CHAPTER 6

SUMMARY
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INTRODUCTION

Health is an indispensable quality in human being. It has been described as soil from which the finest flowers grow. Health indicates psychosomatic well-being of an individual and is a broader concept which includes physical, social, and mental health. Mental health has been reported as important factor influencing individual’s various behaviour, activities, happiness, and performance. Before the second half of the twentieth century mental health was considered as the absence of mental disease but now it has been described in its more positive connotation, not as the absence of mental illness. Mental health has been mentioned as the ability of a person to balance one’s desires and aspirations, to cope up with life stresses and to make psychosocial adjustment.

According to WHO Expert Committee (1950) “mental health implies the capacity in an individual to form harmonious relations with others and to participate in or contribute constructively to changes in his social and physical environment. It also implies his ability to a harmonious and balanced satisfaction of his own potentially conflicting instinctive drives, in that it reaches an integrated synthesis rather than the denial of satisfaction to certain instinctive tendencies as a means of avoiding the thwarting of others”. Park (1995) asserts that “mental health is the balanced development of the individual’s personality and emotional attitudes which enable him to live harmoniously with the fellow men”.

Young people in modern time are more exposed to the problem of depression, social isolation, and drug abuse. They need to build social and emotional resources to cope with these risks so that their mental health can be restored.

Mental Health is determined by various factors. Emotional intelligence, gender, and gender identity are a few of these factors which have been considered as vital in the present research.
Bar-On (1997) characterized emotional intelligence as “an array of non-cognitive capabilities, competencies, and skills that influence one’s abilities to succeed in coping with environmental demands and pressures”. He developed Bar-on E.Q.-i, which stands for Emotional Quotient Inventory. He proposed 5 “realms” i.e., intrapersonal realm, interpersonal realm, adaptability realm, stress management realm, and general mood realm. These realms can further be subdivided into fifteen components or scales. A close examination of all major theoretical conceptions of emotional intelligence reveals the fact that components of emotional intelligence do play significant roles in mental health.


Emotional intelligence training is the process through which we learn to recognize and manage emotions, care about others, making good decisions, develop positive relationships, and avoid negative behaviours. Boyatzis et al. (2000) and Slaski et al. (2003) found the effectiveness of emotional intelligence training programme in improving mental health. Gardner (1983), Goleman (1995), Stenberg (1996), Mayer & Salovey (1997), Chan (2004), and Dulewicz & Higgs (2004) observed that child’s social and emotional intelligence is an essential ingredient to happy and productive life. They found the emotional intelligence training programme was very effective in this regard.

Lorenzo et al. (2006) conducted an emotional intelligence training for managers and found emotional intelligence scores increased genuinely. Sethi & Ajawani (2006), Bhatpahari & Ajawani (2006), Ajawani & Purohit (2008), and Ajawani et al. (2009) have also observed that increased emotional intelligence through
specific training for enhancing it, certainly brings about a raise in adjustment, happiness, and mental health.

Emotional intelligence training programme like other competence enhancement programmes assumes that all children and adolescents can improve their well-being by becoming more responsible decision makers and problem solvers who can cope more effectively with life’s daily challenges and stressful life events (Zigler & Trickett, 1978; and Durlak, 1998).

Society assigns each of us – even those few whose biological sex is ambiguous at birth – to the social category of male or female, the inevitable result is our strong gender identity (our sense of being male or female). Gender identity is a person’s sense of identification with either male or female sex as manifested by appearance, behaviour, and other aspects of person’s life. It is the subjective perception a person has of his or her own gender which occurs as a result of the internalization of masculine and feminine traits.

The term, first was used in 1965, by John Money. Gender Identity was introduced into psychoanalytical studies by Stoller (1968). Increasing attention to the diversity of gender has made the term gender identity adequate to describe the central organizing factor of personality and behaviour. Bem (1983) asserts that people have a generalized readiness to organize informations about the self on the basis of cultural definition of appropriate male and female attributes.

The term gender identity defines a person’s relative sense of his or her own masculine or feminine identity. It is the way in which an individual identifies with a gender category, for example, as being either female or male, or in some cases being neither. Basic gender identity is usually formed by age 3 and is extremely difficult to change after that (Encyclopedia Briternnica Online, 2011).

For years, psychologists took these opposites i.e., masculinity and femininity, as evidence of psychological well-being. Now, many feminists have challenged this
view. They insist that a new standard of mental health is required that allows individuals to express the full range of human emotions and role possibilities without regard to gender stereotype. According to this view, androgynous people should be more flexible in meeting new situations and less restricted in the way they express themselves, leading to a better mental health status. With the recognition of androgyny as a possible gender role, much of the research is focused on the hypothesis that it is preferable to be androgynous than to fit into either the usual male or female gender types. There is large body of research which supports the proposition that “androgynous is good” (Garcia, 1982; Prager & Bailey, 1985; Rosenzweig & Daley, 1989; Measure et al., 1991; Dean-Church & Gilroy, 1993; Mocalls & Struthers, 1994; Williams & D’Alessandro, 1994; Hibokewa et al., 2001; Horlander et al., 2001; and Peter, (2008). Younger et al. (2004) asserts that gender identity plays a large role in psychosocial development and mental health.

Sex is a biological term which refers to the functional differences between males and females and their reproductive potential. It is determined by genes in chromosomes. Male and female are biological terms, which are used to refer to person’s sex. Whereas, gender is a psychological term which refers to our awareness and reaction to biological sex and it is determined by biological, psychological, and sociological factors.

Gender affects many aspects of life, including access to resources, methods of coping with stress, styles of interacting with others, self-evaluation, emotionality, spirituality, and expectations of others. These all are factors which can influence mental health either positively or negatively. Psychological gender studies seek to better understand the relationship between gender and mental health in order to reduce risk factors and improve treatment methods. Cheng & Puge (1989) found that male tended to have higher self-esteem than females. Gramer & Imaike (2002) also reported that men’s emotions are stable than women. A number of studies found that female have scored higher than male on emotional intelligence dimension which is
positively correlated with mental health (Thingujam & Ram, 2000; Mayer et al., 2002; and Brackett & Mayer, 2003)

Over the past few decades a number of studies have shown that gender plays a vital role in mental health status of adolescents (Habibullah, 1969; Lareto & Goldino, 1972; Yung-Ho-Ko, 1976; Law, 1980; Rastogi & Nathawat, 1982; Bezat & Alexandra, 1983; Vello & Debra, 1986; Stewart, 1987; Reddy, 1988; Daniel, 1989; Holmstorm & Reijo, 1989; Gupta, 1990; Patterson, 1997; Siu & Watkins, 1997; Reddy, 2002; and Vasucki & Charumurthy, 2004).

STATEMENT OF PROBLEM

In the present research the author intends to study roles of emotional intelligence, gender, and gender identity in mental health of adolescents. Apart of it, the research also intends to explore impact of emotional intelligence training on mental health of adolescents. For the purpose, the specific problems under consideration and the relevant hypotheses formulated are described here below.

1. The first problem of the present research is whether emotional intelligence plays any role in mental health of adolescents?

   It has been hypothesized that adolescents with high emotional intelligence would enjoy better mental health than those adolescents who are low on emotional intelligence dimension.

2. The second problem of the research pertains to role of gender in regard to mental health of adolescents.

   It has been expected that male adolescents would show better mental health than female adolescents.

3. The third problem of the research pertains to role of gender identity in mental health of adolescents.
It is assumed that androgynous adolescents would be the best while undifferentiated adolescents would be the worst in regard to their mental health. However, the other two groups i.e., masculine adolescents and feminine adolescents, would possess intermediate positions in between these two extreme groups in the same regard.

4. The fourth problem of the present investigation pertains to impact of emotional intelligence training on mental health of adolescents.

It is hypothesized that emotional intelligence training would exert its positive effect on mental health of adolescents. In other words, it is expected that the adolescents of experimental (emotional intelligence training) group would show better mental health level than adolescents of control (nontraining) group.

5. The last problem of the present investigation is whether there is any joint role of emotional intelligence, gender, and gender identity (Study I) and interaction effect of gender, gender identity, and emotional intelligence training (Study II) on mental health of adolescents.

It is expected that there would be considerable interaction effect at first- and second-order levels of the three variables – emotional intelligence, gender, and gender identity (Study I), - and gender, gender identity, and emotional intelligence training (Study II) on mental health of adolescents.

**METHODOLOGY**

**The Sample**

A large group of 750 male students and 750 female students aging 16-17 years and studying in class 11th in Hindi medium schools of Raipur city formed the initial sample of the present research (Study I). Out of these 750 subjects in each gender category, a final sample of 120 subjects was selected randomly out of which
60 were with high emotional intelligence and 60 were with low emotional intelligence and out of this, one-fourth \((n = 15)\) were of ‘androgynous’, another one-fourth \((n = 15)\) were of ‘masculine’, another one-fourth \((n = 15)\) were of ‘feminine’ and the last one-fourth \((n = 15)\) were of ‘undifferentiated’ gender identity.

Q\(_1\)-Q\(_3\) statistics were implied as the criteria of selecting the sample for emotionally low and emotionally high intelligent groups. However, median statistic was used for classifying subjects into four categories of gender identity. Subjects scoring above the respective medians on both masculinity and femininity dimensions were classified as androgynous, those scoring above median on masculinity but below median on femininity dimension were considered as of masculine gender identity, those scoring above median on femininity and below median on masculinity dimension were classified as of feminine gender identity, and those scoring lower than respective medians on both the dimensions i.e., masculinity and femininity, were classified as of undifferentiated gender identity.

In this way, a final random sample of 240 subjects was selected in Study I of the research, out of which equal number of subjects \((n = 15)\) belonged to each of the 16 sub-groups i.e., (i) androgynous males with high emotional intelligence, (ii) androgynous males with low emotional intelligence, (iii) masculine males with high emotional intelligence, (iv) masculine males with low emotional intelligence, (v) feminine males with high emotional intelligence, (vi) feminine males with low emotional intelligence, (vii) undifferentiated males with high emotional intelligence, (viii) undifferentiated males with low emotional intelligence, (ix) androgynous females with high emotional intelligence, (x) androgynous females with low emotional intelligence, (xi) masculine females with high emotional intelligence, (xii) masculine females with low emotional intelligence, (xiii) feminine females with high emotional intelligence, (xiv) feminine females with low emotional intelligence, (xv) undifferentiated females with high emotional intelligence, and (xvi) undifferentiated females with low emotional intelligence.
For Study II, a final random sample of 80 adolescent students with low emotional intelligence was selected to study effect of emotional intelligence training on mental health. For the purpose, 20 subjects were selected randomly from each of the gender identity groups i.e., androgynous, masculine, feminine, and undifferentiated, maintaining male-female ratio as 1:1. Half of these subjects (n = 5) in each 8 sub-groups were further randomly assigned to the control (nontraining) group and another half (n = 5) were assigned to the experimental (training) group.

**Tools Of Study**

Following tests were used to assess three psychological dimensions under consideration in the present research.

1. **Assessment of Emotional Intelligence** – Emotional Intelligence Scale - Youth Version (Ajawani, 2008) was used to assess level of emotional intelligence of the subjects.

2. **Determination of Gender Identity** – Gender Identity Test (Ajawani, 2006) was used to determine gender identity of the subjects.

3. **Assessment of Mental Health** – Mental Health Battery (Singh & Gupta, 2000) was used to determine level of mental health of the subjects.

**Research Design & Procedure**

A 2x2x4 factorial design was used to study independent and interaction effects of 3 independent variables – emotional intelligence, gender, and gender identity, on the dependent variable i.e., mental health for Study I. Similarly, a 2x4x2 factorial design was used to study the independent and interaction effects of 3 independent variables i.e., gender, gender identity, and emotional intelligence training, on mental health of the subjects (Study II).

Initially, a list of all Hindi medium higher secondary schools of Raipur City was prepared and 17 schools were selected randomly to draw initial sample of 1500
students aging 16-17 years and studying in class 11\textsuperscript{th}. All these 1500 students were administered emotional intelligence scale. On the basis of scores on this emotional intelligence scale, all the students scoring below \( Q_1 \) (\( Q_1 = 111 \)) were classified as of low emotional intelligence and those scoring above \( Q_3 \) (\( Q_3 = 125 \)) were classified as of high emotional intelligence.

In the next step, all these students with low and with high emotional intelligence were administered gender identity test. On the basis of norms for scores on gender identity test, subjects were classified as either of four gender identity groups i.e., androgynous, masculine, feminine, and undifferentiated. Random samples of 30 students each were selected from each of four gender identity sub-groups of high and low emotional intelligence levels maintaining male-female ratio as 1:1. In this way, a final random sample of 240 adolescent subjects was selected in Study I for the present research, who were lastly administered Mental Health Battery to determine their level of mental health. Computations were done on the basis of converted percentile scores on Mental Health Battery.

Another random sample of 20 emotionally low intelligent subjects was selected from each of four gender identity groups, maintaining male-female ratio as 1:1. Out of 10 subjects in each gender - gender identity group, one-half (\( n = 5 \)) subjects were randomly allotted to the control (nontraining) group and another-half (\( n = 5 \)) subjects were randomly allotted to the experimental (training) group. In this way, a total of 80 students with low emotional intelligence were studied for their mental health in either of training or nontraining condition. The subjects of control group were firstly tested on mental health and again retested after 18 days while the subjects of training group had undergone emotional intelligence training for 18 days before their retesting on mental health. The emotional intelligence training was conducted in two parts. During first three days, all the subjects were given general emotional intelligence training on all the fifteen dimensions of emotional intelligence followed by specific training on single dimension of emotional intelligence each day for fifteen dimensions of
emotional intelligence i.e., (i) Emotional Self-Awareness, (ii) Assertiveness, (iii) Self-Regard, (iv) Self-Actualization, (v) Independence, (vi) Empathy, (vii) Interpersonal Relationship, (viii) Social Responsibility, (ix) Problem Solving, (x) Reality Testing, (xi) Flexibility, (xii) Stress Tolerance, (xiii) Impulse Control, (xiv) Happiness, and (xv) Optimism. Specific emotional intelligence training was given to only those subjects who were low on these dimensions of emotional intelligence.

Apart of it, they were also retested on emotional intelligence scale to verify the effectiveness of training programme.

The difference between post- and pre-testing percentile scores on Mental Health Battery has been considered as the criterion for further computations and was labeled as “difference mental health percentile scores”.

**DATA ANALYSIS**

The obtained data were analyzed with the help of parametric statistics i.e., F-test, CR, and Tukey’s HSD Test. Hartley Test of Homogeneity of Variance was used to ascertain whether observations were randomly drawn from normally distributed population and all of which have same variance. Apart of it, multiple regression analysis was done to ascertain relative contribution of individual factors to mental health.

**RESULTS & DISCUSSION**

**Study I**

Individual and interaction effects of emotional intelligence, gender, and gender identity on mental health were studied in Study I of the present research.

In reference to role of emotional intelligence, it has been found that adolescents with high emotional intelligence show higher mental health level than those adolescents with low emotional intelligence.
In respect of role of gender in mental health of adolescents, it has been found that females enjoy better mental health than male adolescents.

In reference to the role of gender identity in mental health, it has been found that adolescents with androgynous gender identity enjoy the best mental health while those with undifferentiated gender identity the least mental health. The other two gender identity groups i.e., masculine and feminine, stand second and third in the same regard.

Regarding interaction effects of above three factors on mental health of adolescents, it has been found that interaction effects of emotional intelligence and gender identity, and gender and gender identity are considerable at first-order level, however, the interaction effect of emotional intelligence and gender has not been found true. At, second-order level, interaction effect of all the three factors i.e., emotional intelligence, gender, and gender identity, on mental health of adolescents has been found genuine.

**Study II**

No any significant role of gender in mental health of emotionally low intelligent adolescents has been observed.

Gender identity has been found to play a vital role in mental health of adolescents of low emotionally intelligent too. Adolescents with androgynous, with masculine, and with feminine gender identity have been found to enjoy better mental health than those with undifferentiated gender identity.

In regard to impact of emotional intelligence training, it has been found that adolescent subjects in emotional intelligence training condition truly show greater enhancement in their mental health in comparison to those in nontraining condition.

In regard to interaction effects of three variables considered in Study II of the present research, it has been found that (i) there exists true joint effect of gender and
gender identity on mental health of adolescents, (ii) both the gender groups profited equally from emotional intelligence training in regard to their mental health, (iii) the four gender identity groups i.e., androgynous, masculine, feminine and undifferentiated, genuinely vary in benefiting from emotional intelligence training in respect of their mental health. More specifically, adolescents with undifferentiated gender identity benefited lesser than those with either androgynous or masculine or feminine gender identity, and (iv) there exists true joint effect of gender, gender identity, and emotional intelligence training on mental health of adolescents. In other words, the 8 subgroups formed on the basis of gender and gender identity truly differ in benefiting from emotional intelligence training in respect of their mental health.

The findings strongly suggest that high emotional intelligence and androgyny truly helps in mental health and efforts shall be made to enhance emotional intelligence level of emotionally turmoil youths through appropriate training and to nurture androgyny so that they can be more stress resilient and can thus enjoy better mental health.