CHAPTER – ONE

INTRODUCTION

MENTAL HEALTH

In the present era of globalization, privatization and liberalization, the entire scenario of the whole world is turned into a global village but the social attitudes, value patterns, conduct, and behaviour of people have been radically changed in the inverse direction. Today people live in a money worshipping society which is full of competition with values of consumerism, individualism, materialism, and hedonism; sadism and masochism have significantly increased and sensitivity towards others’ suffering has considerably decreased. Feelings of envy and jealousy toward others are spreading in each society with impersonal relationship, alienation, nonconsciousness and unmindfulness which have damaged the person himself. All kinds of insecurities – physical, mental, social etc., have engulfed the psyche of the people who are crazy for more and more materialistic possessions in order to live luxuriously and also to leave the same for generations to come. Today’s men are unnecessarily running from early morning till late at night for minting money and amassing wealth with their never ending lust. Resulting lack of emotional-social support to fellowbeing has created anxiety, frustration, stress, tension, maladjustment with so many personal and social problems and have disturbed health of the individual to a great extent.

According to the World Health Organization in 2004, depression is the leading cause of disability in the United States for individuals ageing 15 to 44 (Thomson, 2007). Absence from work in the U.S. due to depression is estimated to be in excess of $31 billion dollars per year (Thomson, 2007). Depression frequently co-occurs with a variety of medical illnesses, such as heart disease, cancer, and chronic pain is also associated with poorer health status and prognosis (Munce et al., 2007). Each year, roughly 30,000 Americans take their lives, while hundreds of thousands make suicide
attempts (centers for disease control and prevention). In 2004, suicide was the 11th leading cause of death in the United States (center for disease control and prevention), third among individuals ageing 15-24 years (Thomson, 2007). Despite the increasingly availability of effectual depression treatment, the level of unmet need for treatment remains high (Thomson, 2007). Reducing depression within the United States population has been an essential priority of governmental organizations over the last decade. Mental illness, disability, and suicide are ultimately the result of a combination of biology, environment, and access to and utilization of mental health treatment (Thomson, 2007). Public health policies can influence access and utilization, which subsequently may improve mental health and help to progress the negative consequences of depression and its associated disability (Thomson, 2007). Emotional mental illness has been a particular concern in the United States since the U.S. has the highest annual prevalence rates (26 percent) for mental illnesses among a comparison of 14 developing and developed countries (Demyttenaere et al., 2004). While approximately, 80 percent of all people in the United States with a mental disorder eventually receive some form of treatment, on the average persons do not access care unit nearly a decade following the development of their illness, and less than one-third of people who seek help receive minimally adequate care.

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. People in a state of emotional, physical, and social well-being fulfill life responsibilities, function effectively in daily life and are satisfied with their interpersonal relationships and in themselves. Looking at the divesting scenario of the modern society, mental health is vitally important, as our entire thought process takes place in mind, our all goals originate from our mind, and all kinds of directions are issued from mind which guide, shape, and regulate our communication, conduct, and behaviour and determine our personal and social functioning as well as adjustment.
If the mind is healthy, desirable behaviour exists. It will permit the individual to lead a socially and economically productive life. Mental health is a sense of well-being, and individual experience. It determines individual’s way of living, working and leisure activities. It produces happiness, stability, and security. It is the ability of an individual to make personal and social adjustment.

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 mere absence of mental illness. Every living being yearns for happiness and bliss and tries alike to protect from disease and distress and overcome calamities and hurdles. Health is a vulnerable asset for every individual. According to an Arabian proverb, “A man, who is healthy and has optimistic view, has everything.” In Indian culture, various epics quoted purity and divinity as the two main characteristics of mentally healthy individual. In Sri Bhagvad Gita, the nature of God is described as, “fearless, purity of mind, wider knowledge, concentration, charity, self-control, sacrifice, uprightness, vigour, forgiveness, fortitude, freedom from pride”. The “gurus” has to possess certain characteristics, which everybody should follow and “Guru” is the role-model, the qualities of “Guru” are: nonviolence, truth, freedom from anger, tranquility, aversion towards fault finding, compassion, gentleness, modesty and steadiness. All these characteristics are of a well-adjusted, well-integrated and mentally healthy individual. In Sri Bhagvad Gita, Lord Krishna emphasized on harmonious relations among individuals which leads to sound mental health and adjustment. Lord Buddha, in his book “The Dharmapada” described the enlightened individuals and the procedures to attain real happiness in life, i.e., best relationship, “nirvana” is the highest happiness, cleanse the mind, cultivate and establish thyself in good, the wise are not elated in their happiness, nor depressed when touched by sorrow. Sri Ramkrishna Paramahansa and Swami Vivekananda emphasized on service and sacrifice, which are the essential ingredients of sound mental health. According to Atharvaveda too, the human personality is considered to
be one whole. But in view of ailments, it is considered to have two major aspects, physical and mental. Human personality on physical side has three components as ‘vata’, ‘pitta’, and kapha’ (A.V. XVIII/4/29.33). These three components are in every human body since birth, varying different degrees but these try to maintain equilibrium, and disequilibrium of these components gives rise to physical illness (A.V. 1/2/3). The mental side is also constituted by the three ‘gunas’ or ‘vrittis’ – ‘sattva’, ‘rajas’, and ‘tamas’ (A.V. 1/1/1 and X/8/43). These ‘gunas’ are in ‘manas’ or mental personality since birth but they try to keep a certain equilibrium which generally maintains a healthy mental state in human beings. So the total human personality at any stage, that is, both on physical and mental planes is a matter of balance or imbalance of these components, viz, ‘vatta’, ‘pitta’, ‘kapha’, and ‘sattva’, ‘rajas’, and ‘tamas’.

Thus, equilibrium or homeostasis in both physical and mental planes is a state of holistic health and bliss according to Atharvaveda (Singh, 1977).

The imbalance in these states of three ‘prakriti gunas’ – ‘sattva’, ‘rajas’, and ‘tamas’ – causes the unhealthy states in the beings and only the person having homeostasis in these three mental components will have sound mental health.

Sushrut has taken into consideration the health of the whole personality. According to him, the person, whose ‘Atma’ (soul or psyche), senses, and ‘mana’ (mind) are in a state of well-being is mentally healthy. Some other scholars of Ayurveda such as Vagbhatta (Ashtang Samgrah) and Kashyap have also emphasized the feeling of well-being as the essential condition of mentally healthy personality. Thus, the health of an individual, according to Ayurveda, is a very comprehensive term, which includes his physical, mental, and spiritual well-being. This is the holistic concept of health.

According to ‘Yoga’, mental health is an integral part of the whole healthy personality. The outstanding features of the Indian concept of mental health are balanced physical and mental constitution, happy state of self and mind, and the
holistic nature of health (Khurana & Singh, 1984; Sinha, 1990; Ram, 1998; and Dalal, 2001). Tripathi et al. (2006), stated that the Indian perceptions can make a positive contribution to the state of mental health in the modern life. Egolessness, the paradigm of ‘Sthitapragya’ and ‘Anasakti’, the paradigm of ‘Maitri’, ‘Karuna’, ‘Mudita’ and ‘Upeksha’ are the different perceptions as given by the Indian wisdom literature which complement and supplement holistic view of mental health. According to them mental health, however, is the positive capacity for living and enjoying the good life. Examination of the internal psychological states and process, i.e., ‘chittavritti’ is one of the central themes in the Indian wisdom literature. The Indian thoughts seek to understand and analyze natural inclinations, desires, passions etc., so as to consciously control them. The object of this control is to uplift and refine human personality by our coping and eliminating negative emotions and disvalues like ‘trishna’, ‘raga’, ‘dwesh’ and by replacing them with positive emotions and values like love and compassion. This Indian perception is close to the WHO definition of health/well-being. According to WHO Expert Committee (1959) “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 drive, 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”. Mental health can be conceptualized without restricting its interpretation across cultures. WHO (2001) has recently proposed that mental health is ... “a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community”. World Health Organization (1946, 1986) definitions of positive mental health are still under debate but there has been a movement away from a focus solely on individual attributes such as coping skills or resilience to one which incorporates environmental and social conditions (Rutter, 1985; Health Education Authority, 1997; MacDonald &
So, mental health is an integral component of health through which a person realizes his or her own cognitive, affective, and relational abilities. With a balanced mental disposition, one is more effective in coping with the stresses of life, can work productively, and fruitfully and is better able to make a positive contribution to his or her community (WHO, 2001).

THE HUMANIST CONCEPT OF MENTAL HEALTH

The humanistic concept has certain general premises, the first one being that man is not made for the state, for the purposes of society, but that the state and society have to serve man. The second is that man can be defined not only anatomically and physiologically, but also psychically and mentally. That inspite of differences between individuals, that inspite of differences between nations and races, man is one. Humanity is not an abstract concept, but a reality. That in as much as we are human every one of us represents humanity. We are all saints and all criminals; we are all children and we are all adults, who know that they have to die. We are all different, and yet we are all the same, and it is because of this that we can understand each other, that we can understand even the stranger. Art has many expressions and forms, and yet it is a universal language because it is the expression of universal humanity. This concept, that humanity is one and that all men share in the same basic human qualities, is the concept of humanism, is the concept of the Bible, and it is the concept of Buddha and Lao-tse, as well as it is the concept of Spinoza, Leibniz, Hegel, and Marx.

The third premise of humanism is that there are certain values which are not only a matter of taste, but which have objective validity. This concept of objective values is not too popular today when people are reluctant to be committed to anything but their profit and their amusement. Even most psychiatrists refuse to accept this idea, and yet they find themselves in this peculiar paradox: If a patient comes to them and says: “Doctor, I hate everybody, I hate my wife, I hate my children, and I hate all
strangers,“ then no doubt the psychiatrist would believe that this man is very sick. The psychiatrist would have to admit that in this respect his clinical observation co-exists with certain moral values recognized by all humanistic philosophy, that hatred is morally bad, and that it is a symptom of sickness, psychologically. But he refuses to accept the idea that there are certain positive goals, like love, comprehension, a sense of justice, which are inherent in the very structure of man, and which are desirable both from the standpoint of traditional humanist ethics, and from the standpoint of mental health.

Defining good generally speaking, it may be said that good is what is good for the unfolding of man, given the peculiar peculiarities of existence and the laws which govern it. If we know the specific conditions of human existence, then indeed we can understand that the fully developed man is like the man who has become what he potentially is, the man whose moral maxim is that he ought to be what he could be.

From this standpoint of normative humanism, mental health cannot be defined as the absence of symptoms; it cannot be defined as adjustment to existing society, regardless of whether the society itself is healthy or sick. It can be defined only in terms of the fullest realization and unfolding of man’s potentialities.

Well-being is the state of having arrived at the full development of reason: reason not in the sense of a merely intellectual judgment, but in that of grasping truth by “letting things be“ (to use Heidegger’s term) as they are. Well-being is possible only to the degree to which one has overcome one’s narcissism; to the degree to which one is open, responsive, sensitive, and awake. Well-being means to be fully related to man and nature affectively, to overcome separateness and alienation, to arrive at the experience of oneness with all that exists - and yet to experience myself at the same time as the separated entity I am, as the individual. Well-being means to be fully born, to become what one potentially is; it means to have the full capacity for joy and for sadness or, to put it still differently, to awaken from the half-slumber the
average man lives in, and to be fully awake. If it is all that, it means also to be creative; that is, to react and to respond to myself, to others, to everything that exists – to react and to respond as the real, total man I am to the reality of everybody and everything as he or it is. In this act of true response lies the area of creativity, of seeing the world as it is and experiencing it as my world, the world created and transformed by my creative grasp of it, so that the world ceases to be a strange world “over there” and becomes my world. Well-being means, finally, to drop one’s Ego, to give up greed, to cease chasing after the preservation and the aggrandizement of the Ego, to be and to experience one’s self in the act of being, not in having, preserving, coveting, and using.

The healthy person is constantly changing, and yet he remains the same. He has convictions which originate in himself, and not synthetic opinions as if he were a disc on a record player. He can see the reality of his personal life and of the life of his society, and penetrates through the fictions which most people believe to be the reality. He can know the difference between words and reality, and not mistake the one for the other. Thus, it can be said, the healthy person has a passionate interest in the world. Not everybody necessarily in the same aspects of the world, but still an interest which absorbs him, which excites him, and which to fulfill, gives him satisfaction.

It is quite clear that the development of well-being in humanist sense, depends on certain social premises. A society which is stagnating or which is blocked in its own development, a society which suffers from unsolved contradictions between rich and poor, a society which does not develop its own resource, will be at the same time a society in which most people do not have hope, and hopelessness is one of the basic obstacles to mental health. Hence the first condition for the development of mental health in any given society is the fact that there is hope, but not the kind of fictitious hope which is raised by ritualistic speeches, but that which is based on the reality that the society is developing and unfolding, and that it achieves an ever-increasing equality, and offers the material basis for a dignified and rich human life for all its citizens.
Students are in a particularly fortunate situation as far as mental health is concerned. They have chosen an activity very different from carrying stones, different from doing monotonous work. They have chosen an activity which in itself is interesting and exciting, which more than any other activity lends itself to the development of a passionate interest in the world. The student has, one might say, if he is truly a student, the main pre-requisite for being a healthy person, and yet it is known empirically that so many students lack in mental health. This condition can be changed in two ways, and both must be taken: one by making study truly exciting, and by trying to reduce the number of those students who only study because it seems to them to be the easiest way to make money. The second way is to examine individual factors which make it difficult for a student to be truly interested, inspite of the fact that he has good teachers and an interesting field of study. Here clinical psychology has its wide field, but from the standpoint of the humanist tradition the healthy man is the man who is productive, the man who is related to the world, and concerned with the world, and mental health is never only absence of illness; it is never only the capacity to function well, but it is a state of mind in which the person is stimulated by the world around him, and hence he can be stimulating to others.

KEYE’S STRUCTURE OF MENTAL HEALTH

The hedonic viewpoint defines emotional well-being as the presence of positive emotions and the eudaimonic viewpoint defines psychosocial well-being as the presence of psychosocial functioning (Waterman, 1993; and Keyes, 2002, 2003, 2005a, 2005b).

Although the definition of mental health is multidimensional, mental health is often measured using a single indicator, such as a measure of life satisfaction (Heidrich & Powwattana, 2004), positive and negative affects (Petrocelli & Smith, 2005; Phillips & Silvia, 2005), general level of happiness in life (Heidrich & Powwattana, 2004), and anxiety and/or depression (Bruch et al., 2000; Heidrich et al., [9]
1994; Heidrich & Ryff, 1993a, 1993b). Rarely, mental health indicators are assessed multidimensionally or integratively. Yet, in recent years, using the most popular theoretical view of mental health from the literature, Keyes (1998, 2002, 2003, 2005a, Keyes & Waterman, 2003) was able to propose clearly defined criteria and procedures to measure mental health. He has compiled a list of 14 important indicators or diagnostic symptoms that enable researchers to consistently define and quantify individuals’ level of mental health.

(i) The Hedonic Perspective. The 14 important diagnostic symptoms of mental health that Keyes proposed are derived from the hedonic and eudaimonic philosophical views and these two philosophical perspectives are concerned with individuals’ perception and evaluation of their level of affective state (i.e., emotional well-being) and their level of psychosocial functioning (i.e., psychological and social well-being (Waterman, 1993; Keyes, 1998, 2002, 2003; Ryan & Deci, 2001; Keyes et al., 2002; and Keyes & Waterman, 2003). The hedonic perspective stresses that well-being consists of experiencing happiness and pleasure, which reflects the domain of emotional well-being. Indicators or diagnostic symptoms that comprise the emotional/hedonic well-being domain of mental health are: (1) happiness (i.e., the extent to which individuals generally feel content or happy about life), (2) satisfaction with life (i.e., the extent to which individuals are satisfied with life overall or in specific areas), and (3) the balance of positive and negative affects (i.e., the extent to which individuals experience more positive feelings and fewer negative feelings; Keyes, 2003; Keyes & Waterman, 2003).

(ii) The Eudaimonic Perspective. The eudaimonic perspective highlights that well-being consists of realizing and fulfilling potentials individuals have set for themselves, which reflects the domain of functional well-being (i.e., the psychological and social well-being domains (Keyes, 1998, 2002, 2003; and Waterman, 1993). Indicators that define the functional/eudaimonic well-being domain of mental health consist of two separate indicators that describe only the social domain of well-being. The
psychological well-being domain, described as how well one is functioning, adjusting, and adapting to personal life, includes: (1) autonomy (i.e., the degree to which individuals have the ability to be self-determined and make autonomous decisions in life free from the pressure or influence of others); (2) self-acceptance (i.e., the extent to which individuals have a positive evaluation of self); (3) environmental mastery (i.e., the extent to which individuals can handle their daily life demands and handle their unpredictable complex environments); (4) purpose in life (i.e., the extent to which individuals have meaning, direction, and goals in life); (5) personal growth (i.e., the extent to which individuals are feeling and sensing that they are developing and growing as a person); and (6) positive relations with others (i.e., the extent to which individuals have intimate, trusting, and satisfying relationships with others Keyes & Ryff, 1999; Ryff & Keyes, 1995; and Ryff, 1989). In contrast, the social well-being domain, described as the degree to which one is functioning, adjusting, and adopting to the social aspects of life, consists of five diagnostic symptoms: (1) social actualization (i.e., the extent to which individuals find society has the potential to evolve in a positive direction); (2) social acceptance (i.e., the extent to which individuals have a positive appraisal of or positive attitude toward others); (3) social coherence (i.e., the extent to which individuals find society has meaning or is predictable); (4) social integration (i.e., the extent to which individuals sense that they are a part of society or their community); and (5) social contribution (i.e., the extent to which individuals feel they have something important or of value to contribute to society (Keyes, 1998).

(iii) Level of Mental Health. Based on these 14 indicators, individuals’ level of mental health can be measured on three levels ranging from languishing to moderately mentally healthy to flourishing in life by using empirically well-established psychometric scales as suggested in Keye’s (1998, 2002, 2003) writing. Languishing in life is defined as a state in which individuals feel jaded with life in general, and there are feelings of ennui, emptiness, loss, and a lack of purpose or meaning.
Individuals who are languishing in life can be viewed as lacking the feeling of positive emotions and not functioning well in personal and social life. In contrast, flourishing on life is defined as a state in which individuals have a drive or an enthusiasm for life in general, and there is the presence of determination, motivation, energy, and ambition to live life to the fullest. The life of flourishing individuals is filled with positive emotions and they function psychologically and socially well.

**HOLISTIC PERSPECTIVES OF MENTAL HEALTH**

In the west mental health concept has a long developmental history along with amelioration of mental illness and development of overall health. The term holism was introduced by Smuts (1926) as a way of viewing living things as entities greater than the sum of their parts. A school of psychology as Holistic also came into existence but could not flourish because of medical researches in microbial diseases and development of drugs etc. However, in certain conditions pharmacotherapy proved to be of limited or no use and many other options for cure, health, and well-being claims came into being which paved the way for holistic health lifestyle.

The present concept of mental health in the west evolved first in fragmented and piecemeal fashion and gradually got integrated in a unified and complete entity. Recently, many non-medical alternate therapies and their experts worked jointly to cure diseases and restore optimum health and well-being. Their holistic approach was not only for an individual but for the whole mankind. Broadly holistic approach stands for whole person and whole situation. It includes integration of all physio-medial as well as conventional alternate therapies.

The American Holistic Health Association (AHHA) makes holistic health approach to create total human wellness, which includes:

1. To balance and integrate one’s own physical, mental, emotional, and spiritual aspects.
2. To establish respectful, cooperative relationship with others and the environment.

3. To make wellness oriented lifestyle choices.

4. To actively participate in one’s health decisions and healing process.

Thus, according to AHHA holistic health is actually an approach to life in wholeness. It emphasizes connections between mind, body, and spirit and the goal is to achieve maximum well-being which is also the responsibility of the individual. This view comes very near to the Yoga of Indian antiquity. Yoga is a way of life for every person. Patanjali’s eight components of yoga – ‘Yama’, ‘Niyam’, ‘Asan’, ‘Pranayam’, ‘Pratyahar’, ‘Dharana’, ‘Dhyan’, and ‘Samadhi’ cover the five ‘Kosh’s’, ‘Anna’, ‘Pran’, ‘Mana’, ‘Vigyan’, and ‘Anand’ as interdependent constituents of personality, i.e., whole of man. All cognitive, affective, and conative spheres of life are covered and nothing is left. So, yoga is strictly a holistic way of life to achieve well-being (‘Anand’) in life.

Following are some of the basics of Holistic Health:

1. Holistic health is not merely freedom from sickness but it is complete state of wellness.

2. At any time man is not fully in perfect health. He has to keep working for holistic health. So it is an ongoing process.

3. Because man is a salve of wishes, these are always increasing in different ways and degrees. Choice for life style changes and efforts are further made to maintain equilibrium on the whole.

4. Quality of life is to be raised to the fullest wellbeing. So holistic health is a matter of life long practice.

Not only human personality is made up of interdependent components such as physical, mental, emotional, and spiritual but the environment with its so many interdependent systems, viz., physical, family, social, cultural, and occupational, is also
holistic in nature. Therefore, man becomes a part of the wholeness of the total system. He is constantly responding to environment, which is spread to a vast whole and as a small part of the total system, the happenings in the environment also affect him.

A holistic model of mental health generally includes concepts based upon anthropological, educational, psychological, religious, and sociological perspectives as well as theoretical perspectives form personality, social, clinical, health, and developmental psychology.

An example of a wellness model includes one developed by Myers et al. (2000). It includes five life tasks – essence on spirituality, work and leisure, friendship, love and self-direction and twelve sub-tasks – sense of worth, sense of control, realistic beliefs, emotional awareness, and coping, problem-solving, and creativity, sense of humor, nutrition, exercise, self-care, stress management, gender identity, and cultural identity, which are identified as characteristics of healthy functioning and a major component of wellness. The component provides a means of responding to the circumstances of life in a manner that promotes healthy functioning.

INDICES OF MENTAL HEALTH

After reviewing the literature in the field of mental health (Jahoda, 1958; Maslow & Mittleman, 1951; Rogers, 1961; and Whittaker, 1970) following six popular indices of mental health were selected:-

(i) **Emotional Stability.** It refers to experiencing subjective stable feelings which have positive or negative values for the individuals.

(ii) **Overall Adjustment.** It refers to individual’s achieving an overall harmonious balance of environment, such as home, health, social, emotional, and school on the one hand and cognition on the other.

(iii) **Autonomy.** It refers to a stage of independence and self-determination in thinking.
(iv) **Security – Insecurity.** It refers to a high (or low) sense of safety, confidence, freedom from fear, apprehension or anxiety, particularly with respect to fulfilling the person’s present or future needs.

(v) **Self-Concept.** It refers to the sum total of the person’s attitudes and knowledge towards himself and evaluation of his achievements.

(vi) **Intelligence.** It refers to general mental ability which helps the person in thinking rationally, and in behaving purposefully in his environment.

Various authors have also described components of mental health in terms of indicators, criteria, characteristics etc..

Jahoda (1958) has described six indices of mental health.

1. A positive attitude towards one’s self-acceptance of weakness and pride in strengths, motivation towards inner stability.

2. Growth and development towards self-realization of one’s potentials towards achieving the best of what one might become.

3. Integration of personality involving a balance of psychic forces, unified outlook as life and some capacity for withstanding anxiety and stress.

4. Autonomy of action in which the individual determines behaviour.

5. A perception of reality, free form wishes, desires, concerned with the welfare of others.

6. Mastery of environment by
   - the ability to love,
   - adequate in work, play and leisure,
   - competence in human relations,
   - capacity to adapt oneself to current situations,
• draw satisfaction from one’s own environment, and
• willingness to use problem-solving approaches in the life processes.

Maslow & Mittlemann (1951) have suggested the following criteria for normal psychological health:

1. adequate feeling of security,
2. adequate self-evaluation,
3. adequate spontaneity and emotionality,
4. efficient contact with reality,
5. adequate bodily desires and the ability to gratify them,
6. adequate self-knowledge,
7. integration and consistency of personality,
8. adequate life goals,
9. ability of learning from experience,
10. ability to satisfy the requirements of the group, and
11. adequate emancipation from the group of culture.

Schultz (1977) has noted seven criteria of mental health:

1. extension of the sense of self,
2. warm relationship with self to others,
3. emotional security,
4. realistic perception,
5. skills and assignments,
6. self-objectification, and
7. unifying philosophy of life.
Dimensions of mental health according to Jagdish & Shrivastava (1983) are as below:

(i) Environmental Mastery

- Efficiency in meeting situational requirement.
- Capacity for adjustment.
- Ability to take responsibilities.

(ii) Integration of Personality

- Balance of psychic forces.
- Ability to understand and share others emotions.
- Ability to concentrate on work.
- Interest in several activities.

(iii) Positive Self-Evaluation

- Self-confidence.
- Self-acceptance.
- Self-identity.
- Feeling of worthwhileness
- Self-realization.

(iv) Group-Oriented Attitudes

- Easy get along with others.
- Ability to deal group works.
- Ability to find recreation.
(v) Autonomy
- Self-control in one’s action.
- Self-dependence.
- Stability of self.

(vi) Perception of Reality
- Perception of free from need distortion.
- Absence of excessive fantasy.
- Broad outlook of world.

Larry (1998) explained mental health as absence of mental illness, appropriate social behaviour, freedom from worry and guilt, personal competence and control, self-acceptance and self-actualization, unification, and organization of personality, open mindedness, and flexibility.

Some of the important indicators of mental health are also suggested by Bhatnagar (2000):

1. acceptance of oneself and others in totality,
2. spontaneity, creativity, and freshness of vision and a healthy sense of humour,
3. healthy reactions, capacity to understand problems, ability to make decisions and solution-oriented attitude,
4. personal autonomy, authenticity and responsibility for oneself,
5. healthy interpersonal relationship and adaptability and quality of life,
6. positive thinking, awareness and maximization of one’s potentials,
7. emotional maturity sensitivity, empathy and ability to manage emotions effectively,
8. realization of peace within one’s own self and creation of harmony with others,
9. ability to contribute in a creative and constructive manner to bring about the desired changes in the physical environment and socio-cultural context.
Bhargava and Bhargava (2002) have enumerated some indicators of mental health as below:

1. To accept oneself and others in totality.

2. One should have the ability to analyze his extended self. He must recognize his plus points, accept limitations and should feel comfortable and peaceful within himself, to set reasonable goals for himself and should have the ability to take his own decisions.

3. He should have the ability to manage himself by analyzing his self-concept, self-esteem and self-actualization.

4. As a person, he is the part of the society, so he should have the healthy interpersonal relationship and creating harmony with the other members of the society. He should also be aware of others’ potentialities, to understand his social responsibilities and solve the problems of community as a whole.

5. One should prepare his life planning keeping in view of his skills and capabilities, he should be very systematic within realistic perspective of his surroundings.

6. One should be able to meet the demands of life and should shoulder his daily responsibilities.

7. One should be adaptable to understand the problems relating to any phase of his life and try to solve them in the best possible manner in that particular situation.

8. One should be contributive in a creative and constructive manner to bring about the desired changes in the physical environment, social and cultural context to make lively environment.

9. One should have the clear vision in every sphere of life, think positively and innovatively to take immediate decisions.

10. One should be radical, flexible and changing in accordance to the demands and time.
11. One must keep in mind the existence of the Almighty, i.e., “Ishwar” and any action or thought should be “samarpit” to the Almighty power of the world and never be consequence-oriented. This will give peace and happiness throughout life.

12. One must develop the sense of humour, delightfulness and enthusiasm with managing emotions effectively so that emotionally balanced person may feel emotionally secure.

13. One must be adjusted if he keeps the requirements of reality prevailing values and norms. He should also keep in mind three things – time, place, and person for doing any action.

14. One has the competency of discriminating right and wrong, good and bad. He should be able to ignore unknown or speculative thinking and having the ability to control fear for better mental health.

15. One should develop his integrated personality with consistency of the behaviour.

16. At least one should fix the satisfactory level in accordance with all realities of his life, only then he will feel life satisfaction. Instead of criticizing others, one should evaluate and overcome his weakness.

According to Medical Review Board of About.com (2004) characteristics of good mental health are:

(i) the ability to enjoy life,

(ii) resilience – the ability to bounce back from a adversity or cope well with stress,

(iii) balance in all situations of life,

(iv) flexibility,

(v) self-actualization, and

(vi) concept of self-esteem and healthy sexuality (for adults and adolescents).
Similarly, Tudor (1996) suggests that mental health can be described as multi-factored with six dimensions: affective, behavioural, cognitive, socio-political, spiritual, and psychological. Verma et al. (1998) proposed a dual theory of mental health. This theory regards mental health as an absence of mental illness and a presence of certain factors of positive mental health. The positive mental health factors include a sense of well-being, satisfaction, hope, adjustment, ego-strength, super-ego, creativity, ability to enjoy, happiness, honour, quality of life, self-realization, and social support.

In the west, the concept of mental health evolved from the mental hygiene movement. The movement was directed towards “prevention of mental illness, preservation of mental health, and care of mental illness” (Hadfield, 1960). The popularity of the term ‘mental health’ was gaining ground since its initial ways during the first meeting of the society for mental hygiene held in 1908. Traditionally, absence of ‘psychiatric illness or certain important parameters of mental illness namely depression, anxiety, and tension is considered as an indicator of mental health. It is argued that absence of such negative states does not guarantee whether a person can effectively handle his/her cognitive and emotional faculties for one’s own personal growth and development. It implies that psychological well-being or mental health is contingent upon certain positive states that provide the sense of adequacies and competence (Pattanayak & Mishra, 1997).

Arkoff (1968) has summarized the core of mental health in his description of four sets of qualities in mental health. According to him, the first set of two qualities, which are highly valued in mental health, are happiness and harmony. He asserts that happiness refers to a general sense of well-being and harmony implies a balance between personal and environmental demands.

A second set of qualities subsumed under the heading ‘self-regard’ includes self-insight (a knowledge of oneself), self-acceptance (a positive image of oneself),
self-esteem (a pride in oneself), and self-disclosure (a willingness to let oneself be known to others).

A third set of valued qualities has to do with personal growth, maturity, and integration. While personal growth refers to realization of one’s potentialities, personal maturity implies that one has realized or accomplished certain goals specific to one’s age or stage in life. Personal integration refers to the achievement of unity and consistency in behaviour, i.e., integrity.

A final set of qualities valued in mental health includes contact with the environment, effectiveness in the environment and independence of the environment. While the contact with the environment implies the ability to see the world as others do, effectiveness in the environment means the ability to relate to others and be proactive. Independence of the environment means the ability to be autonomous and not bound by group patterns of behaviour.

**CHARACTERISTICS OF MENTALLY HEALTHY PEOPLE**

Characteristics of a mentally healthy person likely to refer to such signs as the capacity to cooperate with others and sustain a close, loving relationships and the ability to make a sensitive, critical appraisal of oneself and the world about one and to cope with the everyday problem of living.

People with good mental health feel comfortable about themselves. They are not bowled over their own emotions by their fears, anger, love, jealousy, guilt, or worries. They have a tolerant easy-going attitude towards themselves as well as toward others. They can laugh at themselves. Mentally healthy people neither underestimate their abilities nor they easily accept their own shortcomings. They have their own self-respect, and they feel and show respect to others. They feel able to deal with most odd situations that come their way. They enjoy their life and get satisfaction from simple everyday pleasures.
Mentally healthy people have positive attitude toward their own group and other people. They are able to give love and consider the interest of others. They have satisfying and lasting personal relationship with others. They like and trust others and take it for granted that others will like and trust them. They recognize the difference among people but respect these differences. They do not push the people around nor do they allow themselves to be pushed around. They feel happy among the group, they consider themselves as they are part of the group. They feel a sense of responsibility to their friends, neighbours, co-workers and others.

Mentally healthy people are able to meet the demand of life. They solve their own problems and are not disturbed by them. They easily adjust in the environment and they try to shape the environment accordingly. They plan ahead but do not fear the future. Though they welcome new experiences and new ideas yet they prepare their own plans. They make use of their natural capacities. They set realistic goals for themselves. They are able to think for themselves and make their own decisions. They put their best effort into what they do and get satisfaction out of doing it.

Willin (1949) has described the major characteristics of a mentally healthy person as – happy inspite of his shortcomings, independent in actions and decisions, self-confident, fairly relax with himself and others, aware of the feelings of others and eager to attend new and challenging tasks happily.

Bernard (1969) stated that mentally healthy individuals are adjusted to themselves and the world at large with a maximum of effectiveness, satisfaction, cheerfulness and socially considerate behaviour and the ability of facing and accepting their realities of life.

Park & Park (1977) have explained three main characteristics of mentally healthy person:

1. One feels comfortable about oneself, one feels reasonably secure and adequate, one accepts one’s plus points and limitations and having the self respect and confidence.
2. One feels right towards others, therefore he develops friendship and loving
behaviour, he may develop the sense of trust in others, therefore he can take
the responsibility for his neighbors and fellow-men.

3. Mentally healthy person is able to meet the demands of life. He does something
about the problems as they arise. He sets reasonable goals for himself,
shoulders his daily responsibilities, think better about himself and take his own
decisions. He is not howled by his own emotions of fear, anger, love or guilt.

Mental health has many components and they all are influenced by a wide
variety of factors which have the constant interactions also. Thus, a person’s mental
health is a dynamic or ever changing state (Johnson, 1997). According to him a
mentally healthy person has following characteristics:

1. The person is autonomous and independent and can work interdependently or
cooperatively with others. He may consider other’s decisions and behaviour
also but not be dictated by others.

2. The person has an orientation toward growth and maximizing one’s potential.

3. The person can face the challenges of day to day living and tolerate life’s
uncertainties with a hope and positive outlook without knowing the future.

4. The person must have the self-esteem and he has the realistic awareness of
his/her abilities and limitations.

5. The person can deal with and influence the environment in a capable,
competent and creative manner.

6. The person should have reality orientation and he may act accordingly but he
should be away from fantasy.

7. The person has the ability to manage stress, can tolerate life stresses, and
feelings of anxiety or grief, he can get the support from family and friends to
cope with crisis, knowing that stress will not last for ever.
Dual factor theory (Verma et al., 1998) depicts that the two sides – mentally healthy, and mentally ill can have differences on many (not necessarily) characteristics. For example, a mentally ill may be satisfied in his job but not very creative, not very productive or, original. He may even be normal with regard to a few characteristics, whereas mentally healthy would be one with lots of (if not all) the characteristics described below:

1. A mentally healthy individual is one who is usually satisfied in most situations. Even if he is not very satisfied in some situations, he can still take things in the stride and be creative, productive, happy, and well adjusted.

2. A mentally healthy individual is mostly optimistic - never giving up hope even in a most trying situation. He would still be stress-free and tolerate any amount of frustration to keep on trying his level best to cope with the situation and would generally be more resilient.

3. A mentally healthy individual would always look for original, and creative solutions for his as well as for others’ problems.

4. A mentally healthy individual would welcome genuine help from others as well as be ready to help others. He would be at the center of any self-help group and contribute to the welfare of self, family, and of the society at large.

5. A mentally healthy individual is one who would be able to enjoy things in life, take pleasure even in ordinary things and share it with others around him.

6. A mentally healthy individual is one who is able to see the positive things even in a difficult situation, like recognizing real (true) friendship even in the face of calamities and seeing the true faces of people deserting him in times of adversity.

7. A mentally healthy individual is one who is always able to remain self-confident and infuse confidence even in distressed/depressed individuals. Others seek reassurance from him and feel relieved and at ease in his presence, by mere talking to him.
A mentally healthy individual is always relaxed, smiling, reassured, stress-free and able to induce the same feelings and attitudes in others.

A mentally healthy individual is one who has constructive habits and leisure time activities. He makes creative use of leisure.

A mentally healthy individual is able to see hope even if put to a disadvantage and handicap.

Singh (2002) has given the characteristics of a mentally healthy person as below:

1. Development of emotionality, creativity, intellect and spirituality.
2. Maintenance of mutually rewarding social relationship.
3. Ability to face problems and challenges without losing patience and to respond them with full strength and draw lessons for future.
4. Possessions of self-confidence, assertiveness, sensitivity, and empathy with sufferings of others.
5. Prepare constructively for joyful utilization of loneliness and participating in play and fun.
6. To laugh on the occasions which are really amusing, joyful, wonderful and amazing.

After describing the various characteristics of a mentally healthy person in terms of ideal criterion, Korchin (1976) said, that developmentally, the healthy person is highly differentiated and well integrated. He is more motivated by abundance than deficiency needs. There is a strong sense of personal identity, realistic self-esteem, detachment and sensibility to the self and others. Within ecological possibilities he is an autonomous agent, mastering problems rather than being the passive object of the force of the environment, the social order or inner drives.
A healthy personality is considered to be flexible in behaviour and coping with his tension. He has a strong sense of ego. He is secure in himself and is loving toward others. The values are well integrated in his conscience and is not troubled by anything like guilt feeling or to an over possession of idealistic life. Finally, the healthy personality is comfortable with himself and valued by others.

To sum up, it can be reiterated that both east and west thinkers interpret mental health as an ideal condition of personal maturity, self-confidence, optimism, realistic self-assessment, self-acceptance, self-actualization, self-autonomy, sincere spontaneity, sociability, lack of mental conflicts, high moral and the last but not the least a healthy personal and social philosophy.

A mentally healthy person may also face failure and frustration. He may suffer from tension and stresses. At times, he may involve himself in foolish and self defeating act. But what is basic in the healthy personality is that he remains balanced in the sense that the frustrations do not stop him from positive action. Stresses do not create in him the adoption of face saving maneuvers, and adversity does not make him a passive sufferer. With all his power or personality, he tries to overcome his difficulties and doing so his personality emerges as mature, sharper, and better adaptable to the stresses of the environment.

NEEDS AND IMPORTANCE OF MENTAL HEALTH

Mental health means ability to balance in one’s daily living. In other words, it is the ability to face and balance the reality of life (Bhatia, 1982). Mental health is a complex phenomenon and depends on a set of familiarly personal, psychological, and social variables. Mental health is as an important feature as the physical health of a person to make him complex with balance mental disposition to cope with life more effectively and productively. Good mental health depends on the good state of both mind and body. Each exert a direct influence on the other, but owing to the power of matter, good mental health is of supreme importance. According to Hadfield (1960)
mental health is the harmonious functioning of the whole personality. Khan (2003) observed that among the two principal agencies influencing the child’s adjustment and mental health, home is the most important agency, responsible for the adjustment, maladjustment and promotion of mental health of the children. Next to home, the school, is found an effective agency in fostering mental health.

The importance of maintaining a good mental health is crucial to living a long and healthy life. Mental health can enhance or even prevent someone from living a normal life. Richards et al. (2010) assert that there is growing evidence that is showing emotional abilities are associated with prosocial behaviour such as stress management and physical health. They concluded in their research that people who lack emotional expression lead to misfit behaviours. These behaviours are a direct reflection of their mental health. Self-destructive acts may take place in order of suppressing the emotion. Some of these acts include drug and alcohol abuse, physical fights or vandalization. Also without emotional support, mental health is at risk. Strine et al. (2010) observed that “inadequate social and emotional support is a major barrier to health relevant to the practice of psychiatry and medicine, because it is associated with adverse health behaviours, dissatisfaction with life, and disability”. By receiving emotional support one’s health can increase and prevent mental health disorders. Support systems are a valuable asset and those who do not have social and emotional support, are more likely to lead to disorders. This support can lead to an increase personal competence, perceived control, sense of stability, and recognition of self-worth and can have a positive effect on quality of life.

Mental health is essential for us to think and feel about ourselves and about others and how we interpret the world around us. It affects our capacity to manage, to communicate and to form and sustain relationships. It also affects our capacity to cope with change and transition such as life event having a baby, going to prison, experiencing bereavement. Mental health may be central to all health and well-being because how we think and feel has a strong impact on physical health. There is now
an abundance of data demonstrating the importance of mental health and well-being to overall health and productivity. Mental well-being, like physical health, is a resource people need to promote and protect.

The health of children all over the world in developing country is far from satisfactory. The high incidence of mental and behavioural problems among Indian children is increasing, presumably for reasons of maladjustment to the changing social milieu and family environment. The process of modernization, accelerated by scientific and technological developments, has gradually eroded the traditional, social and cultural moorings, bringing in its wake the flux of extra-family relations and social and cultural norms which make conflicting demands on the child’s psyche. The high expectations of parents, created by the new image of success in an increasingly commercialized society, extract their heavy toll from the child. As a result the needs of growing children are overlooked leading to conflicts and frustration with serious consequences on their mental development. Development in the field of mental health started around the year 1950, consequent upon establishment of the All India Institute of Mental Health at Bangalore in 1954, formal training programmes were initiated and manpower was generated in the area of child psychiatry, child psychology and adolescent mental health problems. The Indian Council of Medical Research (ICMR) funded research projects of child rearing practices and behaviour problems; the etiological significance of parental training in behaviour disturbances; and the incidence and causes of personal and emotional problems among pre-primary and secondary school children. The child guidance clinic were established in the country.

All around the world the prevalence of mental disorders reported in the range of 10-30%, mental ill health accounts for 13% of all lost year of healthy life globally rising to 23% in high income countries. Over a third of people with mental health problems rate their quality of life as poor, compared with only 3% of those without mental illness. There is robust evidence that recovery from mental ill health results in a dramatic improvement in quality of life as only about 9% of people who have
recovered from mental illness continue to report poor quality of life. There is also a close relationship between the onset of mental ill health and the immediate deterioration in quality of life (WHO, 2010).

In countries such as India about 20% of the population experience one or other mental health problems which require interventions from a mental health professionals (Math & Srinivasavraju, 2010). The cost of managing this proportion of population with mental health problems is enormous. This is even more burdensome in countries in African subcontinent where there are hardly any resources in managing mental health problems of their population.

In spite of growing awareness about mental health, seven in ten Americans with a mental illness do not receive treatment. Biases against mental illness and lack of public awareness are among the obstacles that limit access to treatment. Fewer individuals with major psychiatric illnesses were institutionalized in the United States in the year 2000 than in 1980, but limited community resources had not yet met existing treatment needs. Over one-third of the homeless in the United States have a severe mental illness. The prevalence of dementia is rising as people are living longer, adding to the need for more resources. One of the main challenges for the field of mental health is overcoming the gap between an increasingly sophisticated understanding and treatment of mental illness and the availability of these advances to individuals and populations in need. In India, too, the development in the area of child mental health, which was more intense in and around Bombay started losing ground around after the mid sixties (Prabhu, 1987).

Mental, or psychiatric, illnesses are a major public health concern. They adversely affect functioning, economic productivity, the capacity for healthy relationships and families, physical health, and the overall quality of life. They cut across racial, ethnic, and socioeconomic lines to affect a significant proportion of communities worldwide. They tend to develop and manifest in the early adult years, often preventing individuals from leading full and productive lives. The National
Comorbidity Survey of 1994 found nearly half of the individuals in its random U.S.
sample had a psychiatric disorder over their lifetime, and almost 30 percent had one
mood and anxiety disorders among the leading causes of morbidity and as the
leading cause of severely limited activity. Mental disorders account for a quarter of
the world’s disability. Comorbidity (having more than one illness) is common and
even further increases the risk of disability. Suicide is the eighth leading cause of
death in the United States and the third leading cause in the fifteen-to twenty-four-
year-old age groups. More people die by suicide than homicide.

A healthy pregnancy, adequate parenting, secure attachments to caretakers,
regular involvement in groups, and stable intimate relationships all contribute to the
development and maintenance of mental health.

Mental health contributes to all aspects of human life. It has both material and
immaterial, or intrinsic, values: for the individual, society, and culture. Mental health
has a reciprocal relationship with the well-being and productivity of a society and its
members. Its value can be considered in several related ways:

• Mental health is essential for the well-being and functioning of individuals.
• Good mental health is an important resource for individuals, families,
  communities, and nations.
• Mental health, as an indivisible part of general health, contributes to the
  functions of society, and has an effect on overall productivity.
• Mental health concerns everyone as it is generated in our everyday lives in
  homes, schools, workplaces, and in leisure activities.
• Positive mental health contributes to the social, human, and economic capital
  of every society.
• Spirituality can make a significant contribution to mental health promotion and
  mental health influences spiritual life (Underwood-Gordon, 1999).
Mental health can be regarded as an individual resource, contributing to the individual’s quality of life, and can be increased or diminished by the actions of society. An aspect of good mental health is the capacity for mutually satisfying and enduring relationships. There is growing evidence that social cohesion is critical for the economic prospering of communities and this relationship appears to be reciprocal.

**RISK FACTORS THAT CAN COMPROMISE MENTAL HEALTH**

Some factors have been identified as the risk factors which can compromise mental health of an individual. These are:

- **Poor connection or attachment to primary caretaker early in life.** Feeling lonely, isolated, unsafe, confused, or abused as an infant or young child.
- **Traumas or serious losses, especially early in life.** Death of a parent or other traumatic experiences such as war or hospitalization.
- **Learned helplessness.** Negative experiences that lead to a belief that one is helpless and that he has little control over the situations in his life.
- **Illness,** especially when it is chronic, disabling, or isolates one from others.
- **Side effects of medications,** especially in older people who may be taking a variety of medications.
- **Substance abuse.** Alcohol and drug abuse can both cause mental health problems and make preexisting mental or emotional problems worse.

Whatever internal or external factors have shaped one’s mental and emotional health, it is never too late to make changes that will improve his psychological well-being. Risk factors can be counteracted with protective factors, like strong relationships, a healthy lifestyle, and coping strategies for managing stress and negative emotions.

To a large extent mental health seems to be a function of emotional security, and the roots of this security are embedded with the home and family in shaping the
individual’s personality and, consequently, in laying the foundations for a mentally healthy person. Home is the matrix of an individual’s personal traits. How his parents, brothers, sisters, other relatives, and grandparents treated him like a child, may serve to account for his present shyness, boldness, nervousness, depression, and ill health. That is why family background is important as it shapes beliefs, attitudes, and ideas of a growing child. A home atmosphere, where there is mental trust adds to one’s feelings of security and aids mental hygiene. The child who feels unwanted or rejected by one or both parents is likely to become the victim of feelings of inferiority. Building up a sense of security in a child is, thus, a major parental responsibility. There are certain self-evident precautions to be observed in the way of not playing favourites by being more generous with one child than with another because there are so many psychological dangers of playing favourites.

Family environment lays the ground work for the future behaviour and the development of attitudes, values, and lifestyle. Poor family environment in terms of parental hostility, rejection, and inconsistencies can all contribute to psychological problems viz., anxiety, neuroticism, depression, and many others (Wilsnack et al., 2004; and Sharma et al., 2008).

A family with poor and unhealthy environment creates stress and anxiety among its members. Though, life without stress cannot be imagined and up to a certain limit it may be necessary for personality development, but if non-congeniality prevails for a larger period of time, these stresses become too severe which may affect the psychic equilibrium producing maladaptive patterns of behaviour (Cherson et al., 2003).

DETERMINANTS OF MENTAL HEALTH

Today’s children are the future of the nation. Sound and fine mental health of children are primary needs of any nation. Kaplan (1959) supported the view and said that mental disorders (illness) are one of the serious health problems of any nation, not only for the individual but also for the whole community.
The 20th century is observed as the age of stress and anxiety. Scientific studies have shown that there are many factors which predispose to many physical and mental disease. Also, there are definite factors for the formation of negative attitude and health. The report of an expert committee convened by WHO indicated life style and behaviour as important catalysts in causing and preventing mental and heart disorders. Stress of life is one of the chief mental factors for poor mental health and happiness. Anxiety, unwanted tensions, negative thoughts are also major factors for the development of negative mental health. Many factors are man-made factors which are preventable. Mental tensions, emotional disturbances, anxiety are risk factors for heart disorders as well as mental disorders. The modern life is full of a variety of confusions, tensions and complications. Individuals face many ups and downs at different development stages in life. The increasing irregularity, competition and workload are the causes of disharmony, whereas for good quality of life, people need an order and harmony. It is the psychological well-being, happiness and harmony that account for individual's mental health. And mental health is the essence of life. Therefore, mental health has become an important issue for the researchers.

The growth and development of a child is not so smooth and continuous as one would like it to be because of the various unfavourable forces acting on him in home, school and society. A child may be born with certain disabilities or may develop social, psychological or physiological problems. This might adversely affect the development of his abilities to the fullest extent and prevent him to perform as well as he should or may cause reactions which are detrimental to other people or the society. This may also lead to him becoming a disturbed child or a child having developmental or learning disability.

The findings of the studies (Lapouse & Monk, 1964) revealed that the prevalence of behaviour deviations declined for school age children as they grew older. The younger children of 6 to 8 years, by far surpassed the older children (9 to 12 years) in the behaviour deviation. Boys had a higher evidence of behaviour
deviations than girls. The frequency of behaviour deviations was higher among Black children than White children. There seemed to be very little difference in the incidence of behaviour deviations between only children and with sibling. Banik et al. (1972) recorded incidence of problem behavior in primary school children under two categories – conduct problems and personality problems. In the first category, 10.3 percent children (more boys than girls) were aggressive, 10.5 present disliked their school, 6.7 percent were attention demanding and 8.4 percent were restless. In the second category, 11.5 percent lacked self-confidence and 10.6 percent had poor concentration, seclusiveness, hypersensitivity, and stuttering were seen in almost 7 percent of children. Muralidharan (1969) reported that smaller family system is more conducive to the development of problem behaviour in children. Almost all studies report a higher prevalence rate of problem behaviour in boys particularly that of conduct disorders. It has been observed (Kasinath, 2003) that mental health plays very important role in exhibiting personality traits of students. It was also reported that the students with good mental health performed better in all the school subjects. External locus of control has been observed to be significantly associated with psychological adjustment problems (Hung Yee-Yi, 1975; Lester, 1982; Maqsud, 1983). Researches revealed the positive contribution of social support to psychological well-being (Moran & Kenrode, 1991; Meehan et al., 1983).

Deanda & Bradely (1997) assert that in the present day adolescents are exposed to stressors, and the extent to which they have developed and used coping strategies for dealing with the stresses and stressors they encounter, determines their level of mental health. Increasing rates of adolescents’ suicide, depression, substance abuse and juvenile delinquency in almost every part of the world have been cited as indicators of increasing stressors and adolescents’ inability to effectively cope with the resulting stress. Numerous studies have found significant relationships between the stressful life events in adolescents lives, mental health and adjustment problems. Strong relationships have been found between stressful life
events and the incidence of psychological and emotional disturbances among adolescents, particularly with regard to depression.

Several research studies have identified the sources of stress and stressors most frequently encountered by the adolescents. These major life stressors included economic hardship (Lempers et al., 1989; and Nastasi et al., 1998) and illness and family discord (Fontana & Dovideo, 1984). Poverty was strongly associated with mental health problems. Unemployment, housing problems, and other problems resulting from poverty were reported to be important risk factors that can trigger clinical depression (Patel, 2001). Children and adolescents are particularly vulnerable to problems associated with poverty. It is guessed that familial poverty jeopardizes children’s mental health and productivity. Lack of food, shelter, clothing, education, and other materials may exert adverse effect on children’s mental health. In addition, economic difficulty is related to ineffective parenting, parental psychopathology, and family hostilities, each of which can be additive source of mental health problems. Furthermore, socio-economic disadvantages often cause or aggravate marital dissatisfaction, conflict, aggression, and violence within the family, thus increasing the risk of mental health problems among children (Beiser et al., 2002). However, other researchers argued that cumulative daily stressors have the greatest impact on lives of adolescents and their mental health (Armacost, 1989). Among these daily stressors were academic problems, school work demands, academic pressures (Nastasi et al., 1998), and relationship with family and peers (Omizo et al., 1988) including same and opposite-sex peers (Patterson & Mccubbin, 1987).

The WHO theme for mental health week for the year 2003 was Emotional and Behavioural Problem of Children and Adolescents. Thirty seven percent of the population in our country are under the age of 18 years (Census of 2001). Epidemiological research in developing countries including India shows prevalence rate of 7% to 9% of emotional and behavioural problems in children. As one third of our hundred and two crore population are children and adolescents their mental health needs to go geared-up.
Mental health is determined by the way one’s basic needs are satisfied especially in his childhood. Needs like physical, organic, and egoistic needs, the need for security through love and affection, the need for recognition as a person of worth and importance, the need to belong to a group are considered indispensable. These needs are satisfied in a home where there is love and affection and where discipline is based on understanding of the child. Similarly, a school/college in which a child/adolescent is respected as an individual, which provides a rich curriculum and experiences that are satisfying is a positive factor in the development of sound mental health. A mentally healthy person is expected to be a well adjusted one, living in harmony internally as well as externally. He is expected to be quite happy and at ease with everyone in all spheres of life (in his home, school, college, work, and society). As a master of the society, he is expected to be productive and constructive, happy, contended, satisfied with a sense of subjective well-being, enjoying every bit of his life.

It is observed that life style of an individual contributes to the extent of roughly 53% to the formation of disease and illness. Different people react to the environmental stress in different ways. Some people simply become indifferent as if they are helpless. They do not react and show learned helplessness (Seligman, 1995). Some avoid anxiety by approach mechanisms of rumination or intellectualization. People may also have different locus of control (Rotters, 1996), where persons with internal locus of control blame themselves for failures in life while the externals blame environment. They are clear rationalizer.

Some persons react optimistically while some show pessimistic attitudes. Some show hardiness (Kobbasa, 1979), a style characterized by a high level of commitment in the task and a strong sense of control over the situation. They take any change as an opportunity for growth. Hetzel & McMichael (1987) have observed that people may know what they should do to improve their health but do not have sufficient motivation to change. The role of health psychology is to identify techniques to reduce unhealthy behaviours, anxieties etc. thereby assisting in adopting healthier life styles.
The preservation of mental health is highly dependent on the capacity of the person to -

- blend in his environment and handle its stresses;
- achieve a good internal balance in his personality that is sufficiency to give a stable character; and
- create a good perspective that would limit the damages of negative experiences.

For some people a good support system such as a sympathetic family or a strong social group may work well to safeguard mental health. Many studies have been conducted to find out the impact of various factors like the family un-cooperation, physical status, faulty home, society and school backwardness etc. upon mental problem. In other words, psycho-socio-physio-cultural factors are responsible for the origin and development of mental illness and daily life adjustment problems. Prathyusha & Venkaramaish (2002) have reported that mental health of children is related to certain personal, social, and personality variables of mothers as occupational status, length of marriage, marital satisfaction, personality characteristics, type of family and social class. Zaheeruddin & Khan (2003) said that noise is responsible for the aversion, distress, negative emotions, anger, dissatisfaction, withdrawal, helplessness, depression, anxiety, displeasure, etc. When mental health deteriorates, problems can arise in wide variety of areas like low self-regard, anxiety, depression, anger distortion of reality, heightened physiological reactivity, reduced competence etc. Emotional upsets, tension, anxiety, a rapid social change, struggle for existence, and chronic personal conflict are all important factors in aggravating and even initiating mental health problems. Alim (2004) reported a relationship between lack of sleep and mental health.

There are several factors that disrupt mental health including: environment or upbringing, biological make up of a person, pre-programmed instructions in the
genes, medical disorders, traumatic experiences such as loss and abuse and substance abuse. While one factor can be dominant than the other, all of these are contributors to the development of the majority of mental health disorders. In some cases, a single factor may be sufficient to trigger the disorder but the majority of disorders require an accumulation of experience that constantly challenge the well-being of a person. Wig (1979) asserts that the increasing population has led to behavioural, emotional, and interpersonal problems which affect mental health of people. Gender and age also have been found to influence mental health (Kim, 2003). Socio-economic status influence our mental health; poverty, and unaffordable housing leading to poor mental health (Parks & Nelson, 1998; and Hudson, 2005).

The Carter Commission on Mental Health recognized that the risk of mental illness was influenced by a range of socio-economic, inter-personal, and hereditary factors (Albee & Ryan-Finn, 1993).

Both genetic inheritance and environmental factors influence one’s vulnerability to mental illness. Twin and family studies and genetic research have demonstrated the former though specific genes have been difficult to identify, and there may be multiple genes involved in most psychiatric disorders. Traumatic events throughout one’s lifetime, including childhood abuse or neglect, major losses, violence, military combat, and dislocation (as among the urban homeless or wartime refugees) are known to threaten mental stability. Nontraumatic stressors, including unemployment, bereavement, and relational or occupational problems, can impact mental health. Nutritional deficiencies (such as vitamin B12), infections (such as syphilis and HIV (human immunodeficiency virus), and heavy mental poisoning (such as lead) can all cause psychiatric syndromes. Substance abuse contributes significantly to the exacerbation or even precipitation of other psychiatric illnesses and complicates their treatment. Poverty and homelessness are risk factors for many of these problems, but may also be the outcome of psychiatric illness and the inability to function independently.
Factors such as insecurity and hopelessness, rapid social change, and the risks of violence and physical ill-health may explain the greater vulnerability of poor people in any country to mental illnesses (Patel & Kleinman, 2003).

The evidence on the personal, social, and environmental factors associated with mental health and mental illness have been reviewed by a number of authors (e.g. Health Education Authority, 1997; Eaton & Harrison, 1998; Wilkinson & Marmot, 1998; Lahtinen, 1999; Patel & Kleinman, 2003; and Hosman & Jane-Llopis, 2004). Stressful life events are associated with poor mental health (Brown & Harris, 1989) and extensively studied in the social sciences (Wethington et al., 1995). Social support is often conceptualized as an environmental variable; however, research shows that it is influenced by genetic factors (Kendler, 1997), correlated with personality, and relatively stable over time (Sarason et al., 1986). Importantly, social support is not latent within the environment but rather is reciprocally maintained through the actions of individuals. Its association with health and, more particularly, positive mental health has been documented in longitudinal work (Cederblad et al., 1995).

Thus, mental health is determined by various factors. Emotional intelligence, gender, and gender identity are a few factors which have been considered as vital in the present research.

EMOTIONAL INTELLIGENCE AND MENTAL HEALTH

Psychologists have identified a variety of intelligence over the year (Gardner, 1983). Most of these can be grouped into one of three clusters “abstract”, “concrete”, or “social” intelligence. Abstract intelligence is an ability to understand and manipulate verbal and mathematical symbols, whereas concrete intelligence is an ability to understand and manipulate objects. Social intelligence, which was first identified by Thorndike in 1920, is an ability to understand and relate to people (Rusel, 1992). Emotional intelligence has its roots in social intelligence (Young, 1996). Mayer & Salovey (1993) define emotional intelligence as the ability to
monitor one’s own and others’ feelings and emotions to discriminate among them and to use this information to guide one’s thinking and action that promote emotional and intellectual growth. In other words, it is a set of skills that enables us to make our way in a complex world – the personal, social, and survival aspects of overall intelligence, the elusive common sense and sensitivity that are essential to effective daily functioning.

Salovey & Mayor (1990) defines emotional intelligence which involves five characteristics namely, self-awareness or knowing one’s emotions, the ability to manage one’s emotions and impulses, self-motivation skills, empathy or the ability to sense how others are feelings and finally, social skills or the ability to handle the emotions of other people.

Bar-On (1997) characterized emotional intelligence as “an array of noncognitive capabilities, competencies, and skills that influence one’s ability to succeed in coping with environmental demands and pressures”.

Cooper (1998) EQ map begins with emotional self-awareness of others, interpersonal connections, and the like, but then goes on to include resilience, creativity, compassion, and intuition among other areas. Cooper & Sawaf (1998) define emotional intelligence as the ability to sense, understand and effectively apply the power and acumen of emotion as a source of human energy, information, connection and influence.

Higgs & Duelewicz (1999) define emotional intelligence as a concept that involves achieving one’s goals through the ability to manage one’s own feelings and emotions, to be sensitive and influence other key people, and to balance one’s motives and drives with conscientious and ethical behaviour.

Stein & Book (2000) define emotional intelligence as what people commonly refer to as “street smart” or that uncommon ability people label as “common sense”.

[41]
Cherniss (2001) defines emotional intelligence as the ability to perceive, express and manage one's own emotion and those of others. He urged community psychologists to look to emotional intelligence for guidance on building a healthier society.

Lynn (2002) asserts emotional intelligence as dimension of intelligence responsible for one’s ability to manage oneself and one’s relationships with others.

Orme & Bar-On (2002) define emotional social intelligence as “the ability to understand and express emotion constructively; the ability to understand other’s feelings and establish cooperative interpersonal relationship; the ability to manage and regulate emotions as effective manner; the ability to cope realistically with new situations and to solve problems of a personal and interpersonal nature as they arise; and the ability to be sufficiently optimistic, positive and self motivated in order to set and achieve goals.

Hein (2003) defines emotional intelligence as being able to know how to separate healthy feelings from unhealthy one’s and how to turn negative feelings, into positive ones”.

Caruso (2004) defines emotional intelligence as a “conceptual inkblot” referring to the large numbers of interpretations associated with emotional intelligence. He identifies three distinct approaches representing different fields of study whereby emotional intelligence has been defined. The first delineated by Bar-On (1997) is influenced by his interests in the aspect of performance not linked to intelligence; the second, Goleman (1998) interpretation, approaches emotional intelligence through competency models; and third represented by Mayer & Salovey (1997) is influenced by their interest in the relationship between cognition and emotion. Caruso & Wolfe (2004) define emotional intelligence as the ability to perceive emotions, access and generate emotions so as to assist thought, understand emotions and emotional knowledge, and reflectively regulate emotions so as to promote emotional and intellectual growth.
Bradbery & Greaves (2005) define emotional intelligence as how we manage behaviour, navigate social competencies and make personal decisions that achieve positive results.

Emotional intelligence refers to an ability to separate healthy from un-healthy feelings and how to turn negative feelings into positive ones, emotional intelligence has also been understood as an ability to recognize the meanings of such emotional patterns and to reason and solve problems or their basis. People who cannot marshal some control over their emotional life fight inner battles that sabotage their ability for focused work and clear thought. There are two types models of emotional intelligence the one which emphasizes more on the cognitive aspects, such as perception, understanding analysis and reflective regulation (thinking about feeling), of emotions (Mayer & Salovey, 1997; and Salovey & Mayer, 1990), and the other while include non-cognitive aspects, such as motivation, general mood and global personal and social functioning along with some cognitive aspects (Bar-On, 1997; and Goleman, 1995).

MODELS OF EMOTIONAL INTELLIGENCE

(i) Academic Model Of Emotional Intelligence

A quick recap through history suggests that the term was first used by literacy criticism book in 1961, which proposed that some of Jane Autin’s characters in her novel ‘Pride and Prejudice’ displayed a “…intelligence which inform the emotions …..”. A couple of decades later, in 1985 an unpublished dissertation referred to the term emotional intelligence (Hein, 1996, 2003). This brings us to Salovey & Mayer (1990), who were attempting to develop a scientific way of measuring different individuals’ emotional abilities such as identifying their own feelings, identifying those of others and solving emotional problems. Thus, in 1990, emotional intelligence was presented as “a type of social intelligence, which involves the ability to monitor one’s own and other’s emotions, to discriminate among these emotions and to use this information to guide one’s thinking an action (Salovey & Mayer, 1990).
Salovey & Mayer (1990) argued that emotional intelligence subsumes both inter- and intra-personal intelligences as proposed by Gardner (1983). Their proposal indicates that emotional intelligence has five principal features:

(i) being aware of one’s own emotions,
(ii) being able to manage one’s own emotions,
(iii) being sensitive to the emotions of others,
(iv) being able to respond to and negotiate with other people emotionally, and
(v) being able to use one’s emotions to motivate oneself.

Mental process includes appraisal and expression of emotion in the self, which suggests that people skilled in this process can recognize, and so, respond more appropriately to their emotions. Such emotionally intelligent individuals can better express these emotions to others. They tend also to be more talented at recognizing others' emotional reactions, thus producing empathic responses to them.

Individuals skilled at accurately gauging affective responses in others are usually talented at choosing socially adaptive behaviours in their responses. Thus, others should see them as warm and genuine. In contrast, individuals who lack such skills can often appear impolite or different.

Emotionally intelligent individuals are said to be particularly adept at regulating emotion. This process is often used as a mean to meeting particular goals, as can lead to more adaptive mood states. In other words, such emotionally intelligent individuals may improve their moods and the moods of others. As a result, they can even go so far as motivating others in achieving worthwhile objectives.

Finally, emotional intelligence can be utilized in problem-solving. Salovey & Mayer (1990) proposed that individuals tend to differ greatly in their ability to organize their emotions in order to solve problems. Both emotions and moods have subtle influence over the strategies involved in problem-solving. They have come to
conclusion that positive mood enables a greater degree of flexibility in future planning which enables better preparation for making the most of future opportunities. Similarly they claimed that a good mood is beneficial in creative thinking, as it increases an individual’s ability for developing category-organizing principles.

(ii) Corporate Model Of Emotional Intelligence

The second definition of emotional intelligence, known as the “corporate version”, includes almost everything except IQ, such as conscientiousness, self-confidence, optimism, communication, leadership, and initiative (Goleman, 1995). This approach which is extremely popular in the business world, emerged following Danial Goleman’s (1995) book, aptly named “Emotional intelligence. Why it can matter more than IQ”. Emotional intelligence was catapulted into the headlines as ability, which could lead to success at home, at school and in the workplace. Salovey & Mayer (1990) also believe that emotional intelligence develops with age, alongside which they suggest emotional knowledge can be enhanced and emotional skills can be learned. Goleman (1995) believes that skills which are most critical to success, include self-awareness, empathy, and sociability associated with an emotional kind of intelligence.

In 2002, Vitello-Cicciu conducted a study, which examined both emotional intelligence and leadership skills in nurse leaders. Eleven leaders scored highly in emotional intelligence and three scored low. Upon interview with these participants, 90% of the high scoring nurses said they read self-help books and 72% of them used meditation, as way of their emotions. These nurse leaders also suggested that the use of strategies, which include not taking things personally, employing stress management techniques and expressing empathy for others, helped to develop emotional intelligence. In comparison with the low scoring individuals, high scoring nurses appeared to have heightened emotional awareness both of themselves and of others. The researcher identifies emotional awareness of self and others, as the underlying cornerstones of an individual’s ability to be emotionally intelligent.
Emotionally intelligent nurse-leaders exemplified the ability to manage their own emotions, which simultaneously managing the emotional response of their staff, patients and family. It is inferred that nurse leaders who lead with both their head and their heart, encourage optimal environments, which promote teamwork, collaboration, and high quality of nursing care, with desired outcomes.

(iii) Four Branch Model Of Emotional Intelligence

In 1997, Mayer & Salovey detailed their “four branch model” of emotional intelligence. They introduced the model by saying that the four branches are arranged from more basic psychological processes to higher, more psychologically integrated processes. For example, the lowest level branch concerns the (relatively) simple abilities of perceiving and expressing emotion. In contrast, the highest level branch concerns the conscious, reflective regulation of emotion."

The four branches of emotional intelligence are

(i) perception, appraisal, and expression of emotion,
(ii) emotion facilitation of thinking,
(iii) understanding and analyzing emotion, and
(iv) emotion and reflective regulation of emotion to promote emotional-intellectual growth.

A. Perception appraisal and expression of emotion: The perception, appraisal, and expression of emotion involve –

A-1. ability to identify emotion in one’s physical states, feelings and thoughts,

A-2. ability to identify emotions in other people, design artwork, etc., through language, sound, appearance and behaviour,
A-3. ability to express emotion accurately and to express needs related to those feelings, and

A-4. ability to discriminate between accurate and inaccurate, honest or dishonest expressions of feelings.

B. Emotional facilitation of thinking: The emotional facilitation of thinking insists that –

B-1. emotions prioritize thinking by directing attention to important information,

B-2. emotions are sufficiently vivid and available that they can be generated as aids to judgment and memory concerning feelings,

B-3. emotional mood swings change the individual’s perspective from optimistic to pessimistic, encouraging consideration of multiple points of view, and

B-4. emotional states differently encourage specific problem approaches, for instance, happiness can facilitate inductive reasoning and creativity.

C. Understanding and analyzing emotions and employing emotional knowledge: This will endow the person with -

C-1. ability to label emotion and recognize relations among the words and the emotions themselves, such as the relation between liking and loving,

C-2. ability to interpret the meaning that emotions convey regarding relationship such as that sadness often accompanies a loss,

C-3. ability to understand complex feelings; simultaneously feelings of love and hate or blends such as a combination of fear and surprise, and

C-4. ability to recognize likely transitions among emotions, such as the frustration from anger to satisfaction or from anger to shame.
D. **Reflective regulation of emotion to promote emotional and intellectual growth:** It involves the -

D-1. ability to stay open to feelings both those that are pleasant and those that are unpleasant,

D-2. ability to reflectively engage or detach from an emotion depending upon its judged formativeness or utility.

D-3. ability to reflective monitor emotions in relation to oneself and others, such as recognizing how clear, typical, influential or reasonable they are, and

D-4. ability to manage emotions in oneself and others by moderating negative emotion and enhancing pleasant ones, without repressing or exaggerating information they may convey.

Hein’s (2003) adopted Mayer-Salovey’s definition and included following abilities in emotional intelligence:

1. **Emotional appraisal, perception, and expression**
   - The ability to perceive and identify emotions in faces, tone of voice, and in body language.
   - The capacity for self-awareness — being aware of one’s feelings as they are occurring.
   - The capacity for emotional literacy — being able to label specific feelings in oneself and others; being able to discuss emotions and communicate clearly and directly.

2. **Emotional facilitation of thought**
   - The ability to incorporate feelings into analysis, reasoning, problem-solving, and decision-making.
   - The potential of one’s feeling to guide him to what is important to think about.
3. **Emotional understanding**

- The ability to solve emotional problem.
- The ability to identify and understand the relationship between emotions, thoughts and behaviours. For example, to see cause and effect relationship, such as how thoughts can affect emotions or how emotions can affect thoughts, and how one’s emotion can lead to the behaviour in oneself and others.
- The ability to understand the value of emotions to the survival of the species.

4. **Emotional management**

- The ability to take responsibility for one’s own emotions and happiness.
- The ability to turn negative emotions into positive learning and growing opportunities.
- The ability to help others identify and benefit from their emotions.

(iv) **Ability Model Of Emotional Intelligence**

The mental ability model of emotional intelligence makes predictions about the internal structure of the intelligence and also its implications for the person’s life. The theory predicts that emotional intelligence is, in fact, an intelligence like other intelligences in that it will meet three empirical criteria. First, mental problems have right or wrong answers, as assessed by the convergence of alternative scoring methods. Second, the measured skills correlate with other measures of mental ability as well as with self-reported empathy. Third, the absolute ability level rises with age.

The model further predicts that emotionally intelligent individuals are more likely to (a) have grown up in bio-socially adaptive households (b) be no defensive (c) be able to reframe emotions effectively (d) choose good emotional role models (e) be able to communicate and discuss feelings and (f) develop expert knowledge in
particular, emotional area such as aesthetics, moral or ethical feeling, social problem-solving, leadership or spiritual feeling (Mayer & Salovey, 1997).

(v) Affective Regulation Model

Goleman (1995) viewed emotional intelligence as the ability to know and manage one’s own emotions, recognize them in other and to handle relationship. It includes abilities such as being able to motivate oneself and persist in the face of frustrations, to control impulse and delay gratification to regulate one’s mood and keep distress from swamping the ability to think, to empathize and to hope. This definition of emotional intelligence includes self-control, zeal, and persistence, and the ability to motivate oneself. Goleman (1995) calls emotional intelligence “a master aptitude – a capacity that profoundly affects all other abilities, either facilitating or interfering with them.

(vi) Emotional Competence Model

Saarni (1997) identified emotional intelligence as the ability to understand, manage, and express social and emotional aspects of one’s life in ways that enable the successful management of life. It includes self-awareness, emotional regulation, working cooperatively, and caring about oneself and others. Saarni (1997) proposed eight skills indicative of an emotionally competent person: (a) be aware of one’s own sometimes-complex emotional states; (b) able to discern other’s emotional states; (c) able to state and communicate own emotions; (d) able to feel with and for others (e) able to understand that we, and others don’t always show emotions accurately; (f) able to cope with different emotional communication, with relating to other; (g) aware of emotional communication and interpersonal relationship; and (h) aware that one is in charge of one’s feeling and may choose one’s emotional response in a given situation.

(vii) The 5 Meta Factors And 15 Sub Factors Of The Bar-On Model

Bar-On (1997) characterized emotional intelligence as “an array of non-cognitive capabilities, competencies, and skills that influence one’s ability to succeed
in coping with environmental demands and pressures”. Darwin’s early work on the importance of emotional expression for survival and adoption has influenced the ongoing development of Bar-On model, which stresses the importance of emotional expression and views the outcome of emotionally and socially intelligent behaviour in Darwinian terms of effective adoption.

From Darwin to the present, most descriptions, definitions and conceptualization of emotional-social intelligence have included one or more of the following key components — (a) the ability to recognize, understand and express emotions and feelings; (b) the ability to understand how others feel and relate them; (c) the ability to manage and control emotions; (d) the ability to manage-change, adopt and solve problems of personal and interpersonal nature; and (e) the ability to generate positive affect and be self-motivated. These meta-factors of the conceptual model of emotional-social intelligence are as follows in the Bar-on measures of this model:

1. Intrapersonal (Self-Awareness and Self-Expression)

This meta-factor of emotional intelligence comprises emotional self-awareness, assertiveness, independence, self-regard, and self-actualization. It relates primarily to self-awareness and self-expression governing our ability to be aware of our emotions and ourselves in general to understand our strength and weakness, and to express our feeling and ourselves nondestructively. It determines how in touch we are with our emotions and feelings our ability to feel good about ourselves and to feel positive about what we are doing in our lives and with these lives. People who have high intrapersonal capacity are emotionally self-reliant, are able to express these feelings and are strong and confident in conveying these opinions and beliefs.

(i) Emotional Self-Awareness: This interpersonal sub-factor is defined as the ability to be aware of and understand our emotions. Emotional self-awareness is the ability to recognize our emotions and to differentiate between them, to know what we are
feeling and why, and to know what caused those feelings. Serious deficiencies in this area are found in an emotional disorder known as alexithymia. Emotional self-awareness is the foundation on which most of the other elements of emotional intelligence are built. It is the first step towards exploring and coming to understand oneself and toward change. This is because what a person does not recognize he can’t manage. If a person is not aware of what he is doing and the way it is affecting others, then he cannot change. Therefore, self-awareness is key and basic i.e., mastering this skill empowers a person to work toward improvement in all other areas of emotional intelligence.

Individuals, with strong sense of emotional self-awareness recognize when they feel irritable, sad or seductive, and perceive how these feelings alter their behaviour in a manner that may alienate others. They are also able to understand what incidents precipitated these feelings. The capacity to know what they are feeling and how they are behaving allows them to have a degree of control over their behaviour.

The goal of emotional self-awareness is not to suppress one’s emotions or not to have emotions. It simply helps a person to take his “emotional temperature” which helps him to recognize what he is feeling. This prevents him from behaving in demeaning, and in angry ways, which can turn others off. Self-awareness is a critical foundation of emotional intelligence because what a person is unaware of, he cannot change and self-awareness is the first step in modifying his behaviour. To do so, a person must be conscious of what he is feeling and the impact these feelings have on others; otherwise he will be unsuccessful in building key relationship. Without self-awareness he will fail to notice when he is feeling stress and he will, thus, weaken whatever capacity for empathy he may have and he will be compromised in his ability to offer sensitively delivered verbal communications to others. Self-awareness is, infact, a very crucial knowledge i.e., self-knowledge to a person. Knowledge is power and self-knowledge is premium power that leads to successful emotional management.
(ii) **Assertiveness**: This interpersonal sub-factor is defined as the ability to constructively express our feelings and ourselves in general. This is the ability to express feelings, beliefs and thoughts and to define our rights in a nondestructive manner. Assertiveness is composed of three basic components: (i) The ability to express feelings like anger, warmth, love etc. (ii) The ability to express beliefs and thoughts openly. Being able to voice opinions, disagree, and take a definite stand, even if it is emotionally difficult to do so. (iii) The ability to stand up for our rights and not to allow others to bother or take advantage of us. Assertive people are not overly controlled or shy, and they are able to outwardly express their feelings (often directly) without being aggressive or abusive.

The ability to act with a proper degree of assertiveness breaks down in three ways. First, the person must have sufficient self–awareness to be able to recognize feelings before he expressers them. Second, he must have sufficient impulse control to express disapproval and even anger without letting it escalate into fury, and to express a range of desires in the appropriate way, with the appropriate intensity. The last, he must stand up for his own rights, his own causes and deeply held beliefs. This means being able to disagree with others without resorting to emotional sabotage, and being able to walk a fine line, defending his wishes while, at the same time, respecting another person’s point of view and being sensitive to their needs. This often results in a constructive compromise- what is known as win-situation in a relationship, the bonds are strengthened because both the persons involved have their needs at least partially fulfilled.

Assertiveness has to be distinguished from aggressiveness. Some people are not assertive because they fear that by being assertive they may hurt others, or they will not be likeable. Assertive people clearly articulate and defend their wishes or thoughts, but they are also considerate of the other person’s position and sensitive to the other person’s feelings. It is this sensitiveness, which separates assertiveness from aggression. Aggressive people do not respect anyone else’s viewpoint, nor are they considerate of the
other person’s needs or desires to be accepted through bullying, intimidation, and manipulation. Aggression leaves no room for compromise. It is one sided.

Aggressive people have trouble achieving their goals because although they might be clear about what they want or where they stand, they put forth their wishes and beliefs in ways that wishes that are disrespectful, inconsiderate or belittling of others. As a result, those around aggressive people perceive them as destructive, self-centered, self-serving or angry and either avoid them or angry to go along them under pressure, but ultimately withdraw support.

Assertiveness is also characterized as a midpoint between passiveness and aggression. Passive people have difficulty in expressing themselves to others. They bottle up things and feelings and avoid dealing with uncomfortable situations. They wait for others to come to them, for things to be handed to them on a platter. Since they do not or cannot communicate what they want, others are not likely to provide it to them. That is why they frequently miss out on number of life’s opportunities and others often take advantage of them. This is the reason why passive people often feel like a door mate, always being stepped on. They constantly feel unhappy and defeated. Success eludes passive people because they are often not clear in their own minds about what they want, and they certainly have difficulty expressing their wishes or needs clearly and unambiguously to others and therefore, others can not give them what they want or aid them in obtaining it.

There is another category of people known as passive-aggressive. They seem to be calm without a complaint, but inside they are seething with resentment about the fact that others constantly exploit their good nature. Instead of speaking out or confronting the issue in an honest way, they repress the anger. But, this happens only for a while and then they lash out, at times subconsciously. Passive aggression is also sometimes manifested by simply not responding to request or expectations. Passive-aggressive behaviour is not good at all. People who behave in this way are prone to brooding and they tend to nature long-delayed revenge. Then they suddenly
explode because they have been bottling up unhappiness for a long time. When they explode, their anger is totally out of proportion and is unrelated to the events at hand.

Assertiveness is full of benefits. It is quiet liberating. It opens up many new possibilities and does indeed “win friends and influence people”. It brings a person in closer and more honest contact with those he meets. Even in an unpleasant situation, if a person is assertive, he lets the other person feel respected and accepted and not put down. Assertiveness helps a person to recognize what he believes in and how he feels. It is a state of mind as well as a skill, which can be learned with practice.

(iii) Self-Regard: This interpersonal sub-factor is defined as the ability to accurately perceive, understand and accept ourselves. Self-regard is the ability to respect and accept ourselves as basically good. Respecting ourselves is like the way we are; and self-acceptance is the ability to accept our perceived positive and negative aspects as well as our limitations and possibilities. This conceptual component of emotional intelligence is associated with general feelings of security, inner strength, self-assuredness, self-confidence and feeling of self-adequacy. Feeling sure of ourselves is independent upon self-respect and self-esteem, which are based on a fairly well developed sense of identity. A person with good self-regard feels fulfilled and satisfied. At the opposite end of the continuum are feelings of personal inadequacy and inferiority.

Self-regard is considered important for success in life. It has been found that many people who are satisfied with their lives and accomplishments score high on self-regard. They do not inflate their self-worth. They do not act as “know-it access, rather, they are accurate at gauging and appreciating their strengths and weaknesses. Once they know what they are good at, they work harder and improve their skills even more. They even know what they’re not good at. They either work at improving themselves in that area or take help for their weaknesses. Thus, an important key to success is being aware of one’s limitations and knowing how to deal with them.
(vi) Self-Actualization: This intrapersonal sub-factor is defined as the ability to set personal goal and the drive to achieve them in order to actualize our potential. Fundamentally self-actualization pertains to the ability to realize our potential capacities. It is manifested by becoming involved in pursuits that lead to a meaningful, rich and full life. Striving to actualize our potential involves developing enjoyable and meaningful activities and can mean a lifelong effort and an enthusiastic commitment to long term goals. Self-actualization is an ongoing, dynamic process of striving toward maximum development of our competencies, skills, and talents. This is associated with persistently trying to do our best and trying to improve ourselves in general. Additionally, excitement about our interests energizes and motivates us to continue these interests. Self-actualization is also associated with feeling of self-satisfaction. Low levels of self-actualization are associated with depression (Hurlock, 1953).

Maslow (1943) describes the term self-actualization, as a part of “Hierarchy of Needs” theory. He believed that are eight needs that must be satisfied if people have to survive and then go on to live happy and fully realized lives. First a person has to achieve the basic needs like air to breathe, water to drink, food to eat and a tolerable temperature. Next is need to achieve safety so that it keeps one away from pain and peril. Next comes love – the need to belong, to be wanted and cared about by friends, relatives, and family. Fourth is self-esteem – the need to achieve self-respect, to take pride in one’s accomplishments and know what he is recognized by others. Fifth need is cognitive need – the need to achieve knowledge, meaning, and self-awareness. Sixth need is aesthetic need. This need is for beauty and balance form. Then comes self-actualization, which Maslow (1943) defines as the intrinsic growth of what the organism is. The last need at top of the hierarchy is self-transcendence.

Hurlock (1953) asserts that the goal of developmental changes is to enable people to adapt to the environment in which they live and self-actualization is essential to this goal.
Self-actualization involves being satisfied with one’s achievement at work, at play, and in relationship. Self-actualized people have a healthy balance between the many activities that make up their lives. They live their lives to the fullest. They do what they love to do and therefore, they perform well and their work becomes a pleasure. Self-actualization means being where one wants to be, in work and in all varied aspects of one’s personal life.

Boyam (2008) characterizes a self-actualizing person as

1. The self-actualized person has more efficient perception of reality and more comfortable relations with it. He can accept the good and the bad, the highs and the lows, and he can tell the difference.

2. The self-actualizing person sees reality as it is and accepts responsibility for it. He is as objective as a subjective being can be in his perceptions.

3. The self-actualizing person has spontaneity, simplicity, and naturalness. In other words, this kind of person is not hung up on being as other think he should be. He is a person who is capable of doing what feels good and natural for himself simply because that’s how he feels. He does not try to hurt others, but he respect for what is good himself.

4. The self-actualizing person is someone who is generally strongly focused on problems outside of himself. He is concerned with the problems of others and the problems of society, and is willing to work to try to alleviate those difficulties.

5. For all his social mindeness, the self-actualizing person has a need to be by himself or a need for solitude. He enjoys times for quite reflection and doesn’t always need people around him. He can be with the few people that he would be close to and not need to communicate with them. Their presence is sufficient in and of itself.

6. The self-actualizing person is capable of doing things for himself and making decisions on his won. He believes in who and what he is.
7. The self-actualizing person experiences a joy in the simple and in the natural. Sunsets are always beautiful and he seeks them out. He can still enjoy playing the games he played as a child and having fun in some of the same ways he did many years before.

8. Self-actualizing people usually have experiences in which they literally feel they are floating. They feel very much in tune or at one with the world around them, and almost feel as if they are, for a momentary period in time, part of a different reality.

9. Self-actualizing people have a feeling for all of mankind. They are aware and sensitive to the people that are about them.

10. Self-actualizing people have deeper and more profound interpersonal relations than other adults. They are capable of fusion, greater love and more perfect identification that other people could consider possible. They generally tend to have relatively few friends, but those relationships are deep and very meaningful.

11. Self-actualizing people tend to believe in the equal nature of human beings, that every individual has a right to say, and that each person has his strengths and each person has his weakness.

12. Self-actualizing people know the difference between means and ends and good and evil, and do not let them in a way that hurt themselves or others.

13. Self-actualizing people tend to enjoy humor. They like to laugh and like to joke, but not at the expense of others. They are generally seen as good natured, even though they are capable of being very serious.

14. Self-actualizing people are capable of being highly creative. Creativeness can be expressed in many dimensions by writing, speaking, playing, fantasies, or whatever, but self-actualizing do have moods of being creative. Maslow has said that a first-rate cook is better than a second-rate painter. Hence, creativeness can be expressed in many dimensions.
15. Maslow feels that the individual is above his culture in some way, that he maintains a strong individually and is not so absorbed that he cannot evaluate the culture objectively in such a way that he can make decisions about what is best for him and those he cares about.

16. Self-actualizing people are individuals who are aware of the fact that they are not perfect, that they are as human as the next person, and that there are constantly new things to learn and new ways to grow. The self-actualizing person, although conformable with himself, never stops striving.

(v) Independence: This intrapersonal sub-factor is defined as the ability to be self-reliant and free of emotional dependency on others. This is the ability to be self-directed in our thinking and actions to be free of emotional dependency.

Independent people are self-reliant in planning and making important decisions. They may, however, seek and consider other people’s opinions before making decisions; but consulting with others is not a sign of dependency in this regard. Independence is, moreover, the ability to function autonomously. Independent people avoid clinging to others in order to satisfy their emotional needs. The ability to be independent rests on our degree of self-confidence, inner strength, as well as a desire to meet expectations and obligations without becoming a slave to them. It means taking charge of one’s own life, being one’s own person and seeking one’s own direction. Independent people are prepared to adopt a course of action after first justifying it in their mind and then they are ready to deal with the possibility that other people might disagree with them. However, they respect the other people’s need for independence also.

Independent actions involve a degree of risk and sometimes such people may do or say the wrong things. They, however, learn from these situations and forgive themselves for it. It does not hinder them in future as they realize that making a mistake is profoundly human. Independence is also linked to self-regard. When a
person feels good about himself people will certainly respect him more. The capacity to be self-directed and self-controlled in one’s thinking and action is a vital component of success. The more a person practices independence, the better he becomes and his level of confidence also rises. People who lack independence tend to be align and needy. They chronically seek protection and support from others, which undermines their ability to determine what they want and to be confident enough to pursue it. True independence does not mean ignoring everyone and charging off in one’s own direction. Never turning for help is as bad as always doing so. Independent people do not reject sensible advice. They are selective enough to consider the options, weigh the result and reach a decision that they find satisfactory.

2. Interpersonal

This metafactor of emotional intelligence comprises empathy, social-responsibility and interpersonal-relationship. It relates primarily to social awareness skills and interaction. This meta-factor is essentially, concerned with our ability to be aware of other’s feelings, concerns and needs, and able to establish and maintain cooperative, constructive and mutually satisfying relationships. Those who function well in this are a tend to function responsible and dependable. They understand, interact and, relate well with others. They inspire trust and function well as part of a team.

(i) Empathy: This interpersonal sub-factor is defined as the ability to be aware of and understand how others feel. It is being sensitive to what, how, and why people do. Empathetic people care about other people and show interest in and concern for them.

Empathy is the ability to see the world from another person’s perspective. It is the ability to tune into what someone else might be thinking and feeling about a situation regardless of whether that view differ from his own perception. Empathy is an extremely powerful interpersonal tool. It helps to establish effective collaboration and strengthen bonds between people. Empathy has to be distinguished from sympathy. Sympathy is what the person is feeling about another person’s condition,
while empathy is simply understanding the other person’s viewpoint and that is why it has the power to change relationship. Empathy also does not mean being nice, and making polite and pleasant statement, nor does it mean that by making an empathic statement a person will be agreeing with or approving of the other person’s behaviour or position. Empathy is simply an acknowledgment of the other person’s perspective.

Some people are naturally empathic while other’s less. It is the ability to ask that take the interchange away from superficial concerns, to focus on understanding more about the others’ perspective, especially if it is different from one’s own view. Covey (1989) writes that empathetic listening is a very powerful tool because it gives a person accurate data to work with. Instead of projecting his own thoughts, feelings, motives, and interpretation, he is dealing with the reality inside the other person’s head and heart. Thus, it helps him to get what he wants to solve problems and create successful interpersonal relationships.

(ii) Interpersonal Relationship: This interpersonal sub-factor is defined as the ability to establish and maintain mutually satisfying relationship and relate well with others. Mutual satisfaction describes meaningful social interactions that are potentially rewarding and enjoyable for those involved. Being adept in interpersonal skills is characterized by giving and receiving warmth and affection and conveying intimacy. This component of emotional intelligence is not only associated with the desirability of cultivating friendly relations with others but with the ability to feel at ease and comfortable in such relationship and to possess positive expectations concerning social interaction. This social skill is based on sensitivity toward others, a desire to establish relation as well as feeling satisfied with relationships.

Good, and supportive friends are among life’s greatest rewards. They are the people a person turn to in times of happiness and distress, or simply to talk about life’s daily hassles. Give and take in these vital relationships is the key to building successful relationship. Individuals who only give are experienced by others as being too compliant and lacking self-regard. Those who only take in a relationship are
ultimately experienced by others as selfish or bullying. Both the individuals those who
give too much and those who take too much are generally unsuccessful in building
solid relationships. Close interpersonal relationships add to the richness of life and
provide valuable support in times of need.

(iii) Social Responsibility: This interpersonal sub-factor is defined as the ability to
identify with one’s social group and cooperate with others. Social responsibilities is
the ability to demonstrate ourselves as cooperative, contributing and constructive
member of our social group. This involves acting in a responsible manner, even
through we may not benefit personally. Socially responsible people possess social
consciousness and a basic concern for others, which is manifested by being able,
take on group – and community-oriented responsibilities. This component of
emotional-social intelligence is associated with doing things for and with others,
accepting others, and acting in accordance with our conscience and upholding social
rules. These people have acquired a sense of interpersonal sensitivity and are able to
accept others and use their talents for the good of the collective (and not just for good
of the self). Individuals who are seriously deficient in this ability, may entertain
antisocial attitudes, act abusively towards others and take advantage of people.

Social responsibility is a concern for the welfare of others, the ability to
integrate oneself into the community at large. Today, social responsibility has an
important place in the corporate board rooms also. Since social responsibility is
directed outward, it is perhaps the easiest component of emotional intelligence to
change. Social responsibility also has many good effects on the individual himself.
By helping others, the individual gains more meaning in his/her own life. Focusing
on the more serious problems and dilemmas of others, give a person a new
perspective about his own problem. This alone can be therapeutic. Real success
comes from being a valued and contributing member of a social group. Caring about
and sharing with others, no matter how rich or poor one is, gives real meaning to
one’s life and one’s success.
3. Adaptability

This meta-factor of emotional intelligence comprises problem-solving, reality testing, and flexibility as detailed below. This meta-factor relates primarily to change management i.e., how we cope with and adopt to personal and interpersonal change as well as change in our immediate environment. It determines how successful we are able to cope with daily demands by effectively ‘sizing up’ and dealing with problematic situations. People who have a high capacity for adaptability are typically flexible, realistic and effective in understanding problematic situations and competent at adequate solutions. These people can generally find good ways of dealing with everyday difficulties. Success in this area means that we can grasp problems and devise effective solutions, deal with and resolve various issues as they arise at home, with friends and in the workplace.

(i) Problem-Solving: This adaptability sub-factor governs the ability to solve problems of a personal and interpersonal nature effectively. Problem-solving entails the ability to identify and define problems as well as to generate and implement effective solutions. It is multi-phasic in nature and includes the ability to go through the following process: (i) sensing a problem and feeling confident as well as motivated to deal with it effectively; (ii) defining and formulating the problem as clearly as possible which necessitates gathering relevant informations; (iii) generating as many solutions as possible; and (iv) implementing one of the solutions after weighing the pro and cons of each possible solution and choosing the best course of action. People who are adept at problem-solving are often conscientious, disciplined, methodical and systematic in pursuing and approaching challenging situations. This skill is also associated with a desire to do our best and to confront problems, rather than avoiding them.

Levine (1994) has developed three rules for problem-solving: externalization, visualization and simplification. Externalization involves displaying the information,
one is working with. It includes writing things down or drawing graphs to define more complex situations. It is useful to have all the facts in front of a person. Visualization includes imaging oneself going through the various steps involved dealing with a problem before one actually carries them out or picturing the outcome of a possible situation. Olympic caliber athletes are trained to rehearse in their mind the most challenging and typically encountered aspects of their sports and to conjure up a clear mental image of themselves performing at peak. By preparing to meet obstacles as they arise, one is better prepared for the real problems when they come along. Finally, simplification involves breaking the problem down to its simplest common denominators. Focusing on the most relevant information and keeping things as specific and concrete as possible helps in the process of problem-solving.

Problems are normal events and part of everyday living. Everyone goes through them, so they should not be taken personally or imagine that they are aimed at oneself specifically. Successful problem-solver see problems as challenges to be overcome or learning experiences that will lead to strength and growth. By starting with a positive approach and putting emphasis on solution, the rest of the steps involved will be much simpler, easier, and most effective. Problem-solving is associated with being conscientious, disciplined, rational, methodical, systematic and persevering. The key is desire to do one’s best in the face of doubt or adversity and to confront problems rather than avoid them. Successful problem-solvers have been observed to have two other capacities. First is intuition, which is commonly known as hutches and impression. However, it doesn’t mean following intuitions blindly or giving it too much credit, but to explore it in a logical and realistic way. Intuition can be used as an early warning signal to identify problems that have not fully emerged but are beginning to edge on the scene. The second capacity is innovation, which is the capacity to come up with fresh new ways of viewing the issue at hand and brainstorming alternative solution. Like intuition, innovation should also involve a clear-headed calculation of the risks involved in the unusual approaches.
Problem-solvers are more successful because they have a vital edge as they identify obstacles that might prevent from attaining their goals in a family, social, or workplace setting. Those who do not have this capacity often fail to see an obstacle until they run into it, they are unable to solve it and rather become frustrated or demoralized.

(ii) Reality Testing: This adaptability sub-factor governs the ability to objectively validate our feelings and thinking with external reality. This includes assessing the correspondence between what is experienced and what objectively exists. Testing the degree of correspondence between what experience and what actually exists involves a search for objective evidence to confirm, justify and support feelings, perceptions and thoughts. Reality testing, essentially, involves ‘tuning in’ to the immediate situation, attempting to keep things in correct perspective and experiencing things, as they really are without excessive fantasizing or daydreaming about them. The emphasis is upon pragmatism, objectivity, the adequacy of our perception and authenticating our ideas and thoughts. An important aspect of this adaptability sub-factor is the degree of perceptual clarity evident when trying to assess and cope with situations; and it involves the ability to focus when examine ways of coping with situation that arise. Reality testing is associated with lack of withdrawal from outside world, a tuning into the immediate situation, and lucidity and clarity in perception and thought processes. In simple terms, reality testing is the ability to accurately ‘size up’ the immediate situation.

When a person experiences an event, how close does he come to perceiving matters as they really are rather than colouring them by one’s fears, wishes, prejudices and a host of defensive or offensive emotions. Reality testing is the capacity to “read” situations accurately and to size up what is going on. Reality testing allows one to tap into a group emotional currents and power relationship, shifting political alliances and allegiances that are present beneath the surface. It, thus, helps to concentrate and focus on coping with what we discover and to keep our emotions in check and to prevent us from excessive dreaming and fantasizing.
People with a strong capacity for reality testing see the world around them in an objective, clear-eyed manner. They are quick to recognize where problems exist and can perceive opportunities when they come into sight. Those who have weaker reality-testing skills either cannot see the problem or they avoid facing problems. They are unable to take advantage of opportunities. Reality testing leads to success because it endows a person with the capacity to identify and address problems and to recognize and build on opportunities. It is compliment to self-awareness, which gives a person the capacity to take his “internal temperature” while reality testing allows him to measure the “external temperature”. Adler (1938) equates adjustment with an ability to evaluate oneself realistically.

(iii) Flexibility: This adaptability sub-factor represents the ability to adapt and adjust our feelings, thinking and behaviour to new situation. This entails adjusting our feeling, thought and behaviour to changing situations and conditions. This component of emotional intelligence refers to our overall ability to adapt to unfamiliar, unpredictable, and dynamic circumstances. Flexible people are agile, synergistic and capable of reacting to change without rigidity. These people are able to change their minds when evidence suggests that they are mistaken. They are generally open to and tolerant of different ideas, orientations, ways and practices. Their capacity to shift thoughts and behaviours is not whimsical, but is in accordance to the feedback they are getting from their environments. Individuals who lack the capacity of flexibility tend to be rigid and obstinate. They adapt poorly to new situations and have little capacity to take advantage of new opportunities.

The flexibility component of emotional intelligence concerns our overall ability to adapt unfamiliar and unpredictable circumstances. Flexibility is also tied to reality testing. This is because if one cannot read the environment accurately then one will be unable to pick up new signals and act in required ways. The skill of flexibility is important for success in today’s business environment because it allows one to take advantage of new information as it arises to adapt to change as it occurs and to
smoothly handle multiple demands. People who are not flexible, continue to practice old behaviour in new settings where they are proved ineffective and inefficient. Rigid people are resistant to new ideas and are unable to adjust to changes and are not able to use new and different ways that are required.

4. Stress Management

This component of emotional intelligence relates primarily to emotional management and control and governs our ability to deal with emotions so that they work for us and not against us. People who are unable to manage it, develop range of more debilitating physical symptoms such as breathing difficulties, chest pain, diarrhea, shortness of breathe, heart palpitations, nausea, loss of appetite and heart burn etc. alongwith anxiety, sleep disturbances with depression. This meta-factor comprises stress tolerance and impulse control abilities.

(i) Stress Tolerance: Effective stress tolerance serves as a preventive measures helping to protect the person from high blood pressure, heart disease and ulcers. It gives him the capacity to be calm and composed, to face difficulties without getting hijacked by strong emotions to tackle and take control of problems one by one rather than surrendering to panic. Stress tolerance can be learned and once learned it offers relief and improve health in both the short and the longer terms. This in turn , allows people to become more flexible and adaptive when other hardships come their ways. Stress tolerant people have the capacity to relax and wind down emotionally. They are described as resilient and they can present themselves with confidence, think clearly assess their environment realistically. Stress tolerance is linked with success and without this competence, reality testing, problem-solving and impulse control are all eroded, and individuals are not able to function successfully.

Coleman (1964) explains mental health as an outcome of the individual’s attempt to deal with stress and meet his needs. In contrast, people who are intolerant to stress have an ill effect on their mental health which can give rise to psychosomatic
problems and difficulties in decision making in their lives. Moreover, without the capacity of stress tolerance, the qualities of reality testing, impulse control, and flexibility are all eroded and lead to poor mental health. Coleman (1964) also characterizes person with maladjustment and poor mental health as with low stress tolerance. Nezu & Ronan (1985) found that poor stress tolerance, was associated with depression and failure to adapt life situations efficiently.

(ii) Impulse Control: This stress-management sub-factor is defined as the ability to effectively and constructively control emotions. More precisely, impulse control is the ability to resist or delay impulse, drive or temptation to act. It entails a capacity for accepting our aggressive impulses, being composed and controlling aggression, hostility and irresponsible behaviour. Problems in impulse control are manifested by low frustration tolerance, impulsiveness, anger control problems, abusiveness, loss of self-control and explosive as unpredictable behaviour.

Impulse control gives an individual the capacity to manage wisely and wholly a wide range of volatile emotional states and urges. Such individuals have the capacity to think first rather than responding reflexively. They weigh alternatives and assess options so that their actions and expressions are reasoned and well considered. They are, thus, able to take decision wisely and their behaviour is responsible.

People who do not have sufficient impulse control are rash, hotheaded, impatient, have a low frustration tolerance and they behave in compulsive and thoughtless ways. They are fine in one minute and difficult the next. They tend to make poor decision under pressure and also spend money unwisely. Outburst of road rage, domestic violence and date rape are all examples of loss of impulse control.

People with an effective impulse control are more successful because they consider different aspects before reacting. They plan, weigh pros and cons and they do not get perturbed and remain calm even under trying circumstances. They are better at maintaining relationship, dealing with clients and can also listen thoughtfully.
to others who are upset. It also focuses on a component of coping with behavioural impulses known as delayed gratification, the ability to wait for something. In his interesting “marshmallow study”, Mischel (1990) found that students who were able to wait, not only had positive behaviour and better mental health but also had higher academic achievement than their marshmallow-grabbing agemates.

5. General Mood

This meta-factor is closely associated with self-motivation. It determines our ability to enjoy ourselves, others and life in general, as well as influences our general outlook on life and overall feeling of contentment. People who are adept in this facilitator of emotional intelligence are typically cheerful, hopeful, positive, well motivated and know how to enjoy life. In addition to being an essential element in interacting with others on a daily basis, this facilitator of emotionally intelligent behaviour is an important motivational component for managing emotions and solving problems of an intrapersonal nature. This metafactor of emotional intelligence comprises dimensions of optimism and happiness.

(i) Happiness: This general mood sub-factor is defined as the ability to feel contented with ourselves, others and life in general. It is the ability to feel satisfied with our lives, enjoy others and have fun. In this context, happiness combines self-satisfaction, general contentment and the ability to enjoy life. Happy people often feel good and ease in both work and leisure; they are able to let their hair down and enjoy the opportunities for having fun. Happiness is associated with a general feeling of cheerfulness and enthusiasm. Happiness acts as a barometric indicator of our overall degree of emotional functioning telling us how we are doing in general; it also functions as a powerful facilitator and motivational factor for various aspects of emotional intelligence. The inability to experience happiness and difficulties in generating positive affect in general are often indicative of dissatisfaction, discontent, and depressive tendencies.
The capacity for happiness is not an isolated ability. It influences and is influenced by other emotional intelligence competencies like reality testing, self-regard, and self-actualization. If the capacity for reality testing is compromised then a person tends to evaluate the environment negatively, and therefore feels unhappy. On the other hand, a strong sense of self-regard and self-actualization positively influences a person’s capacity for happiness. A person may be born with some kind of genetic predisposition toward being happy but whether he actually achieves the state of happiness depends largely on external factors and his reaction to them.

Coleman (1964) characterizes a mentally unhealthy person as full of dissatisfactions and unhappiness. According to him, an unhappy person can be reasoned to have more and continued stress than happy person, which may predispose him to suffer poor mental health.

(ii) Optimism: This general mood sub-factor is defined as the ability to maintain a positive and hopeful attitude toward life even in the face of adversity. It represents a positive approach to daily living and a very important motivating factor in whatever we do. Optimism is the opposite of pessimism, which is the common symptom of depression. Optimism has nothing to do with how rich or poor one is. It is an inner resource, the ability to believe that time may be difficult, but with renewed efforts it will improve and that failure and success are to a great extent, states of mind.

Optimism is the ability to stop thinking or saying destructive things about oneself and the world around oneself. It is a comprehensive and hopeful but realistic approach to daily living and is, therefore closely related to the competence of reality testing. Seligman (1998) found three major attitudes that distinguish optimist from pessimist. First, optimists view bad times as temporary and believe that they won’t last forever. They see troubles and difficulties as delayed success and not as outright defeat. They firmly believe that the situation will change. Second, the optimists view misfortune as situational and specific and not as a manifestation of inescapable
doom. Third, the optimists don’t immediately shoulder all the blame if something goes wrong, rather they take external causes into consideration.

Pessimism is described by three Ps: permanence, pervasiveness and personalizing. Pessimists tend to experience each and every setback as permanent. They believe that nothing ever goes right for them (permanence). They think that whatever they do, things always go wrong (pervasiveness) and their own incompetence or ineffectiveness is to blame (personalization).

Flexible optimism has to be distinguished carefully from blind optimism where a person’s attitude is so positive that it leads to incorrect assessment of given situation. Optimism is, therefore, closely linked to reality testing which gives a person the ability to read the surrounding accurately. Seligman (1998), gives the term flexible optimism for optimism which is based on reality.

Realistic or flexible optimism gives a person the ability to look at the brighter side of life and maintain a positive attitude in the face of adversity. It is a positive approach to daily living. Optimistic people can recognize when they are in difficult situation, but they have positive frame of mind about how things will finally turn out. They are resilient and hardy. They do not feel hopeless and give up rather they persevere. They are also flexible and keep trying different approaches. This makes them more successful.

Research on emotional intelligence has moved on in recent years. There are new a whole hast of studies showing that emotional intelligence is important for mental health. Low emotional intelligence has been associated with depression, anxiety, loneliness, low self-esteem, suicidal feelings, aggressive behaviour, poor impulse control, poor interpersonal adjustment, increased stress, increased alcohol, and drug use and even personality disorder. In contrast, high emotional intelligence linked with increased well-being such as greater satisfaction with life and increased happiness.
According to Maslow (1943) self-actualized people have a healthy balance between many activities that make up their lives leading to a healthier mental state.

Lawton (1951) proposed twenty characteristics that are important in childhood and adulthood. These characteristics can be used to describe and assess mentally healthy people. These can vary according to age and ability. According to Lawton (1951) mentally healthy people are:

(i) able and willing to assume responsibilities appropriate to their age,
(ii) participate with pleasure in experiences belonging to each successive age level,
(iii) willingly accept the responsibilities pertaining to their roles in life,
(iv) attack problem that requires solution,
(v) enjoy attacking and eliminating obstacles to happiness,
(vi) make decisions with a minimum of worry, conflict, and advice-seeking,
(vii) abide by a choice they make until convinced, it is wrong choice,
(viii) get major satisfactions from real than imaginary accomplishments,
(ix) can use thinking as a blue print for action, not as a device for delaying or escaping action,
(x) learn from defeats instead of finding excuses for them,
(xi) do not magnify successes or apply them to unrelated areas,
(xii) know how to work when working and to play when playing,
(xiii) can say “No” to situations, harmful to their best interests,
(xiv) can say “Yes” to situations that will ultimately aid them,
(xv) can show anger directly when injured or when rights are violated,
(xvi) can show affection directly and appropriate in kind and amount,
(xvii) can endure pain and emotional frustration when necessary,
(xviii) can compromise when they encounter difficulties
(xix) can concentrate their energies on a goal that is important to them, and
(xx) accept the fact that life is an endless struggle.

All above described characteristics have correlated with the component of emotional intelligence such as self-regard, impulse-control, happiness, stress-tolerance, flexibility, self-actualization and optimism. Thus, it can be said that a person who is high in emotional intelligence will be a mentally healthy person.

Adler (1938) equates adjustment with an ability to develop social relations which are beneficial to others and not merely designed for the purpose of self-aggrandizement. Coleman (1964) also defines adjustment as outcome of one’s effort to maintain harmonious relationship. He also describes a maladjusted person as with ego centricity and disturbed interpersonal relationship.

According to Goldstein (1939), and Maslow (1954) a mentally healthy person is constantly progressing on the path of self-actualization.

Lawton (1951) also described mentally healthy people as those who are assertive i.e., who can say “No” to situations harmful to their best interest, can say “Yes” to situations that can add them, can show anger directly when injured, when rights are violated and can show affection directly and in the appropriate manner.

Jahoda (1958) also asserts that a mentally healthy person is one who is capable of viewing situations objectively without distortion arising from his own personal needs. According to him, a mentally healthy person engages in continuously testing of reality, objectively determining the extent to which situations depart from or correspond to his needs, and accepting the conclusions.

Rogers (1951), Kashani et al. (1987), Nelson et al. (2004), and Anzi & Owayed (2005) assert that self-regard contributes to full psychological adjustment. A student
with high self-regard transits the passage of school life with fulfilled and appreciating attitude towards oneself and it always enables him to maintain his subjective well-being – a base for good mental health. Salovey et al. (1998) assert that high self-regard is associated with emotional repairing ability to control intrusive ruminative thoughts that often accompany stressful situations, and thus opens a room for better mental health.

Shaffer & Edward (1956) stressed on maintaining consequences without a kneejerky impulsive behaviour to be well adjusted and enjoying good mental health. According to him mentally healthy people do not become overwhelmed by emotions. It is clear that people who lack proper impulse-control are rash, hot-headed, impatient, have a low frustration-tolerance and unpredictable ways of reacting – the conditions which pave way to maladjustment and poor mental health.

Horney (1959) also asserts that good mental health is restored through flexible style of interacting with others. Contrary to this, an individual who lacks this capacity tends to be rigid and obstinate. He adapts poorly to new situations and has little capacity to take advantages of new settings where he may be proved ineffective and inefficient leading to higher stress level in all spheres of his life and thus suffers a poor mental health.

Mowrer (1959) also asserts that adjustment to life situations occurs by the process of problem-solving which results in learning of effective methods for dealing with adversities, anxieties and conflicts of everyday life and thus permits a person to enjoy a good mental health. Lawton (1951) and Nezu et al. (1980) studied the difference between effective and ineffective problem-solvers in regard to psychological distress or maladjustment. The result indicated that the subjects who reported low depression, low anxiety and more internal control orientation having low psychological distress or maladjustment were self-appraised effective problem-solvers and those with high psychological distress were self-perceived ineffective problem-solvers. Similarly,
Timothy et al. (1991), Priester & Clum (1993), and Heppner et al. (2004) also observed that problem-solving appraisal was significantly predictive of less depressive behaviour and psychosocial impairment leading to better mental health.

Coleman (1964) also described a mentally unhealthy person as one who lacked insight and flexibility. This suggests that an adolescent student who is more flexible is aware of himself and his environmental demand and is better able to adapt to circumstances and to manage stress arising out of the demand of higher achievement, and as a result enjoys a good mental health.

Kahana & Kahana (1975) found that several aspects of impulse-control (i.e., delay of gratification, reflectivity, and motor control) had consistent and significant relationship with indices of adaptation and mental health.

Nalini & Shankar (1977) stated that individuals who have low self-esteem tend to create burning problems to themselves as well as to their families and society.

Young people are found to show increased skill in identifying and relating to another person’s feelings if a real life role model demonstrates empathy for a character in a distressful situation (Feshbach, 1982). Guiding children to practice these empathic responses within conflict situations can build habits of thinking and caring about other people’s perspectives and feelings and help them to come up with nonviolent solutions instead of resorting to aggression (Slaby & Guerra, 1998).

People with high self-esteem are generally happier, fare better in stressful situations, are less prone to depression, and lead healthier lives overall than people with low self-esteem (e.g., Antonucci & Jackson, 1983; Hobfoll & Lieberman, 1987; Myers, 1992; Crocker & Luthanen, 2003; Kernis, 2003a, 2003b; Crocker & Park, 2004, and Sinha & Jain, (2004).

Empathy is considered to play an important role in individual’s interpersonal functioning (Davis, 1983; Cowan & Hoffman, 1986, and Eisenberg & Fabes, 1990). It
has been theoretically and empirically linked to various elements of social-emotional development including less prejudice (McFarland & Adelson, 1996), more pro-social behaviour (Hoffman, 1984), higher social competence (Saarni, 1990), and higher friendship quality (Clark & Ladd, 2000).

Happiness and life satisfaction are also implied in health behaviour and well-being studies (Diener, 1984, 2000). Happiness is a part of special category of mental experiences that include such positive emotions as joy, pleasure, satisfaction, etc. Argyle et al. (1989) believed that happiness is composed of three related components: positive affect (pleasant moods and emotions), absence of negative affect and satisfaction with life as a whole. True happiness is living in ease and freedom, fully experiencing the wonders of life while life satisfaction involves the way the individual feels about himself or herself. It refers to an individuals own global judgment of his/her quality of life, feeling of contentment and happiness. Both, happiness and life satisfaction are considered to be positive variables (Seligman & Csikszentmihalyi, 2000) and indicate on individual’s subjective well-being. In addition, proper physical and psychological functioning is also considered to be the indicator of being healthy (Mckague & Verhoef, 2003).

Asarnow & Callen (1985) observed that subjects with poor interpersonal relationship showed less adaptive planning and evaluated physical aggressive responses more positively and positive responses more negatively than subjects with positive interpersonal relationship. The findings of Lead Beater et al. (1989) also supported this finding. Triesh (2001) observed that interpersonal perception was an important predictor of adjustment in stressful situation of school life, which layed the foundation stone for good mental health.

Nezu (1985), and Sadowaski & Kelley (1993) also found that a negative mood state i.e., a state of unhappiness could lead to poor problem-solving adaptive behaviour, a source of poor mental health. Folkman (1997), and Billings et al. (2000)
provide empirical support for prediction that positive emotions like happiness are important facilitators for mental health.

Nezu et al. (1985) observed that subjects having high stress tolerance were able to adapt effectively and thus were able to maintain good mental health in comparison to those who had poor stress tolerance. In a study by Schotte & Clum (1997), it was found that suicidal group subjects were poor stress tolerant and were unable to adapt effectively to life situations and also anticipated negative consequences for their nonadaptive reactions leading to poor mental health. In studies of D'Zurilla & Sheedy (1991), Marx et al. (1992), Sadowaski & Kelley (1993), Thompson & Heller (1993), Christian et al. (1994), and Davilla et al. (1995), the results indicated a negative relationship between stress and mental health.

According to Dodge (1986), Rubin & Kransnor (1986), Eisenberg et al. (1995), Eisenberg & Fabes (1990), Eisenberg et al. (1997), Kochanska et al. (2000), and Mostow et al. (2002), social-emotional information processing is important link between cognitive processes and social behaviour which are key factors to mental health.

Optimists cope more effectively with their stressors than do pessimists. There is substantial evidence that optimists use different coping strategies to cope than do pessimists and that these coping differences contribute to the positive association between optimism and better adjustment and well-being (Scheier et al., 1986; Carver et al., 1989; and Stanton & Snider, 1993). Optimists possess more extensive and supportive social networks, and report longer friendship than do pessimists and social networks influence psychological well-being by operating as a stress buffer (Cohen & Wills, 1985). Individuals who report that members of their social networks would provide them with emotional, instrumental, and informational resources if and when needed display lower level of distress and depressive symptoms in response to stressful life events than those who do not (Cohen & Wills, 1985).

Isen et al. (1987) also found that feeling optimistic about a positive outcome and being in happy mood state improved creative problem-solving and adaptive behaviour.
People whose personality include high level of anxiety, depression, anger, hostility, or pessimism seem to be at risk for developing a variety of illnesses (Friedlander et al., 1987; Scheier & Bridges, 1995; and Everson et al., 1996). People with optimistic explanatory style tend to enjoy good mental health. Optimism helps in sustaining immune functions under stress (Segerstrom et al. 1998). Scheier & Carver (1985) and Scheier et al. (2000) noted that people expecting the best and looking at the bright side of the things reported less fatigue, fewer aches, pains, and minor illness. They also noted that optimists tend to have better mental and physical health and recover more quickly when they become ill.

Carver et al. (1989), Stanton & Snider (1993), Brenner et al. (1994), Jonier et al. (2001), Overskeid (2000), and Grawitch (2003) also supported the findings that optimism increased adaptive behaviour, and thus mental health of the subjects in various life situations. Contrarily, a pessimistic person often faces failures and remains in stress and depressive and dominated by suicidal tendencies and thus, remains mentally unhealthy. Optimism has been linked to various aspects of psychological and physical well-being (Lai, 1995; Schweizer et al., 1999). Seligman (1998) observed that optimism and positive coping skills had enhanced one’s ability to deal with stress and depression and thus, maintained good mental health.

Adolescents can become emotionally autonomous from their parents without becoming detached from them (Collins, 1990; and Grotevant, 1997), and close family relationships foster healthy individuation and high mental health in adolescents (Allen et al., 1994; and Bomar & Sabatelli, 1996). Others also report that individuation has positive effect on adolescents mental health and responsible functioning (Allen et al., 1996; Ryan & Lynch, 1989; and Josselson, 1980), and difficulty in individuating may lead to depression, anxiety, and diminished social competence in adolescents (Allen & McElhancy, 2000; and Holmbeck et al., 2000).

Carpendle (2004), also concluded that mentally healthy people tended to be more adept in understanding emotional situation and being assertive.

Denham et al. (1990), Hartup (1992, 1999), Petrides et al. (2006), Mavroveli et al. (2007), and Domitrovich (2008) found that people with high self-regard received more nominations for cooperation and leadership. They also observed that such students were high on the pro-social factor and low on the anti-social factors.

One piece of evidence consistent with this hypothesis is that adolescent girls do perceive competence as a liability and tend to conceal their intelligence. Indeed one study showed a significant positive correlations between IQ and depression in adolescent girls. For boys, by contrast, there was a small negative correlation between I.Q. and depression (Block et al., 1991).

In his interesting “marshmallow study”, Mischel (1990) found that students who were able to wait, had positive behaviour and better mental health than their marshmallow-grabbing age-mates. It is common observation and well evident fact that impulsive children can not delay the gratification of their desires or impulsiveness to act even for better state of consequences and thus tempt to be maladjusted and unhappy, the signs of poor mental health.

Numerous studies have shown that optimists enjoy generally better mental health than pessimists (Seligman, 1998; Peterson & Bosio, 1991; Scheier & Carver, 1992; Scheier et al., 2000; and Affleck et al., 2002).

People with an upbeat, optimistic explanatory style, on the other hand, tend to enjoy good health (Peterson & Bossio, 1991). They lead healthier, longer lives than do their gloom and doom counterparts. They also have shorter hospital stays, faster recovery form coronary artery bypass surgery, and greater longevity when battling AIDS (Scheier et al., 1989). Optimists also respond to stress with smaller increase in blood pressure and are much less likely to die from heart attacks (Everson et al., 1996).
Among college students optimists – those who agree with statements such as, “in uncertain times, I usually expect the best” and “I always look on the bright side of things” – report less fatigue and fewer aches, pains, and minor illness (Scheier & Carver, 1985).

Optimism has also been found to reduce a number of somatic complaints e.g., headaches, upset stomachs, and sleep problems (Robbins et al., 1991).

People with high self-esteem typically feel good about themselves and have a positive sense of self worth. Myers (1992) argues that self-esteem is one of the best predictors of personal happiness.

Costa & McCrae (1992) showed that happiness was associated with grater extraversion and lower neuroticism, the finding supported by several researches (Furnham & Cheng, 1997; and Hills & Argyle, 2002).

Hamburg (1992), Chung et al. (1998) state that empathy is the key ingredient for facing adjustment problems with success during a period of school transition. Shields et al. (2001), and Adeyemo (2004) also asserted that emotional regulation and empathy made unique contributions toward school adjustment and thus can be reasoned to play its vital role in mental health of students.

Hamburg (1992), Goleman (1995, 1998), Huy (1999), Shields et al. (2001), Poyarazili et al. (2002), Salovey et al. (2002), Adeyemo (2004), and Srinivas & Tob (2006) also found that self-efficacy contributed uniquely to variance in students’ general adjustment level and mental health. Underwood & Hurley (1997) also found that adolescents who had effective self-regulatory skills and were independent could modulate their emotional expressiveness that evoked healthy emotions leading them to maintain good inter-personal relationship and thus seem to inculcate a mentally healthy environment for them.

Scheier & Carver (1992) showed that optimists cope more effectively with stress than pessimists. Positive emotion may be part of the reason for this finding.
Optimistic individuals have more confidence than pessimistic one’s that they will be able to achieve positive self-changes (Carver & White, 1994).

Self-regard enables an adolescent student to deal with academic achievements and with temptations of alcohol, drugs, and sex. It seems that self regard is a key ingredient for facing the demands of transition-trauma-adjustment with success in a school and thus permits an adolescent to enjoy a better mental health.

Hamburg (1992), Shield et al. (2001), Sjoberg (2001), Poyarazili et al. (2002), Adeyemo (2004), and Summerfeldt et al. (2006) also observed a positive association between self-regard and adjustment of students, a core need to be stressfree and mentally healthy.

In recent years, there has been an increasing interest in how emotional reactions and experiences affect both physical as well as mental health. For example, it has been claimed that negative emotional states are associated with unhealthy patterns of physiological functioning, whereas positive emotional states are associated with healthier patterns of responding in both cardiovascular activity and immune system (Herbert & Cohen, 1993). Salovey et al. (2000) discussed extensively the importance of emotional states on physical and mental health. Furthermore, extended research in the field of health psychology has demonstrated the effect of negative mood or unpleasant emotional experiences on a number of habits or behaviours that have been accused for unhealthy conditions, such as smoking (e.g., Brandon, 1994) and drinking (e.g., Cooper et al., 1995). Several studies have also revealed a direct connection between emotional arousal (especially anger) and cardiovascular consequences (Friedman, 1992).

Lewinsohn et al. (1993), Canals et al. (2002), Trzesniewski et al. (2006), and Hjemdal et al. (2007) assert that poor mental health and well-being (i.e., depression, low self-esteem) during the adolescent years can lead to adolescent health risk behaviours, school failure, physical ill-health, suicide, involvement in juvenile, criminal
justice systems, negative life choices, and mental disorders in adulthood. Conversely, better mental health outcomes in adolescents are characterized by greater adaptation in family, society, and school environment, improved quality of life (Haogwood et al., 1996; and U.S. Department of Health and Human Services, 1999).

People with very low self-esteem are most apt to focus on self-protection (Wood et al., 1994). Research consistently indicates that high self-esteem is beneficial while low self-esteem has many negative consequences. Negative self-evaluation is associated with less adequate social skill (Olmstead et al., 1991), depression especially among women (Jex et al., 1994) and averse reactions to job insecurity (Orpen, 1996).


Goleman (1995) and Martinez-Pons (1997) have found emotional intelligence as the strongest predictor of mental health. Goleman (1995) tells us that we really have two different ways of understanding, intellectually and emotionally and our mental life results from the interaction of both functions. It means mental health directly depends on head and heart because intellectual development depends on head (brain) and emotional development depends on heart. Mental health is positively correlated to emotional intelligence and its all the dimensions viz., self-awareness, managing emotions, empathy, motivating oneself, handling relationship, and vice-versa. It means mental health is affected by emotional intelligence.

Research has also found that college students who experienced high stress and low optimism had more somatic complaints than those who were stressed but were high on optimism (Lai, 1995).

The popularity of the emotional intelligence during the past decade has led researchers to examine its potency in various areas of human functioning. Thus, it has
been found that trait or ability emotional intelligence are related to life success (Goleman, 1995; and Bar-On, 2001), life satisfaction and well-being (Martinez-Pons, 1997; and Palmer et al., 2002), work success and performance (Dulewicz & Higgs, 1998; and Vakola et al., 2004), leadership (Palmer et al., 2000), occupational stress (Bar-On et al., 2000; Nikolaou & Tsaousis, 2002, and Slaski & Cart, 2002), interpersonal relationships (Fitness, 2001; and Flury & Ickes, 2001), individual performance (Lam & Kirby, 2002), academic achievement (Van der zee et al., 2002; and Parker et al., 2004), and physical and mental health (Ioannis & Ioannis, 2005) etc..

Bronstein et al. (1996) have found positive association between adolescent emotional expression and overall social and psychological adjustment.

Deegan (1996), and Buysse et al. (2002) also confirmed that better interpersonal relationship ability equipped the children with the social competence to maintain better mental health.

Other studies have reported that people with AIDS who believed their illness is controllable also display increased T cell counts over time and live longer, in contrast, HIV-Positive men who are pessimistic about their fate display a decrease in T cell counts and faster onset of AIDS symptoms over the same period of time (Segerstrom et al., 1996).

Bar-On's (1997) view on emotional intelligence support the reasoning that an emotionally high intelligent person possesses a mentally healthy personality while an emotionally low intelligent person tends to be a poor emotional manager, impulsive, pessimistic, and unhappy person, the sign of neuroticism (Mayer et al., 1990; and Salovey et al., 1999).

Optimism is an outlook on life such that one maintains a view of the world as a positive place. Optimists generally believe that people and events are inherently good, so that most situations work out in the end for the best. It can be defined as expectations of positive outcome. It means having hope and a strong belief and
confidence to deal with situations. Optimists are life’s big winners. Negative thinkers perform more poorly in school, work, and play, than those who cheerfully face obstacles. Pessimists have poorer resistance, weaker immune systems, are more susceptible to depression, and age physically faster than the optimists (Clark, 1997). There are various personal and social outcomes of optimists’ optimistic approach, which may include more achievement in any task and goal, higher level of life satisfaction, better health, more friends, and feeling of control over life, easier to make decisions. Optimism plays an important role in the adjustment to stressful life events (Scheier et al., 2000). Greater optimism has been found to be associated with less mood disturbance in response to a variety of stressors (Scheier et al., 1986; and Carver et al., 1993).

Levine et al. (1997) found that individuals with BPD has deficit in several aspects of their emotional intelligence. It has been suggested that the BPD features of affective instability, chronic feelings of emptiness, and inappropriate, intense anger are all indicative of problems in emotion processing, or to put it another way, these criteria are suggestive of low emotional intelligence. Similarly, impulsivity, self-harm, fear of abandonment and dissociative symptoms (other characteristics of BPD) can all be viewed as abnormal responses to emotions, so those with low emotional intelligence might display these behaviours and characteristics due to insufficient ability to manage their emotions.

Martinez-Pons (1997) showed that emotional intelligence correlated positively with life satisfaction, but negatively with depressive symptoms, suggesting that individuals with higher emotional intelligence report greater life satisfaction and fewer depressive-related symptoms than those with lower emotional intelligence. Saklofske et al. (2003) also reported negative correlations corresponded to theoretical expectations between emotional intelligence and social, family, and romantic loneliness as well as between emotional intelligence and depression-proneness (i.e., the tendency towards developing depressive feelings), and positive correlations between emotional
intelligence and subjective happiness and temporal, past, and concurrent life satisfaction among undergraduate students. The persistence of significant associations with these measures when personality is controlled suggests that emotional intelligence displays incremental validity, implying some degree of explanatory power for these measures over and above those provided by personality trait scores. Schmidt & Andrykowski (2004) demonstrated that emotional intelligence was associated with lower distress and lower avoidance of the disease among a sample of women with breast cancer, and that higher emotional intelligence could act as a buffer against the negative impact of a toxic social environment. Moreover, Brown & Schutte (2006), when examining the relationship between emotional intelligence and subjective fatigue among university students, demonstrated that higher emotional intelligence was associated with less fatigue, probably because emotional intelligence allows individuals to develop coping strategies, such as healthier mood, as well as more adaptive ways of interpreting the world and a better social support to ameliorate the effects of physical stresses. Extremera & Fernandez-Berrocal (2006) using the Trait Meta-Mood Scale (TMMS) reported that low levels of emotional clarity (i.e., understanding owns emotions) and mood repair (i.e., emotional regulation) were related to high levels of depression, but that in contrast, high level of emotional attention (i.e., amount of attention toward own emotions) was related to depression.

Existing literature show that clarity of feelings component of emotional intelligence as measured by a modified version of Trait Meta Mood Scale (TMMS; Salovey et al., 1995) was positively and significantly correlated with satisfaction with life (Palmer et al., 2002). He believed that the clarity of feelings subscale is indexed as perceived ability to understand and discriminate between moods and emotions.

Scioli et al. (1997) observed positive relationships between optimism, hope, and health. There is substantial evidence that optimists use different strategies to cope than do pessimists, and these coping differences contribute to the positive association between optimism and mental health (Scheier & Carver, 1985; Carver et al., 1989; and Stanton & Snider, 1993).
Goleman (1998), too, suggested that individuals who had developed emotional self-awareness were able to communicate better thus, made their intentions more clear; the better communication skills help students to maintain better mental health status.

Jones (1998) indicated that there were strong associations between spirituality and mental health, as well as between spirituality and physical health.

Studies have reported that optimism helps in sustaining immune function under stress (Segerstrom et al., 1998). In a couple of studies optimism and resilience have been found to be negatively correlated with stress (Major et al., 1998; and Scheier et al., 2000). The optimists have been noted to have better physical and mental health and also recover quickly.

Seligman (1998) reported that optimistic people experienced less depression and increased enjoyment in social interactions.

Schutter et al. (1998) reported on a large group of university students and adults significant positive correlations between emotional intelligence score and optimism, and negative ones between pessimism and depressive tendencies.

Optimism has impact on one’s way of handling stress and the way the cardiovascular, nervous, and immune system work. Optimism enhances one’s ability to deal with stress and depression (Gillham & Seligman, 1999).

Positive and negative emotions are reflected in physiological and immune interactions. Altruism has also been noted to be positively correlated with better physical health outcomes (Oman et al., 1999; and Brown et al., 2003). People with another trait resilience, which includes high level of self-esteem personal control, and optimism, appraise negative events as less stressful and revive their strength quickly (Major et al. 1998).

Empathy and interpersonal sensitivity may be turned simply into useful ‘tools’ for adjusting delinquent or disturbed young people to schooling. Lack of empathic concern,
poor communicative responsiveness and high emotional contagion significantly contributed to reduced persona accomplishment (O'Donnel, 1999).

Taremian & Mahjuie (1999) reveals that assertiveness and the promotion of psychological health level are correlated. The lack of this skill causes the individual to come to ineffective and incompatible manners and stresses. Education of such skills to children and adolescents brings up the sense of qualification, capacity of being effective, ability to deal with defeating problems objective and rational approaches to problem.

In another study, Salovey et al. (1990) reported that individuals who can regulate their emotional states are healthier because they “accurately perceived and appraise their emotional states, knew how and when to express their feelings, and can effectively regulate their mood states”. This set of characteristics, dealing with the perception, expression, and regulation of moods and emotions, suggest that there must be a direct link between emotional intelligence and mental health. Indeed, Taylor (2001) argues that “if you are emotionally intelligent then you can cope better with life’s challenges and control others emotions more effectively”, both of which contribute to good mental and physical health. Moreover, Bar-On (1997) includes stress management and adaptability as two major components of emotional intelligence, while Matthews & Zeidner (2000) stated that “adaptive coping might be conceptualized as emotional intelligence in action, supporting mastery emotions, emotional growth, and both cognitive and emotional differentiation, allowing us to evolve in an ever-changing world”.

An objective measure of emotion management skill has been associated with attendency to maintain an experimentally induced positive mood (Ciarrochi et al., 2000), which has obvious implications for preventing depressive states. There is another research to suggest that adolescents who say they are good at managing others’ emotions (MOE) tend to have more social support and to be more satisfied with that support (Ciarrochi et al., 2001). Such increased support may help protect these people from depression and suicidal ideation (Kalafat, 1997).
Mullis & Chapman (2000) studied the relationship between coping, gender, age, and self-esteem in adolescents and found that adolescents with higher self-esteem used more problem focused coping strategies and adolescents with lower self-esteem used more emotion focused coping strategies.

Folkman & Moskowitz (2000) found that emotions may indeed act as a coping resource during periods of experienced stress and threat. Ali et al. (2009) found that teachers who had reported higher emotional intelligence had better mental health.

Kousha & Mohseni (2000), Sam & Lackland (2001), Kenneth et al. (2004), Viren et al. (2007), Tamini & Mohammady Far (2009) indicated that there is a significant difference between the two groups. The A.M.U. student’s life satisfaction was better than S.B.U. student’s because A.M.U. student’s have had better mental health status than S.B.U. student’s life satisfaction and poor mental health makes life dissatisfaction.

A large number of researches have shown a connection of positive emotional outlook, behaviour, and lifestyles with mental and physical health. Peterson (2000), and Vaillant (2000) indicated that being more optimistic or hopeful than facts warrant is a sign of pathology.

Being optimistic, in the sense of one’s expectation for betterment in one’s life, is found to be strongly associated with a high sense of well-being. Hope and optimism are the positive conditions of human strength which include the positive cognitive, emotional, and motivational states. In the past two decades, research has shown that optimism in the face of crisis, make people expect good things to happen and achieve better outcome (Scheier et al., 2000). Optimism may promote longevity, physical well-being and health promoting behaviour (Scheier & Carver, 1992; Peterson et al., 1998; and Peterson, 2000).

Diener (1984) stated that self-esteem is widely recognized as a central aspect of psychological functioning and its strongly related to many other variables including general satisfaction with one’s life.
Empathy is a component of communication and can only be improved with appropriate training (Winefield & Chur-Hansen, 2000). It allows us to understand the intentions of others, predict their behaviour, and experience an emotion triggered by their emotion.

Ciarrochi et al. (2001) stated that emotional intelligence has been found to impact on mental health. Emotional intelligence may protect people from stress and lead to better adaptation. They opine that an objective measure of emotion management skill is associated with a tendency to maintain an experimentally induced positive mood which has obvious implication for preventing stress.

Danner et al. (2001) have found that optimistic people tend to live longest whereas pessimistic people tend to live for the shortest period of time.

According to broaden and build theory, positive emotion increase people’s physical, cognitive and social resources, which in turn helps them cope more effectively with stressful experiences and live healthier (Frederickson, 2001). Among children, the positive emotion experienced during play help build social skills, which in turn foster lasting social bonds and attachments (Aron et al., 2000).

Garner (2001) concluded that stress-management leads to emotional competence and to emotional socialization, which in turn contribute to better mental health. Engelberg & Sjoberg (2004) also observed that the students high on stress tolerance dimension of emotional intelligence were more able to deal with exalting emotional stress as well as were able to deal with social adjustment problems and thus ensuring their good mental health.

Pradhan & Mathur (2001) reveals that emotional well-being is indicative of mental health. It has been the experience and the perception of many that emotion plays a vital role in determining human health and quality of life. The perception of quality of life reflects the level of one’s health status – both physical and mental. They showed that there existed a positive relationship among emotional literacy, quality of life and human health.

In support of this theory, it is found that people who consistently experienced positive emotions with their families as children, and again as adults with their own families, were half as likely to display high level of cumulative wear and fear on their bodies (Ryff et al., 2001).

Salovey (2001) claims that the failure of emotional self-management leads to significant influence on health, for example cardiovascular reactivity. He suggests that a way of coping for people who are low on this dimension is through smoking, drinking, and eating fatty foods, which can also lead to long term health damage. However, he also emphasized that suppressing negative feelings is not a healthy strategy either, suggesting that emotion’s manifestation has a positive impact on mental health when people are confident about their abilities to regulate them.

The relationship between emotional intelligence (as measured by the TMMS) and psychological adjustment variables such as depression, anxiety, and overall physical and mental health has been well documented in adult samples. For instance, individuals who score lower on emotional clarity, and individuals who report an inability to regulate their own emotional states show poor emotional adjustment on a number of measures (Salovey, 2001; and Fernandez-Berrocal et al., 2005).

Trinidad & Johnson (2001) and Brackett & Mayer (2003) have shown that lower emotional intelligence is related with many self-destructive behaviour such as deviant behaviour and cigarette smoking. Unconscious conflicts including anxiety, stress, depression, anger, hostility, and other emotions are also the frequent source of mental disturbance, which leads to heart diseases.
In another interesting study, Ciarrochi et al. (2002) identified that moderating role of emotional intelligence in the relationship between stress and a number of measures of psychological health, such as depression, hopelessness and suicidal ideation among young people. These studies, but mainly the core essence of emotional intelligence, indicate that a negative correlation exists between stress, ill health and emotional intelligence levels, assuming that people scoring high in emotional intelligence are expected to cope effectively with environmental demands and pressures as those commonly assessed by occupational stress and health measures (Nikalaou & Tsaousis, 2002). Ciarrochi et al. (2002) also showed that subjects that can manage others’ emotions seem to respond less intensively to stressful situations and exhibit less suicidal ideation, less depression, and less hopelessness.

Creed et al. (2002) found that high optimism was associated with high self-esteem and decreased psychological stress, while high pessimism was found to be associated with low self-esteem and increased psychological distress. It is reasonable to believe here that such dispositional tendencies of high optimistic students lead them to enjoy better mental health than high pessimistic students.

Gual et al. (2002) studied the relationship of self-esteem and personality factors with eating disorders. These results, support low self-regard in the onset of eating disorders.

Inang (2002) revealed that optimism, quality of life, satisfaction with life and spiritual health were positively and significantly related with subjective well-being.

Krabbendam et al. (2002) observed that baseline neuroticism and low self-esteem predicted 1st-ever onset of psychotic symptoms at year three.

Salovey et al. (2002) stated that individuals showing grater emotional clarity and a greater ability to repair their own emotional states reported higher levels of self-esteem, another important predictor of mental health.
Salovey et al. (2002) found that those who had difficulty in identifying their own emotional reactions reported poor mental health.

Salovey et al. (2002), Williams et al. (2004), Fernandez-Berrocal et al. (2005), and Fernandez-Berrocal et al. (2006) showing a relationship between low self-reported emotional intelligence levels with worse mental health, measured through depression, anxiety, and emotional adjustment scales.

Bar-On (2003) found that there was a moderate yet significant relationship between emotional intelligence and mental health. The aspects of emotional intelligence competencies that were found to impact on mental health are: (a) the ability to manage emotions and cope with stress, (b) the drive to accomplish personal goals in order to actualize one’s inner potential and lead a more meaningful life, and (c) the ability to verify feelings and thinking.

Connolly & O’Moore (2003) indicated that children who bullied exhibited greater emotional inhibition and attributed significantly more negative statements to themselves than children who did not bully. The children who bullied also demonstrated an ambivalent relationship with their siblings, mothers and fathers. The controls on the other hand displayed positive relationships with members of their family. Moreover, children who bullied scored higher on extraversion, psychoticism and neuroticism than their counterparts who did not bully.

Dulewicz et al. (2003), using a relatively small sample of retail managers, examined the role of variables such as stress, distress, morale, and poor quantity of working life play in everyday life. They demonstrated that emotional intelligence was strongly correlated with both physical and mental health.

Furnham & Petrides (2003), and Austin et al. (2005) indicate a link between emotional intelligence and well-being. They assert that, a better emotional regulation should have direct implications to prevent depressive states and emotional intelligence is associated with higher psychological well-being and happiness.
Intelligent person can use his or her understanding of emotion in harmony with good reasoning skills to make good reasonable decisions while maintaining good relationship. Ming (2003), Jordan & Troth (2004), Dreer et al. (2005), and Alex (2008) observed that emotionally high intelligence people were better problem-solvers than those with low emotional intelligence.

Saklofske et al. (2003) showed that self-reported emotional intelligence accounted for variance in happiness and well-being above and beyond personality measures.

Emotion theories have increasingly argued that whether one expresses or suppresses emotional expression is not as important for good mental health as is ability to flexibly express or suppress emotional expression as demanded by the situational context (Parrott, 1993; Barrett et al., 2002; Westphal & Bonanno, 2004). Bonanno et al. (2004) supported this flexibility hypothesis, and indicated that subjects who were able to manage expression of emotions evidenced better mental health in future. Recent research on coping has also indicated that the crucial element in successful adaptation and maintenance of good mental health is not much depend on which particular strategies are used, but rather whether coping strategies are applied flexibly in a manner that corresponds with the nature of the stressor (Chang, 2005).

Brscket et al. (2004), Ahmadi (2005), Austim et al. (2005), Schutter et al. (2007), Augustolanda et al. (2008), Greven et al. (2008), Omarae (2008), Banihashemian et al. (2009), Faghirpour (2009), Mohtasham (2009), Li et al. (2009), Martins et al. (2010); Raena (2010), and Fiori & Antonakis (2011) found a significant relationship between components of emotional intelligence and mental health of students.

Engelberg & Sjoberg (2004) also observed that students who were high self-actualizing were able to deal with exalting emotional stress as well as able to deal with social adjustment problems related to their various life situations, consequently were more mentally comfortable and stressfree.
Brscket et al. (2004), Ahmadi (2005), Austim et al. (2005), Khosrojerdi & Khanzadeh (2007), Schutte et al. (2007), Safavi et al. (2008), Delfan Azari (2010), Raena (2010), Faghripour et al. (2011), stated that social skill of empathy is correlated with mental health.

Brscket et al. (2004), Ahmadi (2005), Austim et al. (2005), Khosrojerdi & Khanzadeh (2007), Schutte et al. (2007), Safavi et al. (2008), Delfan Azari (2010), Raena (2010), and Faghripour et al. (2011) stated that social skill of interpersonal relationship is associated with mental health.


Kerr et al. (2004) also found a link between alexithymia and adjustment of students. They observed that difficulty in identifying feelings was linked to difficulty in personal and social adjustment, leading to poor mental health.

Kerr et al. (2004) suggested that intervention aimed at encouraging assertiveness might improve emotional adjustment of students.

Sinha & Jain (2004) found that reality orientation positively predicted personal effectiveness of individuals.

Ahmadi (2005), Khosrojerdi & Khanzadeh (2007), Schutte et al. (2007), Safavi et al. (2008), Delfan Azari (2010), and Raena (2010), found a strong relationship between social skill and mental health of students.

Bastin et al. (2005) found higher motional intelligence was correlated with higher life satisfaction better perceived problem-solving, coping ability, and lower anxiety.
Salovey et al. (2005), and Extremera & Pizarro (2006) revealed that emotional intelligence directly tied to a person’s ability to deal effectively with the demands and challenges of everyday life to be well adapted and emotionally well-adjusted. It is cognitive – affective factors that influence the general well-being of an individual and his potential to meet desirable life expectations. They found a person will be emotionally more intelligent i.e., able to control his emotions efficiently or more self sufficient then he will be mentally healthy and vice-versa.

Edward & Warelow (2005) examined resilience explore factors or characteristics that assist individuals to thrive from and in adversity. They observed that the protective factors were part of an individual’s general makeup some which were considered genetic, such as personality that is outgoing and social; however, many protective behaviours could be learned. However, coping in the face of adversity involved emotional intelligence and resilience, both of which could be developed through support and education. In this context, fostering resilience and emotional intelligence has the potential to improve clinical outcomes for mental health consumers.

Gannon & Ranzin (2005), and Bracekett et al. (2006) reported that life satisfaction was found to be positively and significantly correlated with all the subscales of emotional intelligence.

Mennin et al. (2005) showed that individuals with GAD exhibited greater emotional experience for negative but not for positive emotions than controls, and had poorer abilities to identify and describe their emotional experience, as well as to modulate their negative emotions. Turk et al. (2005) also reported that individuals with GAD exhibited greater emotion intensity and higher negative emotion expression than individuals with social anxiety disorder.

Millsr et al. (2005) also found that children who had greater emotional vocabulary and recognized emotions more accurately had better social functioning and better mental health.
Tung & Sandhu (2005) suggests that adolescents well-being is influenced to a large extent by their increasing self-responsibility for what they do and what they are, rather than depositing this responsibility on the shoulders of those under whose influence and fuselage they have grown up. A progressive sharpening of one’s sense of self as autonomous, competent, and separate from one’s parents leads to healthy psychological effects on adolescents who have not yet relinquished their childish dependencies on parents or who have lesser self-governance are more vulnerable to lesser well-being. Various researchers have also suggested that emotional autonomy play an important role in adolescents mental health (Fuhrman & Hombeck, 1995; Allen et al., 1996; and Chen & Dornbusch, 1998). It has also been found that autonomous adolescents are quite close to their families, enjoy doing things with their parents have fewer familial conflicts; whereas rebellion, negativism and excessive involvement in the peer group are more common among psychologically immature adolescents. Lesser autonomy in adolescents or over protectiveness of adolescents by the parents has already been reported to be linked to depression, anxiety, and diminished self-competence (Kandel & Lesser, 1972; Josselen et al., 1977; and Holmbeck et al., 2000).

Salovey et al. (2000) stated that emotional repair is also associated with the ability to control intrusive and ruminative thoughts that often accompany stressful situations.

Seligman et al. (1998) indicated that increase in happiness leads to alleviation of symptoms of depression.

Yuval et al. (2005) have examined the association among attachment in intensive real life stress. The results indicated the positive and significant correlation of attachment and personality hardiness with mental health and well-being.

Bindu & Thomas (2006) found a close relationship between maladjustment and the various dimensions of emotional intelligence. They explain the finding on the basis
of the fact that an individual who is emotionally mature and stable may be expected to be well adjusted with his/her and the surroundings. In other words, both emotional intelligence and adjustment bank on very similar psychological processes like objective and realistic assessment of the situations, control over one’s own emotional responses, freedom from crippling inhibitions, respect for oneself and others, etc. They stated that the ability to think in diverse ways and to overcome cognitive rigidity contributes to the development of emotional intelligence. The present finding lends support to the observation model by Cunningham (1966) that individuals who suffer from a “general rigidity syndrome” would be expected to show little variability in behaviour, to be ethnocentric, and to have few methods available for solving problems. On the other hand, those who are high on fluency and flexibility can draw on their own inner resources to deal effectively with their inner conflicts and feeling states.

Fernandez-Berrocal et al. (2006) investigated the link between emotional intelligence and anxiety in a sample of adolescents from 14 to 19 years old. The results showed that the score of the State-Trait Anxiety Inventory is negatively correlated to two facets of EI’s TMMS scale; mood repair and emotional clarity. More exactly, regression analysis demonstrated that adolescents which reported higher abilities to discriminate and understand their emotions, as well as higher skills to regulate their emotional state, exhibited lower anxiety independently to the level of self-esteem. They also found that the ability to discriminate clearly among feelings (Emotional clarity) and the ability to self-regulate emotional states were associated with better psychological adjustment and consequently better mental health. They stated that the ability to repair emotional states predicted various aspects of self-esteem in adolescents. They found that self-reported emotional intelligence is related to emotional adjustment. Adolescents reporting higher ability to discriminate clearly among feelings and to regulate emotional states showed less anxiety and depression, independent of the effects of self-esteem and thought suppression. The result is valuable because both self-esteem and thought suppression are well-documental predictors of anxiety and
depression. In addition findings confirm and extend previous results with university students to a more representative sample as adolescents (Williams et al., 2004).

Geraghty (2006) observed negative relationship between emotional intelligence and stress level. It was found that emotional intelligence training reduced stress level and negative consequences associated with high level of stress.

Ghufran (2006) results of the study revealed self-esteem to be a moderating factor of depression.

Findley et al. (2006) also found that high empathetic peers exhibited greater prosocial behaviour, less aggression and social withdrawal than low empathetic students which seem to be a sign of better mental health.

Findings of the study (Kulshrestha & Sen, 2006) revealed that subjects with high emotional intelligence and internal locus of control scored significantly high on positive affect and scored significantly low on negative affect. Similarly subjects who scored high on emotional intelligence and had internal locus of control were significantly high on all the three dimensions of life satisfaction scale.

Petrides et al. (2006), Mavroveli et al. (2007), and Domitrovitch (2008) also found that people with high problem-solving ability received more nominations for balanced behavior, sign of good mental health and fewer nominations for their disruption, aggression, and dependence which are signs of poor mental health.

Faghirpour (2009), & Faghirpour et al. (2011) stated that self-regulation are associated with mental health.

Summerfeldt et al. (2006) found that emotional intelligence was highly related to social interaction anxiety, but not performance anxiety. It was also found that emotional intelligence factor was the dominant predictor of interpersonal adjustment, substantially reducing the unique contribution made by interaction anxiety. This
pattern reflected the principal contributions made to interaction anxiety by the interpersonal, and particularly, interpersonal domains of emotional intelligence.

Yoo et al. (2006) found higher emotional intelligence was correlated with higher life satisfaction, better perceived problem-solving, coping ability, and lower anxiety. They suggest that recognition of specific emotions may have special functions in intercultural adjustment, and that emotion recognition and emotion regulation play independent roles in adjustment.

Dinesh et al. (2007) also reported that the features of personal positivity, i.e., optimism, happiness, and life satisfaction, are negatively correlated with somatic complaints and psychological distress. It means that when an individual has high optimism, satisfaction with life, and happiness, he/she is likely to have less somatic complaints and psychological distress.

Khosrojerdi & Khanzaden (2007), Gardner & Qualter (2009), Faghirpour (2009), Maccann et al. (2010), Delfan Azari (2010), Raena (2010), and Faghirpour et al. (2011) found positive relationship between self-control and mental health of students.

Schutte et al. (2007) in their study concluded that better mental health status is associated with higher emotional intelligence. Augustolanda et. al. (2008) showed that there is distinct impact of emotional intelligence components in stress and health.

According to Boyam (2008) the self-actualized person sees reality as it is and accepts responsibility for it. He is as objective as a subjective well-being can be in his perception. He asserts that self-actualizing people know the difference between means and ends and good and evil and do not twist them in a way that hurts themselves or others, making such people better adjusted to their life situations and thus, enjoy truly better mental health.

Sjoberg (2008) found significant relationship between emotional intelligence and life adjustment.
Ajawani (2009) found that emotionally high intelligent subjects showed lower neuroticism while emotionally low intelligent subjects exhibit higher neuroticism. He asserts that nurturance of high emotional intelligence way lead to a healthier mental state.

Ali et al. (2009) investigated the effect of emotional intelligence on mental and physical health. For this purpose 250 primary and high school teachers were selected with stratified random sampling selection from schools. The result showed that emotional intelligence explained 43.9% of variance of mental health and 13.5% of variance of physical health.

Nelis et al. (2009) showed a significant increase in emotion identification and emotion management abilities in the training group. These findings suggests that emotional intelligence can be improved and open new treatment avenues.

Faghirpour (2009) found high correlation between ability of students in different components of emotional intelligence i.e., self awareness, self-controls, social skill, social consciousness, and self regulation with mental health.

Cote et al. (2010) found a significant relationship between self-awareness and mental health. They suggest that the person who is aware about own emotions lead a better mentally healthy life.

Hansenne & Bianchi (2009) found that depressed patients exhibited lower total emotional intelligence score and lower subscale scores on optimism/mood regulation and appraisal of emotions.

According to Hertel et al. (2009) “some of the early symptoms of mental illness are related to emotional problems”. People who cannot modulate or express emotions encountered in daily life, are faced wit such deficits. A study done by Hertel et al. (2009) tested three mental disorders which are a direct reflection of emotional abilities. “Major depressive disorders, borderline personality disorder and substance abuse disorder were all associated with significant deficits to emotional abilities”.

[100]
Many people who feel as if they cannot express their emotions turn to other things for a temporary fix to avoid dealing with their emotions. This temporary fix can lead to more severe problems, often resulting in making the emotional health care issues more severe.

Joshi et al. (2009) found that optimist respondents reported more emotionally matured behaviour than respondents who had pessimistic attitude.

Mikolajczak (2009) documented an association between trait emotional intelligence and mental health. Trait emotional intelligence significantly moderated the impact of the experimental stressors on subsequent mood deterioration, the effect held after controlling for social desirability, and trait emotional intelligence had incremental validity to predict mood deterioration over and above the other predictors.

Singh & Mansi (2009) suggests that optimists exhibit improved psychological well-being and better adjustment to stressful life events, people with high score on optimism display higher level of contentment, low level of distress, anxiety, and depressive symptoms. Optimistic people are more achievement oriented in any task in their life, feel easy in taking decisions, and take better solution in handling life problems. Optimistic people report a higher quality of life and have lower risks of all-cause death (Powers & Dawn, 2004), and less likely to develop physical ill health or suicidal tendencies when they face major stressful life events than individuals with a pessimistic style (Carr & Alan, 2004). Optimists generally believe that people and events are inherently good, so that most situations work out in the end for the best.

Zeidner et al. (2009) found a positive association between trait emotional intelligence and well-being related variables.

Martins et al. (2010) indicates that TEIQue showed the strongest association with mental health. The results are encouraging the value of emotional intelligence as a plausible health predictor.
Austin et al. (2010) showed that lower scores of emotional intelligence were associated with higher level of stress among undergraduate students assessed at the start of the semester and before the pre-exam period, and that emotional intelligence mediated the effects of personality on stress and subjective well-being.

Dulhani (2010) found a significant relationship with emotional intelligence and mental health. The author suggests that high emotional intelligence abilities equip a person with sound infrastructure of dealing with adverse and stressful situations of life and thus such individual is able to restore good mental health even under stressful situations of life.

Gupta & Kumar (2010), and Marteins et al. (2010) indicate that emotional intelligence is positively correlated with mental health. Hassan & Shabani (2010) also found a significant relationship of emotional intelligence with mental health scales and sub-scales scored. In addition, this study revealed that mental health scales and sub-scales scores influenced by emotional intelligence.

Nejad (2010) concluded that assertiveness training was found to be positively associated with mental health. The positive association between assertiveness training and mental health can be explained by the fact that people with good assertiveness ability appears to appraise their life experiences as being helpful in maintaining high mental health in contrast to people with poor assertiveness.

Raena (2010), and Faghirpour et al. (2011) found a significant positive association with emotional self-awareness and mental health of students.

Zeidner & Olnick-Shemesh (2010) assert that there are four ways to consider a link between emotional intelligence and well-being First, since individuals with higher emotional intelligence are more aware of their emotion and that they are more able to regulate their emotion, they should exhibit lower distress and therefore higher well-being. Second, since these individuals report greater social skills and higher social
network quality, this can help them to improve their well-being. Third, understanding your emotions and those of others induce a better environmental and social adaptation, leading to a higher well-being. Finally, individuals with higher emotional intelligence experience more positive than negative emotions, which play a role to a better well-being.

Faghirpour et al. (2011), and Shabani et al. (2011), showed that there was significant relationship between component of emotional intelligence of students with mental health. They found that people with high emotional intelligence had better mental health.

Summerfeldt et al. (2006) showed that social phobia is mainly characterized by a lower interpersonal emotional intelligence score (i.e., understanding and identification of others’ emotions) as compared to controls, but that panic disorder and obsessive-compulsive disorder did not differ form controls. In addition they reported that intrapersonal emotional intelligence (i.e., understanding and identification of owns emotions) was reduced within the three clinical groups as compared to controls, but with a greater level in social phobia parents.

Thingujam (2011) found a significant correlation between emotional intelligence and life satisfaction.

Davis & Humpherry (2012) found significant relationship between emotional intelligence and mental health. They found that emotional intelligence is a moderator of stress in adolescents.

Bhardwaj & Dulhani (2012) examined extraverted people are easily adjusted in any situation or well-adjusted in any role of life. They do not easily become upset while facing routine problems. They have good tolerance level with regard to emotionally imbalance situations. They are composed, quite, and organized. All these characteristics are necessary for better mental health.
GENDER IDENTITY AND MENTAL HEALTH

What biology initiates, environment accentuates. 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). That is, some boys more than others exhibit traditional masculine traits and interests, and some girls more than others become distinctly feminine. 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. It occurs as a result of the internalization of masculine and feminine traits.

From a sociological perspective, gender identity involves all the meaning that are applied to oneself on the basis of one’s gender identification. In turn, these self-meanings are a source of motivation for gender-related behaviour (Burke, 1980). A person with a more masculine identity should act more masculine, that is, engage in behaviours whose meanings are more masculine such as behaving in a more dominant, competitive, and autonomous manner (Ashmore et al., 1986). It is not the behaviours themselves that are important, but the meanings implied by those behaviours.

Beginning at birth, the self-meanings regarding one’s gender are formed in social situations, stemming from ongoing interaction with significant others such as parents, peers, and educators (Katz, 1986). While individuals draw upon the shared cultural conceptions of what it means to be male or female in society which are transmitted through institutions such as religion or the educational system, they may come to see themselves as departing from the masculine or feminine cultural model. A person may label herself female, but instead of seeing herself in a stereotypical female manner such as being expressive, warm, and submissive (Ashmore et al., 1986), she may view herself in a somewhat stereotypically masculine fashion such as being somewhat instrumental, rational, and dominant.
The point is that people have views of themselves along a feminine-masculine dimension of meaning, some being more feminine, some more masculine, and some perhaps a mixture of the two. It is this meaning along the feminine-masculine dimension that is their gender identity, and it is this that guides their behaviour.

THE ROOTS OF FEMININITY/MASCULINITY

In western culture, stereotypically, men are aggressive, competitive, instrumentally oriented while women are passive, cooperative and expressive. Early thinking often assumed that this division was based on underlying innate differences in traits, characteristics and temperaments of males and females.

Now, it is understood that femininity and masculinity are not innate but are based upon social and cultural conditions. Mead (1935) addressed the issue of differences in temperament for males and females. This early study led to the conclusion that there are no necessary differences in traits or temperaments between the two sexes. Observed differences in temperament between men and women were not a function of their biological differences, rather, they resulted from differences in socialization and the cultural expectations held of each sex.

One is led to this conclusion because the three societies studied by Mead (1935) showed patterns of temperament which were quite varied compared with our own. Among the Arapesh, both males and females displayed what we would consider a “feminine” temperament (passive, cooperative, and expressive). Among the Mundugamor, both males and females displayed what we would consider a “masculine” temperament (active, competitive, and instrumental). Finally, among the Tchambuli, men and women displayed temperaments that were different from each other, but opposite to their own pattern. In that society, men were emotional, and expressive while women were active and instrumental.
The term gender identity defines a person’s relative sense of his or her own masculine or feminine identity. The terms, 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.

Scientists believe that human sexual identities are made of three components:-

1. the direction of a child’s sexual orientation whether he or she is heterosexual, homosexual, or bisexual,
2. the child’s behaviour, and
3. the core gender identity.

Like biological sex, gender identity consists of more than two categories and there is a space in the middle for those who identify as a third gender, both (two spirits) or neither. In fact, many people feel that they have masculine and feminine aspects of their psyches, and some people fearing that they do seek to purge themselves on one or the other by acting in exaggerated sex stereotype ways (Berk, 2003).

For the first couple of months after conception, only the chromosomes of a human embryo indicate whether it will develop into a boy or girl. Up to this stage, both sexes are identical in appearance and have tissues that will eventually develop into testes or ovaries, as well as a genital tubercle that will become either a penis or a clitoris. But between 2 and 3 months, a primitive sex gland, or gonad, develops into testes if the embryo is genetically male (that is, has XY chromosomes) or into ovaries if the embryo is genetically female (XX chromosomes). Once testes or ovaries develop, they produce the sex hormones, which then control the development of the internal reproduction structures and the external genitals. In addition, genetelia vary greatly or individuals may have more than one of genetelia and other bodily attributes related to a person’s sex (body shape, facial hair etc.). Recent researches suggest
that as many as one in hundred individuals may have characteristics of both sexes. Transgender individuals are those whose gender expression or their sex-chromosomes differ from the traditional definitions. The sex hormones are more important for prenatal development than they are for expressions of adult sexuality.

The critical hormones in genital development is androgen. If the embryonic sex glands produce enough androgen, the newborn will have male genitals; if there is insufficient androgen, the newborn will have female genitals, even if it is genetically male (XY). The anatomical development of the female embryo does not require female hormones, only the absence of male hormones. In short, nature will produce a female unless androgen intervenes.

The influence of androgen, called androgenization, extends far beyond anatomy. After it has molded the genitals, androgen begins to operate on the brain cells. Studies with rats provide direct evidence that prenatal androgen changes the volume and detailed structure of cells in the fetus, ‘hypothalamus’, an organ that regulates motivation in humans as well as in rats (Money, 1988). These effects of androgen essentially masculinize the brain, and may be responsible for masculine traits and behaviours that appear months or years later. Each of us has gender identity in that a key part of our self-concept has the label “male” or “female”. For the vast majority of people, biological sex and gender identity correspond, though in a small proportion of the population, their gender identity differs from their sex.

DEVELOPING A GENDER IDENTITY

The formation of a gender identity is a complex process that starts with conception but which involves the growth processes during gestation and learning experiences after birth. There are differences along the way, but the language and tradition in many societies insist that every individual should be categorized as either a man or a woman. The birth announcement begins with the information, a male - or female - sounding name is selected, pink or blue clothing is bought, the baby’s room
is decorated in either a feminine or a masculine style, and “gender appropriate” toys and clothings are provided. As Angier (1998) puts it, “Society still assumes that boys will be boyish and girls not”.

Despite the pervasive emphasis on gender definition, infants and even toddlers are usually unaware of either sex or gender until they are about two years of age. For a variety of reasons, two is the usual age when children learn to call themselves either “girl” or “boy”, often without a clear idea as to what those words might mean. Gradual gender identity is acquired as the child develops a sense of self that includes maleness or femaleness (Grieve, 1980). This earlier awareness of sexual difference is called core gender identity, a relatively fixed sense of maleness or femaleness usually consolidated by the second year of life, prior to the oedipal phase. There are three components in the formulation of core gender identity.

i. Biological and hormonal influence

ii. Sex assignment at birth

iii. Environmental and psychological influences on an individual

Lenton et al. (2001) assert that between ages four to seven children begin to comprehend the importance of gender consistency. That is, they accept the principle that gender is a basic attribute of each person and of pets and cartoon characters as well. Once these cognitions are firmly in place, their subsequent perceptions are strongly affected by what people have been taught about gender. The stereotypes associated with each gender not only have a powerful influence on how individuals are perceived, but they can even lead to false memories.

Though it has been widely assumed that most observed differences between males and females are based on biological factors, research of various kinds has shown convincingly that many “typical” masculine and feminine characteristics are in fact acquired (Bem, 1984; Eagly & Wood, 1999). Gender schema theory suggests that children have a readiness to organize information about the self on the basis of cultural
definition of appropriate male and female attributes (Bem, 1981, 1983). Such information is applied to self as well as to others. The definitions of appropriate behaviour changes over time especially the stereotypes of women in recent history, because there has been greater changes in the roles a women than of men (Diekman & Eagly, 2000).

As children grow older, sex typing occurs when they comprehend the “correct” stereotypes associated with maleness and femaleness in their culture. A great deal of what children learn about gender is based on observing their parents and trying to be like them, generally, children are rewarded for engaging in gender appropriate behaviour and discouraged (often with ridicule) when their behaviour is gender inappropriate. Children as well as adults play a role in encouraging and discouraging specific behaviours on the basis of gender. In Israel, fifth and sixth grade boys were shown a videotape of a boy of their age playing a masculine (soccer), feminine (jumping rope), or neutral (cards) game with either boys or girls (Lobel, 1994). The viewers attributed stereotypic feminine traits to the boy who played a feminine game with girls, and they judged him to be low in popularity. The boy who played a masculine game with other boys was perceived as the most masculine and the most popular.

After a few years spent observing parents and peers and also being exposed to stereotypes in all aspects of the media, a child gradually acquires the gender stereotypes of his or her culture (for example, It is OK for girls to cry and boys to fight; boys can wrestle, and girls can play cat’s cradle; girls can pretend to be the mother of bady dolls, and boys can wage war with action figures). Clothes and hair styles and chores around the home tend to be gender specific. By the time children reach the sixth grade, they understand the prevailing stereotypes quite well (Carter & McCloskey, 1984). As children reach adolescence, teen magazines supply gender-appropriate scripts (Carpenter, 1988), and they continue to encounter daily examples of the stereotypes throughout life. As a result of all of this experience, most adults are quite accurate in their ability to identify gender stereotypes (Hall & Carter, 1999). The developmental process is summarized in Figure 1.
Adolescence And Adult

Gender identity is well established and gender stereotypes are well understood. The individual may or may not identify with the gender stereotypes associated with his or her sex. That is, a person may adopt these sex-linked stereotypes or those of the opposite sex or those of both sexes or those of neither sex.

Later Childhood

Sex identity becomes very clear, and gender identity (I am a male or I am a female) develops as part of the self-concept. Child also is learning culturally designated “appropriate” and “inappropriate” characteristics associated with gender. By age 5, gender stereotypes begins to be acquired.

Ages 2 To 4

Child learns social categories of male and female and labels self and others as boy or girl, though with a somewhat limited understanding of precisely what this means.

Conception

Genes on the sex chromosomes determine whether a biological male or a biological female has been conceived.

Figure#1: Developmental Aspects Of Gender Identity (Baron & Byrne, 2004)
It is important to distinguish gender identity, as presented above, from other gender-related concepts such as gender roles which are shared expectations of behaviour given one’s gender. For example, gender roles might include women investing in the domestic role and men investing in the worker role (Eagly, 1987). The concept of gender identity is also different from gender stereotypes which are shared views of personality traits often tied to one’s gender such as instrumentality in men and expressiveness in women (Spence & Helmreich, 1978). And, gender identity is different from gender attitudes that are the views of others or situations commonly associated with one’s gender such as men thinking in terms of justice and women thinking in terms of care (Gilligan, 1982). Although gender roles, gender stereotypes and gender attitudes influence one’s gender identity, they are not the same as gender identity (Spence & Sawin, 1985; and Katz, 1986).

TYPES OF GENDER IDENTITY

Femininity/Masculinity

Femininity and masculinity or one’s gender identity (Spence, 1985; and Burke et al., 1988) refers to the degree to which persons see themselves as masculine or feminine given what it means to be a man or woman in society. Femininity and masculinity are rooted in the social (one’s gender) rather than the biological (one’s sex) system. Societal members decide what being male or female means (e.g., dominant or passive, brave or emotional), and males will generally respond by defining themselves as masculine while females will generally define themselves as feminine. Because these are social definitions, however, it is possible for one to be female and see herself as masculine or male and see himself as feminine.

Masculinity, Femininity, And Androgyny

For years psychologists assumed that masculinity and femininity were at opposite ends of a continuum. If a person possessed highly masculine traits, then
that person must be very unfeminine; being highly feminine implied being unmasculine. Bem (1974) challenged this assumption by arguing that individuals of either sex can be characterized by psychological androgyne – that is, by a balancing or blending of both masculine-stereotyped traits (for example, being assertive, analytical, and independent) and feminine-stereotyped traits (for example, being affectionate, compassionate, and understanding). In Bem’s model, then, masculinity and femininity are two separate dimensions of personality. A male or female who has many masculine-stereotyped traits and few feminine ones is defined as a masculine sex-typed person. A person who has many feminine-stereotyped traits and few masculine-stereotyped traits is said to be a feminine sex-typed person. The androgynous person possesses both masculine and feminine traits, whereas the undifferentiated individual lacks both kinds of attributes (Figure 2).

Figure #2: Categories Of Gender-Role Orientation Based On Viewing Masculinity And Femininity As Separate Dimensions Of Personality

Once a person develops a specific gender relevant characteristics his or her behaviour follows. He/she holds specific beliefs, makes specific assumptions, and acts in accordance with specific expectations (Chatterjee & McCarrey, 1991).
This leads to specific typification of a person’s gender identity which may follow either of the following:

1. **Masculinity** – Identifying oneself of male gender and acting accordingly is known as masculinity.

2. **Femininity** – Identifying oneself of being female gender and acting accordingly is known as femininity.

3. **Androgyny** – Having both the characteristics of masculinity and femininity at high level is called androgyny.

4. **Undifferentiated** – Being low on both the basic dimensions of gender identity i.e., masculinity and femininity, is labeled as undifferentiated.

In general, ‘feminine’ is supposed to mean all that is soft, tender and helpless, and ‘masculine’ is supposed to mean everything hard, tough, and independent. Masculine and feminine traits upon which gender identity is based are associated with instrumental/agentic and communal/expression tendencies, respectively. Personality traits such as independence, assertiveness, reason, rationality, competitiveness, and focus on individual goals are the hallmarks of masculinity while understanding, caring, nurturance, responsibility, considerations, sensitivity, interactions, passion, and focus on communal goals are traits associated with femininity. For years, psychologists took these opposites as evidence of psychological health. Now many feminists have challenged this view. They insist that a new standard of psychological health is required, one that allows individuals to express the full range of human emotions and role possibilities without regard to gender stereotype. They term the expanded range of human possibilities androgyny, from ‘andro’ male and ‘gyne’ female. According to this view androgynous individuals should be more flexible in meeting new situations and less restricted in the way they express themselves. Bem (1975a, 1975b) investigated gender role among more than 1500 standard university students. Semester after semester, they found that roughly 50 percent of the students adhere to ‘appropriate’ sex roles, about 15 percent are cross sex-typed, and some 35 percent are androgynous.
Research with college students using self-perception inventories that contain both a masculinity (or instrumentality) scale and a femininity (or expressivity) scale found that roughly 33% of the test takers were “masculine” men or “feminine” women; about 30% were androgynous, and the remaining individuals were either undifferentiated (low on both scales) or sex reversed (masculine sex-typed females or feminine sex-typed males) (Spence & Helmreich, 1978). Around 30% of children can also be classified as androgynous (Hall & Halberstadt, 1980; and Boldizar, 1991).

**Advantageous Of Androgyny**

The concept of androgyny is the presence of high degree of masculine and feminine characteristics in the same individual (Bem, 1977; and Spence & Helmreich, 1978). The androgynous individual might be a male who is assertive (masculine) and sensitive to others’ feelings (feminine), or a female who is dominant (masculine) and caring (feminine).

If a person can be both assertive and sensitive, both independent and understanding, being androgynous sounds psychologically healthy. Most college students – both males and females – believe that the ideal person is androgynous (Slavkin & Stright, 2000). Bem (1975, 1978) demonstrated that androgynous men and women behave more flexibly than more sex-typed individuals. For example, androgynous people, like masculine sex-typed people, can display the “masculine” agentic trait of independence by resisting social pressure to conform to undesirable group activities. Yet they are as likely as feminine sex-typed individuals to display the “feminine” communal trait of nurturance by interacting positively with a baby. Androgynous people seem to be highly adaptable, able to adjust their behaviour to the demands of the situation at hand (Shaffer et al., 1992). Because of this only androgynous parents are viewed as warmer and more supportive than nonandrogynous parents (Witt, 1997). In addition, androgynous individuals appear to enjoy higher self-esteem and are perceived as better adjusted than their traditionally sex-typed peers, although this may be largely because of the masculine qualities they possess (Boldizar, 1991; Spence & Hall, 1996; and Lefkowitz & Zeldow, 2006).
To some extent, social norms remain traditional, and gender-typed behaviour is expected. That is, men should be powerful, dominant, and self-assertive, while women should be caring, sensitive, and emotionally expressive. For those who are comfortable with these norms, it is satisfying to conform to them and upsetting when their behaviour fails to match the expected pattern (Wood et al., 1997). Gender stereotyped behaviour even extends to bodily posture – men sit with their legs apart and arms away from the trunk, while women sit with their upper legs against each other and arms against the trunk. Women who adopt the male posture are seen as masculine, and men who adopt the female posture are seen as feminine (Vrugt & Luyerink, 2000). With the recognition of androgyny as a possible gender role, much of the research has focused in 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 that supports the proposition that “androgyny is good”. For example, compared to gender type individuals, androgynous men and women are found to be better liked (Major et al., 1981), more comfortable with their sexuality (Garcia, 1982), better able to adapt to the demands of varied situations (Prager & Bailey, 1985), better adjusted (Orlofsky & O’Heron, 1987; and Williams & D’Alessandro, 1994), more satisfied with their interpersonal relationships (Rosenzweig & Daley, 1989), less likely to develop eating disorders (Thornton et al., 1991), with their lives in general (Dean-Church & Gilroy, 1993; and Peter, 2008), more flexible in coping with stress (McCall & Struthers, 1994), more creative and optimistic (Norlander et al., 2000), and better able to reduce the stress of others (Hirokawa et al., 2001).

In some cultures masculinity is as advantageous as androgyny. Abadalla (1995) examined the self-efficacy of Arab students in Qatar and Kuwait with respect to making career decisions. Individuals whose gender roles were either masculine or androgynous were higher in self-efficacy than were those who adhered to feminine or undifferentiated roles.
In other contexts, masculinity seems to create interpersonal problems. For example, among adolescent males, high masculinity is associated with having multiple sex partners, the view that men and women are adversaries, and the belief that impregnating a partner is a positive indication of one’s manliness (Pleck et al., 1993). More surprising perhaps is the fact that masculinity (in both males and females) is associated with mortality – the higher the masculinity, the more likely an individual is to die earlier at any given age (Lippa et al., 2000). A possible explanation for this is that masculinity is associated with taking risks and other maladaptive behaviours that reduce life expectancies.

Feminine role identification also has its pitfalls. Those of either gender who are high on femininity tend to have lower self-esteem than either masculine or androgynous individuals (Lau, 1989). High femininity is also associated with depression, especially by the time a woman is middle aged (Bramberger & Matthews, 1996).

Moreover, during childhood, expressing too many of the traits considered more appropriate in the other sex can result in rejection by peers and low self-esteem (Lobel et al., 1997). In addition, one may need to distinguish between the androgynous individual who possesses positive masculine and feminine traits and the one who possesses negative masculine and feminine traits (Woodhill & Samuels, 2003, 2004). People with positive androgyny score higher on measures of mental health and well-being than those with negative androgyny (Woodhill & Samuels, 2003). It may be premature, then, to conclude that it is better in all respects to be androgynous rather than either masculine or feminine in orientation. Still, one can at least conclude that it is unlikely to be damaging for men to become a little more feminine or for women to become a little more masculine than they have traditionally been. Though, not much studies have been conducted but it is believed that androgynous individuals show transient or/and even changing behaviour with various types of mood swings towards mental health which generally they evaluate in other individuals.
Beyond the kind of masculanity and femininity, there is extreme gender role identification. The first of these is hyper masculinity, which is characterized by the endorsement of a pattern of attitudes and beliefs associated with an exaggerated version of the traditional male role (Mosher & Tomkins, 1988; Mosher, 1991). The hypermasculine (or macho) man expresses callous sexual attitude toward women, believes that violence is manly, and enjoys danger as a source of excitement. Such men engage in sexually coercive behaviour (Mosher & Sirkin, 1984), are comfortable rape fantasies (Mosher & Anderson, 1986), and admit their willingness to commit rape if they could be assured of not getting caught (Smeaton & Byrne, 1987).

The analogous extreme of women is hyperfemininity (Murnen & Byrne, 1991). The hyperfeminine women believe that relationships with men are of central importance of her life, agrees that it is acceptable to use attractiveness and sex to “get a man and keep him”, and admits that she “sometimes says no but means yes”. Compared with women low on this dimension, hyperfeminine women report having been the target of sexual coercion (Murnen et al., 1989) and being attracted to hypermasculine men (Smith et al., 1995).

Both hypermasculinity and hyperfemininity are associated with the endorsement of many legal forms of aggression, for example, spanking one’s children, media violence, and the death penalty (Hogben et al., 2001). Even at less extreme levels of masculinity, men who identify strongly with the masculine role behave more violently and aggressively than do men who are only moderately masculine (Finn, 1986).

THEORETICAL BACKGROUND OF GENDER IDENTITY

Early gender identity research hypothesized a single bipolar dimension of masculinity / femininity, that is, masculinity and femininity are opposites on one continuum. Further gender identity was correlated with biological sex and constrained by societal stereotypes of appropriate masculine and feminine behaviours. As
societal stereotypes changes, however, the assumptions of the unidimensional model were challenged. This leads to the development of two dimensional gender identity model, in which masculinity and femininity were conceptualized as two separated, orthogonal dimensions, co-existing in varying degrees within an individual.

Several theories about the development of gender roles and gender identity have been proposed. Some theories emphasize the role of biological differences between the sexes, whereas others emphasize social influences on children. Some emphasize what society does to children; other focus on what children do to themselves as they try to understand gender and all its implications.

Differences in gender roles have existed throughout history. Evolutionary theorists attribute these differences to the physiological characteristics of men and women that described their best function for survival of the species. In primitive societies, men adopted the roles of hunting and protecting their families because of their physical strength. Women’s ability to bear and nurse children led them to adopt the roles of nurturing young, as well as the less physically dependent roles of gathering and preparing food. These gender-dependent labour roles continued into the period of written human history, when people began to live in cities and form the earliest civilized societies.

In the 1800s, the individual movement marked a prominent division of labour into public and private domains. Men began leaving home to work, whereas women worked within the home. Previously, both men and women frequently engaged in comparably respected, productive activities on their homestead. When men began working in the public domain, they acquired money, which was transferable for goods or services. Women’s work, on the other hand, was not transferable. Men’s relative economic independence contributed to their power and influence while women were reduced to an image of frailty and emotionality deemed appropriate only for domestic tasks and child-rearing.
Biological Theory

The biological theory of gender-role development proposed by Money & Ehrhardt (1972) calls attention to the ways in which biological events influence the development of boys and girls. But it also focuses on ways in which early biological developments influence how people react to a child and suggests that these social reactions have much to do with children’s assuming gender roles.

Chromosomes, Hormones, and Social Labeling. Money & Ehrhardt (1972) stress that the male (XY) or female (XX) chromosomes most of us receive at conception are merely a starting point in biological differentiation of the sexes. Several critical events affect a person’s eventual preference for the masculine or feminine role (Breedlove, 1994).

1. If certain genes on the Y chromosome are present, a previously undifferentiated tissue develops into testes as the embryo develops; otherwise, it develops into ovaries.

2. The testes of a male embryo normally secrete more of the male hormone testosterone, which stimulates the development of a male internal reproductive system, and another hormone that inhibits the development of female organs. Without these hormones, the internal reproductive system of a female will develop from the same tissues.

3. Three to four months after conception, secretion of additional testosterone by the testes normally leads to the growth of a penis and scrotum. If testosterone is absent (as in normal females), or if a male fetus’s cells are insensitive to the male sex hormones he produces, female external genitalia (labia & clitoris) will form.

4. The relative amount of testosterone alters the development of the brain and nervous system. For example, it signals the male brain to stop secreting hormones in a cyclical pattern so that males do not experience menstrual cycles at puberty.
Thus, fertilized eggs have the potential to acquire the anatomical and physiological features of either sex. Events at each critical step in the sexual differentiation process determine the outcome.

Once a biological male or female is born, social labeling and differential treatment of girls and boys interact with biological factors to steer development. Parents and other people label and begin to react to children on the basis of the appearance of their genitalia. If children’s genitals are abnormal and they are mislabeled as members of the other sex, this incorrect label will affect their future development. For example, if a biological male is consistently labeled and treated as a girl, he will by about age 3, acquire the gender identity of a girl. Finally, biological factors reenter the scene at puberty when large quantities of hormones are released, stimulating the growth of the reproductive system and the appearance of secondary sex characteristics. These events, with a person’s earlier self-concept as a male or female, provide the basis for adult gender identity and role behaviour.

**Evidence of Biological Influences.** Much evidence suggests that biological factors influence the development of males and females in many species of animals (Breedlove, 1994). Evolutionary psychologists notice that most societies socialize males to have agentic traits and females to have communal one’s; they conclude that traditional gender roles may be a reflection of species’ heredity (Buss, 1995; and Archer, 1996). In addition, individual differences in masculinity and femininity may be partly genetic. Twin studies suggest that individual heredity accounts for 20% to 50% of the variation in the extent to which people describe themselves as having masculine and feminine psychological traits (Loehlin, 1992). In other words, experience does not explain everything.

Biological influences on development are also evident in studies of children exposed to the “wrong” hormones prenatally (Money & Ehrhardt, 1972; and Ehrhardt & Baker, 1974). Before the consequences were known, some mothers who
previously had problems carrying pregnancies to term were given drugs containing progestins, which are converted by the body into the male hormone testosterone. These drugs had the effect of masculinizing female fetuses so that, despite their XX genetic endowment and female internal organs, they were born with external organs that resembled those of a boy (for example, a large clitoris that looked like a penis and fused labia that resembled a scrotum). Several of these androgenized females (girls prenatally exposed to excess androgens) were recognized as genetic females, underwent surgery to alter their genital, and were then raised as girls. When Money & Ehrhardt (1972) compared them with their sisters and other girls, it became apparent that many more androgenized girls were tomboys and preferred boys’ toys and vigorous activities to traditionally feminine pursuits. As adolescents, they began dating somewhat later than other girls and felt that marriage should be delayed until they had established their careers. A high proportion (37%) described themselves as homosexual or bisexual (Money, 1985; Dittman et al., 1992; and Meyer-Bahlburg et al., 2006). Androgenized females may also perform better than most other females on tests of spatial ability, further evidence that early exposure to male hormones has “masculinizing” effects on a female fetus (Resnick et al., 1986; Kimura, 1992; and Malouf et al., 2006).

In addition, male exposure to testosterone and other male hormones may be part of the reason males are more likely than females to commit violent acts (Rubinow & Schmidt, 1996). Evidence from experiments conducted with animals is quite convincing. For example, female rhesus monkeys exposed prenatally to the male hormone testosterone often threaten other monkeys, engage in rough-and-tumble play, and try to “mount” a partner as males do at the beginning of a sexual encounter (Young, et al., 1964; and Wallen, 1996). Men with high testosterone levels tend to have high rates of delinquency, drug abuse, abusiveness, and violence, although nature interacts with nurture so that these links between testosterone and antisocial behaviour are not nearly as evident among men high in socio-economic status as among men low in socioeconomic status (Dabbs & Morris, 1990).
Because testosterone levels rise as a result of aggressive and competitive activities, it has been difficult to establish unambiguously that high concentrations of male hormones cause aggressive behaviour in humans (Archer, 1991). Still, animal studies show that early experiences can alter the developing nervous systems of males and females and, in turn, their behaviour (Breedlove, 1994). Much evidence suggests that prenatal exposure to male or female hormones has lasting effects on the organization of the brain and, in turn, on sexual behaviour, aggression, cognitive abilities, and other aspects of development (Rubinow & Schmidt, 1996). Yet biology does not dictate gender-role development. Instead, gender-role development evolves from the complex interaction of biology, social experience, and the individual’s behaviour.

**Evidence of Social-Labeling Influences.** The social aspect of Money & Ehrhardt's (1972) biosocial theory is also of vital consideration. How a child is labeled and treated can considerably affect gender development. For instance, some androgenized females were labeled as boys at birth and raised as such until their abnormalities were detected. Money & Ehrhardt (1972) reported that the discovery and correction of this condition (by surgery and relabeling as a girl) caused few adjustment problems if the sex change took place before 18 months. After age 3, sexual reassignment was exceedingly difficult because these genetic females had experienced prolonged masculine gender typing and had already labeled themselves as boys. These findings led Money & Ehrhardt (1972) to conclude that there is a critical period (between 18 months and 3 years) for the establishment of gender identity when the label society attaches to the child is likely to stick. Yet some studies in which infants are presented to some people as boys but to others as girls indicate that labeling has little effect on how people perceive and treat these infants (Stern & Karraker, 1989). And biological males who are labeled as girls during the so-called critical period sometimes adopt a male gender identity later in life despite their early labeling and socialization, suggesting that one should refer to a sensitive rather than a critical period. Once again, then, it is observed that both nature and nurture at work in development.
Psychoanalytic Theory

As is true of thinking about most areas of development, thinking about gender-role development was shaped early on by Freud’s psychosexual theory (1917-1924). The 3- to 6-year-old child in Freud’s phallic stage is said to harbor a strong, biologically based love for the parent of the other sex, experience internal conflict and anxiety as a result of this incestuous desire, and resolve the conflict through a process of identification with the same-sex parent. According to Freud (1917-1924), a boy experiencing his oedipus complex loves his mother, fears that his father will retaliate by castrating him, and is forced to identify with his father, thereby emulating his father and adopting his father’s attitudes and behaviours. Freud (1917-1924) believed that a boy would show weak masculinity later in life if his father was inadequate as a masculine model, was often absent from the home, or was not dominant or threatening enough to foster a strong identification based on fear. Meanwhile, a preschool-age girl is said experience an electra complex involving a desire for her father (and envy him for the penis she lacks) and a rivalry with her mother. To resolve her unconscious conflict, she identifies with her mother, her father also contributes to gender-role development by reinforcing her for “feminine” behaviour resembling that of her mother. Thus, Freud (1917-1924) emphasized the role of emotions (love, fear, and so on) in motivating gender-role development and argued that children adopt their identities and roles by patterning themselves after their same-sex parents.

According to psychoanalytic theory, one’s gender identity develops through identification with the same-sex parent. This identification emerges out of the conflict inherent in the oedipal stage of psychosexual development. By about age 3, a child develops a strong sexual attachment to the opposite-sex parent. Simultaneously, negative feelings emerge for the same-sex parent that is rooted in resentment and jealousy. By age 6, the child resolves the psychic conflict by relinquishing desires for the opposite-sex parent and identifying with the same-sex parent. Thus, boys come to learn masculinity from their fathers and girls learn femininity from their mothers.
Freud's (1917-1924) psychoanalytic theory of human development, reflected an attitude of male superiority. Freud (1917-1924) asserted that as children, boys recognize they are superior to girls when they discover the difference in their genitals. Girls, on the other hand, equate their lack of a penis with inferiority. This feeling of inferiority causes girls to idolize and desire their fathers, resulting in passivity, masochistic tendencies, jealousy and vanity – all seen by Freud as feminine characteristics.

A more recent formation of psychoanalytic theory suggests that mothers play an important role in gender identity development (Chodorow, 1978). According to Chodorow (1978), mothers are more likely to relate to their sons as different and separate because they are not of the same sex. At the same time, they experience a sense of oneness and continuity with their daughters because they are of same sex. As a consequence, mothers will bond with their daughters thereby fostering femininity in girls. Simultaneously, mothers distance themselves from their sons who respond by shifting their attention away from their mother and toward their father. Through, identification with their father, boys learn masculinity.

Freud (1917-1924) was right for identifying the pre-school year as a critical time for gender-role development. In addition, his view that boys, because of fear of castration, have a more powerful motivation than girls to adopt their gender role is consistent with the finding that boys seem to learn gender-typed behaviours faster and more completely than girls do. It is also true that boys whose fathers are absent from the home tend to be less traditionally sex-typed than other boys (Stevenson & Black, 1988). Finally, Freud's (1917-1924) notion that fathers play an important role in the gender typing of their daughters and of their sons has been confirmed (Parke, 1996).

On other counts, however, psychoanalytic theory has not fared well. Many preschool children are so ignorant of male and female anatomy that it is hard to see how most boys could fear castration or most girl could experience penis envy (Bem, 1989). Moreover Freud (1917-1924) assumed that a boy's identification with his father is based on fear, but most researchers find that boys identify most strongly with
fathers who are warm and nurturant rather than overly punitive and threatening (Mussen & Rutherford, 1963; and Hetherington & Frankie, 1967). Finally, children are not especially similar psychologically to their same-sex parents (Maccoby & Jacklin, 1974). Apparently, other individuals besides parents influence a child’s gender-related characteristics.

In the 1980s, such psychologists as Gilligan (1982) sought to build respect for stereotypically feminine traits. They introduced the notion that women function according to an ethic of care and relatedness that is not inferior to men – just different. In 1985s, Stern’s developmental theory favoured traditional femininity, suggesting that humans start out as unconnected to others and gradually form more complex interpersonal connections as they mature.

Social Learning Theory

According to social learning theorists, children learn masculine or feminine identities, preferences, and behaviours in two ways. First, through differential reinforcement, children are rewarded for sex-appropriate behaviours and are punished for behaviours considered more appropriate for members of the other sex. Second, through observational learning, children adopt the attitudes and behaviours of same-sex models. In this view, children’s gender-role development depends on which of their behaviours people reinforce or punish and on what sorts of social models are available.

Parents use differential reinforcement to teach boys how to be boys and girls how to be girls (Lytton & Romney, 1991). By the second year of life, parents are already encouraging sex-appropriate play and discouraging cross-sex play, before children have acquired their basic gender identities or display clear preferences for male or female activities (Fagot & Leinbach, 1989). By 20 to 24 months, daughters are reinforced for dancing, dressing up (as women), following their parents around, asking for help, and playing with dolls; they are discouraged from manipulating
objects, running, jumping, and climbing. By contrast, sons are not encouraged to pursue such “feminine” behaviour as playing with dolls or seeking help and they perceive more positive responses from their parents when they play with “masculine” toys such as blocks, trucks, and push-and-pull toys (Fagot, 1978; Fagot et al., 1992; and Blakemore, 2003). Mothers and fathers may also discipline their sons and daughters differently, with fathers more likely to use physical forms of discipline (such as spanking) than mothers and mothers more likely to use reasoning to explain rules and consequences (Russell et al, 1998; and Conrade & Ho, 2001). In addition, boys end up on the receiving end of a spanking more often than girls do (Day & Peterson, 1998).

In research by Morrongiello & Hogg (2004), mothers were asked to imagine how they would react if their 6- to 10-year-old son or daughter misbehaved in some way that might be dangerous (for example, bicycling fast down a hill they had been told to avoid). Mothers reported that they would be angry with their sons but disappointed and concerned with their daughters for misbehaving and putting themselves in harming way. Boys will be boys, they reasoned, but girls should know better. To prevent future risky behaviours, mothers said they would be more rule-bound with their daughters but would not do anything different with their sons. After all, they reasoned, there is no point in trying to prevent these risky behaviours in boys because it is “in their nature”. Girls’ behaviour, on the other hand, can be influenced, so mothers may believe that it is worth enforcing an existing rule or instituting a new one. Fathers are more protective of their preschool-aged daughters than their preschool-aged sons (Hagan & Kuebli, 2007).

This “gender curriculum” in the home influence children. Parents who show the clearest patterns of differential reinforcement have children who are relatively quick to label themselves as girls or boys and to develop strongly sex-typed toy and activity preferences (Fagot & Leinbach, 1989; and Fagot et al., 1992). Fathers play a central role in gender socialization; they are more likely than mothers to reward children’s
gender-appropriate behaviour and to discourage behaviour considered more appropriate for the other sex (Lytton & Romney, 1991; and Leve & Fagot, 1997). Women who choose nontraditional professions are more likely than women in traditionally female fields to have had fathers who encouraged them to be assertive and competitive (Coats & Overman, 1992). Fathers, then, seem to be an especially important influence on the gender-role development of both sons and daughters.

Differential treatment of boys and girls by parents also contribute to sex differences in ability. Benbow & Arjmand (1990), and Eccles et al. (1990) have conducted several studies to determine why girls tend to shy away from math and science courses and are underrepresented in occupations that involve math and science. They suggest that parental expectations about sex differences in mathematical ability become self-fulfilling prophecies. The plot goes something like this:

1. Parents, influenced by societal stereotypes about sex differences in ability, expect their sons to outperform their daughters in math and expect their sons will be more interested in math and science than their daughters (Tenenbaum & Leaper, 2003).

2. Parents attribute their son’s successes in math to ability but credit their daughters’ successes to hard work. Perhaps as a result of this, fathers talk differently to their sons and daughters when discussing science with them (Tenenbaum & Leaper, 2003). With their sons, they use more scientific terms, provide more detailed explanations, and ask more abstract questions than with their daughters. These differences reinforce the belief that girls lack mathematical talent and turn in respectable performances only through plodding effort.

3. Children being to internalize their parents’ views, so girls come to believe that they are “no good” in math. Girls report that they are less competent and more anxious about their performance than boys (Pomerantz et al., 2002).
4. Thinking they lack ability, girls become less interested in math, less likely to take math courses, and less likely to pursue career possibilities that involve math after high school.

In short, parents who expect their daughters to have trouble with numbers may get what they expect. The negative effects of low parental expectancies on girls’ self-perceptions are evident regardless of their performance. Indeed, girls feel less competent than do boys about math and science even when they outperform the boys (Pomerantz et al., 2002). Girls whose parents are nontraditional in their gender-role attitudes and behaviours do not show the declines in math and science achievement in early adolescence than girls from more traditional families display, so apparently the chain of events Eccles et al. (1990) described can be broken (Updegraff et al., 1996).

Peers, like parents, reinforce boys and girls differentially. As Fagot (1985) discovered, boys only 21 to 25 months of age belittle and disrupt each other for playing with “feminine” toys or with girls and girls express their disapproval of other girls who choose to play with boys (Blakemore, 2003). Similarly, on the playground, preschoolers who engage in same-sex play are better liked by their peers than those who engage in play with the opposite sex (Colwell & Lindsey, 2005).

Social learning theorists call attention to differential treatment of girls and boys by parents, peers, and teachers. They also emphasize that observational learning contributes in important ways to gender typing. Children see which toys and activities are “for girls” and which are “for boys” and imitate individuals of their own sex. Around age 6 to 7, children begin to pay much closer attention to same-sex models than to other-sex models; for example, they will choose toys that members of their own sex prefer even if it means passing up more attractive toys (Frey & Ruble, 1992). Children who see their mothers perform so-called masculine tasks and their fathers perform household and child care tasks tend to be less aware of gender stereotypes and less
gender typed than children exposed to traditional gender-role models at home (Turner & Gervai, 1995; and Sabattini & Leaper, 2004). Similarly, boys with sisters and girls with brothers have less gender-typed activity preferences than children who grow up with same-sex siblings (Colley et al., 1996; and Rust et al., 2000).

Not only do children learn by watching children and adults with whom they interact, but they also learn from the media – radio, television, movies, video games – and even from their picture books and elementary-school texts. Although sexism in children’s books has decreased over the past 50 years, male characters are still more likely than female characters to engage in active, independent activities such as climbing, riding, bikes, and making things, whereas female characters are more often depicted as passive, dependent, and helpless, spending their time picking flower, playing quietly indoors, and “creating problems that require masculine solutions” (Kortenhaus & Demarest, 1993; and Diekman & Murnen, 2004). In a recent analysis of 200 popular children’s picture books, Anderson & Hamilton (2007) found that pictures of fathers, but not of mothers, were largely absent. In the few instances where fathers were portrayed, they were not engaged with their children, which conveys the message that it is still mothers who are the primary caretakers of children.

In recent decades, blatant gender stereotyping of television characters has decreased, but not disappeared. Male characters still dominate on many children’s programs, prime-time programs, and advertisements (Glascock, 2001; Ganahl et al., 2003; and Oppliger, 2007). Even on shows with an equal number of male and female characters, the male characters assume more prominent roles (Ogletree et al., 2004). Typically, men are influential individuals who work at a profession, whereas many women-especially those portrayed as married- are passive, emotional creatures who manage a home or work at “feminine” occupations such as nursing (Signorielli & Kahlenberg, 2001). Women portrayed as single are often cast in traditionally male occupations. The message children receive is that men work regardless of their marital status and they do important business, but women only work at important jobs.
if they are single (Signorielli & Kahlenberg, 2001). Children who watch a large amount of television are more likely to choose gender-appropriate toys and to hold stereotyped views of males and females than their classmates who watch little television (Signorielli & Lears, 1992; and Oppliger, 2007).

Perhaps the strongest traditional gender stereotypes are found in today’s video games, which males play at a much higher rate than females (Ogletree & Drake, 2007). College students, both male and female, report that female video game characters are portrayed as helpless and sexually provocative in contrast to male characters who are portrayed as strong and aggressive (Ogletree & Drake, 2007). Men do not find these stereotypes as offensive as do women, perhaps because men already hold more traditional gender stereotypes than women (Brenick et al., 2007).

To recap, there is much evidence that both differential reinforcement and observational learning contribute to gender-role development. However, social learning theorists often portray children as the passive recipients of external influences: parents, peers, television, and video game characters, and other show them what to do and reinforce them for doing it. Perhaps this perspective does not put enough emphasis on what children contribute to their own gender socialization. Youngsters do not receive gender-stereotyped birthday presents simply because their parents choose these toys for them. Instead, parents tend to select gender-neutral and often educational toys for their children, but their boys ask for trucks and their girls request tea sets (Robinson & Morris, 1986; Servin et al., 1999; and Alexander, 2003).

**Cognitive Theory**

Some theorists have emphasized cognitive aspects of gender-role development, noting that as children acquire gender identity and understanding of gender, they actively teach themselves to be girls or boys. Kohlberg (1966) based his cognitive theory on Piaget’s (1952) cognitive developmental theory, whereas Martin & Halverson (1981) based their theory on an information-processing approach to cognitive development.
Kohlberg (1966) proposed a cognitive theory of gender typing that is different from the other theories. Among Kohlberg’s major themes are the following:

- Gender-role development depends on stage like changes in cognitive development; children must acquire certain understandings about gender before they will be influenced by their social experiences.
- Children engage in self-socialization; instead of being the passive target of social influence, they actively socialize themselves.

According to both psychoanalytic theory and social learning theory, children are influenced by their companions to adopt male or female role before they view themselves as girls or boys and identify with (or habitually imitate) same-sex models. Kohlberg (1966) suggests that children first understand that they are girls or boys and then actively seek same-sex models and a range of information about how to act like a girl or a boy. To Kohlberg, it is not “I’m treated like a boy; therefore, I must be a boy.” It is more like “I’m a boy so now I’ll do everything I can to find out how to behave like one.”

Kohlberg (1966) believes that children everywhere progress through the following three stages as they acquire gender constancy or an understanding of what it means to be a female or a male:

1. Basic gender identity is established by age 2 or 3, when children can recognize and label themselves as males or females (Campbell et al., 2002)
2. Somewhat later, usually by age 4, children acquire gender stability – that is, they come to understand that gender identity is stable over time. They know that boys invariably become men, and girls grow up to be women.
3. The gender concept is complete, somewhere between age 5 and age 7, when children achieve gender consistency and realize that their sex is also stable across situations. Now, children know that their sex cannot be altered by superficial changes such as dressing up as a member of the other sex or engaging in cross-sex activities.
Children 3 to 5 years of age often do lack the concepts of gender stability and gender consistency; they often say that a boy could become a mommy if he really wanted to or that a girl could become a boy if she cut her hair and wore a hockey uniform (Warin, 2000). As children enter Piaget’s concrete-operational stage of cognitive development and come to grasp concepts such as conservation of liquids, they also realize that gender is conserved – remains constant – despite changes in appearance. Gender constancy is demonstrated by very few 3- to 5-year-olds, about half of 6- to 7-year-olds, and a majority of 8- to 9-year-olds (Trautner et al., 2003). In support of Kohlberg’s theory, Warin (2000) found that children who have achieved the third level of understanding display more gender stereotypic play preferences than children who have not yet grasped gender consistency.

Bem (1989) criticized this concept asserting that children need not reach the concrete operational stage to understand gender stability and consistency if they have sufficient knowledge of male and female anatomy to realize that people’s genitals make them male or female. Still, knowledge of male-female anatomy alone is no guarantee that children will understand gender stability and consistency (Trautner et al., 2003). The most controversial aspect of Kohlberg’s cognitive developmental theory, however, has been his claim that only when children fully grasp that their biological sex is unchangeable, around age 5 to age 7, do they actively seek same-sex models and attempt to acquire values, interest, and behaviours consistent with their cognitive judgments about themselves. Although some evidence supports Kohlberg, it is clear that children learn many gender-role stereotypes and develop clear preferences for same-sex activities and playmates long before they master the concepts of gender stability and gender consistency and then, according to Kohlberg, attend more selectively to same-sex models (Martin et al., 2002; and Ruble et al., 2007). It seems that only a rudimentary understanding of gender is required before children learn gender stereotypes and preferences.
Gender Schema Theory

Bem’s (1981) gender schema theory suggests that individuals acquire and display traits and behaviour consistent with their gender identity. Moreover, according to Bem (1981) gender identity serves as an organizing principle through which individual process informations about themselves and the world around them, although the ability of gender identity to have such an effect varies depending on whether or not an individual is sex-typed. Thus, a sex-typed male or female is more likely to be influenced by his or her gender identity than are non sex-typed men and women. A notable aspect of Bem’s work is her development of the BSRI was the first to treat masculinity and femininity, as independent dimensions, thus, allowing for an individual to be androgynous, who is characterized by high degrees of masculinity and femininity or allowing an individual to be undifferentiated, who is characterized by low degrees of masculinity and femininity.

Martin & Halverson (1981, 1987) have proposed a somewhat different cognitive theory, an information-processing one, that overcomes the key weakness of Kohlberg’s theory. Like Kohlberg, they believe that children are intrinsically motivated to acquire values, interests, and behaviours consistent with their cognitive judgments about the self. However, Martin & Halverson (1981) argue that self-socialization begins as soon as children acquire a basic gender identity, around age 2 or 3. according to their schematic-processing model, children acquire gender schema which are organized sets of beliefs and expectation about males and females that influence the kinds of information they will attend to and remember.

First, children acquire a simple in-group-out group schema that allows them to classify some objects, behaviours, and roles as appropriate for males and others as appropriate for females (cars are for boys, girls can cry but boys should not, and so on). Then, they seek more elaborate information about the role of their own sex, constructing an own-sex schema. Thus, a young girl who knows her basic gender
identity might first learn that sewing is for girls and building model airplanes is for boys. Then, because she is a girl and wants to act consistently with her own self-concept, she gathers a great deal of information about sewing to add to her own-sex schema, largely ignoring any information that comes her way about how to build model airplanes.

Consistent with this schema-processing theory, children appear to be especially interested in learning about objects or activities that fit their own-sex schemata. In one study, 4- to 9-year-olds were given boxes of gender-neutral objects (hole punches, burglar alarms, and so on) and were told that some objects were “girl” items and some were “boy” items (Bradbard et al., 1986). Boys explored boy–items more than girls did, and girls explored girl-items more than boys did. A week later the children easily recalled which items were for boys and which were for girls; they had apparently sorted the objects according to their in-group–out-group schemata. In addition, boys recalled more in-depth information about boy items than did girls, whereas girls recalled more than boys about these same objects if they had been labeled girl-items.

Once gender schemata are in place, children will distort new information in memory so that it is consistent with their schemata (Martin & Halverson, 1983; and Liben & Signorella, 1993). For example, Martin & Halverson (1983) showed 5- and 6-year-olds pictures of children performing gender-consistent activities (for example, a boy playing with a truck) and pictures of children performing gender-inconsistent activities (for example, a girl sawing wood). A week later, the children easily recalled the sex of the actor performing gender-consistent activities; when an actor expressed gender-inconsistent behaviour, however, children often distorted the scene to reveal gender-consistent behaviour (for example, by saying that it was a boy, not a girl, who had sawed wood). This research gives some insight into why inaccurate gender stereotypes persist. The child who believes that women cannot be doctors maybe introduced to a female doctor but may remember meeting a nurse instead and
continue to state that women cannot be doctors. Even adults have trouble suppressing gender stereotypes and are influenced by their gender stereotypes when reading and interpreting text (Oakhill et al., 2005).

**Multi-Factorial Theory**

Contradicting Bem’s theory is the belief that gender related phenomena are multi-factorial in nature with desirable gendered personality traits. Accordingly, masculinity and femininity are conceptually distinct from gender roles, expectations, attitudes, preferences, and behaviour.

The underlying assumption of multi-factorial gender identity theory is that it is a combination of gender related phenomena associated in varying degrees with each other such as gender related attitudes, interest and role behaviours and gendered personality traits. Not only the gender identity is multi-factorial, but each gender differentiating factor has a different developmental history that varies across individuals because the factors are impacted by multiple variables that are not necessarily gender related. Consequently, the specific array of gender congruent qualities that people display can be quite variable within each sex, although both men and women do develop gender identities and a sense of belongingness to their sex that is maintained throughout the life span.

The differentiating feature of multi-factorial gender identity theory from gender schema theory is that in former the measurement of gender identity requires measuring of different factors (i.e., personality traits, gender attitudes, sex-role behaviour etc.). If only one factor is measured then the applicability of that factor is limited to situation where only that one factor is relevant. Gender schema theory on the other hand, maintains that it is the measurement of only one facet, masculine and feminine personality traits that are needed to indicate multiple gender related concepts.

Masculine gender identity generally refers to as identifying oneself to be of the male gender and acting accordingly. But in women, masculine gender refers to those
women who have a poor feminist i.e., below the median value and a good masculinity i.e., above the median value (Bem, 1981).

After going their separate ways in childhood, boys and girls come together in the most intimate ways during adolescence. Young elementary-school children are highly rigid in their thinking about gender roles, whereas older children think more flexibly, recognizing that gender norms are not absolute, inviolable laws. Curiously, adolescents again seem to become highly intolerant of certain role violations and to become stereotyped in their thinking about the proper roles of males and females in adolescence. They are more likely than somewhat younger children to make negative judgments about peers who violate expectations by engaging in cross-sex behaviour or expressing cross-sex interests (Alfieri et al., 1996).

Like the elementary-school children, eighth-graders clearly understand that gender-role expectations are just social conventions that can easily be changed and do not necessarily apply in all societies. However, these adolescents also begin to conceptualize gender-role violations as a sign of psychological abnormality and cannot tolerate them.

Increased intolerance of deviance from gender-role expectations is tied to a larger process of gender intensification, in which sex differences may be magnified by hormonal changes associated with puberty and increased pressure to conform to gender roles (Galambos et al., 1990; and Boldizar, 1991). Boys begin to see themselves as more masculine; girls emphasize their feminine side. Girls often become more involved with their mothers, and boys spend more time with their fathers (Crouter et al., 1995). Because hormonal influences may be at work, or adolescents may emphasize gender more once they mature physically and being to look like either a man or a woman. Parents may also contribute as children enter adolescence, mothers do more with their daughters and fathers do more with their sons (Crouter et al., 1995).
Peers may be even more important. Adolescents increasingly find that they must conform to traditional gender norms to appeal to the other sex. A girl who was a tomboy and thought nothing of it may find, as a teenager, that she must dress and behave in more “feminine” ways to attract boys and must give up her tomboyish ways (Burn, et al., 1996; and Carr, 2007). A boy may find that he is more popular if he projects a more sharply “masculine” image. Social pressures on adolescents to conform to traditional roles may even help explain why sex differences in cognitive abilities sometimes become more noticeable as children enter adolescence (Hill & Lynch, 1983; and Roberts et al., 1990). It should be noted that the social pressure to conform to gender stereotypes does not need to be real—adolescents’ perceptions of their peers’ thoughts and expectations can affect behaviours and lead to gender intensification (Pettitt, 2004). Later in adolescence, teenagers again become more comfortable with their identities as men and women and more flexible in their thinking.

Research indicates that, overall, neither males nor females are at greater risk for developing mental disorders as such. However, being male or female may indicate susceptibility to certain types of disorders. Neither masculinity nor femininity is uniformly positive; both gender identifications have strengths and weaknesses. For example, femininity appears to be protective against antisocial behaviours and substance abuse, but is associated with high levels of avoidant coping strategies and low levels of achievement. Masculinity appears to be protective against depression, but is high in antisocial behaviour and substance abuse.

Mental health is best achieved by maintaining a balance between masculine and feminine qualities. Taking either set of qualities to an extreme and to the exclusion of the other is detrimental. A nontraditional gender role orientation would combine the best of both genders: a social focus (reciprocally supportive relationships and a balance between interests of self and others) and active coping strategies.

Bem theory of androgyny (Bem, 1975; and Bem et al., 1976) views a balance or healthy personality as an integration of masculine and feminine qualities.
Androgynous women and men, according to Bem (1977), are more flexible and more mentally healthy than either masculine or feminine individuals; undifferentiated individuals are the least competent. One study found that androgyny was linked to well-being and lower levels of stress (Stake, 2000). Another study with emerging adults revealed that androgynous individuals reported better health practices (such as safety belt use, less smoking) than masculine, feminine or undifferentiated individuals (Shifren et al., 2003).

Girls tend to have increased pressure to assume a feminine sex role, the role of home maker that requires the qualities of sensitivity, warmth and gentleness and if they accept this some what nonassertive, dependent role, they may develop low self-esteem and hence may be predisposed to anxiety and depression as high femininity is only required at home and social gatherings but is rejected at work place (Greenhaus & Bentall, 1985). Whereas, high masculinity and less femininity in females make them tomboys and moderate masculinity and high femininity is effective in the office. But, if females are low both on masculinity and femininity, they become undifferentiated and listless thereby breeding depression by lowering their self-esteem.

Horner (1972) suggested that most women have motive to avoid success i.e., disposition to become anxious about achieving success because they expect negative consequences in the form of loss of femininity and fear of rejection. According to Shapiro (1979) fear of success involve anxiety about engaging in sex inappropriate tasks which is culturally oriented. It is a stable latent disposition, acquired early in life as a part of sex-role socialization (Ohri & Kumar, 1990).

Zuckerman & Allison (1976) assert that the fear of success will continue to cast its shadows in achievement of women as long as women are feminine in their attitudes. Hence will, continue to fall prey to depression until their roles remain ambiguous (Sharma & Malhotra, 2007). In order to nullify anxiety and depression, if the women acquire some agentic orientation i.e., getting the job done, then they become high masculine as well.
(androgynous). This type of perception is required for leading a healthy and constructive life style (Bem, 1975; Monga & Malhotra, 1994; and Prabha, 2008).

Androgyny has been found to be associated with higher self-esteem than masculinity and femininity (Hyde, 1991). Whitley (1985) conducted three meta analyses of 32 studies pertaining to models of gender role orientation to psychological well-being. The androgyny model posited that high degrees of both masculinity and femininity correlate to better life adjustment and lack of depression. Another model, referred to as the masculinity model, posited that a high degree of masculinity and low levels of femininity correlates with better life adjustment and lack of depression. Last, the congruence model posited that adherence to the gender role congruent with one’s gender correlates with better life adjustment and absence of depression. The total number of participants across studies was 4551 women and 2909 men from college settings. The effect size for adjustment was .109 for masculinity and .030 for femininity. The effect size for depression was .072 for masculinity and .006 for femininity with higher scores reflecting less depression. Although, no support was found for the congruence model, the results showed support for the androgyny and masculinity models. Interestingly, femininity was not related to depression at all, but femininity was positively and significantly related to life adjustment. Thus, there was partial support for an association between masculinity and well-being, and it would appear that androgynous and masculine gender role orientations were historically associated with psychologically well-being.

Sharpe & Heppner (1991) provided new informations about relationship among gender role variables and psychological well-being. Gender role conflict was not related to masculinity but it is related to femininity and in addition the gender role conflict was negatively related to almost all of the measures of psychological well-being. The gender role conflict is related to less psychological well-being which may result in low self-esteem and higher degree of anxiety and depression.
Klonoff & Landrine (1992) stated that men who score highly on feminine gender role orientation are more likely to report symptoms of illness.

Sanfilipo (1994) examined the relationship between masculinity, femininity, and subjective experiences of depression. The sample was comprised of 63 men and 77 women in college. The results of the study indicated that gender alone was not related to depression. In fact, greater masculinity and greater femininity were both associated with lower levels of depression. The two factors associated with less depression were self-efficacy, more commonly associated with men, and strong interpersonal relationships, more commonly associated with women. This study highlights the importance of masculine and feminine qualities as contributors to psychological well-being.

Thakur & Mishra (1995) showed a positive relationship between the number of roles a person occupies and various indices of psychological well-being including mental health.

Courtenay (2000) suggested that men show their masculinity and power not only by engaging in health-risking behaviours, but also by not seeking medical help when ill.

Robertson et al. (2001) found that in comparing men who varied on measures of gender role stress (a measures of traditional masculinity), found no differences in physiological arousal in response to stressors, but did find variation in expressed emotions; those high on traditional masculinity had greater difficulty in expressing emotions than those with low levels of masculinity.

In a study Woodhill & Samuels (2003), androgyny, gender role behaviour, and emotional intelligence were measured in 76 students and their parents to examine the extent to which these variables exhibited generational effects or consistencies within families. The strongest correlations in masculine and feminine personality and
behaviour were obtained for mothers and daughters. It was also hypothesized that androgyny would predict higher emotional intelligence, multiple regression supported this hypothesis for students, mothers, and fathers.

In close relationships, a feminine or androgynous gender role may be more desirable because of the expressive nature of close relationships. However, a masculine or androgynous gender role may be more desirable in academic and work settings because of their demands for action and assertiveness. Choi (2004) found that masculine and androgynous individuals had higher expectations for being able to control the outcomes of their academic efforts than feminine or undifferentiated individuals.

Younger et al. (2004) assert that gender identity plays a huge role in the development of individuals. Gender identity plays a large role in psychosocial development and mental health.

The findings (Sajatovic et al., 2005) indicated that persons with schizophrenia experience their gender identity in ways that vary from culturally normative standards. Both men and women scored lower on traditional masculine descriptive measures compared with persons without schizophrenia.

Identity formation has emerged as a significant contributor towards the well-being of adolescent boys and girls. Achieving one’s own identity after passing through a period of exploration and evaluation, on gender’s positive outcomes, lack of commitments to various life tasks, and lack of knowing one’s place in society makes adolescent boys and girls vulnerable to maladaptive life course. Tung & Sandhu (2005) suggest that identity achievement is experienced as a sense of psychological well-being, whose most obvious concomitants are a feelings of being at home in one’s body, and a sense of home in one’s body, and a sense of knowing where one is going. Similarly, Nammalvar & Rao (1983) suggest that an integrated identity may fortify the ego and strengthen its defense to cope with problems. Also identity achievement has been found to be linked to psychological well-being by Goldman et al. (2002) and Berzonsky et al. (2003).
Tung & Sandhu (2005) found that girls who were considering and exploring issues pertaining to occupation, religion, politics, and interpersonal arena had higher positive orientation and mental health. Trying out various roles imparts a sense of confidence to adolescents and keep them focused on the construction of their lives. However, lack of exploration of identity and lesser concern about achieving one’s identity does not indicate well-being in adolescent girls.

Sharma et al. (2009) stated that femininity, masculinity, and androgyny are negatively related to depression and vice-versa. They suggested that low masculinity in women could contribute to depression due to lack of strength of mind and agentic orientation in a working situation and in a male dominated society.

GENDER AND MENTAL HEALTH

Adolescents are important commodity worldwide, the future leaders of their nations who will determine economic and political policies and affect family structure, life styles, and educational programmes. Today however, social, economic, and political conditions in our nation are making it difficult for this age group to develop the skills, they need to take on these tasks in responsible ways.

Adolescence is considered to be a stage in life, highly susceptible for developing serious psychological problems, and identifying and treating adolescents. Psychological disturbances can present around 10 to 20 percent of adult psychiatric disorders.

Adolescence is defined as the period of transition between childhood to adulthood that involves biological, cognitive, and socio-economical changes. A key task of adolescents is preparation for adulthood. indeed, the future of any culture hinges on how effective this preparation is (Larson et al., 2002).

Adolescence is the most vulnerable age for development, when the child once entering in this stage required intensive readjustment in school, social, and family life. While many adolescents experience anxiety, unpleasant or strange feelings.
Gender is a psychological and cultural concept, in contrast to sex, which is a biological term. Sex refers to the physical appearance of the genitals and reproductive organs (gondal sex or sex phenotype) or in some cases the chromosomes (genotype). Sexual dimorphism refers to the division of sex into two classes, male or female. However, some individuals are born with physical intersex conditions. Such as a hermaphrodite whose genitals are ambiguous at birth, so that the person cannot readily be typified as one sex or the other.

The word gender was used primarily to refer to classes of nans in language until psychologist John Money adopted the term in 1955 to refer to sexual attitudes of people. He first introduced the term gender role to discuss whether hermaphrodites socially disclosed themselves as male or female. Some were reared as boys, others as girls. In most cases, their gender role corresponded to their assigned sex of rearing.

Since, the 1970s, the use of the term gender has captured the public imagination in contexts that go far beyond hermaphrodites and transsexualism. Gender has evolved as the term, particularly in feminist usage, to represent the social and cultural characteristics of the sexes as distinct from the biological differences between males and females. Thus, gender is used to imply what is acquired or learned by the sexes, while sex is used to refer to what is thought to be biological and unchangeable. In this framework, sex represents intractable nature, and gender represents malleable nurture. This is a reversal in connotation for the term gender, which Money (1955) has used to describe individuals whose physical sex (or intersex) was hormonally and surgically altered in correspond to their psychological gender status.

Gender refers to everything else associated with one’s sex, including the roles, behaviours, preferences, and other attributes that define what it means to be a male or a female in a given culture. Until research provides unambiguous answers, one can simply assume that many of these attributes are probably learned while others may very well be based in whole or in part on biological determinants. An example of the interaction of
genetics and learning occurs when physical attributes are interpreted as indications of masculinity or femininity. Presumably as the result of learned stereotypes, a muscular build and a deep voice are perceived as attributes of masculinity while long hair and a high voice are perceived as feminine (Aube et al., 1995).

From the evolution of human race the differences between males and females is persisting and will exist till the end of life on earth. Sex difference plays a vital role in all the aspects of human behaviour. Origin and development of gender differences have been explained in various perspectives.

(i) Biological Perspective: Sex differences present in all the organ systems across various mammalian species go far beyond the superficial anatomical characteristics necessary for reproduction. These differences are direct response to the levels of circulating hormones, which differ significantly between the sexes. It is quite obvious that these physiological difference predispose males and females to certain behavioural and aptitude learnings.

It has been argued that females are generally more perceptive and aware of context. Perhaps their more responsive sensory system allows them to monitor their environment more completely and with more discrimination. Such a system would give women an advantage in social interaction. McEwen (1981) explained male’s tendencies to be more reactive and quicker to act and to make decisions. It also explains feminine patience and tolerance of more stimuli without reaction. They might be better able to detect slight facial flushing of peers or spouse, which may indicate anger or other emotional upset. Studies suggest that females are better able to read the emotional content of faces such as anger, sadness, or fear (McLaughlin & Shryer, 1988). These more acute senses may give females a general advantage in social interactions.

The limbic system includes the hypothalamus and amygdala and several other nuclei of the midbrain and lower forebrain. It is the seat of drives and emotions. The thresholds to set off responses in the limbic system differ between males and
females. In males, testosterone stimulates the production of neurotransmitters in the hypothalamic area. This excess of neurotransmitters waiting in readiness in the synaptic areas tends to lower the threshold of response in males, such that less stimulation is required to set off behavioural responses to such things as food, sexual, or threat stimuli. Elevated estrogen in females has the opposite effect inhibiting synaptic firings in the brain region and requiring more sensory and cognitive stimulation in order to elicit the same response (McEwen, 1981). This may explain male tendencies to be more reactive and quicker to act and to make decisions. It may also explain feminine patience and tolerance of more stimuli without reaction.

It has been discovered that the lateral isolation of functions into one hemisphere or the other is more characteristic of males. Women tend to be less lateralized with verbal centers and visual spatial centers in both hemispheres and with much greater communication between the two hemispheres. Women, then, could identify words flashed to either the right or left visual field more often than men. Likewise, they could identify abstract shapes and images relatively well from either visual field (Durden-Smith & Desimone, 1983). This fact is supported by studies of McGlone (1980), and Kimura (1992) also. Another observation that suggests that males are more asymmetrical in their cerebral hemispheres. They have a slightly thicker, larger right hemisphere than left (McGlone, 1980). This is more pronounced early in life, and there is some likelihood that the left hemisphere in males is developmentally retarded by testosterone. Perhaps this helps explain why boys are far more likely to suffer from dyslexia, as well as reading, speaking, and spelling deficiencies in early grades. They are more likely to stutter during early development as a result of a conflict between the right and left hemisphere for control of speech (Durden-Smith & Desimone, 1983), while the left hemisphere begins to catch up during later development in males, even in adulthood brain asymmetry is more likely among males than among females.

It is also found that the bridge of nerve fibers or processes between the two hemispheres known as the corpus callosum is significantly larger and contains more
nerve fibers in females. This difference is found at all ages of females (Christine de 
Lacosta-Utamsing, 1983). They also make connections with more neighboring cells. This fact may explain why there are more nerve fibers or processes through the corpus callosum connecting the two hemispheres in females. The female central nervous system may have more interconnections and more networking of nerve fibers.

It appears from all of the above data that women are generally capable of receiving and meaningfully processing more sensory nerve input. Because nerves interact with more neighboring nerves, they are able to integrate more sensory and stored memory information to derive more complete analysis and assessment of a particular circumstance. A biological argument for the purpose of this ability of females to capture more stimuli would be that in the role of child rearing. There is great advantage in being able to receive and process multiple stimuli in order to monitor multiple children and other social contacts. This kind of simultaneous activity appears to be more difficult for men.

Males, with their more lateralized brains, tend to have thought processing more regionally isolated and discrete, with fewer interconnecting nerve interactions and perhaps more straight forward, quick reaction to important stimuli. It may also be conducive to categorical thinking. It can allow more uninterrupted processing of visual/spatial data in the right hemisphere and computational analysis in the left, which can lead to a slight math advantage in males. The more lateralized male brain would be expected to be more single minded, focused, less distractible, and perhaps less socially aware. This, coupled with the hot-wired limbic system, may increase male’s competitive goal-setting, rule-making, hierarchical approach to social interaction.

Puberty also intensifies the sexual aspects of adolescents’ gender attitudes and behaviour (Galambos, 2004). As their bodies flood with hormones, girls may behave traditionally feminine ways and males in traditionally masculine ways. The increased incorporation of sexuality into adolescents’ gender behaviour may heighten
stereotypical male and female behaviour especially, when they interact with the other sex. Thus, girls might behave in a sensitive, charming, and soft-spoken manner with a boy they would like to date while boys might behave in an assertive, cocky, and forceful way. These variations in their neural and hormonal functions may be affecting their behaviour tendencies responsible for differential level of adjustment in various fields of human life, ultimately, affecting mental health aspects of both the gender groups differentially.

Suggestions have also been made that hormonal factors account for gender differences. Studies examining this hypothesis have not been very supportive (Nolen-Hoeksema & Girgus, 1994; and Brems, 1995). Other biological theories have proposed that among women and men sharing a common genetic diathesis, women are more likely to become depressed and men are more likely to become alcoholic (Davison & Neale, 1996). Research has also addressed the possibility that women are simply more predisposed to depression because of some kind of mutant gene on the X chromosome (of which women have two and men only one). However, research does not support any of these biological hypotheses, leading one to look at social and psychological factors (Carson, et al., 2006).

(ii) Psychological Perspective: Social-learning theory developed by Mischel (1966) and other (Bandura & Walters, 1963; Burn, 1996; and Bandura, 2002) claims that individuals learn to be masculine and feminine (among other things) through observation, experimentation, and responses from others. Children imitate the communication they see on television and in parents, peers and others. At first young children are likely to mimic almost anything. However, people around them will reward only some of children’s behaviours and those which are reinforced tend to be repeated. Thus, social-learning theory suggests that others’ communication teaches boys and girls behaviours which are appropriate for them. Because children prefer rewards to punishments, they are likely to develop gendered patterns of behaviour that others approve.
According to social-learning theory, the young girls tend to be rewarded when they are polite, considerate, quiet, emotionally expressive, and obedient – all qualities associated with femininity. They tend to get fewer positive responses if they are boisterous, independent, unconcerned with other, or competitive – qualities associated with masculinity. As parents and others reinforce in girls what is considered feminine and discourage behaviours and attitudes that are masculine, they shape little girls into femininity. Similarly, as parents communicate approval to boys for behaving in masculine ways and curb them for acting feminine – for instance, for crying they influence little boys to become masculine.

Cognitive-development theory also focuses on how individuals learn from interacting with others to define themselves, including their gender. Unlike social learning theory, however, cognitive-development theory assumes that children play active roles in developing their own identity. Researchers claim that children use others to define themselves because they are motivated by an internal desire to be competent, which in western culture includes knowing how to act feminine or masculine. The foundation of cognitive development theory was established by Piaget (1952), Kohlberg (1958), Gilligan (1982), and Gilligan & Pollock (1988). Researches show that children go through several stages in developing gender identities from birth until about 29 to 30 months (Wadsworth, 1996), they search others’ communication for labels to apply to themselves when they hear others call them a ‘girl’ or ‘boy’ they learn to label themselves accordingly. Then children actively look for same sex models they can imitate (Levy, 1999).

Gilligan et al. (1988) theorized that most females are socialized to value connections with others, to communicate, care, and be responsive and to preserve relationships. Males are more likely to value autonomy and to communicate in ways that preserve their independence from others. Each sex learns what society expects of his or her gender, and decides to act in ways that are consistent with social views of gender.
One psychological theory has proposed that by virtue of their roles in society, women are more prone to experiencing a sense of lack of control over negative life events (Radloff, 1975). Feminist literature would agree (e.g., Chester, 1972; Bernard, 1973) for it blames the greater incidence of mental problems among women on their lack of personal and political power. Feminists take the position that more women than men become depressed because their social roles do not encourage them to feel competent. Maracek (1975) reported that the higher incident rate of depression in women is a response to the powerlessness inherent in the traditional female role, Foder (1974) speculates that stereotyping of women as helpless and dependent, makes them more prone to phobic condition and anxiety. Sex role stereotyping is in fact acquired through socialization practices (Bem, 1975; and Kimberling & Quimette, 2002).

In summary, psychological theories emphasize the power of other’s communication to teach lessons about gender and provide models of how to enact masculinity and femininity. Once gender constancy is established, most children learn and strive to develop communication, goals, attitude, and self-presentation consistent with the gender they consider theirs.

(iii) Cultural Perspective: Symbolic interactionism is a very broad theory which holds that new borns do not enter the world with a sense of self-distinct from the world rather they learn from others how to see themselves. As parents and others interact with children, they literally tell them who they are. A child is described as big or dainty, delicate or tough, active or quite and so on. With each label, others offer a child a self-image and child internalizes others’ view to arrive at his own understanding of who he is. Communication is a central process whereby people gain a sense of who they are, from the moment of birth, they engage in interaction with others’, especially with parents, who tell them who they are, what is appropriate for them and what is acceptable.

Researches have shown that gender is communicated by parents through their responses to children (Chodorow, 1978, 1989; Shapiro, 1990), through play activities
with peers and through teacher’s interaction with student (Sandler, 2004). Learning gender behaviour occurs as others define children by sex and link sex to social expectations of gender.

An important contribution to culture theory of gender is the concept of role specificity, i.e., roles for men and women. Within our culture, one primary way to classify social life is through gender roles. Women are still regarded as care-takers and men as bread-winners. Wood (2001) assert that in most cultures females have lesser power and status than males have, and they control fewer resources. In today’s society scenario has drastically changed with lots of women accepting various career options but the stereotypes still exist.

Not only the roles assigned by the society, but their values are assigned as well within major cultures feminine role remains subordinate to masculine role. Men are still regarded as head of the family even if the wife earns much more than him. Men, more often than women, are seen as leaders and given opportunities to lead. Further, the work that men do is highly regarded by society in comparison to work assigned to women. Society teaches women to accept the role of supporting, caring for, and responding to others’ yet that role is undervalued in society.

A second important dimension of role is that it is internalized. At every young ages, girls understand that they are supposed to be nice, put others’ needs ahead of their own, and be nurturing, whereas, boys understand that they are suppose to take command and assert themselves. As people take culture scripts of gender inside themselves, they learn not only that there are different roles for men and women but also that unequal values are assigned to them. Thus, symbolic interactionism, underlines the fact that gender is socially created and sustained through communication that encourages them to define themselves as gendered and to adopt the roles that society prescribes for them.
An important contribution to the cultural perspective is standpoint theory (Collins, 1986; Harding, 1991, 1998; McClish & Bacon, 2002) which offers insight into how a person’s location within the culture shapes his or her life. Standpoint theory amends symbolic interactionism by noting that the social world consists of very different positions within the hierarchies. We may all understand that our culture attaches different values to different classes and races, but each of us experiences being only in a certain race and class. An individual’s standpoint in a society guides what she or he knows, feels and does and shapes his understanding of social life as a whole.

According to Hegel (1997), there can be no single perspective on social life. Each person sees the society as it appears from the perspective of his or her social group, and every perspective is limited. All views are partial, because each reflects a particular standpoint within a culture stratified by power. A particularly important implication of standpoint theory is that, although all perspectives on social life are limited, some are more limited than others. Those in positions of power have a vested interest in preserving their place in hierarchy, so their views of social life, are more distracted than the views of person who gain little or nothing from existing power relationships. This theory claims that marginalized groups have unique insights of how a society works. Minorities, women, gays and lesbians, people of low socioeconomic status, intersexual and others who are outside of cultural center may see the society from a perspective that is less distorted, less biased, and more layered than those who occupy more central standpoints. Marginalized perspective can inform all of us about how our society works. Dominant groups have freedom not to try to understand the perspective of less privileged groups. They don’t need to learn about others in order to survive. According to this theory, different social groups like women and men develop particular skills, attitudes, way of thinking, and understandings of life as a result of their standpoints.

All of us occupy multiple standpoints that overlap and interact. Thus, it would be incorrect to think that an individual is shaped by a single standpoint. For example
An African-American man’s knowledge and identity are shaped by race, sexual orientation and gender standpoints. Because standpoints interact and affect one another, this man’s masculine identity will be different from that of a European-American man. Thus, no person is determined by single category (Calhoun, 1995).

Thus, cultural perspective broadens our understanding by demonstrating that gender is a set of social expectations and values that are systematically taught to individuals.

(iv) Psycho-Social Perspective: The process through which the individual learns and accepts roles is called socialization. Socialization works by encouraging wanted and discouraging un-wanted behaviour. The sanctions such as family, school, media etc. make it clear to the child what behavioural norms he/she is expected to follow: in fact, sex-role training starts in very early childhood. Parents have been observed to talk, handle, and play differently with boy and girl babies, a practice which continues throughout the childhood. Parents’ interaction with child depends somewhat on the parent-child relationship. A father and mother may relate differently to their little girl or boy. The influence of adult-child relationship usually becomes more definite when the child becomes older. There is a clear difference in the approaches that are followed in their upbringing (for example the kind of toys they are given to play, their clothes and choices of colours for them). During the transition from childhood to adolescence, parents allow boys more independence than girls, and concern about girls’ sexual vulnerability may cause parents to monitor their behaviour more closely and ensure that they are chaperoned families with young adolescence daughters, indicate that they experience more intense conflicts about sex, choice of friends, and curfews than do families with young adolescent sons (Papini & Sebby, 1988).

Our educational system also treats girls and boys differently. For example, in elementary school, boys are five time more likely than girls to receive attention from classroom teachers. Boys receive significantly more praise, criticism, and remedial
help than girls do. They are also more likely to be praised for the intelligence of their work; girls are more about to be commended for their neatness. Even in college classes, male students receive more eye contact from their professors than female students, men are more about to receive extra help from their professors (Epperson, 1988, American Association of University of Women, 1992, and Sadker & Sadker, 1994). Also, according to social role theory, behavioural sex differences spring from the differential social roles inhabited by men and women especially those concerning the division of labour (Eagly et al., 2000). Historically, because of economic, social, and technological pressures, women and men were assigned to labour tasks that were consistent with their physical attributes. Thus, men were more likely to fulfill task that required speed and strength, and the ability to be away from home for extended periods of time. Conversely, because women were primarily responsible for child bearing, they were more likely to fulfill tasks related to home and family. As a result of differential social roles inhabited by men and women, based on division of labour, gender roles concerning expectations about the characteristics and behaviours of men and women developed. Thus, socialization and nurturance, have an important role to play in shaping a person’s behaviour, attitude and perspective in life with respect to one’s gender (Eagly & Diekman, 2003).

Tung & Sandhu (2006) revealed that well-being has significant positive correlations with all dimensions of emotional autonomy in boys’ as well as in the girls’ samples. They suggest that individuation, non-dependency on parents, deidealization of parents and perception of parents as people is not associated with any threat to the well-being of adolescents. Adolescents who have emotionally weaned themselves from their parents also depict higher mental health. Being able to free oneself from excessive emotional dependence on parents accompanies better mental health in adolescent boys and girls.

This is a particular problem for developing countries (Biernat, 1991) due to which they are likely to suffer from shame and poor self-esteem (Kilmartin, 2000).
Apart of it, most adolescents are forced to believe that man should be strong, firm, tough, cool, and detached (Broudy, 2000; and Janz, 2000). Thus, they learn early to high vulnerable emotions such as sensitive, love, joy, and sadness because they believe that such feelings are feminine and imply weakness. Overtime some men become strangers to their own emotional lives (Levalt, 1996). The difficulty with tender emotions has serious consequences. First, suppressed emotions can contribute to stress related disorder and worse, men are less likely than women to seek help from health professionals (Addis & Mahalik, 2003). Second, men’s emotional inexpressiveness can cause problems in their relations with partners and with children and peers also (Rohner & Veneziano, 2001).

Due to the influence of feminist theory and the women’s movement research studies began to document the complex ways in which, sex bias, sex-role, stereotyping, and devaluation of women affect the nature, diagnosis and treatment of mental health problems (Zuckerman, 1979). The last decades have seen increasingly recognition of the pervasiveness and destructive effect of gender inequalities and the stress that differentially affect women by virtue of unusual social status especially in the family roles. Consideration of women’s needs and status, therefore, requires recognition of the impact of the social context on mental health. It is generally agreed that women face mental health problems more frequently. Daver (1995) found that mental illness is higher in women rather than in men, with frequency of occurrence as high as 15 percent as compared to 11 percent among men. Whereas men and women do not differ in severe mental illness at the root of which lie bio-genetic factors. His analysis further suggests that: (1) frequency of mental illness in women is higher in their reproductive years, i.e., between the age of 16 to 40 years, (2) divorced, separated and/or widowed women are more frequently ill than married women, and (3) housewives exhibited symptoms more than employed women. Marriage and family have been identified as important stressors causing mental illness among Indian women. Lack of intimacy with the husband and lack of privacy, death of confiding relationship, long-term social and economic adversity, role strain and overload of role
related functions and domestic and other kinds of violence against women have been identified as important psychological stressors affecting women's psychological well-being. A number of studies have consistently indicated a correlation between life events, stress, and psychological and physical disturbances (Holmes & Rahe, 1967; and Warheit, 1979). The exposure to stress tends to occur differentially for those differentially situated in the social hierarchy as in the case of man and woman. The variance in stress exposure is crucially located in the ongoing conditions of social life and in accumulated traumatic life experiences (Turner et al., 1995).

A person’s ability to make positive self-evaluation, to perceive the reality, to integrate the personality, to sense autonomy, and to have group oriented attitudes and environmental mastery that combines as mental health can not be understood if one looks at it only in terms of women’s psychological characteristics, as deficiency or inability to cope. It certainly seems probable that women are more likely to undergo certain experiences which generate these feelings, that is why women still tend to occupy the subordinate position in relationships with men. It is again women who are more likely to be inhibited from forming strong social bonds outside marital relationship, developing other interests or pursuing occupational achievement outside the home. Employment outside the home as it provides protective affect by alleviating boredom, improving economic circumstances; increasing social contacts, general level of satisfaction and intimacy in relationship, and the amount of emotional support that a woman gets in the family were the important factors promoting mental health. But women in India have and still being denied to make choice concerning their education, career, life style, freedom of movement, and so on. Decision-making is an activity by which a cause of action is consciously chosen from available alternatives, suggestions may be sought from family members in the initial stage, but it is the male members of the family who have the final say. Thus women enjoy less empowerment than man. Empowerment is the opportunity to act independently on one’s own behalf and not at the behest and order of someone else. All these exert a negative influence on women’s mental health.
The women who in general do not find opportunity to act independently on one’s own behalf and suppressed and disregarded by their family members by rejecting their suggestions and decisions are at the risk of development of poor mental health. Thus, empowerment of women emerged as the factor that promotes the mental health of women. An empowered women no more occupies a subordinate position in relationship with man rather she perceives herself as having the ability to control and manipulate her environment, acquired a view of self as competent, successful and able, and consequently may develop high self-esteem which in turn acts as buffer against mental health problems. Thus low empowered women face mental health problems more because they generally do not find sufficient opportunity. For experiences of mastery and have limited opportunity to interact with the environment, women do not evaluate themselves positively, find themselves unable to understand and to share other peoples’ emotions, and depend upon others for the development of their own potentialities, find themselves unable to get along with others and lack of efficiency in meeting situational requirements. So the mental health of women can be promoted by empowering them.

As more and more women enter the work force, they are increasingly exposed not only to the same work environment as men, but also to unique pressure created by multiple roles and conflicting expectations (Nelson & Burke, 2000; and Chang, 2002). It has long been observed that women are about twice as likely to become clinically depressed (to have dysthymia or unipolar depression) as are men. These differences occur in most countries around the world (Nolen-Hoeksema & Girgus, 1994; Wilhelm & Roy, 2003; and Ge & Conger 2003).

Kling et al. (1999) conducted a study to examine gender differences in global self-esteem. Result indicated that male scored higher on standard measure of global self-esteem than females but the difference was small.

Alfered-Liro & Sigelman (1998) found that male college students were better in the transition between secondary and tertiary education in terms of their self-concept.
Male and female students started with same level of self-concept, and female declined over the first 18 months of studies before starting to catch up their male counterparts. Marsh (1990) suggests that it is possible that the female students will exhibit lower levels of self-concept than their male peers.

Adolescence has been considered to be a period of strain and storm (Freud, 1958; and Bloss, 1962). The transition from childhood to adulthood entails dramatic developmental changes with impact upon adolescents’ mental health and their well-being (Offer et al., 1991). Larson & Lampman-Petratis (1989) assert that negative effect increases at this stage and the sensitivity to environmental stressors, like conflict also increases leading to higher levels of distress (Larson & Ham, 1993),

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, 1976; Gupta, 1990; Patterson, 1997; Siu & Watkins, 1997; Reddy, 2002; and Vasucki & Charumurthy, 2004).

Gender differences in response to stressful situation were investigated by Leber et al. (1976) and Baider et al. (1989) who observed that women were more depressed and had shown poorer adjustment than male. In a study of role of psychological variables Baider et al. (1997) noted that on all measures of adjustment women did poorly than men.

In one study, Eisenberg & Lennon (1983) observed that when men and women saw depictions of people in distress, the men showed little emotion but the women expressed feelings of concern for those in distress. Basow (1986) observed that women were more likely to become fearful, passive, hopeless, and “sick”. Similarly, Basow (1986) and Simpson et al. (1997) found that women were more likely to suffer from depression, agoraphobia, simple phobia, obsessive-compulsive disorders and somatization disorders.
Seligman et. al. (1994) reported cases of male and female of eating disorders had dropped by half for women over the decade but had doubled for men.

Several reviews (Hall, 1984; Brody & Hall, 1993; and Feingold, 1994) conclude that women report experiencing more sadness, fear, anxiety, shame, guilt than men. Women not only experience, but also express these negative emotions more than men. Nolen-Hoeksema & Rusting (1999) review studies showing that women express more sadness and fear when presented with negative emotional material.

Haring et al. (1984) concluded that men showed a slight tendency to report higher levels of well-being than women. On the other hand, a meta-analysis by Wood et al. (1989) reported a similar, slight tendency toward more happiness, but for women rather than men.

Diener et al. (1985), and Fujita et al. (1991) found that women report experiencing more happiness and more intense positive emotions than men. While several others have found no differences or some what more happiness among men than women (e.g., Diener, 1984, and Haring et al., 1984). One consistent finding is that women express more positive emotions than men (Nolen-Hoeksema & Rusting, 1999). More women than men report expressing joy, happiness and love to others. Observational studies of women’s nonverbal behaviours affirm the greater expressiveness of women. LeFrance et al. (2003) showed that women smile more frequently than men. Studies of smiling in magazine and newspaper, photos, together with observations of smiling among people in shopping malls and parks, and on city streets all shows that women smile more than men (Halberstadt & Saitta, 1987). Women are also more skillful than men at “reading” nonverbal cues and correctly assessing the emotional states of others (Hall, 1984).

Wierson et al. (1988), Neighbors et. al. (1993), and Levalt (1996) found differential vulnerability for boys and girls through adolescence. Boys exhibited more externalizing problems and less competence than girls during pre-adolescence.
During mid-adolescence girls exhibited more psychosomatic symptoms, and were more likely than boys to experience problems in functioning, and expressed more dissatisfaction with available levels of social support (Broudy, 2000; Janz, 2000; Kilmartin, 2000; and Rohner & Venezaino, 2001).

Anand (1989) divulged that girls appears to possess better mental health, were capable of assessing the realities around them, were in a position to tide over the mental disequilibrium.

Cheng & Puge (1989) found that male tended to have higher self-esteem than the female, leading to enjoy better mental health.

Kristainsen (1989), Miller & Cafasso (1992), and Kohlmann et al. (1997) have reported that females are more health conscious and undertake more health protective behaviour than males.

American Psychological Association (1990) noted that the rate of depression among women were twice that of men and ascribed that difference to the more negative and stressful aspects of women’s lives, including lower incomes and the experiences of bias and physical and sexual abuse. Kessler et al. (1994) observed that alienation, powerlessness, and helplessness played an especially important role in anxiety disorders and depression precisely those disorders experienced most often by women.

A survey of children and young people’s (aged 5-15) mental health find that the proportion of children and adolescents with any mental disorders was greater among boys (11%) than girls (8%) across the age range

Not having a close relationship with a best friend, having less contact with friends and peer rejection increase depressive tendencies in adolescents (Vernberg, 1990). Problems in adolescent romantic relationships can also trigger depression (Davila & Steinberg, 2006).
Harper & Marshall (1991), Lytton & Romney (1991) observed that girls had significantly more problems and lower level of self-esteem than boys. Girls had more problems with interpersonal relationship, personal adjustment, health and family issues. Biernat (1991), and Munni (1994) investigated sex differences in adolescents’, self-concept and adjustment. Results indicated that girls scored higher than that of boys in physical, educational, and intellectual dimensions of self-concept, and also in total self-concept, whereas in social, moral, and temperamental dimensions it is just opposite, i.e., boys scored better than girls (Eagly et al., 2000).

Munford (1994) conducted a study and found no significant gender differences in levels of self-esteem. The majority of studies have found that during adolescents, females report lower self-esteem (Cairns et al., 1990; Martinez & Dukes, 1991; Chubb et al., 1997; and Quatman & Watson, 2001) and greater depressive mood (Marcotte et al., 2002) in comparison to males. Some researcher have also shown that not only do adolescent females report lower self-esteem, but their self-esteem decreases and depressive symptoms increase over time when compared with males (e.g., Robins et al., 2002). Peterson et al. (1991) also indicated also that blind men had more positive and realistic self-concept than blind women. Arora (2002) also found in his study that visually challenged girls are emotionally less stable than boys.

Women are much more likely to experience negative emotions and internalizing disorders such as depression and anxiety than men (Kessler et al., 1994; Nolen-Hoeksema, 1995; and Nolen-Hoeksema & Rusting, 1999). Research reviewed by Nolen-Hoeksema & Rusting (1999) also shows that gender difference in depression and anxiety disorders appear early in life. Among girls, mood disorders typically appear between the ages of 11 and 15. No such early developmental onset is found for boys.

Low Male Gender Identity (MGI) subjects were found to be more warm, extraverted, affected by feelings, submissive, sober, moralistic, overprotected,
shrewd, practical, socially aware, and conservative as compared to high MGI females. High MGI females were more assertive, self-assured, independent minded, talkative, experimental, and expressive (Kurian et al., 1995).

When the “Trait-Meta Mood Scale-48” (TMMS-48) and its version were used (Salovey et al., 2000; and Fernandez-Berrocal et al., 2004), the differences found tend towards women placing grater attention on their emotions than men. In other causes, women were perceived to be more skillful at not only dealing with their emotions but also understanding them, while men were more skillful at controlling impulses and tolerating stress (Fernandez-Berrocal et al., 1999; Thayer et al., 2003; Fernandez-Berrocal et al., 2004; Palomera, 2005; Palomera et al., 2006; and Sanchez et al., 2008).

Boyd et al. (1982) assert that the sex rations for biopolar disorders are about equal, so that being females is not specifically a risk factor for biopolar disorder. But as for as depressive symptoms are concerned they are more common in women than in men. In their review of the epidemiologic data on depression, covering 30 countries over a period of more than 40 years, it was found that with few exceptions, depressions had a high prevalence and consistently more common in women than in men.

The gender and age difference in the relative importance of individual, family, and peer risk factors for adolescent depression were examined by Botsari (2003). Using a multi-sample approach, structural equation modeling was employed to explore the network of relations between scholastic competence, physical appearance, relationships with parents, classmate support, self-esteem, and depression. The result showed that –

- Girls were more vulnerable to depressive symptoms than boys with this gender difference widening during adolescence.
• The effect of relationships with parents on adolescents' psychological adjustment weakened during adolescence being always stronger for girls than for boys.

• Self-esteem had an important mediating function in the adolescent's self-system.

Development of social skills and relationship often differs by gender, starting at an early age (Eisenberg et al., 1991; Benenson, 1996; and Roberts & Strayer, 1996). While girls are more likely to possess greater verbal and empathy related skills, boys are more often assertive regarding their own needs (Lloyd & Smith, 1986; Eisenberg et al., 1987; Litvack-Miller et al., 1997; and Nemeth, 1999). Starting as early as age five females tend to better at peaceful conflict-resolution than males (Miller et al., 1986; Ohbuchi & Yamamoto, 1990). Gire & Carment (1993) also found that females were more likely to negotiate conflicts whereas men were more likely to use threats or force.

Gender is an important aspect for investigation. Generally males are considered to be superior and females as inferior commonly in our culture. Social cognitive theory has been especially important in understanding social influence on gender (Bugental & Gruser, 1996). The females have to bear the discrimination of the majority in every sphere starting from their own family to the society who provide impoverished environment, as a result affect their well-being and overall personality (Bussey & Bandura, 1999). The discrimination and differentiation on the basis of gender is leading to inferiority complexes among the females in both joint as well as nuclear families. In a study (Dona et al., 2002) have reported the superiority of males with regard to self-efficacy as compared to females in various cultures.

Zeman & Garber (1996) showed that girls expressed sadness and affliction more often than boys.

Rothemburg (1997) also noted these differences and found that women scored higher on personal identity, physical, family, and social self-concept and men scored higher on self-satisfaction and moral self-concept.

Saewyc et al. (1999) found that both younger and older girls were significantly more likely than their male age-mates to report a history of sexual abuse, dissatisfaction with weight, a negative body image, more frequent dieting, and an earlier age onset of sexual intercourse. Both younger and older boys were significantly more likely than girls to have a positive body image, to rate themselves as healthier than peers, to report no regular source of health care, to be sexually experienced, and to drink alcohol more often and in greater quantity: a significantly greater proportion of older boys than older girls reported alcohol use before school. No significant gender differences were found for measures of mental health, including suicidal ideation and attempts, however, nearly 1 of 3 older boys and girls reported at least one suicide attempts.

A number of studies found that females have scored higher than males on emotional intelligence dimensions which are positively correlated with mental health (Thingujam & Ram, 2000; Mayer et al., 2002; and Brackett & Mayer, 2003).

Gramer & Imaike (2002) proposed that females are less emotionally stable than males. Budaev (1999) found that females had higher agreeableness and lower emotional stability than males. Gramer & Imaike (2002) also reported that men’s emotions were stable than women.

Brebner (2003) indicated that females tend towards affection and sadness, and males incline to pride. Affection and sadness are categorized negative emotions (low emotional stability); pride is classified low agreeableness (Gomez, 2006). In addition, Wolfradt & Dalbert (2003) found that females tend to neuroticism (low emotional stability). Aleem (2005) reported that male students were more emotionally stable than female students.
Cauffman (2004) examined the relation among gender, social-emotional adjustment, and deviant behaviour among serious juvenile offenders. A sample of 105 adolescent offenders completed questionnaires assessing social-emotional characteristics and self-reported involvement in deviant behaviours. Results indicated significant associations between distress and restraint in predicting deviance, a finding that was invariant across gender. Analysis of four distinct social-emotional profiles found that membership in the reactive group was associated with the greatest amount of deviant behaviour. Results also indicated that not only serious offending girls internalize more than serious offending boys, they appear equally likely to externalize. However, although boys exhibited lesser distress than girls, those boys who reported high rates of deviance may exhibit internalizing and externalizing problems similar to girls.

The results of the meta analysis (Munofo et al., 2004) do not offer any support for a moderating effect of sex on the association of the short allele of the SHTT gene with neuroticism. Anorexia and bulimia are apparently much more prevalent among females than males (Turnbull et al., 1996).

Jakucak et al. (2002), and Addis & Mahalik (2003) found that adolescents gender was not related to their adjustment.

Hay & Ashman (2003) investigated gender differences associated with the development of adolescents’ sense of general self-concept and emotional stability were investigated with 655 adolescents. Relationship with parents were important for male’s emotional stability, but not for females.

Fernandez-Berrocal et al. (2004), Silveri et al. (2004), Pandey & Tripathi (2004), Austin et al. (2005), Bindu & Thomas (2006), Brackett et al. (2005), Harrod & Scheer (2005), Van Rooy et al. (2005), Goldenberg et al. (2006) found that boys were better at regulating emotions in comparison to girls. In some areas women turn out to be more skillful at directing and handling their own and other people’s emotions. It is
interesting to note that there seems to be wide gender disparities with regard to the selection of future career goals. Males generally tend to rate high efficacy belief levels in traditionally male and female occupations (Bandura et al., 2001). In contrast, females tend to have a weaker sense of efficacy to master occupations, traditionally held by males. It shows that girls are less self-sufficient as comparison to boys as a result girls are not comparatively mentally healthy too. Main reason of this type of result is our culture where boys get opportunities of social interaction. Gender differences in mental health and emotional intelligence can be glimpsed from infancy due to differential treatment given to boys and girls in their families and societies. Some authors like Guastello & Guastello (2003) have also forwarded similar possible explanation for gender differences that is due to culture and education.

Noorbala et al. (2004) conducted a mental health survey of the adult population in Iran (N = 35014) using a shorter version of Goldberg’s General Health Questionnaire and a semi-structured clinical interviews. Results indicated that women had a relatively higher risk of mental disorder as compared with men. The risk of mental disorder increased with age.

Ahmadi (2005), Balavand (2005), Omarae (2008), Faghirpour (2009), Hadadi Kohsari (2009), Gujjar et al. (2010), and Tannous & Matar (2010) found that female adolescent students had better mental health than male adolescents.

Archer (2005) stated that gender differences in physical aggression are the clearest and most universal. Everywhere in the world it seems males are more physically aggressive than females. In 20 countries he found that men showed consistently higher levels of physical aggression.

Tung & Dhillon (2006) found greater emotional autonomy in females as compared to the males.

Bindu & Thomas (2006) revealed that the two gender groups differed significantly in the mean scores on the variables and also in their intercorrelations.
Maladjustment was identified as the most important predictor of all the other variables, in the case of male sample. Emotional intelligence played a significant role in determining overall creativity and maladjustment in the female sample.

Chandra & Minkovitz (2006) found that more girls than boys turned to a friend for help for an emotional concern, whereas more boys turned to a family member first. Boys had less mental health knowledge and experience and higher mental health stigma than girls. In adjusted analyses, girls were twice as likely as boys to report willingness to use mental health services.

Alim (2007) found that symptoms of depression, insomnia, worries, anxiety, and headache were more in females as compared to males.

Lukomski (2007) examined gender differences between deaf and hearing students’ perceptions of their social emotional adjustment as they transit to college. Results revealed that deaf females rated themselves significantly higher on worry than deaf males. This gender difference between deaf females and deaf males in the social-emotional domain was not consistent with most previous literatures.

Reddy & Sunitha (2007) found that girls had better mental than boys.

In a study Garaigordobil (2009) examined that male adolescents obtained significantly higher scores in cognitions of acceptance of violence, aggressive conflict solving, aggressive strategies for coping with violence, and negative social behaviours. The pre-post change in most of the factors of socio-emotional development assessed were similar in both sexes.

Joshi et al. (2009) found that boys were found to be more emotionally matured than girls.

Bhatnagar et al. (2010) intended to compare the selected dimensions of mental health (positive self personality, autonomy, group oriented attitudes, environmental mastery) of adolescent boys and girls aging 13-15 years. The results
showed that mental health of adolescents were average. Among all the six dimensions of mental health i.e., positive self-evaluation and autonomy of the boys were better than girls, while group oriented attitudes and environmental mastery were better in girls as compared to the boys. It was concluded that gender and type of education influence the mental health of the adolescents.

Bakker et al. (2010) revealed that relationship losses were more strongly associated with internalizing and externalizing problems in girls than boys.

Dey & Manna (2010) found in their study that there was not significant difference between male and female in regard to their mental health level.

Gupta & Kumar (2010) indicated that emotional intelligence was positively and significantly related with mental health and its dimensions. It was further observed that total mean scores of boys were more than those of girls therefore boys were better than girls with regard to mental health and its dimensions.

Sekine et al. (2010) examined poor physical and mental functioning were more common among women than men and those with disadvantaged work and family results revealed that sex differences in family characteristics contributed more to sex differences in mental functioning than sex differences in work characteristics. Men were able to concentrate on their work with relative freedom from their family task and responsibilities, whereas women felt difficulties in maintaining their work-life balance. Such sex differences in work- and family related stresses may contribute to sex difference in health.

Nejad (2010) in his study male adolescent students of first grade had better mental health than female.

Chen & Jacobson (2011) found that females showed higher levels of substance use in early adolescence, although, males exhibited greater changes overtime and higher levels of use in mid-adolescence and early adulthood.
Needham & Hill (2011) conclude that the female excess in internalizing disorders partially mediates, or explains, the female excess in arthritis, headaches, and gallbladder removal, while the male excess in externalizing disorders partially accounts for the male excess in heart disease and high blood pressure.

Oldehinkel et al. (2011) found that girls showed increases in social uncertainty, depressed mood, and worries while boys showed a decrease in self-criticism.

Schwinn et al. (2010) provided evidence that poorer mental health status was associated with increased substance use. Evidence of a moderating effect of gender on the relationship between mental health and substance use was not significant.

Singh & Singh (2011) found that male senior secondary school students had better mental health than females.

The finding of the study by Singh et al. (2012) showed that male adolescents were more satisfied with their life than female adolescents. Although, some studies reported no significant gender differences in life satisfaction (Ng et al., 2009; Arden-Close et al., 2010; and McDonnell et al., 2010), but it seems that differences in gender specific roles play a vital role to determine the life satisfaction. Females subjected to more heavy sex role constraints than males and must contend with culturally created values in the family, and more vulnerable to social criticism in comparison to males (Sjofn et al., 2010).

**EMOTIONAL INTELLIGENCE TRAINING AND MENTAL HEALTH**

Time have changed. Young people are now 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. Children also spend many more years in school which requires that they shall develop concentration, impulse control, and emotional regulation.
Work settings now require teamwork, participating leadership, informal networking and quality performance. Young people no longer learn a trade for life. They must constantly learn new skills and adapt to changing technology and market demands. The freedom they enjoy to make career and lifestyle decision also requires that they shall plan ahead and actively manage their lives. These all needed self-esteem, initiative, motivation adaptability and self-management, and critical thinking in replacing traditional rote-learning method.

When a child trying to learn is caught up in distressing emotion, the centers for learning are temporarily hampered. The child’s attention become preoccupied with whatever be the source of trouble. The child, then, has much less ability to hear, understand, or remember what a teacher or book is saying. Schools will be most successful in their educational mission only when they integrate effort to promote children’s academic, social, and emotional learning. Researchers have found that social and emotional behaviour in the classroom are linked with positive intellectual outcomes.

Emotional intelligence training is the process through which people learn to recognize and manage emotions, care about others, making good decisions, develop positive relationships, and avoid negative behaviours.

Decades of research on the effects of psychotherapy (Hubble et al., 1999), self-help programme (Kanfer & Goldstein, 1991), cognitive behaviour therapy (Barlow, 1985), training programme (Morrow et al., 1997) and education (Pascarella & Terenzini, 1999; Winter et al., 1981) have shown that people can change behaviour, moods and self-image. While purely cognitive capacities remain relative fixed, emotional competencies can be learned at any point in life with the right effort and motivation. Men and women are equally able to increase their emotional intelligence, no matter when they start. Age offers the maturity advantage. Ballou et al. (1999) carried out a study on student in MBA programme and found that the maximum improvement on skills of emotional competence occurred in those students who were twenty nine years or older, as compared to those students who were under twenty five.
Technical training is easier as compared to developing emotional intelligence. The entire present system of education is geared to developing cognitive skills. Purely cognitive abilities are based in the neocortex, the “thinking brain” with personal and social competencies, additional areas of the brain get involved, mainly the circuitry that runs from the emotional centers i.e., particularly from the amygdala up to the prefrontal lobes which is the brain’s executive center. Learning emotional competencies retunes this circuitry. This emotional learning demands a deep change at the neurological levels both weakening the existing habit and replacing it with better one. Unlearning and learning of a person’s habitual repertoire of thought, feeling, and action occur at the level of brain connections. Edelman (1987) found that as people go on thinking, feeling and acting in particular ways, the neural connections that support this repertoire are strengthened, becoming dominant path-ways for nerve impulses. The connections that are unused become weakened or even lost and those which the people use over and over grow increasingly strong. Given a choice between two alternative responses, the one that has the richer, stronger network of neurons will win out. The more the response occurs, the thicker the neural pathways grow to support it. When habit have been well learned, through countless repetitions, then the underlying neural circuitry becomes the brain default option and people act automatically and spontaneously.

Social and Emotional Education (SEE) involves teaching a core group of cognitive, affective, and behavioural life competencies that promote positive development in the children. SEE optimally occurs within safe and supportive environment and is facilitated through a process of modeling, observation, practice constructive reinforcement and guidance. SEE provides opportunities to use their competencies to achieve a range of positive social and emotional outcomes such as affective interpersonal relationships, academic, career development, responsible citizenship, and emotional-physical well-being. To achieve these outcomes requires a child to become socially and emotionally competent that is, to have the ability to understand, manage, and express the social and emotional aspects of his or her life.
in constructive ways, and to adapt to the complex demands of growth and development (Elias et al., 2003). Indeed, there is a growing consensus of opinion that addressing a child’s social and emotional intelligence is an essential ingredient to a happy and productive life (Gardner, 1983; Goleman, 1995; Mayer & Salovey, 1997; and Sternberg, 1996).

Boyatzis et al. (2000) also found the effectiveness of emotional intelligence programme. Pre and post measures of emotional intelligence in the two samples revealed that emotional competency inventory were approximately 11.1 times higher on an average in post programme for Brazilian sample.

Social and emotional competence is both complex and manifested. It is complex in that it involves the adaptive integration of emotions, cognitions, and behaviours to address critical developmental issues, transitions, and stressors at different points in life. Social and emotional competence is multifaceted in that it encompasses multiple domains of functioning (intrapersonal, interpersonal, academic) within multiple context e.g., home, school, peer group, community. Consequently, fostering social and emotional competence requires intervention strategies toward individual children themselves, the significant people in their lives, and the multiple contexts in which they live.

More young people are engaging in multiple risky behaviours than in earlier times (Dryfoos, 1997). According to Dryfoos (1997) 30% of fourteen to seventeen years olds engage in multiple risky behaviours and are consequently at “high risk” for negative outcomes, 35% engage in one or two risky behaviours are at “medium risk”, and 35 % are currently at “low risk” or “no risk” for future adjustment difficulties. Thus 65% of today’s young people are at medium to high risk of experiencing maladaptive outcomes. In addition, the healthy status of the 35% who are currently “safe” could be compromised if their families, communities or schools fails to continue to foster their healthy development. These statistics provide the evidence that there is need for
integrating social and emotional learning skills into the school curriculum itself. Oliva et al. (2002) studied the influence of relationships with parents and peers on emotional adjustment in a sample of Spanish adolescents. Participants in the study were 221 boys and 292 girls, aged between 13 and 19 years, that filled out instruments about family relationships (Parental style; family adaptability, and cohesion, conflicts and communication), peer attachment, self-esteem, and life satisfaction. Results showed that peer attachment and parental support and affection promote emotional adjustment of boys and girls, especially during middle adolescence. It was suggested that training on this aspect will promote emotional-social adjustment and peer-relationship of adolescents Cauffman (2004) assert that the use of social-emotional measures in general, and distinct profiles in particular, may aid in targeting specific programming and treatment in an effort to provide offenders with more effective interventions.

Hawkins & Catalano (1992) and Solomon et al. (1992) found that nurturing the social and emotional growth of children is expected to increase their capacity to focus academic pursuits, improve overall psychological health and reduce the frequency of behavioural disturbances and delinquent acts. Greenberg et al. (1995) evaluated social competency violence prevention programme and observed considerable improvement and in the management of feelings preventing violence and reducing antisocial behaviour. Krashnow et al. (1994) and Black (1995) have also provided evidence for the beneficial effects of this SCP on elementary school-aged children. Teachers training in improving social skills (including empathy, collaborative problem-solving, responsibility and consideration for others), reported a greater sense of self-worth and improvement over class-room participation and time spent on academics and a reduction in problem behaviours, in their students.

Gardner (1983), Goleman (1995), Sternberg (1996), Mayer & Salovey (1997), Akerjordet & Severinson (2004), Dulewicz & Higgs (2004), and Chan (2004) observed that child's social and emotional “intelligence” is an essential ingredient to happy and productive life. They found the program was very effective. Elias et al. (1997), and
Schutter et al. (1998) have evidenced that well designed effectively implemented comprehensive social-emotional learning program can influence children’s skills better, and remain in school. In addition to enhancing academic performance, the mission of the schools also involves preparing young people to be successful in the multitude of roles they currently face and those that await them in future.

The 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).

Cartwright and Slaski (2003) found emotional intelligence training resulted in increased emotional intelligence and improved health and well being.

Rahim and Minors (2003) found that emotional intelligence training improved the concern for quality problem-solving. Luskin et al. (2003) found that participants who completed the year long emotional competence training decreased 29% stress level over the year of project while their reported positive emotional states increased 24% quality of life; anger and physical vitality measures also demonstrated significantly positive change. Sethi (2006), Bhatpahari (2006), Ajawani & Purohit (2008), Purohit (2008), Ajawani et al. (2009), and Dulhani et al. (2012) have observed that increased emotional intelligence through specific training for enhancing it, certainly brought about a raise in adjustment, altruism, happiness, and academic achievement, peer-relationship, and mental health.

Adibrad (2007) conducted the Stress Inoculation Training (SIT) and Emotional Intelligence Training (EIT) on stress symptoms in married nurses and their coping skills. The results indicated that affective, cognitive and behaviour stress symptoms of both experimental groups (EIT and SIT) were reduced while cognitive symptoms were reduced in IST group more and coping skills were increased in both of the experimental groups. There was a significant difference between experimental and
control groups in reduction of stress symptoms. Finally, there was a significant
difference between emotional intelligence training and control groups in regard to
their total emotional intelligence, emotional self-awareness, stress tolerance,
interpersonal relationship and adjustment.

Slaski & Cart (2003) conducted a research on emotional intelligence training
and its implications for stress, health, and performance and found that emotional
intelligence and mental health could be improved by training.

Zeins et al. (2004) found that social-emotional learning programme improved
students attitudes and behaviour leading to better mental health.

Kerr et al. (2004) found a link between alexithymia and college adjustment. They suggested that interventions aimed at encouraging awareness and discussion of emotions might improve academic and emotional well-being for students making transition to college.

Adeyemo (2005) observed that there was a significant relationship between
emotional intelligence and mental health. He suggested for some emotional
intelligence based counseling intervention programme to mitigate the transition trauma of pupils moving from primary to secondary school.

Geraghty (2006) observed negative relationship between emotional
intelligence and stress level. It also was found that emotional intelligence training reduced stress level and negative consequences associated with high level of stress.

Dearing (2007) found that through emotional intelligence training people enhanced empathy essential for better mental health.

Nelis et al. (2009, 2011) asserted that participants in the emotional intelligence training group reported a significant improvement of their physical health, mental health, happiness, life satisfaction, and global social functioning.
Gupta & Kumar (2010) underline the importance of training in emotional intelligence and mental health for female college students.

Purohit and Ajawani (2010) intended to study the impact of emotional intelligence training on adjustment of emotionally low intelligence male and female adolescents. They found that emotional intelligence training positively enhanced adjustment of students.

Di Fabio & Kenny (2011) reported identical positive findings of an emotional intelligence intervention on different psychological characteristics. This study assessed the efficacy of a training programme focused on emotional intelligence among Italian high school students.

On the basis of findings of his study Pittman (2012) concluded that teens who received emotional intelligence training in school had improved scores on several measures of emotional well-being, including less anxiety, depression, and social stress, improvements from the training lasted up to six months after the programme ended.

Franchi (2012) concluded that training teens on how to handle their emotions strengthened their mental health. As a result, they suffered less of mental disorders such as anxiety, depression, and social stress. Ruiz-Aranda et al. (2012) conducted 24 training sessions (each lasted for an hour) involving around 300 Spanish students. The purpose of the training was to improve their emotional intelligence. During the study, teens participated in various activities such as arts, open discussions, games, and role plays which designed to measure their ability to handle emotions and build empathy on solving emotional problems. Six months later, the researchers conducted series of tests to determine the effect of the said training. They found out that those who went through it had lower measures of social stress, depression, and other negative feelings as compared to those who didn’t.
PROMOTION OF SOUND MENTAL HEALTH

People with sound mental health try to understand themselves and their problems without fighting with them. Then they try to solve their problems by keeping their subjective feelings and emotions under control and giving due consideration to the requirements of reality and prevailing value and norms.

Participative management, democratic leadership, social security, welfare measures, safety devices, conducive working conditions, suitable conditions of work, opportunities for meditation, regular exercise within the organizational premises etc., positively contribute to the promotion of mental health.

Promotion of sound mental health require the adoption of a wide variety of measures in different walks of life and a multi-pronged but integrated strategy. Right kind of public policy coupled with suitable mental health legislation, provision of suitable nutrition, drinking water, education, medical and health services, housing, and economically gainful work and opportunities for participation in decision-making relating to matter that directly confront them are essential for promotion of sound mental health of people in this country. Though the National Health Policy and the Mental Health Act, 1987 do exist in the country and a number of health programmes including those dealing with community health and psychiatric treatment have been organized from time to time, the overall situation is not very encouraging. Though there has definitely been a quantitative increase in the care and protection of people suffering from mental ailments yet the quality of services rendered has been far from satisfactory and whatever we have achieved in the area of protection and promotion of mental health in India is just like a drop in the ocean. A large number of factors and forces such as lack of basic infrastructure, social stigma attached to mental ailment, inadequacy of clinical services for the mentally ill, non-availability of essential drugs and counseling, psychotherapy, occupational therapy and support services as also trained manpower, and above all, severe lack of awareness on the part of mental
health and absence of their active participation in the mental health programmes coupled with lack of determined political will may be held accountable for this sad state of affairs (Punnuswami, 2000, 173-177).

For improving mental health of people in this country it is being suggested that mental health care must be made integral part of general health care; necessary awareness regarding mental health should be created by organizing special camps; support, counseling, occupational therapy and psycho-therapy services should be made available by establishing special centers within easy approach of people; manpower engaged in providing mental health services should be trained by organizing special training courses, particularly in promotion of mental health, through civil society organizations; and community participation should be increased by involving people at the grass-root level in decision-making relating to mental health programme and services (Singh, 2002).

India has a rich, centuries old heritage of medical and health sciences. The philosophy of Ayurveda and the surgical skills enunciated by Charaka and Shushruta bear testimony to our ancient tradition in the scientific health care of our people. Under such prevailing condition there is dire need to adopt and incorporate this cost effective and easily approachable Indian philosophy in promoting mental health of our younger generation. The mental health being as relevant and important variable has not been studied extensively, particularly in Indian setting. So the high mental disorders and behavioural problems among children pose formidable challenge before the family, school and child care professionals to put forth some strategies for promoting mental health of young children in the context of Indian philosophy.

Strategic health management is a kind of thinking and planning both at preventive and curative levels so that one may adopt good life styles and skills for feeling wellness, happiness and to be healthy without any disease or symptoms or complications of physical ailments and mental problems. In Indian context the ideal state of wellness or
being healthy is always comprised of the physical, social, mental and spiritual aspects and integrated development of one’s complete personality. But now, it is broadly considered that health is a sense of optimum well-being, a state of physical, mental, social, emotional, spiritual wellness which is gained by self-responsibility through reducing exposure to unhealthy risks and for maximizing the good nutrition and physical exercises and competently managing oneself (Raina, 2004).

Below are given some strategies which should be adopted by anyone or everyone for better mental health:

(1) **Understanding the own problems** – People with sound mental health try to understand themselves and their problems without fighting with them. Then they try to solve their problems by keeping their subjective feelings and emotions under control and giving due consideration to the requirements of reality and prevailing values and norms. Participative management, democratic leadership, social security, welfare measures, safety devices, conducive working conditions, suitable opportunities for meditation and regular exercises positively contribute to the promotion of mental health (Raina, 2004).

(2) **Making it as integral part of general health** – For improving mental health of people in this country it is being suggested that mental health must be made as integral part of general health care. Necessary awareness regarding mental health should be created by organizing special camps, support, counseling, occupational therapy and psycho-therapy services should be made available by establishing special centers within easy approach of people, Manpower engaged in providing mental health services should be trained by organizing special training courses particularly in promotion of mental health, through civil society organizations and community participation should be increased by involving people at the grass-root level in decision-making relating to mental health programmes and services (Singh, 2002).
(3) Developing attitude towards mental health care – While dealing with the problems of mental health and care one has to examine the individual in a broader biological, psychological, economic, political, educational and socio-cultural perspective. Mental health care is the demand of the complex and computerized society likely to appear in and around the 21st century. The psychologists, social workers or therapists can contribute much towards the early detection of the problems of adjustment in different walks of life and make an unhappy man a happy one, and a happy to be a happier one and a happier to be one of the happiest. More and more stress is to be given on the preventive side and unfolding of various capabilities and creativity by controlling conflicting and anxiety-provoking thoughts and actions (Hussain, 2007).

(4) Awareness and promotion of mental health programmes – Mental well-being like physical health is a resource we need to promote and protect. Mental health promotion involves any action to enhance the mental well-being of individuals, families, organizations and communities. It is important to recognize that everyone has mental health needs, whether or not they have diagnosis of mental illness. Mental health promotion programmes that target the whole community will include and benefit people with mental health problems (Ahuja, 2005).

(5) Analysing the extended self and mindfulness – One should have the ability to analyse his extended self. He must recognize his plus points, accept limitations, should feel comfortable and peaceful within himself, to set reasonable goals for himself and have the ability to take his own decisions. He should have the ability to manage himself by analyzing his self concept, self esteem and self actualization. He, as a person, is the part of the society he should have the healthy interpersonal relationship, creating harmony with the other members of the society. He should be aware of other’s potentialities, to understand his social responsibilities and solve the problems of community as a whole. The tragedy with most of people is that they have blown-up egos. So not only they fail to see and recognize themselves, they also miss
the good things in others. The beast in people takes over and they tend to see the negative aspects of things around them. They cease to function as lively, loving and caring human beings, because of the absence of mindfulness (concentration and dedication). History tells that those who worked with mindfulness could achieve any target: Mindfulness gives serenity to restless mind, food for spiritual growth and leads to the overall flowering of the personality. Fearlessness and detachment become the hallmarks of one’s character. To a mindful person, however, who is serene and strong that nothing can really hurt him, the “obstacles and the iron gates disappear” as he goes ahead with determination. Thus, mindfulness is a powerful tool to create a world that is beautiful and strong and yet full of people without inflected egos. That is why the Buddha stressed that self-knowledge is true knowledge and the path of peace (Wangchuk, 2006).

(6) Maintaining healthy social relationship – People can keep good mental health if they value their relationship meaningfully, welcome others for cordial and friendly interactions, being good to others as it does not cost anything, being appreciate of others, help others as much as possible, live collectively and in group because it has strength and power and will feel secure and safe. It helps to look the other persons in totality from different perspectives or see the holistic picture of man. People’s communication must also be authentic, transparent and logical, face the changing realities of the world and create more opportunities in adversity (Sinha, 2007).

(7) Using desirable life skills – Life skills are essentially those abilities that help in promoting mental well-being and competence in people as they face the realities of life. Both WHO and UNICEF agree that life skills are generally applied in various aspects of life such as in the context of human relationships, learning about social influences on behaviour and to know the rights and responsibilities particularly in the context of mental health problems. Further, they can also be utilized in many content areas or issues like prevention of drug abuse, sexual violence, pregnancy, HIV/AIDS and suicidal tendency. WHO, UNESCO, and UNICEF all listed the ten life skills which
are very important to keep anyone mentally healthy. These skills are – problem-solving skill, critical thinking skill, creative thinking skill, decision-making skill, interpersonal relationship skill, communication skill, negotiation skill, self-awareness skill, empathy or sympathetic feelings with others and coping with stress and emotions. With these life skills one is able to explore alternatives, weigh pros and cons and make rational decisions in solving each problem or issue that arises, able to establish cordial interpersonal relationship with others. Therefore, life skills make people’s perception according to the realities of life, making their self-esteem strong and prevent them with many behavioural problems and mental disorders. In order to build life skills among people, workshops, training programmes, group participation camps, sessions to parents, counselor’s training be organized from time to time.

(8) Managing tension and stress – Stress may bring bad appetite, tiresomeness and fatigue, reduces sexual potential, sleeplessness, lack of concentration, wrong decision making, suspicious feeling, irritation, aggressiveness and disturb the total life with all-round maladjustment. Therefore, for keeping mentally balanced and healthy, it should be managed by regular physical exercise, keeping the simplicity, having sufficient sleep, keeping realistic expectations, living in the present and plan for the future, developing a good support system, having positive attitude, by learning the art of reforming, being flexible and adjusting in all situations, giving some time for relaxation, faith in the Almighty and be practical and considerate from other’s viewpoint also (Bhargava, 2007).

(9) Developing “sattva guna” (‘good acharan’) – In Sankhya theory and recently a research has been conducted on relationship among Triguna – ‘Sattava’, ‘Rajas’ and ‘Tamas’ guna with psychological well-being by Rastogi (2005) and it was found that ‘Sattva’ was positively significantly correlated with all seven constructs of psychological well-being – self-acceptance, good relationship with others, autonomy, environmental mastery, purpose in life, personal growth and life satisfaction whereas all were found negatively correlated with ‘Tamas’ guna. The relationship of ‘Rajas’
with these constructs vacillate from negative to positive. Therefore, Vedas and Upanishads offer a path of human life through which virtues and joys of human life can be attained in true sense. Lord Shri Krishna’s preaching given to Arjun in Geeta presents a philosophy of life through which complex knots of life can be dissolved and men may have a healthy mental life if he submits himself to the Almighty power.

(10) Managing emotions in realistic perspective – Emotions play an important role in life. Hence, one should develop the positive emotions like love, compassion, tender feeling, affection, enjoyment, affiliation, sympathy, cooperation so that social support system may be strengthened. If people are secured emotionally and supported, many of their life problems will be solved and they will develop a strong personality with enthusiasm and entrepreneurship. Emotional competency, stability and maturity are very essential for leading a good life. People should, however, manage their emotions in realistic perspective.

(11) Psychological understanding and wellness – The psychological health strategy tends that one should carefully understand oneself, about his capacities, abilities, potentialities, limitations, realistic situations, surroundings and he should act and plan his behavioural manifestations in accordance with the realistic situations of his life, only then the person will feel himself psychologically well and socially adjusted. He should have the clear cognitive vision and integrated development of personality to avoid stress, strains, tension, frustrations and overcome the obstacles in the life. Feeling wellness can only be achieved when people think to evaluate and manage themselves with concentration and avoiding the false achievements in life. If psychological well-being is experienced in life it will be the base of total wellness (Raina, 2004).

(12) Working for social support – Social support is an important resource in maintaining mental health and well-being, as it gives one a feeling of being loved, cared for, esteemed, valued, and belonging to a network of communication and
mental belongingness. People are emotionally, socially, and sometimes financially and physically dependent on others. Supportive relationships like having close friends and involvement in a supportive network contributes to the sense of security, positive evaluations of life experiences, personal worth and competence, which in turn enhances the mental health (Singh, 2005). It also enhances the prospects for recovery among people who are already ill (Wallston et al., 1983).

Supportive interactions and the presence of supportive relationships in people’s lives play a major role in their emotional well-being and physical health (Latha, 1998; Sharma, 1999; and Dalal, 2001). Social support reduces the adverse effects of stress, individuals with more support in the context of stressful experiences may be less likely to engage in health damaging behaviour (Malhotra et al., 1999).

Most researches in this area have shown that social support enhances physiological and mental health or adjustment (Cohen & Wills, 1985; Yarcheski et al., 1992; and Thakur & Mishra, 1999).

(13) Enhancing spirituality & religiosity – There is a strong need to develop spirituality for holistic well-being, for refinement of mind, for search of soul purification of thinking and detaching the person from materialistic world only then he can imagine for better mental health. One should also include the desired life values – love, peace, non-violence, truth, use of various mental faculties and abilities, creativity components, positive emotionality, and rationality. Only then self actualization can be realized (Bhargava, 2005).

Spiritual resources are likely to play an important role in intervention programmes. Spiritual people surrender the uncontrollable into the hands of some transcendent power thus by accepting the human limitations they generate a sense of security and peace. Spirituality also helps the person to find meaning in the event and an enhanced identity. This is because the people connect themselves to the eternity and some higher power.
Empirical evidence shows that religious beliefs decrease level of pain, anxiety, hostility, social isolation, and increase life satisfaction (Jenkins & Paragament, 1995).

Hirshberg (1955, 1956), and Kothari (1994) commented that religious attitudes and understanding help in healthy emotional growth of children. In a good number of studies the link between spirituality and better mental health (Ellison & Levin, 1998; Levin & Chatters, 1998; and Matthews et al., 1998) has been observed.

(14) Working on exercise and aerobic - Aerobic exercise can improve self-esteem, lessen anxiety, and relieve depression. Exercise can act as a form of meditation, changing the state of consciousness and providing a distraction from stressful situations. Many doctors believe that exercise improves mental health.

It has been found to improve self-concept, alleviate feeling of depression and reduce anxiety (Dubbert, 1992). Mood may also improve as exercise affects self-efficacy, enhances confidence, inability to perform behaviour such as running a mile or completing aerobics work etc. (Rodin & Plante, 1989).

(15) Playing music - Music is a universal language. It is a medium for communication which has both a pleasant and a healing affect. It helps in improving peace, health, and also listening to music controls negative aspects of personality. It is found to be one of the most effective ways of controlling emotions, blood-pressure and helps restoring the healthy functioning of individuals lives (Menon, 2005). Music is an efficacious and valid treatment for persons who have psychological, affective, cognitive, and communicative problems. The effects of music are like the effects of meditation that promotes awareness, resulting in the inner controls and increased alpha activity. According to “Shamnism”, diseases are developed due to the imbalance in the rhythm of body and mind (Asha, 1991). Music creates perceptible changes in the brain and restores balance. Pinto (1994) holds that melodies induce a feeling of well-being which translates into regularized cardiac function, lowered blood-pressure, and the appearance of alpha and theta wave frequencies in the EEG.
Music has therapeutic and prophylactic roles. It sedates like tranquilizers, it is pain reliever and cathartic and is also a mode of self-expression. It is boredom reducer and tension releaser (Rama Krishnan, 1990). Music is not a conditioning technique. It affects the total being of the human personality including cortex and the hypothalamus. Persons who do not get conditioned easily may respond more to this techniques (Sharma, 2003).

(16) Dancing - A number of researchers have reported that dance is a mental health promoter (McFee, 1992; McRobbie, 1997; Carter, 2004; and Vaghela, 2011). Singh (2002) also noted that with more and more practice a dancers learns to be more relaxed and learn to make movement less jerky. Badrinathan (2002) holds that the basic postures of dance bring confidence. Carter (2004) in his study showed that dance allows optimum intermingling of thinking, feeling, and acting that leads to growth and autonomy. Quinn et al. (2007) in their study showed that creative dance increase the physical and psychological well-being.

(17) Enjoying life - The ability to enjoy life is essential to good mental health. The practice of mindfulness meditation is one way to cultivate the ability to enjoy the present. People need to plan for the future at times; and they also need to learn from the past. Too often they make themselves miserable in the present by worrying about the future. The life metaphors are important factors that allow us to enjoy life

(18) Developing resilience - The ability to bounce back from adversity has been referred to as "resilience." It has been long known that some people handle stress better than others. The characteristic of "resilience" is shared by those who cope well with stress. Being emotionally and mentally healthy doesn’t mean never going through bad times or experiencing emotional problems. All individuals may go through disappointments, loss, and change. And while these are normal parts of life, they can still cause sadness, anxiety, and stress.
The difference is that people with good emotional health have an ability to bounce back from adversity, trauma, and stress. This ability is called resilience. People who are emotionally and mentally healthy have the tools for coping with difficult situations and maintaining a positive outlook. They remain focused, flexible, and creative in bad times as well as good.

One of the key factors in resilience is the ability to balance one’s emotions. The capacity to recognize emotions and express them appropriately helps an individual avoid getting stuck in depression, anxiety, or other negative mood states.

Resilience involves maintaining flexibility and balance in an individual’s life as he deals with stressful circumstances and traumatic events. This happens in several ways, including:

- Letting himself experience strong emotions, and also realizing when he may need to avoid experiencing them at times in order to continue functioning.
- Stepping forward and taking action to deal with his problems and meet the demands of daily living, and also stepping back to rest and reenergize himself.
- Spending time with loved ones to gain support and encouragement, and also nurturing himself.
- Relying on others, and also relying on himself

(19) Maintaining balance - Balance in life seems to result in greater mental health. People need to balance time spent socially with time spent alone, for example. Those who spend all of their time alone may get labeled as "loners," and they may lose many of their social skills. Extreme social isolation may even result in a split with reality. Those who ignore the need for some solitary times also risk such a split. Balancing these two needs seems to be the key - although people balance these differently. Other areas where balance seems to be important include the balance between work and play, the balance between sleep and wakefulness, the balance between rest and exercise, and even the balance between time spent indoors and time spent outdoors.
(20) **Applying flexibility** – There are people who hold very rigid opinions. No amount of discussion can change their views. Such people often set themselves up for added stress by the rigid expectations that they hold. Working on making one’s expectations more flexible can improve an individual’s mental health. Emotional flexibility may be just as important as cognitive flexibility. Mentally healthy people experience a range of emotions and allow themselves to express these feelings. Some people shut off certain feelings, finding them to be unacceptable. This emotional rigidity may result in other mental health problems.

(21) **Holding boundaries** – Parents and professionals can help to promote positive mental health in young people simply by communicating the limits of appropriate rules and boundaries and the risks of breaking them. Parents and professionals can play a major role in promoting positive mental health amongst children. Such promotion starts with the basics of maintaining boundaries and follows by knowing how to communicate effectively.

(22) **Maintaining communication** – Without speaking or telling how a person feels, he can communicate how he is feeling through his behaviour and body language. In fact 54% of all communication is non-verbal, only 7% is verbal. How one says something can also communicate what he may be feeling – the tone of voice a person uses when he speaks can relay how he may feel. Even though one may not actually by telling someone ‘I feel angry’ ‘I feel excited’ – the anger and excitement can often be heard from the way he speaks. Body language, behaviour, tone of voice and what someone actually says and doesn’t say are primarily what mental health professionals, such as therapists and counselors, listen and look out for – they use total communication. Children and young people may find it difficult to let others know how they may be feeling – they may not have the words or feel able to express themselves verbally. This is why some therapist use art, play, drama, and music when working with young people. However, parents and professionals can look at what a young person is communicating through their body language and behaviour, and listen to their tone of voice, to establish how they may be feeling at any given time.
Practicing yoga – Yoga, in Ayurveda, means UNION and is a traditional system of healing the mind and body. It is the union between a person’s own consciousness and the universal consciousness. Taking into account the interrelationship between body and mind, yoga is a method of learning that aims to attain the unity of mind, body and spirit through these yoga structure: Yam-Niyam, Asan, Breathing (Pranayam) and Meditation. Yoga is designed to put pressure on the glandular systems of the body, thereby increasing its efficiency and total health. The two systems prepare the body and mind for meditation to achieve a quiet mind and relieve stress. By practicing yoga, reduction of nervousness, irritability, confusion, depression and mental fatigue are possible. The positive side of benefit from yoga is renewal of mental alertness. Avoidance of fear, acceptance of faith in life, reduction of annoyance with others, quickens sense of duty and responsibility as human beings (Chaturvedi et al., 2006).

According to Indian culture, while developing body and mind, the goal of self-development has to be achieved. Through the coordination of disease free body, purity and concentration of mind is expected. The act of achieving this coordination is called yoga. It teaches people how to lead a peaceful and happy life. Since education starts in the childhood, it is necessary to find out how yoga can be introduced for promoting mental health of young children at early childhood stage. Yoga is not the physical exercises. It is a practical branch of Indian lifestyle which has eight arms. They are ‘Yama’, ‘Niyama’, ‘Asana’, ‘Pranayama’, ‘Pratyahara’, ‘Dharana’, ‘Dhyana’ and ‘Samadhi’. Yoga is practical branch of development process, which is capable of solving many problems of the children particularly the student community, and can be helpful in their overall development. Some fundamental changes are required in the present education system so that mental health of the young children could be promoted. Yoga education can help any student in confidence building, health management, intellectual refinement, skill perfection and character building, finally promotion of mental health of children.
With increasing pollution of environment and mind, corrupt unhealthy social practices and declining moral values and mental health, the need of the day is to introduce yogic education at every level of life. To begin with young children can be a nice model. It is needless to say that sound mind resides healthy body. In developing personality of student in harmony with own cultural values and social ethic, yoga education plays an important role. Life is full of ups and downs and change is a part of life, which in most of the cases, is unpalatable and unacceptable even if it is positive. Yoga teaches a person to lead a positive life. A student passes through different phases of life, faces difficult situations and tries to search for solutions to his/her problems elsewhere although his/her yoga experience can solve those problems within no time. To overcome such typical disturbing situations and for overall healthy (mental and physical) development of body and mind yoga has to be taught from the early stage of childhood. Gradual introduction of all these techniques in the life of young ones will certainly enhance mental health of young children.

Sharma (1994) explored the effects of selected yogic practices on mental health. She found that some selected breathing and concentrating exercise have highly positive effects on the maintenance of a sound mental health.

Nagendra & Nagarathna (1985) reported the positive effects of yoga on somatoform and psychosomatic disorder. Yoga alleviates mental tensions, stress, and strain, physical fatigue and stimulates the entire nervous system. ‘Shavasana’, a yogic exercise for relaxation was found to be very effective for reducing depression among university students (Kumar & Sarabjit, 1990). In a study (Ahuja, 1996) different yogasanas were performed on ninety mentally retired children which proved beneficial for improving their cognitive, social, and communication abilities and also for motor performance.

A number of studies have reported that a life style that includes yoga benefits patients of chronic diseases. It has been reported that hypertension, anxiety,
psychoneurotic symptoms are cured by yoga practices (Kocher, 1972 and Naug, 1975). Akhilanand (1952), and Swami Satyananda & Swami Satyasangananda (1984) have focused on how the mental health can be managed with yogic practices. Datey et al. (1969), Deshmukh (1971), and Goyeche (1979) have also reported similar findings in the area of stress reduction, managing psychoneurotic, psychotic, and psychosomatic disorders. All the above stated studies have been cited by Bhushan (1996). Sohi (1986) showed the effect of yoga practice on anxiety levels of university students. The subjects as a group experienced a significant reduction in their anxiety level after 15 week yogic practice.

Jacobson (1929) stated that relaxation techniques could be effective for changing anxiety states. Udupa (1988) found a complete relief from several physical and mental disorders as a result of yoga. Vinod, (1991) concluded that the yogic practices like meditation, ‘yogasana’, and relaxation can reduce anxiety level by about 28%. Aminabhavi (1996) found that yoga training helped to develop positive attitude and enhanced mental health of subjects.

(24) Practicing meditation – Meditation is a state of extended reflection. The principle of meditation is to concentrate the mind on thought, vision, and knowledge. To meditate means self-observation. It has been revealed that meditation plays a significant role in the mental health and management of psychological disorders. Subjects practicing meditation were found to be calm, cheerful, considerable, and courteous in their dealings (Singh, 2004).

In last few years a considerable amount of research has appeared on different techniques of meditation to offer hope for the solution to the difficult problems. Transcendental meditation, ‘vipsyana’ meditation, ‘preksha’ meditation, ‘yoga ‘mindra’, and ‘shavasana’ are among these techniques which claim to offer the solution of the mental problems. Meditation is a component of yoga and is deliberate practice of altering consciousness in an effort to achieve the step of tranquility, relaxation, and inner peace.
Scientific researches on different mediation techniques have demonstrated a wide range of psychological and physiological benefits.

Winquest (1969), and Wallace (1970) found reduction in anxiety, drug abuse, and alcoholic consumption due to T.M. practice. Orme-Johnosn et al. (1971) found significant positive changes in personality variables of prisoners. Cunningham & Koch (1973) found a reduction in anxiety and increase in positive behaviour in prisoners. Gaur et al., (1985) found positive effect of T.M. on mental health of prisoners.

Like some other techniques of meditation, ‘yoga nindra’ has also been effective and useful in providing mental relaxation and preventing or managing disorders and symptoms of negative mental health (Bhushan & Sinha, 2002; and Bhushan, 2003).

Meditation has been found to be helpful in the enhancement of general well-being. Besides enhancement of well-being, meditation based intervention have been useful in the treatment of anxiety, addictions, pain management, and also as a supplement to psychotherapy (Kristeller & Hallett, 1999).

Meditation is a scientific technique to elicit relaxation response to transform life-style. Hence, it plays a significant role in the management of positive mental health. Balinet (1970), Eccles (1970), and Aurobindo (1985) claims that meditation is useful to everyone in all situations. It helps to overcome anxiety and strain. Its practice lowers the overactivity of sympathetic nervous system. As over function of sympathetic nervous system is reduced, one is able to maintain mental health.

A common question that is posed by children and parents alike is how to equip oneself to face the challenges of life and maintain positive mental health. A manual has been prepared that gives tips to deal with the stresses of daily life and maintain positive health (Malhotra & Kohli, 2005). The life skills covered under these are:
- Anger management
- Over coming feelings of anxiety and stress
- Relieving tension
- Inter-personal relationships and conflict resolution
- Enhancing communication skills
- Effective study habits
- Positive thinking
- Heterosexual relationships
- Handling adolescence

A thought over these suggestions can help an individual to adopt any or many of these to achieve positive mental health. Think good and feel good is the motto.

Evaluating all these strategies discussed above to promote mental health, it is reasonable to believe that emotional intelligence training may be a vital intervention programme which not only can prevent mental illness but also a vital force to enhance mental health of people of all ages.

Emotional intelligence training is the process through which people 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 & Cart (2003) found the effectiveness of emotional intelligence training programme in improving mental health. Gardner (1983), Golman (1995), Stenberg (1996), Mayer & Salovey (1997), Chan (2004), Akerjordet & Severinsson (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.

Sethi (2006), Bhatpahari (2006), Ajawani & Purohit (2008), Ajawani et al. (2009), Purohit & Ajawani (2010), and Dulhani et al. (2012) 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).

Gupta & Kumar (2010) underline the importance of emotional intelligence training and mental health for female college students.

Geraghty (2006) observed negative relationship between emotional intelligence and stress level. It was also found that emotional intelligence training reduced stress level and negative consequences associated with high levels of stress.

Nelis et al. (2009, 2011) assert that participants in the emotional intelligence training group reported a significant improvement of their physical health, mental health, happiness, life-satisfaction and global social functioning.

Di Fabio & Kenny (2011) reported identical positive findings of an emotional intelligence intervention on different psychological characteristics. This study assessed the efficacy of a training programme focused on emotional intelligence among Italian high school students.

Pittman (2012) revealed that teens who received emotional intelligence training in school had improved scores on several measures of emotional well-being, including less anxiety, depression and social stress.