CHAPTER - I
INTRODUCTION & REVIEW OF LITERATURE
CHAPTER-I

INTRODUCTION

Human behaviour is characterized by continuous interaction with others as well as with his own environment. The state of organism as well as external factors that surrounds the individual at a particular moment of time influences his or her behaviour. In today's socio-technological changing environment people want to satisfy not only biological needs, but also various socio-psychological needs. When an individual is unable to satisfy all these needs in his life, he feels frustrated. Frustration further leads to various physical and psychological problems. Such as stress tension conflicts, aggression, blood pressure, hypertension, heart problems and other such behaviour disorder (decrease in performance low work and feeling of fatigue etc.). Such aspects affect all over development of a human being.

The evaluation of the concept of mental health is linked to the larger development in the understanding of human behaviour. Starting from the explanations of supernatural causations, we have arrived at understanding the status of mind and mental health from a holistic point of view. Rapid advances in the understanding of human brain and individual and group behaviour open up new possibilities for non-medical and wider psycho-social action towards promotion of mental health.

The term 'Health' is a positive and dynamic concept and implies more than absence of illness. The World Health Organization (W.H.O., 1951) has defined health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". The Alma Ata Conference
in 1978 (W.H.O., 1978) is a landmark in the development of concept of health. The concept of mental health is defined as – Mental health is the balance of all aspects of life-social, physical, spiritual and emotional. It affects that how do we manage our surroundings and make choices in our lives. Thus, it is an integrated part of individual’s overall development of personality emotions and attitude, which assess him to live harmoniously with his/her environment. Mental health is not exclusively the matter of relation between person, it is also a matter of the individual with the community. It is a part of individual’s life that determines his way of living in the environment. As Askoff (1968, P.16) has pointed out “Mental health generally thought of as personal quality which to some extent, transcends the setting, of which the person is a part, although it well of course, be affected by what goes on in these settings”. Letter on Abe Askoff (1968, P. 17) has also pointed out, “Mental Health is sometimes reserved to identify desirable personal qualities perhaps qualities which only a few people show in any degree and in this way mental health cannot be something more than good adjustment.” Good adjustment indicates desirable or valued qualities or patterns of behavior in terms of a person's inter-action with the environment by contrast, the concept of mental health is not so closely linked to the environment. Thus mental health is a state of individual as Eysenck (1972) puts it a state in which the need of individual and the claims of environment are fully satisfied or the power by which this harmonious relationship can be attained. On the other hand mental health is the functioning of human personality showing desirable qualities as J.A. Hadfield (1952) has said “Mental health is the full and harmonious functioning
of the whole personality" The changes in attitude towards the treatment of the mentally ill over the years that have noted from punishment to human treatment from fear to sympathy, from incarnation to rehabilitation from emphasis upon prevention and then to promotion of creative, positive growth and functioning is not only due to advances in science and technology but are also due to changes in our society. The definition of mental health in terms of the functioning of personality makes it relative to time, setting and circumstances of a socio-cultural group. This has been demonstrated in a WFMH cross cultural study entitled. "Mental Health and Value System 1963. "This mental health may be assessed in quantitative terms. The above mentioned study group thought that it was a legitimate conclusion that anything that can be done to raise the capacity of the individual to come to terms with himself and to activate the full realisation of his own potential leads to mental health. Thus the mental health of the individual is intimately related to the mental health of the community and vice-versa.

An Ideal State :

Much has been written about the desirable qualities in human beings as found in human behavior which express mental health. The WHO charter emphasises. "The Positive Well being" as the criteria of mental health. This is an ideal state. Thus mental health has been viewed in terms of an ideal rather than in terms of lack of disease, statistical average of conformity pattern.

Jahoda (1958) analysed many definitions of mentally healthy person and offered the following criteria of mental health.
1. **Attitude towards the Self**: These include the accessibility of the self-consciousness; the correctness line; its relations to the sense of identity and the acceptance of the individual of his own self.

2. **Growth development and Self-actualizations**: The extent the individual utilizes his abilities; his orientations towards the future and his investment.

3. **Integration**: The extent to which the psychic forces are balanced a unifying outlook on life and a resistance to stress.

4. **Autonomy**: The aim here is to ascertain whether the self reliant person is able to decide with relative ease and speed as to what suits best to his own needs.

5. **Perception of Reality**: A relative freedom from need distortion and the existence of empathy.

6. **Environmental Mastery**: Under the heading is listed: ability to love, Work and Play, adequacy in inter-personal relationships, meeting situational requirements adoptions and adjustment; and efficiency in problem solving.

**Core or Mental Health**:

A good deal has been written about the qualities of mental health. Abe Askoff (1968, P. 17-18) has summarized the core of mental health in his description of four sets of qualities required in mental health. According to Abe Askoff, two qualities which are highly valued in mental health are happiness and Harmony. As he defines them, "Happiness refers to a general sense of
well being. Harmony implies a balance between personal and environmental demands with each rising consideration. Second Set of qualities subsumed under the heading "Self Regard" include self insight (a knowledge of oneself), self identity (a sharpened stable image of oneself), self acceptance (a positive image of oneself), self esteem (a pride in oneself) and self disclosure (a Willingness to let oneself of be known to others).

A Third Set of valued qualities have to do with personal growth refers to realization to 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 behavior i.e. integrity. The final set of qualities valued in mental health includes contact with the environment, effectiveness in the environment and independence of the environment in living.

According to J.A. Hadfield (1952) suggested three requirements of mental health (i) full expression (ii) harmonization and (iii) the direction to a common end of our native and required potentialities.

**Full Expression**: Full expression is considered necessary for our biological adoption in life and to the development of strong will and character. The native urges, etc. If repressed, deform the personality of the individual. The individual becomes inefficient weak-willed and feeble charactered. Thus, for good mental health, repressions are to be totally avoided. Otherwise, undue suppression leads to pyscho-neurotic conditions and these urges find their outlet in abnormal behaviour.
Harmonization: The potentialities have different aims and functions to perform which are often in conflict with one another. For example, rage comes in conflict with sex, fear with ambition and rage, etc. with the aims and ends of the personality as a whole. In case the potentialities, whether of rage, sex or ambition, function completely but independently of the rest of the personality and its ends, they create mental disorders and the mind becomes disturbed which ultimately results in the breakdown of the personality. Thus, the harmonization and co-ordination of all these tendencies is necessary to the health of the mind.

The Common End: The third criterion for good mental health is the common end. Now, the harmonization of various potentialities into a unified whole is not possible unless and until they are directed towards a common end. If there are different aims or purposes to achieve which are in conflict with each other, then harmonization will not take place.

On the basis of different definitions, we can say that it is difficult to define mental health. But some criteria have been introduced to define mental health in different ways. These criteria are social, individual and functional etc. These criteria explain mental health in different ways from their stand point of view such as social criteria for mental health include determination of how closely a person resembles others in his behaviour. How well he gets along and is linked by others. How much he contributes to and supports his social group how much he conforms to the approved codes and conducts, laws and ideals of society and social groups. Second criteria is individual which explain concept in terms of person himself and his attitude such as
happiness, ability to withstand psychological stress, assumption of personal responsibilities, the integration of his personality, favourable and realistic self perception and self actualization. The Third that is functional criteria, involves the ability of the person to cope with and to master the environmental stress and demands, efficiently, productively and in more matured way. Thus, each of these criteria of mental health places positive or negative values on different behaviour.

These three criteria’s further can be analyzed in terms of various dimensions such as social statistical, interpersonal judgment choice. Social benefit, ethical and ideal individual hedonistic, stress management personal responsibility, self-attitude, integration and functional and coping efficiently in more matured and productive ways. So on the basis of all these criterias O’Doherty (1956) summarised definition of mental health in more precise and scientific ways as. It is an integration of the personality. Judgment freed from obsession with self. Among other things, he writes mental health demands and interpersonal relations with self, with others and also with God. Jahoda (1958) introduced two valuable clarifying statements about mental health.
First, mental health used to describe as series of those sections of the population suffering from some degree of mental disability that the individual or his associates, require some type of help or intervention to do or completed their work. Second statement about mental health explain mental health in terms of describing a state of feeling or being of an individual or a society or a world as a whole that affect the uniquely human behaviour of its members. Despite some technical difficulties of these criterias, multiple criteria described mental health in terms of multiple aspects of mental health such as static, changable and dynamic, to change for better or for worse. Thus what is mental health is not a simple one it must deal with positive and negative aspect of behaviour and each require different approach.

STAGES IN THE DEVELOPMENT OF MENTAL HEALTH

Stage-I : Prenatal conditions, Early Family environment and Behavioural development of the child. Most of children are born healthy but some are born defective or injured. This is the period when the basic influences of heredity and congenital traumas of disease are asserted and the foundations are laid for social learning and personality development. Occasionally adjustment problem of childhood signals the deeper disturbances and some organic difficulties associated with mental deficiency. Needless to say, this is the period of incubation for many mental health problems in development.

Stage-II : Crises of Everyday Living and Development – This development problem started early peer group and social adjustment difficulties in social relationship and responsibility in family and community living, religion, courtship, marriage, parenthood, occupation choices, satisfaction and various
other emotional and environmental stresses. In Selye (1956) terminology, this stage encompasses the stage of alarm and resistance.

**Stage-III:** Onset of Mental Illness: Difficulties develop in first two stages culminated in system of mental break down. In this stage there is a rapid deterioration of work habits, family and social relationship, responsibilities etc. That's why this stage is characterized by overall personal and social control in the home as well as in the community.

**Stage-IV:** is started from the problem of rehabilitation and psychological treatment of mentally unhealthy person. This includes various types of therapies, training and development programme, community services which assist the mentally unhealthy person to return back to community or to say, to become normal person.

Taking all of these considerations in mind, we found that some historical model or theories have been proposed to explain mental health problems. Psychologists believe that there is a direct relationship between people's health and their behaviour. Health psychology is the psychological sub-field concerned with the use of psychological ideas and principles in health enhancement and illness prevention, diagnosis and treatment of disease and rehabilitation process. It is an action oriented discipline that assumes people's ideas and behaviours contributed to the onset and prevention of illness.

Traditionally, physicians looked at health as the absence of disease. A person who was not experiencing adverse effects from injection, an injury or
an abnormal condition of some kind was considered as healthy. Now, however, physician and psychologists acknowledge that health refers not just to the absence of disease but also to the total welfare of a person in terms of social, physical and mental well-being with a focus on the positive side. Health promotion unlike medicine, which focuses on specific disease, health psychology looks at the principles of thoughts and behaviour that clarify fundamental psychological mechanism and effect all areas of a person's life.

**Historical Development:** A psychologist with long experience of mental health work in English speaking countries suggested that one essence of mental health is an attitude of mind that enables the individual to stand up to the difficulties of life, without getting unduly anxious and to be relatively free from obsessional worries and feeling of guilt.

From the last 500 years, the Western approach for deviant or 'abnormal behaviour' has been influenced predominantly by religion and science till about the 17th Century all abnormal behaviour was seen as an act of 'devil' that is against God. The next phase considered all abnormal behaviour as 'Criminal', that is anyone whose behaviour was socially unacceptable was classified as 'bad'. But with the advent of modern scientific thought the focus shifted from 'evil' to 'ill'- in a way, people are not 'bad' but 'mad' or 'insane'. The ill persons were looked after in more human relation approach. 'Mental Hygiene Movement' were emerged from the evils of the asylums. This was a public awareness in the field of mental health movement. At the turn of 20th Century, contribution of Sigmund Freud presented behaviour and mental function as understandable manner and he evolved a
famous coherent theory of personality called as psycho-analysis. Freud's contribution explained that all behaviours illness to wellness rooted in the childhood experiences and parent child relationships. At the same time, others theorists such as Alfred, Adler, Off Rank presented their different explanation for mental health and mental ill behaviour. After that Biochemical Model came and laid emphasis on that mental illness is caused by an imbalance of chemicals in the brain. Example of family treatment model (Therapy) has become ordinary over the last decade. This model concerned that everyone involved in a problem plays a part in its continuance by reinforcing the behaviour of others. In Educational Programme Model Psycho-education is a popular model that teaches and includes families as a part of the therapeutic milieu.

While new thoughts were emerged in the second half of 20th Century. These new thoughts of philosophy was 'Behaviouristic Approach' (Skinner 1953; Watson 1920). This approach is based on learning principles, which explain mental health problems in terms of biological and social context (Rachman, 1963). Due to the effect of all these contributions the antipsychiatry movements were started in the western countries. Review of literature on mental health showed that no such movement was emerged in India to explain clearly the concept of mental health and mental illness. Rather in Indian socio-cultural scenario there were only few members of different professionals who contributed for the mental health.

Finally, Friere (1973;1981; 1970;1982) developed the concept of 'consciousness' in mental health in twenty-first century. The concept is based
on the raising of consciousness, a necessary precursor to social action and social change, both essential aspects of the prevention of mental illness and promotion of mental health.

In the last 30 years, there has been a shift to the social origins of mental health and mental illness. The dominant theories are of life stress, social support, social network, family life etc. (Brown & Birley 1972; Henderson et al. 1981; Holmes & Rahe, 1967; Mehanic & Aliken, 1986; Jackson et al. 2009). These theorists explained mental health problems in terms of social cultural and ethnic factors. If we take into account all of these variables or factors in mind, we find that there are many factors that individually or collectively influence the mental health status of an individual. Some of these variables are demographical, socio-cultural, economic, biomedical and psychological. These variables are not in isolation. They often interact and can jointly produce unanticipated or at times undesired outcomes. Analysis of these variables singly and in contribution may yield new insights about ways in which we may intervene intelligently and critically. Empirical researches along with these lines also helps to create comprehensive and accurate results. On the basis of these factors, some strategic planning and strategies can be made to draw a empirical results.

**The Indian Views About Mental Health:** Before reviewing the development e.g. the modern, it would be appropriate to consider the Indian concepts of mental health. Indian philosophy explain mental health problem in the terms of spiritual dimensions of life. The ultimate goal of life is self-realization or realization of one's innemature. A number of Indian mental
Health professionals have focused on the various aspects of Indian concepts of mental health. (Wig, 1990; Neki, 1977; Satyanand, 1966; Sinha 1968, Vahia et.al.; 1973; Ramu, 1988). Thus Indian researchers identified four areas in the field of mental health. Carstairs and Kapur (1976) have examined the prevalence of mental disorder in different social group in South India. These are references to the role of social stress in the occurrences of mental health problems. Second, mental health problem is also related to ‘dependence-independence principle’. Third area where contribution have been made is the area of using traditional concept for therapy (Vahia et al. 1973; Sharma et al. 2009; Bhardwaj et al. (2009); Shukla and Murthy (2009); Adhikari & Zaidi (2009), which was based upon the concept of patanjali (Ashtamangala) for the treatment of neurotic and psychometric disorders. The fourth area has been in relation to the place of family in therapy. Summarising all of these viewpoint we can say that family, interaction between unhealthy and other family members and traumatic experiences chronologically promotes mental health problems Sharma (2009); Dhull (2009).

After Indian viewpoint, the modern perspective is needed to discuss this modern perspective of mental health in concern with values and desires of individual and also into collective deals and aspiration of group and communities. Some theorists such as Dyke and Raufman, 1970 found association between a wide range of 'health problems' and experienced life stresses. Due to these stressors there is increase not only in suicide problems but also occurrences of accidents, infected disease, heart problems, depression, cancer and alcoholism. In the last decade some research depend
on a variety of few possibilities for intervention and prevention of mental health problem. The next set of possibility of mental health problem started from the life cycle or life style of an individual. A wide range of researches linked the neuropeptide and psychometric network, where the mind and body constantly chatter back and forth using a vocabulary of biochemicals. This consideration opened a new discipline called as “Psychoneuroimmunology”. In recent times, these developments are contributing towards a biosocial model for the understanding of common mental health problems. These new approaches have practical value in understanding of mental disorders as well as treatment of the disorders (Goldberg and Huxley, 1992); Nigam (2009).

**COMPARISON OF WESTERN AND INDIAN APPROACHES:**

The most fundamental difference between the Western and Indian Philosophy is that while reason is the highest in man according to western thought, Indian thought goes beyond reason to supra-rational supracosmic, spiritual, transcendental essence of man. While the western thought finds solution of human problems in reason or in its control over infra-rational in man, the Indian thought consider realisation of spiritual essence as the only sure remedy of human ills.

This fundamental difference in Eastern and Western thought may also be Witnessed in the following distinctions in Western and Indian concept of mental health:

1. Both western and Indian thinkers define mental health in terms of certain qualities of personality but whereas according to Western
approach these qualities are in relation to self and society, according to Indian approach these are first and foremost in relation to ultimate being, the cosmos. The nature and the absolute reality. Thus whereas Western thinking considers moral qualities as the highest. The Indian thinking emphasises spiritual traits. Whereas Western approach considers more and more involvement and social concern as signs of Mental Health. The Indian thinkers plead for detachment, desirableness, and Liberation. However, both the Indian and Western thinkers accept balance and integration as necessary signs of Mental Health.

2. Both Western and Indian thinkers consider mental health and only as a process but also a state of the individual, but which Western thinkers consider this state very much relative to socio-psychological environment. Indian thinkers consider it a stage of development of self.

3. Both Western and Indian thinkers consider mental health as a functioning of personality but while western thinkers consider this functioning in relation to time and socio-cultural environment. Indian thinkers consider the functioning of personality following from the spiritual, transcendental inner self which is the same as cosmic reality.

4. Both Western and Indian thinkers consider mental health as a state or process of self actualisation but both define the self in different ways. To the western thinkers, self is a psycho-socio cultural reality while to the Indian thinkers self is an eternal, absolute consciousness, truth and
bliss. It is not a state but a reality. It is the central reality from which everything else follows.

Both Western and Indian thinkers accept mental health as psychophysical but Indian thinkers lay more emphasis on psychological than physical aspect.

Both Western and Indian thinkers consider self fulfillment as a necessary condition of mental health, but while the Western thinkers realise it through self-expression, the Indian thinkers emphasise self control and even self transformation, self submission and self transcendence.

Both Western and Indian thinkers consider happiness and harmony as two sure sign of mental health but whereas the western thinkers consider these in psychological, sociological and ecological perspective the Indian thinkers stretch it to cosmic and supra cosmic, supramental and transcendental dimension.

Both Western and Indian thinkers have given a preventive as well as positive description of Mental Health, but whereas the Western thinkers seek to make an individual normal. The Indian thinkers have considered a supra-normal transcendent status as necessary for any permanent Mental Health.

In spite of the above mentioned distinctions between the Western and Indian approaches to the concept of mental health. The recent tendency in the west towards continued widening of this concept may ultimately lead to
bridging the gulf between the two. Many western thinkers have emphasised. The need of meeting East and West. Many other have advocated a synthesis of Eastern and Western techniques of mental health.

To sum up, the Western viewpoint defines mental health as an ideal condition of self actualization and functional maturity, as a statistical average, as the amount of conformity to socio-cultural reality, as a process and as a healthy personality having integrity, balance, emotional maturity, self confidence, optimism and adjustment to environment.

This concept of mental health has been widening since its beginning in psychiatry. The field of mental health has widened all the way from the prevention of mental illness to the enhancement of human potentiality. Besides, psychiatry, psychology and sociology, mental health is today, the concern of education, vocational continuation, pediatrics and many others. All these have united around the goal of concern for human welfare. Cultural forces enter into mental health phenomena at all levels. Mental health is not a static property but a state that is subject to variation. It can go deep in to the values and desires of individuals and also into collective ideas and aspirations at the groups and communities. It provided for the full development of the person.

Mental health according to Indian Psychologists is a state as well as a process. It is a condition of self actualization and functional maturity. It shows conformity to socio-cultural reality. And above all, it is reflected in an Integral personality exhibiting balance integrity, emotional maturity optimism and
ny with men, nature and God, in fact with the entire cosmos. The entire
of Indian psychology is directed to the attainment of mental health
personality integration. Emphasizing the value of mental health, Yoga
sthata has pointed out that when mined is cured whole world is cured.

According to Mahesh Yogi (1963 P.P. 327-328). The mind function
the nervous system which serves to connect the subjective nature of
with the objective world around him. Mental health depends upon the
the nervous system and with its end organ, the body. "Explaining his TM
nique- Mahesh Yogi (1963 P.N. 21) claimed." A systematic method has
developed that enables an individual to experience directly the pure
state of being. It is done by consciously entering into the experience of the
de strata of a though, eventually arriving at the direct experience of the
of the thought and then arriving at the very source of thought.
in the conscious mind attains the pure state of being.

Hashmi (2009) says that all the approaches of Eastern and Western
ated to mental health are of great worth and remarkable which can be
owed to keep a balanced mind and to lead a peaceful and healthy life.
The Characteristics of Mentally Healthy Personality:

The principles of mental health which may be good for one individual may not be good for another who is reared up on different environment or possesses different traits. The principles of mental health cannot be taken to be fixed for all. In their application, the type of the individual will have to be taken into consideration and thus they will work out differently for different individuals. There are many erroneous notions regarding the concept of a mentally healthy person. By a mentally healthy person, people usually mean a person who has biological efficiency or is able to carry on nicely in society or is of good morals, etc. Here we have few definitions of the healthy personality according to some famous psychologist:

Hurlock mentions the characteristics of the well-adjusted as:

(i) Realistic goals.

(ii) Acceptance or responsibility.

(iii) Expression of appropriate emotions.

(iv) The ability to relate to others.

Carl Rogers defines a healthy personality as one which shows:

(i) Acceptance of feelings.

(ii) Self-esteem.

(iii) Relating well to others.
(iv) Living fully in the present.

(v) Continuing to learn.

(vi) Openness to new ideas.

(vii) Ability to make independent decisions.

(viii) Creativity.

Eric Erikson believes that persons with a healthy personality have the following characteristics:

(i) Trust others and trust themselves

(ii) Are capable of controlling themselves and feel that they can control themselves.

(iii) Are capable of taking on responsibility.

(iv) Are competent and industrious.

(v) Have a clear, integrated identity.

(vi) Can develop intimate, trusting relationships with others.

(vii) Can guide others to grow or be creative in other ways.

(viii) Have ego integrity, accept themselves as they are.

Of the many characteristics of healthy personalities, the following are the most common:
The well-adjusted person sees himself as he is, not as he would like to be. The gap between the real and the ideal self-concepts, so wide in those who suffer from personality sickness, is very much smaller among the well adjusted. Since the well-adjusted person can appraise himself, his abilities, and his achievements realistically, he does not need to use defense mechanisms to try to convince himself and others that his failure to come up to his expectations is the fault of others or of environmental conditions over which he has no control.

A mentally healthy person does not expect to be perfect, nor does he expect the situations in which he finds himself to be perfect. He approaches situations with a realistic attitude, accepting the bad with the good. This does not mean that he has a defeatist attitude or that he projects the blame onto someone else when things are not to his liking. Rather, he is willing to do what he can to make the situation more to his liking. Such a person has a constructive approach to life.

A well-adjusted person is able to evaluate his achievements realistically and to react to them in a rational way. This contrasts with the maladjusted person who regards his successes as a personal triumph which shows others his superiority over them. The maladjusted person allows himself to develop a superiority complex which he expresses in boasting, bragging, and derogatory comments about those whose achievements fall below his. In explaining how a well adjusted person reacts to his successful
achievements, Lawton remarks, "He does not magnify his successes or extend their application from the field in which they originally occurred."

One of the characteristics of a well-adjusted person is his willingness to accept reality instead of running away from it. While he may not like things as they are, he is realistic enough to know that he can either change them or change to a locale where things will be more to his liking. In many areas, acceptance of reality is essential to a healthy personality. The person must learn to accept his limitations, either physical or psychological, if he cannot change them and to do what he can with what he has. He can also compensate for his limitations by improving those characteristics in which he is strongest. The poorly adjusted person, by contrast, develops a martyr complex, feeling sorry for himself or blaming himself or others for his limitations.

People are poorly adjusted. They are either too lazy to accept responsibility or they feel inadequate to do so. By contrast, the well adjusted person is a responsible person. He feels confident of his ability to cope with life and its problems and to take responsibilities suited to his age and level of ability. "let-John-do-it" boy who is only too willing to let his mother clean up after he has entertained his friends.

The person who is well adjusted accepts responsibility in a number of areas. He accepts responsibility for himself and for his behaviour. If things go wrong and if he is criticized, he accepts the blame and is willing to admit that he made a mistake. This contrasts with the poorly adjusted person who
depends on others for help whenever he meets an obstacle or has to tackle a new problem and who blames others for his mistakes.

Closely related to acceptance of responsibility is autonomy. The well-adjusted person is not only independent in thought and action; he is also self-directing and self-governing in that he charts the course of his life to meet his needs and wants. Says Barrett-Lennard, "He trusts and depends on his own capacities to organize and interpret the data of his experience. He freely steers his own course. The well-adjusted person shows his autonomy in several ways. In decision making, he is able to "make important decisions with a minimum of worry, conflict, advice-seeking, and other types of running away behaviour. After making a choice, he abides by it, until new factors of crucial importance enter into the picture."

Acceptable emotional control, cannot be imposed by others. The person must assume the responsibility for keeping his emotions under control, so that they will not hurt others or himself. For example, he must learn not to blow his top when he is angry or sink into a mood of deep despair when things do not turn out as he had hoped they would. In short, he must be able to meet frustrations without violence or destruction. A well-adjusted person can live comfortably with his emotions. This is possible because he had developed, over a period, a degree of stress tolerance- anxiety tolerance, depression tolerance, and pain and privation tolerance. If this were not so, he would be constantly emotionally disturbed even though he might have learned
to repress the expression of his emotions sufficiently that others regard him as emotionally mature.

Most people have goals they hope to reach. There are, however, two major differences between well- and poorly adjusted people in this respect. The first is that the well-adjusted sets realistic goals while those who are poorly adjusted set more unrealistic goals than realistic ones. When the well-adjusted set goals which they later find are unrealistic, they are willing to lower them to more realistic levels.

The result is that a balanced person is a well organized one. He integrates his various functions and roles in life according to a consistent, harmonious pattern. He is thus able to make the best use of his time and effort, and this increases his chances of reaching his goals. This, of course, does not mean that he is a compulsive worker or that he is driven to achievements by someone else. The goals are set by him, rather than imposed upon him by others, and so he has a strong motivation to do all he can to achieve them.

Well-adjusted people are outer-oriented while those who are poorly adjusted tend to be inner-oriented or self-bound. The former belong to the group known as "extroverts" while the latter are "introverts." Most young children are self-bound, largely because their helplessness makes them dependent on others to do things for them. As children acquire skills and knowledge, those who are well-adjusted start to turn out-ward. Boys tend to be slightly more extroverted than girls, and girls show a regressive trend
toward introversion from the time they reach puberty. The well-adjusted
person's interest in others is revealed in a number of ways. He is unselfish
about his time, effort, and material possessions. He is willing to respond in
any way he can to the needs of others and does not regard it as an
imposition. The ability to empathize with others, to understand and to
sympathize with them in happiness and sorrow without feeling envious of their
successes or scornful of their failures, is common among the well adjusted
and uncommon among the poorly adjusted.

A person who is well accepted has no need for boasting, showing off,
or other patterns of behaviour characteristic of maladjusted people who are
trying to win greater social acceptance. He can be natural, at ease, friendly in
his relationships with others, and all this increases his social acceptance.

Just as well-adjusted people are goal-oriented, so do they direct their
lies by a philosophy which helps them to formulate plans to meet their goals in
a socially approved way. This philosophy of life may be based on religious
beliefs, it may be based mainly on what they believe is right because it is best
for all concerned, or it may be based on personal experiences. Many well-
adjusted people have a philosophy of life that is influenced by, if not actually
based upon, religious faith. They regard religion as a personal experience and
accept the parts of their faith that meet their needs best. The poorly adjusted,
however, tend to reject all religions and claim to be atheists or they cling to an
orthodox faith that puts more emphasis on religious practices than on religious
beliefs. For them, religion is often a crutch or an escape mechanism for feelings of insecurity and unhappiness.

To sum up, 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 acts. But what is basic in the healthy personality is that he remains balanced in the sense that the frustrations do not hold him from positive action. Stresses do not create in him the adoption of face-saving manoeuvres and adversity does not make him a passive suffer. With all his power or personality, he tries to overcome his difficulties and in doing so his personality emerge as maturer, sharper and better adaptable to the stresses 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 productive. Independence of the environment means the ability to be autonomous and not found by group patterns behaviour.

RELATIONSHIP BETWEEN MENTAL HEALTH AND CERTAIN PSYCHOLOGICAL VARIABLES

Mental health problem like physical problems is due to multiple causes. There are many unknown factors of agent host and environment in the natural history of mental health problems. Health or illness are affected by complex inter-relationship among many events. Accordingly, health researchers have explored five broad variables that correlated strongly with the health and illness; personality cognitions, social environment, gender and socio-cultural
variables. (Rodin and Salovery 1989). Among all of these known and unknown factors some variables such as personality, social environment, gender differences and also some socio-cultural variables that are important to effect health are selected for the present research work.

Certain Socio-Psychological Variables

PERSONALITY TRAITS: Personality traits have been described and defined in many ways though most of the descriptions and definitions are similar in that they include certain common salient points. A trait has been described as an aspect or dimension of personality which consists of a group of related and
consistent reactions characteristic of a person's typical adjustment. All
descriptions and definitions of traits emphasize that traits are learned
tendencies to (1) evaluate situations in a predictable way and (2) react in a
manner which the person has found more or less successful in similar
situations and when similarly motivated.

Characteristics of Traits:

Every trait has three characteristics: uniqueness, degree of
likableness, and consistency. Uniqueness does not mean that a person has
certain traits that are peculiarly his. It means that he has his own individual
quantity of a particular kind of behaviour. As Woodworth and Marquis point
out, "Traits are dimensions of behaviour in which individual differ." A trait is
not something that is either present or absent. Instead, like intelligence, it is
distributed according to the curve of normal distribution. This means that a
traits is present in all or almost all people, but in varying degrees, and in the
curve of normal distribution. This means that a trait is present in all or almost
all people, but in varying degrees. And in the curve of normal distribution,
most people cluster around the mean or average in any particular trait.

The second characteristic of traits is likableness. Some traits, such as
honesty, generosity, and trustworthiness, are liked by others, while some are
disliked- rudeness, cruelty, and egocentrism, for example. These attitudes
towards traits result from social learning in a particular cultural setting and are
almost universal within a culture. Traits are liked or disliked because they
contribute to social harmony or disharmony and add to the satisfaction or
dissatisfaction experienced from being with a person who has the traits.
The third characteristic of traits is consistency. This means that a person can be expected to behave in approximately the same way in similar situations. Consistency, like uniqueness, is relative. A person may be self-confident in a situation because he has mastered the skills needed to adjust to it and has experienced success in similar situations. But in situations requiring skills and modes of adjustment which he has not mastered so well or has had less success with in the past, he will show less self-confidence and may even show fear.

**Traits versus habits:**

Emphasis on the consistency of behaviour, which is characteristic of all traits, may lead one to believe that traits and habits are the same. Both, it is true, are learned patterns of behaviour. Both are consistent in that in similar situations it is possible to predict that the person's behaviour will be similar to his behaviour in the past, and both imply that learning has resulted in behaviour that occurs so automatically that the person does not have to plan his act and is often not aware of what he is doing until after he has done it.

The major difference between habits and traits is that habits are narrow and limited determining tendencies while traits are more generalized determining tendencies. And because they are more generalized, traits are more variable in their expression than habits. Traits are often the result of the integration of several specific habits that have the same adaptive significance for the person.
Common and Unique Traits:

Within the personality pattern are both common and unique traits. The combination of the two contributes to the individuality of the person. Which will play a dominant role in the personality pattern varies greatly in different people and may even vary in the same person at different times in the life span.

Common traits are qualities that are found in most people within a cultural group, such as dominance, sociability, truthfulness, need for achievement, and generosity. However among the members of the cultural group, common traits are found in varying degrees. These traits are the result of similar environmental influences, similar cultural values, and similar child-training methods. In other cultures, where values, child-training methods, and environmental conditions are different, other traits are common.

Unique traits are patterns of behaviour which characterize a particular individual and may not be found or found to the same degree in other people. They are developed from unusual combinations of hereditary qualities, from personal experiences, and from the social environment with its cultural values.

Do certain personality variables predispose people to illness or illness predispose a person to a specific personality? Some evidence suggest that angry, hostile people are more prone to illness than people who are optimistic. But which comes first? Perhaps the lack of illness cause optimism, or at least a positive life style. Thus, the role of personality variables in illness and health is still unclear and much more research is needed. Keeping in mind the importance of personality in promotion of mental health, present attempt has
been undertaken. In this investigation nine personality traits such as (Empathy, ego-ideal, pessimism, introversion, neuroticism, need-achievement, self-confidence, dogmatism and dominance) were selected to observe their effects on mental health. Personality traits have many patterns of response and tendencies. Generally, traits may be defined as attributes and any distinguishable, relatively enduring way in which one individual differs from another. Thus, traits can be considered as individual variables. There are three basic assumptions about traits.

1. Traits are common to many individual and vary in absolute amount between individuals.

2. Traits are relatively stable and exert fairly universal effects on behaviour regardless of the environmental situation. Thus a consistent functioning of personality variables is predictive of a wide variety of behaviours.

3. Trait can be inferred from the measurement of behavioural indicators.

Two most widely trait theories came from the work of Allport and Cattell. Allport (1942) basis his theory on the distinction between common traits and personal disposition. Common traits are used to compare people. He has identified six trait for comparative purpose. While personal dispositions are completely unique. These are cardinal (most pervasive) control (unique and limited in number) or secondary (peripheral). This uniqueness emphasizes the personality of the individual that Allport has developed. While Cattell (1965) has developed a similar set of trait and also construct personality test (16 P.F.). He has taken a different approach from
Allport and identified two categories of traits- Surface traits and Source traits. He identified total 35 traits, 23 surface traits and twelve source traits.

**TYPES OF TRAITS**

There are three types of traits as given below:-

1. **Continuous Type:** When typology is based on the normally disturbed traits and the personality who are located at the opposite poles of each of the characteristics, we have continuous type.

2. **Specific Type:** When typology is such that an individual can be placed in either this or that category and there are few or none intermediataries, we have 'specific' types.

3. **Discontinuous Type:** These are hybrid. Such types have characteristics of both continuous and specific types.

   Every trait has three qualities characteristics. Uniqueness, degree of likeableness and consistency. Uniqueness means a person has his own individual quality of a particular kind of behaviour. As Woodworth and Marquis (1947) point out, “Traits are dimensions of behaviour in which individual differ”.

   The Second characteristics of traits is likableness. It means that some traits, such as honesty, generosity and trustworthiness, are liked by others. While some are disliked.

   The Third characteristics of trait is consistency, means that a person can be expected to behave in approximately the same way of similar situations.
In the present investigation personality traits have been selected to find out correlation between these nine personality traits and mental health status of professionals. These traits are described as:

1. **Empathy**: Empathy refers to inter-personal sensitivity. This involves the realisation and understanding of another person’s feeling need and suffering. As Rogers (1975) wrote “The state of empathy or being empathic is to perceive the internal frame of reference of another with accuracy and with the emotional components and means which pertain there to as if one were the person; but without ever losing the as if condition (Quoted in Gallo 1989). This variable has been considered important for people in leadership positions. It is a self-conscious efforts to share and comprehension accurately the presumed consciousness of another person. O’Donnel et.al. 1999 investigated that in the absence of empathetic concern, poor communicative responsiveness and high emotional contagion significantly contributed to reduced personal accomplished. Empathy allows one to quickly and automatically relate to the emotional state of others, which is essential for the regulation of social interactions coordinated activities, cooperation toward shared goals. Even though cognition is often critical, it is a secondary development (Waal, 2008). In the words of Winefield and Hansen (2000), Empathy is a component of communication and can only be improved with appropriate training. Iqbal and Yadav (2008) found that subject improved significantly in post condition of self-esteem and empathy.
2. **Ego-ideal**: The ego-ideal is composed all fantasies which portray the person as a hero accomplishing great deals or achieving recognition. As Zvi (1997) investigated that individual psychological dynamics associated with the group ideal which is substituted for the ego-ideal, promoting a mass delusional ideology. According to Robinson et.al. (1996) assumed that ideology is the primary decision criteria among revisionists and traditionalists for selecting introductory English syllabi.

3. **Pessimism**: It is a tendency to look upon the future with uncertainty, disbelief or disdain, accompanied sometimes by expectation of negative happenings regardless of the actualities of the situation. Clinic (2002) investigated that optimist may be in better over all health, as they age than pessimist. But earlier some researchers of Mayo Clinic has suggested that optimists live longer and less likely to die prematurely than pessimists. Croydonjohn (2009) found that paranoid delusions were associated with a combination of pessominic thinking style (low self-esteem a pessimistic way of explaining event and negative emotion) and impaired cognitive performance.

Some other psychologists as Denollet and Brutsaert; 1988, Pederson and Denollel; 2003, Denollet (2005) pointed out that type-D (distress personality having some negative and neurotic tendencies also) have been associated with a variety of emotional and social difficulties, including all negativity of behaviour lack of social support and low level of subjective well being.
4. **Introversion:** The introvert tends to be self-oriented and introspective. His interest run towards the intellectual and artistic and he shows more concern for abstract areas than reality. His extreme concern for internal matters may result in insufficient to political affairs and his values are more up to be idealistic or sentimental than realistic. He tends to behave in serious, quiet constrained, even inhibited manner and avoid social gatherings and personal involvements. The introvert tends to be highly ego-involved in achievement or in competitive situations and thus vulnerable adventure in high-risk situations. Resignation or withdrawal from the stress-situations is the natural response of the introvert.

5. **Neuroticism:** This concept implies to a highest sensitivity to stressful environmental situations; a low degree of stress tolerance. Some psychologists as Denollet et.al.1998, Pederson, 2003; Denollet, (2005) made an investigation on some neurotic tendencies (Type-D personality means distressed personality) and found that type-D personality have all the negative behaviour, lack of support and low level of subjective well being. Khan et. al. (2005)) found that with high levels of neuroticism are vulnerable to suffer from more than one psychiatric disorders at the same time (comorbidity). They also found that neuroticism reflects emotional instability, vulnerability to stress and anxiety process and the most striking findings was that neuroticism, on average, accounted for 26% of the comorbidity among the other disorders.
6. **Need-achievement**: This implies a desire or tendency to come up to a standard of excellence where, (i) one winning or doing primary concern (ii) effective concern over one's goal attainment (iii) there is no competition with others but involves meeting an imposed requirement of a good response. Therefore, the term active in definitive terms means striving to increase, or keep possible one's own capability in all activities in which an excellence in thought to apply and where the execution of activities can, therefore, either succeed or fail. As Mourya (2009) made a research on need-achievement and found gender difference was significant as academic anxiety and achievement (2) Academic anxiety and need for achievement significant at types of school (government and non-government) (3) gender boys and girls was not significant on type of school.

7. **Self-Confidence**: To be a leader in any situation, an individual has to appear to make positive contribution to the group. Because self-confidence has a positive relationship with leadership. Therefore, self-confidence is an important variable as it indicates the assurance one possesses about one's capacities and abilities not only confronting problem situations but also in finding solutions. As Kumari & Saxena (2009) examined that Yogasana has effects on self-confidence which put positive spin on emotional Bhardwaj A. (2009) illustrated that person who attended 5 Urja Jagaran Satra have improvement in self-confidence.
decrement in inferiority and insecurity. Brown et. al. (2007) found that self-processed interest and prior training in mental health are associated with self-processed interest in mental health care predicts confidence and self-perceived skills in recognition, assessment and management of common mental health problems. Caplin (2006) found that law student exhibited more self-confidence and autonomy.

8. **Dogmatism:** It is a clear way of thinking which could be associated with any idealology regardless of content: an authoritarian out-look, on life, on intolerance towards those with opposing beliefs. To say that a person is dogmatic or that his belief-system is closed to say something about the way he believes and the way he thinks not only about single issue but also about networks of issues.

9. **Dominance:** Individual whose personalities are characterized by dominance or ascendance will more frequently be found to occupy or emerge in leadership roles the primary desires prestige and material gain. Some of the behavioural components of these variables are to control one’s human environment to influence or direct the behaviour of others by suggestion reduction, persuasion or command. Morris et.al. (2009) found no significant difference with any of 5 personality factors (Dominance, liveliness, warmth, apprehension and sensitivity), between the three groups Religious participants (Christians and Muslim Combined) scored higher for general well being than non-religious participants. Christians scored significantly lower for death anxiety than
both non-religious and Muslim groups and Muslims scored significantly higher than non-religious groups.

**PROFESSION:** Profession is the second important variable to assume its effects on mental health. Doctors and advocates were selected for the present research work. A new statement (1917) article by the Webbs quoted "A profession is a vocation founded upon specialized educational training, the purpose of which is to supply disintegrated counsel and service to others, for a direct and definite compensation. According to the Oxford English Dictionary, profession involves the application of specialized knowledge of a subject’s field, or science to fee-paying clientele.

A profession arises when any trade or occupation transforms itself through" the development of formal qualifications based upon education and examinations, the emergence of regulatory bodies with power to admit and discipline members. In the present investigation, we have selected Doctors and advocates in the category of profession. Thus professional group occupy higher position in our society. The work of these professional groups are not routine type of jobs or static in nature rather, dynamic. They work round the clock. They are mentally, emotionally as well physically involved in their job. They have lot of strains on their job. Problems of ordinary day-to-day life social functioning, moral as well as all over mental health are generally governed by these working hours. Their way of working directly or indirectly influences the mental health of both doctors and also advocates. Tyseen et.al.; (2002); Ulmer (2002) studied mental health and job satisfaction among doctors and found that mental health problems were found highest during first
year postgraduate and job satisfaction were found in both rural and urban general practitioners while working full time were predictive of lower job satisfaction in women.

Pilgrim et.al. (2001) conducted a research on Mental Wealth Act reforms: Emerging challenges on the psychologist as clinical supervisors that before volunteering for the incipient role, psychologists should be aware that in the present form, becoming a clinical supervisor will substantially increase the possibility that they or their employers will be sued for negligence or for breach of Human Right Act. Persaud (2000) investigated that psychiatrists also suffer from stigma and media lobbying could became a more central role of the Royal college of Psychiatrists.

Al Keilnawi et.al. (1999) made an investigation on gender and biomedical/traditional mental health utilization and found a gender difference in symptomatology and in a patient construction of etiology.

Dimatteo et.al. (1993) examined the prediction of occupational stress, general life stress and mental health among 108 dentists and predicted poor mental health by baseline occupational stress. Shore et.al. (1998) conducted a research beyond self-interest: Professional advocacy and integration of theory, research and practice. They found that for age range advocacy requires a careful look at the values principles, and structure underlying the current status of work. Sharma et.al. (2009) investigated the relationship between quality of Life (QOL) and well being and found positive relationship between Quality of life and well being and also that doctors who were doing regular exercise have better well being than their counterpart also.
Copline & Williams (2006) made a study to assess descriptions of self and ideal lawyer among women law students and found that law students exhibited more self-confidence and autonomy. Chopra (2009) illustrated that workplace stress is associated with an adverse impact on emotional well being and is linked with an increased risk of CMDs (Common Mental Disorders). Brown et.al. (2007) Constructed a research on General Practitioners (GPs) and the results of this study highlighted that self-professed interest and prior training in mental health are associated.

**GENDER:** Sex is third important variable which contribute to the mental health of individual some health concerns apply to women (Menopause) and other affects women disproportionately. Therefore, the health concerns of women differ from sense of men. Span between men and women have been decreasing. Women are changing life style and the work patterns are highly correlated with increased medical problems and decreased average life span. Rodin & leckovies (1990) assert, the redefinition of gender roles and the changing social support structure for women affect health, treatment and psychological functioning of women. Women constitute almost half of the population of India. Their contribution is no way lesser than man in various areas of work (Sajjad 2002).

The Indian women today are increasingly playing multiple roles in addition to their traditional roles as wife, mother, guardian of the household, and keeper of cultural tradition. She is now becoming professionals as doctors, engineers, advocates etc. Due to this there have been significant changes in social out-comes, modes of living and life styles. But
contemporary Indian women are still playing dual role conflicts, which affect mental health of dual career women. In this respect male are different from female. Studies on doctors and advocate’s mental health are rare and this research is an effort to understand the mental health of male and female professionals. Share (2009); Amoli (2009) found that practicing of Yoga is beneficial for managing girl’s mental health and altruism.

Najam (1995); Umberson (1996) investigated the relationship between sex difference and psychological effects of unemployment. Sample was of 60 unemployed Pakistanis (aged 20-35 years) with master of professional degrees. Results indicated that male and female differ on the attributions. Simon & Robin (1995) examined gender differences in the consequences of combining spouse, parent and worker roles for mental health and found that work and family roles have different meaning for men and women. Hintikka et. al. (2002) investigated the difference between the mental well being of men, women & friends, they found that mental well-being might be promoted if mentally distressed man seeking professional help were supported in building & maintaining social networks and mentally distressed women were supported in harmonizing their family life.

Kopper & Beverly (1993) conducted opinion survey on 407 female 222 male college students and investigated the relationship of gender, sex role identity and Type A behaviour to multiple dimensions of anger expression and mental health functioning and found that gender makes no difference. Uskuela (1996), Sachs (2002) investigated psychological difference between male and female Ss were 35 male (aged 30-44 years) and 29 females (aged
32-44 years) and found that females are not as strong as male while facing physical and psychological problems.

Koskela (2000) examined in a nation wide sample (869 Women and 773 men, aged 18-74 years) whether there were gender differences in association between religious attendances and mental well being. Rautio (2001). Author (2003 to 2007) made a study on aged 75 in 1989 and 80 in 1990 and found that socio-economic factors are associated with physical and mental capacity in elderly people and male shows a greater propensity to suffer stress due to workload rather than female. Mishra (2009) examined Husbands mental health is better compare to wife mental health. Angela, 2007 made a computer search using the term, 'help seeking' and 'mental' (350 studies) and found consistently to be predictive of mental health utilization and attitudes towards female help seeking.

Rowlands (2008) shows that the sexes do not have the same triggers for workplace stress. Kochyop & Kumor (2009) investigated that marital status and gender differences do not affect the mental health. Rizwana & Singh (2009) revealed that Urban and rural males are not different on type A behavioural pattern, which is likely to show the possibility that males of urban and rural areas are equally prove to negative effects of TABP (Type A behaviour pattern). Stroud et. al. (2002) demonstrated that women showed greater psychological response to social rejection and men tended to react more to achievement challenges.

**Occupation of Spouse:** Is also an important variable occupation of other partner is actively and intimately connected with all financial, social and
psychological needs. The role of occupation within society is defined by the nature of the work that individuals perform occupation of other partner is actively and intimately connected with financial and socio-psychological need. Some studies showed that higher income may lead to higher motivation and satisfaction which ultimately affect mental health of individual such aspect has been emphasised by researchers as Richard and Price (2001), Roudoff et.al. (2002). The status of other spouse is closely related to the economic position which in turn depends upon their access to productive resources and opportunities for participation in economic activities.

Simen et.al. (1995) explored gender differences in the consequences of combining spouse parent and worker roles for mental health and found that work and family roles have different meanings for men and women. Not only gender but socio-economic state is also important variables that affects mental health of professionals (Adler et.al. (1994)). Robertson et.al. (1993) examined the experience of men who are voluntary Homemakers and their female partners (Primary Wages earners). They found that men were associated to be psychologically healthy and really happy with their lives and choices.

Travers et. al. (1993); Barnett (1992) found that teachers as compared with other highly stressed occupational groups, experienced lower job satisfaction and poor mental health and also found that the relationship between job stress and psychological distress was exacerbated among men who had troubled relationship with their partners. Goldenhar et.al. (1998);
illustrated that having responsibility for others' safety and having support from supervisors and male coworkers was related to greater job satisfaction.

Bruce et al. (2004) investigated a sample of 776 police officers having a spouse or partner in the same profession, and both have reported significantly lower concern of spouse or partner concern but the same level of work & family conflict. Perrone & Kristin, (2005) highlights information for career counselors when they were addressing work family interface with individuals who are members of same, sex, dual earner couples or families.

Mansuri (2008) found that married working women have shown good mental health. Private and public sector working women were the same on mental health and Family Environment Score. Urban working women have shown poor mental health in same Family environment and differ in mental health and Family Environment as compared to rural working women. Sharma (2009) found a significant difference in the level of stress between working and non-working women. As Tripathi et al. (2008) found that cognition functions of working women are greater than non-working women.

Some researchers (Zill & Zahoor 2009); Chaudhary S. 2009 made a research on Male and Female Higher education Teachers and working women and housewives. The results show that female higher education teachers have greater organizational commitment as compared to male higher education teachers. The level of life satisfaction was higher among working women and housewives in terms of the level of stress. Sharma et al. 2009; Tomar et al. 2009; Rani. 2009, found a negative relationship between stress and life satisfaction as well as self-esteem and stress but positive
relationship was found between self-esteem and Life-satisfaction. Second investigation shows that different predictors of mental-health were found among dual career couples across four stages of life cycle and Third study shows that marital adjusted women scored higher than divorced women but in the field of working or non-working marital adjusted women have no difference but divorced women have difference on MMHSI (Mithila Mental Health Status Inventory).

James (1999); Kumari et.al. (2000) found a negative relationship between daily stress, intimacy and marital quality personal efficacy and a lower degree of anxiety found in comparison of housewives and nurses. James (2009) found the policies contribute to decreased work related stress and have a positive impact on the mental well-being not only of employee, but his or her spouse and other family members. Sarcen (2009) tried to identify the factors that affect mental health of employers and suggest some strategy that could creat a happy work place.

**Demographic Variables:** Besides these variables, we have selected some demographic variables also. Such as age, depression, marital status experience, anxiety, Income etc. These variables also play a great role to influence the mental health. As Sharma & Kumari (2009) found negative relationship between stress and life satisfaction and positive relationship between self-esteem and life satisfaction.

Khokhar (2009) proved that children women and aged persons are affected by depression many times Karimi et.al. (2009) found a significant different between two groups in anxiety after intervention. Kashyap et.al.
(2009) examined the impact of gender and marital status on psychological well-being and found no significant difference among marital status and gender. Sujata et al. (2009) found that gratitude positively correlated with hope but not with well-being where as hope is correlated positively with well-being. Higher age group (40 years and above) have higher well being in comparison to the younger (20-40 years). Mental health of students influenced by academic anxiety. (Chaudhary et al. 2009; Shirotriya 2009).

In the light of above discussion it is reasonable to infer that mental health has been extensively and intensively investigated by researchers because the personality development is linked to it. But if we look to our own country we observe that most of the Indian researchers have tried to borrow and utilize factors and also methodology used by psychologists in developed countries, the socio-cultural differences usually discarded. It is apparent that factors, which are peculiar to Indian psychologist, were not taken into account while studying mental health. But present study focuses on the assumptions, gaps, biases in the literature intends to incorporate some demographic variables especially profession, gender differences, occupation of spouse etc. That have direct and indirect effect on mental health of individual.

A review of literature on personality trait also revealed that relationship between mental health and personality traits such as empathy, ego-ideal, pessimism, introversion, neuroticism, need-achievement, self confidence, damnation and Dominance etc. have been thoroughly investigated but its relationship with certain demographic variables (Profession, gender differences and occupation of spouse) have not been investigated to the
desired extent by Indian Researchers in the context of mental health. Thus
keeping in view of the importance of personality traits and demographic
variables and also dearth of the studies in this area, the present attempt has
been undertaken.

Thus, a better understanding of mental health of Indian doctors and
advocates may help in evolving appropriate strategies for enhancing their
better mental health. In this respect the present study may have applied
implications. That is the findings of the present study may throw light on
holistic approach to mental health will help substantially in the overall
development of Indian Profession.