered on an ongoing basis or for a specific number of sessions. In an ongoing group, once the group starts, it continues indefinitely, with some group members completing treatment and leaving the group, and others joining along the way as openings are available in the group. Most of these groups have between six

and twelve members, plus the psychologist. There are some psychologists who have had a therapy group running for ten years or more.

Time limited groups are just as you would expect, limited in the amount of time they will run. This does not refer to the length of the group sessions, but to the number of sessions, or the number of weeks, the group will run. Time limited groups have a distinct beginning, middle and end, and usually do not add additional members after the first few sessions. Most time limited groups run for a minimum of eight to ten sessions, and many will run for up to twenty sessions. The length of these groups always depends on the purpose of the group, and the group membership. The psychologist running the group will structure it to run for the number of sessions necessary to accomplish the goals of the group.

Second:- The focus of the group is another way of categorizing group therapy. Some groups are more general in focus, with goals related to improving overall life satisfaction and effective life functioning, especially in the area of interpersonal relationships. These groups tend to be heterogeneous. This means that the group members will have varying backgrounds, and varying psychological issues that they bring to the treatment group. The psychologist will select group members who are likely to interact ways that will help all group members. These groups tend to be open-ended, because of the nature of the group therapy process. However, some of these groups are also time-limited, but they may run longer than most time-limited groups.

Other groups are "focused" or "topical" therapy groups. The group members tend to have similar problems because the group is focused on a specific topic or problem area. For example, there are therapy groups for Depression, Adult Children of Alcoholics, or Parents of ADHD Children. Some focus therapy groups are skill development groups, with an emphasis on learning new coping skills or changing maladaptive behavior. There are groups to help people develop Stress Management Skills, Parenting Skills, Assertiveness, and Anger Management Skills, among others. Focus therapy groups can be either open-ended or time-limited groups. The skill development groups (Stress Management, etc.) tend to be time limited and usually run between eight and sixteen sessions. The single-issue focus groups (Adult Children of Alcoholics, Women's or Men's Groups, etc.) may

Group Therapy vs. Individual Therapy

Group therapy is different from individual therapy in a number of ways, with the most obvious difference being the number of people in the room with the psychologist. In conducting research on the effectiveness of these therapy groups, psychologists discovered that the group experience benefited people in many ways that were not always addressed in individual psychotherapy. Likewise, it was also discovered that some people did not benefit from group therapy.

In group therapy, you learn that you are not alone in experiencing psychological adjustment problems, and you can experiment with trying to relate to people differently in a safe environment, with a psychologist present to assist as needed. Additionally, group therapy allows you to learn from the experiences of others with similar problems, and also allows you to better understand how people very different from yourself view the world and interact with people. Of course, there are many other differences between group therapy and individual psychotherapy. Many people are anxious about participating in group therapy, because they don't want other people (in addition to the psychologist) to know about their problems. Group members are told not to discuss information shared in the group with others, and usually the need for mutual confidentiality preserves the privacy of the information

Principles of Group Therapy

In The Theory and Practice of Group Psychotherapy, Irvin D. Yalom outlines the key therapeutic principles that have been derived from self-reports from individuals who have been involved in the group therapy process:-

- **The instillation of hope**:- The group contains members at different stages of the treatment process. Seeing people who are coping or recovering gives hope to those at the beginning of the process.
- **Universality:** Being part of a group of people who have the same experiences helps people see that what they are going through is universal and that they are not alone.
- **Imparting information**:- Group members are able to help each other by sharing information.

How does Group Work?

A group therapist appropriately selects people (usually 5 to 10) who would be helped by the group experience and who can be learning partners for one another. In meetings, people are encouraged to talk with each other in a spontaneous and honest fashion. A professionally trained therapist, who provides productive examination of the issues or concerns affecting the individuals and the group, guides the discussion.

Not every group is alike. There are a variety of styles that different groups use. For instance, some focus more on interpersonal development, where much of the learning actually comes from the interaction between members. Others address thoughts and behaviors, where the emphasis is on learning how to control negative thoughts, address phobias or relieve anxiety-inducing situations.

Group therapy focuses on interpersonal relationships and helps individuals learn how to get along better with other people under the guidance of a professional. Group psychotherapy also provides a support network for specific problems or challenges. The psychotherapy group is different from support and self-help groups in that it not only helps people cope with their problems, but also provides for change and growth. Support groups, which are generally led by professionals, help people cope with difficult situations at various times but are usually geared toward alleviating symptoms. Self-help

groups usually focus on a particular shared symptom or situation and are usually not led by a trained therapist.

Why is Group Therapy Useful?

Group Therapy is useful because it provides opportunities to learn with and from other people, to understand one's own patterns of thought and behavior and those of others, and to perceive how group members react to one another. We live and interact with people every day and often there are things that other people are experiencing or grappling with that can be beneficial to share with others. In group therapy, you learn that perhaps you're not as different as you think or that you're not alone. You'll meet and interact with people, and the whole group learns to work on shared problems -- one of the most beneficial aspects. The more you involve yourself in the group, the more you get out of it.

Types of Group Therapy

Group therapy were more effective for orphan adolescents because they having difficulties with interpersonal relationships they dealing with specific problems such as depression, anxiety, serious medical illness, loss, addictive disorders or behavioral problems. Group Therapy teaches socialization skills needed to help function with environments. On the basis of these evidences, In the present research researcher used two forms of Group Therapy :-

1. Progressive Muscular Relaxation technique (PMRT).
2. Self Management Training (SMT).

a) **Progressive Muscular Relaxation Technique:-**

Progressive relaxation is a technique for learning to monitor and control the state of muscular tension. It was developed by American physician **Edmund Jacobson** in the early **1920s**. Dr.

Jacobson wrote several books on the subject of Progressive Relaxation. A relaxation technique (also known as relaxation training) is a method, process, procedure, or activity that helps a person to relax; to attain a state of increased calmness; or otherwise reduce levels of anxiety, stress or anger. Relaxation techniques are often employed as one element of a wider stress management program and can decrease muscle tension, lower the blood pressure and slow heart and breath rates, among other health benefits. The technique involves learning to monitor tension in each specific muscle group in the body by deliberately inducing tension in each group. This tension is then released, with attention paid to the contrast between tension and relaxation. These learning sessions are not exercises or self-hypnotism.

A modification of the technique is "Biofeedback" in which one uses external measuring devices to indicate how successful one is in relaxing and then to use those techniques to relax without the help of external measuring devices.

ONE OF THE MOST simple and easily learned techniques for relaxation is Progressive Muscle Relaxation (PMR), a widely used procedure today that was originally developed by E. Jacobson in 1939. The PMR procedure teaches you to relax your muscles through a two-step process.

First you deliberately apply tension to certain muscle groups, and then you stop the tension and turn your attention to noticing how the muscles relax as the tension flows away. Through repetitive practice you quickly learn to recognize—and distinguish—the associated feelings of a tensed muscle and a completely relaxed muscle. With this simple knowledge, you can then induce physical muscular relaxation at the first signs of the tension that accompanies anxiety. And with physical relaxation comes mental calmness—in any situation.

There are two steps in the self-administered Progressive Muscle Relaxation procedure:

(a) Deliberately tensing muscle groups, and

(b) Releasing the induced tension.

Suggestions for Practice

- ✔ Always practice full PMR in a quiet place, alone, with no electronic distractions, not even background music.
- ✔ Remove your shoes and wear loose clothing.
- ✔ Avoid eating, smoking, or drinking. It's best to practice before meals rather than after, for the sake of your digestive processes.
- ✔ Never practice after using any intoxicants.
- ✔ Sit in a comfortable chair if possible. You may practice lying down, but this increases the likelihood of falling asleep.
- ✔ If you fall asleep, give yourself credit for the work you did up to the point of sleep.
- ✔ If you practice in bed at night, plan on falling asleep before you complete your cycle. Therefore, consider a practice session at night, in bed, to be in addition to your basic practice.
- ✔ When you finish a session, relax with your eyes closed for a few seconds, and then get up slowly. (Orthostatic hypotension—a sudden drop in blood pressure due to standing up quickly—can cause you to faint.) Some people like to count backwards from 5 to 1, timed to slow, deep breathing, and then say, "Eyes open. Supremely calm. Fully alert."

Muscle Groups

- ✔ Right foot; Right lower leg and foot; Entire right leg;
- ✔ Left foot; Left lower leg and foot; Entire left leg;
- ✔ Right hand; Right forearm and hand; Entire right arm
- ✔ Left hand; Left forearm and hand; Entire left arm
- ✔ Abdomen; Chest; Neck; Shoulders; Face

b) **Self Management:-** Self management is also a part of therapeutic treatment to reduce Anxiety & Depressive Symptoms. In education, and psychology, self-management refers to methods, skills, and strategies by which individuals can effectively direct their own activities toward the achievement of objectives, and includes goal setting, decision making, focusing, planning, scheduling, time management, task tracking, self-evaluation, self-intervention, self-development etc. also known as executive processes.In the 1980s and 90s, self-management

programs began to be developed for people with chronic conditions. Because chronic conditions are common, it became clear that self-management education and training for people was a very important part of being as healthy as possible.

Self Management skills have been defined as “the abilities for adaptive and positive behavior that enable individuals to deal effectively with the demands and challenges of everyday life” (WHO, 2014).

‘Adaptive’ means that a person is flexible in approach and is able to adjust in different circumstances. ‘Positive behavior’ implies that a person is forward looking and even in difficult situations, can find a ray of hope and opportunities to find solutions.Self management skills include psychosocial competencies and interpersonal skills that help people make informed decisions, solve problems, think critically and creatively, communicate effectively, build healthy relationships, empathize with others, and cope with managing their lives in a healthy and productive manner.

Essentially, there are two kinds of skills - those related to thinking termed as "thinking skills"; and skills related to dealing with others termed as "social skills". While thinking skills relate to reflection at a personal level, social skills include interpersonal skills and do not necessarily depend on logical thinking. It is the combination of these two types of skills that are needed for achieving assertive behavior and negotiating effectively.

“Emotional” can be perceived as a skill not only in making rational decisions but also in being able to make others agree to one's point of view. To do that, coming to terms first with oneself is important. Thus, self management is an important skill including managing/coping with feelings, emotions, stress and

resisting peer and family pressure. Young people as advocates need both thinking and social skills for consensus building and advocacy on issues of concern.

Education works on the premise that improving a person's knowledge will result in health behavior change. Unfortunately for all our efforts, this approach isn't particularly successful. Self-management on the other hand is based on improving a person's self-efficacy or self-confidence. Increased self-confidence is far more effective in leading to behavior change and improving a person's sense of well-being.

Subjects covered in the Self-Management Program include:

- Techniques to deal with problems such as stress and tension, anger, frustration, depression, suicidal thoughts, and isolation
- Appropriate exercise for maintaining and improving strength, flexibility, and endurance.
- Pacing activity and rest
- How to evaluate new treatments
- Motivation
- Improving a person's self-efficacy or self-confidence

Finally, we have come down to this conclusion that most of the problems in orphans is 'Depression, which is leads Suicidal Ideation'.(Bland et.al, 2008). Conclusion is that orphans suffered various psychological problems which are result of the unwelcome changes in later life such as insecurity, lack of affection, rejection, loneliness, depression, stress, aggression and suicidal ideation. Thus it is a dire need of the time to help by psychological counseling, group therapy, relaxation therapy and other alternative techniques or a combination of all of them to promote self efficacy management and well being.

For this reason, the aim of this research is to study the effect of a combination of Group therapy on Suicidal Ideation, Depression and Coping Strategies among orphans. So, first and the foremost thing which is very important is to get acquaint which have already been done in this area.


MY NAME IS
ORPHAN

CHAPTER- 2
Significance of Study

X is a 17 years an orphan adolescent. She lost her mother due to HIV at age of 3 years. Her mother was commercial sex worker as she was illiterate and lost her husband at very early age. Her mother wants to educate her daughter hence she approached to the orphanage which is located at Lucknow City for care, protection & education. She was very calm, quiet & innocent during her childhood. She was very sad about her that she doesn't even know that who are her parents and she suddenly started feeling alienated & isolated then gradually she started losing interest in her work. She now talks less & sits alone. Now she finds it difficult to wake up early in the morning to do her regular work. She feels unenthusiastic about her own life and of her being in this world, sometimes she feels its better she kill herself.

Story like X is all too familiar among Orphans. The orphans are the unfortunate dregs of a consumerist society. Alienated and ostracized by society, they are children who have never known the joys of childhood. Their innocent smiles will melt your heart, but only for a moment. As soon as you move on, you forget the momentary pang of pity which had arisen in your heart.

Human being is the most amazing and critical creation of nature. In the long journey from birth till death a person passes different aspects of life as well as the stages of ages. The most critical and crucial stage of life is "ADOLECENT". Adolescent is the stage which plays a very important role not only in the personality development of mankind but it is much more important for mental health and social identification. Many of the psychologists defined this age as the "**STAGE OF STORM STRESSES".** These stresses can be of many kinds, but the major stresses which found the teenagers are **"How they prove themselves?** Sometimes when they find them alone or in great pressure by the side of society, parents, teacher or peer-group and find them to unable the gain or achieve their goals or fulfill the wishes of other persons they became depressed and sometimes their thoughts may be converted to suicidal-ideation. To meet all the challenges, overcome depression & lead a normal and healthy life they need the support of their parents and family. They come back again to main stream by

their emotional and moral support and spend a normal and smooth life, but unfortunately ORPHAN has no option, no way and no mental or moral support.

The present study has tried to explore the Depression, Suicidal Ideation and Coping Strategies used by orphan adolescents and their management through intervention by Group Therapies. In the First Step, the study focused on the present level of Depression, Suicidal Ideation and Coping Strategies used by orphan adolescents and in the Second Step, they were treated by Progressive Muscular Relaxation Training and Self Management. This chapter provides the rational of the entire study which is presented below.

Why Suicidal Ideation, Depression & Coping Strategies?

During the last decade, Suicide is a serious health problem as it is currently the second leading cause of death for teenagers between the ages of 15 and 29 years **(WHO, 2015).** The majority of suicide attempts and suicide deaths happen among teens with depression. About 1% of all teens attempts suicide and about 1% of those suicide attempts results in death (that means about 1 in 10,000 teens dies from suicide). But for adolescents who have depressive illnesses, the rates of suicidal thinking and behavior are much higher. Most teens who have depression think about suicide, and between 15% and 30% of teens with serious depression who think about suicide go on to make a suicide attempt **(Statistical Survey of India, 2014).**

Depression, which is also a serious problem for adolescents, is the most significant biological and psychological risk factor for adolescent's suicide. Adolescence is a developmental period when youth begin to experience a desire for intimacy and increased responsibilities both socially and individually. A number of factors influence how adolescents navigate this period of change. Positive outcomes are more likely if adolescents engage in healthy activities, have adequate social support, and are connected with their families. However, the negotiation of developmental tasks in adolescents may also be quite challenging and difficult, leading to the onset of adolescent severe depression, and ultimately suicide.

Depression is one of the most common reasons adolescents seek treatment. Most of the time for most adolescent's depression is a passing mood. The sadness, loneliness, grief, and disappointment we all feel at times are normal reactions to some of the struggles of

life. With the right support, some resilience, an inner belief that there will be a brighter day, and decent coping skills, most teens can get through the depressed mood that happens occasionally when life throws them a curve ball. But sometimes depression doesn't lift after a few hours or a few days. Instead it lasts, and it can seem too heavy to bear. Several studies are suggested that adolescents are particularly prone to depression **(Singh et.al, 2016).** Adolescents may cycle through this cognitive, affective, and behavioral process numerous times, with each cycle leading to greater dysfunction and depressed mood. The coping process is particularly important in adolescence because the adolescent is confronted with many depressive episodes, life stressor and strain for the first time and has not yet developed a repertoire of coping responses from which to draw.

Once suicidal behavior occurs, it may sensitize adolescents to future suicide related thoughts and behavior. Suicidal behavior makes the suicidal cognitive schema more easily accessible and triggered in future stressful situations. **Joiner (2015),** suggests that suicide attempts habituate individuals to the experience of engaging in dangerous self injurious behavior. When combined with interpersonally related cognitive distortions, this habituation increases the possibility of future suicidal behavior. Once the taboo against suicide has been broken, it becomes easier to view suicide as a viable solution to life's problems. Poor Coping Strategies are responsible for depression and suicidal ideation. Coping Behavior is an important component of psychosocial competence, by which an adolescent is able to balance and manage the developmental tasks of this stage of the life cycle.

These problems are very crucial among adolescents. A major responsibility of psychologist is to help adolescents and specially orphans suffering from depression, suicidal ideation, behavioral problems and emotional disturbances. Orphan adolescents need help to cope up with their Suicidal Ideation and Depressive thoughts and for this it is important to first identify their present level and then try to reduce their Suicidal Ideation & Depression and do efforts for improving Coping Strategies.

Why Group Therapy?

Group therapy is a kind of psychological therapy that takes place with a group of people together rather than with an individual during a one to one session. While the term can

technically be applied to any kind of psychotherapy that is delivered to a group, it is most commonly associated with a specific therapy type that makes use of the group dynamic. Group therapy can be based on any theoretical approach, from cognitive-behavioral to humanistic. The present study has utilized two types of Group Therapy for intervention of Suicidal Ideation, Depression & Overall Coping Strategies. They are Progressive Muscular Relaxation and Self Management Training. Group Therapy was specially planned for the present study because the study has tried to deal with very vital issues (Depression, Suicidal Ideation & Coping Strategies) of Orphan Adolescents. So it was necessary to get them realize that they are not the only ones who are facing Suicidal Ideation and Depressive thoughts. This feeling of universality makes the respondents relaxed and more comfortable in handling their problems. Another point of using Group Therapy in the present study was that it took lesser time otherwise it would not been possible to counsel all the respondents in one to one sessions by two different Group Therapies.

The Group Therapies have some basic principals discussed below which increase the likelihood of success, so it was used in the present study.

The group Therapy according to Yalom (2008) has certain principals which help the group members to deal their negative thoughts more efficient in the presence of the people. These are:-

- ✔ **Altruism**: Group members share their strengths and experiences in order to help others. The experience of being able to give something to another person can lift the member's self-esteem and help develop more adaptive coping styles and interpersonal skills.
- ✔ **Catharsis:** The experience of relief from emotional distress through the free and uninhibited expression of emotion. When members tell their story to a supportive audience, they can obtain relief from chronic feelings of shame and guilt.
- ✔ **Cohesiveness:** It has been suggested that this is the primary therapeutic factor from which all others flow. Because all members share a common goal, there is a shared sense of belonging, acceptance, and validation.

- ✔ **Development of socializing techniques:** The group setting provides a safe and supportive environment for members to take risks by practicing interpersonal behavior and improving social skills.
- ✔ **Existential factors:** Group therapy helps members realize that they are responsible for their own lives, behaviors, and decisions.
- ✔ **Imparting information:** Group members report benefiting from sharing information about themselves and one another, such as personal experiences.
- ✔ **Imitative behavior:** One way in which group members can develop social skills is through a modeling process, observing and imitating the therapist and other group members.
- ✔ **Instillation of hope:** In a mixed group that has members at various stages of the treatment process, seeing members that are in later stages of coping or recovery may give hope to those in early stages.
- ✔ **Interpersonal learning:** Group members achieve a greater level of self-awareness through the process of interacting with others in the group, who give feedback on the member's behavior and impact on others.
- ✔ **Universality:** Sharing an experience with a group helps people see that they are not going through something alone. It also serves to remove a group member's sense of isolation, validate their experiences, and raise self-esteem.

So, keeping in view the above factors of group Therapy the present study has utilized Group Therapy for dealing with Suicidal Ideation and Depression & improving Coping Strategies.

Why Progressive Muscular Relaxation Training and Self Management Training?

The first Group Therapy which is used by researcher in this study is Progressive Muscular Relaxation Technique by Jacobson. Jacobson's Progressive Muscular Relaxation Technique, is a type of therapy that focuses on tightening and relaxing specific muscle groups in sequence. By concentrating on specific areas and tensing and then relaxing them, you can become more aware of your body and physical sensations.

Jacobson invented the technique in 1929 as a way to help his patients deal with anxiety. Jacobson (1929) felt that relaxing the muscles could relax the mind as well. General instructions for Jacobson's technique involve tightening one muscle group while keeping the rest of the body relaxed, and then releasing the tension.

Keeping this view, what has been said in the preceding paragraphs, Progressive Muscular Relaxation techniques have been considered as an adjunctive therapy for depression & Suicidal Ideation and can provide clients with self-maintenance coping skills to reduce depressive symptoms because this is a relaxation technique which involves the sequential tensing and releasing of major skeletal muscle groups with the aim of inducing relaxation.

The second Group Therapy is used in the present study in Self Management Training.

Theme of Self Management

YOU ARE RESPONSIBLE FOR EVERYTHING THAT HAPPENS IN YOUR LIFE. LEARN TO ACCEPT TOTAL RESPONSIBILITY FOR YOURSELF. IF YOU DO NOT MANAGE YOURSELF, THEN YOU ARE LETTING OTHERS HAVE CONTROL OF YOUR LIFE. THESE TIPS WILL HELP "YOU" MANAGE "YOU."

- ✔ Look at every new opportunity as an exciting and new-life experience.
- ✔ If you catch yourself worrying about an upcoming task, go ahead and do it now so it no longer is a distraction.
- ✔ Get into the habit of finishing what you start.
- ✔ Give up "waiting time" forever. Have something with you at all times to work on. For example: plan your day, work on a report, or read a page from your book.
- ✔ Be a professional who exhibits self-confidence and self-assurance in your potential to complete any task.
- ✔ Avoid worry. The majority of the things you worry about never occur.
- ✔ Agree with yourself in advance that you will have a good attitude toward the upcoming task.

Hence, the Self Management Training (used in present study) is some experiential and motivational learning selected along with the process used in psychotherapy. These practices direct a person in the path of happiness, compassion, selflessness, change negative thoughts into positive thinking (which help a person to cope with depression

and suicidal ideation) and improve positive coping skills. There are many Self Management techniques in tradition which could play an important role to make life better and which may have therapeutic effects. This Self Management Training is the processes of realization about the qualities of individual which differentiate him from others. Self Management Training given by the Self Management Training Manual (Gupta & Neharshi, 2015). This manual consist various experiential and motivational activities.

- **Self Awareness** is an experiential learning used in present study which is very close to Self Actualization (Concept of Maslow).
- **Effective Communication** skills are very important in present scenario, because it helps to improve teamwork, decision making and problem solving approaches.
- **Motivation** is also experiential learning which helps to remove the negative thoughts and creates positive thinking. It is a combination of humanistic treatment and enhance cognitive behavioral strategies designed to treat Depression, Suicidal Ideation & Coping strategies.
- **Games** this section based on simple ice-breaking activities. Games maintain the same enthusiasm in entire therapeutic sessions.

Using self-management support in primary care can have a positive effect on the care and health outcomes of orphans with depression, suicidal ideation and coping strategies.

Although, there are many other therapeutical techniques which are used in groups, but in the context of Orphans we find that they are more depressed and stressful other than peers, so Progressive Muscular Relaxation Training is much essential for them for better understanding and positive attitude, on the other hand Orphans not have proper guidance, love, care, affection and all those things which other can get by their families and parents, so the training of Self Management can make Orphan more adequate towards his/her life. This is the basic reason and thinking of conducting research on Self Management & Relaxation Training. In this study researcher used both type of therapies not only for treating Depression & Suicidal Ideation among orphans but also improvise their Coping Strategies. Although, both the therapies have different orientations, therefore this is also an attempt was made to explore the effectiveness of both the therapies among orphans.

Why Orphans Were Selected?

The term **ORPHAN** is defined as a child whose natural parents are absent or not alive. Today, even when a normal adolescent cannot adjust fully with the various demand of the life. Orphans are more susceptible to experience Suicidal Ideation and Depressive thoughts while facing and Coping with the daily hassles and demands of life because they are still at the mercy of others and remain a constant target of isolation and exploitation. The death of a parent is a risk factor for the development of psychosocial issues in adolescents; In fact, adolescents who experience the death of parents(s) are at twice the risk of suffering Depression, Suicidal Ideation and Coping Strategies than adolescents who have live parents. Keeping these facts in view the researcher felt the need for carrying out the interventional research among Orphans. In this study ORPHAN means adolescence living in the orphanage.

The phenomenon called "ORPHAN" is becoming increasingly complex and posing a threat to the existence of a civil society. In our country, there are countless children who still suffer from patronage without heart. These are the children who have not known the joy of childhood. Life full of hardship is always meant for them. Orphans have several personal, physical, social, psychological, moral and educational problems. Society can no longer ignore the orphan as they are the future of society. The stories of their deprived condition, social degradation, mocking, hunger, brutal exploitation and inhuman treatment, abuse by the adults on the street and the conditions in which they live will put any civilized society to shame.

The very existence of children whom nobody wants is an uncomfortable cold truth. They are considered to be the unwanted elements of family and society. Though the orphans were the original inhabitants of the land for centuries, they were not treated as citizens, and were kept in ignorance and thus neglected from the main stream of national life to very backward positions. They are relatively placed in a far worse position than anybody had been in preciously. Many of them are found starving. Usually, the orphans are unnaturally quite. He may often fall to respond, fail to gain weight as he should in spite of good food, sleep badly and show no initiative. Orphans have deep psycho-social disturbances. All the orphans show severe personality disturbance centering on an inability to give or receive affection. Their troubles included hopelessness, inferiority, aggressiveness, abstinence, selfishness, lack of marital status, excessive crying, food

difficulties, speech defects, over activity, fears, financial and educational problems. They have no social ancestry.

Why This Study in India?

India has the largest and fastest-growing population of Orphans. Out of 20 million children population of India 4% are orphans. The high proportion of abandoned children among orphans highlights the fact that poverty is a major reason behind the situation.

In the heart of every child, there is a desire of hunger for home. It is not only for food, place and sleep, but for safety and community also. Most importantly: for love. “There are 153 million children are orphaned worldwide, 145 million reside in less wealthy nations where their number has increased dramatically because of HIV/AIDS and other causes” (UNICEF, 2015). “India has the highest population of children below the age of 18 years- (41% of the total population). Although over 4% of them are orphan as per the study, around 13% live with a single parent. “The children of India are in high need as they consistently get lost in the continuously developing, and densely populated country”. “The major cause of children becoming orphans in India is illiteracy. Most of the people in India are unaware from sexually transmitted diseases. Many of the people, mostly labor class are involved in unprotected sexual activities” (Guru Nanak Devanath Asharam 2009). There are approximately 39 cities in Punjab, having orphan home for children, ranging from newborn to young adults. “In the recent week, there have been several cases of new born girls found abandoned in garbage dumps, park fields and canals. Taking the serious note, the Punjab government recently notified five orphan ages across the state that assured protection for abandoned babies”. Death of parents introduces a major change in the life of a child. This change may involve moving from a middle or upper-class urban home to a poor rural relative's home, separation from siblings, forced to live on own and constituting child-headed families. All these changes easily affect not only the physical but also the psychological well-being of a child.

According to UNICEF Report (2015), Uttar Pradesh, Bihar and West Bengal had more orphans than India’s richer states. Generally, the country's central and eastern regions were found to be worse affected than the north and the south. Combined, the states of Madhya Pradesh, Uttar Pradesh and Chhattisgarh are home to 6 million orphaned

children under the age of 18. By 2021, these states will probably be home to 7.1 million orphans. The eastern region, encompassing Bihar, Orissa, Jharkhand and West Bengal, now houses 5.2 million orphans, but will likely have 6 million by 2021. Each of these regions is home to more than double the number of orphans living in either the north or west regions.

An estimated 41 per cent of India's population is below that age of 18 – the largest child population in the world. 20 millions Orphans are frequently lack sufficient food, shelter, schooling and medical care and they suffered by depression, suicidal ideation and various psychological problems also. Most research work on Orphan concentrates on basic need. There is little available research, but increasing concern, regarding the interventional approach for dealing and suicidal ideation, depression and improving to coping strategies of orphans. Since each society has its own cultural background which may characterize a distinguishable nature of orphan's problems. The present study tries to explore the level of Suicidal Ideation, Depression and Coping strategies of Indian's orphans. In this context for effective intervention there should be opportunities for orphans to express their personal problems. It is also important to understand how they cope with their problems so that their need can be more accurately assessed.

Orphan children need more additional support and mental health services as compare to the normal children but in India there are insufficient resources, for this reason The Present study tries to explore the effectiveness of Progressive Muscular Relaxation Training and Self Management on Suicidal Ideation, Depression and Coping Strategies among Orphans. It is hoped that as a result, the concerned bodies, policy makers, schools, family, governmental and non-governmental organization will work together on orphans or strengthen the existing programs in order to increase the psychological well-being of orphan children. This research is important for those involved in therapy and in counseling to identify children who are at low level of psychological wellbeing and to develop and improve prevention and intervention methods for orphans. The finding of this study will also provide important direction for conducting further research in the areas of Depression, Suicidal Ideation and Coping strategies of orphans in Indian Scenario.

Orphans need more attention, more sympathy, more tolerance, more support & more guidance, to move smoothly with social context & practices. These orphans are also

want to be an active part of society, prove themselves & search the new horizons of happiness & relationship. These orphans do not want the mercy in our eyes but they want to shake hand with society and step towards for their bright & secure future, so **the present study is an attempt to manage Suicidal Ideation, Depression and Coping strategies among orphans through Self Management and Progressive Muscular Relaxation Training.**

CHAPTER-3
Methodology

The purpose of this chapter was to provide an overview of the plan and procedure of the study. The description of the methods and procedure used in the present study is made under the following heads:-

- Objectives
- Hypotheses
- Research Design
- Sample & Sampling
- Variables & Measures
- Procedure

✔ Objectives

The present study has tried to explore the level of Depression, Suicidal Ideation and Coping Strategies of orphan adolescents. For effective intervention, there should be opportunities for orphans to express their personal problems. This understanding would make us able to do something for the betterment of their psycho-physical health. Appropriate Intervention Programs can also be formulated. So the main objective of the present research was to explore the following:

1. To explore Suicidal Ideation, Depression and Coping Strategies in relation to Group Therapies (Progressive Muscular Relaxation Training and Self Management Training) among male & female orphans.
2. To explore Gender Differences on Suicidal Ideation, Depression and Coping Strategies among orphans.
3. To explore interactions of Group Therapy (PMRT and SMT), Conditions (Pre and Post) and Gender (Male and Female) on all the dimensions of Suicidal Ideation, Depression and on all the dimensions of Coping Strategies among male & female orphans.

✔ Hypotheses

Based on the review of literature and findings of the relevant studies, the following hypotheses were formulated:

H.1 The respondents with Progressive Muscular Relaxation Training and Self Management Training will differ significantly from each other on Suicidal Ideation.

H.2 The respondents with Progressive Muscular Relaxation Training and Self Management Training will differ significantly from each other on Depression.

H.3 The respondents with Progressive Muscular Relaxation Training and Self Management Training will differ significantly from each other on Overall Coping Strategies.

H.3.1 There will be a significant difference on Progressive Muscular Relaxation Training & Self Management Training on Problem Solving Coping Strategy among male and female orphans.

H.3.2 There will be a significant difference on Progressive Muscular Relaxation Training & Self Management Training on Cognitive Restructuring Coping Strategy among male and female orphans.

H.3.3 There will be a significant difference on Progressive Muscular Relaxation Training & Self Management Training on Express Emotion Coping Strategy among male and female orphans.

H.3.4 There will be a significant difference on Progressive Muscular Relaxation Training & Self Management Training on Social Support Coping Strategy among male and female orphans.

H.3.5 There will be a significant difference on Progressive Muscular Relaxation Training & Self Management Training on Problem Avoidance Coping Strategy among male and female orphans.

H.3.6 There will be a significant difference on Progressive Muscular Relaxation Training & Self Management Training on Wishful Thinking Coping Strategy among male and female orphans.

H.3.7 There will be a significant difference on Progressive Muscular Relaxation Training & Self Management Training on Self Criticism Coping Strategy among male and female orphans.

H.3.8 There will be a significant difference on Progressive Muscular Relaxation Training & Self Management Training on Social Withdrawal Coping Strategy among male and female orphans.

H.4 There will be a significant gender difference on Suicidal Ideation among male and female orphans.

H.5 There will be a significant gender difference on Depression among male and female orphans.

H.6 There will be a significant gender difference on Overall Coping Strategies among male and female orphans.

H.6.1 There will be a significant gender difference on Problem Solving Coping Strategies among male and female orphans.

H.6.2 There will be a significant gender difference on Cognitive Restructuring Coping Strategies among male and female Orphans.

H.6.3 There will be a significant gender difference on Express Emotion Coping Strategies among male and female orphans.

H.6.4 There will be a significant gender difference on Social Support Coping Strategies among male and female orphans.

H.6.5 There will be a significant gender difference on Problem Avoidance Coping Strategies among male and female orphans.

H.6.6 There will be a significant gender difference on Wishful Thinking Coping Strategies among male and female orphans.

H.6.7 There will be a significant gender difference on Self Criticism Coping Strategies among male and female orphans.

H.6.8 There will be a significant gender difference on Social Withdrawal Coping Strategies among male and female orphans.

H.7 There will be a significant difference in Pre-test and Post-test conditions of both the therapies (PMRT and SMT) on Suicidal Ideation among male and female orphans.

H.8 There will be a significant difference in Pre-test and Post-test conditions of both the therapies (PMRT and SMT) on Depression among male and female orphans.

H.9 There will be a significant difference in Pre-test and Post-test conditions of both the therapies (PMRT and SMT) on Overall Coping Strategies among male and female orphans.

H.9.1 There will be a significant difference in Pre-test and Post-test conditions of both the therapies (PMRT and SMT) Problem Solving Coping Strategy among male and female orphans.

H.9.2 There will be a significant difference in Pre-test and Post-test conditions of both the therapies (PMRT and SMT) on Cognitive Restructuring Coping Strategy among male and female orphans.

H.9.3 There will be a significant difference in Pre-test and Post-test conditions of both the therapies (PMRT and SMT) on Express Emotion Coping Strategy among male and female orphans.

H.9.4 There will be a significant difference in Pre-test and Post-test conditions of both the therapies (PMRT and SMT) on Social Support Coping Strategy among male and female orphans.

H.9.5 There will be a significant difference in Pre-test and Post-test conditions of both the therapies (PMRT and SMT) on Problem Avoidance Coping Strategy among male and female orphans.

H.9.6 There will be a significant difference in Pre-test and Post-test conditions of both the therapies (PMRT and SMT) on Wishful Thinking Coping Strategy among male and female orphans.

H.9.7 There will be a significant difference in Pre-test and Post-test conditions of both the therapies (PMRT and SMT) on Self Criticism Coping Strategy among male and female orphans.

H.9.8 There will be a significant difference in Pre-test and Post-test conditions scores of both the therapies (PMRT and SMT) on Social Withdrawal Coping Strategy among male and female orphans.

H.10 There will be a significant interaction between Gender (Male and Female) and Therapy (PMRT and SMT) on Suicidal Ideation.

H.11 There will be a significant interaction between Gender (Male and Female) and Therapy (PMRT and SMT) on Depression.

H.12 There will be a significant interaction between Gender (Male and Female) and Therapy (PMRT and SMT) on Overall Coping Strategies.

H.12.1 There will be a significant interaction between Gender (Male and Female) and Therapy (PMRT and SMT) on Problem Solving Coping Strategy.

H.12.2 There will be a significant interaction between Gender (Male and Female) and Therapy (PMRT and SMT) on Cognitive Restructuring Coping Strategy.

H.12.3 There will be a significant interaction between Gender (Male and Female) and Therapy (PMRT and SMT) on Social Support Coping Strategy.

H.12.4 There will be a significant interaction between Gender (Male and Female) and Therapy (PMRT and SMT) on Express Emotion Coping Strategy.

H.12.5 There will be a significant interaction between Gender (Male and Female) and Therapy (PMRT and SMT) on Problem Avoidance Coping Strategy.

H.12.6 There will be a significant interaction between Gender (Male and Female) and Therapy (PMRT and SMT) on Wishful Thinking Coping Strategy.

H.12.7 There will be a significant interaction between Gender (Male and Female) and Therapy (PMRT and SMT) on Self Criticism Coping Strategy.

H.12.8 There will be a significant interaction between Gender (Male and Female) and Therapy (PMRT and SMT) on Social Withdrawal Coping Strategy.

H.13 There will be a significant interaction between Conditions (Pre and Post) and Gender (Male and Female) on Suicidal Ideation.

H.14 There will be a significant interaction between Conditions (Pre and Post) and Gender (Male and Female) on Depression.

H.15 There will be a significant interaction between Conditions (Pre and Post) and Gender (Male and Female) on Overall Coping Strategies.

H.15.1 There will be a significant interaction between Conditions (Pre and Post) and Gender (Male and Female) on Problem Solving Coping Strategy.

H.15.2 There will be a significant interaction between Conditions (Pre and Post) and Gender (Male and Female) on Cognitive Restructuring Coping Strategy.

H.15.3 There will be a significant interaction between Conditions (Pre and Post) and Gender (Male and Female) on Social Support Coping Strategy.

H.15.4 There will be a significant interaction between Conditions (Pre and Post) and Gender (Male and Female) on Express Emotion Coping Strategy.

H.15.5 There will be a significant interaction between Conditions (Pre and Post) and Gender (Male and Female) on Problem Avoidance Coping Strategy.

H.15.6 There will be a significant interaction between Conditions (Pre and Post) and Gender (Male and Female) on Wishful Thinking Coping Strategy.

H.15.7 There will be a significant interaction between Conditions (Pre and Post) and Gender (Male and Female) on Self Criticism Coping Strategy.

H.15.8 There will be a significant interaction between Conditions (Pre and Post) and Gender (Male and Female) on Social Withdrawal Coping Strategy.

H.16 There will be a significant interaction between Conditions (Pre and Post) and Therapy (PMRT and SMT) on Suicidal Ideation among male and female orphans.

H.17 There will be a significant interaction between Conditions (Pre and Post) and Therapy (PMRT and SMT) on Depression among male and female orphans.

H.18 There will be a significant interaction between Conditions (Pre and Post) and Therapy (PMRT and SMT) on Overall Coping Strategies among male and female orphans.

H.18.1 There will be a significant interaction between Conditions (Pre and Post) and Therapy (PMRT and SMT) on Problem Solving Coping Strategy among male and female orphans.

H.18.2 There will be a significant interaction between Conditions (Pre and Post) and Therapy (PMRT and SMT) on Cognitive Restructuring Coping Strategy among male and female orphans.

H.18.3 There will be a significant interaction between Conditions (Pre and Post) and Therapy (PMRT and SMT) on Social Support Coping Strategy among male and female orphans.

H.18.4 There will be a significant interaction between Conditions (Pre and Post) and Therapy (PMRT and SMT) on Express Emotion Coping Strategy among male and female orphans.

H.18.5 There will be a significant interaction between Conditions (Pre and Post) and Therapy (PMRT and SMT) on Problem Avoidance Coping Strategy among male and female orphans.

H.18.6 There will be a significant interaction between Conditions (Pre and Post) and Therapy (PMRT and SMT) on Wishful Thinking Coping Strategy among male and female orphans.

H.18.7 There will be a significant interaction between Conditions (Pre and Post) and Therapy (PMRT and SMT) on Self Criticism Coping Strategy among male and female orphans.

H.18.8 There will be a significant interaction between Conditions (Pre and Post) and Therapy (PMRT and SMT) on Social Withdrawal Coping Strategy among male and female orphans.

H.19 There will be a significant interaction between Conditions (Pre and Post), Gender (Male and Female) and Therapy (PMRT and SMT) on Suicidal Ideation.

H.20 There will be a significant interaction between Conditions (Pre and Post), Gender (Male and Female) and Therapy (PMRT and SMT) on Depression.

H.21 There will be a significant interaction between Conditions (Pre and Post), Gender (Male and Female) and Therapy (PMRT and SMT) on Overall Coping Strategies.

H.21.1 There will be a significant interaction between Conditions (Pre and Post), Gender (Male and Female) and Therapy (PMRT and SMT) on Problem Solving Coping Strategy.

H.21.2 There will be a significant interaction between Conditions (Pre and Post), Gender (Male and Female) and Therapy (PMRT and SMT) on Cognitive Restructuring Coping Strategy.

H.21.3 There will be a significant interaction between Conditions (Pre and Post), Gender (Male and Female) and Therapy (PMRT and SMT) on Social Support Coping Strategy.

H.21.4 There will be a significant interaction between Conditions (Pre and Post), Gender (Male and Female) and Therapy (PMRT and SMT) on Express Emotion Coping Strategy.

H.21.5 There will be a significant interaction between Conditions (Pre and Post), Gender (Male and Female) and Therapy (PMRT and SMT) on Problem Avoidance Coping Strategy.

H.21.6 There will be a significant interaction between Conditions (Pre and Post), Gender (Male and Female) and Therapy (PMRT and SMT) on Wishful Thinking Coping Strategy.

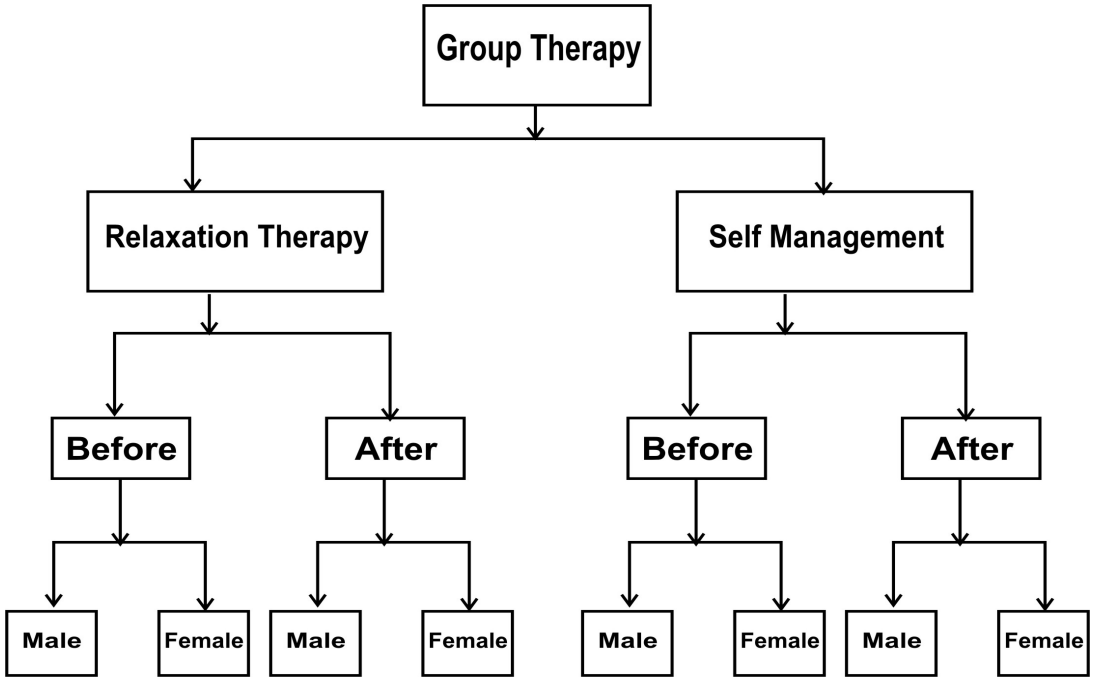
H.21.7 There will be a significant interaction between Conditions (Pre and Post), Gender (Male and Female) and Therapy (PMRT and SMT) on Self Criticism Coping Strategy.

H.21.8 There will be a significant interaction between Conditions (Pre and Post), Gender (Male and Female) and Therapy (PMRT and SMT) on Social Withdrawal Coping Strategy.

✔ Research Design

A 2×2×2 factorial mixed design was utilized to conceptualize the study and analyze the obtained data. Three classificatory variables were used to classify the respondents into eight categories. The first classificatory variable being Group Therapy which was divided into two types i.e. Progressive Muscular Relaxation Training & Self Management Training were matched on two conditions of therapy i.e. Pre & Post (the second classificatory variable). The third classificatory variable corresponding to the sex of the respondents led to two categories of Gender i.e. Males & Females. The classificatory scheme yielding the respondents is as follows:-

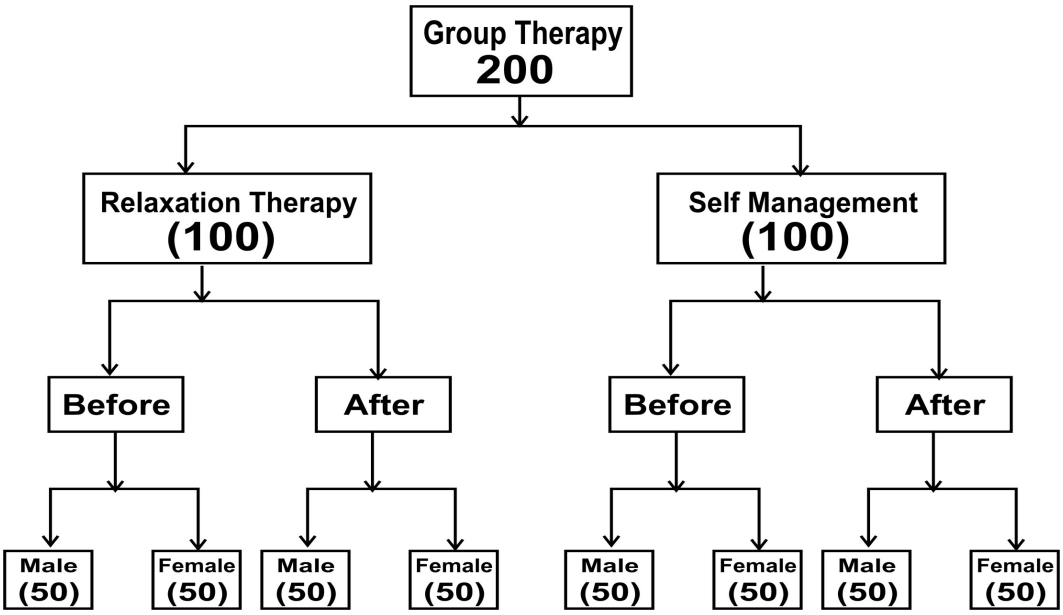
Figure 3.1 - The Distribution of the Respondents



✔ Sample & Sampling

The purpose of the present study was to see the impact of Progressive Muscular Relaxation Training & Self Management Training (Types of Group Therapy) on Suicidal Ideation, Depression and Coping Strategy among orphan adolescents. For this, different orphanages in Lucknow City were contacted and the respondents were selected using Quota Sampling. A total no of 200 respondents were selected through Quota Sampling from different orphanages of Lucknow City, U.P they were equally divided into males and females. They were further divided randomly into equal groups having different types of group therapy. The sample scheme is given as an under:-

Figure 3.2 - The Distribution of the Respondents



✔ Variables & Measures

Two sets of variables were used to design the present study. The first of these were the classificatory variables which were used to divide the sample into various subgroups and the second were the psychological variables. The present study has tried to study six variables, out of which Therapy, Conditions and Sex are classificatory variables while Suicidal Ideation, Depression and Coping Strategies are psychological variables.

INDEPENDENT VARIABLE –

1. Group Therapy
    a) Progressive Muscular Relaxation Training
    b) Self Management Training.
2. Conditions
    a) Before
    b) After
3. Sex
    c) Male
    d) Female

DEPENDENT VARIABLE

A. Suicidal Ideation
B. Depression
C. Coping Strategies

Tools Used

Having selected the sample, the next step was to choose suitable data gathering devices in order to accomplish the objectives of the study. The selection of the tools for particular study depends upon various considerations such as the objectives of the research, availability of suitable test, personal competence of the investigator, techniques of scoring and interpretation and the like. Taking all these factors into consideration a review of instruments needed for the study was made thus carefully selected and constructed tools & therapies have been used.

The following Tools & Therapies have been used in the Present Study:-

- The Modified Scale of Suicidal Ideation constructed by **Miller W.I, et al (1986)** was used to measure Suicidal Ideation of the orphan adolescents.
- Beck Depression Inventory (BDI) constructed by **Beck, et al (1961)** was used to measure Depression of the orphan adolescents.
- Coping Strategies Inventory constructed by **Tobin D.L (2001)** was used to measure Coping Strategies of the orphan adolescents.
- Progressive Muscular Relaxation Training by **Jacobson (1930)** was used to dispute the suicidal ideation and depression and tried to modify the coping strategies of the male & female orphans.
- Self Management Training Manual developed by **Gupta & Neharshi (2015)** was used to dispute the suicidal ideation and depression, of the respondents and tried to the their coping strategies of the male and female orphans.

✔ Description of Tools: –

1. The Modified Scale for Suicidal Ideation by Miller et.al (1986).

The Modified Scale for Suicide Ideation (MSSI; Miller, et.al 1986) is a revised version of the Scale for Suicide Ideation (SSI; Beck et al., 1979). The MSSI is an 18 item scale that contains 13 items from the SSI and 5 additional items. These new

items are related to intensity of ideation, courage and competence to attempt, and talk and writing about death. The MSSI was designed to be a semi-structured interview that could be administered by both professionals and paraprofessionals. The MSSI assesses suicide symptoms over the past year. The first 4 items have been designated as screening items to identify those individuals whose suicide ideation is severe enough to warrant the administration of the entire scale. Each item is rated on a 0-3 point scale and the ratings are summed to yield a total score ranging from 0 to 54. The MSSI takes approximately 10 minutes to administer. (*See Appendix A).*

Samples Studies

The MSSI has been administered to adults in psychiatric inpatient (Miller et al., 1986) and outpatient settings (Rudd et.al. 1996). The characteristics of the outpatient sample included 82% male, 61% White, 26% African American, and 11% Hispanic; the mean age was 22 years (SD = 2.3) (Rudd et al., 1996). The MSSI also has been given to college students who were seeking treatment for their suicidality (Clum & Yang, 1995). In this sample, 48% were men, 71% were White, 12% were Asian; the mean age was 20 years, ranging from 18 to 24 years. A French-Canadian self-report adaptation of the MSSI has also been developed for use with adolescents and adults (De Man et.al.1993).

Dimensionality

The MSSI has been found to consist of two to three factors. One study with college students found three factors: Suicidal Desire (9 items), Preparation for Attempt (6 items) and Perceived Capability of Making an Attempt (3 items) (Clum & Yang, 1995). A subsequent study with a larger sample size with psychiatric patients revealed two factors: Suicide Assessment 10 Suicidal Desire and Ideation (9 items) and Resolved Plans and Preparation (9 items) (Joiner et.al. 1997).

Scoring

MSSI consisted 18 questions was to assess the presence or absence of suicidal ideation and the degree of severity of suicidal ideas. If Item 1 & 2 is scored less than “2” and Item 3 & 4 are scored “0” then stop. Otherwise continue with full scale.

Table 3.3 - Total Score

1	Wish to die
2	Wish to live
3	Desire – active attempt
4	Desire – passive attempt
5	Duration of thoughts
6	Frequency
7	Intensity
8	Deterrent
9	Reasons
10	Method - specificity
11	Method – availability
12	Courage

Table 3.4 - Categories based on MSSI Total Score

0-8	Low Suicidal Ideation
9-20	Mild-Moderate Suicidal Ideation
21+	Severe Suicidal Ideation

Reliability

The MSSI has high internal consistency, with Cronbach alpha coefficients ranging from .87 (Clum & Yang, 1995) to .94 (Miller et al., 1986) and good item-total correlations (.41 to .83; Miller et al., 1986). The MSSI also has adequate test-retest reliability (r = .65) over a two-week period (Clum & Yang, 1995).

Concurrent Validity

Concurrent validity of the MSSI has been established. The MSSI has a moderately high correlation with the SSI (r = .74; Clum & Yang, 1995) and a moderate correlation with the suicide item from BDI (r = .60; Miller et al., 1986). Also, the

MSSI is significantly correlated with the total BDI (r = .34; Miller et al., 1986), the Zung Depression Scale (r = .45; Clum & Yang, 1995), and the Beck Hopelessness Scale (r = .46; Clum & Yang, 1995). In addition, patients who had multiple suicide attempts scored higher on the MSSI than patients who had attempted suicide only one time or suicidal patients who had not attempted suicide (Rudd, Joiner, & Rajab, 1997).

Evaluation

The MSSI is a modification of the SSI that includes the addition of several items that assess aspects of suicide thinking. Ratings of individual MSSI items use a 4-point scale instead of the 3-point scale. The reliability and concurrent validity of the MSSI has been established. MSSI items measure suicide ideation as defined by O'Carroll et al. (1996). This scale is less frequently used than the SSI and there is a little research on the predictive validity of this measure.

2. Beck Depression Inventory (BDI II) by Beck et.al (1961).

The Beck Depression Inventory (BDI), of Beck (1961), is a 21 questions multiple choice survey that is one of the most widely used instruments for measuring the severity of depression. Although Beck Depression Inventory (BDI: Beck., et.al., 1961) was originally designed to be "interviewer" assisted, the current practice appeared to allow respondents to self –administer the inventory by marking their responses on a paper and pencil type form of the BDI. Although the inventory was designed as a clinical instrument, in practice it was frequently employed in studies using college populations, dichotomizing students info "depressed" and "non-depressed" groups.

This scale was designed to measure the severity of depressive symptoms that the test taker is experiencing "at that moment." The original BDI included 21 items concerning different symptom domains, with four possible answers describing symptoms of increasing severity associated with a score from 0 to 3. It was later amended to BDI-IA, and after the publication of the DSM-IV, to the BDI-second edition (BDI-II). Four new items (agitation, worthlessness, concentration difficulty, and loss of energy) were added to make the BDI-II more reflective of DSM-IV criteria of MDD, and some BDI-IA items (i.e., weight loss, body image change,

work difficulty, and somatic preoccupation) were eliminated because they were considered less indicative of the overall severity of depression. Beck and colleagues also rewrote almost all other BDI-II items for clarity, and the time frame for ratings was extended from 1 to 2 weeks. The present study was utilized BDI-II for measuring Depression of the orphan adolescents.

Scoring

The scale consisted of 21 questions expressing how the subjects were feelings to the last week. Each set of four possible answer choices range in increasing intensity. When the test was scored, a value of 0-3 was assigned for each answer and then total score was compared to a key to determine the depression severity.

Table 3.1 - A list of 21 questions of BDI

Sadness	Crying	Concentration Difficulty
Guilt Feelings	Worthlessness	Loss of Pleasure
Suicidal Thoughts or Wishes	Changes in Appetite	Self Criticalness
Indecisiveness	Past Failure	Loss of Interest
Irritability	Self Dislike	Loss of Interest in Sex
Pessimism	Agitation	Tiredness & Fatigue
Punishment Feelings	Loss of Energy	Changes in Sleeping Pattern

The total score was calculated by adding up the score for each of the 21 questions. The highest possible total for the whole test was 63. The lowest possible score for the whole test was 0. Only one score per question was added i.e. (the highest rated if more than one was circled) (See Appendix B).

Table 3.2 Interpretation of the Scores of BDI

Classification	Total Score	Level of Depression

Low	1-10	Normal ups and Downs
	11-16	Mild Mood Disturbance
Moderate	17-20	Borderline Clinical Depression
	21-30	Moderate Depression
Significant	31-40	Severe Depression
	Over 40	Extreme Depression

Scores above 40 was significantly indicative of severely depressed persons, suggesting possible exaggerations of depression: possibly characteristics of histrionic or borderline personality disorders.

Self-rating scales, such as the BDI, offer some advantages over clinician-rated scales, as they may take less time, do not require trained personnel, and their administration and scoring process appear more standardized.

Reliability and Validity

Beck and colleagues in 1988 published a meta-analysis of all the psychometric studies on the BDI from 1961 to June 1986 and found a mean coefficient alpha of 0.86 for psychiatric subjects. In 1996, after the publication of the BDI-II, Beck and 2 Rating Scales for Depression 11 coworkers compared the BDI-II and BDI-IA scales in a sample of 140 psychiatric outpatients with various psychiatric disorders and found coefficient alpha for the BDI-II and the BDI-IA of 0.91 and 0.89, respectively .The BDI and the BDI-II were also tested on a larger sample (n = 500), where the BDI-II showed improved clinical sensitivity, with reliability (alpha = 0.92) higher than the BDI (alpha=0.86) (Psychological Corporation Website, 2003).

Test–Retest Reliability

With self-administered measures, assessing test–retest reliability may be complicated by the fact that the correlation coefficient may increase spuriously because of practice or because of memory effects. However, in a Spanish study, test–retest reliability for the BDI was between 0.65 and 0.72 .

Validity

The convergent validity with the BDI has been reported to be extremely variable, ranging between 0.27 and 0.89. Beck and colleagues showed that in psychiatric patients, the mean correlations of the BDI were 0.72 with clinical ratings and 0.73 with the HAM-D and 0.57–0.83 with the Zung SDS.

3. Coping Strategies Inventory by Tobin D.L (2001).

The coping Strategies Inventory is a 72 item self reported questionnaire designed to assess coping thoughts and behaviors in response to a specific stressor. The format of the CSI is adapted from the Lazarus "Ways of Coping" Questionnaire (Folkman & Lazarus, 1981). Persons are requested to describe, in a paragraph or two, the events and circumstances of a stressful episode. Users have the option of requesting this stressor in an open-ended manner, or of requesting a particular type of stressor (e.g., one that precipitates headaches or one that was ineffectively coped with). The norms reported in this manual were developed with an open-ended format. After describing a stressful situation, persons taking the CSI are asked to respond to 72 questions in a 5-item Likert format. Respondents indicate for each item the extent to which they performed that particular coping response in dealing with the previously described situation. *(See Appendix C).*

a. None
b. A Little
c. Some
d. Much
e. Very Much

Subscales of the Coping Strategies Inventory

There are a total of 14 subscales on the CSI including eight primary scales, four secondary scales, and two tertiary scales. Construction of the subscales was based on a review of the coping assessment literature (Tobin et.al. 1982) and the factor structure obtained using Wherry's hierarchical rotation (Wherry, 1984; Tobin et.al. 1985). Twenty-three of the items were taken from the "Ways of Coping" questionnaire

(Folkman & Lazarus, 1981) and 49 items were written to reflect the dimension of the hypothesized subscale.

Table 3.5- Primary Subscales

Problem Solving	**This subscale includes items referring to both behavioral and cognitive strategies designed to eliminate the source of stress by changing the stressful situation.**
Cognitive Restructuring	**This subscale includes cognitive strategies that alter the meaning of the stressful transaction as it is less threatening, is examined for its positive aspects, is viewed from a new perspectives, etc.**
Social Support	**This subscale includes items that refer to seeking emotional support from people, one's family, and one's friends.**
Express Emotions	**This subscale includes items referring to releasing and expressing emotions.**
Problem Avoidance	**This subscale includes items referring to the denial of problems and the avoidance of thoughts or action about the stressful events.**
Wishful Thinking	**This subscale refers to cognitive strategies that reflect an inability or reluctance to reframe or symbolically alter the situation. The items involve hoping and wishing that things could be better.**
Self Criticism	**This subscale includes items that reflect blaming oneself for the situation and criticizing oneself.**
Social Withdrawal	**This subscale items involves shutting oneself and one's feelings off from others.**

Higher Order Subscales

In Wherry's hierarchical factor analysis variance shared between primary factors is loaded onto more general or higher order, factors (Wherry, 1984). Wherry's method makes it relatively easy to interpret higher order factors because it provides correlations between higher order and the original variables. In this way one can avoid the problem of interpreting the loadings of factors on factors. Hierarchical

factor analysis of the CSI supports four secondary subscales and two tertiary subscales (Tobin, Holroyd, Reynolds, & Wigal, 1985).

Tables 3.6 - Secondary Subscales

Problem Focused Engagement	**This subscales includes both the Problem Solving and Cognitive Restructuring subscales. These subscales involve cognitive and behavioral strategies to change the situation or to change the meaning of the situation for the individual. These coping efforts are focused on the stressful situation itself.**
Emotion Focused Engagement	**This subscale includes both Social Support and Express Emotions. The items reflect open communication of feelings to others and increased social involvements, especially with family and friends. These coping efforts are focused on the individual's emotional reactions to the stressful situation.**
Problem Focused Disengagement	**This subscale includes both Problem Avoidance and Wishful Thinking. The items reflect denial, avoidance and an inability or reluctance to look at the situation differently. They reflect cognitive and behavioral strategies to avoid the situation.**
Emotion Focused Disengagement	**This subscale includes both Social Withdrawal and Self Criticism. The subscale involves shutting oneself and one's feelings off from others, and**

	criticizing or blaming oneself for what happened.

Table 3.7- Tertiary Subscales

Engagement	**This subscales includes Problem Solving, Cognitive Restructuring, Social Support and Express Emotions. The subscale reflects attempts by the individual to engage the individual in efforts to manage the stressful person/environment transaction. Through these coping strategies individuals engage in an active and ongoing negotiation with the stressful environment.**
Disengagement	**This subscale includes Problem Avoidance, Wishful Thinking, Social Withdrawal and Self Criticism. The subscale includes strategies that are likely to results in disengaging the individual from the person/environment transaction. Feelings are not shared with others, thoughts about situations are avoided, and behaviors that might change the situation are not initiated.**

Scoring

Current scoring practices for the CSI involve giving all items in particular subscale equal weights. To obtain the raw score for a subscale, simply add the item scores. Some people may prefer to look at secondary or tertiary scores rather than the individual coping strategies (Primary Scales). Investigators are advised to restrict hypothesis testing to only one factor level (Primary vs. Secondary vs. Tertiary) at a time.

Researchers who elect to enter all 14 subscales into the same multivariate analysis will face the problem of co linearity between the scales.

Tables 3.8 - Primary Subscales Items

Problem Solving	1, 9, 17, 25, 33, 41, 49, 57, 65
Cognitive Restructuring	2, 10, 18, 26, 34, 42, 50, 58, 66
Express Emotions	3, 11, 19, 27, 35, 43, 51, 59, 67
Social Support	4, 12, 20, 28, 36, 44, 52, 60, 68
Problem Avoidance	5, 13, 21, 29, 37, 45, 53, 61, 69
Wishful Thinking	6, 14, 22, 30, 38, 46, 54, 62, 70
Self Criticism	7, 15, 23, 31, 39, 47, 55, 63, 71
Social Withdrawal	8, 16, 24, 32, 40, 48, 56, 64, 72

To calculate the secondary and tertiary subscales scores, simply add together the primary scales that make up that subscale.

Table 3.9 - Secondary Subscales Items

Problem Focused Engagement	Problem Solving + Cognitive Restructuring
Emotion Focused Engagement	Express Emotions + Social Support
Problem Focused Disengagement	Problem Avoidance + Wishful Thinking
Emotion Focused Disengagement	Self Criticism + Social Withdrawal

Table 3.10 - Tertiary Subscales Items

Engagement	Problem Focused Engagement + Emotion Focused Engagement
Disengagement	Problem Focused Disengagement + Emotion Focused Disengagement

Reliability:-

Chronbach's alpha has been the most frequently reported coefficient of reliability for measures of coping process. The alpha coefficients for the CSI range from .71 to .94 (m_= 83). To data, no other measures of coping process have reported test-retest reliability. Repeated assessments of coping process present problems that are not encountered with trait measures. Natural stressors may change over time to the extent that new ways of coping are demanded. When faced with a chronic stressor, people may try alternative strategies over a period of time. Different stressors may require very different ways of coping.

Research with the CSI has demonstrated some of these difficulties. When persons are asked to complete the CSI at several assessments, many people complete the scale with reference to different stressors. Two week test-retest Pearson correlation coefficient reflect the effect of these different situations on coping; the correlations range from .39 to .61 (m_ = .73). Both alpha coefficient and the Pearson correlations indicate the scale reliably assesses coping process.

Validity:- Validity for the CSI has been assessed in a number of ways. Several studies with be briefly reviewed.

Factor Structure- The factor structure of the CSI (Tobin, Holroyed, Reynolds & Wigal, 1985) supports a hierarchical relationship between the proposed subscales. Using Wherry's (1984) hierarchical factor analysis program, eight primary factors, four secondary factors and two tertiary factors were obtained. Item loadings were representative of the hypothesized subscales previously presented.

Criterion Validity- The successful discrimination between symptomatic and normal samples from several different populations supports the CSI's clinical utility. The CSI has successfully differentiated depressed from non-depressed samples (Tobin et.al. 1985), headache from non-headache suffers (Holroyed et.al, 1983), and Neurotic vs. Normal samples (Tobin et.al. 1982).

Construct Validity- There have been several studies that have looked at the relationship of the CSI to instruments measuring other important constructs in the stress and coping literature. The CSI is particularly predictive of depressive symptoms for individuals who are under high levels of stress (Tobin et.al, 1982). Also, persons who have greater self-efficacy report doing more problem-solving and less problem avoidance than individuals with lower self efficacy (Tobin et al, 1984).

- **Description of Therapies : –**

4. Progressive Muscular Relaxation Training by Jacobson, 1930

Progressive muscle relaxation is a systematic technique for managing stress and achieving a deep state of relaxation. It was developed by Dr. Edmund Jacobson in the 1930 and adopted by Gupta & Neharshi, 2015. He discovered that a muscle could be relaxed by first tensing it for a few seconds and then releasing it, (Jacobson, 1930). Progressive Muscular Relaxation is a technique that involves tensing specific muscle groups and then relaxing them to create awareness of tension and relaxation. This PMRT program was developed to help individuals cope more effectively with stress and to remediate a number of specific problems associated with depressive situations. In order to achieve this goal individual and/or group programs are utilized as a means for teaching a reliable and valid method of relaxation. During these programs each individual is also assisted in making some changes in his internal reactions and behaviors toward particularly stressful situations. *(See Appendix E)*

✔ **Procedure:-** Progressive Muscular Relaxation Training Manual provides a systematic and active procedure to teaching relaxation. The program consists of one-hour sessions for the One month.

SUMMARY OF PROGRESSIVE MUSCLE RELAXATION

- ✔ Right hand and forearm.
- ✔ Shoulders.
- ✔ Shoulder blades/Back.
- ✔ Chest and stomach.
- ✔ Right upper leg.
- ✔ Right lower leg.
- ✔ Right foot.
- ✔ Left upper leg.
- ✔ Left lower leg.
- ✔ Left foot.
- ✔ Neck.
- ✔ Right upper arm.
- ✔ Left hand and forearm.
- ✔ Left upper arm.
- ✔ Forehead.
- ✔ Eyes and cheeks.
- ✔ Mouth and jaw.

Tense and Relax each Muscle Group as follows:

- ✔ **Forehead** - Wrinkle your forehead, try to make your eyebrows touch your hairline for five seconds. Relax
- ✔ **Eyes and nose** - Close your eyes as tightly as you can for five seconds. Relax.

- ✔ **Lips, cheeks and jaw** - Draw the centers of your mouth back and grimace for five seconds. Relax. Feel the warmth and calmness in your face.

- ✔ **Hands** - Extend your arms in front of you. Clench your fists tightly for five seconds. Relax. Feel the warmth and calmness in your hands.

- ✔ **Forearms** - Extend your arms out against an invisible wall and push forward with your hands for five seconds. Relax.

- ✔ **Upper arms** - Bend your elbows. Tense your biceps for five seconds. Relax. Feel the tension leave your arms.

- ✔ **Shoulders** - Shrug your shoulders up to your ears for five seconds. Relax.

- ✔ **Back** - Arch your back off the floor for five seconds. Relax. Feel the anxiety and tension disappearing.

- ✔ **Stomach** - Tighten your stomach muscles for five seconds. Relax.

- ✔ **Hips and buttocks** - Tighten your hip and buttock muscles for five seconds. Relax.

- ✔ **Thighs** - Tighten your thigh muscles by pressing your legs together as tightly as you can for five seconds. Relax.

- ✔ **Feet** - Bend your ankles toward your body as far as you can for five seconds. Relax.

- ✔ **Toes** - Curl your toes as tightly as you can for five seconds. Relax.

- ✔

5. Self Management Training Manual by – Gupta & Neharshi, (2015).

After consulting a relevant literature Self Management Training Manual was constructed. This Manual was given to many experts to evaluate whether it is a reliable tool or not for reducing Suicidal Ideation and Depression and for improving Coping Strategies. After making modifications and amendments as advised by experts only four types of group activities were included in the final training

manual. Then a pilot study was done on a sample of 10 respondents to check whether they understood all the activities or not. . After this pilot study the final manual constituted four types of activities.

Figure 3.3

Overview of Self Management Training Manual

Self Management Training (SMT) is a systematic intervention approach for evoking change in Depressive Orphans. It is based on principles of motivational psychology and is designed to produce rapid, internally motivated change. This training strategy does not attempt to guide and train the orphans, step by step, through recovery, but instead employs motivational strategies to mobilize the orphan's own change resources.

This Manual is for people working with orphans aged 14-17. The sessions need to be adapted to the needs and experience of the orphan adolescents. This manual is divided into 7 sections.

SECTION ONE

Section one explains the nature & significance of self management training (SMT) for orphan adolescents. Self Management Skills are important because they give a person more control & power to improve their lives.

There are four main pillars of this manual like wheels of the bus without which it can't move at all. These four pillars tells about the basic tasks to the individuals so that they may keep themselves healthy so theses four key aspects must be pumped up and must be in smooth running of the life. These four areas are:-

1. Information- Of the right kind, at the right time, taught in the right way.
2. Ability to Act- Knowing about and being able to avoid depressing situations.
3. Motivation- Motivation can come from outside or inside a person. Self Management Skills provide motivation and inspiration.
4. Environment- Knowing about surrounding.

SECTION TWO

Section two is based on conceptual framework. This section provides guidance on how to plan and develop a Self Management Program. It explains what is meant by active learning and also explains the time for each activity session. Most activities take approximately 1 hour since a lot of the activities are involved in Group Work & Discussions. The time may be fluctuated depending upon the efficiency & motivational level of the respondents. Whole activities depend upon the needs and requirements of the respondents. The therapist also tried her best to boost up the confidence level of the respondents in each and every activity so that they perform better & more importantly they perform more openly in front of the group.

SECTION THREE TO SIX

These sections involve on different type of activities. In all the activities, participants may be asked to think & talk about their ideas and feelings openly. They were also supposed to work either in groups or in pairs and in some activities the respondents

were supposed to either address the whole group or to draw something together. The role of the therapist was very crucial in all these activities. The therapist interacts personally or in pair depending upon the need of the participants.

Table 3.11

Section wise activities

Name of the Activities	
SECTION 3 ***Self Awareness***	
Mindfulness Breathing (Two Session)	Positive Strokes (Two Session)
SECTION 4 ***Effective Communication***	
Chain of Communication (Two Session)	Drawing Together (Two Session)
SECTION 5 ***Motivational Therapy***	
Motivational Stories (Two Session)	Audio-Video Technique (Two Session)
SECTION 6 ***Games***	
Name Game (One Session)	Knots Game (One Session)

Section Seven- This section provides glimpses of whole Intervention program.

This Self Management Training Manual can be adopted and used in different cultural contexts worldwide.

✔ Procedure

The Present study proceeded through the following steps:-

Step 1

✔ **Construction of the Training Manuals:-** Progressive Muscular Relaxation and Self Management Training Manual were prepared to help and guide orphan adolescents, suffering from Depression & Suicidal Ideation. These manuals were also used to enhance the positive coping strategies used by the respondents & to weaken the negative coping strategies used by them. These manuals provide active & experiential learning activities for teaching Progressive Muscular Relaxation & Self Management Skills to respondents.

Step 2

✔ **Selection of the Orphanage and Approach:-** A list of various Orphanages at Lucknow City was prepared and five orphanages were selected through Purposive Sampling. For administration of various tests & group therapies prior permission was taken from the authorities of the concerned orphanages. After completing all the formalities required by the authorities of the orphanages, the main task of data collection was started. For this purpose researcher visited to selected orphanages of Lucknow City.

Step 3

✔ **Selection of the Respondents:-**

For data collection, firstly the respondents who were eligible for the study were chosen. The description of which is given as under:-

Stage One – The orphanages contained many orphans of different age groups such as some were children, some were adults and adolescents. The researcher decided to select the adolescents group of the orphans (Age Range 14-17) for the purpose of the study. It was also decided to select only those adolescents who were residing at least from the last 5 years in the same orphanages rest of the orphans since they were not fulfilling the basic criteria of the study were not included.

Stage Two- A total numbers of 200 subjects (M=100, F=100, n=200) who fulfill all the eligibility criteria were selected through quota sampling.

Stage Three- The chosen respondents were further divided randomly into two equal groups for two types of group therapies. The one group who were decided to be give PMRT and the another for SMT.

Step 4

✔ **Data Collection:-**

Phase One- (Rapport Building)

General testing conditions were satisfactory. Sincere efforts were made to establish rapport with the subjects in order to elicit reliable and authentic information. Subjects were told that the information was being collected purely for research purpose. They were also assured that the information to be collected would remain strictly confidential and would be presented only in a form in which no person could be identified.

Phase Two- (Pre-Test)

All the selected participants of the study were given Beck Depression Inventory (BDI) by Beck et.al (1961), Modified Scale of Suicidal Ideation (MSSI) by Miller et.al (1986) and Coping Strategies Inventory by Tobin et.al (2001) for measuring their Depression, Suicidal Ideation and Coping Strategies respectively. The score of the scales were statistically analyzed. After analyzing the pretest data only those subjects who were having Mild to Moderate Depression (Score Range= 11-30) and Suicidal Ideation (Score Range= 9-20) were included in the study & rest of the subject were excluded from the study. If the respondents did not fulfill the requirements, they were still given the impression that they have supplied valuable information for the study and were thanked.

Phase Three- (Intervention Phase)

In third step the group which were decided to be treated by PMRT & SMT were given training for One month (thrice in a week) while in other days they were instructed to practice the technique by themselves.

Phase Four- (Post-Test)

After one month post test was conducted from the same subject Depression, Suicidal Ideation & Coping Strategies scales were again administered on the same respondents. Finally data were analyzed with the help of appropriate statistics.

✔ Statistical Analysis

After data collection obtained data of Pre test & Post test of PMRT & SMT were analyzed by using SPSS.20 software. The obtained data were analyzed using Means, SD, and ANOVAs.

CHAPTER- 4
Result and Data Analysis

Variables	*PMRT (N=100)*				*SMT (N=100)*			
	Male (N=50)		*Female (N=50)*		*Male (N=50)*		*Female (N=50)*	
	Mean	*SD*	*Mean*	*SD*	*Mean*	*SD*	*Mean*	*SD*
Depression	17.820	3.905	21.040	3.923	17.340	4.392	19.560	4.399
Suicidal- Ideation	12.820	3.062	14.240	2.959	12.980	3.396	12.980	2.889
Coping Strategies (Total)	158.900	15.360	173.560	13.509	157.800	17.512	173.440	14.669
Problem Solving	5.600	2.850	3.540	1.832	5.900	2.936	4.120	2.291
Cognitive Restructuring	8.840	3.419	7.820	2.960	8.780	3.893	7.900	3.477
Social Support	21.380	5.458	22.480	3.394	22.380	6.308	23.200	3.540
Express Emotions	17.980	3.744	27.060	5.056	17.880	5.294	28.000	5.119
Problem Avoidance	30.140	5.810	25.680	2.691	29.780	5.946	25.180	2.946
Wishful Thinking	22.500	4.718	27.040	4.223	21.420	5.515	26.000	4.150
Self Criticism	22.300	5.007	30.920	4.882	22.400	5.414	29.660	5.065
Social Withdrawal	30.160	7.547	29.020	3.941	29.260	6.663	29.380	4.389

Table 4.1: Mean & SD of Orphans (Males & Females) in Pre-conditions of Progressive Muscular Relaxation Training and Self Management Training on all the Dimensions of Depression, Suicidal Ideation and Coping Strategies

Table No 4.1 depicts Mean & SD of Preconditions on all variables under study i.e. Suicidal Ideation, Depression & all the dimensions of Coping strategies across Group Therapies i.e. Progressive Muscular Relaxation Training & Self Management Training among orphan males & females.

As it is clear from the inspection of Table 4.1 that Depression was found to be more in females in both Progressive Muscular Relaxation training (M = 17.82 & F= 21.04) & Self Management Training (M= 17.34 & F= 19.56) while Suicidal Ideation was found to be more among females in pre condition of PMRT (M= 12.82 & F= 14.24) while no gender difference was obtained in Suicidal Ideation in SMT (M= 12.98 & F= 12.98). Overall Coping strategies were found to be better in females in both the Group Therapies i.e. in PMRT (M= 158.90 & F= 173.56) & in SMT (M= 157.80 & F= 173.44).

Few dimensions of Coping Strategies were found to use more by males as compared to females in pre-conditions of both the therapies. Males were found to use more Problem Solving (M= 5.60 & F= 3.54,) Cognitive Restructuring (M= 8.84 & F= 7.82) & Problem Avoidance Coping

Strategies (M= 30.14 & F= 25.68) than females in pre condition of PMRT while in SMT Males were also found to use more Problem Solving Coping Strategy (M= 5.90 & F= 4.12) Cognitive Restructuring Coping Strategy (M= 8.78 & F= 7.90) & Problem Avoidance Coping Strategy (M= 29.78 & F= 25.18) than females.

While remaining dimensions of coping strategies i.e. Social Support, Express Emotions, Wishful Thinking & Self Criticism Coping Strategies were found to use more by females in Pre-Conditions of both the Therapies. Females were found to use more Social Support Coping Strategy (M= 21.38 & F= 27.06), Express Emotion Coping Strategy (M= 17.98 & F= 27.0), Wishful Thinking Coping Strategy (M= 22.50 & F= 27.04) and Self Criticism Coping Strategy (M= 22.30 & F= 30.92) than males in PMRT while in SMT the females also reported more Social Support Coping Strategy (M= 22.38 & F= 23.20), Express Emotion Coping Strategy (M= 17.88 & F= 28.00) and Wishful Thinking Coping Strategy (M= 21.42 & F= 26.00) & Self Criticism Coping Strategy (M= 22.40 & F= 29.66) than males.

Social Withdrawal Coping Strategy was found to use more by males in Pre-Condition of PMRT and no Gender difference was found in use of Social Withdrawal in Pre-Condition of SMT.

Variables	*PMRT (N=100)*				*SMT (N=100)*			
	Male (N=50)		*Female (N=50)*		*Male (N=50)*		*Female(N=50)*	
	Mean	*SD*	*Mean*	*SD*	*Mean*	*SD*	*Mean*	*SD*
Depression	11.360	3.556	12.040	2.603	9.740	3.630	10.700	2.279
Suicidal- Ideation	8.520	2.197	8.560	1.960	6.160	1.867	8.220	1.941
Coping Strategies (Total)	168.100	10.953	162.720	18.721	167.440	10.554	151.380	13.881
Problem Solving	26.660	4.084	14.560	2.643	27.180	4.039	17.900	4.678
Cognitive Restructuring	27.000	3.393	17.600	5.447	27.580	3.351	19.060	4.701
Social Support	27.580	3.258	21.100	5.567	27.460	4.042	22.680	6.277
Express Emotions	25.780	3.418	24.820	6.880	26.900	2.837	30.620	5.375
Problem Avoidance	16.440	3.418	20.200	4.571	13.580	2.596	16.380	4.295
Wishful Thinking	15.700	3.234	21.180	4.521	16.320	3.407	15.300	3.835
Self Criticism	13.620	3.843	22.420	4.647	14.920	3.636	15.500	4.820
Social Withdrawal	15.320	3.407	20.840	4.078	13.500	3.309	13.940	2.860

Table No 4.2 depicts Mean & SD of Post conditions on all variables under study i.e. Suicidal Ideation, Depression & all the dimensions of Coping strategies across Group Therapies i.e. Progressive Muscular Relaxation Training & Self Management Training among males & females.

As it is clear from the inspection of Table 4.2 that Depression was found to be more in females

in PMRT (M = 11.36 & F = 12.04) than SMT (M = 9.74 & F = 10.70) while Suicidal Ideation was found to be more in females in post conditions of both the therapies i.e. PMRT (M = 8.52 & F = 8.56) & SMT (M = 6.16 & F = 8.22). Overall Coping Strategies were found to be better in males in both the group therapies in PMRT (M = 168.10 & F = 162.72) while in SMT (M = 167.44 & F = 151.38).

Few dimensions of coping strategies were found to use more by males as compared to females in post conditions of both the therapies. Males were found to use more Problem Solving, Cognitive Restructuring & Social Support Coping Strategies in post conditions of PMRT. Problem solving coping strategy (M = 26.66 & F = 14.56), Cognitive restructuring coping strategy (M = 27.00 & F = 17.60) & Social support coping strategy (M = 27.58 & F = 21.10) than females while in SMT males were also found to use more Problem solving coping strategy (M = 27.18 & F = 17.90), Cognitive restructuring coping strategy (M = 27.58 & F = 19.06) & Social support coping strategy (M = 27.46 & F = 22.68) than females.

While remaining dimensions of coping strategies i.e. Problem Avoidance, Self Criticism and Social Withdrawal Coping Strategies were found to use more by females in post conditions of both the therapies. Females were found to use more Problem avoidance coping strategy (M = 16.44 & F = 20.20), Self criticism coping strategy (M = 13.62 & F = 22.42) & Social withdrawal coping strategy (M = 15.32 & F = 20.84) than males in PMRT while in SMT the females also reported more Problem avoidance coping strategy (M = 13.58 & F = 16.38), Self criticism coping strategy (M = 14.92 & F = 15.50) & Social withdrawal coping strategy (M = 13.50 & F = 13.94) than males.

Variables	*PMRT (N=100)*		*SMT (N=100)*	
	Mean	*SD*	*Mean*	*SD*
Depression	19.430	4.217	18.450	4.513
Suicidal- Ideation	13.530	3.080	12.980	3.137
Coping Strategies (Overall)	166.230	16.167	165.620	17.890
Problem Solving	4.570	2.599	5.010	2.769
Cognitive Restructuring	8.330	3.223	8.340	3.699
Social Support	21.930	4.556	22.790	5.106
Express Emotions	22.520	6.357	22.940	7.260
Problem Avoidance	27.910	5.031	27.480	5.210
Wishful Thinking	24.770	5.005	23.710	5.374
Self Criticism	26.610	6.555	26.030	6.365
Social Withdrawal	29.590	6.017	29.320	5.614

Table 4.3: Mean & SD of Orphans (Total Population N=200) in Pre-condition of Progressive Muscular Relaxation Training and Self- Management Training

Express Emotion coping strategy was found to use more by males in post condition of PMRT (M = 25.78 & F = 24.82) than females while in SMT Express emotion coping strategy was found to use more by females (M = 26.90 & F = 30.62). Wishful Thinking coping strategy was found to use more by females in post-condition of PMRT (M = 15.70 & F = 21.18) than males while in SMT Wishful Thinking coping strategy was found to use more by males (M = 16.32 & F = 15.30) than females.

Table No 4.3 depicts Mean & SD of orphans (total Population *N*=200) in Pre conditions of PMRT & SMT.

As far as dimensions of Coping Strategies are concerned problem solving coping strategy (PMRT = 4.57 & SMT = 5.01), & Social support coping strategy (PMRT = 21.93 & SMT = 22.79) were found to be more in pre condition of SMT while Wishful thinking coping strategy (PMRT = 24.77 & SMT = 23.71) was found to be more in Pre-Conditions of PMRT as compared to SMT. However, no difference were found on Cognitive restructuring coping strategy (PMRT = 8.33 & SMT = 8.34), Express emotions coping strategy (PMRT = 22.52 & SMT = 22.94), Problem avoidance coping strategy (PMRT = 27.91 & SMT = 27.48), Self criticism coping strategy (PMRT = 26.61 & SMT = 26.03) & Social withdrawal coping strategy (PMRT = 29.59 & SMT = 29.32) in pre conditions of PMRT and SMT.

Variables	*PMRT (N=100)*		*SMT (N=100)*	
	Mean	*SD*	*Mean*	*SD*
Depression	11.700	3.119	10.220	3.054
Suicidal- Ideation	8.540	2.072	7.190	2.159
Coping Strategies (Total)	165.410	15.497	159.410	14.685
Problem Solving	20.610	6.977	22.540	6.376
Cognitive Restructuring	22.300	6.534	23.320	5.901
Social Support	24.340	5.585	25.070	5.776
Express Emotions	25.300	5.426	28.760	4.667
Problem Avoidance	18.320	4.438	14.980	3.801
Wishful Thinking	18.440	4.783	15.810	3.645
Self Criticism	18.020	6.128	15.210	4.258
Social Withdrawal	18.080	4.655	13.720	3.085

Table 4.4: Mean & SD of Orphans (Total Population N=200) in Post-condition of Progressive Muscular Relaxation Training and Self- Management Training

As it is clear from the inspection of Table 4.3 that Depression (PMRT = 19.43 & SMT = 18.45), Suicidal Ideation (PMRT = 13.53 & SMT = 12.98) & Overall Coping Strategies (PMRT =

166.23 & SMT = 165.62), were found to be more in Pre-Conditions of PMRT as compared to SMT.

Table No 4.4 depicts Mean & SD of orphans (total Population *N*=200) in Post conditions of PMRT & SMT.

As it is clear from the inspection of Table 4.4 that Depression (PMRT = 11.70 & SMT = 10.22), Suicidal Ideation (PMRT = 8.54 & SMT = 7.19) & Overall Coping Strategies (PMRT = 165.41 & SMT = 159.41) were found to be less in Post-Conditions of SMT as compared to PMRT.

It is clear also clear from Table 4.4 that all the dimensions of coping strategies in post conditions of SMT was found to be more effective problem solving coping strategy (PMRT = 20.61 & SMT = 22.54), Cognitive restructuring coping strategy (PMRT = 22.30 & SMT = 23.32),Social support coping strategy (PMRT = 24.34 & SMT = 25.07), Express emotions coping strategy (PMRT = 25.30 & SMT = 28.76), Problem avoidance coping strategy (PMRT = 18.32 & SMT = 14.98), Wishful thinking coping strategy (PMRT = 18.44 & SMT = 15.81), Self criticism coping strategy (PMRT = 18.02 & SMT = 15.21), Social withdrawal coping strategy (PMRT = 18.08 & SMT = 13.72) than PMRT.

Variables	*PMRT (N=100)*		*SMT (N=100)*	
	Mean	*SD*	*Mean*	*SD*
Suicidal- Ideation	11.03	2.57	10.08	2.64
Depression	15.565	3.66	14.33	3.78
Coping Strategies (Total)	165.82	15.82	165.51	16.28
Problem Solving	12.59	4.78	13.77	4.56
Cognitive Restructuring	15.315	4.87	15.83	4.79
Social Support	23.13	5.06	23.93	5.43
Express Emotions	23.91	5.88	25.85	5.96
Problem Avoidance	23.11	4.73	21.23	4.50
Wishful Thinking	21.60	4.89	19.76	4.50
Self Criticism	22.31	6.33	20.62	5.30
Social Withdrawal	23.83	5.33	21.52	4.34

Table 4.5 (Part A): Mean and SD of Respondents in Group Therapy (PMRT N=100 and SMT N=100) on Suicidal Ideation, Depression, Coping Strategies and all the dimension of Coping Strategies

Variables	*Pre Condition (PMRT N=100) (SMT N=100)*		*Post Condition (PMRT N=100) (SMT N=100)*	
	Mean	*SD*	*Mean*	*SD*
Suicidal Ideation	18.94	3.07	10.96	1.98
Depression	13.25	4.15	7.86	2.98
Coping Strategies (Total)	165.92	15.4	162.41	13.52
Problem Solving	4.79	2.47	21.57	3.85
Cognitive Restructuring	8.33	3.43	22.81	4.21
Social Support	22.36	4.66	23.40	5.54
Express Emotions	22.73	4.79	27.03	4.62
Problem Avoidance	27.69	4.34	16.65	3.71
Wishful Thinking	24.24	4.64	17.12	3.74
Self Criticism	26.32	5.08	16.61	4.25
Social Withdrawal	29.45	5.63	15.9	3.40

Table 4.5 (Part B): Mean and SD of Respondents in Pre Condition (PMRT N=100 and SMT N=100) and Post Condition (PMRT N=100 and SMT N=100) of Group Therapies on Suicidal Ideation, Depression, Coping Strategies and all the dimension of Coping Strategies

	PMRT				*SMT*				*TOTAL*			
	Pre-test		*Post-test*		*Pre-test*		*Post-test*		*Pre-test*		*Post-test*	
	Mean	*SD*	*Mean*	*SD*	*Mean*	*SD*	*Mean*	*SD*	*Mean*	*SD*	*Mean*	*SD*
Male	12.82	3.06	8.52	2.19	12.98	3.39	6.16	1.86	12.90	3.22	7.34	2.02
Female	14.24	2.95	8.56	1.96	12.98	2.88	8.22	1.94	13.61	2.91	8.39	1.95
Total	13.53	3.01	8.54	2.07	12.98	3.13	7.19	1.90				

Table 4.6: Part A: ***Mean and SD on Suicidal Ideation among orphans***

Part A:- Table 4.6 (A) reveals the scores of Means & SDs for Suicidal Ideation across Gender (Male & Female), Conditions (Pre & Post) and Therapy (Progressive Muscular Relaxation Training & Self Management Training) among male & female orphans.

Table 4.6 Part (A) shows that the means of Progressive Muscular Relaxation Training for pre & post test conditions were respectively 13.53 & 8.54 while means of Self Management Training for pre & post test conditions were respectively 12.98 & 7.19. This shows that the mean score of Suicidal Ideation after Self Management Training was found to be less than Progressive Muscular Relaxation Training. The mean score of males for Suicidal Ideation Pretest & Posttest was 12.9 & 7.34 respectively while the mean scores of females for Suicidal Ideation 13.61 & 8.39 respectively. It shows that females had more Suicidal Ideation as

compared to males in both the Pre & Post test condition. Although the amount of Suicidal Ideation has been reduced in Posttest condition but it was still more than the Suicidal Ideation of males.

Source	*SS*	*Df*	*MS*	*F*	*Sig.*
Gender	77.440	1	77.440	7.785	.006
Therapy	90.250	1	90.250	9.073	.003
Gender × Therapy	2.250	1	2.250	.226	.635
Errors (*BS*)	1949.620	196	9.947		
Conditions	2905.210	1	2905.210	821.747	.000
Conditions × Gender	2.890	1	2.890	.817	.367
Conditions × Therapy	16.000	1	16.000	4.526	.035
Conditions × Gender × Therapy	73.960	1	73.960	20.920	.000
Error (*WS*) (Conditions)	692.940	196	3.535		

Table 4.6: Part B: ***Summary of ANOVA on Suicidal Ideation among orphans***

Part B:- Table 4.6 (B) reveals the result of Analysis of Variance for Suicidal Ideation across all the three variables under study. The main effect of Conditions, the main effect of Gender and the main effect of Therapy was found to be significant at 0.01 level. The interaction effect of Conditions (Pre & Post) & Therapy (Progressive Muscular Relaxation Training & Self Management Training) and the combined interaction effect of Condition (Pre & Post test), Gender (Male & Female) & Therapy (Progressive Muscular Relaxation Training & Self Management Training) was found to be significant at .01 level on Suicidal Ideation while the interaction effect of Conditions (Pre & Post) & Gender (Male & Female) and the interaction effect of Gender (Male & Female) & Therapy (Progressive Muscular Relaxation Training & Self Management Training) was found to the insignificant.

	PMRT				*SMT*				*TOTAL*			
	Pre-test		*Post-test*		*Pre-test*		*Post-test*		*Pre-test*		*Post-test*	
	Mean	*SD*	*Mean*	*SD*	*Mean*	*SD*	*Mean*	*SD*	*Mean*	*SD*	*Mean*	*SD*
Male	17.82	3.90	11.36	3.55	17.34	4.39	9.74	3.62	17.58	4.14	10.55	3.58
Female	21.04	3.92	12.04	2.60	19.56	4.39	10.70	2.27	20.3	4.15	11.37	2.43
Total	19.43	3.91	11.7	3.07	18.45	4.39	10.22	2.94				

Table 4.7: Part A: ***Mean and SD on Depression among orphans***

Source	*SS*	*Df*	*MS*	*F*	*Sig.*
Gender	313.290	1	313.290	14.410	.000
Therapy	151.290	1	151.290	6.959	.009
Gender × Therapy	3.240	1	3.240	.149	.700
Errors (*BS*)	4261.18	196	21.74		
Conditions	6368.040	1	6368.040	1266.860	.000
Conditions × Gender	90.250	1	90.250	17.954	.000
Conditions × Therapy	6.250	1	6.250	1.243	.266
Conditions × Gender × Therapy	10.240	1	10.240	2.037	.155
Error (*WS*) (Conditions)	985.220	196	5.027		

Table 4.7: Part B: ***Summary of ANOVA on Depression among orphans***

Part A:- Table 4.7 (A) reveals the scores of Means & SDs for Depression across Gender (Males & Female), Conditions (Pre & Post) and Therapy (Progressive Muscular Relaxation Training & Self Management Training) among male & female orphan.

Table 4.7: Part (A), shows that the means of Progressive Muscular Relaxation Training for pre & post test conditions were respectively 19.43 & 11.7 while means of Self Management Training for pre & post test conditions were respectively 18.45 & 10.22. This shows that the mean score of Depression after Self Management Training was found to be less than Progressive Muscular Relaxation Training.

It is also cleared the inspection of above table that the post test mean of males & females were respectively 10.55 & 11.37. This shows that the mean of females was greater than males.

Part B:- Table 4.7 (B) reveals the result of Analysis of Variance for Depression across all the three variables under study. The main effect of Conditions, the main effect of Gender and the main effect of Therapy was found to be significant at .01level. The interaction effect of Conditions (Pre & Post) & Gender (Male & Female) on depression was found to be significant at .01 level while the interaction effect of Conditions (Pre & Post) & Therapy (PMRT & SMT) and the interaction effect of Gender (Male & Female) & Therapy (PMRT & SMT) was found to the insignificant. The combined interaction effect of Condition (Pre & Post test), Gender (Male & Female) & Therapy (PMRT & SMT) was also found to be insignificant on Depression.

	PMRT				*SMT*				*TOTAL*			
	Pre-test		*Post-test*		*Pre-test*		*Post-test*		*Pre-test*		*Post-test*	
	Mean	*SD*	*Mean*	*SD*	*Mean*	*SD*	*Mean*	*SD*	*Mean*	*SD*	*Mean*	*SD*
Male	158.90	15.35	168.10	10.95	157.80	17.51	167.44	10.55	158.35	16.43	167.77	10.75
Female	173.56	13.50	162.72	18.72	173.44	14.66	151.38	13.88	173.5	16.11	157.05	16.3
Total	166.23	14.42	165.41	14.83	165.62	16.08	159.41	12.21				

Table 4.8: Part A: ***Mean and SD on Overall Coping Strategies among orphans***

Source	*SS*	*Df*	*MS*	*F*	*Sig.*
Gender	490.623	1	490.623	2.483	.117
Therapy	1092.303	1	1092.303	5.529	.020
Gender × Therapy	588.063	1	588.063	2.977	.086
Errors (*BS*)	38722.290	196	197.563		
Conditions	1235.522	1	1235.522	5.345	.022
Conditions × Gender	16731.423	1	16731.423	72.386	.000
Conditions × Therapy	726.303	1	726.303	3.142	.078
Conditions × Gender × Therapy	849.723	1	849.723	3.676	.077
Error (*WS*) (Conditions)	45303.530	196	231.140		

Table 4.8: Part B: ***Summary of ANOVA on Overall Coping Strategies among orphans***

Part A:- Table 4.8 (A) reveals the scores of Means & SDs for Overall Coping Strategies across Gender (Male & Female), Conditions (Pre & Post) and Therapy (Progressive Muscular Relaxation Training & Self- Management Training) among male & female orphans.

Table 4.8: Part (A), shows that the means of Progressive Muscular Relaxation Training for pre & post- test conditions were respectively 166.23 & 165.41 while means of Self- Management Training for pre & post -test conditions were respectively 165.62 & 159.41. This shows that the mean score of Overall Coping Strategies after Self -Management Training was found to be less than Progressive Muscular Relaxation Training.

It is also cleared the inspection of table that the post test mean of males & females were 167.77 & 157.05 respectively. This shows that the mean of males was found to be greater than females.

Part B:- Table 4.8 (B) reveals the result of Analysis of Variance for Overall Coping Strategies across all the three variables under study. The main effect of Conditions and the main effect of Therapy and the combined interaction effect of Condition (Pre & Post test), Gender (Male & Female) & Therapy (Progressive Muscular Relaxation Training & Self Management Training) was found to be significant at .05 level on Overall Coping Strategies while the main effect of Gender was found to the insignificant. The interaction effect of Conditions (Pre & Post) & Gender (Male & Female) was found to be significant at .01 level while the interaction effect of Gender (Male & Female) & Therapy (Progressive Muscular Relaxation Training & Self Management Training) and Conditions (Pre & Post) & Therapy (Progressive Muscular Relaxation Training & Self Management Training) was also found to the insignificant.

	PMRT				*SMT*				*TOTAL*			
	Pre-test		*Post-test*		*Pre-test*		*Post-test*		*Pre-test*		*Post-test*	
	Mean	*SD*	*Mean*	*SD*	*Mean*	*SD*	*Mean*	*SD*	*Mean*	*SD*	*Mean*	*SD*
Male	5.60	2.84	26.66	4.08	5.90	2.93	27.18	4.03	5.75	2.88	26.92	4.05
Female	3.54	1.83	14.56	2.64	4.12	2.29	17.90	4.67	3.83	2.06	16.23	3.65
Total	4.57	2.33	20.61	3.36	5.01	2.61	22.54	4.35				

Table 4.9: Part A: ***Mean and SD on Problem Solving coping Strategy among orphans***

Source	*SS*	*Df*	*MS*	*F*	*Sig.*
Gender	3975.303	1	3975.303	408.281	.000
Therapy	140.423	1	140.423	14.422	.000
Gender × Therapy	60.063	1	60.063	6.169	.014
Errors (*BS*)	1908.390	196	9.737		
Conditions	28173.623	1	28173.623	2334.669	.000
Conditions × Gender	1922.823	1	1922.823	159.339	.000
Conditions × Therapy	55.503	1	55.503	4.599	.033
Conditions × Gender × Therapy	40.323	1	40.323	3.341	.069
Error (*WS*) (Conditions)	2365.230	196	12.068		

Table 4.9: Part B: ***Summary of ANOVA on Problem Solving copy Strategy among orphans***

Part A:- Table 4.9 (A) reveals the scores of Means & SDs for Problem Solving Coping Strategy across Gender (Male & Female), Conditions (Pre & Post) and Therapy (Progressive Muscular Relaxation Training & Self Management Training) among male & female orphans.

Table 4.9: Part (A), shows that the means of Progressive Muscular Relaxation Training for pre & post test conditions were respectively 4.57 & 20.61 while means of Self Management Training for pre & post test conditions were respectively 5.01 & 22.54. This shows that the mean score of Problem Solving Coping Strategy after Self Management Training was found to be greater than Progressive Muscular Relaxation Training.

It was also cleared the inspection of table that the post test mean of males & females were 26.92 & 16.23 respectively. This shows that the mean of males was found to be greater as compared to females.

Part B:- Table 4.9 (B) reveals the result of Analysis of Variance for Problem Solving Coping Strategies across all the three variables under study. The main effect of Conditions the main effect of Gender (Male & Female) and the main effect of Therapy on Problem Solving Coping Strategy were found to be significant at .01 level. The interaction effect of Conditions (Pre & Post) & Gender (Male & Female) the interaction effect of Gender (Male & Female) & Therapy (Progressive Muscular relaxation Training & Self Management Training) and the interaction effect of Conditions (Pre & Post) & Therapy (Progressive Muscular relaxation Training & Self Management Training) and was found to be significant at .01& .05 level respectively. The

combined interaction effect of Condition (Pre & Post test), Gender (Male & Female) & Therapy (Progressive Muscular Relaxation Training & Self Management Training) was found to the insignificant on Problem Solving Coping Strategy.

	PMRT				*SMT*				*TOTAL*			
	Pre-test		*Post-test*		*Pre-test*		*Post-test*		*Pre-test*		*Post-test*	
	Mean	*SD*	*Mean*	*SD*	*Mean*	*SD*	*Mean*	*SD*	*Mean*	*SD*	*Mean*	*SD*
Male	8.84	3.41	27.00	3.39	8.78	3.89	27.58	3.35	8.81	3.65	27.29	3.37
Female	7.82	2.96	17.60	5.44	7.90	3.47	19.06	4.70	7.86	3.21	18.33	5.07
Total	8.33	3.18	22.30	4.41	8.34	3.68	23.32	4.02	---	---	---	---

Table 4.10: Part A: ***Mean and SD on Cognitive Restructuring CopyStrategy among orphans***

Source	*SS*	*Df*	*MS*	*F*	*Sig.*
Gender	2455.203	1	2455.203	153.736	.000
Therapy	26.523	1	26.523	1.661	.199
Gender × Therapy	6.503	1	6.503	.407	.524
Errors (*BS*)	3130.170	196	15.970		
Conditions	20952.562	1	20952.562	1436.910	.000
Conditions × Gender	1604.003	1	1604.003	110.001	.000
Conditions × Therapy	25.503	1	25.503	1.749	.188
Conditions × Gender × Therapy	3.423	1	3.423	.235	.629
Error (*WS*) (Conditions)	2858.010	196	14.582		

Table 4.10: Part B: ***Summary of ANOVA on Cognitive Restructuring Coping Strategy among orphans***

Part A:- Table 4.10 (A) reveals the scores of Means & SDs for Cognitive Restructuring Coping Strategy across Gender (Male & Female), Conditions (Pre & Post) and Therapy (Progressive Muscular Relaxation Training & Self Management Training) among male & female orphans.

Table 4.10 Part (A), shows that the means of Progressive Muscular Relaxation Training for pre & post test conditions were respectively 8.33 & 22.30 while means of Self Management Training for pre & post test conditions were respectively 8.34 & 23.32. This shows that the mean of Self Management Training was found to be greater as compared to Progressive Muscular Relaxation Training.

It was also cleared the inspection of the table that the post test mean of males & females were 27.29 & 18.33 respectively. This shows that the mean of males was found to be greater as compared to females.

Part B:- Table 4.10 (B) reveals the result of Analysis of Variance for Problem Solving Coping Strategy across all the three variables under study. The main effect of Conditions (Pre & Post) and the main effect of Gender (Male & Female) were found to be significant at .01 level. The interaction effect of Conditions (Pre & Post) & Gender (Male & Female) was found to be significant at .01 level while the interaction effect of Gender (Male & Female) & Therapy (Progressive Muscular relaxation Training & Self Management Training) and the interaction effect of Conditions (Pre & Post) & Therapy (Progressive Muscular relaxation Training & Self Management Training) was found to the insignificant. The main effect of Therapy and the combined interaction effect of Condition (Pre & Post test), Gender (Male & Female) & Therapy (Progressive Muscular Relaxation Training & Self Management Training) were found to the insignificant on Cognitive Restructuring Coping Strategy.

	PMRT				*SMT*				*TOTAL*			
	Pre-test		*Post-test*		*Pre-test*		*Post-test*		*Pre-test*		*Post-test*	
	Mean	*SD*	*Mean*	*SD*	*Mean*	*SD*	*Mean*	*SD*	*Mean*	*SD*	*Mean*	*SD*
Male	21.38	5.45	22.38	6.30	22.38	6.30	27.46	4.04	21.88	5.87	24.92	5.17
Female	22.48	3.39	21.10	5.56	23.20	3.53	22.68	6.27	22.84	3.46	22.15	5.91
Total	21.74	4.42	21.93	5.93	22.79	4.91	25.07	5.15				

Table 4.11: Part A: ***Mean and SD on Social Support Coping Strategy among orphans***

Source	*SS*	*Df*	*MS*	*F*	*Sig.*
Gender	545.223	1	545.223	23.960	.000
Therapy	63.203	1	63.203	2.777	.097
Gender × Therapy	12.602	1	12.602	.554	.458
Errors (*BS*)	4460.050	196	22.755		
Conditions	549.903	1	549.903	22.005	.000
Conditions × Gender	1085.703	1	1085.703	43.446	.000
Conditions × Therapy	.422	1	.422	.017	.897
Conditions × Gender × Therapy	24.503	1	24.503	.981	.323
Error (*WS*) (Conditions)	4897.970	196	24.990		

Table 4.11: Part B: ***Summary of ANOVA on Social Support Coping Strategy among orphans***

Part A:- Table 4.11 (A) reveals the scores of Means & SDs for Social Support Coping Strategy across Gender (Male & Female), Conditions (Pre & Post) and Therapy (Progressive Muscular Relaxation Training & Self Management Training) among male & female orphans.

Table 4.11: Part (A), shows that the means of Progressive Muscular Relaxation Training for pre & post test conditions were respectively 21.93 & 21.74 while means of Self Management Training for pre & post test conditions were respectively 22.79 & 25.07. This shows that the mean of Self Management Training was found to be greater than Progressive Muscular Relaxation Training.

It was also revealed that the post test means of males & females were 24.92 & 22.15 respectively. This shows that the mean of males was higher than females on Social Support Coping Strategy.

Part B:- Table 4.11 (B) reveals the result of Analysis of Variance for Social Support Coping Strategy across all the three variables under study. The main effect of Conditions (Pre & Post) and the main effect of Gender (Male & Female) were found to be significant at .01 level on Social Support Coping Strategy. The interaction effect of Conditions (Pre & Post) & Gender (Male & Female) was found to be significant at .01 level. The main effect of Therapy was not

found to be significant while the interaction effect of Gender (Male & Female) & Therapy (Progressive Muscular relaxation Training & Self Management Training) and the interaction effect of Conditions (Pre & Post) & Therapy (Progressive Muscular relaxation Training & Self Management Training) was found to the insignificant The combined interaction effect of Condition (Pre & Post test), Gender (Male & Female) & Therapy (Progressive Muscular Relaxation Training & Self Management Training) was found to the insignificant on Social Support Coping Strategy.

	PMRT				*SMT*				*TOTAL*			
	Pre-test		*Post-test*		*Pre-test*		*Post-test*		*Pre-test*		*Post-test*	
	Mean	*SD*	*Mean*	*SD*	*Mean*	*SD*	*Mean*	*SD*	*Mean*	*SD*	*Mean*	*SD*
Male	17.98	3.74	25.78	3.41	17.88	5.29	26.90	2.83	17.93	4.51	26.34	3.12
Female	27.06	5.05	24.82	6.87	28.00	5.11	30.62	5.37	27.53	5.08	27.72	6.12
Total	22.52	4.39	25.3	5.14	22.94	5.2	28.76	4.1				

Table 4.12: Part A: ***Mean and SD on Express Emotions Coping Strategy among orphans***

Source	*SS*	*df*	*MS*	*F*	*Sig.*
Gender	3014.010	1	3014.010	107.597	.000
Therapy	376.360	1	376.360	13.436	.000
Gender × Therapy	204.490	1	204.490	7.300	.007
Errors (*BS*)	5490.380	196	28.012		
Conditions	1849.000	1	1849.000	95.146	.000
Conditions × Gender	1689.210	1	1689.210	86.923	.000
Conditions × Therapy	231.040	1	231.040	11.889	.001
Conditions × Gender × Therapy	82.810	1	82.810	4.261	.040
Error (*WS*) (Conditions)	3808.940	196	19.433		

Table 4.12: Part B: ***Summary of ANOVA on Express Emotions Coping Strategy among orphans***

Part A:- Table 4.12 (A) reveals the scores of Means & SDs for Express Emotion Coping Strategy across Gender (Male & Female), Conditions (Pre & Post) and Therapy (Progressive Muscular Relaxation Training & Self Management Training) among male & female orphans.

Table 4.12: Part (A), shows that the means of Progressive Muscular Relaxation Training for pre & post test conditions were respectively 22.52 & 25.3 while means of Self Management Training for pre & post test conditions were respectively 22.94 & 28.76. This shows that the mean of Self Management Training was found to be greater than Progressive Muscular Relaxation Training.

It was cleared the inspection of the table that the mean of post test of male was 26.34 and the post test of female was 27.72. This shows that the mean of male was less than females on Express Emotion Coping Strategy.

Part B:- Table 4.12 (B) reveals the result of Analysis of Variance for Express Emotion Coping Strategy across all the three variables under study. The main effect of Conditions (Pre & Post) and the main effect of Gender (Male & Female) and the main effect of Therapy (Progressive Muscular relaxation Training & Self Management Training) were found to be significant at .01 level. The interaction effect of Conditions (Pre & Post) & Gender (Male & Female) the interaction effect of Conditions (Pre & Post) & Therapy (Progressive Muscular relaxation Training & Self Management Training) and the interaction effect of Gender (Male & Female) & Therapy (Progressive Muscular relaxation Training & Self Management Training) were found to be significant at .01 level. The combined interaction effect of Condition (Pre & Post test), Gender (Male & Female) & Therapy (Progressive Muscular Relaxation Training & Self Management Training) was found to be significant at .01 level on Express Emotion Coping Strategy.

	PMRT				*SMT*				*TOTAL*			
	Pre-test		*Post-test*		*Pre-test*		*Post-test*		*Pre-test*		*Post-test*	
	Mean	*SD*	*Mean*	*SD*	*Mean*	*SD*	*Mean*	*SD*	*Mean*	*SD*	*Mean*	*SD*
Male	30.14	5.80	16.44	3.41	29.78	5.94	13.58	2.59	29.96	5.87	15.01	3.00
Female	25.68	2.69	20.20	4.57	25.18	2.94	16.38	4.29	25.43	2.81	18.29	4.40
Total	27.91	4.24	18.32	3.99	27.48	4.44	14.98	3.44				

Table 4.13: Part A: ***Mean & SD on Problem Avoidance Coping Strategy among orphans***

Source	*SS*	*Df*	*MS*	*F*	*Sig.*
Gender	39.063	1	39.063	2.345	.127
Therapy	355.323	1	355.323	21.333	.000
Gender × Therapy	7.563	1	7.563	0.454	.501
Errors (*BS*)	3264.650	196	16.656		
Conditions	12199.203	1	12199.203	640.603	.000
Conditions × Gender	1524.903	1	1524.903	80.075	.000
Conditions × Therapy	211.703	1	211.703	11.117	.001
Conditions × Gender × Therapy	4.203	1	4.203	0.221	.639
Error (*WS*) (Conditions)	3732.490	196	19.043		

Table 4.13: Part B: ***Summary of ANOVA on Problem Avoidance Coping Strategy among orphans***

Part A:- Table 4.13 (A) reveals the scores of Means & SDs for Problem Avoidance Coping Strategy across Gender (Male & Female), Conditions (Pre & Post) and Therapy (Progressive Muscular Relaxation Training & Self Management Training) among orphan adolescents.

Table 4.13: Part (A), shows that the means of Progressive Muscular Relaxation Training for pre & post test conditions were respectively 22.52 & 25.3 while means of Self Management Training for pre & post test conditions were respectively 22.94 & 28.76. This shows that the mean of Self Management Training was found to be greater than Progressive Muscular Relaxation Training.

It was cleared the inspection of the table that the mean of post test of male was 26.34 and the post test of female was 27.72. This shows that the mean of male was less than females on Problem Avoidance Coping Strategy.

Part B:- Table 4.13 (B) reveals the result of Analysis of Variance for Problem Avoidance Coping Strategy across all the three variables under study. The main effect of Conditions (Pre & Post) and the main effect of Gender (Male & Female) and the main effect of Therapy (Progressive Muscular relaxation Training & Self Management Training) were found to be significant at .01 level. The interaction effect of Conditions (Pre & Post) & Gender (Male & Female) the interaction effect of Conditions (Pre & Post) & Therapy (Progressive Muscular relaxation Training & Self Management Training) and the interaction effect of Gender (Male

& Female) & Therapy (Progressive Muscular relaxation Training & Self Management Training) were found to be significant at .01 level. The combined interaction effect of Condition (Pre & Post test), Gender (Male & Female) & Therapy (Progressive Muscular Relaxation Training & Self Management Training) was found to be significant at .01 level on Problem Avoidance Coping Strategy.

	PMRT				*SMT*				*TOTAL*			
	Pre-test		*Post-test*		*Pre-test*		*Post-test*		*Pre-test*		*Post-test*	
	Mean	*SD*	*Mean*	*SD*	*Mean*	*SD*	*Mean*	*SD*	*Mean*	*SD*	*Mean*	*SD*
Male	22.5	4.71	15.70	3.23	21.42	5.51	16.32	3.40	21.96	5.11	16.01	3.31
Female	27.04	4.22	21.18	4.52	26.00	4.15	15.30	3.83	26.52	4.18	18.24	4.17
Total	24.77	4.46	18.44	3.87	23.71	4.83	15.81	3.61	----	----	----	----

Table 4.14: Part A: ***Mean & SD on Wishful Thinking Coping Strategy among orphans***

Source	*SS*	*Df*	*MS*	*F*	*Sig.*
Gender	1152.603	1	1152.603	69.482	.000
Therapy	340.403	1	340.403	20.520	.000
Gender × Therapy	260.823	1	260.823	15.723	.000
Errors (*BS*)	3251.350	196	16.589		
Conditions	5062.322	1	5062.322	257.684	.000
Conditions × Gender	135.722	1	135.722	6.909	.009
Conditions × Therapy	61.623	1	61.623	3.137	.078
Conditions × Gender × Therapy	267.323	1	267.323	13.607	.000
Error (*WS*) (Conditions)	3850.510	196	19.645		

Table 4.14: Part B: ***Summary of ANOVA on Wishful Thinking Coping Strategy among orphans***

Part A:- Table 4.14 (A) reveals the scores of Means & SDs for Wishful Thinking Coping Strategy across Gender (Male & Female), Conditions (Pre & Post) and Therapy (Progressive Muscular Relaxation Training & Self Management Training) among male & female orphan.

Table 4.14: Part (A), shows that the means of Progressive Muscular Relaxation Training for pre & post test conditions were respectively 24.77 & 18.44 respectively while means of Self Management Training for pre & post test conditions were respectively 23.71 & 15.81 respectively. This shows that the mean of Self Management Training was less than Progressive Muscular Relaxation Training.

It was cleared the inspection of the table that the mean of post test of male was 16.01 and the post test of female was 18.24. This shows that the mean of male was less than females on Wishful Thinking Coping Strategy.

Part B:- Table 4.14 (B) reveals the result of Analysis of Variance for Wishful Thinking Coping Strategy across all the three variables under study. The main effect of Conditions (Pre & Post) and the main effect of Gender (Male & Female) and the main effect of Therapy (Progressive Muscular relaxation Training & Self Management Training) were found to be significant at .01 level. The interaction effect of Conditions (Pre & Post) & Gender (Male & Female) the interaction effect of & Gender (Male & Female) & Therapy (Progressive Muscular relaxation Training & Self Management Training) were found to be significant at .01 level while The combined interaction effect of Condition (Pre & Post test), Gender (Male & Female) & Therapy (Progressive Muscular Relaxation Training & Self Management Training) was found to be significant at .01 level. The interaction effect of Conditions (Pre & Post) & Therapy (Progressive Muscular relaxation Training & Self Management Training) was found to be insignificant on Wishful Thinking Coping Strategy.

	PMRT				*SMT*				*TOTAL*			
	Pre-test		*Post-test*		*Pre-test*		*Post-test*		*Pre-test*		*Post-test*	
	Mean	*SD*	*Mean*	*SD*	*Mean*	*SD*	*Mean*	*SD*	*Mean*	*SD*	*Mean*	*SD*
Male	22.30	5.00	13.62	3.84	22.40	5.41	14.92	3.63	22.35	5.20	14.27	3.73
Female	30.92	4.88	22.4	4.64	29.66	5.06	15.50	4.82	30.29	4.97	18.95	4.73
Total	26.61	4.94	18.01	4.24	26.03	5.23	15.21	4.22	----	----	----	----

Table 4.15: Part A: ***Mean & SD on Self Criticism Coping Strategy among orphans***

Source	*SS*	*Df*	*MS*	*F*	*Sig.*
Gender	3987.923	1	3987.923	181.217	.000
Therapy	287.302	1	287.302	13.055	.000
Gender × Therapy	573.603	1	573.603	26.065	.000
Errors (*BS*)	4313.250	196	22.006		
Conditions	9418.702	1	9418.702	424.941	.000
Conditions × Gender	264.063	1	264.063	11.914	.001
Conditions × Therapy	124.322	1	124.322	5.609	.019
Conditions × Gender × Therapy	294.123	1	294.123	13.27	.000
Error (*WS*) (Conditions)	4344.290	196	22.165		

Table 4.15: Part B: ***Summary of ANOVA on Self Criticism Coping Strategy among orphans***

Part A:- Table 4.15 (A) reveals the scores of Means & SDs for Self Criticism Coping strategy across Gender (Male & Female), Conditions (Pre & Post) and Therapy (Progressive Muscular Relaxation Training & Self Management Training) among male & female orphans.

Table 4.15: Part (A), shows that the means of Progressive Muscular Relaxation Training for pre & post test conditions were respectively 26.61 & 18.01 while means of Self Management Training for pre & post test conditions were respectively 26.03 & 15.21. This shows that the mean of Self Management Training was less than Progressive Muscular Relaxation Training.

It was cleared the inspection of the table that the mean of post test of male was 14.21 and the post test of female was 18.95. This indicates that the mean of male was less than females on Self Criticism Coping Strategy.

Part B:- Table 4.15 (B) reveals the result of Analysis of Variance for Self Criticism Coping Strategy across all the three variables under study. The main effect of Conditions (Pre & Post), the main effect of Gender (Male & Female) and the main effect of Therapy (Progressive Muscular relaxation Training & Self Management Training) were found to be significant at .01 level. The interaction effect of Conditions (Pre & Post) & Gender (Male & Female) the

interaction effect of Conditions (Pre & Post) & Therapy (Progressive Muscular relaxation Training & Self Management Training) and the interaction effect of Gender (Male & Female) & Therapy (Progressive Muscular relaxation Training & Self Management Training) were found to be significant at .01 level. The combined interaction effect of Condition (Pre & Post test), Gender (Male & Female) & Therapy (Progressive Muscular Relaxation Training & Self Management Training) was also found to be significant at .01 level on Self Criticism Coping Strategy.

	PMRT				*SMT*				*TOTAL*			
	Pre-test		*Post-test*		*Pre-test*		*Post-test*		*Pre-test*		*Post-test*	
	Mean	*SD*	*Mean*	*SD*	*Mean*	*SD*	*Mean*	*SD*	*Mean*	*SD*	*Mean*	*SD*
Male	30.16	7.54	15.32	3.40	29.26	6.66	13.50	3.30	29.71	7.10	14.41	3.35
Female	29.02	3.94	20.84	4.07	29.38	4.38	13.94	2.86	29.20	4.16	17.39	3.46
Total	29.59	5.74	18.08	3.73	29.32	5.52	13.72	3.08				

Table 4.16: Part A: ***Mean & SD on Social Withdrawal Coping Strategy among orphans***

Source	*SS*	*df*	*MS*	*F*	*Sig.*
Gender	152.523	1	152.523	6.258	.013
Therapy	535.923	1	535.923	21.988	.000
Gender × Therapy	91.203	1	91.203	3.742	.055
Errors (*BS*)	4777.250	196	24.374		
Conditions	18373.803	1	18373.803	854.439	.000
Conditions × Gender	304.503	1	304.503	14.160	.000
Conditions × Therapy	418.203	1	418.203	19.448	.000
Conditions × Gender × Therapy	251.223	1	251.223	11.683	.001 .001
Error (*WS*) (Conditions)	4214.770	196	21.504		

Table 4.16: Part B: ***Summary of ANOVA on Social Withdrawal Coping Strategy among orphans***

Part A:- Table 4.16 (A) reveals the scores of Means & SDs for Social Withdrawal Coping Strategy across Gender (Male & Female), Conditions (Pre & Post) and Therapy (Progressive Muscular Relaxation Training & Self Management Training) among male & female orphans.

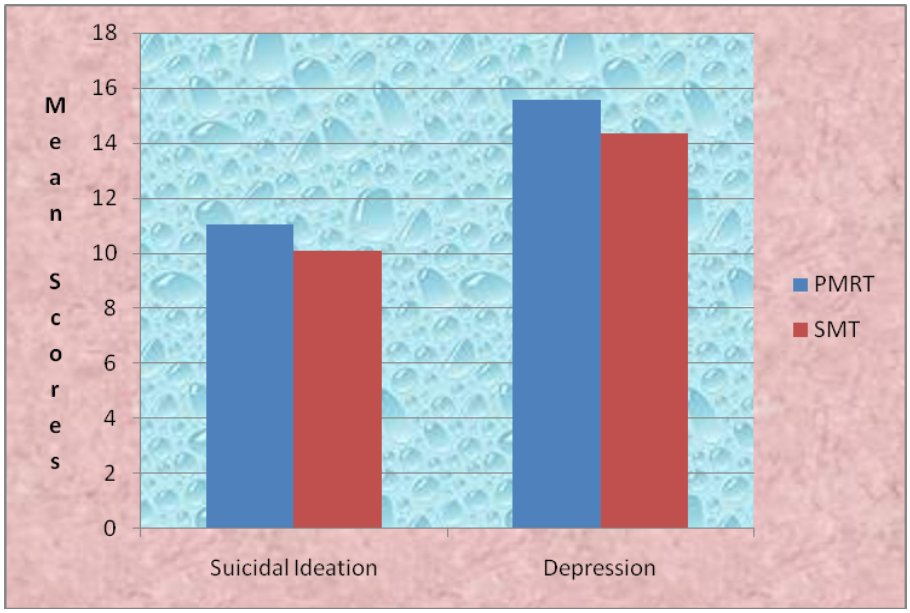
Table 4.16: Part (A), shows that the means of Progressive Muscular Relaxation Training for pre & post test conditions were respectively 26.61 & 18.01 while means of Self Management Training for pre & post test conditions were respectively 26.03 & 15.21. This shows that the mean of Self Management Training was less than Progressive Muscular Relaxation Training.

It was cleared the inspection of the table that the mean of post test of male was 14.21 and the post test of female was 18.95. This indicates that the mean of male was less than females on Social Withdrawal Coping Strategy.

Part B:- Table 4.16 (B) reveals the result of Analysis of Variance for Social Withdrawal Coping Strategy across all the three variables under study. The main effect of Conditions (Pre & Post), the main effect of Gender (Male & Female) and the main effect of Therapy (Progressive Muscular relaxation Training & Self Management Training) were found to be significant at .01 level. The interaction effect of Conditions (Pre & Post) & Gender (Male & Female) the interaction effect of Conditions (Pre & Post) & Therapy (Progressive Muscular relaxation Training & Self Management Training) and the interaction effect of Gender (Male & Female) & Therapy (Progressive Muscular relaxation Training & Self Management Training) were found to be significant at .01 level. The combined interaction effect of Condition (Pre & Post test), Gender (Male & Female) & Therapy (Progressive Muscular Relaxation Training & Self Management Training) was also found to be significant at .01 level on Social Withdrawal Coping Strategy.

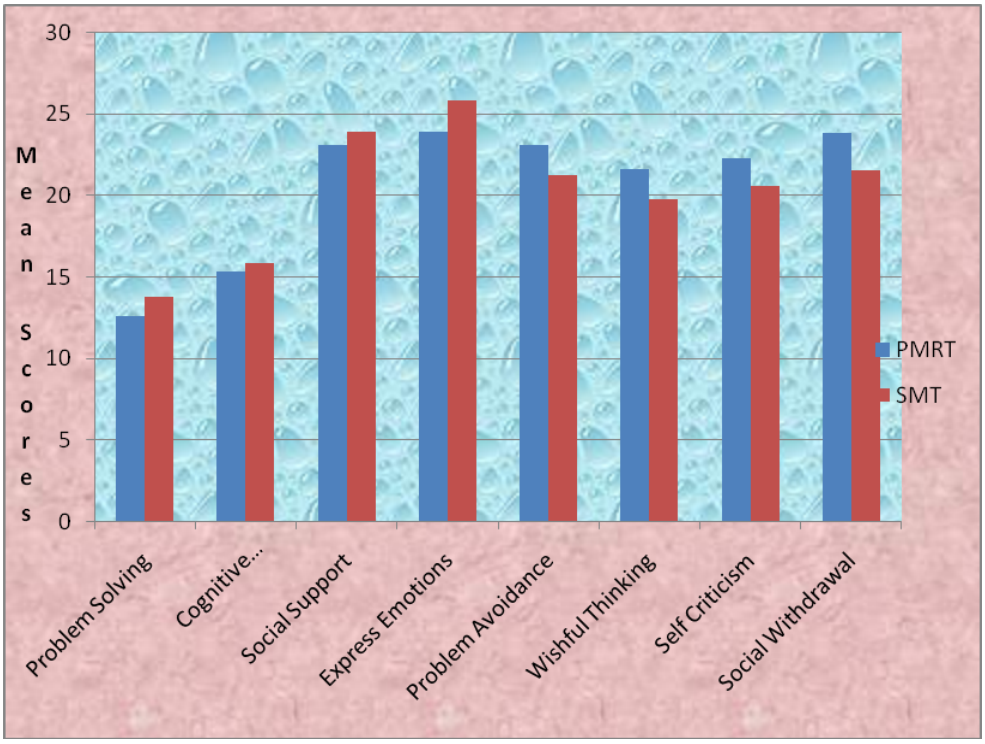
1. Graph No 4.1 to 4.2: Main Effect of Therapy

Graph 4.1 Mean of respondents on Suicidal Ideation and Depression in PMRT and SMT



The Graph 4.1 is showing Means of respondents on Suicidal Ideation and Depression in PMRT and SMT. As it is clear from the inspection of the above graph that SMT was found to be more effective in reducing Suicidal Ideation as well as Depression as compared to PMRT.

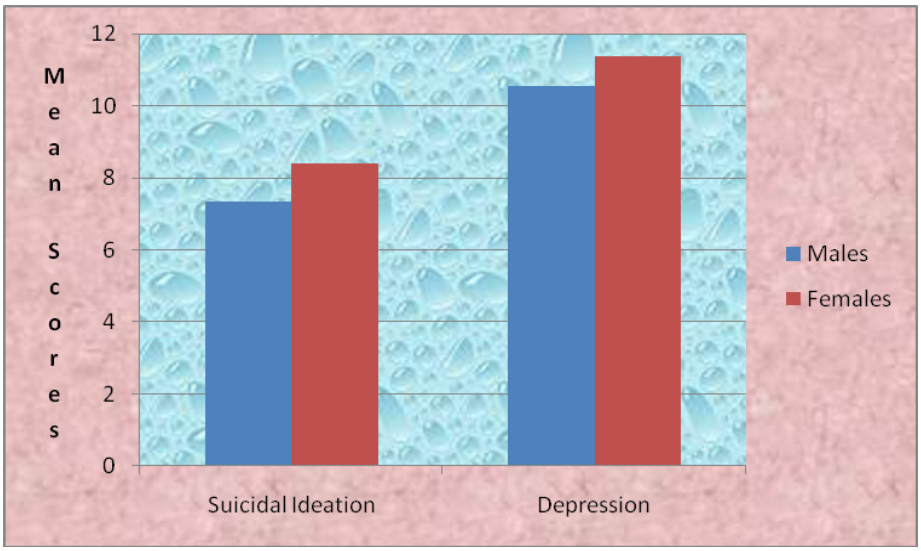
Graph 4.2 Mean of respondents on Various Dimensions of Coping Strategies in PMRT and SMT



The Graph 4.2 is showing Mean of respondents on various dimensions of coping strategies in PMRT and SMT. As it is clear from the inspection of the above graph that SMT was found to be more effective in improving the Positive Coping Strategies Bar 1 to 4 and in reducing Negative Coping Strategies Bar 5 to 8. All the dimensions of Coping Strategies except second and third i.e. Cognitive Restructuring and Social Support were found to improve more in SMT as compared to PMRT.

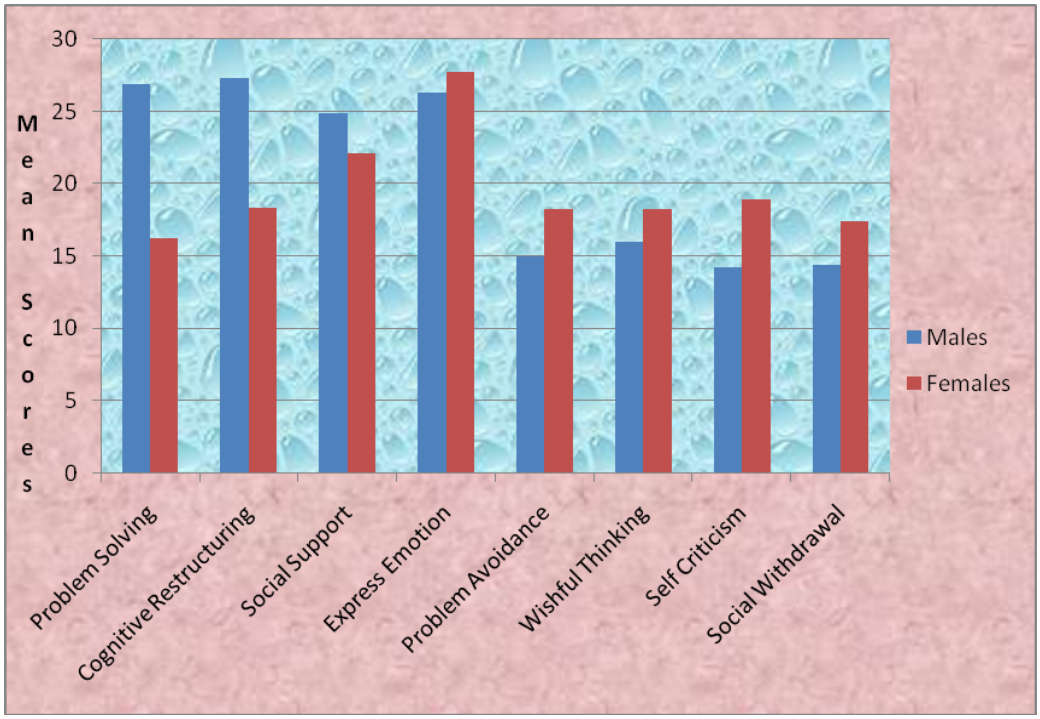
2. Graph No 4.3 to 4.4: Main Effect of Gender

Graph 4.3 Mean of Male and Female Orphans on Suicidal Ideation and Depression



The Graph 4.3 is showing the Mean of Male and Female Orphans on Suicidal Ideation and Depression. As it is clear from the Bars that Male and Female differ significantly on Suicidal Ideation and Depression. Females as compared to males were found to report more Suicidal Ideation and Depression.

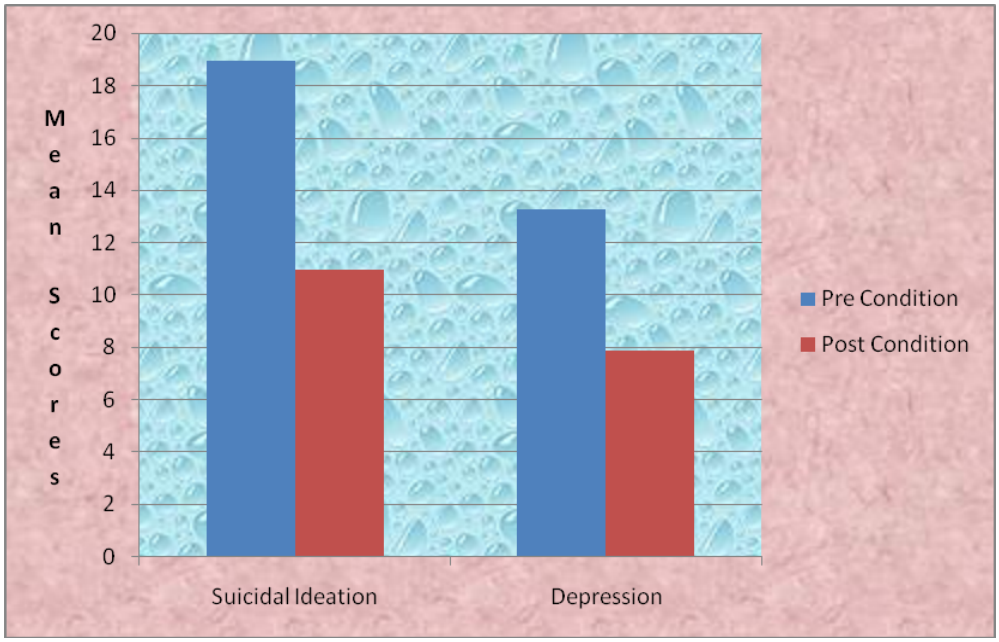
Graph 4.4 Mean of Various Dimensions of Coping Strategies among Males & Females



The Graph 4.4 is showing Mean of Male & Female Orphans on various dimensions of Coping Strategies. As it is clear from the inspection of the above graph that the Males and Females differ significantly on all the dimensions of Coping Strategies except Problem Avoidance Coping Strategy. As it is clear from the above graph that males have improved their positive coping strategies (Bar 1to 3) and modified their negative coping strategies (Bar 4 to 8) more than females. Express Emotion Coping Strategy (Bar no 4) was improved more in females as compared to males.

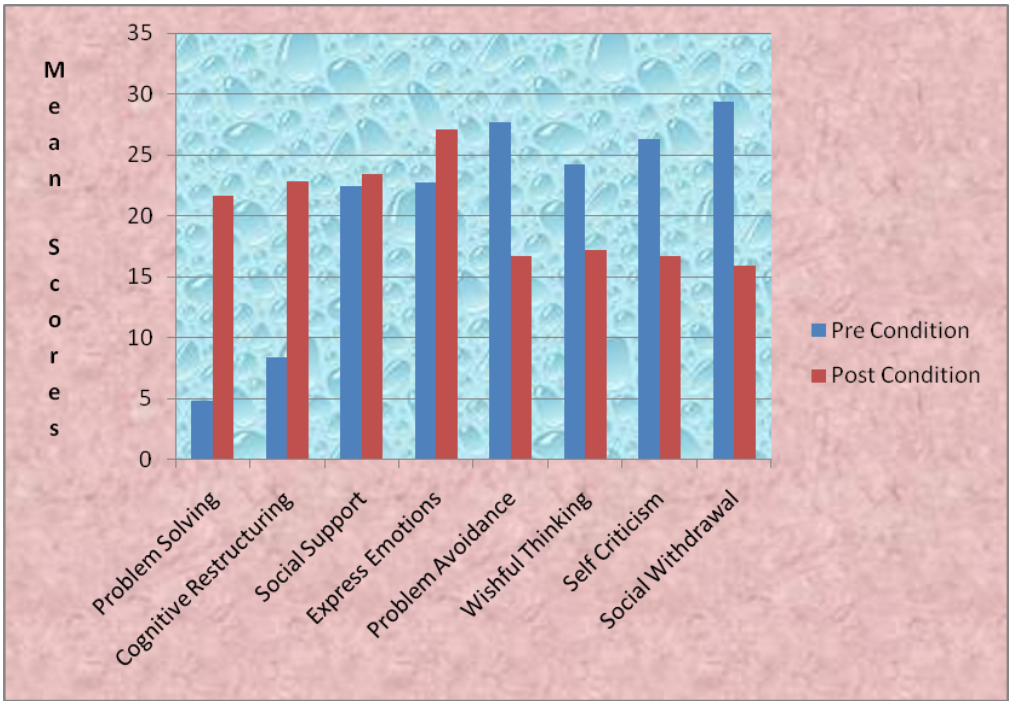
3. Graph No 4.5 to 4.6: Main Effect of Conditions

Graph 4.5 Mean of respondents in Pre Condition (PMRT, N=100 and SMT, N=100) and Post Condition (PMRT N=100 and SMT N=100) of Group Therapies on Suicidal ideation and Depression



The Graph 4.5 is showing the Mean of respondents on Suicidal ideation and Depression in the pre and post condition of group therapies. As it is clear from the inspection of graph 4.5 that Suicidal Ideation and Depression were significantly lesser in Post condition of both the group therapies.

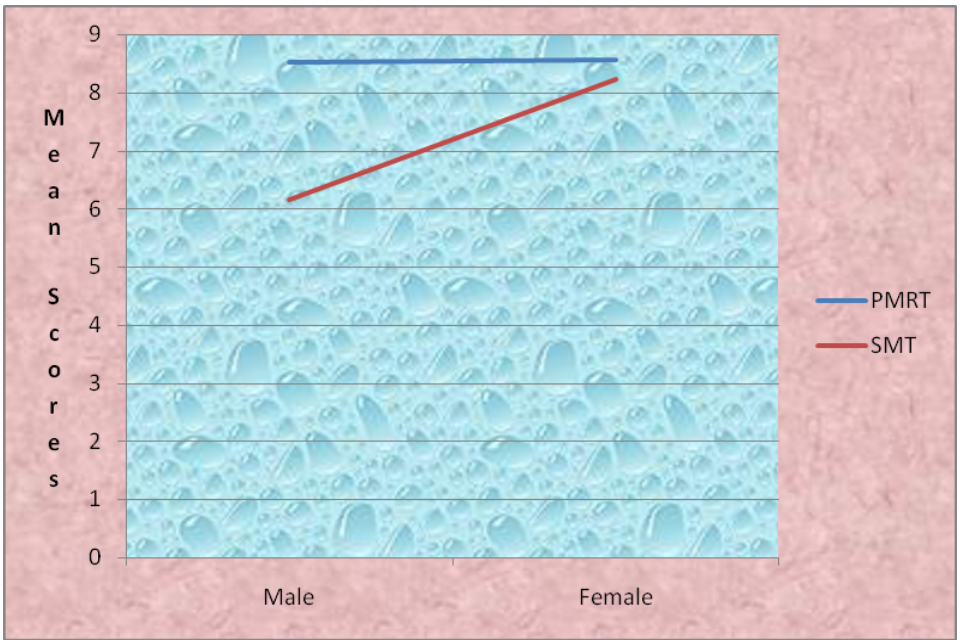
Graph 4.6 Mean of respondents in Pre Condition (PMRT N=100 and SMT N=100) and Post Condition (PMRT N=100 and SMT N=100) of Group Therapies on All the Dimensions of Coping Strategies



The Graph 4.6 is showing Mean of respondents on Various Dimensions of Coping Strategies in the Pre and Post condition of group therapies**.** As it is clear from the inspection of the above graph that the post condition of group therapies have modified all the dimensions of Positive Coping Strategies i.e. Problem Solving, Cognitive Restructuring, Social Support, Express Emotion, (Bar 1 to 4) and Negative Coping Strategies such as Problem Avoidance, Wishful Thinking, Self Criticism and Social withdrawal (Bar 5 to 8).

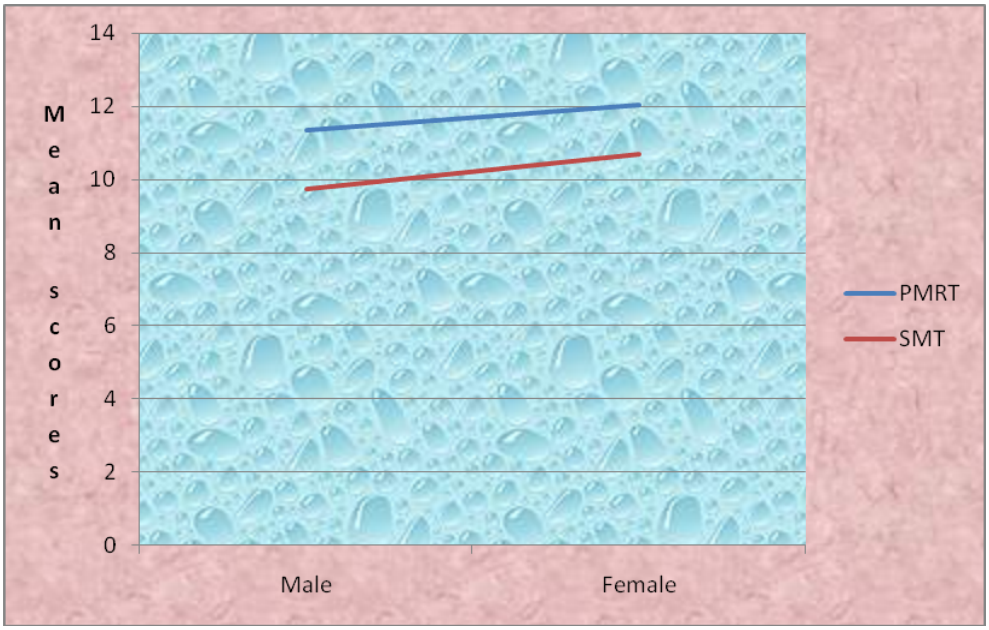
4. Graph No 4.7 to 4.16: Interaction Effect of Gender and Therapy

Graph 4.7 Mean of respondents on Suicidal Ideation in relation to Gender (Male and Female) and Group Therapy (PMRT and SMT)



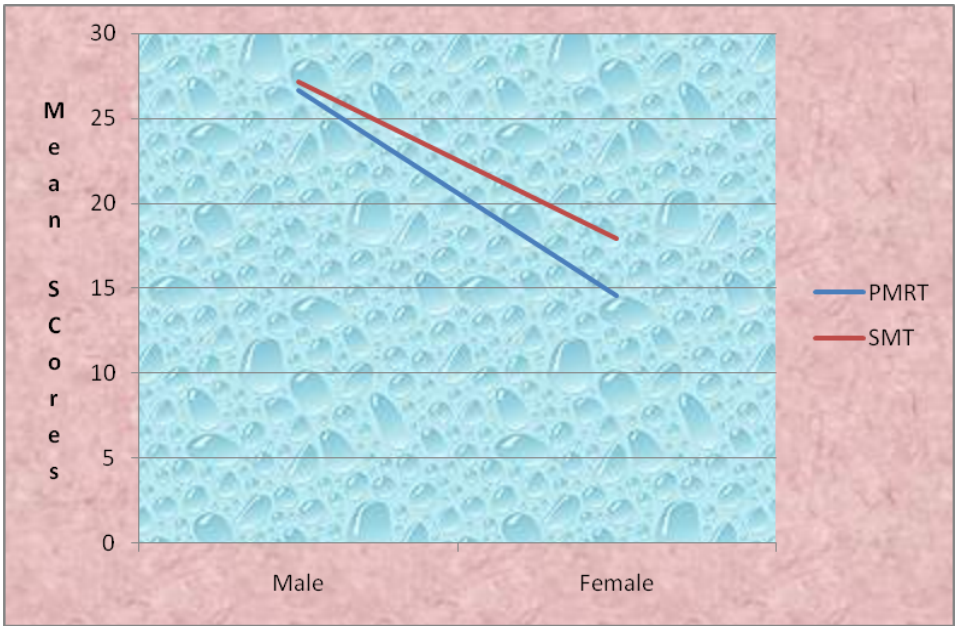
The Graph 4.7 is showing the Mean of respondents on Suicidal Ideation in relation to Gender and Therapy. It is clear from the inspection of Graph No. 4.7 that the interaction effect of Gender and Therapy was not found to be significant on Suicidal Ideation.

Graph 4.8 Mean of respondents on Depression in relation to Gender (Male and Female) and Group Therapy (PMRT and SMT)



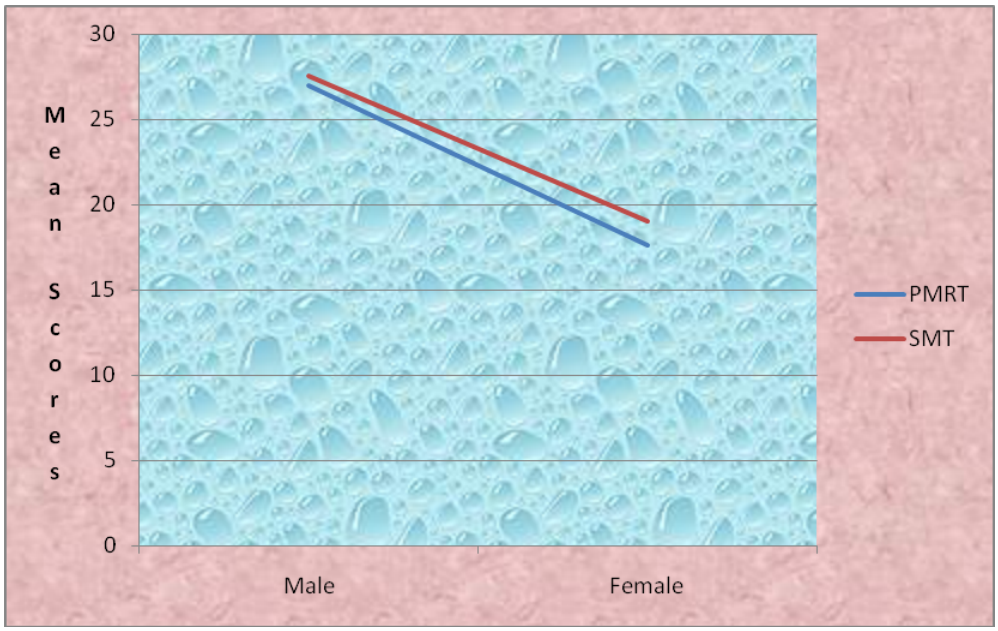
The Graph 4.8 is showing the Mean of respondents on Depression in relation to Gender and Therapy. It is clear from the inspection of Graph No. 4.8 that the interaction effect of Gender and Therapy was not found to be significant on Depression.

Graph 4.9 Mean of respondents on Problem Solving Coping Strategy in relation to Gender (Male and Female) and Group Therapy (PMRT and SMT)



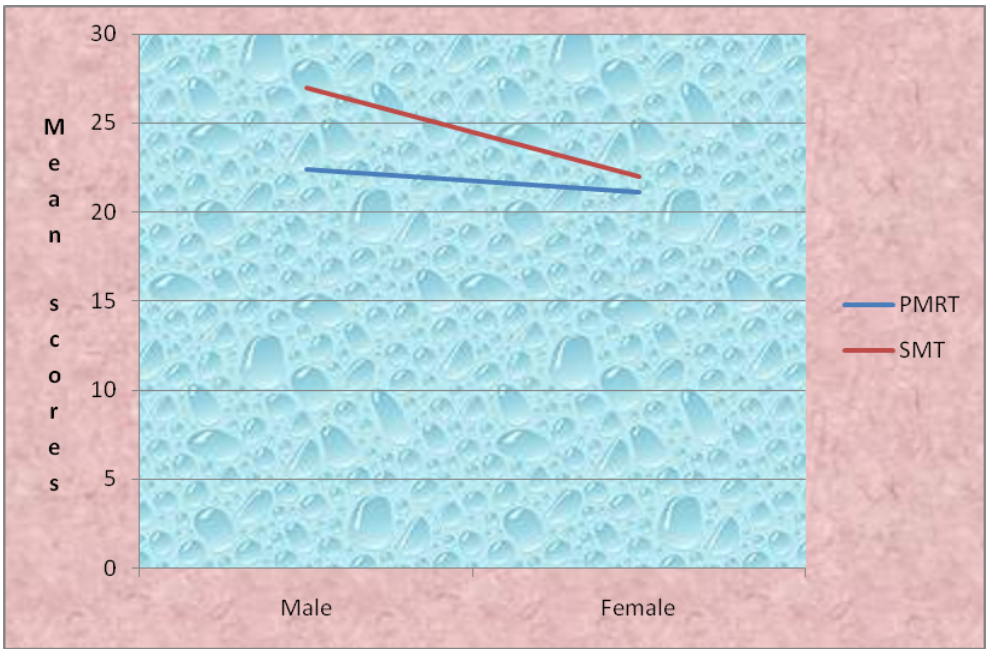
The Graph 4.9 is showing the Mean of respondents on Problem Solving Coping Strategy in relation to Gender and Therapy. It is clear from the inspection of Graph No. 4.9 that the interaction effect of Gender and Therapy was found to be significant Suggesting that males were found to improve more in SMT.

Graph 4.10 Mean of respondents on Cognitive Restructuring Coping Strategy in relation to Gender (Male and Female) and Group Therapy (PMRT and SMT)



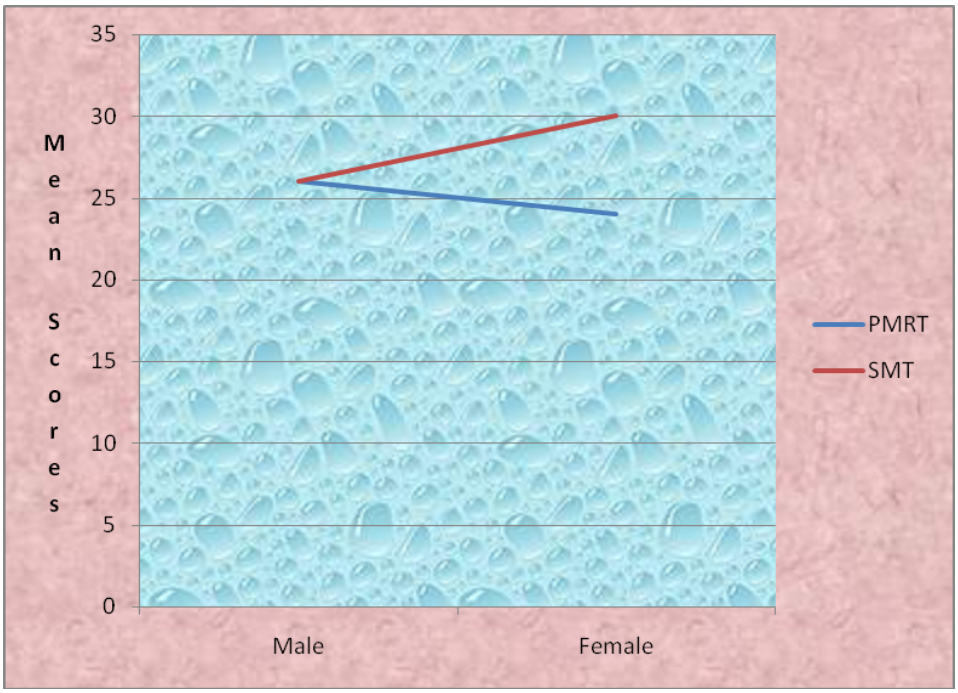
The Graph 4.10 is showing the Mean of respondents on Cognitive Restructuring Coping Strategy in relation to Gender and Therapy. It is clear from the inspection of Graph No. 4.10 that the interaction effect of Gender and Therapy was not found to be significant on Cognitive Restructuring Coping Strategy.

Graph 4.11 Mean of respondents on Social Support Coping Strategy in relation to Gender (Male and Female) and Group Therapy (PMRT and SMT)



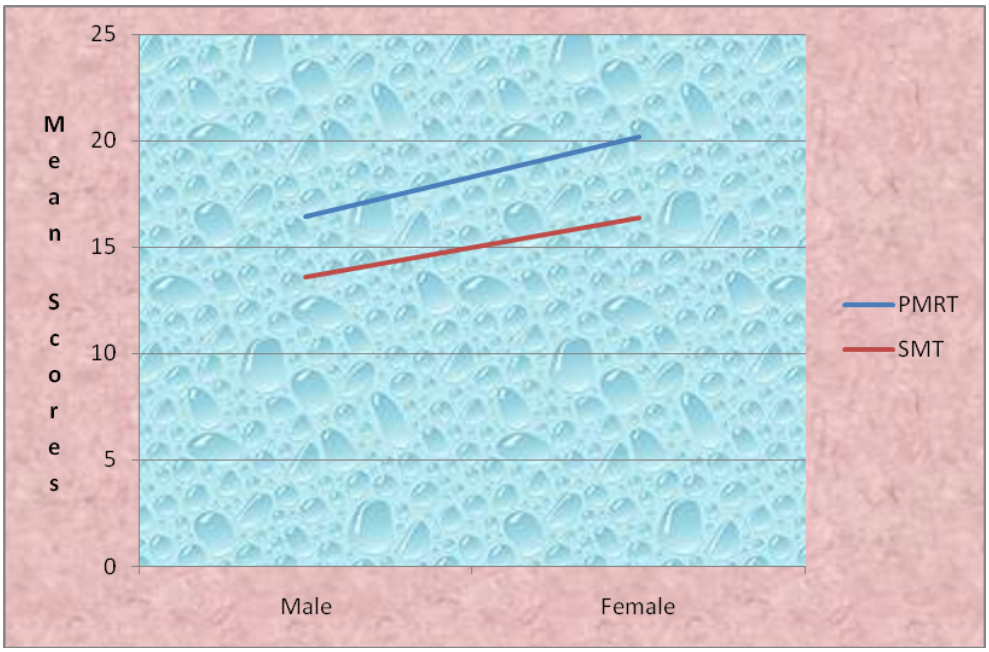
The Graph 4.11 is showing the Mean of respondents on Social Support Coping Strategy in relation to Gender and Therapy. It is clear from the inspection of Graph No. 4.11 that the interaction effect of Gender and Therapy was not found to be significant on Social Support Coping Strategy.

Graph 4.12 Mean of respondents on Express Emotion Coping Strategy in relation to Gender (Male and Female) and Group Therapy (PMRT and SMT)



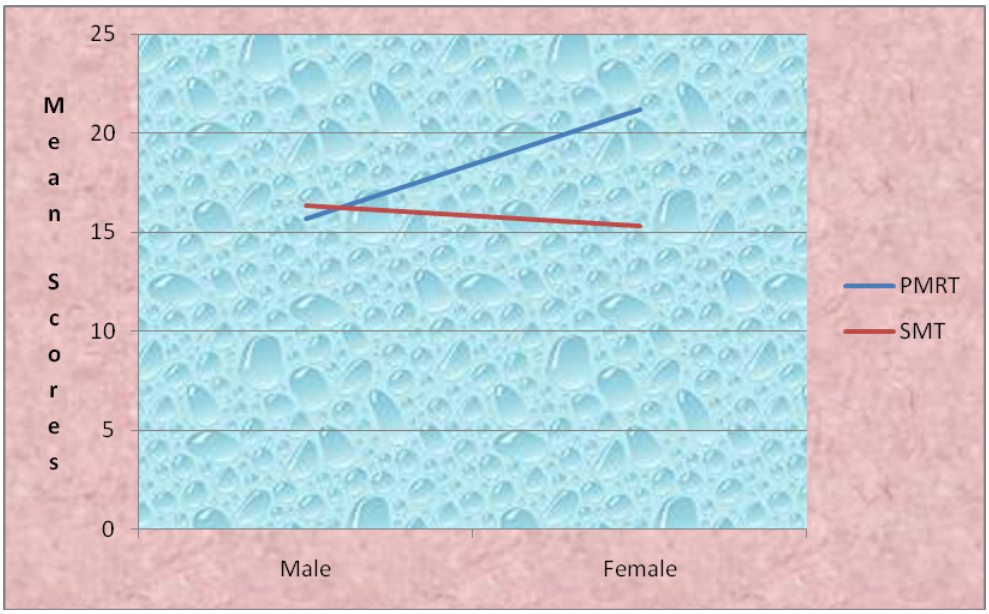
The Graph 4.12 is showing the Mean of respondents on Express Emotions coping Strategy in relation to Gender and Therapy. It is clear from the inspection of Graph No. 4.12 that the interaction effect of Gender and Therapy was found to be significant on Express Emotion Coping Strategy suggesting that females improved more than males in SMT as compared to PMRT.

Graph 4.13 Mean of respondents on Problem Avoidance Coping Strategy in relation to Gender (Male and Female) and Group Therapy (PMRT and SMT)



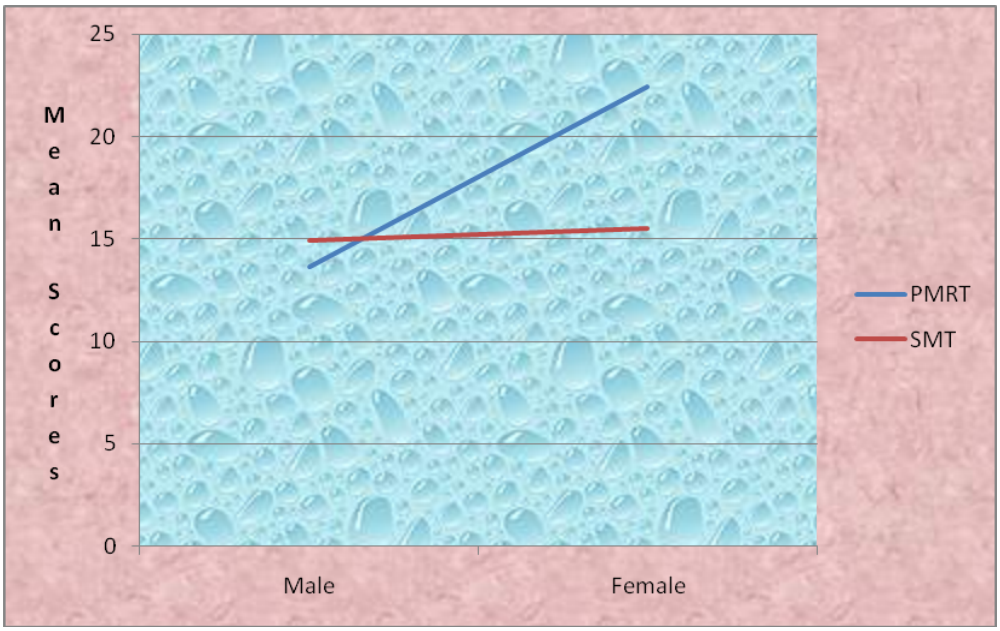
The Graph 4.13 is showing the Mean of respondents on Problem Avoidance coping Strategy in relation to Gender and Therapy. It is clear from the inspection of Graph No. 4.13 that the interaction effect of Gender and Therapy was not found to be significant on Problem Avoidance Coping Strategy.

Graph 4.14 Mean of respondents on Wishful Thinking Coping Strategy in relation to Gender (Male and Female) and Group Therapy (PMRT and SMT)



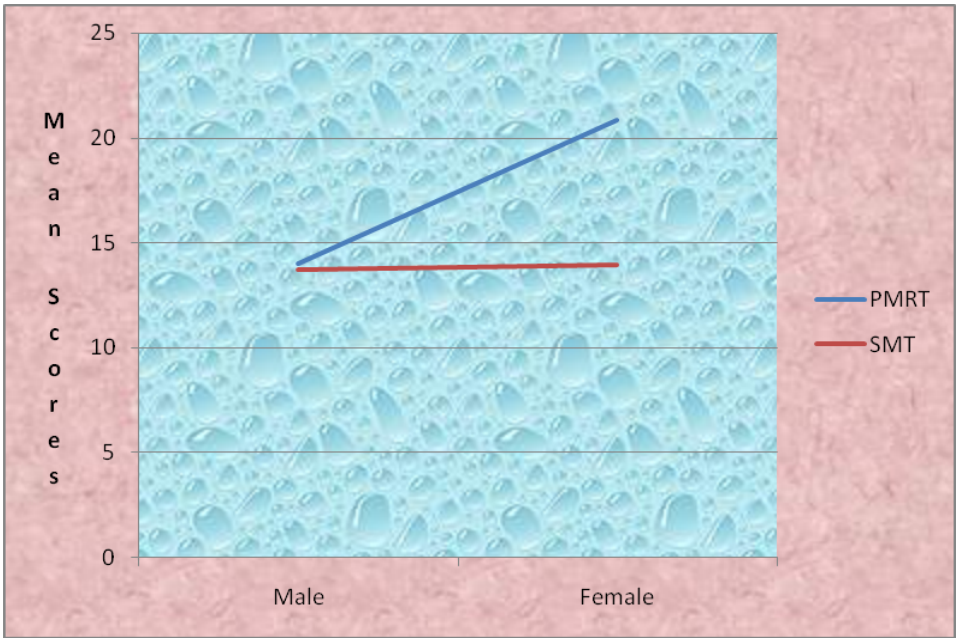
The Graph 4.14 is showing the Mean of respondents on Wishful Thinking Coping Strategy in relation to Gender and Therapy. It is clear from the inspection of Graph No. 4.14 that the interaction effect of Gender and Therapy was found to be significant on Wishful Thinking Coping Strategy suggesting that females have improved more on this dimension than males in SMT.

Graph 4.15 Mean of respondents on Self Criticism Coping Strategies Coping Strategy in relation to Gender (Male and Female) and Group Therapy (PMRT and SMT)



The Graph 4.16 is showing the Mean of respondents on Self Criticism Coping Strategy in relation to Gender and Therapy. It is clear from the inspection of Graph No. 4.16 that the interaction effect of Gender and Therapy was found to be significant on Self Criticism Coping Strategy suggesting females have improved more on this dimension than male in SMT as compared to PMRT.

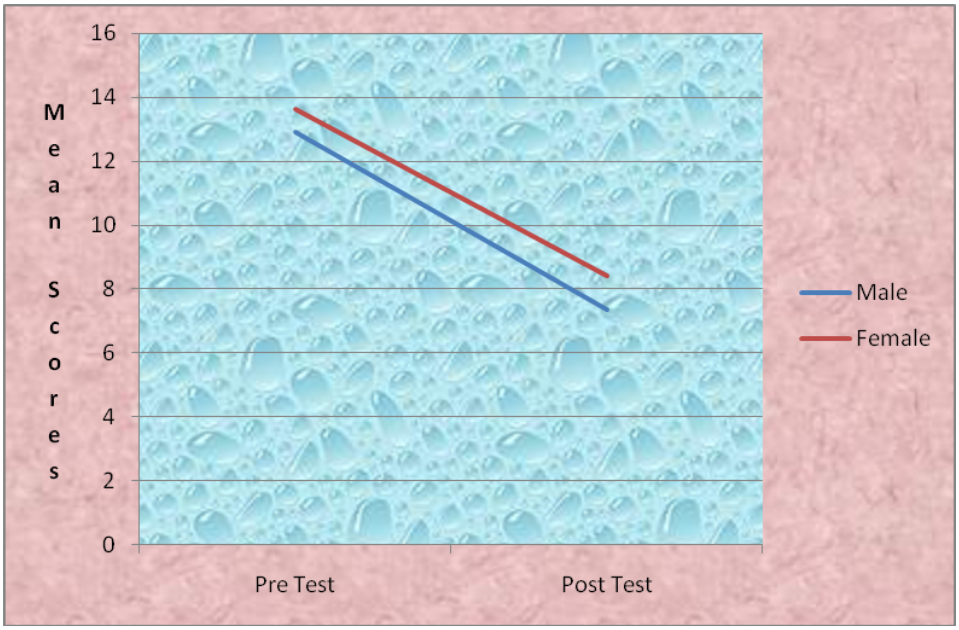
Graph 4.16 Mean of respondents on Social Withdrawal Coping Strategies in relation to Gender (Male and Female) and Group Therapy (PMRT and SMT)



The Graph 4.16 is showing the Mean of respondents on Social Withdrawal Coping Strategy in relation to Gender and Therapy. It is clear from the inspection of Graph No. 4.16 that the interaction effect of Gender and Therapy was found to be significant on Social Withdrawal Coping Strategy suggesting that females have improved more on this dimension than males in SMT than PMRT.

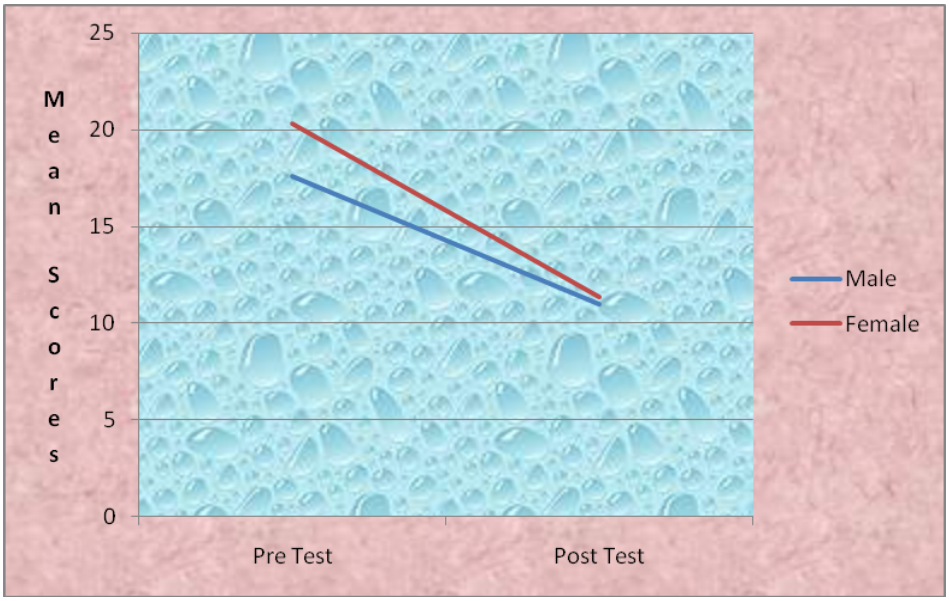
5. Graph No 4.17 to 4.26: Interaction Effect of Conditions and Gender

Graph 4.17 Mean of respondents on Suicidal Ideation in relation to Conditions (Pre and Post) and Gender (Male and Female)



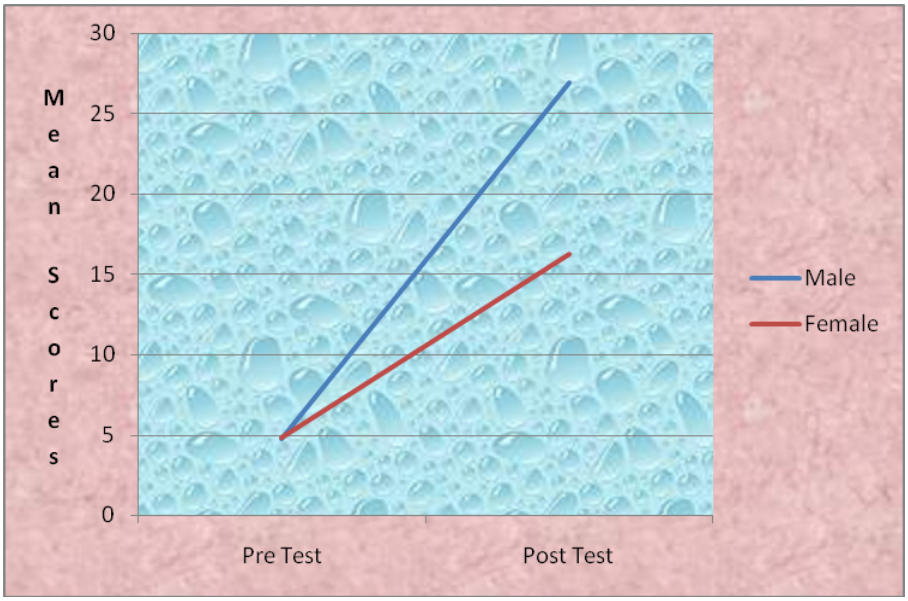
The Graph 4.17 is showing the Mean of respondents on Suicidal Ideation in relation to Conditions and Gender. It is clear from the inspection of Graph No. 4.17 that the interaction effect of Conditions and Gender was not found to be significant on Suicidal Ideation.

Graph 4.18 Mean of respondents on Depression in relation to Conditions (Pre and Post) and Gender (Male and Female)



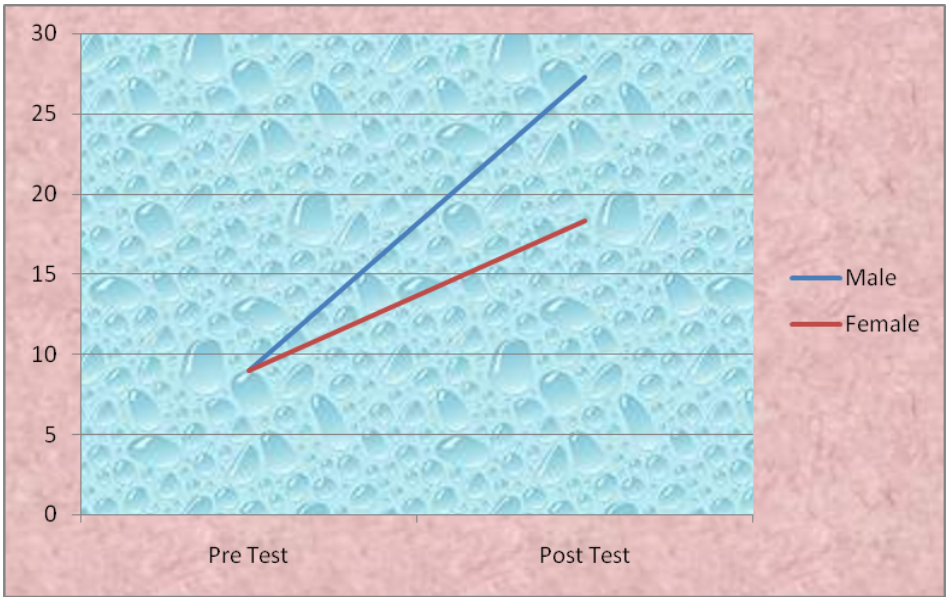
The Graph 4.18 is showing the Mean of respondents on Depression in relation to Conditions and Gender. It is clear from the inspection of Graph No. 4.18 that the interaction effect of Conditions and Gender was found to be significant on Depression. Males have reported less Depression in the Post Condition of Therapies as compared to Females.

Graph 4.19 Mean of respondents on Problem Solving Coping Strategy in relation to Conditions (Pre and Post) and Gender (Male and Female)



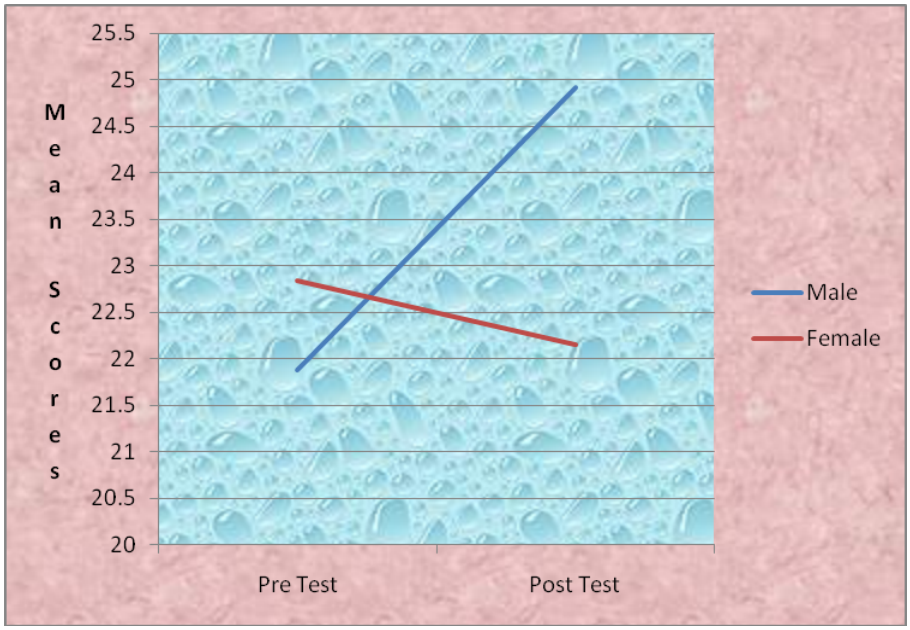
The Graph 4.19 is showing the Mean of respondents on Problem Solving Coping Strategy in relation to Conditions and Gender. It is clear from the inspection of Graph No. 4.19 that the interaction effect of Conditions and Gender was found to be significant on Problem Solving Coping Strategy. Males were found to report improved Problem Solving Coping Strategy than Females in the Post Conditions of Therapies.

Graph 4.20 Mean of respondents on Cognitive Restructuring Coping Strategy in relation to Conditions (Pre and Post) and Gender (Male and Female)



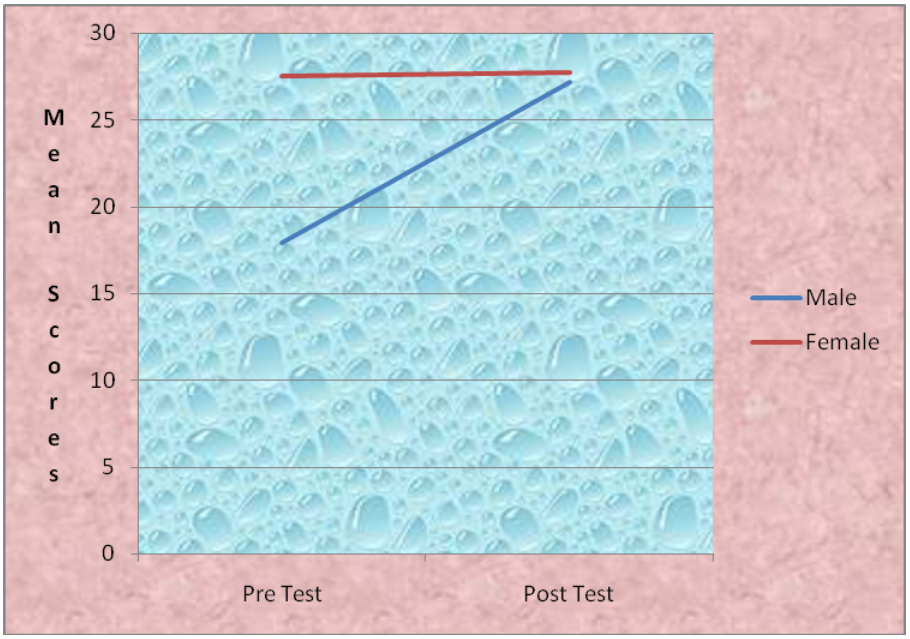
The Graph 4.20 is showing the Mean of respondents on Cognitive Restructuring Coping Strategy in relation to Conditions and Gender. It is clear from the inspection of Graph No. 4.20 that the interaction effect of Conditions and Gender was found to be significant on Cognitive Restructuring Coping Strategy. Males were found to report improved Cognitive Restructuring Coping Strategy than Females in the Post Conditions of Therapies.

Graph 4.21 Mean of respondents on Social Support Coping Strategy in relation to Conditions (Pre and Post) and Gender (Male and Female)



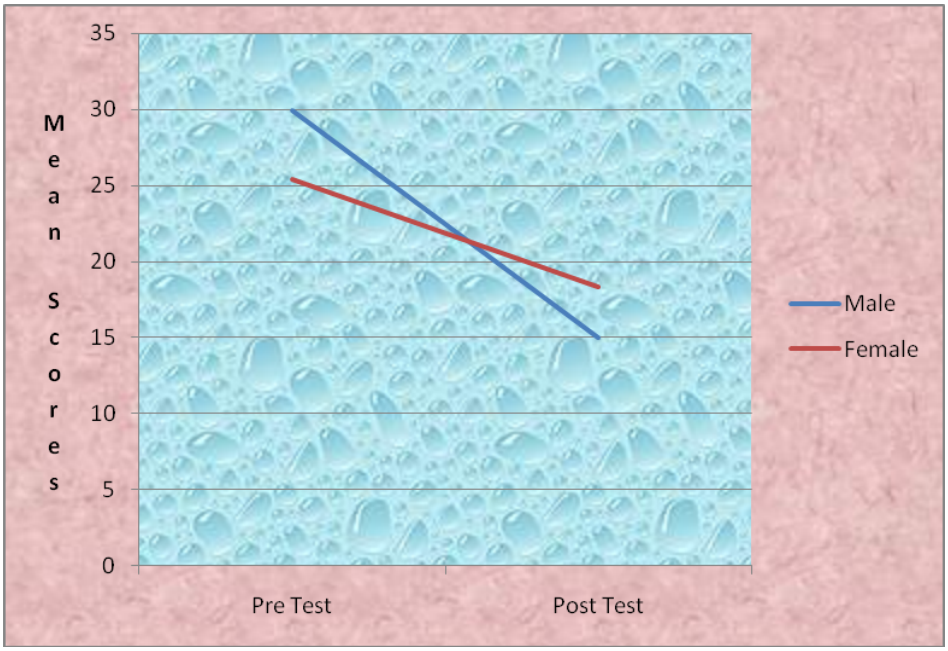
The Graph 4.21 is showing the Mean of respondents on Social Support Coping Strategy in relation to Conditions and Gender. It is clear from the inspection of Graph No. 4.21 that the interaction effect of Conditions and Gender was found to be significant on Social Support Coping Strategy. Males were found to report improved Social Support Coping Strategy than Females in the Post Conditions of Therapies.

Graph 4.22 Mean of respondents on Express Emotion Coping Strategy in relation to Conditions (Pre and Post) and Gender (Male and Female)



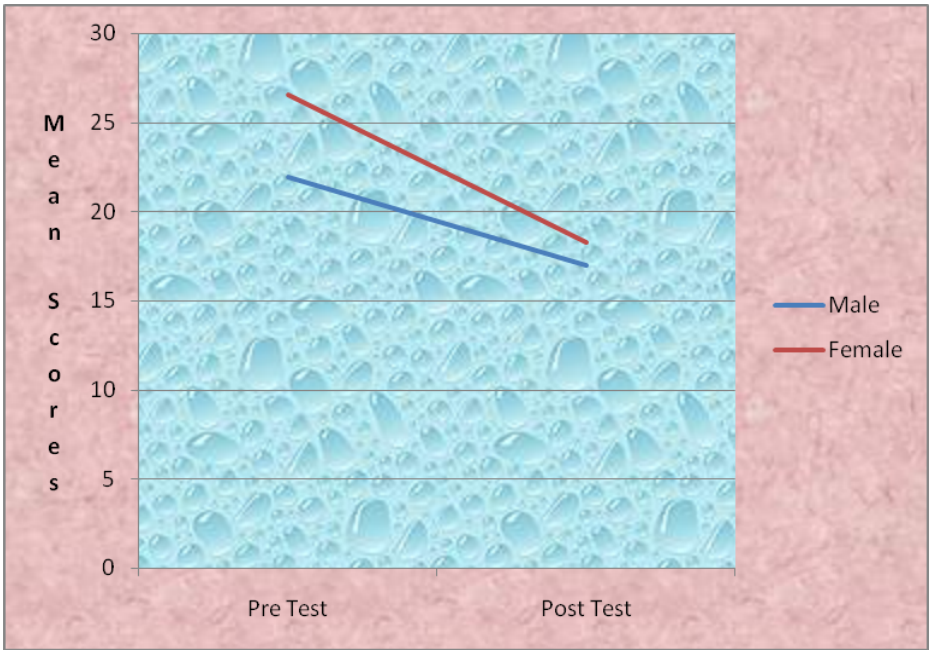
The Graph 4.22 is showing the Mean of respondents on Express Emotion Coping Strategy in relation to Conditions and Gender. It is clear from the inspection of Graph No. 4.22 that the interaction effect of Conditions and Gender was found to be significant on Express Emotion Coping Strategy. Females were found to improve more on this dimension than males in the post condition of the Therapies.

Graph 4.23 Mean of respondents on Problem Avoidance Coping Strategy in relation to Conditions (Pre and Post) and Gender (Male and Female)



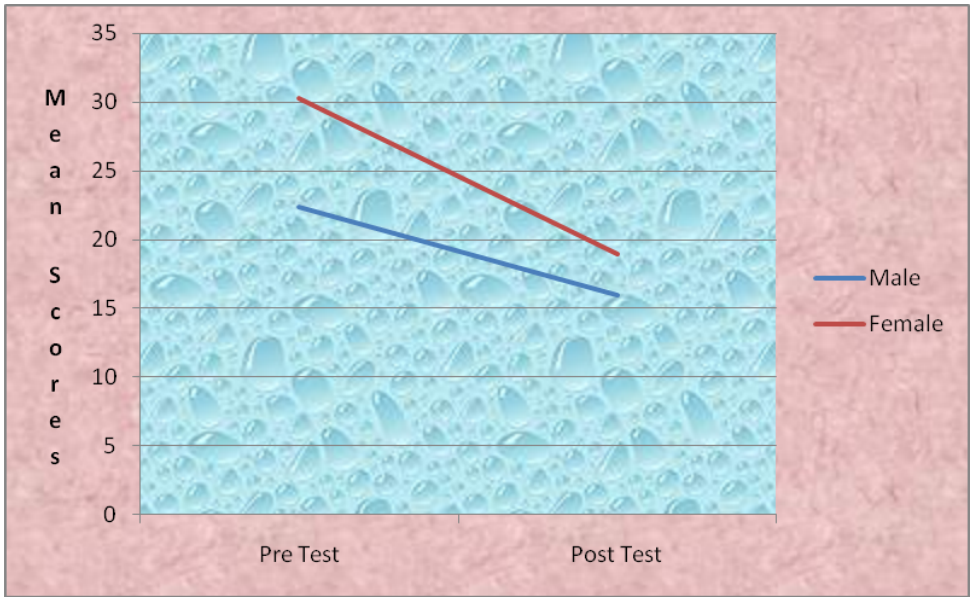
The Graph 4.23 is showing the Mean of respondents on Problem Avoidance Coping Strategy in relation to Conditions and Gender. It is clear from the inspection of Graph No. 4.23 that the interaction effect of Conditions and Gender was found to be significant on Express Emotion Coping Strategy. Males were found to report improved Problem Avoidance Coping Strategy than Females in the Post Conditions of Therapies.

Graph 4.24 Mean of respondents on Wishful Thinking Coping Strategy in relation to Conditions (Pre and Post) and Gender (Male and Female)



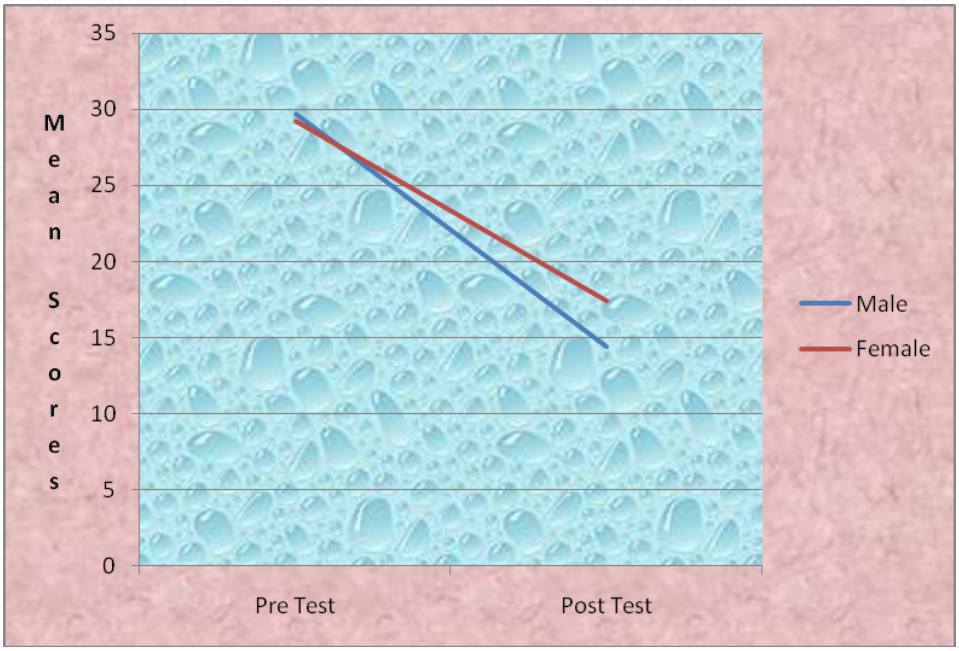
The Graph 4.24 is showing the Mean of respondents on Wishful Thinking Coping Strategy in relation to Conditions and Gender. It is clear from the inspection of Graph No. 4.24 that the interaction effect of Conditions and Gender was found to be significant on Wishful Thinking Coping Strategy. Males were found to report improved Wishful Thinking Coping Strategy than Females in the Post Conditions of Therapies.

Graph 4.25 Mean of respondents on Self Criticism Coping Strategy in relation to Conditions (Pre and Post) and Gender (Male and Female)



The Graph 4.25 is showing the Mean of respondents on Self Criticism Coping Strategy in relation to Conditions and Gender. It is clear from the inspection of Graph No. 4.25 that the interaction effect of Conditions and Gender was found to be significant on Self Criticism Coping Strategy. Males were found to report improved Self Criticism Coping Strategy than Females in the Post Conditions of Therapies.

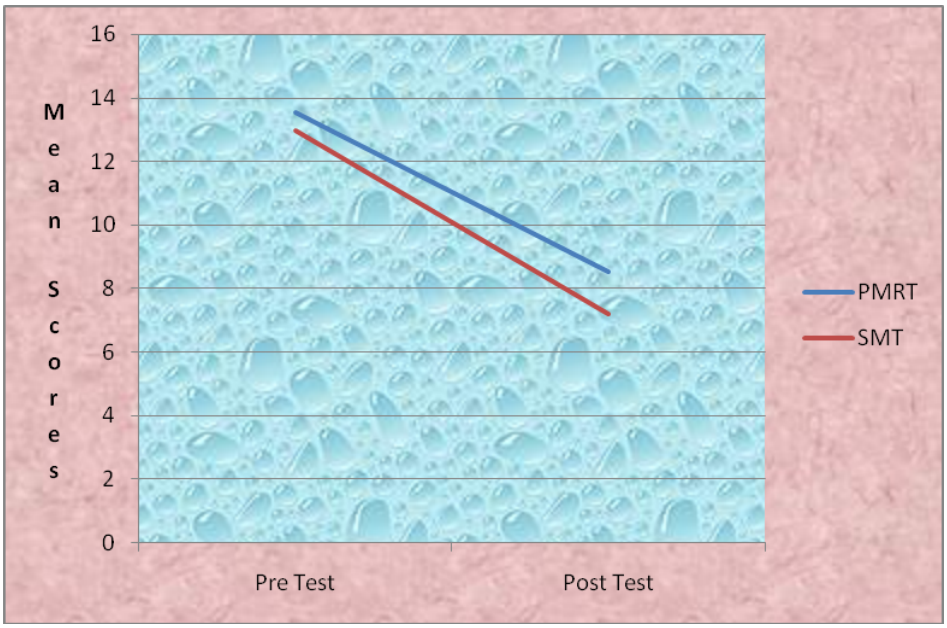
Graph 4.26 Mean of respondents on Social Withdrawal Coping Strategy in relation to Conditions (Pre and Post) and Gender (Male and Female)



The Graph 4.26 is showing the Mean of respondents on Social Withdrawal Coping Strategy in relation to Conditions and Gender. It is clear from the inspection of Graph No. 4.26 that the interaction effect of Conditions and Gender was found to be significant on Social Withdrawal Coping Strategy. Males were found to report improved Social Withdrawal Coping Strategy than Females in the Post Conditions of Therapies.

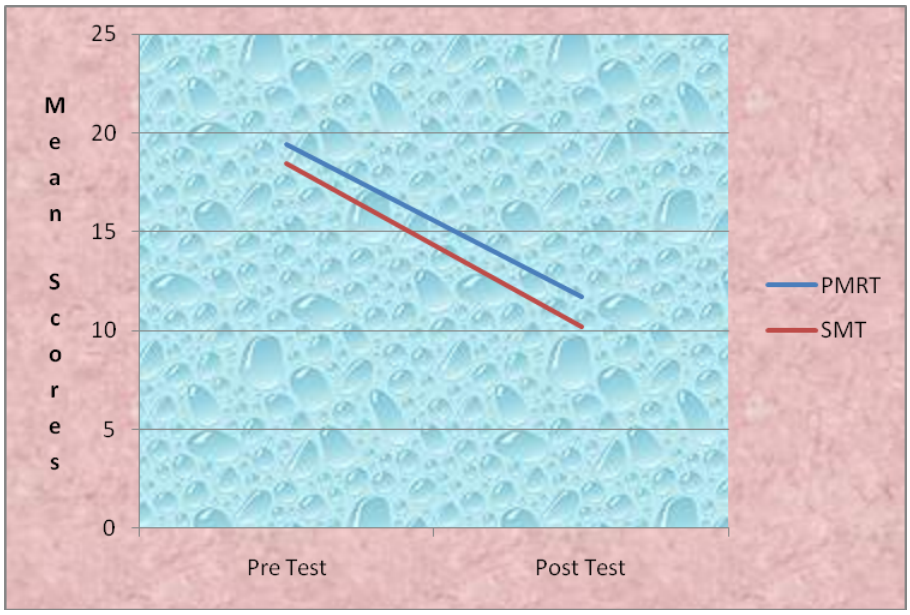
6. Graph No 4.27 to 4.36: Interaction Effect of Condition and Therapy

Graph 4.27 Mean of respondents on Suicidal Ideation in relation to Conditions (Pre and Post) and Therapy (PMRT and SMT)



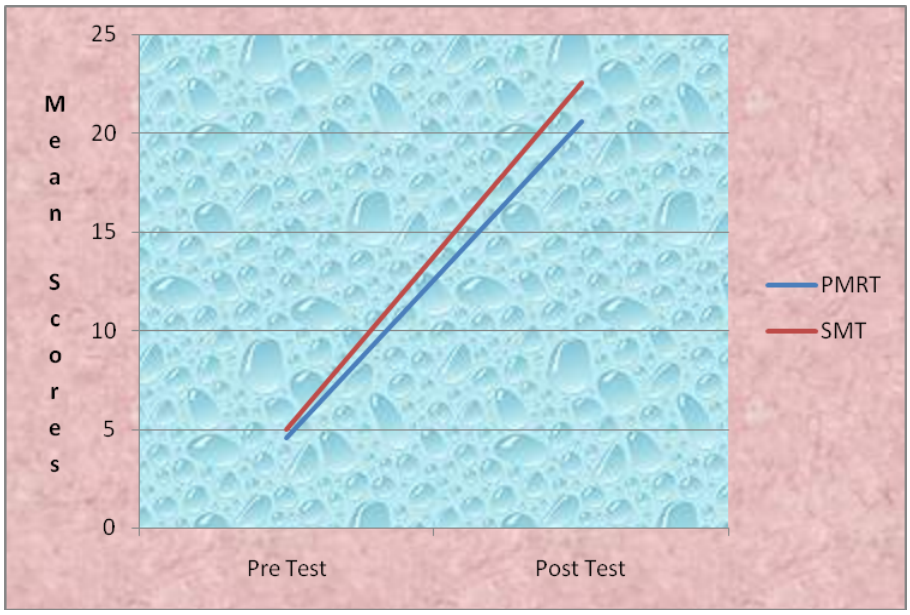
The Graph 4.27 is showing the Mean of respondents on Suicidal Ideation in relation to Conditions and Therapy. It is clear from the inspection of Graph No. 4.27 that the interaction effect of Conditions and Therapy was found to be significant on Suicidal Ideation. Suicidal Ideation was found to be less in the post condition of SMT as compared to PMRT.

Graph 4.28 Mean of respondents on Depression in relation to Conditions (Pre and Post) and Therapy (PMRT and SMT)



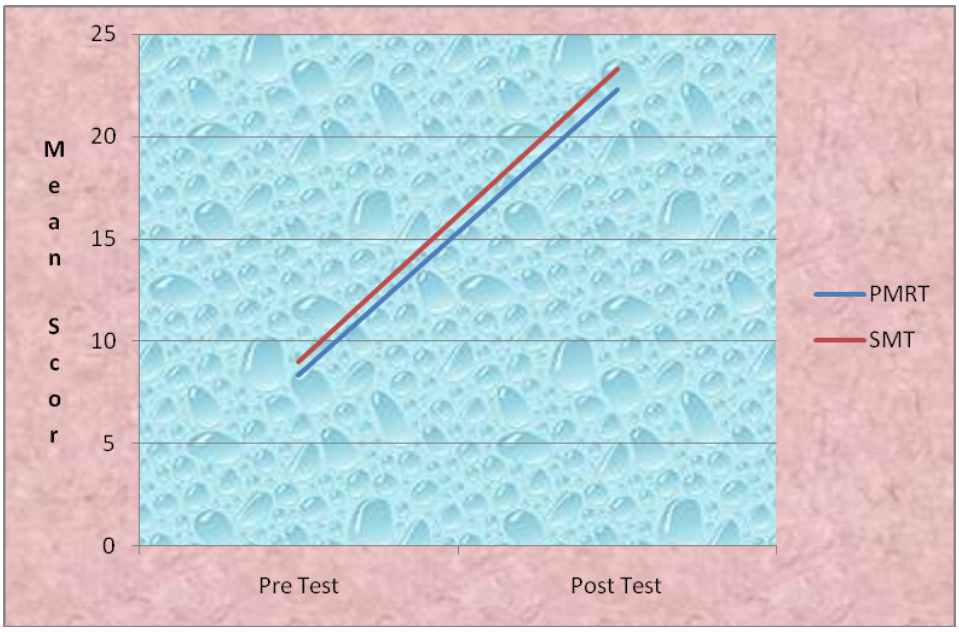
The Graph 4.28 is showing the Mean of respondents on Depression in relation to Conditions and Therapy. It is clear from the inspection of Graph No. 4.28 that the interaction effect of Conditions and Therapy was not found to be significant on Depression.

Graph 4.29 Mean of respondents on Problem Solving Coping Strategy in relation to Conditions (Pre and Post) and Therapy (PMRT and SMT)



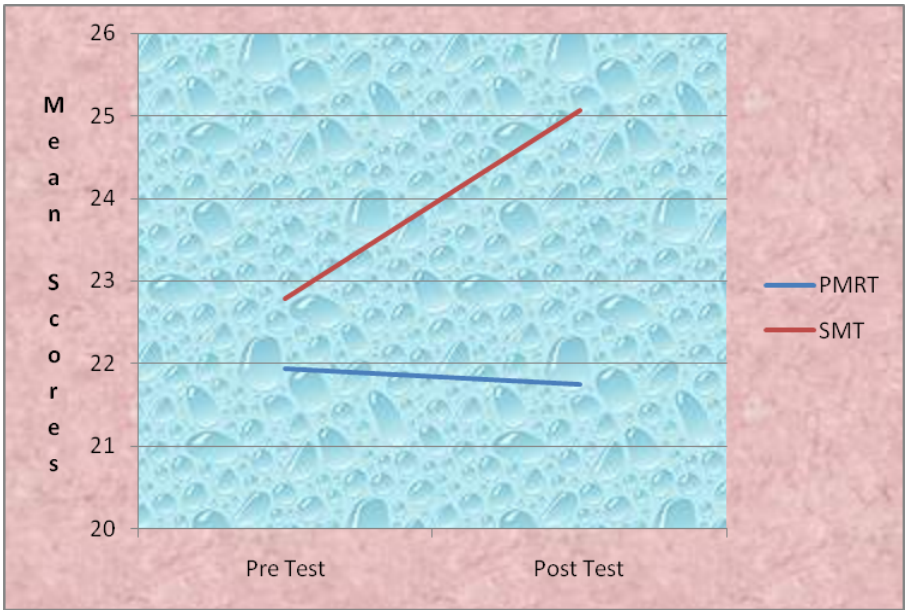
The Graph 4.29 is showing the Mean of respondents on Problem Solving Coping Strategy in relation to Conditions and Therapy. It is clear from the inspection of Graph No. 4.29 that the interaction effect of Conditions and Therapy was found to be significant on Problem Solving Coping Strategy. Problem Solving Coping Strategy was found to improve more on the Post Condition of SMT than PMRT.

Graph 4.30 Mean of respondents on Cognitive Restructuring Coping Strategy in relation to Conditions (Pre and Post) and Therapy (PMRT and SMT)



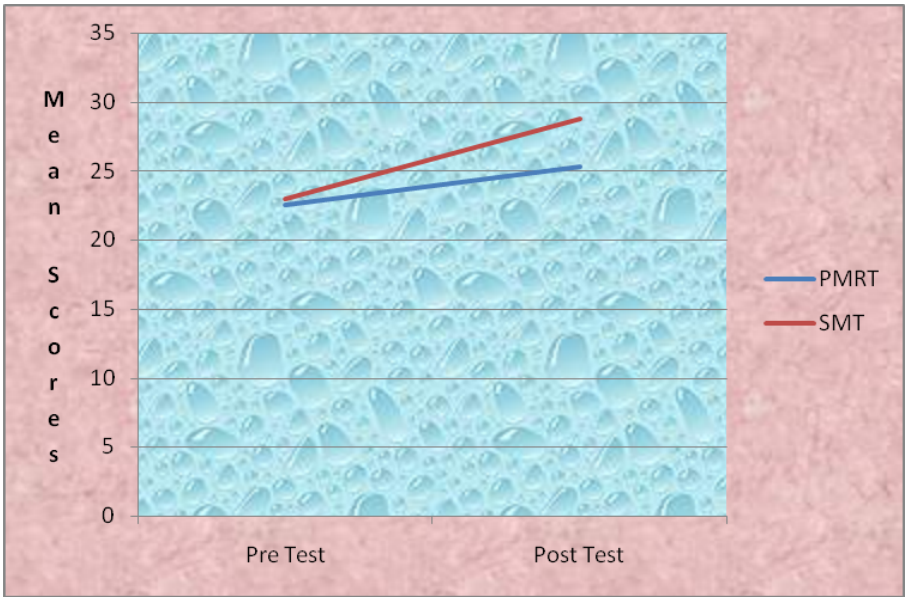
The Graph 4.30 is showing the Mean of respondents on Cognitive Restructuring Coping Strategy in relation to Conditions and Therapy. It is clear from the inspection of Graph No. 4.30 that the interaction effect of Conditions and Therapy was not found to be significant on Cognitive Restructuring Coping Strategy.

Graph 4.31 Mean of respondents on Social Support Coping Strategy in relation to Conditions (Pre and Post) and Therapy (PMRT and SMT)



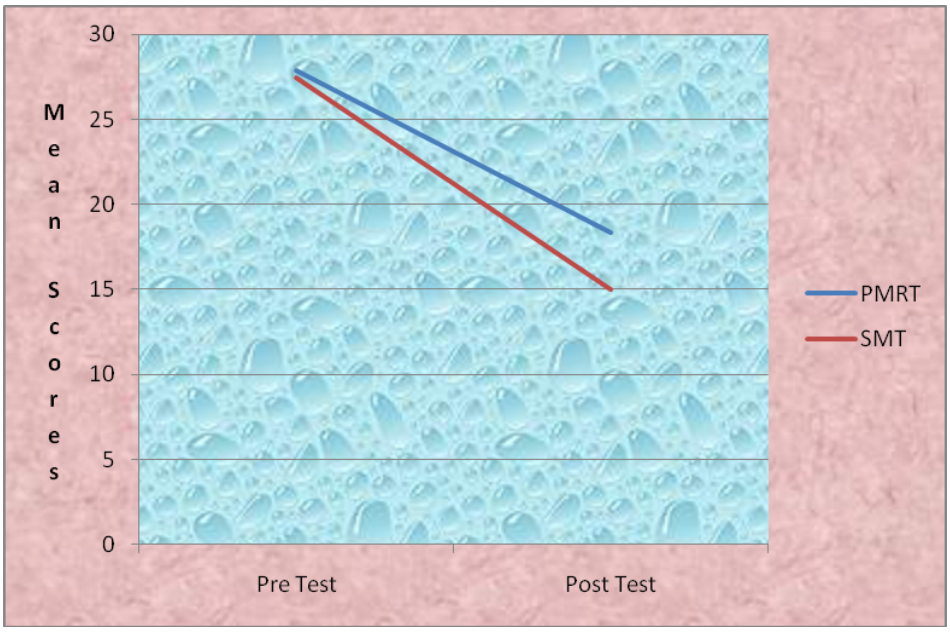
The Graph 4.31 is showing the Mean of respondents on Social Support Coping Strategy in relation to Conditions and Therapy. It is clear from the inspection of Graph No. 4.31 that the interaction effect of Conditions and Therapy was not found to be significant on Social Support Coping Strategy.

Graph 4.32 Mean of respondents on Express Emotion Coping Strategy in relation to Conditions (Pre and Post) and Therapy (PMRT and SMT)



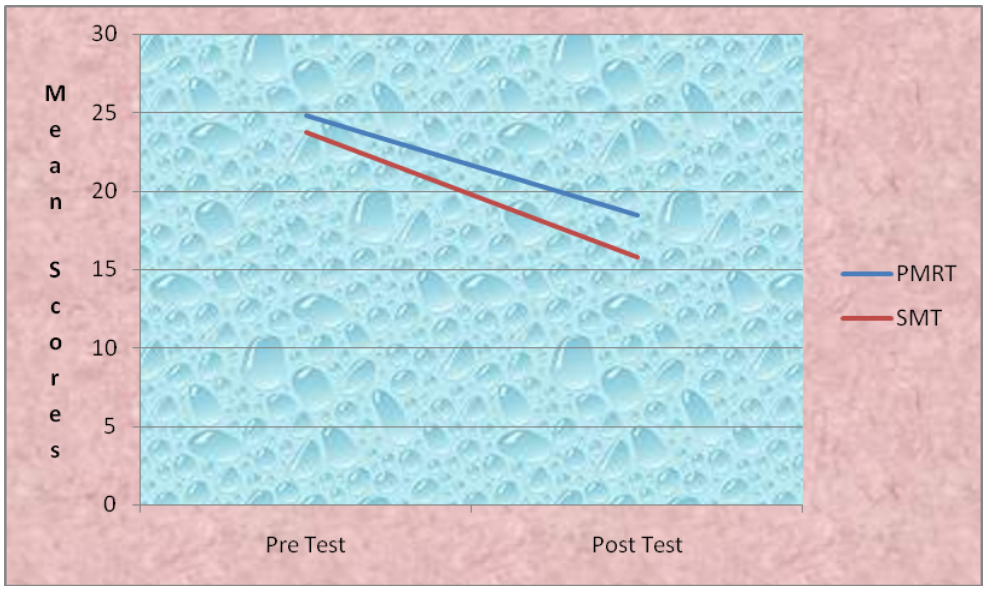
The Graph 4.32 is showing the Mean of respondents on Express Emotion Coping Strategy in relation to Conditions and Therapy. It is clear from the inspection of Graph No. 4.32 that the interaction effect of Conditions and Therapy was found to be significant on Express Emotion Coping Strategy. Express Emotion Coping Strategy was found to improve more on the Post Condition of SMT than PMRT.

Graph 4.33 Mean of respondents on Problem Avoidance Coping Strategy in relation to Conditions (Pre and Post) and Therapy (PMRT and SMT)



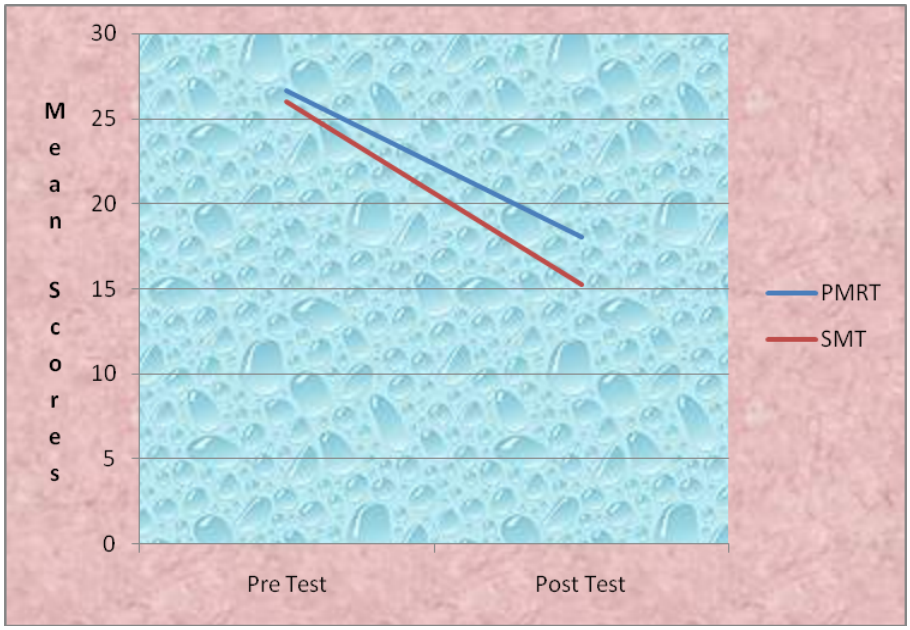
The Graph 4.33 is showing the Mean of respondents on Problem Avoidance Coping Strategy in relation to Conditions and Therapy. It is clear from the inspection of Graph No. 4.33 that the interaction effect of Conditions and Therapy was found to be significant on Problem Avoidance Coping Strategy. Problem Avoidance Coping Strategy was found to improve more on the Post Condition of SMT than PMRT.

Graph 4.34 Mean of respondents on Wishful Thinking Coping Strategy in relation to Conditions (Pre and Post) and Therapy (PMRT and SMT)



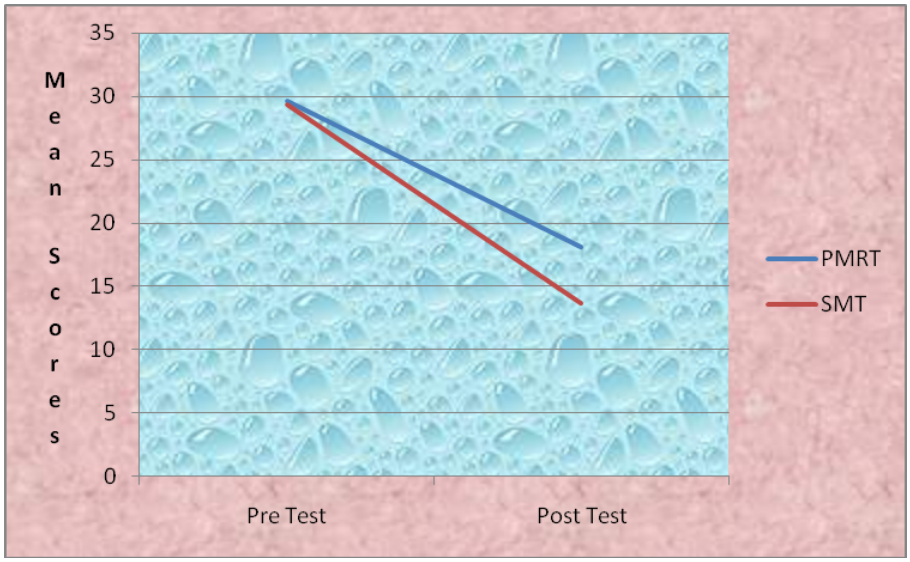
The Graph 4.34 is showing the Mean of respondents on Wishful Thinking Coping Strategy in relation to Conditions and Therapy. It is clear from the inspection of Graph No. 4.34 that the interaction effect of Conditions and Therapy was not found to be significant on Wishful Thinking Coping Strategy.

Graph 4.35 Mean of respondents on Self Criticism Coping Strategy in relation to Conditions (Pre and Post) and Therapy (PMRT and SMT)



The Graph 4.35 is showing the Mean of respondents on Self Criticism Coping Strategy in relation to Conditions and Therapy. It is clear from the inspection of Graph No. 4.35 that the interaction effect of Conditions and Therapy was found to be significant on Self Criticism Coping Strategy. It was found to reduce (since it is a negative coping strategy) more in post condition of SMT than PMRT.

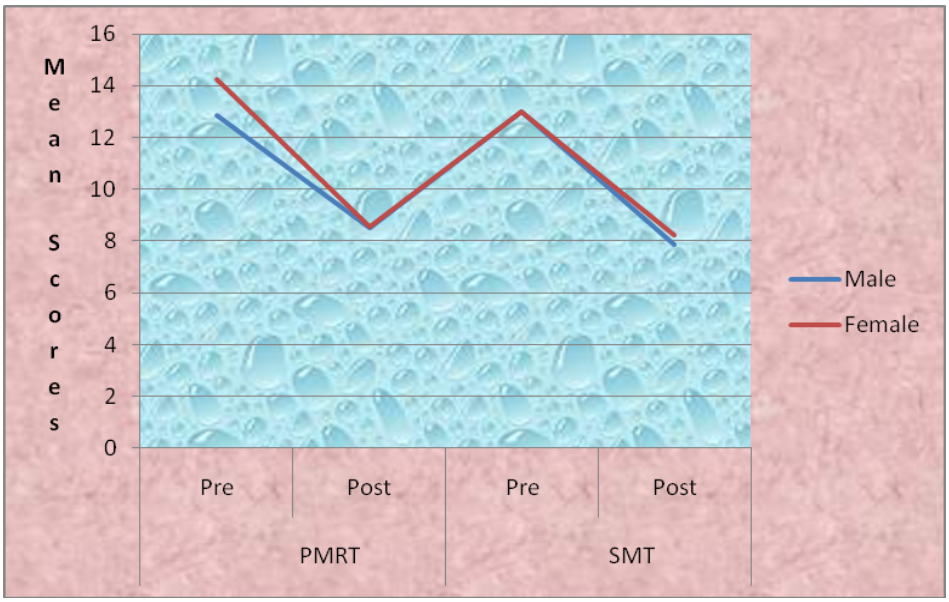
Graph 4.36 Mean of respondents on Social Withdrawal Coping Strategy in relation to Conditions (Pre and Post) and Therapy (PMRT and SMT)



The Graph 4.36 is showing the Mean of respondents on Social Withdrawal Coping Strategy in relation to Conditions and Therapy. It is clear from the inspection of Graph No. 4.36 that the interaction effect of Conditions and Therapy was found to be significant on Social Withdrawal Coping Strategy. It was found to reduce (since it is a negative coping strategy) more in post condition of SMT than PMRT.

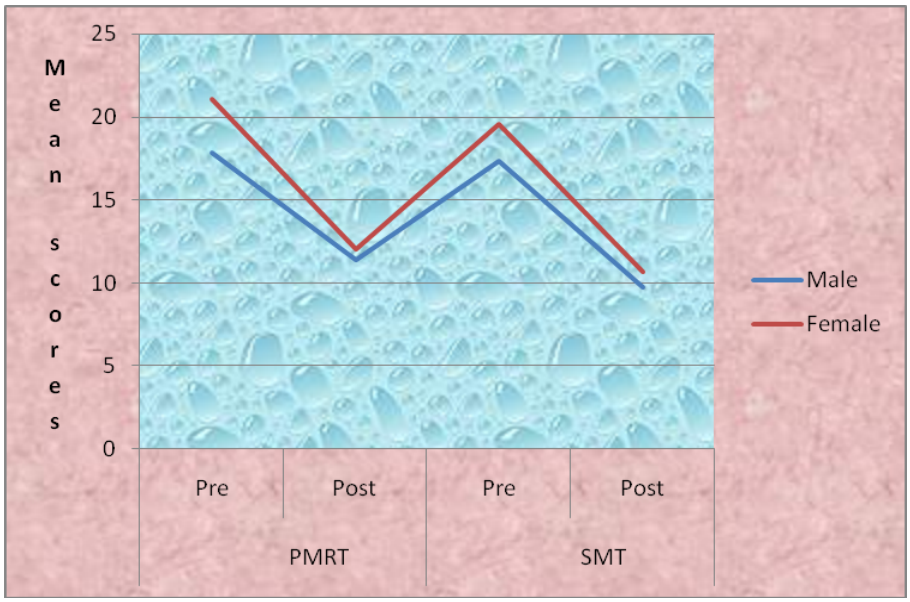
7. Graph No 4.37 to 4.46: Interaction Effect of Condition, Gender and Therapy

Graph 4.37 Mean of respondents on Suicidal Ideation in relation to Conditions (Pre and Post), Gender (Male and Female) and Therapy (PMRT and SMT)



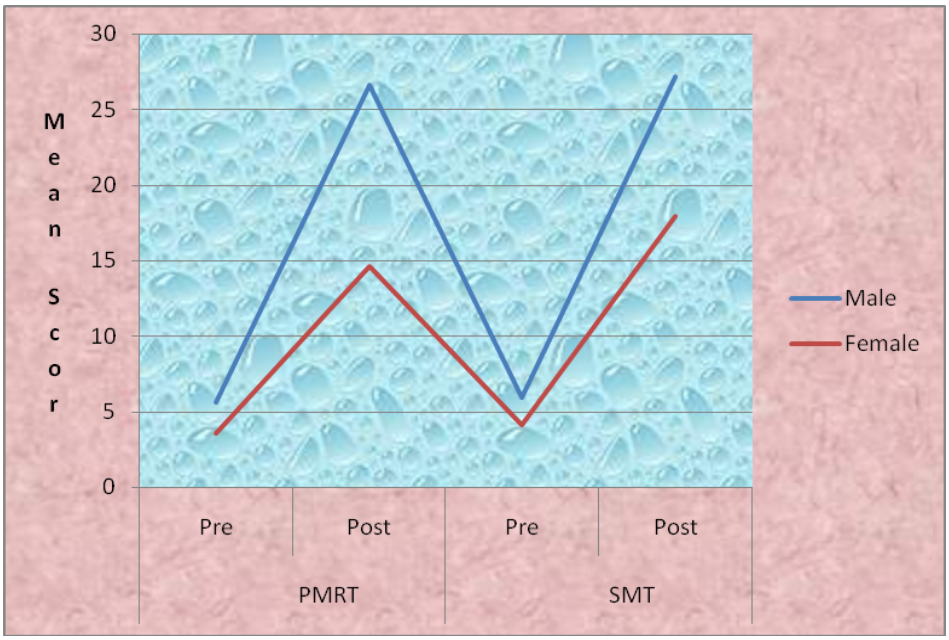
The Graph 4.37 is showing the Mean of respondents on Suicidal Ideation in relation to Conditions, Gender and Therapy. It is clear from the inspection of Graph No. 4.37 that the interaction effect of Conditions, Gender and Therapy was found to be significant on Suicidal Ideation. Female respondents were found to report less Suicidal Ideation in the post condition of SMT.

Graph 4.38 Mean of respondents on Depression in relation to Conditions (Pre and Post), Gender (Male and Female) and Therapy (PMRT and SMT)



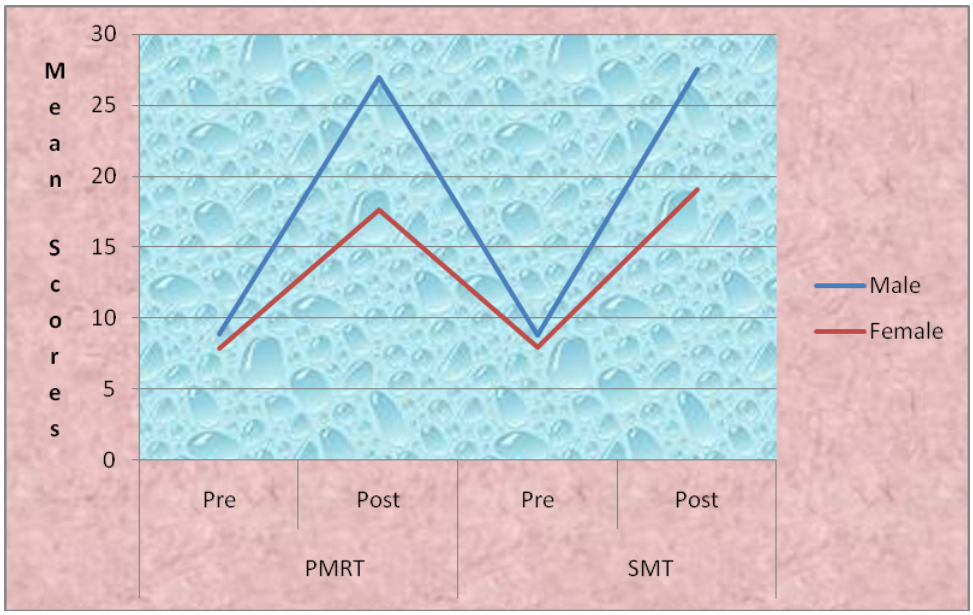
The Graph 4.38 is showing the Mean of respondents on Depression in relation to Conditions, Gender and Therapy. It is clear from the inspection of Graph No. 4.38 that the interaction effect of Conditions, Gender and Therapy was not found to be significant on Depression.

Graph 4.39 Mean of respondents on Problem Solving Coping Strategy in relation to Conditions (Pre and Post), Gender (Male and Female) and Therapy (PMRT and SMT)



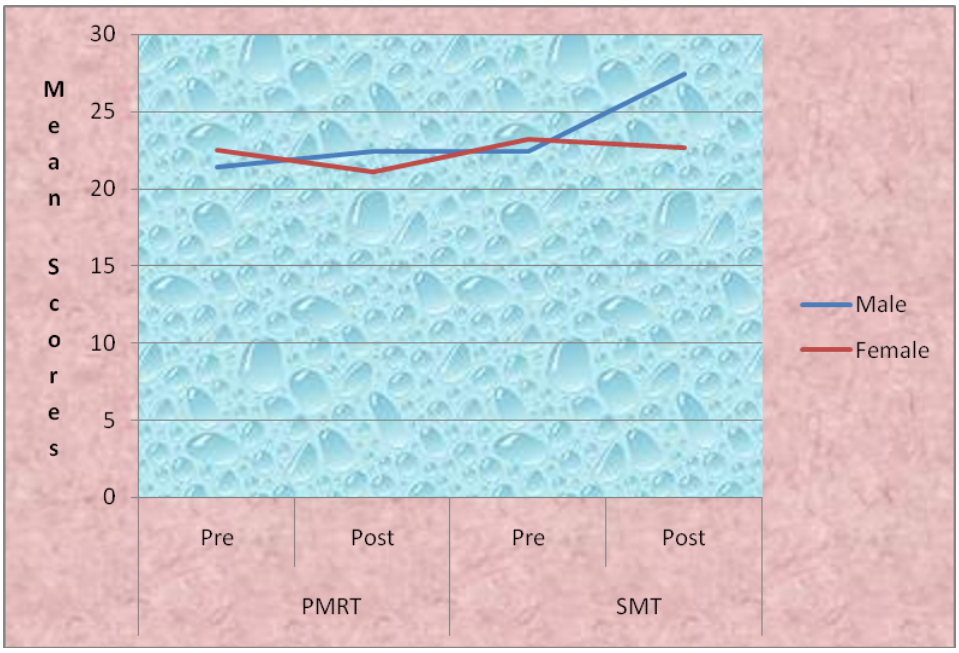
The Graph 4.39 is showing the Mean of respondents on Problem Solving Coping Strategy in relation to Conditions, Gender and Therapy. It is clear from the inspection of Graph No. 4.39 that the interaction effect of Conditions, Gender and Therapy was not found to be significant on Problem Solving Coping Strategy.

Graph 4.40 Mean of respondents on Cognitive Restructuring Coping Strategy in relation to Conditions (Pre and Post), Gender (Male and Female) and Therapy (PMRT and SMT)



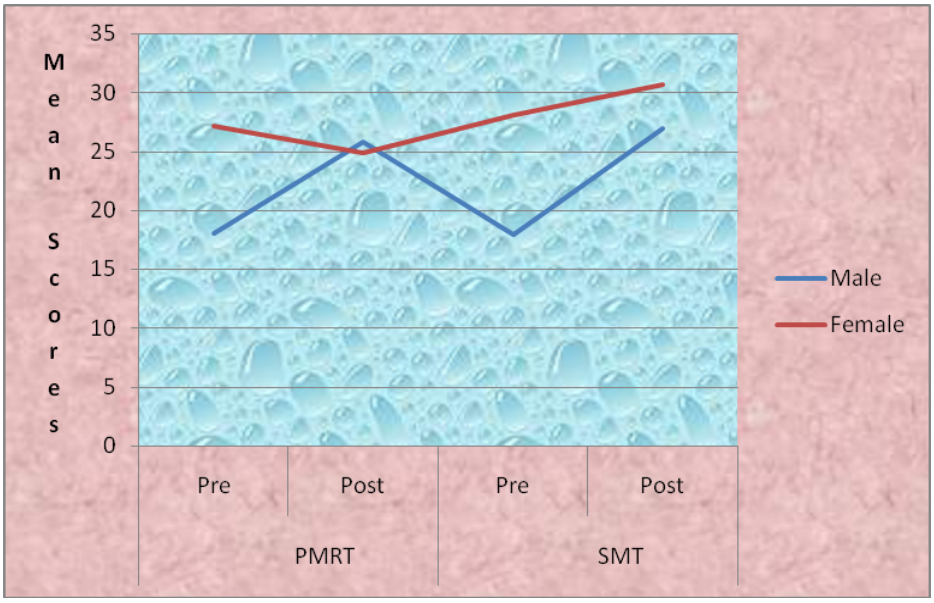
The Graph 4.40 is showing the Mean of respondents on Cognitive Restructuring Coping Strategy in relation to Conditions, Gender and Therapy. It is clear from the inspection of Graph No. 4.40 that the interaction effect of Conditions, Gender and Therapy was not found to be significant on Cognitive Restructuring Coping Strategy.

Graph 4.41 Mean of respondents on Social Support Coping Strategy in relation to Conditions (Pre and Post), Gender (Male and Female) and Therapy (PMRT and SMT)



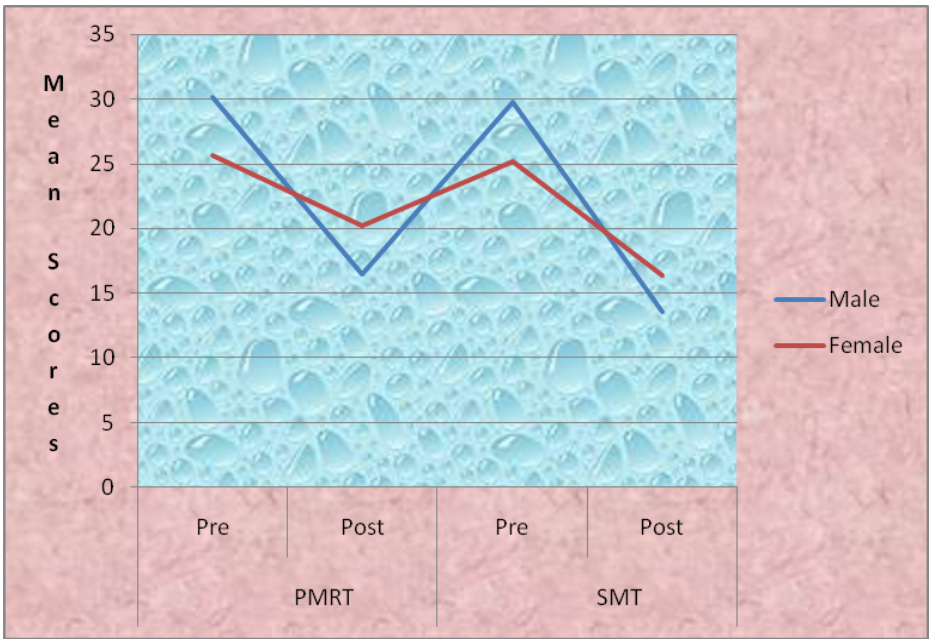
The Graph 4.41 is showing the Mean of respondents on Social Support Coping Strategy in relation to Conditions, Gender and Therapy. It is clear from the inspection of Graph No. 4.41 that the interaction effect of Conditions, Gender and Therapy was not found to be significant on Social Support Coping Strategy.

Graph 4.42 Mean of respondents on Express Emotion Coping Strategy in relation to Conditions (Pre and Post), Gender (Male and Female) and Therapy (PMRT and SMT)



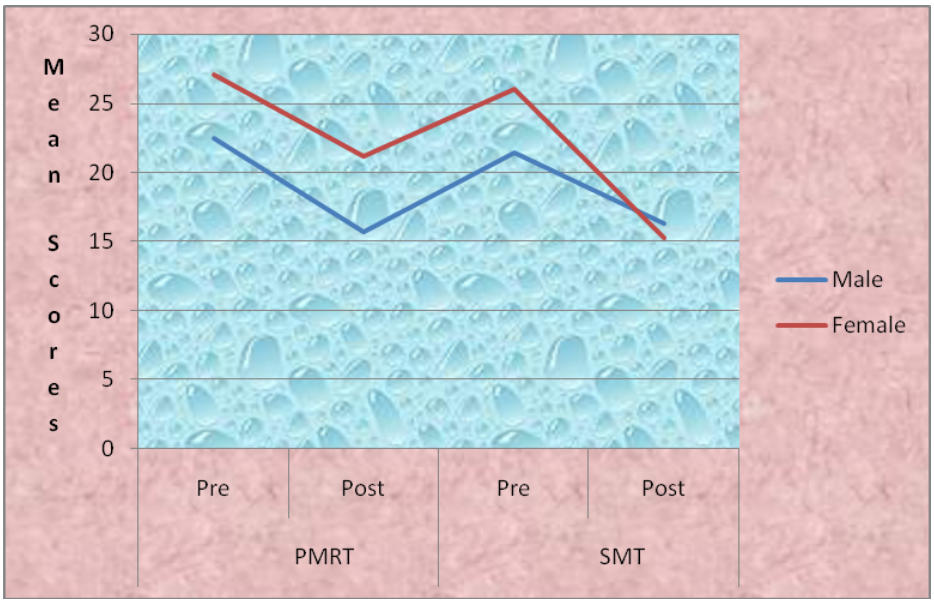
The Graph 4.42 is showing the Mean of respondents on Express Emotion Coping Strategy in relation to Conditions, Gender and Therapy. It is clear from the inspection of Graph No. 4.42 that the interaction effect of Conditions, Gender and Therapy was found to be significant on Express Emotion Coping Strategy. Females were found to express their emotions better in the post condition of SMT.

Graph 4.43 Mean of respondents on Problem Avoidance Coping Strategy in relation to Conditions (Pre and Post), Gender (Male and Female) and Therapy (PMRT and SMT)



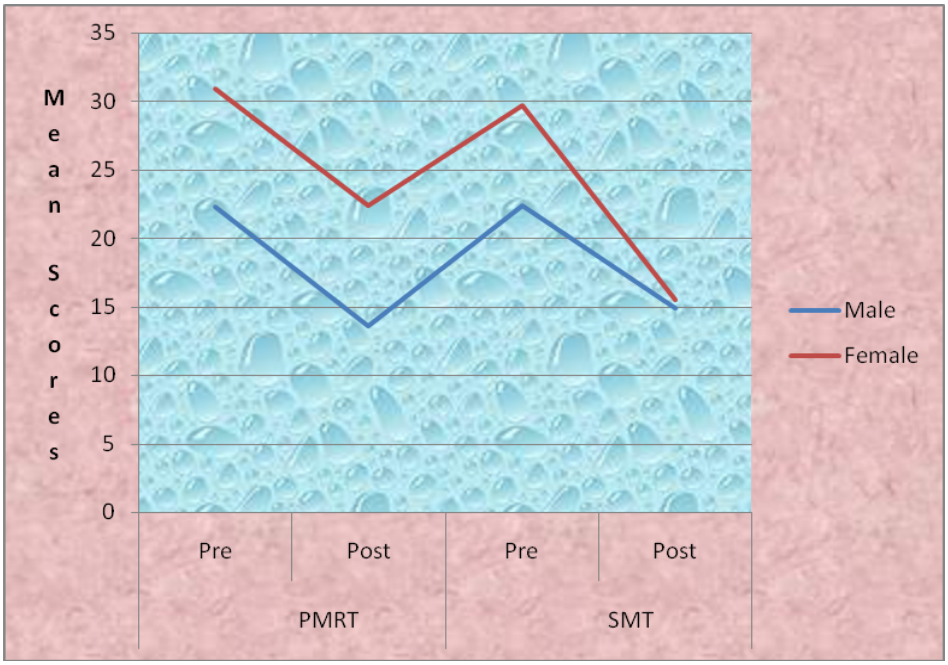
The Graph 4.43 is showing the Mean of respondents on Problem Avoidance Coping Strategy in relation to Conditions, Gender and Therapy. It is clear from the inspection of Graph No. 4.43 that the interaction effect of Conditions, Gender and Therapy was not found to be significant on Problem Avoidance Coping Strategy.

Graph 4.44 Mean of respondents on Wishful Thinking Coping Strategy in relation to Conditions (Pre and Post), Gender (Male and Female) and Therapy (PMRT and SMT)



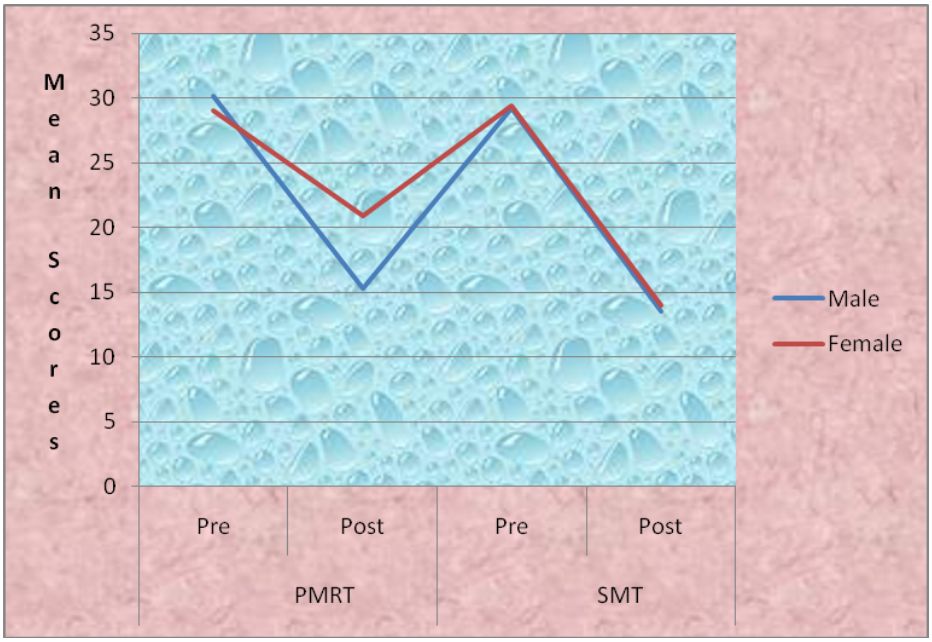
The Graph 4.44 is showing the Mean of respondents on Wishful Thinking Coping Strategy in relation to Conditions, Gender and Therapy. It is clear from the inspection of Graph No. 4.44 that the interaction effect of Conditions, Gender and Therapy was found to be significant on Wishful Thinking Coping Strategy. Males were found to report less Wishful Thinking in the post condition of SMT.

Graph 4.45 Mean of respondents on Self Criticism Coping Strategy in relation to Conditions (Pre and Post), Gender (Male and Female) and Therapy (PMRT and SMT)



The Graph 4.45 is showing the Mean of respondents on Self Criticism Coping Strategy in relation to Conditions, Gender and Therapy. It is clear from the inspection of Graph No. 4.45 that the interaction effect of Conditions, Gender and Therapy was found to be significant on Self Criticism Coping Strategy. Males were found to report less Self Criticism in the post condition of SMT.

Graph 4.46 Mean of respondents on Social Withdrawal Coping Strategy in relation to Conditions (Pre and Post), Gender (Male and Female) and Therapy (PMRT and SMT)



The Graph 4.46 is showing the Mean of respondents on Social Withdrawal Coping Strategy in relation to Conditions, Gender and Therapy. It is clear from the inspection of Graph No. 4.46 that the interaction effect of Conditions, Gender and Therapy was found to be significant on Social Withdrawal Coping Strategy. Males were found to report less Social Withdrawal in the post condition of SMT.

CHAPTER- 5
Discussion

The present Endeavour was to study Suicidal Ideation, Depression and Coping Strategy among male and female orphans and their management through Group Therapy: A Comparative Study.

The subjects with Depression were screened for the sample by using Beck Depression Inventory- II developed by Beck (1961).

For measuring Suicidal Ideation Modified Scale for Suicidal Ideation developed by Miller et.al (1986) was used.

Coping Strategies Inventory by Tobin (1984, 2001) was used to find out the various coping strategies used by the respondents.

The respondents were contacted personally and sample was drawn by using quota sampling technique. A total 200 male and female orphans who had mild to moderate level of Suicidal Ideation and depression within the age range of 14-17 years were selected from various orphanages of Lucknow city (U.P).

To fulfill the prime objective of the study a 2 x 2 x 2 factorial mixed design was used where the two levels of Group Therapy (Progressive Muscular Relaxation Training & Self - Management Training) were matched with two levels of Conditions (Before & After) and two levels of Genders (Males & Females) to yield eight conditions.

Considering the main objectives of the study Means, SDs and ANOVAs were computed which are presented in Tables 4.1 to 4.16. The scoring was done using SPSS 20 (licensed) software. The obtained results are discussed as under:

1. Suicidal Ideation, Depression and Coping Strategies in relation to Group Therapy:-

The **Hypothesis 1** of the present study was that ***"The respondents with PMRT and SMT will differ significantly from each other on Suicidal Ideation".***

To test the above hypothesis Means, SDs & F ratios were computed for **Suicidal Ideation**. The obtained Mean, SD & F ratio for Suicidal Ideation are shown in Table 4.5 Part (A) & Table 4.6 Part (B). As it is clear from the inspection of Table 4.6, Part (B) that the main effect of therapy was found to be significant at .01 levels. It is clear from the observation of Table 4.5 Part (A) & Graph 4.1 that Self -Management Training (SMT) was found to be more effective (Mean being 10.08) than Progressive Muscular Relaxation Training (PMRT) (Mean being 11.03) in reducing Suicidal Ideation among respondents.

These results support the First hypothesis stated above. As it is clear from the results that SMT was found to be more effective in reducing Suicidal Ideation among respondents.

The reason may be contributed to the fact that greater percentage of adolescent's population need to self- manage themselves because it involves greater intrinsic motivation. Thus, SMT is significantly effective in reducing suicidal ideation. These results are supported by the findings of Gupta (2020) who reported that SMT was found to be a very effective technique for Purple Collar workers in handling their anger.

SMT is actually a combined training technique which utilized various techniques such as Self Awareness, Effective Communication, Motivational Learning and Games for training the respondents through Self- Management. Self-Awareness is an experiential learning used in present study which is very close to Self- Actualization. Self- Awareness means self- knowledge, therefore, the statement of Carl Rogers (2009) ***"I am at my best as a therapist, when I am closest to my inner, intuitive self. Then whatever I do seems to be full of healing"*** is very close to the concept of Self Awareness. Important factor is that suicidal ideation is directly related to negative thinking. Thinking has a significant impact on how we feel. Negative thoughts encourage negative feelings and positive thoughts encourage positive feelings. Cohen (2009) suggested that whenever we have negative thoughts, our brain releases chemicals that cause ill feeling. Good thoughts have the reverse effect making us feel good. Clearly, suicidal ideation is strongly influenced by our thinking. A study of Joormann (2011) has revealed that orphans suffering from suicidal ideation get stuck on bad thoughts because of the loss of loved ones. They're unable to turn their attention away. Though a majority of the orphan population (if they have any support) is able to pull out of the negative thoughts caused by these situations, some fail to do so. This leads them to develop suicidal ideation. In the process of SMT which focuses more on Self

Awareness a person regularly thinks positive about himself- the positive feelings reduce suicidal ideation.

Mindfulness Breathing is another technique of SMT used in the present study also helps to create self-awareness and helps to reduce suicidal ideation. The regular practice of Mindfulness Breathing activates the functions of hypothalamus and the sympathetic process affects the functions of neurotransmitters as a result the secretion of dopamine is increased. Dopamine is responsible for happiness (Markand, 2004). The whole process of mindfulness breathing works like self-motivating technique, which encourages a person to think in a positive way and increases the self -confidence and takes away the feeling of sadness & suicidal ideation.

Many researches Gupta & Srivastava (2016), Sahu (2009) Shukla, (2007) have revealed that Mindfulness Breathing is significantly effective to deal with Suicidal Ideation. These might be the reasons why SMT was found to be more effective than PMRT. One more reason may be attributed to effective communication which has also been used as the Self-Management Training. Effective Communication skills are very important in present scenario, because it helps to improve teamwork, decision making and problem- solving approaches. Effective communication helps us better understand a person or situation and enables us to resolve differences, build trust and respect, and create environments where creative ideas, problem solving, affection, and caring can flourish (Martin et.al 2014). Effective Communication builds strength and creates a supportive environment by making behavioral changes which weaken depressive thoughts & suicidal ideation (Watson & Bedard, 2011).

Motivational Therapy and Games another technique of Self -Management Training also systematically replace the negative thoughts with positive thoughts. The study of Williams (1998) & Abner (1997), revealed the significant positive effects of Motivational Therapy. Motivational Therapy a technique of SMT is also a type of experiential learning which helps to remove the negative thoughts and creates positive thinking. It is a combination of humanistic treatment and enhances cognitive behavioral strategies both of which are very helpful in reducing Depression & Suicidal Ideation. (Larson et.al, 2013). While in PMRT the respondents need a lot of concentration & attention to follow the instruction of the

researcher. PMRT might give better results for some other constructs but as far on Suicidal Ideation is concerned it was not found to be much effective.

A number of studies Maxwell & Cockriel, (1995), Roy et.al., (1999) & Blane (1985) have concluded that those who use more self-management techniques tend to have a more positive outlook, higher satisfaction and a better quality of life.

The **Hypothesis 2** of the present study was that ***"The respondents with PMRT and SMT will differ significantly from each other on Depression".***

To test the above hypothesis Means, SDs & F ratios were computed for **Depression**. The obtained Mean, SD & F ratio for Depression are shown in Table 4.5 Part (A) and Table 4.7 Part (B). As it is clear from the inspection of Table 4.7 Part (B) that the main effect of therapy was found to be significant at .01 levels. It is clear from the observation of Table 4.5 Part (A) and Graph No. 4.1 that Self- Management training was found to be more effective (Mean being 14.33) than Progressive Muscular Relaxation Training (Mean being 15.56) in reducing Depression among respondents. So, the H.2 has been accepted.

As it is clear from the results that Self -Management training was found to be more effective than Progressive Muscular Relaxation Training even in reducing depression also. This finding stands in contrast with the findings of Gupta (2020) who found PMRT as effective technique for managing depression among No-Collar workers. The reason of the finding of the present study may be contributed to the fact that a key skill in self- management is self-regulation. Self -Regulation refers to individuals monitoring, controlling and directing aspects of their learning for themselves. The best use of self-management support is the collaborative interaction between the therapist and the client. Motivating, listening, and coaching are important self-management support skills that can make the therapist client interaction stronger and in which all members of the care team can become knowledgeable. Through ongoing training and practice, supporting clients in self- care will become part of day-to-day care. SMT is effective for building greater awareness and self -acceptance, changing unsatisfying patterns and behaviors, motivation and developing the necessary skills to face life's challenges. This training also helps to live in the present moments and open true nature, which encompasses the inherent qualities of happiness and well- being (Cohen, 2006).

As it is well known that the SMT is a kind of experiential and motivational learning. These practices direct a person in the path of happiness, compassion, selflessness, and change negative thoughts into positive thinking which help a person to cope more effectively with depression. Thus, SMT is the process of realizing that every individual possesses unique qualities which differentiate him from others.

Progressive Muscular Relaxation Training was found to be less effective as it is a type of therapy that focuses on tightening and relaxing specific muscle groups in sequence. The SMT is found much effective because by this training the changes are found in cognitive level also while in PMRT the changes of cognitive level are not found.

The results of Singh (2006), Nandi (1994) and Lingaswami (1992) have supported the results of present study that increase in the level of Self- Management Training significantly reduces Depression of Indian adolescents. The results are also supported by the study of Das et.al, (2013), who found that Motivational Therapy significantly reduces the level of Depression among orphans. San Francisco General Hospital (1983) studied the effect of deep breathing along with motivational counseling on depressive patients and found the significant positive effect of deep breathing & motivational counseling. Hannig (2010) wrote about motivational therapy that, it is a process like counseling, very close to the Catharsis, an emotional release.

The **Hypothesis 3** of the present study was that ***"The respondents with PMRT and SMT will differ significantly from each other on Overall Coping Strategies."***

To test the above hypothesis Means, SDs & F ratio were computed for **Overall Coping Strategies**. The obtained Mean, SD & F ratio for Overall Coping Strategies are shown in Table 4.8 Part (B). As it is clear from the inspection of Table 4.8 Part (B) that the main effect of therapy was found to be significant at .05 levels. It is clear from the observation of Table 4.5 Part (A) that here also SMT was found to be more effective (Mean being 167.51) than PMRT (Mean being 165.82) in strengthening positive coping strategy and in weakling negative coping strategies among respondents. So, the H.3 was accepted.

These results are supported by the study of Mangal & Dubey (2012), in which the researchers reported that motivational counseling had a beneficial effect on coping skills

and personality development of adolescents at their physical, mental, emotional and intellectual levels. They concluded that all the changes developed as the results of accumulation of the effects of motivational techniques and due to the contribution to the positive self- image of the individual and developed positive coping skills thereby. The results are also supported by the study of Bharti et.al, (2001) who reported that self-managing skills are more effective for improving coping of adolescents. Gupta (2021) also found SMT more effective in enhancing the EQ of wives of Dual Career Families. Researchers have found the Depression to be positively correlated with negative coping strategies; some have found them to be unrelated. They have also found that effective communication skills tend to enhance the coping strategies.

In contrast to the findings of present study, (Kamlesh, 2005), reported that regular practice of Progressive Muscular Relaxation Training improves the positive coping strategies among orphans.

The present study has also tried to explore different **Dimensions of Coping Strategies.** The descriptions of these dimensions are given as under: -

Firstly ,only those dimensions of Coping Strategies are being described which were found to be significant and then those dimensions of Coping Strategies will be described collectively which were not found to be significant. So, considering this, Hypothesis no **3.1, 3.3, 3.5, 3.6, 3.7 & 3.8 were accepted.** They are described as under: -

H.3.1 There will be significant difference on Progressive Muscular Relaxation Training & Self-Management Training on Problem Solving Coping Strategy among male & female orphans.

H.3.3 There will be significant difference on Progressive Muscular Relaxation Training & Self -Management Training on Express Emotion Coping Strategy among male & female orphans.

H.3.5 There will be significant difference on Progressive Muscular Relaxation Training & Self- Management Training on Problem Avoidance Coping Strategy among male & female orphans.

H.3.6 There will be significant difference on Progressive Muscular Relaxation Training & Self- Management Training on Wishful Thinking Coping Strategy among male & female orphans.

H.3.7 There will be significant difference on Progressive Muscular Relaxation Training & Self -Management Training on Self Criticism Coping Strategy among male & female orphans.

H.3.8 There will be significant difference on Progressive Muscular Relaxation Training & Self-Management Training on Social Withdrawal Coping Strategy among male & female orphans.

To test the above hypotheses Means, SDs & F ratios were computed for Problem Solving, Express Emotions, Problem Avoidance, Wishful Thinking, Self-Criticism and Social withdrawal Coping Strategies. The obtained F ratios are shown respectively in Table 4.9 Part (B), 4.12 Part (B), 4.13 Part (B), 4.14 Part (B), 4.15 Part (B) & 4.16 Part (B). As it is clear from the inspection of above said tables that the main effect of therapy was found to be significant at .01 levels. It is clear from the observation of Table 4.5 Part (A) and Graph No 4.2 Problem Solving Coping Strategy (Mean being 13.77 in SMT and 12.59 in PMRT), Express Emotions Coping Strategy (Mean being 25.85 in SMT & 23.91 in PMRT), Problem Avoidance Coping Strategy (Mean being 21.23 in SMT & Mean being 23.11 in PMRT), Wishful Thinking Coping Strategy (Mean being 19.76 in SMT & Mean being 21.60 in PMRT), Self- Criticism Coping Strategy (Mean being 20.62 in SMT and 22.31 in PMRT) & Social withdrawal Coping Strategy (Mean being 21.52 in SMT & 23.83 in PMRT) that SMT was found to be more effective than PMRT. Since Problem Solving (PS) and Express Emotion (EE) are positive dimensions of coping Strategies and rest of the dimensions of coping strategies such as Problem Avoidance (PA), Wishful Thinking (WT), Self -Criticism (SC) and Social Withdrawal (SW) are negative dimensions of coping strategies, so Mean values of positive coping strategies like PS and EE were found to be greater in SMT than PMRT suggesting that SMT has improved these two positive coping strategies. These results are supported by the study of Kumar & Singh (2009) suggested that Motivational Enhancement therapy (MET) along with Mindfulness Breathing were significantly effective to improve the level of Express Emotions & Problem- Solving Coping Strategies among adolescents.

While the Mean values of negative coping strategies like PA, WT, SC and SW was lesser in SMT as compared to PMRT suggesting that SMT has modified the negative coping strategies. In other words with the help of SMT the respondents coping abilities have modified and as results of which now they can better cope with their Depression & Suicidal Ideation.

The intervention by SMT has improved the respondents coping strategies. Now they are better able to eliminate the source of stress by changing the stressful situation more effectively and now they are better able to release & express their emotions which help them to purge out their negative thoughts and feelings leading to feel less depressed. A person feels more depressed when he/she always tend to criticize himself for everything, wishing everything could be better i.e. they are not satisfied with their present situation & finally when they don't want to face the stressful situation. The results have indicated that with the intervention of SMT & PMRT the subjects' tendencies to criticizing (SC) themselves for everything, dissatisfaction with the events (WT) and withdrawn reaction (SW) were controlled more by SMT.

These findings are supported by the study of Gupta (2007) who found the impact of Self Awareness on Social withdrawal behavior. In this study it was found that the practice of self- awareness had a significant impact on social withdrawal behavior and improved the level of self-confidence. It was reported that self -management training was more effective to improve engagement coping strategies as compared to life skill training among depressed adolescents. Dubey et.al., (2015) suggested that through engagement coping strategies individual engage in an active and ongoing negotiations in the stressful environment while in disengagement coping strategies individuals do not share their own feelings with others. They avoid problems and don't take initiative behavior.

The rest of the two dimensions of coping strategies i.e. Cognitive Restructuring and Social Support were not found to be significant. These results reject the H. 3.2 and H. 3.4 which are stating that :-

H.3.2 ***There will be significant difference on Progressive Muscular Relaxation Training & Self- Management Training on Cognitive Restructuring Coping Strategy among male & female orphans.***

H.3.4 ***There will be significant difference on Progressive Muscular Relaxation Training & Self- Management Training on Social Support Coping Strategy among male & female orphans.***

Cognitive Restructuring and Social Support Coping Strategies were positive coping strategies. Cognitive Restructuring Coping Strategy refers to cognitive strategies that alter the meaning of the stressful transaction as it is less threatening while Social Support Coping Strategy refers to seeking emotional support from people, one's family, and one's friends.

These results were supported by the study of Dayal & Kapoor (2003) who concluded on the basis of their findings that relaxation therapy was not effective to improve the level of positive coping among adolescents.

2. Suicidal Ideation, Depression and Coping Strategies in relation to Gender:-

The **Hypothesis 4** of the present study was that ***"There will be a significant gender difference on Suicidal Ideation among male & female orphans".***

To test the above hypothesis Means, SD & F ratio were computed for **Suicidal Ideation**. The obtained Mean, SD & F ratio for Suicidal Ideation are shown in Table 4.6 Part (A) & 4.6 Part (B). As it is clear from the inspection of Table 4.6 Part (B) that the main effect of Gender was found to be significant at .01 levels. It is clear from the observation of Table 4.6 Part (A) & Graph 4.3 that females were having more Suicidal Ideation (Mean being 13.61& 8.39 in pre-& posttest conditions) than Males (Mean being 12.9 & 7.34 in pre & posttest conditions). Thus H. 4 stated above was accepted.

The reason may be attributed to our societal structure & different varying practices for males & females. In line with these findings, Ehnvall et.al. (2008) reported that feeling rejected by parents was a significant predictor of lifetime suicide attempts for women, although not for males. Briere et.al. (2015) reported deprived of love and emotional abuse; was strongly predict suicidal ideation for females as compared to males. A longitudinal study of patients with mood disorders found that women had more suicide attempts than men. (Simon et.al., 2000). Azorin et.al. (2014) also reported that females were more

associated with suicide attempts. Kessler et.al., (1999) & Marcus et.al., (2008) also concluded that women are nearly twice as likely as men to report moderate difficulty with suicidal feelings or behaviors. A nine-country study reported that women had consistently higher rates for suicide attempts. (Weissman, Bland & Canino,1999).

Gender-based violence is a significant predictor of suicidality in women, with more than 20% of women who have experienced violence attempting suicide. (Stark & Flitcraft,1996). Rehman et. al. (2012) has indicated that behavioral and emotional disorders are highly prevalent among female orphans than male orphans. Anderson et.al. (2002) reported an increased rate of suicide attempts in abused women compared to men, although investigators questioned whether the findings reflected higher abuse prevalence in women rather than differential susceptibility to the abuse. However, they found that early sexual abuse predicted suicidal behavior among adolescent girls but not among boys.

In contrast to the findings of the present study, Fried et.al. (2014) demonstrated that under conditions of stress, males were found to have more suicidal ideation. Schneider (2014) also found in a recent cohort study that male sex predicted risk for suicide. Fergusson and colleagues (2015) reported that teen boys who had been sexually abused displayed more suicidal behaviors than sexually abused girls. Diefenbah (2009) & NIMH (2009) in their collaborative study found no gender differences in number of suicide attempts Peter et.al (2004) conducted a study to identify the psychosocial problems of orphans and non-orphans. Findings showed that prevalence and seriousness of psychosocial problems (negative emotion, stigma, depression and behavioral problems) was higher among orphans than non-orphans. No gender differences were found in this study.

The **Hypothesis 5** of the present study was that ***"There will be a significant gender difference on Depression among male & female orphans"***.

To test the above hypothesis, Mean, SD & F ratios were computed for **Depression**. The obtained Mean, SD & F ratios for Depression are shown in Table 4.7 Part (A) & Table 4.7 Part (B). As it is clear from the inspection of Table 4.7 Part (B) that the main effect of gender was found to be significant at .01 levels. It is clear from the observation of Table 4.7 Part (A) and Graph No 4.3 that females had more depression (Mean being 20.3 & 11.37

in pre-& posttest conditions) than Males (Mean being 17.58 & 10.55 in pre-& posttest conditions). The results support H.5.

The reason may be attributed to the fact that females still have second position in society. Situations become acute with orphan females because they feel more helpless than males, they cannot change anything, they are unable to express their emotions which make them feel more anxious and depressed as compared to males. Since no one seems to understand them, they tend to internalize their emotions. Although the trend is changing rapidly but the gender discrimination has so deeply rooted that it operates in each and every spheres of life. In education Nursery Rhymes, G.K or Color Preference gender difference operates at all levels. In family gender differences operates even in the division of household works. The boys will either be not signed any work or if assigned they are given mainly works such as buying things from market etc but girls are given typical works which are especially meat for females such as dusting, cooking etc. So, it operates at every level so females are not generally encouraged to talk about themselves and to express how they feel so when given the opportunity they often have trouble verbalizing their emotions.

The gender difference in depression is one of the most robust findings in psychiatric epidemiology. (Norman et.al 1989) These results are supported by Survey of Voice of Azamgarh Community Radio (2015) which was done on adolescence females of marginalized community. In this survey the main reason for girls' depression was contributed to the fact that they were treated as second citizen in the society, they don't have their own identity, thoughts, desires and freedom. These females don't have many opportunities to share their emotions even they can't share or express their physical & mental health problems. Malnutrition, lack of awareness and social taboos were identified as the other main reasons of depression.

The present finding is also supported by the study of Piccinelli & Homen (1997) who reported that depression contributes most significantly to the global burden of disease and it most frequently encountered female's mental health. Major depression occurs approximately twice as often in adolescent females as in adolescent males. A comprehensive study of almost all orphan population conducted in the United States of America, Puerto Rico, Canada, France, Iceland, Taiwan, Korea, Germany and Hong Kong, reported that women predominated over men in lifetime prevalence rates of major

depression. (Bracke, 2000). Depression may also be more persistent in women and female gender is a significant predictor of relapse. Kuehner (1999) & Kessler et.al. (1995) found that women also have significantly higher rates of Depression than men General population surveys have reported that around 1 in every 12 adults experiences depression at some time in their lives and women's risk of developing depression following exposure to trauma is approximately two-fold higher than men. (Breslau et al 1998). In contrast to the finding of the present study Sangmittra (2014) reported that no gender difference in depression.

The **Hypothesis 6** of the present study was that ***"There will be a significant gender difference on Overall Coping Strategies among male & female orphans".***

To test the above hypothesis, Mean, SD & F ratio was computed for **Overall Coping Strategies.** The obtained Mean, SD & F ratio for Overall Coping Strategies are shown in Table 4.8 Part (A) & 4.8 Part (B). As it is clear from the inspection of Table 4.8 Part (B) that the main effect of gender was not found to be significant. So, these results reject H. 6 stated above.

These results are supported by the study of Christensen et.al. (2005) who reported that there was no significant gender difference in coping skills, however they observed a general tendency suggesting that boys were more likely to use active coping skills than girls, those involving the expression of emotion. The results are also supported by the study of Mirkovic et.al. (2015) who reported no significant differences between boys and girls on total scores for productive coping, nonproductive coping, and reference to others coping strategies. Jacob et.al. (2009), explained coping strategies used more by female orphans adolescent than boys. They have also proved that a number of challenges faced by these orphans, they had strong attachment to their parents, all of them experienced sadness, sorrow, hopelessness so they still developed some coping strategies to adapt in their adversities

In contrast to the findings of present study Li et.al., (2006) showed that girls with depression used more emotion-focused and ruminative coping than boys.

The present study has also tried to explore different **Dimension of Coping Strategies.** The descriptions of these dimensions are given as under: -

Firstly, those dimensions of Coping Strategies are being described which were found to be significant & then those dimensions of Coping Strategies are described collectively which were not found to be significant. Most of the dimensions of Coping Strategies were found to be significant. Such as Problem Solving, Cognitive Restructuring, Express Emotions, Social Support, Wishful Thinking, Self-Criticism & Social Withdrawal Coping Strategies. The hypotheses on these dimensions are: -

H.6.1 There will be a significant gender difference on Problem Solving Coping Strategies among male & female orphans.

H.6.2 There will be a significant gender difference on Cognitive Restructuring Coping Strategies among male & female Orphans.

H.6.3 There will be a significant gender difference on Express Emotion Coping Strategies among male & female orphans.

H.6.4 There will be a significant gender difference on Social Support Coping Strategies among male & female orphans.

H.6.6 There will be a significant gender difference on Wishful Thinking Coping Strategies among male & female orphans.

H.6.7 There will be a significant gender difference on Self Criticism Coping Strategies among male & female orphans.

H.6.8 There will be a significant gender difference on Social Withdrawal Coping Strategies among male & female orphans.

To test the above hypotheses, Mean, SD & F ratios were computed. The obtained Mean, SD & F ratio are shown in Table 4.9, 4.10, 4.11, 4.12, 4.14, 4.15 & 4.16 Part (B). As it is clear from the inspection of above said Tables Part (B) that the main effect of gender was found to be significant at .01 levels so all the above hypotheses were accepted. It is clear from the observation of Table 4.9 Part (A), 4.10 Part (A), 4.11 Part (A), 4.12 Part (A), 4.14 Part (A), 4.15 Part (A) & 4.16 Part (A) and Graph No 4.4 that Males were found to report more Problem Solving Coping Strategy (Mean being 5.75 & 26.92 for males & Mean being 3.83 & 16.23 for females), Cognitive Restructuring Coping Strategy (Mean being 8.81 & 27.29 for males & Mean being 7.86 & 18.33 for females)

& Social Support Coping Strategy (Mean being 21.88 & 24.92 for males & Mean being 22.84 & 22.15 for females) in pre & post conditions while Females were reported more Express Emotions (Mean being 27.53 & 27.52 & Mean being 17.93 & 26.34 for males), Wishful Thinking (Mean being 26.52 & 18.24 for females & Mean being 21.96 & 16.91 for males), Self-Criticism (Mean being 30.29 & 18.95 for females & Mean being 22.35 & 14.27 for males), & Social Withdrawal (Mean being 29.2 & 17.39 for females & Mean being 29.71 & 14.41 for males) in pre & posttest conditions respectively.

Wishful Thinking, Self-Criticism, Social Withdrawal & Problem Avoidance Coping Strategies are negative coping strategies while Express Emotion Coping strategy is the form of positive coping strategy which helps the respondents to cope by releasing & expressing their emotions frequently. It is noticeable that females as compared to males use more negative coping strategies. The reason may be attributed that our society is male dominating not only in family but in other contexts females are pressurized by the restrictions, taboos and prejudice & they are sexually abused also. The pressures & expectations make them much weaker, self-blaming, self-centered, socially withdrawn and tend to avoid the problems. They live their lives "As an When" basis. In orphan populations, studies have indicated that men were more likely to engage in distracting behaviors that dampened their depressive mood, whereas women were more likely to amplify their mood by ruminating. According to the literature review by Christensen and Kessing (2005) the general tendency for men was to distract themselves using active coping strategies, whereas women used strategies involving the expression of emotion. Thompson et.al. (2005), reported that girls and boys tend to cope differently and that the coping styles adopted by girls put them at greater risk of experiencing depression and suicidal ideation. Naqashbandi et.al. (2012) found female orphans feel it difficult to adjust in the society after leaving institution.

Gearing et. al. (2013) conducted a study to establish prevalence of mental health and behavioral problems among male & female orphans in institutional care and found that institutionalized female orphans suffer mental and behavioral problems and they use more problem avoidance coping strategies than males. According to Allgower et.al (2001) lack of social support coping strategy linked to poorer mental and physical health among males. Social support generally functions as a buffer to reduce depression, suicidal ideation and enhance positivity for female adolescents in

depressive events. The studies of Mann (2013), also support the findings of the present study. All these studies reported that males were found to use greater problem focused coping skills than females while emotion focused coping skills was found to be used more by females as compared to males.

In contrast to the findings of the present study Srivastava & Sinha (2014) & Bhatt (2014) revealed no significant gender difference in problem focused and emotion focused coping strategies among male & female adolescents.

One dimension of coping strategy was not found to be significant that is hypothesis no 6.5 stated that: -

"There will be a significant gender difference on Problem Avoidance Coping Strategies among male & female orphans".

As it is evident from the results that the main effect of gender on Problem Avoidance Coping dimension (Table 4.13 Part B) was not found to be significant. So, this finding rejects the H. 6.5.

The study of Sharma & Lal (2008) found in contrast with this result of the present study in which they reported that females were use more negative coping strategies than males while males were found to use more positive coping strategies such as cognitive reframing, problem oriented & social support.

3. Suicidal Ideation, Depression and Coping Strategies in relation to Conditions :-

As it is evident from the inspection of Table No. 4.6 to Table No. 4.16 Part (B) that the main effect of conditions (Pre-& Post) was found to be significant on **Depression, Suicidal Ideation, Overall Coping Strategies & on all its dimensions.** So, all the hypotheses related to the conditions were accepted. The description of them is given as under: -

H.7 ***There will be a significant difference in Pre-test & Post-test condition scores of both the therapies (PMRT & SMT) on Suicidal Ideation among male & female orphans.***

H.8 There will be a significant difference in Pre-test & Post-test condition scores of both the therapies (PMRT & SMT) on Depression among male & female orphans.

H.9 There will be a significant difference in Pre-test & Post-test condition scores of both the therapies (PMRT & SMT) on Overall Coping Strategies among male & female orphans.

H.9.1 There will be a significant difference in Pre-test & Post-test condition scores of both the therapies (PMRT & SMT) Problem Solving Coping Strategy among male & female orphans.

H.9.2 There will be a significant difference in Pre-test & Post-test condition scores of both the therapies (PMRT & SMT) on Cognitive Restructuring Coping Strategy among male & female orphans.

H.9.3 There will be a significant difference in Pre-test & Post-test condition scores of both the therapies (PMRT & SMT) on Express Emotion Coping Strategy among male & female orphans.

H.9.4 There will be a significant difference in Pre-test & Post-test condition scores of both the therapies (PMRT & SMT) on Social Support Coping Strategy among male & female orphans.

H.9.5 There will be a significant difference in Pre-test & Post-test condition scores of both the therapies (PMRT & SMT) on Problem Avoidance Coping Strategy among male & female orphans.

H.9.6 There will be a significant difference in Pre-test & Post-test condition scores of both the therapies (PMRT & SMT) on Wishful Thinking Coping Strategy among male & female orphans.

H.9.7 There will be a significant difference in Pre-test & Post-test condition scores of both the therapies (PMRT & SMT) on Self Criticism Coping Strategy among male & female orphans.

H.9.8 There will be a significant difference in Pre-test & Post-test condition scores of both the therapies (PMRT & SMT) on Social Withdrawal Coping Strategy among male & female orphans.

All the above Hypotheses were accepted.

As it is clear from the inspection of Table No. 4.5 Part (B) that values of post tests on all the variables and on all the dimensions of Coping strategies except for positive coping strategies such as PS, CR, SS & EE were found to be lesser than the values on pre-conditions. The Mean values of Positive Coping Strategies were found to be more in post condition of both the group therapies. As it is evident from the Table No. 4.5 Part (B) and Graph No. 4.5 that Suicidal Ideation (Mean being 18.94 in Pre &10.96 in post condition) and Depression (Mean being 13.25 in Pre & 7.86 in Post condition) were reduced significantly in post conditions, Overall Coping Strategies (Mean being 165.92 in Pre & 162.41 in post condition), Problem Solving Coping Strategy (Mean being 4.79 in Pre & & 21.57 in post condition), Cognitive Restructuring Coping Strategy (Mean being 8.33 in Pre & 22.81. in post condition), Social Support Coping Strategy (Mean being 22.36 in Pre & 23.40 in Post condition), Express Emotion Coping Strategy (Mean being 22.73 in Pre & 27.03 in Post condition) were improved in post conditions and Problem Avoidance Coping Strategy (Mean being 27.69 in Pre & 16.65 in Post condition), Wishful Thinking Coping Strategy (Mean being 24.24 in Pre & 17.12 in Post condition), Self-Criticism Coping Strategy (Mean being 26.32 in Pre & 16.61 in Post condition), Social Withdrawal Coping Strategy (Mean being 29.45 in Pre & 15.9 in Post condition) were reduced significantly in post conditions of the Group Therapy (Graph No. 4.6).

These results suggest that intervention is significantly affecting the Suicidal Ideation, Depression, Overall Coping Strategies and all the dimension of Coping Strategies among male & female orphans because before the intervention the respondents were having more Suicidal Ideation & Depression, but after intervention it reduced a lot while the amount of Positive Coping Strategies were found to be very low and Negative Coping Strategies were found to be very high but after the intervention it was found that Positive Coping Strategies were improved & Negative Coping Strategies were reduced among male & female orphans.

Winnie et.al. (2010) suggested that progressive muscle relaxation is a useful adjuvant technique for reducing negative & suicidal thoughts. According to Yoo et.al. (2011) progressive muscle relaxation involves tensing and relaxing the muscles, one body part at a time to bring about a feeling of physical relaxation. By using progressive muscle relaxation patient can counter the physical changes, reduction of suicidal ideation, depression and sensations to achieve a

"relaxation response." Researchers report that relaxation training methods, including progressive muscle relaxation works best if a person is trained. After two hours of intervention, patients usually experience enough to successfully practice the techniques on their own. It involves systematically constricting and relaxing various muscle groups from feet upward or head downward. All these finding suggest the effectiveness of group therapy in reducing Depression & Suicidal Ideation.

The interventions were found effective for Depression as the post condition Mean are much lesser than the pre-condition Mean. Few of the researches have been carried out to assess and manage depression among orphans. Gorden (2005), also recommended that relaxation, deep breathing, walking, imagery or visualization were more effective type of non-pharmacological methods for chronic depression. Raghvan et.al (2014) also reported that P.M.R.T is one of the cognitive behavioral coping strategies which have been found beneficial in depressive patients.

The studies were found to be effective on all the dimensions of the coping strategies. The study of Khan (2013) supported the findings of the present study in which he concluded that Motivational Counseling was more effective than CBT to improve problem focused coping strategies among adolescents. Sinha & Pal, 2010), explained that regular practices of deep breathing exercises enhance positive coping strategies.

4. Suicidal Ideation, Depression and Coping Strategies in relation to Gender (Male \and Female) and Group Therapy (PMRT and SMT) (Interaction):-

As it is evident from the inspection of Table No. 4.6, Table No 4.7 & Table No 4. 8 Part (B) that the interaction effect of Gender & Therapy was not found to be significant on **Suicidal Ideation, Depression and Overall Coping Strategies**. The hypotheses which were framed for these variables are stated as under:-

H.10 There will be a significant interaction between Gender (Male and Female) and Therapy (PMRT and SMT) on Suicidal Ideation.

H.11 There will be a significant interaction between Gender (Male and Female) and Therapy (PMRT and SMT) on Depression.

H.12 There will be a significant interaction between Gender (Male and Female) and Therapy (PMRT and SMT) on Overall Coping Strategies.

The results of the present study reject all the three above stated hypotheses since they were not found to be significant. These finding suggest that there is no significant gender differences on Suicidal Ideation, Depression & the way the respondents cope with their Suicidal Ideation and Depression in relation to therapies (PMRT & SMT). In other words, it can be concluded that males and females experience equal levels of Suicidal Ideation & depression in both types of group therapies i.e. PMRT & SMT. The reason may be contributed to the fact that in the present scenario we all are living in a very stressful situation. In the context of the present study both types of respondents (males & females) are sharing the same environment and more or less are exposed to the same stressors. So, no significant gender differences were found across therapies. Since none of them are trained or guided how to get rid of their Suicidal Ideation and how to cope up with their depression, they don't even differ significantly in their ways of coping with the depression and with their suicidal thoughts.

Zaheer et.al (2014) also supported the results of the present study by concluding no significant difference in coping strategies among males & females after the group life skill training. This study was concluded on orphan population in Kashmir. In contrast to the findings of present study Richerdson (2011) revealed that PMRT was a very effective technique to reduce depression and enhance cognitive & problem focused coping for male adolescents as compared to female adolescents.

As far as **Dimensions of Coping Strategies** are concerned it is evident from the inspection of results that the interaction of gender & therapy was found to be significant only on five dimensions of coping strategies. These dimensions of coping strategies are Problem Solving Coping Strategy (Table No 4.9), Express Emotion Coping Strategy Table (No 4.12), Wishful Thinking Coping Strategy Table (No 4.14), Self-Criticism Coping Strategy Table No (4.15), & Social Withdrawal Coping Strategy (Table No 4.6). The hypotheses which were framed on these dimensions are: -

H.12.1 There will be a significant interaction between Gender (Male and Female) and Therapy (PMRT and SMT) on Problem Solving Coping Strategy.

H.12.4 There will be a significant interaction between Gender (Male and Female) and Therapy (PMRT and SMT) on Express Emotion Coping Strategy.

H.12.6 There will be a significant interaction between Gender (Male and Female) and Therapy (PMRT and SMT) on Wishful Thinking Coping Strategy.

H.12.7 There will be a significant interaction between Gender (Male and Female) and Therapy (PMRT and SMT) on Self Criticism Coping Strategy.

H.12.8 There will be a significant interaction between Gender (Male and Female) and Therapy (PMRT and SMT) on Social Withdrawal Coping Strategy.

All the above stated hypotheses of the present study were accepted as the interaction effect of Gender & Therapy on these dimensions were found to be significant.

Problem Solving coping strategies, Wishful Thinking coping strategy, Self-Criticism coping strategy and Social Withdrawal coping strategies were found to be modified more in males in post conditions of SMT as compared to females while Express Emotion coping strategy was found to be more among females as compared to males. SMT was found to be more effective in strengthening the positive & weakening the negative coping strategies as compared to PMRT.

These finding of the present study suggest that males of the present study were found to improve their behavioral & cognitive strategies by eliminating the source of stress by changing the stressful situation after the intervention, they also reduce their Depression by expressing their emotions and also tried to stop self-criticism and they now try to face the stressful situations more efficiently with the help of SMT.

These results of the present study are contradicted by the study of Kapoor & Singh (2001) who reported that 28 sessions of CBT along with PMRT helped the male patients to reduce negative coping skills. This result of the present study was contrasted by the study of Pandey (2013) who reported that 12 sessions of CBT with PMR enhances the problem focused coping strategies in adolescent girls as compared to adolescent boys. Christensen et.al. (2005) after the relaxation-based intervention results revealed that the general tendency was for men to distract themselves using active coping strategies, whereas women used strategies involving the expression of emotion. It has been suggested that these factors of a cognitive nature could explain sex differences regarding depression and suicidal behaviors in adolescence. Thompson et.al. (2005) studied that girls and boys tend to cope

differently and that the coping styles adopted by girls put them at greater risk of experiencing depression and suicidal ideation.

5. Suicidal Ideation, Depression and Coping Strategies in relation to Conditions (Pre and Post) and Gender (Male and Female) (Interaction):-

As it is evident from the inspection of Tables No 4.6 Part (B) that the interaction effect of Condition and Gender was not found to be significant on **Suicidal Ideation.** The hypothesis which was framed for this variable is stated as under: -

H.13 There will be a significant interaction between Conditions (Pre and Post) and Gender (Male and Female) on Suicidal Ideation.

The results of the present study reject the above stated hypothesis. This finding suggests that there is no significant gender deference on Suicidal Ideation in pre-& post condition. In other words it can be concluded that males & females experience equal level of Suicidal Ideation before & after the intervention. These findings are supported by the study of Merry et.al (1997) in which the researcher reported relaxation training was not significantly reduce the level of Depression & Suicidal thoughts in males as compared to females. In contrast to the finding of present study Vibhu (2004) reported that MET with PMRT reduced the level of suicidal tendencies in females as compared to males.

For **Depression & Overall coping strategies** it was concluded on the basis of the Table No.4.7 & 4.8 Part (B) that the interaction effect of Depression & Overall Coping Strategies was found to be significant. The hypotheses which were framed for these variables are stated as under: -

H.14 There will be a significant interaction between Conditions (Pre and Post) and Gender (Male and Female) on Depression.

H.15 There will be a significant interaction between Conditions (Pre and Post) and Gender (Male and Female) on Overall Coping Strategies.

Both of the above stated hypotheses were accepted since they were found to be significant. These finding suggest that there was significant gender difference on Depression & Coping Strategies in relation to pre-& post conditions. In other words, it can be concluded that post

conditions of intervention significantly reduced Depression while improved Overall Coping Strategies more among males as compared to females. The reason may be attributed that the intervention of the present study took the approach of self-management & relaxation techniques. Self-Management & Relaxations approach typically teach cognitive restructuring skills, which assist respondents in identifying and managing their negative & unconstructive thoughts.

These finding were supported by the study of Hernardez (2004) who reported that after the intervention given by PMRT male adolescents reduced more depression than female adolescents. Hermenau et al. (2011), and Mkinga, & Hecker (2015) reported that significant gender differences were found to reduce the level of depression after PMRT and Guided Imagery.

As it is evident from the inspection of Table No 4.9, Table No 4.10, Table No 4.11, Table No 4.12, Table No 4.13, Table No 4.14, Table No 4.15, Table No 4.17 Part (B) that interaction effect of the condition & gender was found to be significant on all **Dimension of Coping Strategies**. These dimensions of coping strategies are Problem Solving, Cognitive Restructuring, Social Support, Express Emotion, Problem Avoidance, Wishful Thinking, Self-Criticism, Social Withdrawal the hypothesis which were framed on these dimensions are:-

H.15.1 There will be a significant interaction between Conditions (Pre and Post) and Gender (Male and Female) on Problem Solving Coping Strategy.

H.15.2 There will be a significant interaction between Conditions (Pre & Post) and Gender (Male and Female) on Cognitive Restructuring Coping Strategy.

H.15.3 There will be a significant interaction between Conditions (Pre and Post) & Gender (Male and Female) on Social Support Coping Strategy.

H.15.4 There will be a significant interaction between Conditions (Pre and Post) and Gender (Male and Female) on Express Emotion Coping Strategy.

H.15.5 There will be a significant interaction between Conditions (Pre and Post) and Gender (Male and Female) on Problem Avoidance Coping Strategy.

H.15.6 There will be a significant interaction between Conditions (Pre and Post) and Gender (Male and Female) on Wishful Thinking Coping Strategy.

H.15.7 There will be a significant interaction between Conditions (Pre and Post) and Gender (Male & Female) on Self Criticism Coping Strategy.

H.15.8 There will be a significant interaction between Conditions (Pre & Post) and Gender (Male & Female) on Social Withdrawal Coping Strategy.

All the above stated hypotheses of the present study were accepted as the interaction effects of condition & gender on all the dimensions of coping strategies were found to be significant. As it is clear from the inspection of Table No 4.12 part (A) that on Express Emotion Coping Strategy dimension female improved more than males in post conditions of the therapies while on Problem Solving, Cognitive Restructuring, Social Support, Problem Avoidance, Wishful Thinking, Self-Criticism and Social Withdrawal dimension of coping strategies males modified more than females in post conditions of therapies.

These results of the present study were supported by the study of Chaurasiya et.al. (2000) found significant gender difference in various coping skills among adolescents after the post condition of Group Therapy. Males were found to use problem focused coping skills while females were found to be use emotion focused coping skills. Nrugham et.al. (2014) reported that productive coping strategies were found to be negatively associated with depression among college girls. Froh et.al. (2006) reported that emotion focused coping strategies were linked to higher levels of depressive symptoms in females. Conversely, problem-focused coping was found to be negatively associated with depression in males. Li et.al. (2006) showed that girls with depression used more emotion-focused and ruminative coping than boys. Hoeksema et.al. (2000) indicated that men were more likely to engage in distracting behaviors that dampened their depressive mood, whereas women were more likely to amplify their mood by ruminating.

6. Suicidal Ideation, Depression and Coping Strategies in relation to Conditions (Pre and Post) and Group Therapy (PMRT and SMT) (Interaction):-

As it is also clear from the inspection of Table no 4.6 Part (B) that the interaction effect of Conditions & Therapy was found to be significant on **Suicidal Ideation**. The hypothesis which was formulated on Suicidal Ideation was:

H.16 There will be a significant interaction between Conditions (Pre and Post) and Therapy (PMRT and SMT) on Suicidal Ideation among male & female orphans.

The above hypothesis was accepted since the interaction of Condition and Therapy was found to be significant. These findings suggest that Suicidal Ideation varied significantly among respondents in relation to PMRT & SMT.As it is evident from the inspection of Table 4.6 Part (A) that SI was less in the post conditions of SMT as compared to PMRT. The reason may be attributed that interventions follow a comprehensive behavior change approach which focuses on the development of life skills which help an individual to deal effectively with his/her surroundings. In the present study PMRT provides awareness for different stressors while SMT works on the individual skills that help people to make healthier decisions when exposed to stressors in their lives.

These findings were supported by many studies. For example, the study of Thakur et al (1994) reported that after the intervention depression and suicidal tendencies were decreased among college going girls. Marcos et.al. (2010) conducted a study in Turkey on effects of SMT on Problem & Behavioral focused coping strategies among 27 depressive orphans. The findings of the study revealed that S.M.T improved more Problem focused coping strategies as compared to behavioral focused coping strategies and reduced negativity among orphans. Reeves et.al (2008) explained the importance of physical interventions such as changes in patient positioning, relaxation techniques and energy conservation techniques for fatigue in patients with depression. Denijs et.al. (2008) article on nursing intervention for suicidal ideation during the treatment of depression from 1995 to 2005 produced 18 studies. Studies dealt with sleep promotion through instruction and education, exercise, distraction and relaxation. Significant effects were found in studies including exercise, a positive effect of education and counseling on sleep while distraction and relaxation were found effective only for few hours after intervention.

As it is evident from the inspection of Table no 4.7 & Table no 4.8 Part (B) that the interaction effect of Conditions and Therapy was not found to significant on **Depression & Overall Coping Strategies**. The hypotheses which were framed for these variables are stated as under: -

H.17 There will be a significant interaction between Conditions (Pre and Post) and Therapy (PMRT and SMT) on Depression among male and female orphans.

H.18 There will be a significant interaction between Conditions (Pre and Post) and Therapy (PMRT and SMT) on Overall Coping Strategies among male and female orphans.

Both the above hypotheses were rejected since they were not found to be significant. These finding suggest that there was no significant difference on Depression & Overall Coping Strategies across group therapies (PMRT & SMT).

These findings are supported by the study of Oken et.al (2006) who found that mindfulness breathing practices for 6 months revealed no significant improvement in coping skills. The findings of Molassiotis (2002) stand in contrast with the present study. He concluded that effects of Cognitive-Behavioral Group Therapy and Peer Support/Counseling in decreasing depression & improving quality of life in Chinese orphans. The study demonstrated that psychological interventions could decrease depression and improve quality of life.

As it is evident from the results that the interaction of Condition and Therapy was found to be significant only on few **Dimensions of Coping Strategies**. These dimensions of coping strategies were Problem Solving Table No 4.9 Part (B), Express Emotions Table No 4.12 Part (B), Problem Avoidance Table No 4.13 Part (B), Self-Criticism Table No 4.15 Part (B) and Social Withdrawal Table No 4.16 Part (B) were found to be significant. The hypotheses which were framed on these dimensions are: -

H.18.1 There will be a significant interaction between Conditions (Pre and Post) & Therapy (PMRT and SMT) on Problem Solving Coping Strategy among male and female orphans.

H.18.4 There will be a significant interaction between Conditions (Pre & Post) and Therapy (PMRT and SMT) on Express Emotion Coping Strategy among male and female orphans.

H.18.5 There will be a significant interaction between Conditions (Pre and Post) and Therapy (PMRT & SMT) on Problem Avoidance Coping Strategy among male and female orphans.

H.18.7 There will be a significant interaction between Conditions (Pre & Post) and Therapy (PMRT and SMT) on Self Criticism Coping Strategy among male and female orphans.

H.18.8 There will be a significant interaction between Conditions (Pre & Post) and Therapy (PMRT and SMT) on Social Withdrawal Coping Strategy among male and female orphans.

All the above stated hypotheses of the present study were accepted as the interaction effect on these dimensions were found to be significant.

As it is evident from the results that Express Emotion & Problem Solving Coping Strategies were found to enhance more on the post condition of SMT as compared to the post condition of PMRT (Mean being 30.62 for SMT & 24.82 for PMRT Mean being 17.90 for SMT & 14.56 for PMRT) in posttest respectively and negative coping strategies i.e. Problem Avoidance coping strategy (Mean being 16.38 for SMT & 20.20 for PMRT), Self-Criticism coping strategy (Mean being 15.50 for SMT & 22.4 for PMRT) & Social Withdrawal coping strategy (Mean being 13.94 for SMT & 20.84 for PMRT) were reduced more in SMT as compared to PMRT in post conditions. All the coping strategies were modified by the intervention of SMT. Positive coping Strategies such as Express Emotion & Problem Solving were improved and negative coping strategies such as Problem Avoidance, Self-Criticism & Social Withdrawal were reduced in the post conditions of the SMT.

These finding suggests that SMT was more effective therapeutic technique to modify coping strategies of the respondents as compared to PMRT.

These results supported by the study of Sharma et.al (2014) who reported that mindfulness breathing along with PMRT reduced the level of self-blaming behavior. All these findings reporting the effectiveness of intervention in post conditions of SMT support the results of the present study as most of the dimensions of coping strategies like Problem solving, cognitive restructuring, express emotion, social support coping strategies etc. were modified after the intervention. The study of Herry et.al (2013) stand in contrast with the finding of the present study who found that PMRT enhance the positive and engagement coping strategies among adolescents.

Suicidal Ideation, Depression and Coping Strategies in relation to Conditions (Pre and Post) , Gender (Male and Female) & Group Therapy (PMRT and SMT (Interaction):-

As it is evident from the inspection of Table no 4.6 Part (B) that the interaction effect of Conditions, Gender and Therapy was found to be significant on **Suicidal Ideation**. The hypothesis was formulated on Suicidal Ideation was:

H.19 There will be a significant interaction between Conditions (Pre and Post), Gender (Male and Female) and Therapy (PMRT and SMT) on Suicidal Ideation.

As it is clear from the inspection of Table no 4.6 Part (A) that female orphans were found to report significantly less Suicidal Ideation in the post condition of SMT as compared to respondents in post condition of PMRT. The reason may be attributed to the fact that Children who live in orphanages are more likely to suffer from depression, stress and environmental deprivation of varying degrees. These combined problems can lead to suicidal ideation. Orphan children may not receive proper physical and emotional care because they are unaccompanied, displaced, and lacking family support. Solutions of this problem have different dimensions. The welfare of children is the concern and responsibility of all. It is necessary to work together and teach them to the principals of self-regulation. Yet, there are many techniques which are used in groups for therapeutically use but in the context of orphans researcher find that they are most depressed and stressful other than peer groups so SMT was found to be effective for building greater awareness and self-acceptance, changing unsatisfying patterns and behaviors, developing the necessary skills to face life's challenges. This training also helps to live in the present moment and open true nature, which encompasses the inherent qualities of happiness and well-being. Self-management is a skill in itself, once learners acquire self-management; other skills can be targeted using the self-management approach. This makes self-management not only an intervention, but a foundational skill that can make it easier to teach learners with depression & suicidal ideation a variety of other skills. This finding is support by the finding of Lorence et.al (1994) who reported that Mindfulness exercises was effective to reduce suicidal thoughts and self-blaming behavior among adolescents. Kaushik et.al (2015) indicated that combined therapies were effective for ventilating emotional suffocation.

Table no 4.7 & Table no 4.8 Part (B) indicates that the interaction effect of Conditions, Gender and Therapy was not found to be significant on **Depression** and **Overall Coping Strategies**. The hypotheses which were framed for these variables are stated as under:

H.20 There will be a significant interaction between Conditions (Pre and Post), Gender (Male and Female) and Therapy (PMRT and SMT) on Depression.

H.21 There will be a significant interaction between Conditions (Pre and Post), Gender (Male and Female) and Therapy (PMRT and SMT) on Overall Coping Strategies.

These hypotheses were rejected as they were not found to be significant.

The finding of Sandhya (2015) stand in contrast to the findings of the present study who reported that motivational & musical intervention was found to reduce the symptoms of depression among male & female adolescents while Nagar et.al (2015) reported reduced level of depression after the intervention of relaxation therapy among institutionalized orphans. However no gender differences were found.

As far as **Dimensions of Coping Strategies** are concerned it is clear from the inspection of the result that the interaction of Condition, Gender & Therapy were found to be significant only for few dimensions of coping strategies. These dimensions are Express Emotion Table No 4.12 Part (B), Wishful Thinking Table No 4.14 Part (B), Self-Criticism Table No 4.15 Part (B) and Social Withdrawal Table No 4.16 Part (B). The hypotheses which were framed for these variables are stated as under:

H.21.4 There will be a significant interaction between Conditions (Pre and Post), Gender (Male and Female) & Therapy (PMRT and SMT) on Express Emotion Coping Strategy.

H.21.6 There will be a significant interaction between Conditions (Pre and Post), Gender (Male and Female) and Therapy (PMRT and SMT) on Wishful Thinking Coping Strategy.

H.21.7 There will be a significant interaction between Conditions (Pre and Post), Gender (Male and Female) and Therapy (PMRT and SMT) on Self Criticism Coping Strategy.

H.21.8 There will be a significant interaction between Conditions (Pre and Post), Gender (Male and Female) and Therapy (PMRT and SMT) on Social Withdrawal Coping Strategy.

As it is clear from the inspection of Table No 4.12 Part (A) that No female orphans were found to express their emotions better in the post conditions of SMT as compared to respondents in the post condition of PMRT while males were found to report less wishful thinking Table No 4.14 Part (A) less self-criticism Table 4.15 Part (A) and found to do less social withdrawn behavior Table No 4.16 Part (A) in the post condition of SMT as compared to the respondents in the post condition of PMRT.

These results indicate that after the intervention by Group therapies male orphans significantly reduced their tendency to blame themselves for the situation and reduced the tendency to criticize themselves. They also reduced the habit of shutting themselves and their feelings off from others in the post condition of SMT. SMT was found to be better therapeutic technique. It may be because as its name implies it is self-management training. The person is supposed to manage his own negative thoughts and feelings and is supposed to divert them in a more positive directions so that they can live a healthier, positive and better life by skillfully managing their negative thoughts.

These results supported by the study of Stanly et.al (2002) who reported that mindfulness training & group counseling techniques were effective tools in reducing the negative coping of adolescents. An assessment was made for measuring the post effect; results revealed that the level of negative coping of adolescents was reduced in experimental group. In control group among girls scores for pre-& post were constant while in the group of boys it reduced. These results can be due to environmental factor while in control group the pre and post score test was constant for girls but they reduced in posttest in the group of boys.

It is clear from the results that rest of the dimensions of coping strategies such as Problem-Solving Table No 4.9 Part (B), Cognitive restructuring Table No 4.10 Part (B), Social Support Table No. 4.11 Part (B) and Problem Avoidance Table No 4.13 Part (B) were not found to be significant. These results reject the Hypotheses No. 21.1, 21.2, 21.3 & 21.5 which were framed as under:

H.21.1 There will be a significant interaction between Conditions (Pre and Post), Gender (Male and Female) and Therapy (PMRT and SMT) on Problem Solving Coping Strategy.

H.21.2 There will be a significant interaction between Conditions (Pre and Post), Gender (Male and Female) and Therapy (PMRT and SMT) on Cognitive Restructuring Coping Strategy.

H.21.3 There will be a significant interaction between Conditions (Pre and Post), Gender (Male and Female) and Therapy (PMRT and SMT) on Social Support Coping Strategy.

H.21.5 There will be a significant interaction between Conditions (Pre and Post), Gender (Male and Female) and Therapy (PMRT and SMT) on Problem Avoidance Coping Strategy.

As it is clear from the results that the interactions of Condition, Gender and Therapy was not found to be significantly different for Problem Solving, Cognitive Restructuring, Social Support and Problem Avoidance dimensions of Coping strategies. These results suggests that males and females don't differ significantly in pre and post conditions of either of the Therapies i.e. PMRT and SMT on these four dimensions.

CHAPTER- 6
Conclusions, Contributions, Limitations & Suggestions

➢ Conclusions:-

The present study is a comparative study which has tried to examine Suicidal Ideation, Depression and Coping Strategies among orphans and their management through Group Therapy.

It is therefore, logical to present here some findings deducted from scrupulous analysis and interpretation of data, which are as follows: -

I. Suicidal Ideation, Depression and Coping Strategies in relation to Group Therapy:-

- ✔ SMT was found to be more effective than PMRT in reducing Suicidal Ideation and Depression among respondents.
- ✔ SMT was found to be more effective than PMRT in improving Overall Coping Strategies among respondents.
- ✔ SMT was found to be more effective than PMRT in improving two out of four positive coping strategies. They are Problem Solving and Express Emotion coping strategies.
- ✔ SMT was found to be more effective than PMRT in weakening all the four negative coping strategies (Problem Avoidance, Wishful Thinking, Self-Criticism and Social Withdrawal) among respondents.
- ✔ No significant differences in PMRT & SMT were found on Cognitive Restructuring and Social Support coping strategies among respondents.

II. Suicidal Ideation, Depression and Coping Strategies in relation to Gender:-

- ✔ Females were having more Suicidal Ideation and Depression than Males.
- ✔ No significant gender differences were found on Overall Coping Strategies.
- ✔ Problem Solving, Cognitive Restructuring, Social Support, Wishful Thinking, Self Criticism and Social Withdrawal dimensions of coping strategies were found to modify more among males as compared to females.
- ✔ Express Emotion coping strategies was found to be used more by females than males.
- ✔ No significant Gender Difference was found on Problem Avoidance dimension of coping strategy.

III. Suicidal Ideation, Depression and Coping Strategies in relation to Conditions:-

- ✔ Post Conditions of both the therapies (PMRT & SMT) were found to be more effective to reduce the level of Depression and Suicidal Ideation.
- ✔ Post Conditions of both the therapies (PMRT & SMT) were found to be more effective in modifying Overall Coping Strategies.
- ✔ Post Conditions of both the therapies (PMRT & SMT) were found to improve positive coping strategies such as Problem Solving, Cognitive Restructuring, Social Support and Express Emotion and reduce negative coping strategies such as Problem Avoidance, Wishful Thinking, Self-Criticism and Social Withdrawal.

IV. Suicidal Ideation, Depression and Coping Strategies in relation to Gender and Group Therapy:-

- ✔ No Significant Interaction between Gender and Therapy were found on Suicidal Ideation, Depression and Overall Coping Strategies.
- ✔ Problem Solving was found to improve more among males in SMT as compared to females while Express Emotion, Wishful Thinking, Self-Criticism and Social Withdrawal were found to improve more among females in SMT as compared to males.

V. Suicidal Ideation, Depression and Coping Strategies in relation to Condition and Gender:-

- ✔ No Significant Gender Differences were found on Suicidal Ideation in post conditions of both the therapies.
- ✔ Depression was reported less among males than females in post conditions of both the therapies (PMRT & SMT).
- ✔ Overall Coping Strategies were found to modify more among males in post conditions of both the therapies (PMRT & SMT).
- ✔ Males as compared to females were found to report improved Problem Solving, Cognitive Restructuring, Social Support, Problem Avoidance, Wishful Thinking, Self Criticism and Social Withdrawal coping strategies in the post conditions of both the therapies (PMRT & SMT).
- ✔ Females were found to improve Express Emotion Coping Strategy more than Males in post conditions of both therapies.

VI. Suicidal Ideation, Depression and Coping Strategies in relation to Condition and Group Therapy:-

- ✔ Suicidal Ideation was less in the post condition of SMT as compared to PMRT.
- ✔ The interaction effect of Condition and Therapy was not found to be significant on Depression and Overall Coping Strategies.
- ✔ The interaction of Condition and Therapy was found to be significant only on few dimensions of coping strategies found to be significant. These dimensions are Problem Solving, Express Emotions, Problem Avoidance, Self-Criticism and Social Withdrawal. All these coping strategies were found to be improved in the post condition of SMT.
- ✔ The interaction of Condition and Therapy was not found to be significant on Cognitive Restructuring, Social Support and Wishful Thinking dimensions of coping strategies.

VII. Suicidal Ideation, Depression and Coping Strategies in relation to Condition, Gender and Group Therapy:-

- ✔ Female orphans were found to report significantly less Suicidal Ideation in the post condition of SMT as compared to respondents in post condition of PMRT.

- ✔ The interaction effect of Conditions, Gender and Therapy was not found to be significant on Depression and Overall Coping Strategies.
- ✔ Female orphans were found to express their emotions better in the post conditions of SMT as compared to respondents in the post condition of PMRT while males were found to report less Wishful Thinking, less Self Criticism and found to do less Social Withdrawn behavior in the post condition of SMT as compared to the respondents in the post condition of PMRT.
- ✔ The interaction of Condition, Gender and Therapy was not found to be significant on rest of the dimensions of coping strategies such as Problem Solving, Cognitive restructuring, Social Support and Problem Avoidance.

➢ Contributions:-

The present study has tried to explore the effectiveness of Group Therapy i.e. PMRT and SMT in reducing suicidal ideation and depressive thoughts among orphans and an attempt was also made to explore how these respondents enhance their ways to cope up with their suicidal ideation and depression.

The main contributions of the present study are as follows: -

- ✔ The results of the present study may contribute significantly to the existing body of the literature since very few works has been done till date together on these variables and very few attempts have been made to explore the effectiveness of different intervention trainings on managing and coping Suicidal Ideation and Depression faced by orphans. The study has also tried to enhance the positive coping strategies and tried to weaken the negative coping strategies used by the respondents with the help of group therapies while facing the stressful life situations. Results of the present study can guide counselors and policy makers to help the related group accordingly.
- ✔ Since the study is done on orphans it become even more enlightening for the future researches because it is the need of today's time to understand the life style and psychology (i.e. how orphans perceive and feel about certain life situation) of the orphans since this is the sample of the population which may be considered as deprived group. The stories of their deprived condition, social degradation, mocking, hunger, brutal exploitation and

inhuman treatment, abuse by the adults on the street and the conditions in which they live will put any civilized society to shame. So their conditions need to be studied so that the findings may help to improve the condition of orphans in the society.

- ✔ The other contribution of the present study is that it will throw light on how deprived group of people i.e. orphans are dealing with their negative thoughts with the help of different intervention training programs because orphan children and the normal child both having different environment and different exposure are likely to handle their emotional and psychological problems differently. Orphans have deep psycho-social disturbances. All the orphans show severe personality disturbance centering on an inability to give or receive affection. Their troubles included hopelessness, inferiority, aggressiveness, abstinence, selfishness, lack of marital status, excessive crying, food difficulties, speech defects, over activity, fears, financial and educational problems. So, the results of the present study become very relevant in the present scenario. It will help policy makers and educationist to make policies and educational programs which can help to develop the real potential of the orphans and can be more beneficial for the healthy personalities of them.
- ✔ The next very important contribution of the study is that it not only tried to see the effectiveness of Group Therapies but it also compared the effectiveness of two very important and useful Group Therapies i.e. PMRT and SMT in dealing with Suicidal Ideation, Depression and using various Coping Strategies. The findings have suggested that SMT was found to the more effective intervention training as compared to PMRT. These results are very enlightening since most of the past literature has suggested PMRT as very effective technique in reducing Suicidal Ideation, Depression and enhancing Coping Strategies but the findings of the present study have suggested that the combination of different therapies can even lead to better intervention. The reason may be attributed to the versatility of SMT. It comprises many techniques which need active participation by the respondents generating more interest and motivation among them so they don't need any external push to deal with their problems.
- ✔ The study also focused light on the fact that we not only deal with Suicidal Ideation and Depression by strengthening positive coping strategies but also deal with Suicidal Ideation and Depression effectively by weakening on negative coping strategies. So, there is a need in the present time, to promote positivity & discourage negativity among people by doing their proper counseling so that people will better able to see the same world from a different and healthy perspective. SMT was found to fulfill this purpose effectively.

- ✔ The present study is very relevant in India because a study by an international children's charity (2011) for orphaned and abandoned children found that India is home to 20 million orphans, a figure projected to increase by 2021. Combined, the states of Madhya Pradesh, Uttar Pradesh and Chhattisgarh are home to 6 million orphaned children under the age of 18. By 2021, these states will probably be home to 7.1 million orphans. The eastern region, encompassing Bihar, Orissa, Jharkhand and West Bengal, now houses 5.2 million orphans, but will likely have 6 million by 2021. According to CDC Report (2015) Suicide is the third leading cause of death among persons aged 10-14, the second among persons aged 15-34 years, so keeping in view of this statistics the present study becomes more relevant and significant in India.

The present study has tried to build the lives of orphans through Group Therapies and tried to make them more productive citizens of tomorrow and has provided opportunities to harness their talents and dreams so that they can contribute their maximum to their society and country.

➢ Limitations:-

Although the researcher had tries to do as best and accurate as possible. But inspite of all the best efforts had done by the researcher. There are some limitations of the present study due to time, money and facilities constraints. Had all these limitations controlled, the study could be contributing significantly to the existing body of the research.

- ✔ The data for the present study is collected only from the Orphanages of Lucknow City. The results would have been more enlightening if the data would have been collected from the orphanages of other cities of U.P also.
- ✔ Due to time & money constraints the process of randomization was not applied in sampling. The present study has utilized the Quota Sampling procedure for data collection. The results of the present study would have more generalizability if random sampling procedure had applied for sampling.
- ✔ The present study has compared the effectiveness of Group Therapy of institutionalized orphans only. The results would have been more interesting if institutionalized and non-institutionalized orphans would have also been compared.
- ✔ The comparison can also be made between orphans and normal children. It would have been given the procedural difference between levels of Suicidal Ideation, Depression and the types of Coping Strategies used by both the groups.

- ✔ The present study has examined the Suicidal Ideation, Depression and Coping Strategies used by adolescent Orphans. The comparison of orphans belonging to different age groups on Suicidal Ideation, Depression and Coping Strategies would have been more interesting.
- ✔ The data was collected 'Before and After' the intervention while no follow-up was done. This follow-up after intervention could be more beneficial and informative to rightly judge the effectiveness of both the therapies.
- ➢ Adolescents' period is a period of storm. A person feels many problems in his physical, emotional, mental and psychological spheres. But it was not so the focus was done only Depression, Suicidal Ideation & Coping Strategies other sensational & emotional issues like, sexual abuse, aggressiveness, hopelessness, adjustment and many more are neglected in this focus studies which are also important for changes in Orphan's life.
- ➢ Self-management Training is a long process while reflect its proper effect through regular interaction, training & practice. The clear positive results want much more time duration for intervention less duration of this period is one more limitation of this study.

➢ Suggestions for Future Researches:-

In the light of above said contribution and limitation of study there are some suggestions for future researchers.

- ✔ For conducting this study, the investigator selected only a few psychological variables but when she was analyzing the results it was felt that some other variables should also be taken. These may be sexual abuse, harassment, life satisfaction, aggression etc.
- ✔ Again, a comparative study may be made between the institutionalized & non-institutionalized orphans, Urban & Rural orphans on the same variables.
- ✔ Random sampling should be used then study will be more reliable.
- ✔ The study & training should not be lemmatized in the boundaries of Orphanages but it should be applied on unsheltered orphans, orphans who lived with their relatives.
- ✔ Regular counseling sessions by trained counselors should be organized. Through this study it is highly recommended to the responsible authorities.
- ✔ This study should be done in other orphanages also which run by different religious organizations like Madarsa (Yateemkhana) of charity homes. It will help to explore the tendencies of orphan adolescents in various environment, thoughts & socio-cultural atmosphere.
- ✔ More therapeutic techniques can be used for better results.

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