CHAPTER 2

REVIEW OF RELATED LITERATURE

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Review of literature provides important facts and studies related to the present investigation. It helps and guides the investigator to know the current status of the problem, which he is going to study. It is expected to provide the guidelines for formulating the hypotheses to be tested in the study. A literature review is an account of what has been published on a topic by accredited scholars and researchers. In writing the literature review, the purpose of the researcher is to convey to the reader what knowledge and ideas have been established on a topic, and what their strengths and weaknesses are.

Besides enlarging knowledge about the topic, writing a literature review helps the researcher to gain and demonstrate skills in two areas:

1. Information Seeking: It is the ability to scan the literature efficiently, using manual or computerized methods, to identify a set of useful articles and books.

2. Critical appraisal: It is the ability to apply principles of analyses to identify unbiased and valid studies.

A literature review must do the following things:

a. Be organized around and related directly to the thesis or research question.

b. Synthesize results into a summary of what is known and is not known.

c. Identify areas of controversy in the literature.

d. Formulate questions that need further research.
This chapter includes the facts and studies related to the present investigation as this literature has helped the researcher in defining the problem. Knowledge of the available data often serves to narrow the problem itself, as well as the techniques that might be used.

**History of Life skills and Social Problems**

Life skill means creating suitable and effective inter-individual relations, doing social responsibilities, making proper decisions and solving conflicts and arguments without choosing actions which are harmful to themselves and others. The Institute of TACADE the author of [Necessary Skills for Primary Schools] provides another definition of life skills as; “personal and social skills that children and adolescents should have learned in order to take effective and certain actions regarding other people and society (Nori, 1998).

Caring and cooperation are basic fundamental life skills which lay the foundation for cooperative learning, conflict resolution, and positive social skills. In order to adjust socially, people must be able to cooperate with each other and achieve common goals. They must be able to resolve conflicts and demonstrate positive social skills. Lickona (1991) believes that cooperative learning teaches the most important life skills and interpersonal moral skills. Lickona says that we have not fully educated our children until we teach them conflict resolution skills. Jordan and Lemetais (1997) believe that cooperative learning helps to foster and develop life skills in students of all ages. Cooperative learning, conflict resolution, social skills, caring and cooperation are all inter-related. The following documentations give credence to the life skills of caring and cooperation as fundamental skills for success at school and elsewhere.
During the early 1900's, people became more aware of social problems and began to organize efforts to try to solve them through organized guidance services. In 1908, Frank Parsons founded a vocational bureau for young men in Boston (Shertzer & Stone, 1976).

Many humane and charitable societies were organized. Through the efforts of those humanitarians, organized guidance services originated. The National Vocational Guidance Association was officially founded in 1913. There was an ascendance of guidance during the 1960's, during which time education came to be viewed as a vehicle for restructuring society and helping to solve some of its problems (Shertzer & Stone, 1976). One author believes that people learn best in a caring environment where they feel nurtured, as well as challenged. It is also important for learners to feel valuable and worthwhile. This author believes that we long for community, but we have to settle for institutions. The departments of the schools take precedence over the problems of the communities. Meaningful teaching has to be built on a shared vision between schools and communities (Ayers, 1993).

The first president of the Association for Specialists in Group Work, one of the fundamental characteristics of group counseling is that it involves caring, understanding, and acceptance (Shertzer & Stone, 1976). Group counseling attempts to modify attitudes by dealing with affective involvement, thereby creating a climate of mutual respect and acceptance of others.

Human beings are motivated largely by social urges because they are involved in social activities. Alfred Adler was a neo-Freudian who abandoned some of Freud's basic contentions. He believed that status and power motives were
more crucial for behavior development than sexual drives. A point which Alfred Adler emphasized is the social interest or life-style. He tried to assist clients by helping them to become more aware of their own self images and life-styles. Adler believed that people have a basic desire to belong and that they pursue this goal all their lives. He believed that some children hurt others because they feel hurt and abused themselves. They secure a place for themselves in the group by being considered vicious. Social adjustment is one of the basic goals of Adlerian counseling (Hansen, Warner & Smith, 1980).

LIFE SKILLS

Caring and cooperation are crucial life skills which impact our lives from birth. Without them, our lives would be chaos and daily living would be almost impossible. The importance of these life skills also carries over into the workplace. The jobs of the future will require workers who can cooperate with others in order to get the work done.

The life skills of caring and cooperation are as important to adults as they are to children. Caring means feeling and showing concern for others. A caring environment helps to produce self-confident individuals and the best quality education (Mackinnon, 1994).

The life skills of caring and cooperation are also important in the workplace, which is changing to a more group-oriented method of problem solving and task performance. Therefore, collaborative learning will become more important as a method of instruction. Teams will be more prevalent in the workplace of the future, making the skills of cooperation and compromise more valuable (Dede, 1989). Collaborative learning can help to prepare students to deal with complex problems in the workplace.
Wenc (2005), cohesiveness in the classroom is produced by caring and mutual support. Charlene Wenc, the author of the book, Learning Through Cooperation: Laughter, searched for the crucial ingredient found in cohesive classrooms. She found this ingredient in classrooms where students have learned the art of cooperation. However, she also found that this ingredient is the result of intention, planning, organization, preparation, and plain hard work. It has been theorized by (Gysbers & Henderson, 1994) that interpersonal skills are extremely important to effective life career development. Gysbers and Henderson outlined some student competencies that are essential in order to prepare for a career. These competencies include self knowledge and interpersonal skills. It is extremely important to develop and utilize the ability to maintain effective working relationships with peers and adults. Students need to develop listening and expression skills that will enable them to function in problem-solving and helping relationships with other people. According to Gysbers and Henderson (1994), cooperation is vitally important in career development.

Networking is one form of cooperative learning which is becoming prevalent today. This system of people connections has actually been around since the beginning of human history. It is a very good way to learn and meet people who can teach us new skills and attitudes (Bard, Bell, Stephan & Webster, 1987).

**COOPERATIVE LEARNING**

Sylwester (1995), we become a cooperative species as community tasks are assigned to individuals according to their specific talents so that the entire group can benefit from the strengths of each individual. The best spear thrower was given the position of being the lead spear thrower in the hunting party so that the whole group could eat better. The author contends that the human race would not have
survived if it were principally and violently competitive. By helping one another, the human race became a dominant form of life. It seems logical that schools would encourage social and cooperative behavior, since students are educated in group settings. However, traditional classroom design and procedure separates students and evaluates them individually and competitively. Sylwester has observed that many teachers embrace cooperative learning.

Another author advocates that children learn morality by living it (Lickona, 1991). The children need to be in a community in order to form relationships and work out problems. From their social experiences, children learn lessons about cooperation and respect for the worth and dignity of individuals. The conditions for a moral community in the classroom include caring about other students and being able to cooperate with others in the group.

Lickona (1991), cooperative learning teaches values and academics in a single stroke through the instructional process. Students learn that helping each other is a good thing, and this encourages altruistic attitudes and positive social behaviors. Cooperative learning helps to build community in the classroom and teaches basic life skills. The benefits include improved academic achievement, self-esteem, and attitude toward school. Through cooperative learning activities, students learn to care about people who are different from themselves and they can also benefit from helping other students who are having academic problems. Cooperative learning helps to temper the negative effect of competition that may manifest itself in negative behaviors and actions. For example, businesses will sometimes do anything to maximize profits, no matter what effect it has on people and medical students will sometimes sabotage each other's lab work in order to get top grades. If cooperative interaction is experienced regularly during the school years of children, there is at least some hope of tempering these negative effects.
In order to develop empathy in the classroom and beyond, students need experience in helping relationships. One way to encourage caring in the classroom is through a "class buddies" program in which an older class adopts a younger one. Cross-age tutoring is another way for students to offer meaningful service to other people. Students can also be encouraged to reach out to the community by volunteering in libraries, hospitals, nursing homes, programs for the handicapped, and other social agencies (Lickona, 1991).

There is some evidence that cooperative learning contributes to the development of social skills in students of all ages (Jordan & Lemetais, 1997). In fact, the lack of social skills has been identified as one contributing variable in the misbehavior of some school students. Jordan and Lemetais focused on a case study in which a program of life skill development and cooperative learning activities was introduced over a period of six weeks. Cooperative learning was used to develop students' life skills, thereby improving their behavior. There was some evidence that students became more socially aware and more skilled. The authors are committed to cooperative learning as a means of developing students' life skills.

According to the authors of one article (Leonard & Mcelroy, 2000), there is much research supporting the benefits of cooperative learning in the classroom. In this study, one teacher found that an interaction within groups is dependent upon the way that the activity is constructed. In other words, the decisions of teachers affect how the students participate and interact within a group activity.
In this study, most of the students were highly engaged in the activity and worked together to accomplish the goal. The design of the activity generated a great deal of student discussion for some of the students.

The structure of the activity was also conducive to group interdependence. The students in the group collaborated with each other and each student participated and attempted to do assigned tasks or roles. The students in the groups had to engage in problem solving, understand the task, make conjectures, and test their ideas. A group leader emerged from the activity, as well as several assertive students who attempted to assist in leading the group. Although there was one passive student, this student attempted to do the assigned task. The recorder even assisted in the solving of the dilemma.

The authors state that all students must have a role of equal status. Students must realize the importance of everyone's thinking. If everyone can participate in a high-status position, they may be more willing to cooperate and work together. Roles must be clearly defused and students must be held accountable for their assigned tasks. In this way, individual responsibility and group accountability can be maintained (Leonard & Mcelroy, 2000).

Another study was done over a period of two years to determine the effects of cooperative learning on student achievement, attitude, and meta cognitive awareness. This was done by using a cooperative learning approach to reading and language instruction. Second through sixth grade mainstreamed, academically handicapped students worked in heterogeneous learning teams on reading and writing activities. The results of this study favored the cooperative learning program over the regular instruction and pull-out remedial programs because of the
improvement in student achievement, attitude, and metacognitive awareness (Stevens & Slavin, 1995).

Carlson (1996) shows that some causes for disruptive behavior in the classroom may be broken social bonds, violent environments, stress and conflict, and inadequate curriculum. This researcher recommends a program called the Masters Action Research Project which was designed to decrease negative peer interaction in order to improve academic achievement and interpersonal relationships through cooperative learning.

Lickona (1991) two year study of a Cooperative Elementary School Model involved 2 treatment schools, 3 comparison schools, and 102 students. Findings indicated positive effects on academic achievement and social relations after the cooperative learning model was implemented. Cooperative learning helps to teach children that they can do more together than they can do alone.

**Conflict Resolution**

Violence is prevalent in our society today, which may be seen by reading the newspapers or watching the news on television. Conflict resolution skills are crucial if we are going to try to curb this violence. Williams & Williams (1995) have developed a strategy to help increase empathy and sensitivity toward other people. This strategy includes an approach which teaches students how to understand the motivations of others and reduce the mistrust which we often feel about the behavior of others. In this approach, instead of always assuming that another person's motives are evil, one should play out the scenario internally and decide when the behavior would be acceptable. For example, if a slow person is ahead of you in line, you should try to think of reasons that the person may be
slow. The slow person may be senile, sick, or not as quick as in younger days. The ability to empathize grows when we try to see another person or group from their own perspective. In turn, this produces less hostility. By looking at situations from the perspectives of others, we can help to stop cynical beliefs before they generate the anger which is harmful to our health. A Classroom Discussion Model for resolving conflicts was developed by Nelson, Thomas, & Pierce (1995). The goal of their process is to help students learn how to express themselves and behave in an acceptable manner with other people. The students will gain the interpersonal skills which will enable them to work together in groups and solve problems. This process also enables educators to gain the cooperation of students.

Wallach (1995) a series of curriculum kits produced by the Committee for Children were designed to help reduce impulsive and aggressive behavior in children. This curriculum entitled Second Step also aims to increase children's level of life skills and competence. Skill areas include empathy, impulse control, and anger management. Families play a critical role in the program. The Committee for Children recognizes that violence is a major problem in our society. The Second Step Program is based on the belief that violence can only be curbed by a cooperative effort among families, schools, and the community. In order to develop conflict resolution skills, human beings need to be able to recognize and verbalize their feelings, develop empathy, and think of alternatives to violence. emphasizes the effect which violence has on students, even if they are only witnesses to the crime and brutality in the streets today. Students also see violence in their homes. Research has shown that children suffer the consequences if they experience violence directly and also if they witness it. Wallach also supports the notion that young children may suffer anxiety as a result of violence in their environment.
The capacity to feel someone else's emotions as if they were your own starts to develop in childhood as a result of firsthand experience. Children must also see empathy modeled by loved ones in order to develop this capacity. People who can understand the anger of other people may be better able to diffuse emotions and help to prevent violent acts (Shure, 1994). According to former U.S. Secretary of State Madeleine Albright, peace means more security and prosperity to people all over the world. Violence is an enemy to everyone and a basic commitment against violence makes good sense (Albright, 1997).

SOCIAL SKILLS

Some believe that friendships are vital to the healthy development of students. They say that students who do not develop the necessary characteristics for maintaining social attachments are more likely to have health problems, emotional disturbances, and personality disorders in adulthood. Students need help in learning how to show concern and empathy (Lawhon, 1997). According to Harry S. Dent, empathy is considered a sign of maturity and great virtue. Good character requires self-control and self-discipline. A lack of self-control can cause irrational actions and even criminal acts (Dent, 1996).

It is encouraging to note that there are many curriculum guides to help teach social skills to school students. One such book describes five domains of interrelated social behaviors which represent important characteristics of socially-skilled individuals. These five domains include cooperation, assertion, responsibility, empathy, and self-esteem. Forty three social skills, which have been deemed to be critical by parents and teachers throughout the United States, are represented in the five domains of social behaviors. These social skills are critical in order for
students to develop successful relationships with peers, parents, and teachers (Elliott & Gresham, 1991).

Another therapy guide suggests that we teach students to be good, as opposed to trying to prevent them from being bad. The author advises parents to teach students to behave in acceptable ways because it is easier to teach a new positive behavior than it is to extinguish a negative one. The author believes that some students have trouble getting along with others because they have trouble understanding nonverbal cues. He supports activities such as teaching students to maintain a proper distance from other people. They should also be taught to interpret facial expressions, voice tones, posture, and body language. Students should also be taught through demonstration how various forms of touching can be misinterpreted (Shapiro, 1994).

Another study hypothesized that the lack of discipline in the home was associated positively with grade retention in school. Most of the children in the study were from homes in which the fathers were absent and the mothers were not able to provide sufficient discipline. The hypothesis was supported in the study. The students did not receive adequate training in social skills which would prepare them for life. Therefore, the consequences were negative (Rodney, Rodney & Mupier, 1999).

The authors of a project of the Southern Poverty Law Center contend that friendship is a basic need from early childhood. There is evidence that friendship helps to support young children's cognitive and emotional development. School is most often the primary place for young children to acquire a sense of belonging and friendship. The authors of this project argue that healthy peer relationships help empower children to develop social competence. Programs that encourage
friendship as an important component will help to prepare children to be responsible citizens in today's world. The authors suggest that cooperation and commitment be emphasized by having children work toward long-term common goals (Bullard et al., 1997).

School play is surprisingly important because it gives children experiences which are not typically formed at home. Children who are engaged in play are developing individually and they are also learning to be cooperative as part of a group. The personal and social development often occur at the same time because of the interactions which take place as they strive to be a part of the group. The authors of this article stress the importance of recess play at school because it is preparing children for a quality life. If recess is a positive time, then children can acquire the knowledge to help them lead a fuller life. The learning that takes place on a playground contributes in many ways to the educational process. It is a type of education which helps to develop the whole child (Thompson, Knudson & Wilson, 1997).

One rather interesting study suggests that it is a possibility that social norms require girls to show more positive social skills than boys, whether or not they feel empathic. Boys, according to this article, are permitted to express more anger than girls and are under less pressure to express positive social skills. The findings of the article imply that males are more likely to exhibit positive social skills if they have developed the skill of empathy (Roberts & Strayer, 1997).

A joint cooperative effort between home and school is crucial in the educational development of Students. For teachers, it is important to have a parent's perspective if there is a concern about a child. The information which parents can share should be acknowledged as important. One study examined the
cooperation between home and school. The conclusions showed that the rate of completion of weekly goals were greater for the study group children than for the control group children who were not exposed to the treatment program (Smith, 1994).

Timothy Pies also believes that it is important for children and adults to be educated in a non judgmental and trusting environment. Learners sense when learning facilitators are sincere and they react accordingly (Pies, 1994). Adults and children need a psychological climate of mutual respect and collaboration in order to learn effectively. Therefore, it is important that the learning environment is caring, supportive, and challenging (Galbraith, 1989). It is vital for parents to care about the education of their children in order for teachers to educate the children. Children need to feel the sense of cooperation between their homes and schools. School counselors must be able to work with families in order to help children deal with problems. Progress is often hampered because of negative attitudes on the part of teachers or parents. Counselors often face the task of trying to overcome these problems in order to help the child. Parents may even blame the school or the teacher for their children's problems. In turn, teachers sometimes blame the parents for the problems of the children. Counselors need to help the teachers to see the parents as expert resources to be used in the search for answers. They are faced with the responsibility of trying to foster a sense of cooperation between home and school. Coming to the school can be a negative experience for some parents who have bad memories of school. It is the job of educators to make the school a more inviting place to visit and develop a more cooperative relationship (Edwards & Foster, 1995).

Parent involvement encourages a collaborative problem-solving structure. The process of parent-community partnerships encourages and supports cooperation between parents and educators. Schools can no longer operate as autonomous
institutions that are disconnected from the community. Collaboration is vital because students today have so many personal and social needs. Learning is not possible until these needs are addressed. Educators are realizing this and schools are reaching out to the community for support (Hobbs & Collison, 1995).

Another study investigated the interactive effects which social skills and general mental ability have on salary and job performance. Their results indicated that neither social skills nor general mental ability by themselves would lead to higher levels of salary or job performance. However, workers who are high in both social skills and general mental ability are more likely to have the highest salaries and receive the highest ratings of their performance. Therefore, social skills are extremely important in the world of work today (Ferris, Hochwarter, & Will, 2001). One innovative approach suggests that professionals should work together as a team to help families. The authors believe that a cooperative effort between professionals is more effective and more efficient in solving problems. This team would include counselors, physicians, educators, and any other agencies involved in the case (Downing, Pierce & Woodruff, 1993)

Public school leaders are trying to build bridges between schools and communities. The idea is to make schools less isolated from the community. Partnerships between schools, businesses, and community agencies help to create more harmony. School-based management operates on this premise. If community education is fully implemented, education could be transformed. This could increase resources and bring a universal involvement of people in the educational process. Barbara Nielsen, the Former State Superintendent of Education in South Carolina, also believed that it is necessary to build a spirit of collaboration in order to provide a Total Quality Educational environment for our students. She believed that communities have to work with schools in order to accomplish this goal and those
partnerships between schools and businesses are essential to ensure the best possible conditions for the education of the children of South Carolina and the rest of the world (Nielsen & Dunlap, 2002).

The concept of community schools was important to Barbara Nielsen. Community schools are collaboration between the school and the community that allows the school buildings to be used for after-school programs, family literacy programs, parenting programs, recreation programs, etc. This encourages participation by many different segments of the community. Because of the need for a cooperative effort, community education stands out as one of the most prevalent issues when schools are attempting to restructure themselves. An educative community is one in which all of the agencies of the community are involved in the educational process in some way (Nielsen & Dunlap, 2002).

Communities have many resources to offer educational programs. Students need to learn about the problems of the community and be allowed to help solve them. Service learning is one way of doing this and should be included as an integral part of the educational process. In this way, the community can become a laboratory to enable students to better understand problem solving (Nielsen & Dunlap, 2002).

**Interpersonal problem solving**

Interpersonal and personal problem solving requires the application of cognitive problem-solving skills to social or practical situations (Lazarus & Folkman, 1984). Knowledge of effective problem solving strategies equips a person with the skills to work cooperatively with others, resolve interpersonal
conflicts and solve personal problems. This in turn enables the person to cope with adverse situations and enhances an individual's adaptability to meet the demands of the environment (Nastasi & Dezolt, 2006).

The important features and steps of interpersonal problem-solving process are the following (Nastasi & Dezolt, 2006):

1. Recognizing feelings of self and others. This step involves awareness and explicit communication of each other's feelings which are used as cues to problem identification.

2. Identification and definition of problem. This step requires identifying the problem, defining the nature of the problem, and setting the desired goal.

3. Brainstorming possible solution. This step involves unrestricted generation of ideas without evaluating any of the solutions.

4. Evaluating each solution. This step involves considering possible outcomes of each solution. Feasibility, positive or negative effects, short- and long-term consequences, and possibilities of solving the problem are discussed.

5. Selecting the best solution. This step requires choosing the best solution as decided by everyone involved in the process of problem solving.

6. Implementing the solution. This step requires implementation of the solution and taking action towards problem resolution.
7. Evaluation of the effectiveness of the solution.

8. Effectiveness of the solution that was implemented. If the selected solution was not effective, the entire process is repeated to find an alternative solution.

**Social interaction skills**

Social interaction skills refer to the communication skills and behavior necessary for interacting effectively in diverse contexts within an individual's ecology (Lazarus & Folkman, 1984). "These include skills that are important for initiating and maintaining social contacts; engaging in prosocial forms of behavior such as sharing, helping and comforting and exhibiting behaviors that are appropriate to contextual demands (Nastasi & Dezolt, 2006). Effective social interaction skills promote interpersonal relationships and collaborative interaction, and facilitate coping with social and academic stressors (Harter, 1990a). Social interaction skills influence collaborative problem solving and conflict resolution. Successful social interactions are likely to promote one's perception of social competence, and self-esteem, in turn influencing the mental health of that individual. For school-age children, successful social interaction skills influence the their participation in cooperative learning or seeking academic help which in turn is likely to increase their academic competence. Promoting social interaction skills therefore is instrumental in facilitating coping in students (Nastasi & Dezolt, 2006).

The researchers argue that the development of personal-social competence involves bi-directional interplay of self-efficacy; interpersonal problem-solving and social interactions and the critical competencies interact with the wider
context in a reciprocal manner across the life span (Nastasi & Dezolt, 2006). Early experiences in family, school and community contexts influence the development of personal-social competencies, which in turn influence the child's interaction with similar environmental conditions. Thus the internalization of the experiences from environment and resolution of the existing discrepancies between various contexts affect the development of a person's self-concept (Harter, 1990b). The researchers suggested that an integrated, positive self-concept serve as a shield against major and everyday life stressors and are related to a wide way of coping mechanisms and positive emotional state (Nastasi & Dezolt, 2006).

**SELF-ESTEEM**

Self-esteem is a personal qualification which appears in the individual’s views regarding himself (Coopersmith, 1967).

Self – esteem is often used which is related to self-esteem is also self-confidence, self-worth, self-assurance, self-efficacy, self-satisfaction, and self-acceptance. Brockner (1988) pointed out that there existed subtle differences between these terms and self-esteem and that self-esteem was a term that stood alone. For example, Bandura (1982) discussed self-efficacy in terms of the person's belief about his or her ability to perform necessary behaviors. Bandura noted that high self-esteem individuals had more favorable efficacy beliefs than did low self-esteem individuals.

Self-esteem is the degree of admission and preciousness that a person feels regarding himself (Biabangard, 1993).
Self-understanding and self-esteem are two different concepts and they provided two different definitions. They believe that self-understanding is the approach of self-understanding, his manner and his view of others believes, meanwhile self-esteem includes a person’s satisfaction of himself. Positive and negative evaluations have different effects on self-esteem. The people with low self-esteem are less sure of their values and are more affected by the social evaluation and respect them more (Biabangard, 1993).

Many personality theorists, such as Freud, Adler, and Erickson, have suggested that personality, including self-esteem, is formed during the early years of childhood and adolescence (Schultz, 1990). They advocated that self-esteem was formed based on interpersonal interactions and on our interpretations of those events (Adler, 1927; Rosenberg, 1979). People tend to carry forward to the present these interpretations of themselves and reinforce or modify them based on new interpersonal contacts. Steffenhagen and Burns (1987) in their discussion on self-esteem noted that self-esteem was a construct created out of our past constructs about the world. They believed that people tended to interpret the past from their present point of view and also interpreted the present on the basis of their past constructs. They concluded that each person's self-esteem was always changing because it was based on a comparison of their present actions, their past beliefs, and their ability to attain future goals.

**Earlier Views on Self-Esteem**

For a time, Erikson’s (1968) theory of identity formation provided one of the most compelling accounts of development through adulthood, and even though he did not develop a theory of self, he identified central issues and related developmental conflicts that could have provided the basis for many
self definitions. For example, Erikson theorized that it is at the stage of intimacy versus isolation that the young adult first begins to relate his or her own identity to that of another person. This means that the self requires some form of "maturity" in order to develop reciprocity and differentiation in relating to other identities, as, for example, the individual's own identity versus his or her partner, career, parent, etc. Erikson (1968) went further to explain that it is only when the individual can place these various identities into a larger perspective, coordinate them with those of others, and consider them within a temporal context, in terms of appreciating his or her place within the context of society, culture, and history, that the development of self-esteem capacities emerge. Erikson holds that self-definition is based on the degree to which conflicts are experienced and resolved. It is to be noted that little work, if any, seems to have been done on the theory of identity formation and how it influences the development of self-perception and its corollary self-esteem. Brim (1976) gives several reasons for this omission; among them, the fact that we have for too long overemphasized and allowed ourselves to be overly influenced by childhood experiences as predictors of adult personality. Affect has generally been recognized as an important element of self-esteem. The relevance of affect to self-esteem is based on the role of emotion as a component of the evaluative processes that lead to self-definition. This has been emphasized in the work of neo-Freudians in their respective ways: for Homey (1955), her theory of neurosis is assumed to imply that self-demeaning feelings are at the root of basic anxiety. To cope with it, the individual must construct an idealized image and try to enhance his or her self-esteem. Sullivan (1955) thought that anxiety was caused by threats to one's self-esteem or by rejection and negative evaluation by others. Adler (1927), held the view that inferiority complex was the result of organ deficiencies and that body weaknesses were a threat to self-esteem. This viewpoint, if valid, would place all persons with disability in this
category. Epstein (1973) treatment of self-esteem also emphasized affect. Epstein contended that the major functions of the self-theory were to optimize the pain/pleasure balance and to maintain self-esteem. The process follows a developmental pattern in which threats to the child's sense of self, cause him or her an emotional pain or an injury to the psychological self. Other theorists have defined self-esteem in similarly imprecise but more motivational language. Kaplan (1975) has referred to self-esteem as a universal motive, "a dominant motive in the individual's motivational system": a definition that is so wide as to wrongly suggest that self-esteem is synonymous with such terms as desire, impulse, incentive, and drive.

**Self-Esteem and Self-Confidence**

Some studies seem to see self-esteem and self-confidence within the same light and to use them interchangeably. The failure to see the distinction between the two appears to have contributed to the confusion in the self-esteem literature. Rosenberg (1979), in acknowledging the differences, explains that "Self-confidence essentially refers to the anticipation of successfully mastering challenges or overcoming obstacles or, more generally, [it refers] to the belief that one can make things happen in accord with inner wishes. Self-esteem, on the other hand, implies self-acceptance, self-respect, feelings of self-worth." Self-confidence would appear then to be synonymous with self-efficacy, as defined by Bandura (1977): the conviction that one can successfully execute a behavior required to produce a desired outcome. While also differentiating between the two terms on the grounds that level of self-confidence at any one moment may be unrelated to an overall level of self-esteem, Dickstein (1977) stated that several experiments purporting to be on self-esteem were, in fact, on self-confidence. This statement is exemplified in Coopersmith's (1967) study in
which subjects were requested to estimate the probability of their success at a particular skill or game.

Against the background of Rosenberg's definition of self-confidence, Coopersmith's (1967) study was about self-confidence, not self-esteem. Dickstein (1977) explains further: "Without measuring self-confidence over a wide variety of situations, or determining the importance of a particular activity for the subject, the results of such studies may be misleading with regard to the role of various factors associated with self-esteem." An empirical study of the distinction between self-esteem and self-confidence is provided by Epstein (1973), whose study of the sex-difference literature suggested that girls at a certain age level suffer from low self-confidence, but not low self-esteem. It may be noted for clarity that Dickstein's (1977) emphasis on the importance of a particular activity is intended to show that the importance of an activity will determine the degree to which success or failure affects overall self-evaluation. This perspective incorporates dimensions of perceived importance and perceived competence into her measure of self-esteem.

Rosenberg (1979) has investigated the role of the importance of dimension under the general rubric of psychological centrality: How a particular characteristic is central to one's self-definition. On the dimension of likability, for example, he found that the relationship between likability and self-esteem depended on how important or central the characteristic of likability was to the individual. If, for example, an individual does not care about what people think about him or her, their opinions, good or bad, will not affect the individual's self-esteem.
**Self-Concept and Self-Esteem**

Self-concept and self-esteem are notions that often appear in educational, personality, and psychological literature and that have been credited with an important role in explaining, predicting, and controlling behavior (Bandura, 1982; French, 1969; Hall, 1971). Burnett (1994) did a study whose purpose was, among other things. To develop a valid and reliable psychometric instrument to investigate self-concept which he defined as beliefs that people have about specific characteristics associated with themselves as people. In the process, Burnett (1994) realized that the use of self-concept and self-esteem has been characterized by lack of a clear definition of the terms, the role each plays in behavior and performance, and a failure to identify any link that may exist between the two terms. The same problems had been encountered by Hattie (1992), Hughes (1984), and Wylie (1979). This has resulted in a great deal of disagreement and confusion on the theoretical and empirical bases of many of the studies relating to self-concept and self-esteem (Dickstein, 1977; Rosenberg, 1979; Wylie, 1979). Self-concept does not appear to be the same as self-evaluation. Self-concept would refer to the descriptive aspects of the self; it is the constellation of all the things a person uses to describe himself or herself, irrespective of whether or not these descriptions are evaluative (I love playing basketball) or non-evaluative (I play football). Self-esteem, on the other hand, would refer to the evaluation contained in the self-concept and that is derived from an individual's feelings about all the things he or she is; that is, the evaluation of an individual's described self (I love what I see of myself). In other words, it is the value placed on self-concept that makes the difference between high and low self-esteem (Higgins, Strauman, & Klein, 1986; Pope, Mchalle, & Craighead, 1988). The distinction between self-concept and self-esteem may thus also be viewed as the distinction between

Models of Self-Esteem

Current Perspectives

Recent theorists see self-esteem from three perspectives: as a global self-esteem, as a differentiated aggregate of evaluations, or as both a global and differentiated aggregate. Mullener and Laird (1971) have stressed domain-specific components and have suggested, apparently on the basis of the assumption that self-image matures (Erikson, 1968), that self-esteem undergoes increasing differentiation with age. In a study of seventh graders, high school, and college students, Mullener and Laird (1971) found increasing differentiation in five domains: achievement traits, intellectual skills, physical skills, interpersonal skills, and a sense of social responsibility. This would mean that while a single global self-concept may exist at one point in development, it dissolves into a variety of different evaluations with age.

Rosenberg (1979) has asserted that there is both a global self-esteem as well as a body of discreet, disparate and independent constituent parts of this complex concept. "Both exist within the individual's phenomenal field as separate and distinguishable entities". While suggesting that each should be studied in its own right, Rosenberg (1979) has contended that it is the failure to recognize the need to distinguish between the global and the discreet aspects of self-esteem that seems to have led to the misleading studies and inferences that have become so much a part of the self-esteem literature. An example might be seen in the wrong conclusion drawn by Proshansky and Newton (1968) to the
effect that minorities have lower self-esteem because they report negative attitudes towards their skin color or race. The argument seems to indicate that skin color or race one is unlikely to adversely impact one's overall self-esteem. In the same vein, the attribution of poor achievement of underprivileged children to their perception of not being smart, and hence all the measures designed to improve their self-esteem, does not appear to have any basis in the literature. "The assessment of one's academic ability and the view of one's general self-worth are two separate attitudes whose relationship must be investigated, not assumed". Rosenberg has further documented that it is not skin color or race or even religion per se that damages self-esteem, but their "contextual dissonance."

In a very comprehensive paper on the subject, Harter (1982) has reviewed the literature, summarized her own studies, and discussed the subject in a more integrated and coherent manner than many of the previous studies. This has been done in a way that debunks spurious theories and faulty studies, and redirects attention to areas where research efforts might be more fruitful. The studies by Harter on the self, both as a cognitive construction and as a social process, have paved the way for research that should be able to examine the cognitive and social aspects of self-esteem and similar self-referent phenomena. Besides the acknowledgment that both trait and situation-specific concepts of self-esteem are valid characteristics, Harter has thrown new light on the concept by arguing for both, a global concept of self-worth and domain-specific evaluations of competence, social acceptance, and control of the outcomes of one's life. Characteristically, Harter Perceived Competence Scale for Children was based on these four domains and thus brings to bear on the concept of self-esteem a new and integrating approach that seems to clear some of the confusion.
Self Theories Related to Self-Esteem

It is hardly adequate to study the concept of self-esteem, and for that matter any self-referent phenomenon, without bringing into relief its relationship with the self and how the self, as the hub from which such phenomena radiate, influences and shapes its conceptualization and manifestation. Even before the interregnum of behaviorism, early psychologists such as Hall (1998) had recognized the self as the focal element that is instrumental in organizing the perception of the individual's social world. Post-behaviorists were no less emphatic on the vital role they attributed to the self in an individual's understanding of his or her world (Krech & Crutchfield, 1998). Combs and Snygg (1989) have also described the centrality of the self to behavior in no uncertain terms: "As the central point of the perceptual field, the phenomenal self is the point of orientation for the individual's every behavior. It is the frame of reference in terms of which all other perceptions gain their meaning." This is perception represented as cognitive, but laced with powerful emotional components. By phenomenal self is meant the awareness that an individual develops as a result of his or her interaction with the environment, his or her beliefs and values, attitudes and traits, and how these impact his or her behavior (Jones & Gerald, 1967). This would mean that the self is both a process and a structure: a process because it is the means by which the individual conceptualizes his or her behavior from the point of view of both his or her external and internal states; a structure because it constitutes an available system of concepts which is used to organize, modify, and integrate the functions of the individual and thus help the individual to define himself or herself (Epstein, 1973; Kernberg, 1977; Reykowski, 1975).
Self-Esteem as a Function of the Self

Self-esteem, like many of the self phenomena (self-regulation, self-monitoring, self-determination), is not realized by dint of will power. Recent studies indicate that it operates through a set of sub functions that must be developed and mobilized in order to effect a self-directed change (Bandura, 1977; Epstein, 1979; Kanfer, 1977). In this regard, intention and desire one are of marginal utility unless the right conditions have been created. Erikson (1968) saw the process in terms of the ability of the self to develop differentiation and reciprocity in relating to others within the context of society, history, and culture. Epstein (1979) saw it within the context of the Cognitive-Experiential Self Theory as coming under the umbrella of a person's implicit theory of self and as developing from an internalization of a child's need to be loved by her parents. Self-esteem, therefore, is defined by Epstein (1979, 1990) as a broad assessment of worthiness that is closely associated with emotions. Describing self-esteem as a concomitant of self-appraisal, Simon (1979) stated that self-esteem is based on factors that are not only relevant to the individual, but also on factors that must satisfy a certain criterion of adequacy in order to activate the self-evaluative reactions that lead to self-esteem. This adequacy is defined on the basis of three related criteria: performance level, internal standards, and the performance of others (Bandura, 1982).

Performance level

It is a matter of everyday experience that when people's successes are attributable to their own abilities and efforts, they take pride in those successes and are motivated to achieve more successes. In the same vein, they respond self-critically to poor performances for which they are responsible. Thus, self-
evaluative responses seldom, if ever, occur when accomplishments depend on others or on external factors (Weiner & Lerman, 1978); when performance is due to debilitating circumstances like illness and fatigue; or when performance is conditioned by situational inducements in the form of aids and supports (Bem, 1972). There is also a zero development of self-evaluative reactions when attributes like praise are unmerited. This suggests that pedagogues who shower indiscriminate praise on pupils operate outside the performance-level criterion and diminish the students' self-evaluative reactions. In the context of these observations, it seems appropriate to state that it is the failure to appreciate and reckon with performance level within the framework of the criterion of adequacy that has, to a large extent, created the confusion in the self-esteem literature and tended to diminish the impact of self-esteem enhancement on positive behavior. Damon (2003) has chastised parents, teachers, and Local Education Agencies for unduly trusting self-esteem to be a path to learning and general positive development, on the basis of claims that, in his opinion, could not be empirically sustained. Damon (2003) contended that there was no research to support the position that a causal relationship existed between self-esteem and an enhanced performance in a child's personal or academic life. Consequently, he has suggested that "teaching skills, building knowledge, and exposing children to the experience of the thrill of real accomplishment" might be a more effective and rewarding alternative than expending resources to enhance self-esteem. For him, it would appear that self-esteem is a futile proposition.

The scientific evidence in problems of this nature is derived from empirical studies and the strength of an association, in this case, between self-esteem and achievement in school. Since the 1960s, a plethora of studies has indicated that children with high self-esteem perform better in their school work
relative to children with lower self-esteem (Bodwin & Bruck, 1992). More recent studies go beyond school work to link self-esteem with task performance in general (Chapman, 1981). Other researchers have based their studies on the relationship between self-esteem and task performance on the self-consistency theory states that the level of performance achieved by an individual will be consistent with that individual's level of self-esteem (Midkiff & Burke, 1991). These researchers contend that high self-esteem individuals perform at a higher level vis-a-vis individuals with low self-esteem because high levels of performance are consistent with high self-esteem individuals' self-perceptions of adequacy and competence. On the other hand, individuals with low self-esteem perform at a lower level because they perceive themselves as less adequate and less competent as a result of past frustrations and experiences (Swann, Pelham & Krull, 1989). A number of correlational studies on this issue have also reported positive association (Greene & Vroff, 1989; Hadley, 1988; Kostelnik, Stein. & Whiren, 1988; Pope, Mchale, & Craighead, 1988; Purkey, 1970; Walberg & Uguroglu, 1980; Waldie & Mosley, 1996; Wylie, 1979). One should make the concession that correlation does not necessarily mean causality; it does, however, provide a plausible basis for arguing that self-esteem may influence achievement or vice versa. In one of the few unequivocal and rewarding studies on this matter. Weiner & Sierad (1975) conducted a true experimental study in which college students, classified as possessing either low or high levels of confidence, were administered a drug (in actual fact, a placebo) which was said to have adverse effects on the subjects' performance on a task involving hand-eye coordination. The prediction was that subjects with low levels of confidence would perform better, having been provided with a reason for their usually poor performance (with the administration of a performance-reducing drug!), while subjects with high levels of confidence would perform less well because of the presumed interference of the drug. The predictions were borne out. Covington
(1989) has described the results of this experiment as a conclusive "demonstration of causal influence on performance cognition associated with self-esteem." It would appear from this study that several factors, beyond praise, contribute to the enhancement of self-esteem and how it manifests itself in everyday situations. Praise is relevant to self-esteem to the extent that it serves as a source of encouragement.

**Internal standards**

Self-evaluative reactions are, to a large extent, dependent on internal standards that function to guide behavior and against which actions may be judged. These standards are forged through information received from different sources, including how significant others have reacted to one's behavior or how one has behaved in similar situations, standard norms based on representative group behavior or referential performances (Simon, 1979; direct teaching (McMains & Lievert, 1968; Rosenhan, Frederick, & Burrows, 1968); and prescribing for one's self one's own self-evaluative standards that may include previous behavior. Since the internal standard prescribed, modeled or taught, differs in accordance with the environment (i.e., activity, setting, or source), people form generic personal standards which are the real bases for self-evaluative cognitive and affective responses (Simon, 1979). The purpose of these standards is to assist the individual to develop the capacity for self-directed influence by creating incentives for his or her own action (Brockner, 1988; Mruk, 1995). It is these incentives that motivate the individual to expend the needed effort in order to attain the required level of performance. But internal standards go beyond serving as a criterion for adequacy; they are also aspirations which the individual tries to attain through the agency of motivation. These aspirations become more easily attainable when they are cast in the form
of goals. The more specific and proximal the goals, the more they become sustainable and create incentives for action (Lathan & Yuki, 1975; Steers & Patter, 1979). The rationale is that if goals are specific, one is more easily able to designate the amount of effort required to achieve them. A similar view was expressed by Epstein (1979) when he stated that goals that are projected far into the future may provide some general direction, but are too far removed in time to serve as an effective incentive and guide to what one does here and now.

**Performance of others**

The statement that human beings are social animals refers to the environmental influences that generally shape and direct human behavior. These influences can be attributed to settings, activities, and individuals. (Bandura, 1977; Bower, 1975; Neisser, 1976). Mead (1994) has amply demonstrated that the "generalized other" plays a major role in shaping self-definitions. The process is both by direct influence of others and the individual's perception of and reaction to that influence. Added to this may be mentioned social referential comparisons which take different forms for different tasks and are used by individuals to compare themselves to others either as a measure of adequacy or to determine their relative standing. This comparison may be with school mates, other associates in similar situations, or representative groups based on culture, ethnicity, clan, family, and so on. The resulting self-appraisal and its concomitant value system, self-esteem, varies with the characteristics of the comparison group and the purpose of the comparison (Bandura, 1977). The basis for situation specific self-esteem, the various dimensions and aspects, thus become immediately apparent.
RECURRENT IDEAS ABOUT SELF-ESTEEM

People are accustomed to using the term self-esteem to imply ideas, feelings and behaviors that may be too narrow and specific or too broad and vague (e.g., awareness, identity, consciousness, image congruence, etc.), but none seem to grasp the full import of the term. The result is that an acceptable definition has become elusive (Kitano, 1989). A procedure that might capture the essence of the term might be to identify its accepted components and concepts related to it as well as traits and behaviors of individuals usually associated with the concept, and to integrate them into a coherent set of behavioral indicators that would answer the description of self-esteem.

Components

Smelser (2004) has reviewed the literature and emphasized three components of self-esteem: (a) cognitive element that is often demonstrated in an individual's perceptions when answering questions about the kind of person he or she is in terms of power, confidence, agency and about the interactive relationship between behavior and the environment; (b) affective component, as demonstrated in the role of emotion as a component of the evaluative process that leads to self-definition (Coopersmith, 1967; Epstein, 1973; Kaplan, 1975). The affective element addresses the issue of acceptance and affiliative experience; (c) evaluative component, the attribution of some level of worthiness (Epstein, 1973) according some ideally held standards or some successes by which individuals make self-evaluative judgments (Wells & Marwell, 1976). These standards may be made up of or include an ego idea that one holds for oneself (i.e., an absolute standard); a relative standard that measures one's self-worth in relation to an internal aspiration or a desired level of attainment. It
could also be a point of reference that measures one's self-worth in relation to another person or a group (Rosenberg, 1979).

**High self-esteem**

A background or history of activities characterized by a high degree of competence and a high level of worthiness results in high self-esteem. This seems to protect people from succumbing to the problems of life (the shielding quality of high self-esteem). People who enjoy high self-esteem seem to be less critical of themselves, are more able to withstand social and personal pressures, and are better able to act on their own beliefs and values. Developmentally, such people have acquired a "developmental momentum," resulting from past successes and a high sense of worthiness to the extent that they are better prepared for the problems they encounter. It might even be plausible to suggest that high self-esteem has an inherent predisposition to avoid low self-esteem situations and behaviors. Mruk (1995) has stated that there is a hedonistic quality to self-esteem: "The positive affect experience associated with self-esteem reinforces the individual to continue in that direction because it is more effective and pleasurable than the alternative." This seems to be the basis for the statement that high self-esteem is self-motivating and self-reinforcing.

Elias & Branden (1988) defined high self-esteem as an individual's feelings or self-worth and self-respect and defined low self-esteem individuals as often seeing themselves as inadequate, deficient, or unworthy.

**Low self-esteem**

As seen from the matrix, low self-esteem involves deficiencies in both competence and worthiness. It seems to make a person vulnerable to himself or
herself and others. For example: feelings of unworthiness could involve a person in relationships that might be unsupportive or even demeaning (Mruk, 1995), rendering a person powerless to stand up for his or her rights to the extent that even an experience of competence and worthiness might be regarded by the individual as disrupting existing patterns.

Epstein (1990) has given a succinct explanation to both the self-motivating and self-reinforcing nature of high self-esteem and the learned helplessness associated with low self-esteem. Epstein's explanation, based on his Cognitive-Experiential Self Theory (CEST), may be summarized as follows: As a preconscious postulate or belief, self-esteem has profound effect on behavior. When an individual with high esteem is negatively evaluated, both that individual's need for enhancement and his or her need to maintain the stability of his/her conceptual system evoke unpleasant feelings and resistance to the assimilation of that evaluation. The situation is even worse for an individual with low self-esteem. He or she finds it almost impossible to assimilate highly positive information. This is because the two sources of motivation or need involved (the person's need for enhancement or propensity towards anything that is good and proper versus the need to maintain the stability of his/her conceptual system) act in opposite directions. The need for enhancement favors assimilation; the need for stability favors resistance to assimilation. One would think that a large dose of enhancement (praise, for example) would be good for the person with low self-esteem. This is not the case; a large dose of enhancement is apt to be preconsciously perceived as threatening because it becomes potentially destabilizing and therefore anxiety-producing.
The tendency is that low self-esteem is likely to produce low self-esteem because the interacting forces create a vicious circle that creates recurrent feelings of worthlessness. By the same token, deficiencies in competence or the perception of lack of competence could predispose a person to failure because the individual tends to focus on problems rather than potential solutions. This might lead to negative self-talk and the attendant unhappiness with the self, depression, poor relationships, and attribution of failure to internal causes. To break this barrier to positive intervention outcomes, both the composite and phenomenological self-esteem enhancement methods stress prior assessment to help create a descriptive picture of target persons as a basis for developing a good rapport in an atmosphere of caring and trust that is conducive to learning.

Levels of Self-Esteem

It has been suggested that self-esteem exists in a continuum and that there are degrees or levels of self-esteem. Bednaz, Well & Paterson, (1989), this dimension of self-esteem might be better understood in terms of (a) clinically significant and (b) growth-related self-esteem problems, and the type of treatment measures associated with each type. This categorization describes growth-related self-esteem problems as those amenable to psycho-educational intervention programs, while severe problems like depression might fall under the clinically significant type and might require more intensive formats.

Mruk (1995) has attempted to depict and to explain these two levels on the matrix: growth-related self-esteem problems cluster around the center of the matrix and are manifested within the lower levels of the scale. For example, at the level of low competence within the positive competence and the positive
worthiness quadrant, the dynamics of self-esteem would appear to show that people suffer from modest self-esteem problems and might live a satisfactory life without working on them, but at a cost of reduced effectiveness and satisfaction. People associated with this level of self-esteem problems might be those who are afraid to try, especially new endeavors, for fear of failure, who see the worse in themselves, and who are anxious about others criticizing them. However, as one moves diagonally along the quadrant, a transition occurs (the square) and self-esteem problems or limitations acquire clinical significance. Even the highest levels of competence and worthiness are not free from these problems which might manifest as arrogance, lack of insight and empathy, and overzealousness. On the opposite side of this quadrant, where there is a complete lack of competence and worthiness, self-esteem problems increase to the point where people develop clinical depression and suicidal tendencies. Tennen & Affleck (2006) have documented suicidal tendencies in people who have experienced both a sense of worthlessness and an inability to face the challenges of life. Epstein (1985) stated that there was a connection between lack of self-esteem and psychosis.

Similar explanations might be given about the two types of defensive self-esteem depicted in the remaining opposite quadrants. Defensive self-esteem Type II or pseudo self-esteem would occur where people have competence but no worthiness. Those who fall under this category might be skilled and have a background of accomplishments. However, their deficiency in worthiness produces performance anxiety which shows in ordinary life as insecurity. If one should move further into the clinical range of this (quadrant) type of self-esteem, one might see the link between self-esteem and some major personality disorders. Tennen & Affleck (2006) stated that anti-social behavior was a combination of high competence coupled with low degree of
worthiness. People with pseudo self-esteem might be highly competent, but might manipulate and abuse the rights of others; they might be anti-social, sadistic personalities who ignore the issue of worthiness to the extent that the question of decency is not factored into their behavior. Defensive self-esteem Type I or narcissistic self-esteem, in which there is high worthiness and no competence, deals with problems associated with a distorted or unrealistic sense of worthiness. Such people might be self-centered and think highly of themselves without supporting accomplishments. They might be boastful about non-existent or flimsy accomplishment to satisfy personal ego, but fail to impress others. The extreme form might show as extreme sensitivity to the slightest criticism.

As a phenomenological approach to understanding self-esteem, the matrix not only shows as a self-structure, but also how competence and worthiness interact to give meaning to how self-esteem is lived in ordinary lives. The self-esteem meaning matrix may, therefore, be understood as being "one of the foundational self-structures that act as a blueprint through which to organize perceptions, experience, and behavior over time" (Mruk, 1995).

**Methods for Enhancing Self-Esteem**

Self-esteem enhancement programs seem to be a fairly recent development (Mruk, 1995). They began surfacing only in the mid-80s, after the development of the major self-esteem theories which were heavily influenced by the psychological orientations of the authors (Frey & Carlock, 1989). As a result of the differing orientations, most of the programs were perspectival, with each emphasizing certain dimensions of self-esteem rather than others. The result was a virtual lack of a comprehensive and integrated set of behaviors or self-esteem
components which could be translated into practical and effective ways of enhancing self-esteem for all age groups and at the various levels of self-esteem problems. Currently, there seem to be two main approaches to self-esteem enhancement: the composite approach (Pope, McHale & Criaghiead, 1988), based on the composite concept of self-esteem, and the phenomenological approach (Mruk, 1995), which focuses on increasing the target person's competence and worthiness. The self-esteem enhancement program developed by Frey and Carlock (1989) exemplifies some of the shortcomings sometimes associated with the composite approach. Although systematic and flexible in terms of the kinds of individuals and groups it could be used with, Mruk (1995) has characterized its components as a collection of human growth and development activities that cannot be subjected to either observational or experimental validation and, therefore, are unlikely to produce results consistent with enhanced self-esteem.

Bednaz, Well and Paterson, (1989) developed a composite self-esteem enhancement program that was cognitive in approach and based on the concept of information processing, a procedure that involves the processes of feedback, self-regulation, and coping skills relative to psychological threats. The main thrust of the program was learning through experience, so that the individual could reduce behaviors that promote avoiding problems and increase those that promote willingness and a capacity to cope with problems of life. "Experiential learning, then, is the crucial consideration in helping clients come to a fuller realization of their self-defeating patterns of avoidance". As effective as the program was, it had limited applications because it addressed only serious self-esteem problems and, therefore, was oriented rather heavily towards the clinical range of self-esteem problems. This made it very difficult, time-consuming, and expensive to use as a psycho-educational intervention program (Mruk, 1995). It
would appear from the brief analysis of the Mruk programs, described above, that a good composite enhancement program should be systematic and have theoretical consistency and clearly stated components that not only are traceable to the major self-esteem theories, but are also highly likely to have positive impact on the target person's sense of self and level of self-esteem.

MENTAL HEALTH

Recent epidemiological data indicated that 15% to 22% of children and adolescents have mental health problems severe enough to warrant treatment. However, fewer than 20% of these youth with mental health problems currently receive appropriate services. Research also indicates that 25% to 50% of the general populations of adolescents engage in multiple high-risk behavior, such as drug use, unprotected sexual intercourse, and violence (Dryfoos, 1990). Therefore, adolescents today are at high risk for emotional, behavioral, and physical health difficulties due in part to their likelihood of engaging in dangerous activities.

Positive mental health is a necessary condition for the development of an individual. Definite positive mental health can act as a major part of one’s life and it is a source of satisfaction and dissatisfaction.

Mental health and mental illness are dynamic, ever-changing phenomena. At any given moment, a person’s mental status reflects the sum total of that individual’s genetic inheritance and life experiences. The brain interacts with and responds—both in its function and in its very structure—to multiple influences continuously, across every stage of life. At different stages, variability in expression of mental health and mental illness can be very subtle or very
pronounced. as an example, the symptoms of separation anxiety are normal in early childhood but are signs of distress in later childhood and beyond. It is all common for people to appreciate the impact of developmental processes in children, yet not to extend that conceptual understanding to older people. In fact, people continue to develop and change throughout life. Different stages of life are associated with vulnerability to distinct forms of mental and behavioral disorders but also with distinctive capacities for mental health.

Jordan (1997) gives 6 criteria of mental health like,

- Attitudes toward self-knowledge of self, self acceptance, self concept
- Self Actualization-Utilizing ones abilities
- Integration – Unifying outlook on life and resistance to change
- Autonomy – Self reliance in decision making
- Perception of Reality- free from need distortion
- Environmental mastery – Ability to love, work and play, adequately in interpersonal relations, efficiency in solving problems.

The experts of WHO define psychological health as the ability of making balanced and harmonized relations with others, modification and rectification of individual and social environment and solving contradictions and personal tendencies in a logical, fair and suitable manner (Milanifar, 2002).
Another definition by WHO is as follows: psychological health consists of a general concept of health and health means, total ability for playing social, psychological & physical roles. Health is not just illness or underdevelopment (Ganji, 2000).

Mental health has been defined variously by scholars from different cultures. Concepts of mental health include subjective well-being, perceived self-efficacy, autonomy, competence, intergenerational dependence, and self-actualization of one's intellectual and emotional potential, among others. From a cross-cultural perspective, it is nearly impossible to define mental health comprehensively. It is, however, generally agreed that mental health is broader than a lack of mental disorders (Taremian, 1999).

Studies on risk and protective factors for children and adolescents have led mental health professionals to become interested in prevention programs. One well-studied prevention effort is life skills training. Life skills training is an effective prevention method for a range of problems with adolescents, as well as an effective intervention for adolescents experiencing a wide variety of emotional, behavioral, and physical problems.

**Mental Health in Adolescence**

The adolescent stage of life is a fascinating and crucial period characterized by change, transition, and challenge. During adolescence, children experience a number of stresses associated with the tremendous developmental changes in physical, cognitive, emotional and social spheres and the consequent adjustment difficulties. The school and peer group experience, development of sex
roles and morality, and assumption of new roles within family structure all become very critical at this stage (Biswas, Kapur & Kaliaperumal, 1995). Adjustment difficulties at this stage of life can substantially contribute to low self-esteem and self-efficacy, sense of inadequacy, unrelatedness, helplessness and powerlessness (Biswas, Kapur & Kaliaperumal, 1995). These adjustment difficulties contribute significantly to mental health problems in adolescence and adulthood.

**Theoretical Model of Mental Health**

A substantial number of researchers have attempted to conceptualize mental health in several ways focusing around different theoretical frameworks. The following section describes three theoretical models of mental health, ecological-developmental perspective, environmental and person-centered model, and primary prevention of mental illness model through promotion of personal social competence.

**Ecological-Developmental Perspective**

Recent research studies on mental health have documented the need for examining and understanding the mental health of the children from an ecological-developmental perspective espoused by Bronfenbrenner, 1979; Nastasi & Dezolt, 2006; Nastasi, Varjas, Sarkar, & Jayasena, 1998. An ecological approach to human development involves scientific study of a `progressive, mutual accommodation between an individual and the environment, in view of the social, cultural and historical contexts in which the immediate environment is embedded (Bronfenbrenner, 1979).
The immediate ecological context within which the child develops, called 'microsystem' by Bronfenbrenner (1979), is profoundly influential in the mental well-being of a child. The microsystem, characterized by a constant interaction among the individuals within the system, consists of factors like activity, role and interpersonal relations of the people. A child thus learns from the family about appropriate roles or activities that are expected of her/him. From an ecological perspective, an individual's interaction with the environment are not only influenced by the immediate environment but also by the individual's personal characteristics or history that were in part influenced by one's prior interaction with the same or similar environments (Nastasi & Dezolt, 2006). Development of personal-social competencies within the family involves a continuing process of mutual accommodation to the needs, demands and rules of the family. Behaviors that facilitate the stability of the system are thus reinforced among the family members. In a family, if gender-appropriate behavior is reinforced among the children, it maintains the stability of the family, it is likely that the children will develop gender-specific behaviors.

In addition, consideration of the context in which the family is embedded, such as the society or culture, as they are called 'macro system' by Bronfenbrenner, is also essential (Nastasi & Dezolt, 2006). As observed by Roberts (1996), any program examining the mental health of the children should see the child in the context of the family and the family in the context of its surroundings. According to Bronfenbrenner, societies, cultures and even subcultures can be different in different parts of the world based on their own ideology, life styles and other factors. As he describes: the systems blueprints differ for various socioeconomic, ethnic, religious, and other subcultural groups, reflecting contrasting belief systems and lifestyles, which in turn help to
perpetuate the ecological environments specific to each group (Bronfenbrenner, 1979).

So, in order to understand an individual's environment, it is necessary to examine the wider context, such as culture, or society, apart from the person's immediate environments like family, school or community. It should be noted that family, school or community rules, practices and values reflect the existing cultural or societal norms and values. For example, when the American parents expect their sons to be superior in science and mathematics compared to their daughters, it shows the differential expectation explained by the widespread belief and expectation of male superiority in mathematics or science achievement over females in the American society.

Person and Environment-Centered model of Mental Health

Elias and Branden (1988) explained mental health of an individual from person-and environment-centered perspectives. The person-centered model postulated that behavioral and emotional difficulties in the individual are a function of stress that is experienced and physical vulnerability to stress, in relationship to the personal coping mechanisms, social resources and self-esteem of that individual. In an environment-centered model, Elias suggested that occurrences of behavioral-emotional disorders within a community or culture are influenced by the prevalent stressors and risk factors, in relationship to socialization practices, social resources and opportunities for relatedness (Elias & Branden, 1988; Nastasi & Dezolt, 2006). Nastasi has adapted the person- and environment-centered model of mental health suggested by Elias and Branden, by incorporating some changes into that model. She has proposed that mental health is influenced
by the interaction between critical person- and environment-centered factors. Mental health of the individual is determined by the personal vulnerabilities in relationship to socially or culturally valued competencies and personal mechanisms for coping with stress. The mental health within the community is influenced by the social-environmental stressors, in relationship to available social resources and culture-specific socialization practices (Jayasena & Nastasi, 1997).

Based on the person- and environment-centered model of mental health mentioned above, Nastasi, Varjas, Sarkar & Jayasena, (1998) have identified several general constructs related to mental health: (a) **culturally-valued competencies** (e.g., academic competence, physical attractiveness) and **adjustment difficulties** (e.g., behavioral problems); (b) **personal vulnerabilities** due to personal and family history (e.g., school failure and family history of mental illness or domestic violence); (c) **social stressors** (e.g., violence, drug abuse); (d) culture-specific **socialization practices** and socialization agents (e.g., family, school, community) responsible for influencing the development of the competencies; (e) **personal resources** (e.g. problem-solving and decision-making skills) for coping with daily and other major life stresses; (f) **socio-cultural resources** available to youth (e.g., peers, family, teachers, religious organizations or professional services) to facilitate coping with the stressors.

**Stressors and Mental Health**

Adolescence has been described as a period of tremendous tumultuous development, a time of emotional upheaval and one marked by mental disorders and deviant behaviors more commonly than any other period of life (Erikson, 1968; Freud, 1958). Although some recent researchers have criticized these `myths' of adolescence as simplistic overgeneralizations (Bandura & Walters,
1963; Offer & Schonert, 1992), there is still concern regarding the extent of the stress experienced by adolescents as part of the normal development process, the degree to which present-day adolescents are exposed to stressors, and the extent to which they have developed and used coping strategies for dealing with the stresses and stressors they encounter. Increasing rates of adolescent suicide, depression, substance abuse and juvenile delinquency in almost every part of the world have been cited as indicators of increasing stressors and adolescents' inability to effectively cope with the resulting stress (Deanda & Bradley, 1997).

In addition to normal developmental stresses, other stressful life events also influence the adolescent's adjustment. Numerous studies have found significant relationships between the stressful life events in adolescents' lives and health, mental health and adjustment problems (Deanda & Bradley, 1997). Strong relationships have been found between stressful life events and the incidence of psychological and emotional disturbances among adolescents, particularly with regard to depression (Deanda & Bradley, 1997).

Some scholars have suggested that life stressors have an additive effect on the mental health of an individual (Biswas, Kapur & Kaliaperumal, 1995). Some studies have shown that there is a positive relationship between the numbers of recent stressful life events (SLEs) and adjustment difficulties, between SLEs and behavioral problems, and between adjustment difficulties and behavioral problems, indicating that with the presence of one factor, the chance of the presence of the other factor is significantly high (Biswas, Kapur & Kaliaperumal, 1995; Cowen, Weissberg & Guare, 1984; Sterling, Cowen, Tennen, & Affleck, 1993). The major life stressors in adolescents are significantly related to mental health status, decreased self-esteem, disruptive and delinquent behavior and poor academic performance (Biswas, Kapur & Kaliaperumal, 1995).
Several research studies have identified the sources of stress and stressors most frequently encountered by the adolescents. These major life stressors included economic hardship (Lempers, Clark & Simons, 1989; Nastasi, Varjas, Sarkar, & Jayasena, 1998), illness and family discord (Fontana & Dovidio, 1984). Poverty was strongly associated with mental health problems. Unemployment, housing problems and other problems resulting from poverty were reported to be important risk factors that can trigger clinical depression. Children and adolescents are particularly vulnerable to problems associated with poverty. It is argued that familial poverty jeopardizes children's mental health and productivity. Lack of food, shelter, clothing, education and other materials may exert adverse effects on children's mental health. In addition, economic difficulty is related to ineffective parenting, parental psychopathology, and family hostilities, each of which can be additive sources of mental health problems. Furthermore, socioeconomic disadvantages often cause or aggravate marital dissatisfaction, conflict, aggression and violence within the family, thus increasing the risk of mental health problems among children (Beiser, Hou, Hyman & Tousignant, 2002).

However, other researchers argued that cumulative daily stressors have the greatest impact on the lives of the adolescents (Armacost, 1989). Among these daily stressors were academic problems, school work demands, academic pressures (Nastasi, Varjas, Sarkar, & Jayasena, 1998) and relationships with family and peers (Omizo, Omizo & Suzuki, 1988) including same-and opposite-sex peers (Patterson & Mccubbin, 1987).

**Primary Prevention of Mental Illness**

Another perspective on mental health promotion advocates the primary prevention of mental illnesses and other mental health problems by integrating
promotion of personal-social competencies into education. Primary prevention is defined as "coordinated actions seeking to prevent predictable problems, to protect existing states of healthy functioning, and to promote desired potentialities in individuals and groups" (Bloom, 1996).

The primary prevention model postulates the necessity to increase individual strengths and decrease individual limitations in order to prevent mental health problems and promote mental health of individuals. Among other models, integrating training programs to promote an individual's personal-social competence within the school curriculum was espoused by several researchers (Elias & Weissberg, 2000; Hall & Tones, 2002; Kapur, 1997; Nastasi & Dezolt, 2006). This model of primary prevention of mental health problems and promotion of personal-social competence is also consistent with World Health Organization's emphasis on providing life skill training to the children within school setting (Kapur, 1997; Nastasi, Varjas, Sarkar, & Jayasena, 1998).

**Personal-Social Competencies**

Definition of personal-social competence has been characterized by a consistent set of behaviors (Nastasi & Dezolt, 2006). These critical features of personal-social competence include (1) self-efficacy, self-perceptions/self-esteem and intrinsic motivations associated with an individual's effort to adapt to life situations; (2) social interaction skills related to establishing and maintaining interpersonal relationships and interactions; and (3) interpersonal problem-solving skills essential for solving interpersonal conflicts and problems (Nastasi & Dezolt, 2006).
Coping and Mental Health

Coping is not only a behavior that people display when encountering significant stressors, but is a general way of dealing with everyday life challenges (Lazarus & Folkman, 1984; Monnier, Stone, Hobfoll & Johnson, 1998). The coping process is particularly important during adolescence as it may be the first time that young people confront many different types of stressors and they may not yet have a wide range of coping strategies at their disposal (Patterson & Mccubbin, 1987). Moreover, the styles of coping with stress that develops during one's younger years influence how the individual handles new life events occurring in later adolescence and adulthood (Copeland & Hess, 1995; Newcomb, Huba, & Bentler1986).

Lazarus, a pioneer in the study of coping, proposed that individuals develop coping styles that can maximize or minimize problems (Lazarus, Kanner.,& Folkman,1980). Coping is seen in part as a two-stage process of appraisal. Primary appraisal occurs when an environmental stimulus is evaluated for any potential threat and the secondary appraisal is the evaluation the individual makes about the resources at her/his disposal to deal with the threat. Greater availability of perceived resources are associated with lower levels of perceived threat and more effective coping (Bright, Hayward & Clements, 1997; Folkman & Lazarus, 1985).

The coping mechanisms or strategies used by individuals to deal with stressful and threatening situations have been divided into emotion-focused and problem-focused (Lazarus & Folkman, 1984). Emotion-focused coping involves attempts to modify the level of emotional distress or regulate the aversive emotions generated by the situation, without addressing the source of distress;
problem-focused coping refers to overt behavioral and cognitive attempts to deal directly with the problem situation and its effects (Bright, Hayward & Clements, 1997; Lazarus & Folkman, 1984; Nastasi & Dezolt, 2006). Thus, whereas problem-focused strategies involve engagement in problem-solving, emotion-focused strategies include seeking social support, avoiding, self- or externalized-blame, distancing, emphasis on positive aspects and minimization of negative aspects (Bright, Hayward & Clements, 1997; Nastasi & Dezolt, 2006).

Researchers have argued that people use coping strategies that are both adaptive and maladaptive. Adaptive coping strategies are those which mediate positive outcomes, whereas maladaptive strategies result in poor outcomes (Bright, Hayward & Clements, 1997). Studies of the coping strategies of the adolescents have reported that they use both adaptive and maladaptive strategies. Diversions and distractions including watching television, listening to music or reading have been found to be common coping strategies for dealing with stress (Deanda & Bradley, 1997). They have also been found to seek interpersonal support from parents and peers. Among the maladaptive strategies adopted by adolescents are substances (Deanda & Bradley, 1997).

Hobfoll, Dunahoo, Benporath & Monnier (1994) advanced the Dual Axis Model of Coping to address coping in a social context. This model included a second dimension in addition to the activity dimension that is consistent with previous models. The second dimension is called the prosocial-antisocial means of coping. Prosocial coping was conceptualized as the positive use of social resources in the face of stressors, whereas antisocial coping is conceptualized as coping behaviors that tend to be harmful to those in the environment while meeting the individual's personal needs. In this model, antisocial coping is not viewed as not an indicator of clinical pathology in an individual, but rather as the opposite pole

**Resources and Mental Health**

Resources for coping with stressors have been investigated by many authors, and both personal and social factors have been thought to affect coping in stressful situations. Researchers have indicated that perceived resources at a person's disposal to deal with a stressor influence the person's evaluation of the threat underlying the situation. Perceptions of abundant resources are associated with lower levels of perceived threat and the more efficacious coping (Folkman & Lazarus, 1985). High self-esteem and self-efficacy, good social network and personal support system have been reported to function as buffers in stressful environments and mediate healthy psychological adjustment (Bright, Hayward & Clements, 1997). For example, personal-social competencies like self-esteem, self-efficacy and interpersonal relationship are the personal resources that are available and influential in helping an adolescent coping with major or daily life stressors. Parents, peers, siblings, teachers and mental health professionals in the schools and community are some of the social resources that may be available to the adolescents as part of their social network for coping with stressful situations. Researchers have also suggested that coping methods influence the social resources available to an individual (Deanda & Bradley, 1997). Coping in a prosocial manner, such as tending to others' needs and concerns for social aspects of behaviors, may bolsters an individual's support network, which in turn provides additional resources for successfully coping with stress in the future. On the other hand, coping in an antisocial manner, such as through aggression and self-focus, strains one's support network, thereby depleting the social resources needed for the future. Antisocial methods may address and answer personal needs, but alienate
the supporters, thereby reducing and exhausting the availability of social resources. Prosocial methods, in addition to effectively meeting personal needs, may help build relationships, and thus enhance the individual's social network (Deanda & Bradley, 1997).

**Mental Health Services in Schools**

As schools play a crucial role in children's and adolescents’ lives as a socialization agent and the children spend a significant amount of time in schools, it is important to examine the role of schools in promoting mental health among adolescents. Numerous research studies throughout the world have advocated for involving schools in mental health promotion programs (Hall & Torres, 2002; Kapur, 1997; Nastasi & DeZolt, 2006). Several studies have designed and implemented school-based mental health promotion and intervention programs for adolescents in the United States and other countries (Duffy, 2000: Durlak & Wells, 1998).

Almost all young people encounter significant stressors or stressful events and adjustment problems in their lives. Many enter adulthood without any major mental health problems, but some cannot cope with these stressors successfully and become vulnerable to mental health problems and mental illnesses. Nearly 20% of all children and adolescents will have emotional and behavioral disorders at some time in their youth irrespective of region or socioeconomic status (Kapur, 1997). At least 10% of the child population suffers from mental disturbances and adjustment difficulties with serious related problems like learning problems, health problems and substance abuse at any given time (Raegrant, 1991). At least 3% of school-age children suffer from serious emotional disturbances such as depression,
suicidal ideation, psychoses, serious attention deficit disorders or obsessive compulsive disorders (Kapur, 1997).

In most parts of the world, school is the second most influential institution after the family in a child's life. Schools play a critical and a formative role in the domains of cognitive, language, emotional, social and moral development of children (Kapur, 1997). Therefore, schools have the opportunity and the responsibility to promote mental health of the children in order to improve their lives. Recently, schools are finding it necessary to expand their roles by providing health services to deal with factors interfering with schooling (Adelman & Taylor, 1991).

Kapur (1997), in their report to the World Health Organization (WHO) regarding mental health programs in schools, recommended that schools are currently the best places to develop mental health programs. In support of their argument, they cited the following reasons: Almost all children attend schools sometime during their lives.

1. Schools have a significant influence on children, their families and the community.

2. Schools are often the most powerful and effective social and educational institutions available for intervention.

3. Mental health (or well-being) of the children influences their ability and motivation to stay in school, to learn and to make effective utilization of what they learn.
4. Schools can act as a `safety net', protecting children from perils that interfere with their learning, development and psychological well-being.

5. In addition to the family, schools play a crucial role in promoting or hindering self-esteem and a sense of personal/social competence (Kapur, 1997).

School-based mental health intervention programs should focus on promoting children's mental health or personal-social competencies for strengthening their coping abilities and increasing their resilience in the faces of environmental stressors and adverse situations encountered in their growing years. Some of the available school-based comprehensive health programs have resulted in higher school attendance, increased academic achievements, lower rate of school dropouts, and reduced criminal behavior (Kapur, 1997). Mental health and life skills education programs endorsed by the WHO have been shown to reduce alcohol abuse, smoking, and other drug use in children and adolescents (Elias & Branden, 1988). These reports support the notion of addressing mental health related issues and promoting mental health during adolescence and young adulthood so that people can enter adulthood without significant mental health problems or mental illnesses.

Mental Health, Culture and Gender

Psychiatrists associated with the Division of Mental Health of the World Health Organization defined health and mental health as "a state of complete physical, mental and social well-being, not merely the absence of disease"(Lefley,
1999). It has been suggested that throughout the world, an individual's personal well-being is affected by the interaction of the individual's personal characteristics with at least three interrelated factors—cultural norms and expectations, the status of the population subgroup of which an individual is a member, and the social stability of that subgroup within the dominant culture (Lefley, 1999).

In defining mental health, cultures have ideal roles as well as normative expectations that may differently influence the sense of well-being in different individuals under very different conditions. Other things being controlled, cultural norms determine whether the traits of submissiveness and nuance or assertiveness and competitiveness are related to a sense of well-being in women. Individualism may be valued in one setting, and despised in another. There may be very different thresholds for mental well-being in agrarian versus industrial economies (Kleinman & Good, 1985). Furthermore, researchers have suggested that cultural context similarly plays a major role in the course of psychiatric disorders. So, investigating the role of culture as a mediating factor in the course of psychiatric disorders has the potential to improve research and practice in the field of mental health (Stanhope, 2002).

Recently researchers have argued that gender, as a cultural variable, creates differences in roles, beliefs, practices, specific vulnerabilities to mental health problems, and the presentation of mental illness. Knowledge of gender and cultural differences (as culture contributes to gender differences by defining gender roles) among adolescents in defining mental health (e.g., their vulnerabilities to mental illness, their use of specific coping mechanisms, sources of stress as they viewed, processes of socialization they undergo, and their experiences of social resources like family support system or mental health services) is important to understanding
mental health needs and providing culture-appropriate services across all cultures and both genders (Baxter, 1998).

Gender and cultural differences in the psychological constructs related to the mental health have been documented extensively by the researchers. Researchers have shown that physiological, social, psychological, and environmental factors each predict gender differences in mental health constructs such as personal-social competencies (self-esteem, self-efficacy), perceptions of stressors and use of coping strategies (Stanhope, 2002). Socio-cultural factors play a very important role in influencing mental health of individuals through the process of socialization. For instance, socialization practices within a particular culture impact the process of gender role socialization. Through its various agents of socialization (e.g., family, school, peers, media), culture fosters development of gender role attitudes, beliefs/stereotypes, and gender-specific behavior which contribute to the gender differences in mental health constructs.

**ASSERTIVENESS**

It is the ability to vindicate a claim or title, to affirm positively, to come forward and assume one’s right, claims etc. A certain amount of assertiveness is desirable but too much or two little is undesirable (Taylor, 1997).

Assertiveness is an interpersonal behavior resultant of an intrapersonal cognitive state. In other words, it is a cognitive/behavioral phenomenon which was first identified and characterized by Lazarus in 1984. Alberti and Emmons (1995) define assertiveness as behavior which promotes equality in human relationships, enabling an individual to act in his or her own best interest, to stand up for himself or herself without anxiety, to express honest feelings
comfortably and to exercise his or her own rights without denying the rights of others.

Various levels of assertiveness have been categorized in the literature. Higher assertiveness levels have been linked with self-esteem, adjustment, and success in college students and health care professionals. For example, higher levels of assertiveness and an increased sexual self-efficacy were reported in 195 college students regarding their abilities to refuse sexual advances (Akinsulure, 1997). Likewise, Albayrak (1993) found that of 205 female college students, those with higher levels of assertiveness were regarded as more adjusted, as defined by peer popularity and scored higher on internal locus of control measures than those with lower levels of assertiveness.

Studies of assertiveness levels conducted by Hebert (1992) and Curtis (1994) produced similar results. Hebert (1992) found that those university students of both genders, 48 males and 192 females, who scored higher on a measure of assertiveness also held more internal control beliefs, while those who scored lower on the assertiveness measure held a belief in external control. Meanwhile, Curtis (1994) associated success, defined as the altering of therapeutic care to include specific physical therapies, with increased levels of assertiveness and effort in 86 physical therapists who had experienced interprofessional conflicts with physicians. Collaboratively, these studies (Akinsulure, 1997; Albayrak, 1993; Curtis, 1994; Hebert, 1992) suggest that higher levels of assertiveness may have some benefits in predicting psychological adjustment.

Much like the positive correlation found between higher assertiveness levels and psychological adjustment, a definite correlation between lower assertiveness levels and psychological maladjustment has been found in the
literature. Lower assertiveness levels specifically have been linked to anxiety, stress, and depression. For instance, Lee and Ellis (1990) found that although coping strategies of nursing personnel depended on experience and seniority, a group of 56 graduate nurses generally lacked assertiveness and expressed high anxiety.

In a study examining the relationship between problem-solving coping and adjustment in 48 college men and 54 college women, Mundt (1992) found that the women consistently reported more problems with assertiveness and exploitation, whereas the men in the study reported more extreme problems with domination and emotional coldness.

Chan (1993) analysis of responses given by 183 Chinese university undergraduate students also indicated that non assertive behaviors correlated with depressed mood. Collectively, these studies (Chan, 1993; Lee & Ellis, 1990; Mundt, 1992) provide empirical data upon which to suggest a possible relationship between lower assertiveness levels and psychological maladjustment, much like that found between higher assertiveness levels and psychological adjustment.

Ways of Coping and Assertiveness

Coping is defined as the constantly changing cognitive and behavioral effort an individual uses to manage specific external and/or internal demands appraised as taxing to or exceeding his or her resources (Lazarus & Folkman, 1984). Lazarus and Folkman (1984), there are two forms of coping: problem-focused coping or behavioral and emotion-focused coping or cognitive. Problem-focused coping is used predominantly in situations appraised as changeable,
whereas, emotion-focused coping is used predominantly in situations appraised as not amenable to change.

Although the two forms of coping, emotion-focused and problem-focused, are beneficial in clarifying distinctions between cognition and behavior, they do not reflect the richness and complexity of human coping processes. Thus, Lazarus and Folkman (1984) identified ways of coping in order to describe those strategies that may serve both an emotion-focused and a problem-focused function. Their efforts eventually led to the identification of eight coping scales: confrontive coping, distancing, self-controlling, seeking social support, accepting responsibility, escape-avoidance, problem-solving and positive reappraisal.

The original two scales, emotion-focused and problem-focused coping, provided the foundation upon which the eight coping subscales were built. Lazarus and Folkman (1984) contend these eight subscales better reflect the complex human coping process. Furthermore, recent research has divided these eight coping subscales into positive and negative forms (Aldwin, 1994). Of these, the self-controlling ways of coping subscale and the escape-avoidance subscale have been highly correlated with distress. Because coping is a complex changing process, attempts to better describe coping have led to the examination of variables thought to impact it. Ways of coping have been found to be largely the product of a stressful situation where their use is specific only to that particular moment and demand (Folkman & Lazarus, 1980; Folkman, Lazarus, Dunkel; Mcrae, 1984; Mcrae & Costa, 1986). If the situational context to which coping is directed is thought to be one determinant of coping methods, further analysis of other variables, such as individual differences, has been conducted for their effects on the coping process.
A comprehensive review of the coping literature over the past several decades was conducted, in which coping was found to be sensitive to situational and individual factors. The review specifically focused on research that reported coping strategies as a result of both factors, which create a unique cognitive / behavioral process in order to manage particular stressors. Several of these studies have examined specific situational and individual characteristics which produce differences in ways of coping.

**Assertiveness Training**

Assertiveness training means people how to be appropriately assertive in social situations, often included as part of health behavior modification programs in the assumption that some poor health habits such as excessive alcohol consumption or smoking, develop in part to control difficulties in being appropriately assertive, is highly important. Then only he can be a success in life, in the school or the work place (Chenevert, 1994).

Assertiveness training is one of a group of cognitive / behavioral therapies. It is a learning-based technique designed to reduce anxiety that occurs in interpersonal situations. Assertiveness training involves cognitive restructuring to affect some action-oriented event in order to facilitate assertive communication skills which aid in overcoming personal barriers to self-expression (Alberti & Eammons, 1990a, 1990b; Alberti & Emmons, 1995; Wolpe, 1990; Wolpe & Lazarus, 1966).

This strategy is particularly useful in people who are inhibited or fearful of doing and saying things which are reasonable and well within the rights of the person to say or do (Chenevert, 1994). The person, as a desired result of
assertiveness training, becomes unafraid to assert himself or herself and is comfortable in developing the skills required to satisfy his or her needs (Alberti & Emmons, 1995; Kahn, 1981). Assertive behavior is now considered healthy behavior for all people that, when present, mitigates against personal powerlessness and results in personal empowerment (Kipper, 1992).

Assertiveness training, as a form of cognitive/behavioral therapy, emphasizes cognitive processes to influence behavior for the purposes of resolving personal and social problems, thus enhancing human functioning (Kazdin, 1978; Kwekkeboom, 1999; Kwekkeboom, Huseby, & Ward, 1998). Cognitive/behavioral therapy has evolved to view human behavior as amenable to systematic and structured counseling or cognitive restructuring. Behavior modification aims to increase a person's skills so that the number of his or her response options is increased. By overcoming debilitating behaviors that restrict choices, one is freer to select possibilities that were not available earlier (Corey, 1996).

Because cognitive/behavioral therapists believe that behavioral procedures are more powerful than strictly verbal ones in affecting cognitive processes (Bandura, 1977, 1986, 1991), they maintain the importance of altering a person's beliefs in order to effect an enduring change in behavior and emotion. Cognition and behavior are thought to continuously and reciprocally influence each other; new behavior can alter thinking, and that a new mode of thinking can, in turn, facilitate the new behavior.

The general goal of cognitive/behavioral therapy is to create new conditions for learning which foster self-help. A variety of these therapeutic procedures exist; one is assertiveness training. Assertiveness training offers a
treatment of choice for many clients with interpersonal difficulties. Focus on a client's negative self-statements, self-defeating beliefs, and faulty thinking are paramount. The challenge of those beliefs that accompany a lack of assertiveness will teach the client how to make constructive self-statements and how to adopt a new set of beliefs that will result in assertive behavior.

The role of assertiveness training in health care situations is basically nonexistent. The history of health care delivery may provide an explanation of this deficiency. Early studies and anecdotal writings demonstrate the demoralization of patients that has occurred in medical institutions. Traditionally, members of the medical profession have assumed complete control of health care issues and treatments, negating client desires, requests, or wishes and thereby, fostering powerlessness. As decisions regarding health care became more and more authoritarian in nature, the consumer, or client, fell at the mercy of the system; one that assumed the client does not think.

Programs in assertiveness training, though, have shown the ability to affect significant cognitive and behavioral changes in populations of students and professional workers. For instance, Blood (1995) examined techniques on assertive communication, as a part of a cognitive/behavioral treatment package in a group of 72 adolescents who stutter. Program results indicated fewer incidences of non-fluent communication, positive changes in attitude, and feelings of control in all participants after 12 months of treatment.

These findings were supported by Lee and Crockett's (1994) survey of 60 female nurses that examined the effectiveness of assertiveness training in reducing levels of stress and increasing levels of assertiveness. Pre-test scores showed considerable low levels of assertiveness and high levels of job-related
stress in both the control and experimental groups. However, post-test scores of subjects in the experimental group were higher in levels of assertiveness and lower in ratings of job-related stress as compared to those obtained during the pre-test period. Parsons, (1998) found that skill-building interventions, emphasizing assertiveness skills and self-efficacy regarding communication about safer sex, provided direct positive effects on safer sexual behaviors in 119 serologically negative females involved with men infected with HIV and hemophilia.

Changes in behavior following assertiveness training, as found in the studies of Blood (1995), Lee and Crockett (1994) and Parsons (1998), suggest some value to its use as a means to address concerns regarding self-expression. However, like research on the variable of assertiveness, there is also a paucity of research on assertiveness training in people with physiological illnesses. Specifically, people who stutter, if stuttering is considered of physiological origin, were the only population found in which assertiveness training was conducted. Therefore, because assertiveness training has been studied, for the most part, in populations that are either physiologically healthy or with some mental health concern, its potential value as an intervention in seriously ill clients is not known.

**LIFE SKILLS TRAINING**

Life skills include group of skills and abilities which help individuals for efficient resistance and also in attending to life situations and conflicts. These skills enable the individual to act adaptive and right in connection with environment and provide self-esteem. Mental health means that anybody who comes with his/her deep problems, compromises with others and the self and not
be paralyzed against internal inevitable conflicts and thrown by community (American psychiatric association, 2000). Also self-esteem refers to personal feeling of being valued and the domain in which human beings valued and love them (Lane, 2004). According to world health organization ten skills include the life Skills, those are the ability for effective a communication skills, the ability for effective interpersonal relationship, decision making ability, problem solving ability, creative thinking ability critically thinking ability, the ability of being aware of the self, the ability of having sympathy with others, the ability to deal with emotions (failure, anxiety, depression and ...) and the ability to deal with stress.

Dusenbury and Botvin (1990) used a life-skills training program (LST) to prevent adolescent substance abuse. The LST curriculum has three general components. First, the LST provides information and skills specific to resisting social influences to smoke, drink, or use drugs. Second, the LST focuses on personal coping skills. Third, LST also focuses on general social skills. The LST consisted of 18 sessions used with 7th graders. Two booster curricula consisted of a 10-session booster for 8th graders, and a 5-session booster for 9th graders. This LST curricula has been evaluated in a series of school-based field trials. Data collected included self-reports of substance abuse as well as various measures of knowledge, attitudes and psychological factors, and biochemical validations (e.g., drug tests) that were used to enhance the veracity of self-reports. In a total of eight separate studies, the LST program has reduced new cigarette smoking from 40-75% of the experimental group at the end of the intervention. In addition, the booster sessions were demonstrated to maintain or even enhance these effects.

Jupp and Griffiths (1990) conducted a study with shy, socially isolated adolescents comparing psychodramatic role-play and a more traditional discussion intervention. Their sample consisted of 30 eighth graders from a middle-class
school district in Australia. The intervention lasted for 13 weeks, and significantly improved teacher-observed socially skillful behaviors. There were also significant improvements in the self-concept of the role-play group.

Ralph (1991) attempted to determine the utility of a social problem solving intervention by using the Social Training for Adolescents. The adolescents in this study were reported to have no friends and were referred by a school counselor or the parents. The LST program was 12 sessions and had three phases: identifying potential friends, making and increasing contact with the potential friends, and termination of the sessions. The key elements of the LST program were selecting target peers with whom successful contact is probable, setting valid assignments which were likely to be achieved, and bringing participants under instructional control so that assignments were attempted and diaries accurately completed (Ralph, 1991). This was a pilot study and Ralph indicated that the preliminary results were promising.

Ralph (1991) reported that social problem solving has been utilized as a means of transferring social competence from the office to the real world. However, they reported that "a convincing demonstration of the utility of this approach has yet to be reported" (Ralph, 1991). They explained that nearly all of the studies on social problem solving demonstrated immediate treatment effects, but conclusions about the occurrence of generalization to the real world were severely limited.

Caplan (1992) with urban and suburban adolescents in an effort to increase social adjustment and decrease alcohol use. Their sample consisted of an inner-city sample including 72 randomly assigned treatment and 134 control participants. The inner-city group was 90% African-American, 8% Hispanic, and
2% mixed ethnicity. The suburban group consisted of 37 treatment and 39 control participants. This group was 99% Caucasian and 1% Hispanic. They reported broad gains in the treatment of students' quantity and effectiveness of coping skills in response to a hypothetical peer pressure situation and a more general stress-inducing situation. Teacher ratings of adjustment improved significantly for treatment group participants, but not for those in the control group. Ratings of popularity also improved significantly for the treatment group. Self-reported intentions to use substances also decreased for the treatment group. The results were comparable for both the inner-city and suburban samples.

Forman (1993) identified three skill areas for achieving social competence: social problem-solving, life skills, and assertiveness. Social problem-solving emphasizes teaching new thinking processes in order to have relevance to a wide variety of social situations. The six steps in social problem-solving identified by Forman are as follows: 1) identifying the problem, 2) determining goals, 3) generating alternative solutions, 4) examining consequences, 5) choosing the solution, 6) evaluating the outcome.

Forman (1993) also included life skills as one of the important areas in the broader context of coping strategies for children and adolescents. She also mentioned relaxation, using self-instruction techniques, and decreasing irrational beliefs in her review of important coping skills for adolescents.

Forman (1993) also included assertiveness training in her review of important interventions to improve social competence. Assertiveness training is defined by Alberti and Emmons (1995) as an intervention that "focuses on teaching the individual to act in his or her own best interests, to stand up for herself or
himself without undue anxiety, to express honest feelings comfortably, or to exercise personal rights without denying the rights of others”.

Another substance abuse prevention program focused on developing refusal skills in a diverse group of adolescents (Elder, 1994). Elder maintained that prevention programs for substance abuse have been successful, but indicated that uncertainty remains regarding the specific mediating variables that are activated in life skills training programs. They studied 389 high-risk adolescents enrolled in Project SHOUT. SHOUT is a comprehensive psychosocial tobacco use prevention program that includes a training component emphasizing the teaching of social skills to resist pressure to use tobacco. High risk students were identified as experimenters (i.e., students who reported trying tobacco in the last two years, but did not currently use it more than once a month) and never-users (i.e., never tried but had friends and parents who used tobacco). The participants were about 50% Caucasian, 26% Hispanic, and 23% other ethnic groups. The results indicated a modest effect on the intervention related to refusing peer offers of tobacco. Ethnicity was associated with refusal skills in that Hispanic subjects in the intervention group demonstrated greater competency in refusing tobacco offers than did subjects in all other ethnic groups.

Vitaro and Dobkin (1996) also attempted to address adolescent substance abuse in their study. Both at-risk and no-problem children were included. Variables targeted by the program were increased knowledge, assertiveness, self-esteem, influence ability, social anxiety, and attitudes towards and use of substances. The Life Skills Training program described in the previous paragraph was used to address these goals. The participants were 121 children (mean age was 10.9 years old). The results of this study indicated that boys became more assertive than girls overall (after the LST), and high-risk boys and girls in the
experimental condition became more assertive than their high-risk counterparts in the control group. No changes were found in self-esteem. Knowledge pertaining to cigarettes increased for the participants in the prevention program. Children in the prevention program also developed more negative attitudes towards cigarettes from pre-test to post-test. There were no changes in cigarette smoking or alcohol consumption, although there was an increase in cigarette smoking for high-risk children regardless of experimental condition. Overall, a review of studies using the LST program demonstrated significant reductions in the onset and prevalence of cigarette smoking, as well as marijuana and alcohol use, when compared to untreated controls (Ellickson & Bell, 1990; Hawkins, 1992 & Rogers, Howard, & Bruce, 1989).

Bauman (1997) developed the Teen Education and Employment Network program (TEEN), which used a peer counseling program to enhance competence. Competence was defined as self-esteem, social skills, and coping behaviors. The program included the goals of learning social and communication skills; formation of a peer support group while in training; availability of the trainer as a role model and mentor; the experiencing of rehearsing job roles; achievement by successful completion and graduation from the training program; and the experience of being in a helping relationship with others. The TEEN program consisted of two parts: twelve sessions of formal communications and social skills training and a four-month, part-time job internship. The results indicated that the TEEN program did not increase social competence as measured by a social competence scale including nine areas of social competence, but did increase adolescents' internal resources, particularly self-esteem, and promoted mental health.

Weitlauf, Smith and Cervon. (2000) in a study on women under the title of conveying the effect of life skills training on the self – efficiency, assertiveness and aggression showed that such as training caused the growth of assertiveness
and self efficacy on individuals. Also in interpersonal relationship significant reduction was found in levels of aggression on hostility.

Lange and Jakubowski (2001) have identified twelve training goals they consider essential for successful assertiveness training groups:

1. Identify specific situations and behaviors which will be the focus of training.

2. Teach the participants how to ascertain if they have acted assertively rather than aggressively or non assertively.

3. Help individuals to accept their personal rights and the rights of others.

4. Identify and modify the participants' irrational assumptions which produce excessive anxiety and anger, and result in non assertion and aggression.

5. Provide opportunities for the participants to practice alternative assertive responses.

6. Give specific feedback on how the members could improve their assertive behavior.

7. Encourage the members to evaluate their own behavior.

8. Positively reinforce successful improvements in assertive behavior.
9. Model alternative assertive responses as needed.

10. Structure the group procedures so that the member's involvement is widespread and supportive.

11. Give considerable permission and encouragement for the participants to behave assertively within and outside of the group.

12. Display leadership behavior which is characterized by assertion rather than aggression or non assertion.

Weissberg, Barton & Shriver (2003) conducted a study which used a generalized thinking strategy that teaches students self-control, stress management, problem solving, decision making, and communication skills. Their program is called the Social-Competence Program for Young Adolescents. Social-Competence Program for Young Adolescents includes three modules, the social problem-solving module, the substance use prevention module, and the human growth and development, AIDS prevention, and teen pregnancy prevention module one of their studies included 421 urban adolescents. It was unclear whether these adolescents were high-risk participants or not. When compared with no-treatment controls, their intervention resulted in students gaining problem solving skills, prosocial attitudes toward conflict resolution, improved teacher-rated impulse control and peer sociability, and self-reported decreases in delinquent behavior.

In relation to HIV, life skills are said to facilitate the negotiation of risk and vulnerability in the face of the epidemic. They enable people to communicate openly and freely about sex and drugs, indicating their
preferences and what they wish to avoid. They result in clear thinking, having the right attitudes and staying safe (Griffin, Botvin, Nichols, & Doyle, 2003).

Mcneilly and Yorke (2004) screened 149 adolescents for assertiveness difficulties, which resulted in a sample of 48 nonassertive junior high school adolescents. These adolescents were assigned to one of four conditions: modeling only, instructions only, modeling plus instructions, and a no-treatment control. The modeling condition consisted of watching relevant role play, student practice, role playing, and feedback. The instructions only condition included teaching students to become aware of negative self-statements that inhibit assertive behavior, teaching students about coping strategies by presenting an audiotape and written handouts, and practice sessions with another student. The modeling plus instructions group received the instructions during non-practice sessions, and received the modeling treatment in other sessions. The results of this study indicated that life skills improved in all treatment groups. Changes also occurred in students' self-reported perceptions of mastery and improvements on assertiveness measures.

An important point is, Life Skills Training (LST) help individual in controlling problems such as depression, anxiety, lone lines, rejection, diffidence, anger, confliction in interpersonal relationship lack and failure (Smith, 2004).

Smith’s study (2004) showed that life skills training significantly decrease alcoholic use and drug among young people. Smith showed in their research that the training of coping skills caused the improvement of interpersonal relationship and the reduction of aggression and behavioral problems in instructed
people. Smith showed that life skills training had a significant effect on management and leadership abilities among young people.

Sukhodolsky, Golub, Stone and Orban, (2004) showed in a research that giving life skills with stressed situation caused the prevention and reduction of mental disorders and psychosomatic diseases among many people.

Boler and Aggleton (2005) analyze the background to current advocacy for Life Skills Training. They point to the speed with which a set of ideas which have their origins in the treatment of mental health problems and in management training have been taken up and transferred to the fields of HIV and AIDS, and sexual health. They also highlight the manner in which many skills-based approaches construct young people as “deficit systems” lacking in competence while adults are normally assumed to live risk-free lives and know all the answers.

Phuphaibul and et al., (2005) in a research as generalizing Life skills for individuals with severe mental illness showed that giving coping skills cause the improvement of performance and growth of quality of life in people with severe mental illness.

In countries such as the United States life skills-based programs have been said to reduce alcohol and tobacco use, reduce substance use, and contribute to reductions in gang crime and reoffending (Botvin, Griffin, & Nichols, 2006).
Mishara and Ystgaard (2006) in a sample consisted of 500 students showed that life skills training are effective in increasing mental and physical health and also in decrease behavioral and social problems. It also considered that in conveying the efficiency life skills trainings on student's mental health, it is the life skills trainings.

A recent review of life skills work in southern Africa concluded that life skills programs in general are too simplistic to offer any valuable solution to the complex needs of African young people (Crewe, 2007).

Effective Life Skills interventions were shown to have positive effects on knowledge, attitudes, and skills and sometimes on behaviors (Ross et al., 2007).