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Gender and Mental Health: Are There Differences?

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ABSTRACT

Mental health is clearly an integral part of health. There is no health without mental health. It is the foundation of well-being and effective functioning for an individual and for a community. Mental health and mental illnesses are determined by the interaction of multiple social, psychological and biological factors. The current study focuses on the gender differences in mental health among youth in Kerala. The participants consisted of 211 undergraduate students between 18 and 24 years. The data were collected using the Demographic proforma and the Mental Health Inventory (MHI). Results showed that youth in Kerala had average mental health. There were no significant associations between demographic characteristics and mental health. Independent sample t test revealed no significant gender difference in overall mental health but gender difference was observed in General positive affect. General positive affect was greater among males than in females. Findings of the current study conclude that male and female youth of Kerala do not differ in terms of their mental health. Limitations, strengths, and implications of the findings are discussed in detail.

Keywords: *Mental health, Youth, Gender, Positive affect*

Mental health is very much fundamental to physical health and quality of life, and thus it needs to be addressed as an important component for improving overall health and well-being of an individual. Mentally healthy individuals are reality oriented, know their limitations and possibilities, value themselves, respond to challenges efficiently, establish and maintain close relationships, pursue work that suits their abilities, and feel a sense of fulfillment. World Health Organization (WHO) (2001, p.1) defines health as "a state of complete physical, mental and social wellbeing and not merely the absence of disease and infirmity". On par with this, mental health is also defined as "a state of well-being in which the individual realizes own abilities, copes with the normal stresses of life, works productively and fruitfully, and makes a contribution to the community" (WHO, 2001, p.1). While 12% of the global burden of diseases is attributed to mental disorders, the prevalence of these among the adult population is found to be 10%. It is revealed that the lifetime prevalence of one or more mental and behavioural disorders is 25% (Praveenlal, 2013). Because children below 19 years in countries that are not

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developed constitute 35–50% of the population (Patel, Flisher, Nikapota, & Malhotra, 2008), their mental health requires greater attention from authorities.

Review of literature suggested that 'mental health', as a concept for research, has drawn much attention in the recent times. A cohort study by Keyes, Dhingra and Simoes (2010) found that improvement in mental health predicts reduction in mental illness and vise versa. Emotional intelligence and intelligence show a relationship with mental health (Mathews, Roberts, & Zeidner, 2004). Emotional intelligence of the individual moderates the relationship between stress and mental health (Ciarrochi, Deans, & Anderson, 2000), and emotional repair is one of the main predictors of mental health (Montes-Berges & Augusto, 2007) whereas social disadvantage negatively influences it (Sharma, 1984).

Extant research shows that there is better mental health among Indian adolescents and youth with low prevalence of mental disorders compared to their counterparts in several other countries. In a multi-country study Tamini and Mohammady Far (2009) found that Indian students had better mental health and life satisfaction compared to Iranian students. Low prevalence of psychiatric disorders among children and adolescents (prevalence rate of 12.5% in 0-16 yrs) compared to Western countries is reported by Srinath, Girimaji, Gururaj, Seshadri, Subbakrishna, Bhola and Kumar (2005). More than 5% of them showed significant disability (4-16 yr group) and highest prevalence was reported in middle class urban areas. Pillai, Patel, Cardozo, Goodman, Weiss, and Andrew (2008) found that prevalence of any DSM–IV diagnosis among adolescents in Goa, India was about 2%. While anxiety disorders (1%), behavioural disorder (0.4%), depressive disorder (0.5%), and attention-deficit hyperactivity disorder (0.2%) were the commonest diagnoses, higher prevalence was observed among adolescents from urban areas, particularly among girls who faced gender discrimination. In a prospective, longitudinal, 6 years follow-up study, evaluating the incidence of childhood mental disorder among school children in India, 20 children out of 186 followed up had mental disorder hinting the annual incidence rate of 18/1000/Yr, as reported by Malhotra, Kohli, Kapoor, & Pradhan (2009) whereas according to Malhotra, Kohli, and Arun (2002) the prevalence rate of mental disorders was 6% among 4 to 11 years old children in Chandigarh. On the whole these prevalence rates were less than that of several western countries such as Canada - 18.1% (Offord, 1987), Switzerland -22.5% (Steinhausen, Metzke, Meier, & Kannenberg, 1998), and Germany -20.7% (Weyerer, Castell, Biener, Artner, & Dilling, 1988).

Relating gender to mental health is a very helpful strategy to aid in the identification of appropriate responses from the mental healthcare system, to understand the epidemiology of mental health problems, and thereby to increase public participation in mental health care (Vlassof, Garcia Moreno, 2002). Gender differences are observed in the prevalence of mental disorders such as depression, anxiety and somatic problems. Females report more problems although these disorders vary across age groups (Scott, 1998; Parker & Roy, 2001; Kessler, McGonagle, Zhao, *et al*, 1994; Hawton, Rodham, Evans & Weatherall, 2002; Linzer, Spitzer,

Kroenke, *et al.,* 1996) also. It is observed that Indian females exhibit high threshold of suffering and thus postponing or not receiving treatment for their health issues. This is thought to be associated with gender inequalities (Amin & Bentley, 2002). While examining patterns of gender socialization among youth in India and its association with mental health, Ram, Strohschein and Gaur, (2014) have also found that gender inequality is still present in Indian families. Although females had more gender-egalitarian attitudes they also had more constraints on their freedom than males. Gender bias was more recognized by males whereas mental health problems were more among females. Irrespective of the gender sample of this study identified two risk factors to mental health and these were violence in the family and restrictions to freedom. Extant literature also reveals contradictory findings on mental health-gender association. In a recent investigation, Mishra and Jha (2015) observed independent effect of gender on mental health among college students with males having better mental health. Whereas several other studies (Anand, 1999; Nanda, 2001; Deshmukh & Singh, 2013) have reported better mental health among females.

While Kerala is on the top for various indices of health compared to rest of the states in the country, it is not so with respect to mental health. Hackett, Hackett and Bhakta (1999) found mental disorders prevalent (9%) among 8 to 12 years old children from a community sample in Kerala. A survey (Rajan, Mohamed, Kumar & Mohammed, 2002) among 1000 households in Kerala identified gender-related issues in areas of stress experience, mental health, human well-being, and gender ideology. It is seen that men were having relatively better sense of well being, mental health and more progressive gender ideology. Women experienced more stress in most of the areas. But a change in trend in a positive direction indicated that the younger, better educated and the unmarried had better mental health irrespective of their gender. From North to Southern region of Kerala well being and mental health of men was found to be gradually increasing whereas for women the reverse was true. Recently it is observed that psycho-social problems are prevalent among Kerala's adolescents. In a sample of 600 adolescents from 10 higher secondary schools in five districts of Kerala, Mumthas and Muhsina (2014) estimated considerable prevalence of emotional (32%) and behavioural (27%) problems. While almost half of the sample felt that they are impatient and shy, majority reported being very anxious and getting angry easily. They also reported suicidal ideations (4%), feelings that they are not respecting others (9%), and, being very talkative, unorganized, and hyperactive and introverts (33%).

From the above review it is evident that mental health in association with gender among Kerala population is not much studied particularly among youth. Youth play an important role in building the nation and there is pressing need to examine mental health-gender association. Attention is required not only in terms of preventive and promotional measures, and health care services but also in terms of authentic research evidences to reconsider strategies to improve mental health. Hence the aim of this study was to undertake a cross sectional random survey of youth in a selected District of Kerala to estimate the level of their mental health with respect to gender. It was hypothesized that there will be significant difference in mental health among male and female youth.

MATERIALS AND METHODS

The current study uses a cross sectional survey approach and correlative design, and the key variables targeted in this investigation are: 'mental health' and 'gender'. Data were collected using a Demographic proforma and Mental Health Inventory (MHI) (Veit & Ware, 1983). Data for the present paper come from the pilot study conducted during April-May 2013 on ACEs, an epidemiological study conducted in Kerala.

Participants

The participants for the study were 211 Undergraduate youth between the age group of 18 to 24 years (Mean =18.76, SD=1.62) who were chosen from selected colleges in Kottayam district, Kerala through random sampling. Sample was chosen based on specific criteria for inclusion and exclusion. Informed written consent was obtained from participants prior to the study.

Measures

1. Demographic proforma: Data on age, gender, birth order, education type, family structure, domicile, marital status, mother's and father's education, mother's and father's occupation, monthly income of the family were obtained using a demographic proforma.
2. Mental Health Inventory (MHI) (Veit *et al.*, 1983): The Mental Health Inventory, developed by Veit and Ware and standardized in 1983, has 38 items. It is designed to measure the mental health of an individual within the past month. The MHI consists of six subscales for dimensions such as Anxiety, Depression, Loss of behavioural /emotional control, General positive affect, Emotional ties and Life satisfaction; two global scales *viz.,* Psychological Distress and Psychological Well-being; and, Global Mental Health Index score (A global Mental Health Index score is designed as the high level summary index of the person's mental health status reflecting the degree of psychological health). MHI has author reported, moderate test-retest reliability (.56 to .64) and the internal consistency of various sub scales obtained for the current study ranges from .81 to .96. Its validity has also been established.

Procedure

Ethical dimensions of the study were met by obtaining administrative permission from concerned institutional authorities, written consent from subjects, and approval from institutional ethical committee of Jubilee Mission Medical College and Research Institute, Thrissur. The investigator personally met students in their class. The sample was assured about the confidentiality of their data. After ascertaining that they understood the purpose of the study the instruments were administered with instructions. Participants reviewed a letter of information and completed questionnaire measures. Names were not included to safeguard the autonomy and identity and it was explained that participation was voluntary.

Statistical analysis

Statistical analysis was done with SPSS version 20. Descriptive statistics, Chi square test to find the association between mental health and demographic variables, and independent sample *t* test (for testing gender differences in mental health) were applied.

RESULTS

Among 211 youth participated in the survey 75 were females (36%) and 136 were males (65%). Majority (72%) were living in rural area with their biological parents (84%). More than half of the mothers (54%) and approximately half of the fathers (48%) had completed higher secondary education. Majority of fathers (60%) were self employed and mothers (71%) were home makers. About 47% of them were Hindus. The average monthly income of the family was between 5000 and 10000 Rs/- (Table not shown).

On analysis no statistically significant association was found between mental health and demographic factors such as place of residence, parents' education and occupation, monthly income of the family and religion (Table not shown). Analysis showed that the mean Global Mental health Index score of the sample was 156.73 ± 21.536 (± SD) which indicated average level of Mental health. Further, association between gender and mental health was tested with independent sample *t* test.

Table .1 Mean, SD, and 't' value of Mental health of male and female youth (N = 211)

	Male		Female			
Mental health	**M**	**SD**	**M**	**SD**	***t* value**	***p****
Global Mental Health Index	158.67	22.63	153.23	19.05	1.77	.079
Subscales						
Anxiety	22.90	6.39	23.77	6.10	-0.96	.338
Depression	11.71	3.06	11.97	2.68	-0.62	.538
Loss of Behavioural or Emotional Control	21.38	6.59	22.51	6.10	-1.22	.225
General Positive Affect	38.26	7.82	35.99	7.42	2.06	.041*
Emotional ties	8.57	2.62	8.23	2.82	0.88	.382
Life Satisfaction	3.81	1.25	4.05	1.17	-1.39	.166

*$p < .05$ level

Table 1. shows that there is no statistically significant difference between Global Mental Health Index score ($t_{(209)} = 1.77$, $p > .05$ level) among males and females although mental health was slightly higher among male youth (*M*= 158.67, *SD*= 22.63) than female youth (*M*= 153.23, *SD*= 19.05). On subscales of MHI, General positive affect was significantly greater ($t_{(209)} = 2.06$, $p < .05$ level), among male youth (*M*= 38.26, *SD*= 7.82) than female youth (*M*= 35.99, *SD*= 7.42). Though males had slightly higher scores on Emotional ties (*M*=8.50, *SD*=2.62) than females (*M*=8.23, *SD*=2.81), females scored high on Life satisfaction (*M*=4.05, *SD*=1.17) than males

(*M*=3.81, *SD*=1.25) showing a reverse trend. However these differences did not attain any statistical significance (Emotional ties- $t_{(209)} = 0.88$, $p > .05$ level, Life satisfaction- $t_{(209)} = 1.39$, $p > .05$ level) indicating that the observed differences were due to chance.

On the whole, there was no significant difference in over all mental health among males and females although males had significantly greater general positive affect than females. These findings indicate that Keralite youth's mental health is not affected by their gender except on the aspect of positive affect. Males are more joyful, proud, elated, and contented than females. Whereas there was no gender difference in the degree of concern over losing one's mind, degree of anxiety or stress, depressed feelings, relationship with others or positivity of emotions.

Although the findings relating to the relationship between Gender and Mental health are contradictory, it is partially supportive to the findings from extant literature (Rajan *et al.,* 2002) and also in the positive direction. In an earlier study, Eapen and Kodath (2002) found that Kerala women did not have a favourable status on several indicators of their health including mental health. However the current study reveals that overall mental health of youth is average and males have more positive affect than females. When individuals are psychologically healthy they are also in control of their emotions and behaviour. They are able to overcome life's challenges, develop and maintain healthy relationships, and recover from failures in life. So promoting one's psychological health benefits all aspects of life. According to Kumar and Radha Devi (2010) Keralite females are better off on many health indicators compared to their counter parts in other parts of the country. Although youth have only average mental health, it is promising that the condition of females has improved considerably from that of the past.

The present study revealed higher positive affect among males which may be attributed to unequal power relation between men and women. Children learn gender roles by connecting maleness with authority and power, and femaleness with subservience. In the patriarchal and feudalistic structure of the Kerala society the status of women is not equal to the status of men in terms of access, participation and reward. It is seen that positive affect depends upon the success of individuals at their targeted goals (Emmons, 1986). It may also be that males have greater sense of accomplishment. Personal well-being result from satisfaction of basic psychological needs, and extrinsic goals have a direct effect on one's well-being (Brdar, 2006). Rask (2003) found that male gender and the individual's perception of high level of maturity as significant predictors of global satisfaction. The current findings may also be attributed to the variations in the exposure to favourable and unfavourable factors (UNICEF, 2007) or temperament (Malhotra, Varma, & Verma, 1986). Patel *et al.,* (2008) have summarized risk factors of mental disorders as individual determinants (gender, disabilities, temperament and neurobiological risks etc.); family determinants (family's structure, parenting styles, parental mental health, family functioning, attachment patterns, physical abuse and punishment etc.); and social and community determinants (ecological factors, socioeconomic deprivation, conflict and war etc.).

Findings of the study have several implications. The Kerala scenario in terms of mental heath – gender association indicates that an effective approach is required to promote mental health of young people in Kerala. Ganga and Kutty (2012) suggest that a life cycle approach may be helpful while planning interventions for promoting mental health in young people. Mental health in childhood is influenced greatly by the nature and quality of childhood experiences, and mental health in adulthood is determined by one's mental health in childhood and adolescence (Fergusson, Horwood, Grant, & Ridder, 2005; Anda *et al.*, 2006). It is found that majority (50%) of adult mental disorders originate by the age of 15 (Kim-Cohen, Caspi, Moffitt, Harrington, Milne, & Poulton, 2003). Concerted efforts should be directed towards strengthening the recognized protective factors such as better opportunities for education, emotional autonomy and better physical health, the role of the extended family etc. Promotion of mental health needs to focus on promoting resilience whereas prevention must target general population (universal), individuals or subgroups that are greater risk of developing a disorder (selective), and high-risk groups that have evidence of an incipient disorder (indicated) (Mrasek, & Haggerty, 1994). Patel *et al.*, (2008) provide principles to be followed for promotion and prevention of mental health which include: (a) having a holistic framework with respect to mental health; (b) linking capacity development with achievable goals; and, and (c) equipping the health care work force. Strengthening individuals and families through public health programmes with a focus on parenting and education; and, empowering children below 18 years through health promotion, provision of adequate education, development of life skills etc., is very important. Equally important is strengthening the community by promoting health in educational institutions and by empowering the health system through the development the work force capacity. Raising awareness in the community about mental health and its related factors, vulnerable groups; and, reducing structural barriers through legal reforms, research, policy making etc will also be very essential.

Current findings require careful interpretation since the subscale measuring General positive affect consists of only one item in the MHI. Because the sample was constituted by students, youth with mental health problems or youth from vulnerable groups were excluded from the study which limits the generalizability of the findings. Further, like other confounders, gender may operate in association with other variables and this requires further examination. The data were cross-sectional, limiting causal inference. Despite these shortcomings, this study provides insight regarding the mental health of a contemporary cohort of Keralite youth, revealing the extent to which being male or female affect their mental health.

CONCLUSION

"No health without mental health". Mental health isn't only the absence of mental illness. The scope and importance of mental health range from the promotion of mental health to the care of the ill. Promotion of mental health can be attained by appropriate public health and social interventions. For effective mental health promotion, Kerala must focus on developing the strengths and resilience of individuals. Further studies on potential risk factors and protective

factors including gender are necessary to explore the possible interactions. There needs to be more emphasis on promotion of mental health through the collective action of society. Additional research with larger sample from deprived groups and systematic evaluation of effectiveness ongoing programmes are required to increase the evidence base also.

REFERENCES

Amin, A., Bentley, M. E . (2002). The influence of gender on rural women's illness experiences and health-seeking strategies for gynecological symptoms. *Journal of Health Management, 4*, 229-249.

Anand S.P. (1999). A study of students mental health attitude and motivation for studies. *Journal of Educational Research, 36* (2), 55-61.

Anda, R., Felitti, V., Bremner, J., Walker, J., Whitfield, C., Perry, B., . . . Giles, W. (2006). The enduring effects of abuse and related adverse experiences in childhood: a convergence of evidence from neurobiology and epidemiology. *European Archives of Psychiatry and Clinical Neuroscience, 256* (3), 174-186.

Brdar, I. (2006). Life goals and well-being: are aspirations important for happiness? *Positive Psychology, 15* (4-5), 619-960.

Ciarrochi, J.P., Deans, F. and Anderson, S. (2000). Emotional intelligence moderates the relationship between stress and mental health. *Journal of Personality and Individual Differences,32,*197-209. http://dx.doi.org/10.1016/S0191-8869(01)00012-5.

Deshmukh, A. & Singh, B.G. (2013), Sex variations in obsession-compulsion of tobacco users. *Indian Journal of Health and Well Being, 4* (9), 1736-1738.

Eapen, M., & Kodoth, P. (2002). *Family Structure, Women's Education and Work: Re-examining the High Status of Women in Kerala.* (Working Paper No. 341), Thiruvananthapuram: Centre for Development Studies.

Emmons, R. A. (1986). Personal strivings: An approach to personality and subjective well-being. *Journal of Personality and Social Psychology, 51*, 1058-1068.

Fergusson, D. M., Horwood, L. J., Grant, H., & Ridder, E. (2005). *Early Start evaluation report.* Christchurch, New Zealand: Early Start Project Ltd.

Ganga, N.S., & Kutty, V.R. (2012). Identifying key strategies to promote positive mental health of young people in the state of Kerala, India. *International Journal of Mental Health Promotion, 14* (5), 276-288. doi: 10.1080/14623730.2013.789627.

Hackett, R., Hackett, L., & Bhakta, P. (1999). The prevalence and associations of psychiatric disorders in children in Kerala, South India. *Journal of Child Psychology and Psychiatry, 40*, 801-807.

Hawton, K., Rodham, K., Evans, E., & Weatherall, R. (2002). Deliberate self harm in adolescents: Self report survey in schools in England. *British Medical Journal, 23,* 1207-1211.

Kessler, R. C., McGonagle, K. A., Zhao, S., et al. (1994). Lifetime and 12-month prevalence of DSM-III-R psychiatric disorders in the United States. *Archives of General Psychiatry, 51,* 8-19.

Keyes, C. L. M., Dhingra, S. S., & Simoes, E. J. (2010). Changes in level of positive mental health as a predictor of future risk of mental illness. *American Journal of Public Health, 100* (12), 2366-2371. doi:10.2105/AJPH.2010.192245.

Kim-Cohen, J., Caspi, A., Moffitt, T., Harrington, H., Milne, B., & Poulton, R. (2003). Prior juvenile diagnoses in adults with mental disorder: Developmental follow-back of a prospective-longitudinal cohort. *Archives of General Psychiatry, 60,* 709-717.

Kumar, N. A., & Radha Devi. D. (2010). *Health of Women in Kerala: Current Status and Emerging Issues.* (Working Paper No. 23), Kerala: Centre for Socio-economic & Environmental Studies.

Linzer, M., Spitzer, R., Kroenke, K., et al. (1996). Gender, quality of life, and mental disorders in primary care: Results from the PRIME-MD 1000 study. *American Journal of Medicine, 101,* 526-533.

Malhotra S., Kohli, A., & Arun, P. (2002). Prevalence of psychiatric disorders in school children in India. *Indian Journal of Medical Research, 116,* 21-28.

Malhotra, S., Kohli, A., Kapoor, M., & Pradhan, B. (2009). Incidence of childhood psychiatric disorders in India. *Indian Journal of Psychiatry, 51,* 101-107.

Malhotra, S., Varma, V.K., & Verma, S.K. (1986). Temperament as determinant of phenomenology of childhood psychiatric disorders. *Indian Journal of Psychiatry, 28,* 263–276.

Matthews, G., Roberts, R. D., & Zeidner, M. (2004). Seven myths about emotional intelligence. *Psychological Inquiry, 15,* 179 –196.

Mishra, S., & Jha, M. (2015). Role of gender and residence on mental health. *IOSR Journal Of Humanities And Social Science, 20* (3), 51-55.

Montes-Berges, B., & Augusto, J. M. (2007). Exploring the relationship between perceived emotional intelligence, coping, social support and mental health in nursing students. *Journal of Psychiatric Mental Health Nursing, 14* (2), 163-171.

Mrasek, P. J., & Haggerty, R. (1994). *Reducing risks for mental disorders: Frontiers for preventive intervention research.* Washington, DC: National Academy Press.

Mumthas, N. S., & Muhsina, M. (2014). Psycho-social problems of adolescents at higher secondary level. *Guru Journal of Behavioral and Social Sciences, 2* (1), 252-257.

Nanda, A. K. (2001). Mental health of high school students: A comparative study. *Indian Psychological Review, 56* (1), 2-7.

Offord, D. R. (1987). Ontario Child Health Study: II, Six month prevalence disorder and rates of service utilization. *Archives' of General Psychiatry, 44,* 832-836.

Parker, G., Roy, K. (2001). Adolescent depression: A review. *The Australian and New Zealand journal of psychiatry, 35,* 572-580.

Patel, V., Flisher, A J., Nikapota, A., & Malhotra, S. (2008). Promoting child and adolescent mental health in low and middle income countries. *Journal of Child Psychology and Psychiatry, 49* (3), 313–334. doi:10.1111/j.1469-7610.2007.01824.x

Pillai, A., Patel, V., Cardozo, P., Goodman, R., Weiss, H. A., & Andrew, G. (2008). Non-traditional lifestyles and prevalence of mental disorders in adolescents in Goa, India. *The British Journal of Psychiatry, 192,* 45–51. doi: 10.1192/bjp.bp.106.034223.

Praveenlal, K. (2013). Policy and programmes for mental health in Kerala. *BMC Proceedings, 7* (Suppl 5), O12. doi:10.1186/1753-6561-7-S5-O12.

Rajan, S. I., Mohamed, E., Kumar, K. A., & Mohammed, P.M. S. (2002). *Gender and Mental Health in Kerala (Kerala Mental Health Survey),* (Report submitted under the MIMAP Gender Network Project) (Phase II). Retrieved from www.isst-indiaorg/PDF/Gender%and%Mental%20Health.pdf.

Ram, U., Strohschein, L, & Gaur, K. (2014). Gender socialization: Differences between male and female youth in India and associations with mental health. *International Journal of Population Research, 2014,* http://dx.doi.org/10.1155/2014/357145.

Rask, K. (2003). Adolescent subjective well-being and family dynamics. *Scandinavian Journal of Caring Sciences, 17,* 129-138.

Scott, S. (1998). Aggressive behaviour in childhood. *British Medical Journal, 316,* 202-206.

Sharma, R.G. (1984). The effects of social disadvantage on mental growth and mental health of children. *Indian Journal of Clinical Psychology, 11,* 1–13.

Srinath, S., Girimaji, S. C., Gururaj, G., Seshadri, S., Subbakrishna, D. K., Bhola, P., & Kumar, N. (2005). Epidemiological study of child and adolescent psychiatric disorders in urban and rural areas of Bangalore, India. *Indian Journal of Medical Research, 122,* 67-79.

Steinhausen, H. C., Metzke, C. W., Meier, M., & Kannenberg, R. (1998). Prevalence of child and adolescent disorders: The Zurich epidemiological Study. *Acta psychiatrica Scandinavica, 98,* 262-271.

Tamini, B. K., & Mohammady Far, M. A. (2009). Mental Health and Life Satisfaction of Irani and Indian Students. *Journal of the Indian Academy of Applied Psychology, 35* (1), 137-141.

UNICEF. (2007). *State of the world's children – gender and the life cycle.* New York: UNICEF.

Veit, C.T., & Ware, J.E. Jr. (1983). The structure of psychological distress and well-being in general populations. *Journal of Consulting Clinical Psychology, 51,* 730-742.

Vlassoff, C., & Garcia Moreno, C. (2002). Placing gender at the centre of health programming: Challenges and limitations. *Social Science and Medicine, 54,* 1713-1723.

Weyerer, S., Castell, R., Biener, A., Artner, K., & Dilling, H. (1988). Prevalence and treatment of psychiatric disorders in 3 to 14 year old children: Results of a representative field study in the small rural town region of Traunstein, Upper Bavaria. *Acta psychiatrica Scandinavica, 77,* 290-296.

W H O (2001). *Mental Health: New Understanding, New Hope*. Geneva: WHO.