Chapter I
INTRODUCTION
THE CONCEPT OF MENTAL HEALTH

Mental health is probably one of the oldest and most often used phrases in the psychological literature of all times. Yet, it is the singular issue with the most volatile and amorphous boundary, its precise nature being subject to strong cultural variability and shift in orientational focus (Cowen, 1994). As it lacks the specificity and precision of definition of physical health, it is most often defined in terms of its polar opposite, that is illness (Brown, 1980). Indeed, Myers and Diener (1995) found that psychologists overwhelmingly focus on the negative aspects of individuals' lives - the number of psychological articles published on negative states exceeds those published on positive states by a ratio of 17 to 1. Yet, it should be recognized that the positive aspect of mental health has also been appreciated quite early, though its explicit elaboration and emphatic application is a relatively recent trend.

As early as in 1946 the World Health Organization defined health itself as “a state of complete physical, mental and social well being and not merely the absence of disease or infirmity”. This integration of the physical, mental and social facets and stress on wellness has been reverberated in latter conceptions of health and particularly of mental health. In 1981 WHO defined mental health as “the capacity of the individual, the group and the environment to interact with one another in ways that promote subjective well-being, the optimal development and use of mental abilities (cognitive, affective and relational), the achievement of individual and collective goals consistent with justice and the attainment and preservation of conditions of fundamental equality”. This definition has two significant characteristics. It stresses the complex web of interrelationships that determine mental health and recognizes that the factors that determine health operate on multiple levels. Its second characteristic is that it goes beyond the biological and the individual, and stresses the person’s perspective and experience.

In 1984 Offer and Sabshin delineated 4 concepts relating to normality or sound mental health. The first one is absence of pathology, the second is normality as utopia or ideal, the third is the concept of mental normalcy as a statistical average. It is apparent that from the first to the
third there is a growing distancing from the negative denotation of mental health and an evolving preference for defining it in terms of positive attainable or experienced criteria. The fourth perspective is that of normality conceived of as transactional system. Here normality in mental health is understood as the end result of interacting systems, which change over time as a function of development and the type of environment. This approach was further developed in the Canadian report namely “Mental health for all Canadians” in 1988, which summarily recognized that mental health is an intrapsychic experience combining effective relational ability with cognitive and affective adequacy. In 1999 WHO clearly emphasized the social ability and positive effectiveness of mentally healthy individuals. It defined mental health as a state of well-being in which the individual realizes her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her community. Mentally healthy children and adolescents have positive social skills and relationships, can cope with stress effectively and are able to adapt to change. WHO also recognized that mental health has an influence on learning and success in school (World Health Organization, 1999).

In the psychological literature therefore, both the negative and positive aspects of mental health have been amply represented. Indeed these two have been found consistently to be slightly negatively correlated (Heady et al, 1985). Also with WHO’s consistent emphasis on wellness factors the focus of research is shifting from sickness to wellness aspects. The field of "subjective well-being" (SWB), which examines such topics as happiness, life satisfaction and morale, has flourished. (see Diener et al, 1997; Kahneman et al, in press; Myers & Diener, 1995; and Strack et al., 1991).

The variables used in the studies with either the positive or the negative aspects of mental health can be divided in two categories: one is the vulnerability / resource variable and the other is the outcome variable. Examples of negative vulnerability factors are parental mental illness and familial dysfunction (Goodnow and Collins, 1990), temperamental instability (Kobasa et al., 1981), developmental factors (Van Hasselt and Hersen, 1987; Baltes, 1993) etc. Among the negative outcome variables are the various aberrations of cognition, affect etc. like depression, anxiety, somatic symptoms (Mechanic, 1974; Barlow, 1988; Gross and Munoz, 1995) and relational and occupational dysfunctions like aggression, loneliness, burnout, errors in output etc. (Foder, 1976; Mott, 1976; Freudenberger, 1980; Eron, 1987; Huesmann, 1994)). Side by
side wellness related conceptualization of mental health or the concept of quality of life has also
been forwarded, emphasizing positive outcome indices like adjustment, happiness, well-being,
self-esteem etc. (Bradburn, 1969; Rosenfeld, 1980; Nagpal and Sell, 1985). A corollary of this
second line of study is the growing emphasis on the individual’s intrinsic personality resources
and socially facilitatory conditions that promote psychological growth and adaptability.
Examples are locus of control, coping and ego strength (Zika and Chamberlain, 1987;
MacCoby, 1983), and availability of and ability to utilize social support (Liberman and Mullan,
1978).

In the present study the focus is on the positive aspect of mental health studied in relation
to gender among urban middle class college students. Here both the outcome variable and the
resource variable of mental health have been considered. As pointed out earlier, any study of
mental health must include a reference to life stress as processed through personality factors
(Abramson et al., 1988). In the present study the focus is on gender stereotype variables in
conjunction with stressful life events as probable determinants of mental health among young
adults. The two components studied here in relation to gender are subjective well being and ego
functions, the former being an outcome variable and the latter a resource variable. In the
following sections these two concepts have been elaborated.

THE CONCEPT OF SUBJECTIVE WELL-BEING (SWB)

A considerable number of psychological theories and philosophical arguments converge in
their depiction of the good, healthy, positively functioning life as one that involves multiple
components of well-being; for example, possessing positive self regard, setting and pursuing
goals, realizing one’s unique potential, experiencing deep connections to others, effectively
managing surrounding demands and opportunities and exercising self-direction (Heady and
Wearing, 1989; Brunstein, 1993). Not only in the theoretical realm, but a number of empirical
researches have also focussed on SWB as a multi-dimensional construct involving factors like
happiness, positive affect, social sensitivity etc. (Larsen and Diener, 1985; Ryff, 1989; Diener
and Lucas, 2000). Diener et al. (1997) enumerated the three primary components of SWB:
satisfaction, pleasant affect, and low levels of unpleasant affect, each of which can in turn be
broken into subdivisions. Global satisfaction can be divided into satisfaction with the various
domains of life such as recreation, love, marriage, friendship, and so forth. Pleasant affect can be split into specific emotions such as joy, affection, and pride. Finally, unpleasant affect can be separated into specific emotions and moods such as shame, guilt, sadness, anger, and anxiety.

SWB is a person's positive evaluation of her life. This evaluation may occur in the form of cognition (Diener, 1984), when a person makes conscious evaluative judgments about her satisfaction with life as a whole, or evaluative judgment about specific aspects of her life, such as progress and commitment to work or even to daily cores (Emmons, 1992; Omodei and Wearing, 1990; Palys and Little, 1983). This evaluation may occur not only at the cognitive level, but also in the affect system when people experience unpleasant or pleasant moods or emotions. Thus SWB has a hedonic component as well (Andrews and Withey, 1976; Campbell et al., 1976). Although these components are separable (see, e.g., Lucas, Diener, & Suh, 1996), they often interrelate, suggesting the existence of a higher order construct of SWB (Kozma, 1996).

It has been found that low difficulty and the absence of ambivalence and conflict among and within various life goals ensures psychological and physical harmony and wellness. It should further be noted that positive affect has been reported by a large section of the population most of the time (Diener & Diener, 1996). This is true across age groups, socioeconomic groups, and ethnic groups as well as across nations (Diener & Diener, 1995; Veenhoven, 1993). Therefore, when we discuss the correlates and possible causes for emotional well-being, the focus is on understanding why some people manage to be happier than others.

Diener et al. (1997) enumerated the cardinal characteristics of SWB. First, it covers the entire range of affective existence from agony to ecstasy. Applicable to the clinical field, it is concerned not just with the description and causes of depression and anxiety, but also with the factors that differentiate slightly happy people from moderately happy and extremely happy people. Second, SWB is defined in terms of the individual's own perspective or the internal experience of the respondent. An a-priori external frame of reference is not imposed when assessing SWB. It is a measure from within. Thirdly, it is defined as longer-term state, not just passing momentary alterations of moods.

Subjective well-being is not synonymous with mental health, but definitely a very important aspect of it. Ryff (1989) proposed a comprehensive model of well-being by relating it to the perception that life is purposeful and meaningful. Diener et al. (1997) discusses why
SWB is not a sufficient condition for mental health, but considers it an important component of the latter. Diener also asserts that “Nevertheless, the subjective frame of reference implicit in the concept of SWB has the strength of being based on the respondent's own internal perspective, and thus gives priority and respect to people's own views of their lives.” (Diener et al., 1997, p. 26).

THE CONCEPT OF EGO FUNCTIONS (EF)

The ego is conceived of as the executive organ of the psyche and one that controls motility, perception, contact with reality, and through the mechanism of defense available to it, the delay and modulation of drive expression (Kaplan and Sadock, 1998). Indeed the concept of ego, originating in the early psychoanalytical conceptualization as surface differentiation of the id (Freud, 1923) may now be recognized as subserving the entire cognito-motor spectrum of the organism, thus being the major tool of adaptation.

In his 1923 book ‘The ego and the id’ Freud viewed ego as the coherent organization of mental processes and functions primarily organized around the perceptual –conscious system (Pcpt-Cs), and also responsible for resistance and unconscious defenses. In this preliminary formulation the ego was depicted as a weak and passive agency, a helpless rider of the three horses called the id, super-ego and reality. In ‘Inhibitions, symptoms and anxiety’ in 1926, Freud introduced the concept of signal anxiety that was an autonomous function of the ego for the initiation of defense. The ego was no longer a mere servant of the id impulses, but was recognized to have active manipulative schemes to deal with the complex situations of inner and outer life. Freud’s subsequent elaboration of the reality principle included the ego function of adaptation, which enabled the control of instinctual drives running amok in response to real and imagined danger or in search of pleasure. In dealing with these complexities, the ego was in position to assay the realistic demands and limitations, and could enable delay of gratification. In his 1937 book ‘Analysis terminable and interminable’ Freud made the clear assumption that from the start the ego evolved independently of the id.

The post-Freudian psychoanalysts systematized the function of the ego to designate its adaptive, judgmental and manipulative functions to a greater extent. Anna Freud (1936) has already systematized the specific defensive endeavors and Melanie Klein (1932) has commented
upon the effect of splitting of the ego on object relationship. Hartmann (1949) asserted that the ego evolves as a partially independent aspect of the personality which uses neutralized libidinal and aggressive energy for immediate manipulation as well as stores it for future use. Thus the ego has apparatuses of primary autonomy due to inborn factors and secondary autonomy as a result of its subsequent development. Fairbairn (1946) emphasized the role of the ego in object relations and Erikson (1960) developed an elaborate scheme of psychosocial stages of the ego development as the result of individual-society intercourse. Apart from the psychoanalysts mentioned here, Winnicott (1958), Kris (1951), Lowenstein (1953), Rapaport (1960) etc. commented on ego development as related to early interpersonal experience.

During this emphasis on the ego development the various functions of the ego were also being enumerated. Hartmann (1950) specified the functions connected with reality orientation, e.g., organization and control of motility and perception, delay of gratification, control of anxiety, inhibitory processes and synthetic processes. Arlow and Brenner (1964) included functions like consciousness, sense perception, perception and expression of affect, thought, control of motor action, memory, language, defense mechanism, control and regulation of instinctual energy, integration and harmonization, reality testing, inhibition of functions. Bellak (1955) enumerated 7 ego functions which he later elaborated into 12 specific functions (Bellak et al., 1973). These are (1) Reality testing (2) Judgment (3) Sense of reality (4) Drive control (5) Object relation (6) Thought process (7) Adaptive regression (8) Defensive function (9) Stimulus barrier (10) Autonomous function (11) Synthetic integrative function and (12) Sense of mastery and competence.

This last model serves as the baseline for the present study, because it is developed upon the thorough theoretical and clinical evaluation of early researches and has resulted in a construct of ego functions which can be assayed within the general psychometric framework of the science. The definitions of the 12 functions would be given in Chapter III.

**LIFE STRESS AND POSITIVE INDICES OF MENTAL HEALTH**

The impact of stressful life events on the negative indices of mental health is an established phenomenon (Paykel et al., 1969; Brown et al., 1973; Patrick et al., 1978; Brown and Harris, 1989). Stress as conceptualized by Selye (1956) is a broad and general concept...
describing the organism’s total reaction to environmental demands. Selye also noted that any change could act as stressors causing physiological arousal and enhanced susceptibility to illness. Since then life events research has started to focus on the role of life changes on physical and mental dysfunctions (Dohrenwend and Dohrenwend, 1974).

Researchers however have noted that this effect is not unilateral and moderated by a number of personality and social resources or vulnerability elements. The stress diathesis model essentially says that the effect of stressor is not absolute, but a function of moderating factors like inner strength and coping techniques (Toves et al., 1981; Lazarus and Folkman, 1984; Folkman and Lazarus, 1988). For example Antonovsky (1987) proposed that the underlying sense of coherence as an inbuilt personality dimension allows a person to cope with stressor effectively. Kobasa (1979) argued that a general personality dimension named hardiness moderates the effect of stressful life events on physical health. Other coping variables like locus of control, relatedness etc. have been studied by Johnson and Sarason (1978), Sandler and Lakey (1982), Ganellen and Blaney (1984).

However much of the existing literature here deals with the negative indices of health and the exact relation of this stress with wellness and resource factors is as yet an undecided issue. In the literature on SWB there are some evidences that it may remain independent of events (Diener, 1984), while others have strongly suggested that certain experiential factors are influential determinants of wellness (Zika and Chamberlain, 1987). So far as ego functions are concerned direct studies relating stress with ego functions per se are very few. However if we consider ego function as the organizing and stabilizing capacity of the individuals (Fenichel, 1945), that is as a kind of coping resource, then the indirect literature can easily be brought to bear upon the concept.

In this context it is worth mentioning that in Indian tradition much of the stress management techniques, including breathing exercises, Yogic practices and meditation have consistently taken into account the promotion of wellness and stability factors along with suppression of negative affects (Udupa, 1985).
SEX, GENDER AND MENTAL HEALTH

It has long been known that the prevalence of psychiatric disorder is asymmetric between the sexes. The concept of 'gender and mental health' however became particularly audible in the last decade. In general, certain disorders like depression, anxiety disorders including phobia, panic disorder, obsessive compulsive disorder, and certain somatoform disorders, eating disorders etc. are more notable, or at least more diagnosed in women (Desjarlais et al., 1995; Denton and Walters, 1999). Maximum attention has been focused on depression (Brown & Moran, 1994; Brown, Harris & Eales, 1996) since this has been identified by WHO (2000) as one among the five major killers by 2020. Contrarily, addiction, alcoholism and antisocial personality disorders are prevalent all over the world among men (Russo, 1990). While chronicity of disorders is greater for women, fatality is not, at least in the developed countries. This sex difference has been obtained in epidemiological surveys in almost all countries of the world (Russo, 1990; Busfield, 1996; McIntyre and Hunt 1997).

A similar but not identical condition is observed in India. Malik (1993) in his Presidential address of the 45th Annual Conference of the Indian Psychiatric Society stated, "Only a small part of the iceberg of morbidity is visible in health statistics or clinical practice......Its gender hue varies.......The bulk of the iceberg is of feminine shade". Epidemiological studies have been conducted in various states of India including West Bengal (Nandi et al., 1992; Shaji et al., 1995). The sex difference in prevalence of psychiatric disorders is similar to the West in India (Venkataswamy Reddy and Chandrashekhar, 1998), although somatization is more common and eating disorder is less prevalent in majority of the communities (Malik, 1993). In contrast to developed countries not only morbidity, but mortality rate in women is also high in India. This is true even in case of physical disorders, not to say of psychological ones.

The observed sex difference in mental health has been explained in terms of assigned cultural role to persons belonging to a given sex, that is, to gender role. The 1993 WHO report explicitly stated that "A range of studies indicate that women are disproportionately affected by mental health problems and their vulnerability is closely associated with marital status, work and roles in society." (p. 8). The same emphasis on gender specific role was repeated in the Fourth World conference organized by WHO in 1995 in Beijing, China. Since then a large
number of studies have been and are being carried all around the globe to relate various gender related factors to different aspects of mental health.

These studies have attempted to explain gender differences in mental disorders in relation to different help-seeking behaviors of the sexes, biological differences, social causes and the different ways in which women and men acknowledge and deal with distress (Paykel, 1994). Besides, Blue et al. (1995) from their comparison of low income women from six countries argue that while all these factors may contribute to higher rates of depression or psychological problems among women, social causes seem to be the most significant explanation. Women living in poor social and environmental circumstances with associated low education, low income and difficult family and marital relationships, are much more likely than other women to suffer from mental disorders. They conclude that mental (ill)-health is the result of combined impact of gender role and social variables.

It is important to note that although WHO has emphasized 'gender' aspect of mental health rather than women’s mental health only, special attention to male mental health problems have started but recently. A considerable number of works stem from the studies of gender role conflict and gender role stress of men (Eisler et al., 1988). The relationship of inhibited expressiveness and mental health in men is receiving considerable attention these days.

More detailed discussion of this issue would be presented in Chapter II. However to clarify the basic intention of the study, the nature of gender and gender stereotype as used in the present treatise needs to be understood.

**SEX, GENDER AND GENDER STEREOTYPE**

Despite their diversity, all societies are divided along what is known as the 'fault line of gender' (Moore, 1988; Papenek, 1990). This means that women and men are defined as different types of beings, each with their own opportunities, roles and responsibilities. For operationally distinguishing sex and gender Unger’s (1979) concept has been adopted. According to this definition “The term gender may be used to describe those non-physiological components of sex that are culturally regarded as appropriate to males and females” (p.108). That is sex refers to biological distinctions between females and males, while gender refers to its cultural counterpart.
This definition has three components:

i) Gender entails a nomothetic approach

ii) Gender is concerned with the non-physiological aspects of the person - a broad term involving a whole gamut of cognitive, affective and social phenomena,

iii) Gender entails an element of value judgment it refers to the appropriateness or desirability of certain qualities of behavior.

An almost identical note is reflected in a recent definition by Baron and Byrne (1995) that “gender is the sum total of all the attributes, behaviors, personality characteristics and expectancies associated with one’s sex in a given society.”

Gender stereotype may be understood as gender in cultural perception. Reber (1985) in his dictionary defined stereotype as a set of generalizations, widely shared within a culture about the psychological characteristics about a group or class of people. Gender stereotype is one specific kind of stereotype. It is defined as the preconceived simplified generalizations and assumptions about sex typical behaviors (Shepherd — Look, 1982). It refers to the psychological functions that people believed to be associated with women and men (Matlin, 1987) and therefore such stereotypes may or may not reflect what women and men actually are.

Although gender stereotype has always prevailed in society, the first systematic investigation of gender as stereotype started in late 60's and early 70's and followed by many others (Broverman et al. 1972; Bem, 1974; Spence et al., 1978; Williams and Best, 1990) These researchers came out with a large number of characteristics, for example affectionate, submissive etc. for females and dominant, active etc. for males. Judging these stereotyped characteristics women have been believed to be more communion oriented and men more agentic (Lippa, 1995). Spence & Helmreich (1980, 1991) have used the term 'expressive' for women and 'instrumental' for men.

The effect of this stereotyped cognition of women and men is two- fold. On the one hand it influences the evaluation, attitude and action of others and on the other hand it affects the self-perception and consequent action orientations.

That gender stereotype is an umbrella concept involving many components has been demonstrated (Deaux and Lewis, 1984). Some such components are attributes, physical characteristics, roles occupations, sexual orientation etc. Biermat (1991) argues that this componential model recommends "adopting a multidimensional view of the gender concept
rather than the unitary perspective ..." (p. 568). In a critique of available measures of gender stereotype, Archer (1980) has observed that there are two basic aspects of gender stereotype. These are

i) Gender role identity, referring to what an individual considers himself or herself to be in terms of perceived masculinity and femininity and

ii) Gender role attitude referring to the belief as to what the members of a given sex should do.

**Gender Role Identity**

In the present study Sandra Bem's gender schema theory (Bem, 1984) has been accepted in understanding identity. Bem (1974, 1981, 1984) proposed that there exists a generalized readiness to process information on the basis of sex linked attributes. From this bias in cognition arises gender schema which is constituted of cultural definitions of maleness and femaleness. This schema is readily available and through social learning incorporated in the individual's identity.

Bem's special credit lies in assertively eschewing the earlier conceptualizations of masculinity and femininity as opposed to each other (Constantinopole, 1973) and prescribing these two as orthogonal components of stereotype. Thus each person has one's own share of both. Depending upon the relative contribution in identity formation, a person may be Masculine (high in masculinity, low in masculinity), Feminine (high in femininity, low in masculinity), Androgynous (high in both masculinity and femininity) and Undifferentiated (low in both masculinity and femininity).

The concept of self-schema is not a new one (Markus, 1977). The novel aspect of Bem's theory consists of two interrelated theories. Individuals differ in the centrality or strength of their gender schema and hence in the degree to which they are sex-typed in their behaviors, attitudes, attributes and readiness to process information about themselves and external events in gender terms. Moreover it is important to note that gender schema theory is a theory of process, not of content. Thus it is more flexible as it is not culture bound in terms of its content.

A review by Taylor and Crocker (1981) suggested that the schema concept is heuristically valuable. Although the concept of maleness and femaleness may be somewhat fuzzy and organized around vague cultural prototypes (Cantor & Mischel, 1979), the theory does not
explicitly commit itself with respect to the exact nature or structure of gender schema. The intent of this theory is not to specify the precise structural representation of gender knowledge for even to establish that the gender schema satisfies some well-defined set of necessary and sufficient conditions for calling it a schema. Rather, the purpose of the theory is to provide a new perspective of the process of sex-typing and to test a set of empirical properties deriving from that perspective.

**Gender role attitude**

Gender role attitudes examine people's idea about which roles women and men should fulfil in families and careers (Barber & Axinn, 1988). Although attitudes represent orientations toward actual behavior they do not really testify to the real life action, nor the future plans for the respondents (Ajzen, 1988).

Gender role attitude is usually designated as traditional versus modern (Clarkberg et. al., 1995). Such attitudes are transmitted from the cultural imperatives to the individual's personal cognitive system. Theoretically speaking this transmission may be viewed either from the cohort perspective (e.g. Bengston & Cutler 1976) or from a lineage perspective. (e.g. Gecas & Seff, 1990). The former assumes that individuals belonging to a particular generation will form another group with respect to specified attitudes or behavior. The latter view holds that attitudes formed in the family context are inherited by the younger generation and thus an inter-generational similarity may be observed (Inman-Amos et. al., 1994). Integrating these two perspectives, it may be stated that the ultimate development of traditional or modern attitude is a dynamic process characterized by intra-generational and inter-generational similarity or dissimilarity depending upon the relative weightage of the primary, secondary and tertiary groups in a person's life history.

There exists controversy as to whether gender role identity, gender role attitude and manifest expression go with each other. There have been evidences on both sides. One group of studies indicate that sex typed individuals are more traditional in attitude and their behavior also correspond to the traditional norm (Bem, 1977; Galambos et al., 1985). A second group of studies, including some in Kolkata, India, demonstrate that identity and attitude are independent of each other, and behavior is only selectively determined by the stereotype (Datta et al., 1995). In fact, the inconsistency would appear less striking if it is understood that gender role identity
deals with self perception, and gender role attitude is concerned more with judgment of others in a relatively self-independent context. That the dynamics of judging the self and others are different has long been pointed out by the social psychologists (Messick et al., 1985, Markus and Wurf, 1987; Myers, 1993). In fact the behavioral utilization of gender stereotype can be understood well if the model suggested by Deaux and Lewis (1984) is adopted. This model demonstrates how the ultimate operation of gender stereotype is enabled in interaction with situational contingencies. It may be stated that stereotype as culturally built schema functions in intricate and dynamic ways and in interconnection with the psycho-social context to influence ultimate behavioral expression.

GENDER STEREOTYPE IN RELATION TO MENTAL HEALTH WITH SPECIAL REFERENCE TO INDIAN SITUATION: THE PRESENT STUDY

From the above exposition it may be understood that the components of gender stereotype, namely, gender role identity and gender role attitude are potential determinants of the individual’s mental health status. Indeed a number of early studies have demonstrated that appropriate sex typing is correlated with high self esteem and adjustment (Orlofsky, 1977). Contrarily others have observed that sex typed individuals have poor mental health (Consentini and Heilbrun, 1964). Androgyny has been found to be associated with positive mental health by a number of early workers (Bern, 1974; Spence & Helmreich, 1978) Later studies however demonstrated superiority of masculinity in identity (Taylor & Hall, 1982; Whitley, 1983, Cook, 1985).

In the face of this contradictory results it may be hypothesized that masculine, feminine and androgynous identity are associated with certain personality variables and thereby predispose individuals toward typical styles of stress management. Supportive studies on the channelization modes of aggression are by Campbell et al. (1997), and Koteswaraiyah and Rani (1995), and in India Jahan (1996). In relating gender role identity to basic personality dimensions Zeldow et al. (1985) reported the negative correlation between masculinity and neuroticism, and positive relation between masculinity and extraversion. Examining the relations of Eysenck's E and N dimensions with masculinity and femininity, Kimlicka et al.(1988) also found positive relation of masculinity with extraversion and negative with
neuroticism. Marsh and Byrne (1991) in this context developed a model that recognize positive effects of both masculinity and femininity on mental health, but their relative contributions are seen as dependent on the specific criterion variables.

Review of literature on the relationship between gender role attitude and mental health also show equivocal results. Jordan et al. (1970) found that it is the non traditional women who is likely to be psychologically more ill at ease. Adapting traditional roles have been associated with positive health behavior (Hibbard and Pope, 1987). On the other hand, other studies have shown a positive correlation between traditionality and anxiety (Spence et al., 1975; Braggio and Nielsen, 1976).

In the context of this earlier research endeavor, developed in further detail in Chapter II, the present study intends to investigate to what extent indices of wellness and positive mental health resource are related to life stress, gender role identity and gender role attitude. It is particularly important because there remains the possibility that the gender related status of mental health is different in India than in other countries, particularly the West. In the first place there is ample evidence that women in developing countries have a greater share of psychiatric morbidity. Data from the World Bank study revealed that depressive disorders accounted for close to 30% of the disability from neuropsychiatric disorders amongst women in developing countries but only 12.6% of that among men. The disparity in rates between men and women tend to be even more pronounced in underserved populations (World Bank, 1994).

In guiding the approach to women's mental health problem WHO in June 2000 stated “It is essential to recognize how the socio-cultural, economic, legal, infrastructural and environmental factors that affect women’s mental health are configured in each country or community setting. A gender-based, social model of health needs to be adopted to investigate critical determinants of women’s mental health with the overall objective of contributing to improved, more effective promotion of women’s mental health. Risk factors for mental disorder as well as for good mental health need to be addressed and where possible, a clear distinction should be made between the opportunities that exist for individual action and individual behaviour change and those that are dependent on factors outside the control of the individual woman” (Fact sheet No. 248). In the context of India, the 1995 Symposium on Women and Mental Health organized in NIMHANS, Bangalore addressed a number of psychosocial factors
of mental ill health. The symposium upheld the need for a holistic approach and gender sensitive orientation for dealing with women’s mental health problems.

As has been stated earlier, even considering international literature, much research attention has been devoted in the last three decades to the impact of gender role in women’s mental health. But relatively little attention has been directed toward the specifically male mental health issues as related to gender stereotype. In India, this category of research is virtually lacking, apart from being incorporated in the general discussion in any psychiatric research. It remains to be seen how and in what fashion, gender role imperatives of men influence their expressed mental health status.

Also, gender sensitive research in India has been more concerned with the negative indicators of mental health, and less toward the positive signs. Since negative and positive indices are qualitatively different aspects, and not merely opposite to each other, the understanding of the entirety of mental health status needs a consideration of this aspect also.

Although western studies have reported a uniform pattern of happiness among various occidental cultures (Diener and Diener, 1995) there has been some indication that the picture is different in developing and/or oriental cultures (Inglehart and Klingemann, 2000). To take care of this issue the mental health status difference between the sexes must be placed in cultural perspective. The meanings of masculinity and femininity have evolved in every culture as a function of sociopolitical development. Therefore transferring this concept from the West to the East needs sensitivity to context (Chitnis, 1988, Chang, 1999). In the West the typical feminine role has evolved when the agrarian society changed into an industrialized and urbanized one (Chafetz and Dworkin, 1986; Staggenborg, 1998). However the two world wars precipitated women’s increasingly labor force participation which changed the balance between the sexes. The Western feminist critique came forward to revolt not only against the oppression of women but also against the unnecessary confusing and mystifying stereotype of female identity (Friedan, 1963). In the East however the development was not exactly parallel but much more complex and circumscribed. There was observable difference with the West in terms of cultural, historical, political and economic context. First a large part of India is still agricultural and modern technology is sparsely available to all. Second the impact of the world wars in colonial India was different from the West. Third, the expansive cultural tradition of India is replete with apparently contradictory and ambiguous ideas about womanhood and manhood. The woman’s
position has fluctuated from supreme glorification to abysmal degradation (Altekar, 1959). Also in traditional Hindu religion, the mother goddess has been depicted simultaneously as the protector and killer (Kinsley, 1998), as a result of which the archetypal female-male relationship has developed on a different paradigm than in the West (Kakar and Ross, 1986; Mitra, 1985).

This different presentation of gender stereotype may have resulted in different functional requisites of expressing emotional lability as well as dysfunction for women and men. If we presume that the measured mental health status is the ultimate expression of perceived strength and stress in oneself, it is quite likely that this expression will abide by the meaning of stress within the social context, and also by the perceived self image and acceptance of the expression of distress within the given society. Presumably owing to this reason the feminist agenda in India also follows a somewhat different course than in the west and the meaning of gendered existence here has been ambiguous (Davar, 1999). From the above point of view it remains questionable whether the processing of stressful events to effect mental health, and the function of gender role stereotype to mediate this effect bear the same connotation as in the West.

Therefore the broad objectives of the present study were as follow: -

1) To determine the effect of sex on some positive indices of mental health among young adult college students.

2) To determine the nature and degree of association of life stressors, gender role identity and gender role attitude with indices of mental health among young adult college students.

3) To predict the mental health variables from life stressors, gender role identity and gender role attitude among young adult college students.