CHAPTER 2
THEORETICAL CONCEPTS & FRAMEWORKS

SELF ESTEEM

Branden (1969) described self-esteem as the experience of being competent to cope with basic challenges of life and being worthy of happiness. He further explained that self-esteem is the feeling that we are appropriate to life and to the requirements of life. Self-esteem refers to an individual’s sense of his or her value, worth, or the extent to which one appreciates, prizes, or likes him or herself (Blascovich and Tomaka, 1991).

Szymanski, Kashubeck and Meyer (2008a) indicated that people who are aware that they are viewed negatively in society because of their sexual orientation will incorporate those negative attitudes into their self-concept, which in turn, lowers their self-esteem.

Hewitt (2002) suggested that self-esteem respects the feeling of individualism and it should be studied by keeping in mind its historical and cultural context. Aspinwall and Taylor (1992) mentioned that self-esteem reflects positivity and optimism in our response while low self-esteem represent negative thinking about people surrounding us. Bednar and Peterson (1995) stated that self-esteem involves acceptance of our duties and right towards humanity and our desire to fulfill interest of our society.

Sullivan (1953) explained that our self-system is basically characterized by self-evaluations which describe it as ‘good me,’ ‘bad me’ and ‘not me’. Horney (1942) mentioned that the way we respect ourselves and are respected by others develops the feeling of self-esteem as well as self-alienation. Various factors such as respect a person receives from others, success a person experiences in his life, evaluation of one’s experience and our reaction to these evaluations determine our self-esteem (Coopersmith, 1967).

Theoretical perspectives
Rosenberg Self Esteem Theory (1986)

Rosenberg (1986) in his theory, considered self-esteem as central to the structural and motivational system of self-concept. He stated that self-esteem helps us in maintaining and
increasing our sense of self. It is very crucial for human development and involves our positive
and negative feelings about our self. Feeling of being worthy and self-regard nourishes self-
estee.m. It enables one to focus on his/her strengths and weaknesses. Coopersmith (1967) stated
that feeling of self-esteem is closely related with satisfaction and enables one to function
effectively. He further defined that self esteem represents our evaluation of our own self; belief
in one’s capability, worthiness and involves approval and disapproval of our actions.

Maslow Need Theory (1987)

Maslow (1987) included self esteem in the hierarchy of need theory. He described two
different forms of esteem: need for respect from others and need for self respect or inner self
esteem. Maslow referred that self esteem reflects a person's overall evaluation or appraisal of his
or her own worth. It encompasses beliefs and emotions such as triumph, despair, hide and shame.
According to Maslow, without the fulfillment of the self esteem need, individual will be unable
to grow and obtain self actualization. Maslow (1939) referred that all individuals want to be
evaluated for self-esteem and regard. This evaluation of their strength, position, recognition,
success and importance etc. enhances their well being and satisfies their esteem needs.

Multiple Influence Model (Wood et al., 2000)

This model told that people having high self esteem tend to focus less on negative self-
evaluating thoughts, which in turn, lead to reduction in their negative feelings and emotions. It
indicates self esteem helps us in regulating our mood also.

Terror management Theory

Greenberg (2008) in terror management theory stated that self esteem act as a
protective factor and lessens anxiety about life and death. Heimpel, Wood, Marshall and
Brown (2002) explained that people with low self-esteem are less willing to change their mood
states; they were less likely to take initiative to improve their mood. They may have accepted
their negative situation and have lost hope of improving their situation. Bryant (2003) also
shared similar views and told that self esteem affects one’s ability to maintain positive feelings,
mood and emotions. Other than this, self esteem influence our way of dealing with a problem
and use of coping strategies. People with high self esteem used more social support and less
avoidance coping (Askinwall and Taylor, 1992).
Self esteem in Adler Theory

Rather than discussing self esteem directly, Adler used the word inferiority feeling and told that our main aim is to maintain superiority (Wells and Marwell, 1976), which in turn, is important for our self esteem. Support and response from significant others affect development of self-esteem. Adler told that involvement and participation in society and fulfillment of one’s interest increases feeling of self-acceptance (Coopersmith, 1967).

Epstein (1985) viewed self-esteem as a need and told that it is basic need and feeling of human being to be loved and respected. He further explained that there are three component of self esteem which are global; self esteem specific to a situation and amount of self esteem in various areas such as competition, love, liking, power, morality, self control, physical appearance and body functioning (O’Brien and Epstein, 1983). Mruk (1995) stated that self esteem is alive in our actions and behaviors. We experience it, and express through words. He further explained that we feel and live self esteem just like our culture, traditions, values and it is our worthiness to deal with challenges of life.

Explicit self esteem and implicit self- esteem are subtypes of self esteem. Implicit self esteem refers to a person’s disposition to evaluate them positively or negatively in a spontaneous, automatic or unconscious manner while explicit self esteem involves more conscious and reflective self evaluation (Koole and Pelham, 2003). Self esteem refers most generally to an individual’s overall positive evaluation of the self (Rosenberg, Schooler, Schoenbach and Rosenberg, 1995).

ANXIETY

Anxiety is a bodily response to a perceived threat or danger. It is triggered by a combination of changes in the body, the patient’s personal history, memory and the social situation. English and English (1958) considered anxiety as an unpleasant and unwanted state which include fear, feeling of threat and apprehensions regarding future. Freud (1949) also viewed anxiety as an unpleasurable and uncomfortable feeling.

According to Spielberg (1966), state anxiety is a transitory emotional state or condition of human organization that varies in intensity and fluctuates over time. This condition is characterized by subjective, consciously perceived feelings of tension and apprehension, and also
involves activation of autonomic nervous system. He defined trait anxiety, ‘as an individual's predisposition to respond’, and state anxiety, ‘as a transitory emotion characterized by physiological arousal and consciously perceived feeling of apprehension, dread and tension’. According to him, the distinction between trait and state anxiety is analogous to the distinction between potential and kinetic energy.

According to Eysenck (1997), introvert people develop anxiety more frequently than extrovert. Eysenck concluded that anxiety is in fact introverted neurosis. Various studies have proved anxiety’s relation with self concept. Phillips, Hindsman and McGuire (1960) found self dissatisfaction to be highly correlated with anxiety. They further reported that anxiety is related with self criticism, self hatred and guilt feeling. Sarason and Mandler (1962) mentioned test anxiety, which generally occurs in a person in an achievement situation. They told that despite of having high test anxious feeling, these people function properly but they tend to highlight and exaggerate the threat of evaluation in a situation. They further pointed out that anxiety rises when a person feels insecure and threatened about the loss of a satisfaction and any pleasurable feeling.

Theoretical Perspectives

Psychoanalysis Theory (Freud, 1926)

Freud (1926) in his theory of anxiety and affects, stated that there are two ways in which anxiety arise. First, by being produced automatically as the result of a specific disturbance in psychic economy; secondly, by being actively produced by ego as a signal of approaching danger. The ego fears the superego's anger, punishment, and confiscation of its love. It responds to this fear with anxiety. Hence, the ego is the real set of anxiety and is not expressed in the super ego.

The id can't experience anxiety either, because it is not an organization and can't estimate situations of danger. In addition to these cases, anxiety develops as a discharge from an excess of unutilized libido. For women, the loss of love is a determinant of anxiety, which contributes to the typically feminine condition of hysteria. For men, the threat of castration and the dread of the superego can be determinants of anxiety, which lead to compulsion neurosis.

In 1936, Freud used the word ‘Transformed Libido’ for anxiety. He mentioned that when anxiety occurs in response to external danger, then it is called objective anxiety and if it is
associated with some unconscious conflict, then it is called neurotic anxiety. According to him, ego gives rise to anxious feelings after the perception of danger, which in turn, channelizes various defense mechanism of a person, so that he can deal with situation effectively.

Horney’s Theory of Basic Anxiety (Horney, 1939)

Horney talked about basic anxiety in her theory. She referred this concept of basic anxiety as high feeling of loneliness in a hostile world. Harsh, hostile and untrustworthy environment foster this feeling of anxiety.

Anxiety/Uncertainty Management (AUM) Theory (Gudykunst, 1995)

This theory assumes that managing uncertainty and anxiety are central processes, influencing the effectiveness of our communication with others (Gudykunst, 1995). That is, individuals can communicate effectively to the extent that they are able to manage their anxiety and accurately predict and explain other's attitudes, feelings, and behaviors. Anxiety and uncertainty management, therefore, are the 'basic' causes of effective communication. It further assumes that the effects of other variables (e.g., desires, expectation, and capability) are mediated through anxiety.

Unified Theory (Eysenck, 1997)

Various definitions of anxiety have emerged and it has been covered extensively in Psychological research. According to unified theory (Eysenck, 1997) there are four sources of information which influence the level of experienced anxiety: (I) experimental stimulation, (ii) internal physiological activity, (iii) internal cognitions (iv) one’s own behavior.

Sullivan Interpersonal Theory of Anxiety

Sullivan (1953) was not interested in symptoms of anxiety; rather he focused on interpersonal relations which lead to anxiety. He believed that anxiety emerges early in life when a child interact with his caretaker. He further stated that anxiety is associated with rejection and disapproval by significant others.

Spielberger Concept of Anxiety

Spielberger (1966) mentioned two concept of anxiety- state anxiety and trait anxiety. He explained that traits are that part of our system which makes us to perceive and react to different
kinds of situation in a consistent manner. States, on the other hand, are responses to our interest in us (ourselves). He further reported that state anxiety is a transitory emotional state of varied intensity, subjective in nature and involves conscious perception of threat. State anxiety depends on the perception of a situation, more threatening the situation a person perceives, higher state anxiety he experiences.

Spielberger (1966) also explained trait anxiety. It is basically an individual’s tendency to perceive the situation in a specific and certain way and to react in a consistent manner to different kinds of situation. Intensity of an individual’s emotional state is determined by the strength of his personality traits. People having high level of trait anxiety are more likely to perceive a situation as dangerous and stressful as compared to people who are low in trait anxiety and react to harmful situation with state elevations of higher frequency and intensity.

Izard and Tomkins (1966) considered anxiety as negative affect. They linked anxiety with fear and even went to the extent of using them interchangeably as they did not find any theoretical difference between them. Carson, Butcher and Mineka (2000) also shared similar views. They referred it as negative affect and considered it responsible for various psychological problems.

Researchers consider it a complex process as it involves multiple component which are hard to define. Anxiety as a whole involves cognition, affective, behavioral and physiological aspects.

INTERNALIZED HOMOPHOBIA

Internalized homophobia indicates the GLBT’s direction of negative views towards the self (Meyer and Dean, 1998). Internalized homophobia also involves the desire and feeling a need to be heterosexual (Herek, 2004). Meyer (2003) noted that it not only involves irrational fear of homosexuals, but also considers homosexuals as ‘sick’ or ‘immoral’. Locke (1998) referred that internalized homophobia is a feeling of self hatred which occurs due to the feeling of being socially unaccepted and stigmatized person.

Internalized homophobia may lead to cognitive dissonance. Individual go through conflict while managing conscious or unconsciousness sexual desires with values gained from society, religion or upbringing. Such a situation increases repression of homosexual desires.
Internalized homophobia negatively affects various aspects of lesbian, gay and bisexual's life such as self-concept, mental health, happiness and well-being (Rowen and Malcolm, 2002).

Freidman and Downey (2002) described that internalized homophobia involves inclusion of negative societal and cultural views about homosexuality into an individual's perception of his or herself and identification as a lesbian, gay or bisexual person. Internalized homophobia leads to rise in self-hatred and avoidant coping style, which further increases maladaptive behavior such as drug abuse, ignoring relationships, less meetings, less communication and anonymous sex (Coleman, Rosser and Strapko, 1992).

Individuals who are high on homophobia are comparatively rigid, have low self regard, experience more conflict and find it hard to share their sexuality and feelings with others (Ross and Rosser, 1996). This sort of behavior if maintained for a long time leads to more problems such as guilt, shame, higher level of closeting, disturbed relationships, inappropriate disclosure and more contact with homophobic GLBT (Meyer, 1995). Though, sometimes, closeting helps in dealing with physical, social and emotional problems (Greene, 1997 b), but in long turn, it affects their ability to mingle with GLBT community, active participation in gay parties, functions and organization, being in a gay relationship openly (Meyer, 1995). Sometimes, due to homophobia or other reasons GLBT adopt false identity which, in turn, makes them more prone to anxious feelings, guilt, self doubt, blackmail, isolation and high drug abuse (Lourea, 1985).

Theoretical Perspectives

Traits due to victimization Theory (Allport, 1954)

Allport (1954) presented theory –‘Traits due to victimization. This theory is consistent with the idea that GLBT may internalize prejudice and bias experienced by them in heterosexual society. Due to prejudice, stigmatized individuals engage in defensive reactions. These defensive reactions may be extroverted or introverted. Extroverted reactions include excessive concern with the stigmatizing characteristic while introverted include self denigration.

Psychoanalysis Theory (West, 1977)

According to West (1977), psychoanalytic theory explains homophobia as a threat to an individual’s own same sex impulses, whether those impulses are imminent or merely hypothetical. This threat causes repression, denial or reaction formation. This theory consider
that homophobia is a result of repressed homosexual urges or homosexual arousal which the individual is either unaware of or denies. Theorists like, Thomas and Butler have suggested that homophobia can be rooted in an individual’s fear of being identified as gay (West 1977).

Psychodynamic Theory and Sociodevelopmental Theory

Psychodynamic theory consider internalized homophobia as defensive reaction which help in reducing stress and anxious thought related with same sex feelings. These reactions can occur in different forms such as projection, denial and rationalization (Shidlo, 1994).

Sociodevelopmental theory emphasize that sexual minority people, that is, GLBT face lack of contact to reference group (GLBT community) and role models, who can help them in developing healthy sociosexual identity (Meyer and Dean, 1998). Same sex attraction and pressure to abide by heterosexual norms occur simultaneously (D’Augelli et al., 1998). Discovery of same sex attraction by peers increase homophobia, especially when gay support groups are not available.

Identity development Theory

Theories of identity development among GLBT found that internalized homophobia is experienced in the process of GLBT identity formation and for the development of healthy self concept, it is important to overcome it.

Fingerhut, Peplau and Ghavami (2005) mentioned that identity development theories among GLBT suggest that internalized homophobia generally occurs during the process of identity development of GLBT and it should be controlled properly for the healthy development of self.

Feminist and Minority Stress Theory

Both Feminist (Szymanski, 2006) and Minority stress theories (Meyer, 2003) have tried to see the impact of internalized homophobia on GLBT’s lives. Both theories imply that due to socio-cultural environment GLBT internalize negative views into their self which leads to poor mental health.

Meyer and Dean (1998) pointed out that internalized homophobia is negative attitude towards homosexuality, which affects an individual’s perception of self. Other then perception of self, gradually, it starts affecting perception of others in GLBT community (Kus, 1992). As negative belief about homosexuality is developed before the individual identify his sexuality,
majority of these beliefs remain unchanged, and thus have an adverse effect on their mental health (Meyer, 1995). This internalized homophobic behavior is consistently strengthened by religion, socialization process and oppression of GLBT community (Brown, 1986).

Awareness of homosexual identity during early stage may create confusion, chaos and loss of personal integrity. This conflict and confusion between personal desires and societal expectations leads to rise in distorted sense of self, self regard and sexual identity development (Friedman and Downey, 1999). This may further increase feeling of shame, guilt, doubt and disturbed sexual identity development. It lowers their self esteem, self regard, self acceptance and increases self hatred, guilt and acceptance of myth about homosexuality. It also hampers the process of sexual identity development and positive self identity (Otis and Skinner, 1996).

They further reported that if conflict during sexual identity development remains unresolved, then it leads to various negative emotions such as anxiety, depression, sadness, guilt and fear. It is related to the feeling of suicide, fear of rejection, loneliness, sexual problems, substance abuse, low social support and demoralization (Meyer and Dean, 1998). HIV positive GLBT community found to be more prone to higher homophobia (Wagner, Serafini, Rabkin, Remien and Williams, 1994), which in turn, worsens their situation by creating medical complications, low self care and reduced social contact. High homophobia leads to withdrawal from gay community, functions, social alienation and suppression of same sex thoughts and feelings (Ross and Rosser, 1996).

Other than this, internalized homophobia affects psychosexual adjustment of GLBT people (Dupras, 1994). Researches have shown that it is closely related with feeling of sexual depression, sexual anxiety, unusual concern about sexual image, alcohol dependence for sex, low sexual control, sexual self regard, sexual satisfaction and high sexual impulsivity (Meyer, 1995; Rosser, Metz, Backting and Buroker, 1997).

These collective effects of internalized homophobia have adverse consequences on GLBT’s feelings, self confidence, self respect and ability of relating to self and others (Wagner, Brandolo and Rabkin, 1996). Irrespective of internalized homophobia’s importance in psychological and overall adjustment of GLBT community (Ross and Rosser, 1996), it is not widely studied. It is of particular concern, considering its relevance in GLBT people’s mental health and physical well being.
NEGATIVE AFFECT

Affect refers to the experience of feeling or emotion. Watson & Clark (1984) defined negative affectivity, ‘as a mood dispositional dimension that reflects persuasive individual differences in negative emotionality and self concept’. Negative affectivity is one of a small set of global traits which not only include one’s general approach to life but also summarize the tendencies of individuals. Individuals high in negative affectivity view themselves negatively and tend to focus on mistakes, disappointments, threats and short comings (Watson & Clark, 1999).

People having high negative affectivity, view themselves and a variety of aspects of the world around them in generally negative terms. Wills (1986) stated that anxiety is a state of high negative affectivity while depression is a state of both high negative affectivity and low positive affectivity (Waston, Clark & Carey, 1988). Researchers have tried to distinguish anxiety and depression from negative affect (Foa and Fea, 1982; Clark and Watson, 1988). As both reflect negative affect, so it becomes difficult to distinguish them either empirically or by using self report method (Crawford and Henry, 2004).

Paykel (1992) referred that negative affect involves thoughts and feelings related with anxiety, sadness, distress and frustration. It is a wide concept and is characterized by negative emotions such as sadness, depression, fear etc. Due to its relations with negative emotions, it comes under the category of psychological distress (Watson et al., 1988). Russell and Carroll (1999) told that affect is directed by subjective feeling and mood rather then cognition related to a particular event.

Berry and Hansen (1996) stated that high negative affect generates the feeling of guilt, negativity, nervousness, and low self regard.

Initially, affect was considered bipolar in nature but later on theorist such as, Costa and McCrae (1980) denied it and referred that opposite states of affect are independent from each other. Based on psychometric evidence, it is found that even at the same time positive affect did not predict level of negative affect. These bipolar opposite correlated very poorly and therefore, it is fare to consider them as independent of one another (Russell and Carroll, 1999). Individuals high in negative affectivity are characterized as being easily distressed, upset, agitated, pessimistic and dissatisfied.
Theoretical Perspectives

Affect Theory

Ekman (2004) stated that affect theories were evolved as an effort to explain the biological side of emotions. Affect is basically our subjective feeling and way of perceiving an emotion or event. Positive and negative affect are two important parts of affect. Tomkins (1962) stated that the word affect refers to ‘biological portion of emotion’. He mentioned nine affects: positive (joy, interest), neutral (surprise, startle), negative (anger, disgust, distrust, fear, shame).

Tripartite Theory of Emotional Expression

Watson, Clark and Tellegen (1988) tried to explain it on the basis of Tripartite theory of emotional expression. He told that depression involves both negative affect (high amount) and positive affect (low amount) while anxiety involves negative affect exclusively and shows no relation with positive affect. Watson and Clark (1984) referred that negative affectivity makes people more vulnerable to negative feelings, distress and emotions.

They are more likely to experience anxious feelings, sadness and nervousness. They are more prone to view negative side of a situation and are less optimistic as compared to other people. They further explained that people with high negative affectivity tend to be less satisfied with self and life in general, report more negative emotions across time and emphasize on how individual feel about the world rather then on how to handle oneself in the world.

Instrumental and Temperamental Views

McCrae and Costa (1991) gave instrumental and temperamental views to explain this behavior. Instrumental view explains that our thoughts and attitudes are modified by the situations which we create for ourselves. People having high negative affect miss rewarding situation and thus, experience less satisfaction in their life. The temperamental view gives different explanation. It refers that our personality tends to react differently to various stimuli. High negative affect people may be more sensitive and responsive to negative situation and in this process they tend to develop more negativity around them.

Description of affect involves conceptual chaos. It is seen that inspite of being different, affect, mood and emotions are used interchangeably. Affect can be described as a super ordinate category for both emotion as well as mood. Campbell – Sills and Barlow (2007) told that affect
is basically an umbrella term that involves both emotion and mood. Negative affect regulation is very crucial for maintaining well being, mental peace and social relations (Eisenberg, Fabes, Guthrie and Reiser, 2000).

If a person is unable to handle negative affect then it affects their social interaction, physical health, work ability (Larsen, 2000) and personal relationships. Other than this, individual’s inability to control negative affect leads to rise in anxious feelings, drug abuse (Sher and Grekin, 2007), impulsivity, mood disorders (Campbell – Sills and Barlow, 2007) and hyperactive behavior. Negative affectivity is a trait that describes the tendency of an individual to experience a variety of negative emotions across time and situations.

**DEPRESSION**

Depression is an emotional state which involves high level of sadness and dejection (Carson, Butcher and Mineka, 2000). Research has revealed that the average age of onset of depression for adolescent has been decreasing rapidly (Lewinsohn and Rosenbaum, 1987). Depressed people try to cope with stressful situation by seeking emotional support from others. When deprived, they may even experiment with various sexual activities.

Due to depression individual infer that they are worthless; that they have failed as parents, students, spouses, and that there loss is irrecoverable. They may feel inferior when they compare themselves with models of their idealized selves, and it is found that these comparisons lead to depression.

Meyer (2003) explained Minority stress model which implied that GLBT people like members of the other minority group, also go through the feeling of psychological distress, sadness and depression due to stigmatization. Various studies show that due to hostile attitude of society and discrimination gay and bisexual experience high level of depression (Huebner, Nemeroff and Davis, 2005). Because of consistent discrimination, these people develop negative self view, which enhances their depressive tendency. Eaves and Rush (1984) indicated that people who are higher in depression also found to be higher in negativity, distorted thoughts and pessimism. Hammen and Brennan (2002) mentioned that depressed people report more interpersonal conflicts, insecure relationships and negative interaction.
Beck (1976) gave a theory of depression, emphasizing that depressed persons are dominated by negative views of self, the outside world and future. They see themselves as losers, and all their perceptions and actions are directed by this feeling. Fenichel (1945) reported that we tend to internalize hostile feelings by developing guilt, shame and self-abusive thoughts, which in turn, hurt our ego. He further told that when one follows unrealistic standard and grows in highly disciplined and restricted environment, then ‘sadistic superego’ emerges, which gradually leads to rise in depressive feelings.

Theoretical perspectives

Depression is a wide concept. Some researchers consider it a single disease while others argue that it involves different sets of problems which differ in their nature, symptoms and etiology (Eysenck, 1970). Because of this viewpoint, numerous approaches have emerged for explaining different forms of depression such as psychotic vs. neurotic, primary vs. secondary etc. (Nelson and Charney, 1980). Distorted cognitions, reduction in social involvement and stressful relations come in the etiology of depression (Beck, 1976). However, some of these problems can appear in the form of symptoms of depression also.

Cognitive Theory

In recent years, cognitive theories have replaced psychoanalytic theories and have thrown light on different aspect of depression (Lewinsohn and Rosenbaum, 1987). Dember (1974) used the word ‘Cognitive revolution’ to describe the increasing role of cognition in explanation of human behavior. In his cognitive theory of depression, Beck (1967) emphasized that depressed person develops negative cognitive schema. They develop the tendency to analyze themselves, their behavior, events and their surrounding in negative way. Gradually, he starts internalizing these negative feelings and remains surrounded by them which, in turn, strengthen their negative schema. Cognitive viewpoint gives importance to the thinking of people and resultant conclusion emerging from this thought pattern.

Beck further explained that people form schema based on their life experiences. Evaluations of these schema or experiences are important for normal functioning of our life. However, some experiences or assumptions are rigid, dominates a person’s overall thought process and becomes unbearable, negative and dysfunctional with passage of time.
When this dysfunctional assumption is accompanied by incidents supporting it, then it shakes one’s belief system. Gradually, these negative thoughts become automatic in nature. As these thoughts increase, depression also arises and adversely affects our behavioral (low activity level), emotional (guilt, shame), motivational (loss of interest), cognitive (lack of concentration) and physical (disturbed sleep) aspect of body. Beck (1976) firmly believed that negative, self-deprecating thinking are major contributory factors in the development and maintenance of depression.

Learned helplessness Theory

Another theorist, Seligman also focused on cognition and control of reinforcers in understanding of depression. In their Learned helplessness theory Abramson, Seligman and Teasdale (1978) told that depression can result when people expect bad things to happen to them and assume that they will not be able to prevent them.

They further explained that when we consider our stressful and aversive events as internal, stable and global then we are more likely to feel depress. They further told that depressed person tend to perceive negative events as caused by stable personal qualities; view them as uncontrollable and global in nature. Sweeney, Anderson and Baileu (1986) also confirmed this. They also found depressed person to be higher on negativity if they consider an event as a result of internal, stable and global assumption.

Psychoanalytical theory

This theory describes depression as resulting from an overly demanding superego that sets standards too high for the person to live up to and from early loss of attachment figure (Freud 1957). Freud further stated that due to depression, people withdraw from life, cease to look after them and are full of self-reproaches. He argued that these self-reproaches, in fact, refer to another person, ‘the sexual object which they have lost or which has become worthless to them through its own fault’. However, cognitive therapists argued that these reproaches are self-evaluations that result from faulty inferences causing the illness.

Social Cognitive Theory

According to social cognitive theory, Bandura (1998) explained that depressed individuals have negative beliefs about themselves, based on experience of failure, observing the
failure of social models, and a lack of social persuasion that they can succeed. These influences may result in a negative self concept and a perceived lack of self-efficacy, that is, they do not believe that they can influence events or achieve personal goals.

**WELL BEING**

Stressful life events and identity confusion are bound to have ill effect on the life of a person. It adversely affects quality of life, physical health and mental well being. Well being refers to subjective feeling of contentment, happiness, satisfaction about one’s role in life, sense of achievement, feeling of utility and belongings, with no distress, dissatisfaction and worry (Verma, Mahajan and Verma, 1989). Well being is also linked to self confidence, self esteem and self regard. WHO defined that physical, psychological and spiritual well being constitute health (WHO, 1987 as cited in Verma, Mahajan and Verma, 1989).

Well being involves both, objective and subjective component. Subjective well being is affected by the perception of an individual. It enables a person to maintain balance between an individual’s desires and opportunities he get from his environment. While objective well being refers to good living standard, good education and financial status. Objective and subjective well being should be balanced otherwise it can lead to dissatisfaction. Well being involves optimism, hope, trust and goodwill. It not only involves evaluation of quality of life (Moen, Robinson and McClain, 1995) but also include various psychological states such as satisfaction and happiness (Okun, 1995). Nature involves both aspects of life- pain and pleasure. Well being consists the greatest balance of pleasure over pain.

Ryff (1995) in her model of psychological well being, mentioned six components of well being which fulfill its definition and gives indepth understanding of this feeling. These components are- personal growth, autonomy, mastery over environment, positivity in relations, feeling of self-acceptance and purpose in life. Lu (1995) mentioned that happiness, subjective well being, objective well being, quality of life, trust, feeling of worthy and life satisfaction all come under the category of well being.

**Theoretical Perspectives**

Ryan and Deci (2001) considered wellbeing as a complex process which involves healthy psychological functioning and experiences. Cacioppo and Berntson (1999) reported that well
being is a broader concept, not just the absence of any mental problem. Cognitive theories mention that inability to actualize one’s aspiration increases ill being. Healthy understanding of one’s desires and capability on the other hand, increases well being (Headey and Wearing, 1989). Even short pleasant experiences, feelings from everyday life also enhances positivity and well being in our life.

Bottom- Up and Top-Down theories

Bottom-up theories assume that specific moments of happiness in life leads to satisfaction and wellness (Diener, Sandvik and Pavot, 1991). Feeling of happiness emerge from combination of pleasant and unpleasant experiences. According to them, a person comparatively experiences more happy moments, so, he is more likely to be happy while top-down approach suggested that our tendency to react to certain events in positive and negative way determine our level of well being. Some people are more likely to be happy, irrespective of life experiences, because they enjoy life’s beauty, satisfaction and pleasure; they view things in a positive way and generally remain happy.

Ryff’s Model of Well being (1995)

Ryff (1995) theoretical model of well being proposed that well being encompasses six distinct dimensions of wellness, that is, autonomy, environmental mastery, personal growth, positive relations with others, purpose in life and self acceptance. Ryff (1995) also explained primary conceptions for the study of well being. First primary conception differentiated well being between positive and negative affect and considered happiness as a result of maintaining balance between these two parts. The second primary conception considered life satisfaction as main factor for well being.

Cognitive focused and Affect focused approaches

Heady and Wearing (1989) stated that cognitive focused approaches believe that ill-being is caused by inability to meet one’s needs, while affect focused approaches explained that positive experiences and reduced aversive states increases satisfaction in one’s life. Lucas and Diener (2000) stated that widely accepted model of well being emphasize that a construct involves both, affective component as well as cognitive component.
Personality and Hedonism Theories

Costa and McCrae (1980) proposed a personality theory of well being. They showed that individuals have differing baseline or set point of well being, due to differences on scores on the stable personality traits of extraversion (E) and Neuroticism (N). Bentham (1996) stated that according to Hedonism theory, what is good for me, might be thought to be naturally linked to what seems good to me, and pleasure does, to most people, seems good. The more pleasantness one can pack into one's life, the better it will be, and the more painfulness one encounters, the worse it will be. Well being is not just a feeling of pleasure rather it is a combination of flourishing being, sound mental health and practical understanding of reality. Diener and Diener (1995) told that most of the people remain above neutral in well being, but it is seen that only few people consider themselves as very happy and found it difficult to maintain that happy state of mind for a long time (Diener and Seligman, 2002) as well being grows from that state of mind which is healthy cognitively as well as affectively.

Ryff (1989) mentioned that an individual’s perception and conception of well being also differs according to his experiences, past, socio economic status and culture. Campbell, Converse and Rodgers (1976) also shared similar views and told that an individual’s experiences define his well being. Verma, Mahajan and Verma (1989) considered general well being as a subjective feeling of satisfaction, belongingness, worthiness, sense of fulfillment and mastery in work with no stress and anxiety. It is a feeling of positivity, goodwill, trust, enjoyment and understanding the value of life. Well being can be subjective as well as objective. The objective well being involves quality of things, good standard of living, good education, work opportunities, better facilities and comfort of life while subjective well being can be defined as a person’s ability to strike a balance between the individual’s desires and environmental realities and opportunities. Balance between a person’s expectations and actual situation are crucial for subjective well being.

Various things such as, evaluation of self satisfaction, evaluation of qualities of a person by others and evaluation of positive and negative events of one’s life etc. describe the meaning of well being. Material comfort, status and facilities enhances the feeling of subjective well being up to a point but ultimately, it is maintained only when a person learns to manage his expectations according to his ability and available resources. Problem occurs when expectations
exceed beyond the capacity of a person. Veenhoven’s (1991) gave the definition of life satisfaction which also represent meaning of well being. He gave importance to perception of overall quality of life in life satisfaction which is necessary for well being also.

**SEXUAL RELATIONSHIP**

Rathus, Nevid and Rathus (1997) explained sexuality. They told that sexuality is basically our feeling and expression of ourselves as sexual being. It is our sense of being male or female and involves erotic experiences.

Giddens (1992) told that sexuality is not a simple concept. It represents one’s identity and involves body, culture and norms of a society. Though, it is true that biological explanation have dominated the concept of sexuality but without mentioning society, culture, rules and norms, it is difficult to describe human being’s sexual behavior.

Tiefer (1987) explained that sexuality is not a force rather it is our capability or potentiality. Even from biological point if we define it as an inherent force, then it mystifies various social and psychological factors related with our sexual behavior.

Sexual health involves identifying a developmentally healthy sexuality, considering biosocial, cultural and psychological aspects alongside recognizing cognitive and moral development. Sexual health affirms sexuality as a positive force leading to enhancement in other dimensions of life.

Sexual satisfaction is an integral component of sexual health and wellbeing (Henderson, Lehavot and Simoni, 2008). Sex is elastically defined as the instinct or attraction of sex towards another. According to WHO (2005), ‘sexual health is a state of physical, emotional, mental and social wellbeing in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity’.

Sexual health requires a positive and respectful approach to sexuality and sexual relationship, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, predicted and fulfilled.
Theoretical perspectives

Sexual concepts and sexualities have been evolved, improved and modified constantly over time. Like various other concepts, sexuality too has different meanings.

Equity theory (Hatfield and Sprecher (1982)).

Equity theory proposed that satisfaction in relationship results when partner perceive that the proportion of rewards to cost is equal to both partners. Script theory (Gagnon, 1990) proposed that people in sexual relationship adhere to various sexual scripts, scripts that define the situation, the actors, and their roles in the script and behavior that accompany these scripts. This theory further stated that the subjective understanding of individuals of their sexuality, determine the person's choices of sexual actions and the qualitative experiencing of those sexual acts.

Goettsche’s (1989) views on sexuality

He described sexuality as our capability to react to physical experiences which involves genital excitation. Society’s rules and regulations affect expression of sexual behavior and feelings but they don’t generate sexuality. It is something which grows within individual, rather then emerging from some outside source. Sexual health involves an ability to be intimate with a partner, to communicate explicitly about sexual needs and desires, to be sexually functional and to set appropriate sexual boundaries. It also includes a sense of self-esteem, personal attractiveness and competence, as well as freedom from sexual dysfunction. He further cleared that sexuality is capability of all human beings but it is socially constructed process and is influenced by internal as well as external forces of our surrounding and culture. Though, sexual behavior and emotions are different from each other but they can occur together also.

Social learning theory

Social learning theory treats human sexuality as at least partially learned and cognitively oriented. Tiefer (1991) stated that biological approach consider it as an uncontrollable drive. But this viewpoint restricts definition of sexual behavior by underestimating various social factors such as sexual socialization, financial inequalities and social climate etc., which contribute in development of sexual behavior.
Hyde (1994) referred that culture, society and especially our religion play a significant role in maintaining attitude and expression of our sexual behaviour. He further told that these factors enable one to make decisions and evaluations about one’s sexuality as well as other’s sexual behaviour. These factors and legal discourses (Rubin, 1998) determine boundaries of ‘right or wrong’ of sexual behavior. Freud exhibited different forms of sexuality by describing various concepts such as ‘libido’, ‘erogenous zones’ and ‘psychosexual stages of development’ of sexual behaviour (Hyde, 1994). Sexual health involves an ability to be intimate with a partner, to communicate explicitly about sexual needs and desires, to be sexually functional and to set appropriate sexual boundaries. It also includes a sense of self-esteem, personal attractiveness and competence, as well as freedom from sexual dysfunction.

**COPING**

Weiten and Loyd (1993) mentioned that coping enables one to minimize the hurtful effects of a situation. Whenever a stressful situation emerges, our coping mechanism adopts behavior to encounter it and manage our emotions related to this situation. Naime (1996) referred that coping leads to mastery over a threatening or demanding situation.

Carson et al. (2000) defined coping strategies as effects to deal with stress, caused by the adjustive demands on the stressors. Folkman and Lazarus (1985) stated that coping is seen as a response to demands in stressful situations. Moos and Shaefer (1984) referred that numerous factors affect an individual’s judgment of a crisis and their subsequent use of a coping behavior. These factors are maturity, will power, past experiences (personal factors), disease, physical disability, pain, injury (illness factors), gender, age (demographic factor) and family and peer support, dependence on others, role models (environmental factors).

Schuler and Sethi (1984) defines coping as steps taken by an individual to protect oneself from the adverse consequences of a situation. Shapiro (1996) mentioned that when a stressor troubles an organism, then the organism try to eliminate the situation or to reduce its impact by using various coping mechanisms.

Krohne (1996) classified theories of coping according to two independent parameters as trait oriented versus stated oriented and micro analytic versus macro analytic approaches. Coping is a part of a psychosocial pattern of reactions which include social support and self efficacy. It
entails planning, purposiveness and a cognitive representation of activities, both previous and future.

Frydenberg (1997) mentioned that coping is a way of handling life, turning negative things into positive, developing capacity to deal with problems, and enables an individual to make the most of a situation.

A glance at the research on coping shows that there is a shift from ‘disability’ approach to a rising interest in the area of ‘ability’ model. This shift tries to understand different aspects of human behavior; focus on positivity, happiness, well being and an individual’s ability to deal with a situation (Lu and Argyle, 1991). It focuses on the healthy aspect of a behavior and the abilities an individual possesses to cope with a situation.

Theoretical perspectives

Coping generally occurs, when a person experiences drastic change or problems that are difficult in nature, generates uncomfortable feelings such as anxiety, sadness, grief, guilt or shame and leads to rise in new behavior. White (1974) reports that coping is a process which involves efforts regarding the solution of a problem. Lazarus (1976) also mentioned that coping helps a person in dealing with problematic and emotionally charged demands. It saves people from harmful situations, either by eliminating stresses or by keeping emotional responses under control.

Stress and Coping Model:

Lazarus and Folkman’s (1984) stress and coping model emphasized that a person and their environment continuously interact while dealing with stress and coping. Cognitive appraisal and coping are two important aspects of this model. Cognitive appraisal involves assessment of a threatening situation and available resources to cope with it.

This appraisal further is divided into two components—primary appraisal and secondary appraisal. In primary appraisal, a person evaluates whether the situation is threatening or not. If it is, then the individual evaluates further to identify whether we have resources to deal with this alarming situation. This thought further leads to secondary appraisal (These two processes can occur simultaneously also). In this situation, a person decides his future course of action, that is, resources available for coping and consequences of a particular coping strategy.
Other than cognitive appraisal, another important aspect of this model is coping. After evaluating the threat and resources, a person applies suitable coping strategy to eliminate the harmful situation. Folkman and Lazarus (1985) divided coping in two forms, ‘problem focused coping’ and ‘emotion focused coping’. According to them, in problem focused coping, we try to alter the situation which creates stress for us while in emotion focused coping, we regulate problematic situation by avoiding any direct confrontation with it. Folkman and Lazarus considered these two categories as mutually exclusive. Lam and Hong (1992) gave different viewpoint. They regarded these categories as independent dimensions which can be used to explain any coping behavior. They insisted that a response to any situation can involve both, problem focused and emotion focused strategies.

Some early models of coping explained that an individual’s self concept and use of different coping strategies lead to variation in an individual’s adjustment to a demanding situation (Lipowski, 1970; Pless and Pinkerton, 1975).

Wallander, Varni, Babani, Banis and Wilcox (1989b) model, mentioned that use of a particular coping strategy also depends on a person’s competence, which is further defined as the effective response of an applied coping strategy during an alarming situation.

Krohne (1993) Model of Coping Modes

This model stated that an individual’s preference for vigilant or avoidant coping strategies indicates individual differences under stressful condition. This model explains following coping modes:

1. Sensitizers: Persons who are high on vigilance and low on avoidance direct their attention towards stress relevant information in order to reduce uncertainty.

2. Repressors: In this mode an individual deal with the experience of arousal by avoiding aversive information.

3. Non-defensives: In this mode an individual adapts to the demands of a stressful encounter and scores low on both dimensions.

4. High anxious: Individuals having high score on both dimensions apply vigilant as well as avoidant coping strategies.
Social evaluation theory

This theory suggests mechanism for minority coping (Pettigrew, 1967). According to it, members of stigmatized groups who have a strong sense of community cohesiveness evaluate themselves in comparison with others who are like them, rather than with members of dominant culture. This reappraisal is less injurious to psychological well being.

Minority Stress Theory

According to Minority stress theory, social support coping helps in dealing with stress while avoidant coping strategy is not that effective for long term (Meyer, 2003). Avoidant coping strategy fails to address the cause of the problem for long term as compared to other coping strategies such as problem solving strategies (Barnes and Lightsey, 2005). Coping involves managing taxing circumstances, expanding effort to solve personal and interpersonal problems, and seeking to master, minimize, reduce or tolerate stress or conflict.

People tend to use one of the three main coping strategies: either appraisal focused, problem focused or emotion focused (Weiten and Lloyd, 1993). Appraisal focused strategies occur, when the person modifies the way they think. People, using problem focused strategies try to deal with the cause of their problem. Emotion focused strategies involve releasing pent-up emotions, distracting one self, meditating, managing hostile feeling etc.

Williams, Connolly, Pepler and Craig (2005) mentioned that social support coping is very crucial for GLBT people. They cope with various kind of stressors related to their sexuality. They can overcome harsh stigma and discrimination if social support is present in their life. With the help of social support, they can manage stigma associated with their sexual orientation and can develop a positive identity even in harsh and hostile atmosphere (Munoz-Plaza, Quinn and Rounds, 2002). Besides, it also increases well being in GLBT (Hershberger and D’ Augelli, 1995).