

MENTAL HEALTH AND ANGER AS A FUNCTION OF RELIGION, AGE AND GENDER

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ABSTRACT

This study examines the extent to which social and individual factors are associated with aggression and mental health. There is a close relationship between mental health and aggressive behavior; the greater the effort to deal with aggression during early manifestations of aggression, the greater will be the positive impact on mental health of an individual. Since aggression statistically appears to be more troublesome among the youth and growing ones; increased effort to reduce aggression could significantly prove effective in achieving positive mental health. A sample of 160 participants with equal number in religion (Muslim and Hindu), age (14-17 & 21-24 years) and gender (male & female) were employed. To assess mental health and anger expression, PGI Health questionnaire by Wig and Verma and Anger Expression Questionnaire by Spielberger were used. ANOVA and Post hoc mean comparison were used to analyze the data. Result revealed that adolescents were having poor mental health as compared to adults. Muslim participants were experiencing more anger than their counterparts. Moreover, adolescents showed more capacity of suppressing their anger in contrast to adults. Significant gender differences were observed on the dimension of anger control, whereas females exhibited more control on their aggression.

KEYWORDS: *Mental Health, Anger Expression, Aggression, Adolescents, Adults*

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INTRODUCTION

In today's era, the main concern of the society is the emerging mental health problems among youth. Young people are considered as an important asset worldwide; they are the future leaders of nation who will determine economic and political policies, and affect life style and family structure. However, young generation health is often complex and requires a comprehensive and bio-psychosocial approach (NSW Dept of Health 2010). Youth, generally experiment with their attitude, appearance and behavior which sometimes make them to engage in risky behaviors that can affect their health (Australian Institute of Health and Welfare 2007). These behaviors are established as a young person and go on to become the lifestyles of adults leading to chronic physical and mental health problems (Bennett, D., Kang, M., and Chown, P 2004). The majority of health problems they experience are psychosocial. Mental health problems such as stress, anxiety, depression, and self-injurious aggressive behavior are at mark. Young people have specific health problems and developmental needs that differ from adults.

Studies reported that an average of five times as many students in 2007 exceeded the thresholds in one or more mental health category, compared to the students in 1938. In fact, in a few categories, as many as six times as many

students exceeded the thresholds. A number of epidemiological studies have reported prevalence rates ranging from 12% to 20% for psychiatric disorders among children and adolescents. For example, Roberts, Attkinson, and Rosenblatt (1998), in an international meta-analysis of 52 studies, reported a mean prevalence rate of 15.8%. According to NIMH report (2015), approximately 1 in 5 youth aged 13 to 18 years (21.4%) experiences a severe mental disorder at some point during their life. For children aged 8–15, the estimate is 13%.

Among one of the most important public health issues is mental health. In view of the “Alma Ata Declaration”, the goal being health for all by 2000 A.D defining health as physical, mental and social well-being. Shah (1982) has expressed that mental health is “the most essential and inseparable component of health... an integrated component of public health and welfare programs...” Mental health is the balanced development of the individual’s personality and emotional attitudes, which enable him to live harmoniously with his fellowmen. In 1951, WHO Expert Committee reviewed that “mental health is influenced by both biological and social factors. It is not a static condition but subject to variations and fluctuations of degree; it implies the capacity in an individual to form harmonious relations with others, and to participate in, or contribute constructively to, changes in his social and physical environment”. It is also referred as the ability to achieve a harmonious and balanced satisfaction of one’s own potentially conflicting instinctive drives. Jahoda (1958) set certain criteria for positive mental health. It includes attitude toward self, growth, development, and self-actualization, integration, autonomy, perception of reality, environmental mastery. With these dimensions a coherent picture of healthy and mature personality emerges.

An important source of mental illnesses is anger, which has been extensively studied by the researchers. Anger is defined as an emotional state typically accompanied by psychological interpretation (a person been offended, blamed or denied) and biological changes. It can vary from minor annoyance to rage. Anger is intrinsically social and cannot be categorized by being exclusively individual or social components. No matter what the outcomes are, either positive or negative, they all take place in social context. According to Golden (2003), anger is a response to distress related to environmental obstacles. The major problems like depression, suicidal tendencies, substance abuse, alcohol addiction, rage, violence, and crime in adolescents and adults can occur if the anger is not controlled. Many studies supported that anger plays an important role in the experience, onset, and maintenance of depressive symptoms and disorder (Ingram et al., 2007; Sheeber et al., 2009; Wenzel et al. 2006). A survey reported that 42% of adolescents stated fighting within the past year, and 26% had carried a weapon during the preceding month (Healthy people 2000).

There are two aspects of anger, i.e., state anger in which the individual responds emotionally to circumstances and another is trait anger which is a more pervasive response (Spielberger 1999). Beside this, Spielberger also suggested three approaches of anger expression. The tendency to express one’s anger in an outwardly negative manner represented an outward directed style known as *anger-out*. It involves the use of aggressive actions (e.g. assaultive behavior, destruction of property, or making offensive gestures) and aggressive verbal behavior (e.g. insults, offensive/inappropriate language or shouting). Another approach is *anger-in*, in which individuals suppress their anger. High level of suppressed or unexpressed anger can lead to pathological expression of anger, such as passive-aggressive behavior or a personality that seems perpetually cynical and hostile. It can also create other problems when the angry feelings being suppressed and replaced with guilt and stress because the person starts blaming himself for the problem surrounding the anger-provoking situation. Last approach is *anger-control*; it is defined as a tendency not to become angry. It is the conscious control over anger emotions and the ability of the person to direct his/her anger into creative and constructive channels. In a study by Smits and Kuppens (2005), anger expression is related to both the behavioral activation system and behavioral inhibition

systems, data from young adults showed that tendencies toward expressing anger outwardly have been found to be positively associated with the behavioral approach system, whereas anger expressed inwardly has been found to be associated with the behavioral inhibition system. In support to this study, Daniele *et al.* (2009) reported that trait anger and anger expression is highly correlated to suicidal attempts. Study results showed that among boys high trait anger and outward anger expression is related to increased likelihood of suicidal attempts. Whereas in girls, trait anger and both the inward and outward expression of anger moderated the risk for suicide attempts associated with major depression. Brent and Mann (2006) also stated in their study that physical fighting and impulsive aggression apparently related to outward expression of anger, and act as a significant factor in suicidal attempts among young people.

There is a close link between mental health problems and individual anger expression. It can be predicted with some degree of certainty that the greater the effort to deal with negative anger emotions during early manifestations, the better will be the mental health of the individual. Since anger expression, statistically appear to be more troublesome among the young and growing ones, it is certain that increased efforts to reduce anger expression could significantly improve their mental health. Therefore, in this context, the present study aims to investigate to which extent individual characteristics (age and gender) and religious beliefs predict manifestation of anger and their impact on mental health.

METHODOLOGY

Sample: A total number of 160 participants with equal number from the Muslim and Hindu communities were randomly selected from schools and colleges of Delhi. Further, the sample was split on the basis of age and gender. Thus, 80 subjects were divided into 20 adolescents (14-17 years) and 20 adults (21-24 years), males as well as females for both the religious groups.

Measures: The following tools were used for data collection:

- *PGI Health Questionnaire:* PGI Health questionnaire (N-2) developed by Wig and Verma (1978) was used to assess mental health. It consists of 60 items that measure subject's physical and psychological health, 50 items (1-50) are N-scale items (i.e. Neuroticism) and 10 items are L-scale items (i.e. lie scale). Response pattern for each item is to put tick mark against the item, which refers to that respondent. Split half reliability for N-scale is 0.92 and for L- scale is 0.81.
- *Anger Expression Questionnaire:* It is developed by Spielberger *et al.* in 1985. Authors formulated a working definition and distinguished between anger as an emotional state (S-anger), how often angry feelings are experienced (T-anger) and the behavior that people engage in when they feel angry or furious. Scale measures three dimensions of anger, namely anger-in, anger-out and anger-control. It comprises of 20 items and yields four different scores for each item, viz almost never, sometimes, often and almost always. The internal consistency of scale is evaluated by computing alpha coefficients and item remainder correlations. The item-remainder correlations for the Ax-Ex scale are based on and all 20 comprising these sub-scales. The alphas ranged from .73 to .84 and are highest for the Ax/In sub scales.

Procedure: In this study, principals of the selected schools were approached and the objective of the study has been explained to them. Permission has been taken to conduct the study in their schools. Objectives of the study were explained to the students. In small groups, PGI health questionnaire and anger expression scale were administered. It was ensured that subjects have understood and responded to each of the item. After collecting the whole data, the responses of subjects were scored and put for adequate statistical analysis.

RESULTS

The data was analyzed by using descriptive and inferential statistics. Mean and standard deviation were calculated on the measure of mental health and anger expression. Three-way ANOVA and Newman Keul's multiple range statistical techniques were used to study the group differences between male and female, adolescents and adults, and Muslim and Hindu on the measure of mental health and anger expression.

In table 1, means and standard deviations were reported on the measures of mental health, anger-in, anger-out and anger-control for three groups: religion (i.e. Muslims and Hindus), age (i.e. adolescents and adults) and gender (i.e. male and female).

Table 1: Means and Standard Deviations for the Measures of Mental Health, Anger-IN, Anger-Out, and Anger-Control for Various Groups (N = 20)

Measures		Muslims				Hindus			
		Adolescents		Adults		Adolescents		Adults	
		Male	Female	Male	Female	Male	Female	Male	Female
Mental Health	Mean	17.45	15.50	12.90	12.80	15.75	24.60	14.75	19.70
	SD	7.11	6.17	5.89	7.17	6.32	8.47	8.21	42.44
Anger-In	Mean	18.45	20.00	17.10	15.90	16.75	16.45	16.75	16.65
	SD	3.65	58.34	2.93	2.88	2.57	3.12	3.90	3.20
Anger-Out	Mean	18.00	18.85	15.10	15.00	17.60	17.80	16.55	14.85
	SD	3.52	4.9	3.32	2.88	2.93	2.93	2.66	2.87
Anger-Control	Mean	9.95	9.45	9.80	9.20	10.05	8.10	10.50	10.30
	SD	2.09	2.33	1.88	1.99	1.96	1.37	1.67	2.32

Table 2: Summary of ANOVA on the measure of Mental Health

Source of Variation	Sums of Squares	df	Mean Squares	F - Value
Religion (A)	60.02	1	60.02	1.34
Age (B)	980.10	1	980.10	21.90***
Gender (C)	0.62	1	0.62	0.01
Relg x Age (AB)	70.22	1	70.22	1.57
Relg x Gen (AC)	52.90	1	52.90	1.18
Age x Gen (BC)	180.22	1	180.22	4.23*
Relg x Age x Gen (ABC)	384.40	1	384.40	8.59***
Error (within grps)	6802.40	152	44.75	
Total	8539.90	159		

* P<0.05; ** P<0.01; *** P <0.001

In table 2, the three-way ANOVA on the measure of mental health is reported. The main effect of age (F-value 21.90) was found significant at 0.001 level of confidence, indicating that mean scores of adolescents group (18.33) were greater than those of adult group (15.04). Two-way interaction of age x gender was significant at 0.05 level of confidence. Further, three-way (ABC) interaction of religion x age x gender (F-value 8.59) was also found significant at 0.001 level of confidence.

Table 3: Post-hoc Mean Comparisons of Mental Health for Age and Gender Groups

Ordered Groups	Ad M	Ad F	Adl M	Adl F	Range	Ms Error N = 1.06	
						q (r,152) 0.95	q (r,152) 0.99
Ordered Means	13.83	16.25	16.60	20.05			
13.83		2.42	2.77	6.22**	4	3.85	4.66
16.25			0.35	3.8*	3	3.51	4.37
16.60				3.45*	2	2.94	3.86
*P<0.05; **P<0.01; N=40; df = 152; Ms Error = 44.75							
Adl = Adolescents; Ad = Adults; M = Male; F = Female							

The above table shows that the mean scores of female adolescents were higher than those of the other comparison groups. This group differs significantly from adult males and females as well as for adolescent males and females. It shows that adult males and females have better mental health as compared to adolescent females.

Table 4: Post-hoc Mean Comparisons of Mental Health for Religion, Age and Gender Groups

Ordered Groups	Mu Ad F	Mu Ad M	Hi Ad M	Mu Adl F	Hi Adl M	Mu Adl M	Hi Ad F	Hi Adl F	Range	Ms Error N =1.49	
										Q (r,152) 0.95	q (r,152) 0.99
Ordered Means	12.80	12.90	14.75	15.50	15.75	17.45	19.70	24.60			
12.80		0.1	1.95	2.7	2.95	4.65	6.9	11.8**	8	6.39	7.43
12.90			1.85	2.6	2.85	4.55	6.8*	11.7**	7	6.21	7.27
14.75				0.75	1	2.7	4.95	9.85**	6	6.00	7.09
15.50					0.25	1.95	4.2	9.1**	5	5.75	6.85
15.75						1.7	3.95	8.85**	4	5.40	6.55
17.45							2.25	7.75**	3	4.93	6.13
19.70								4.90*	2	4.12	5.42
* P<0.05; **P<0.01; N=20; df = 152; Ms Error = 44.75											
Mu= Muslims; Hi=Hindus											

Table 4 shows that mean scores of mental health of Muslim adult females were lower (i.e. showing better mental health) and Hindu adolescent females were highest (i.e. poor mental health). Moreover, Muslim adult males differ slightly from Hindu adult females. Significant mean differences were also found between Hindus adolescent females and males.

Further, the results of anger expression has been separately analyzed on the basis of its three dimensions i.e. anger-in, anger-out and anger-control.

Table 5: Summary of ANOVA on the Measures of Anger-In

Source of Variation	Sums of Squares	df	Mean Squares	F - Value
Religion (A)	58.81	1	58.81	5.59*
Age (B)	68.91	1	68.91	6.55**
Gender (C)	.006	1	.006	.001
Relg x Age (AB)	79.81	1	79.81	7.58**
Relg x Gen (AC)	1.41	1	1.41	.134
Age x Gen (BC)	16.26	1	16.26	1.54
Relg x Age x Gen (ABC)	21.76	1	21.76	2.07
Error (within grps)	1599.55	152	10.52	
Total	1846.49	159		
* P < 0.05; ** P < 0.01				

As per table 5, the F-value of the main effect of religion was found significant ($F = 5.59$) at 0.05 level of confidence. Mean values of Muslims (21.61) and Hindus (16.65) differed significantly on the measure of anger-in, indicating that Muslims showed more anger-in as compared to Hindus. The F-value (6.55) of the main effect of age was also found significant. In case of adolescents group, mean scores were 21.66 and for adults 16.60, indicating that in adolescent anger-in was high as compared to adults. The main effect of gender did not yield significant F-values, but mean value of males (17.26) were lesser than those of females (21.00). Moreover, two-way interaction of religion and age yielded significant F-value (i.e. 7.58), which was significant at 0.01 level of confidence.

Table 6: Post-hoc Mean Comparisons on Anger-In for Religion and Age Groups

Ordered Groups	Mu Ad	Hi Adl	Hi Ad	Mu Adl	Range	Ms Error N = 0.51	
Ordered Means	16.50	16.60	16.70	26.73		q (r,152) 0.95	q (r,152) 0.99
16.50		0.10	0.20	10.23**	4	1.85	2.24
16.60			0.10	10.13**	3	1.69	2.10
16.70				10.03**	2	1.41	1.86

**P<0.01; N=40; df = 152; Ms Error = 10.52

Post hoc mean comparisons of religion and age interaction (table 6) indicated that mean scores of anger-in for Muslim adults were lowest (i.e. showing better capacity of anger-in) and that of adolescents were highest (i.e. showing low capacity of anger-in). Moreover, significant mean differences were obtained between Muslim adolescents and Hindu adolescents and adults, indicating that later two groups had less anger-in, as compared to the former group.

Table 7: Summary of ANOVA on the Measure of Anger-Out

Source of Variation	Sums of Squares	df	Mean Squares	F - Value
Religion (A)	127.81	1	127.81	0.96
Age (B)	35.17	1	35.17	0.26
Gender (C)	150.15	1	150.15	1.13
Relg x Age (AB)	45.16	1	45.16	0.34
Relg x Gen (AC)	56.41	1	56.41	0.42
Age x Gen (BC)	242.65	1	242.65	1.83
Relg x Age x Gen (ABC)	91.51	1	91.51	0.69
Error (within grps)	20195.85	152	132.87	
Total	20944.59	159		

The three-way ANOVA on the measure of anger-out was reported in Table 7. It is observed that there were no significant differences between Muslim and Hindu, adolescent and adult, and male and female on the measure of anger-out. Moreover, the two-way and three-way interactions were not statistically significant.

Table 8: Summary of ANOVA on the Measure of Anger-Control

Source of Variation	Sums of Squares	df	Mean Squares	F - Value
Religion (A)	0.76	1	0.76	0.19
Age (B)	12.66	1	12.66	3.25
Gender (C)	26.41	1	26.41	6.78**
Relg x Age (AB)	23.26	1	23.26	5.97**
Relg x Gen (AC)	2.76	1	2.76	0.71
Age x Gen (BC)	6.81	1	6.81	1.75
Relg x Age x Gen (ABC)	8.56	1	8.56	2.20
Error (within grps)	592.25	152	3.90	
Total	673.44	159		

**P < 0.01

As per table 8, the F-value of the main effect of gender was significant at 0.05 level of confidence. In case of male, group mean scores were 10.08 and for females 9.26, showing that females have the ability to control their anger as compared to males. The obtained F-value (5.97) for the two-way interaction of religion and age was found significant at 0.05 level of confidence.

Table 9: Post-hoc Mean Comparisons of Anger-Control for Religion and Age Groups

Ordered Groups	Hi Adl	Mu Ad	Mu Adl	Hi Ad	Range	Ms Error N = 0.31	
Ordered Means	9.08	9.50	9.70	10.40		q (r,152) 0.95	q (r,152) 0.99
9.08		0.42	0.62	1.32*	4	1.12	1.36
9.50			0.2	0.9	3	1.02	1.28
9.70				0.7	2	0.85	1.13

*P<0.05; N=40; df = 152; Ms Error = 3.90

Table 9 showed that on the measure of anger-control, significant mean differences were found between Hindu adults and Hindu adolescents. Mean anger control scores of Hindu adults were greater than those of their counterparts

DISCUSSIONS

This study found that individual characteristics (age and gender) and social characteristics (religion) of the students were having a significant impact on mental health and anger expression. On the measure of mental health, adolescents exhibited poor mental health as compared to adults. The findings can be attributed to the view that adolescence period is considered to be of great turmoil, lot of energy flowing, moving in all direction following the path of least resistance, without sound and balanced thinking. Ill-conceived notions lead the adolescents to take wrong paths and goals with greater enthusiasm and misdirected interests. They may isolate themselves and become resistant to change and to follow healthy advice of their well-wishers. This period is a dramatic change for the adolescents, as they require adjustment to changes in the self, family and in peer groups. In this respect early adolescents is the most crucial period and they are more at risk in developing poor mental health as reported by Sinha (2002). Further, findings revealed that adolescent females have poor mental health as compared to their counterparts and both the gender groups of adult age group. Adult males have sound mental health, it may be because they are more alert to the role of emotions in everyday life, and have better understanding about their own feelings and their effects on daily activities as compared to adolescent females, who are immature in making judgment of their lives and are plagued with lots of worries, anxieties and frustration. Few studies are in conjunction with the findings of the study. Females of younger group tend to have more episodic problems, such as depression and milder manifestation, such as nonaggressive conduct disorders. A two-stage cross-sectional analysis of a random sample of a rural population found that females mainly demonstrated neuroses and manic-depressive psychosis (Gove and Tudor 1977). Sometimes the environment as well as family in which they brought up becomes an obstacle in the development of positive mental health. Because environment not only determines the individual attitudes but also provide the framework to formulate the mental health. The findings support the growing recognition in the literature on young people that many mental health symptoms are related to problems in such domains as relationships and family (Frost, et al., 1999; De Goede, et al., 1999) Moreover, findings also showed that Muslim adult females have better mental health compared to Hindu adolescent females who have meager mental health.

The results of anger expression were separately analyzed on the basis of its three dimensions i.e. anger-in, anger-out and anger-control. Findings on the dimensions of anger expression revealed that in *anger-in* Muslim subjects differ significantly from Hindu subjects. Though, in other two dimensions i.e. *anger-out* and *anger-control* they did not differ. It indicated that Muslim subjects often experienced angry feelings and easily provoked by annoyed situations, but they did not express their anger as compared to Hindu subjects who did not suppress their anger but express it at the same moment. Religion is a very important sociological variable which has been widely studied and found affecting the human characteristics. The findings are in line with the studies done by Kanekar and Suresh (1983) who examined aggression, retaliation and religious affiliation in 480 Indian under graduates. They rated the morality, intelligence and likeability of an aggressor and victims in an incident in which the target religion (Hindu vs. Muslims) and response (retaliation vs. non-retaliation) were manipulated. Results obtained showed that the non-retaliating victim was rated higher on all 3 variables. Males rated the aggressor lower on morality than females, and Muslim subjects rated the aggressor lower on likeability than Hindu subjects.

Findings showed that adolescents possess the ability to suppress their anger in contrast to adults. Few studies supported this finding, for e.g., Walker (1998) examined aggression among older adults. Findings indicated that adults are more likely to employ strategies that are adaptive to their life circumstances and that maximize effects of aggression while minimizing personal risk. Past research on direct and indirect aggression, conflict strategies, emotional regulation and gender roles provide support for the idea that aggression among adults exists but is unseen, i.e. adults are likely to employ more indirect than direct aggressive strategies when faced with interpersonal conflict.

Finally, in case of gender differences in anger expression, males differ significantly from females on the dimension of *anger-control*. Finding clearly indicates that females have good tendency to control their aggression as compared to their counterparts. However, on the dimension of anger-in and anger-out they do not differ significantly. The findings are in line with those obtained by Harris (1996), who observed that males had experienced more aggression both over a lifetime and scored significantly higher on scales on physical and verbal aggression. Moreover, Buntaine and Costenbader (1997) found superiority of males in outward expression and superiority of females in suppression of anger. Females have to bear sufferings without making or showing any grudges, it may be because of gender biases, which are very prominent in Indian society. Men tended to be more aggressive than women primarily in those studies in which aggression resulted in pain or physical injury to the victim when aggression produced mainly psychological harm the greater aggressiveness of the men was attenuated (Eagly and Steffen 1986; Griffin, *et al.* 2000, & Bardone, *et al.* 1998).

CONCLUSIONS

This study contributed to the literature in several ways. First, significant mental health problems were found among adolescents. Therefore, it is recommended that this population be targeted at health sites in order to screen them for emotional problems and symptoms. Second, the findings suggest that there is also a need to address aggressive behavior of males as this behavior is likely to affect their later psychosocial health. Therefore, it is suggested that through early identification and by providing conducive environment to adolescents may be prove useful in the prevention of aggression among youth. Such programs should encourage nonviolent attitudes and teach non aggressive conflict resolution strategies to give adolescents the tools they need to reduce aggressive behavior.

Study revealed important role of gender, age and religion on the mental health and manifestation of aggression. School teachers and public health practitioners are encouraged to work together to address both the immediate and more

subtle factors associated with adolescent negative mental health in order to stem the escalating acts of aggression seen in our society today.

REFERENCES

1. Australian Institute of Health and Welfare (AIHW), (2007), *Young Australians: their health and wellbeing*, Australian Government.
2. Bardone, M. A., Moffitt, T. E., Caspi, A., Dickson, N., Stanton, W. R., & Silva, P. A. (1998). Adult physical health outcomes of adolescent girls with conduct disorder, depression, and anxiety. *Journal of the American Academy of Child Psychiatry*, 37(6), 594-601.
3. Bennett, D., Kang, M. & Chown, P. (2006). *Cultural Diversity in Adolescent Health Care*, in Greydanus, D., Patel, D & Pratt, H. *Essential Adolescent Medicine*. McGraw-Hill. New York.
4. Brent, D., & Mann, J. (2006). *Familial pathways to suicidal behavior – Understanding and preventing suicide among adolescents*. *New England Journal of Medicine*, 355, 2719–2721.
5. Buntaine, R. L., & Costenbader, V.K., (1997). *Self-reported differences in the experience and expression of anger between girls and boys*. *Sex Roles*, 36, 625-37.
6. Daniel, S.S, Goldston, D.B, Erkanli, A, Franklin, J.C, & Mayfield, A. M. (2009). *Trait anger, anger expression, and suicide attempts among adolescents and young adults: a prospective study*. *Journal of Clinical Child Adolescence Psychology*, 38(5), 661-71.
7. De Goede, M., Spruijt, E., Iedema, J., & Meeus, W. (1999). *How do vocational and relationship stressors and identity formation affect adolescent mental health?* *Journal of Adolescent Health*, 25, 14-20.
8. Eagly, A. H., & Steffen, F. J. (1986). *Gender and aggressive behavior: A Meta Analytic review of the social psychological literature*. *Psychological Bulletin*, 100, 309-30.
9. Frost, A. K., Reinherz, H. Z., Pakiz-Camras, B., Giaconia, R. M., & Lefkowitz, E. S. (1999). *Risk factors for depressive symptoms in late adolescence: A longitudinal community study*. *American Journal of Orthopsychiatry*, 69(3), 370-381.
10. Golden, B. (2003). *Healthy anger: How to help children and teens manage their anger*. New York: Oxford University Press
11. Gove, W., & Tudor, J. (1977). *Sex Differences in Mental Illness: A Comment on Dohrenwend and Dohrenwend*. *American Journal of Sociology*, 82(6), 1327-1336.
12. Griffin, K.W., Botvin, G. J., Scheier, L. M., Diaz, T., & Miller, N. L. (2000). *Parenting practices as predictors of substance use, delinquency, and aggression among urban minority youth: Moderating effects of family structure and gender*. *Psychology of Addictive Behaviors*, 14(2), 174-184.
13. Harris, M.B. (1996). *Aggressive experiences and aggressiveness: Relationship to ethnicity, gender, and age*. *Journal of Applied Social Psychology*, 26, 843-870.
14. *Healthy People 2000: National Health Promotion and Disease Prevention Objectives*. Washington, DC: US Dept of Health and Human Services; 1991. DHHS publication PHS 91-50213.

15. Ingram, R. E., Trenary, L., Odom, M., Berry, L., & Nelson, T. (2007). Cognitive, affective and social mechanisms in depression risk: Cognition, hostility, and coping style. *Cognition & Emotion*, 21, 78–94.
16. Jahoda, M. (1958). *Current Concept of Positive Mental Health*. New York: Basic Books.
17. Kanekar, Suresh, Mrerchant, & Shariffa, M. (1982). Aggression, retaliation, and religious affiliation. *Journal of Social Psychology*, 117, 295-296.
18. NIMH 2015. <http://www.nimh.nih.gov/health/statistics/prevalence/any-disorder-among-children.shtml>. Any disorder among children. (n.d.)
19. NSW Department of Health (2010). *NSW Youth Health Policy 2011-2016: Healthy bodies, healthy minds, vibrant futures*. NSW Department of Health, North Sydney.
20. Roberts, R.E., Attkisson, C.C., & Rosenblatt, A. (1998). Prevalence of psychopathology among children and adolescents. *Am J Psychiatry*. 155(6), 715-25.
21. Shah, A.V. (1982). *Community & Mental Health Problems in India*. New York: Basic books.
22. Sheeber, L., Allen, N. B., Leve, C., Davis, B., Shortt, J.W., & Katz, L.F. (2009) Dynamics of affective experience and behavior in depressed adolescents. *Journal of Child Psychology and Psychiatry*, 50, 1419–1427.
23. Sinha, U.K. (2002). *Adolescent Mental Health: Current Status and Challenges*. Proceedings.
24. Smits, D.J.M., & Kuppens, P. (2005). The relations between anger, coping with anger, and aggression, and the BIS/BAS system. *Pers Individ Dif*, 39, 783-93. 7.
25. Spielberger, C. D., Johnson, E. H., Russell, S. F., Crane, R. J., & Wordon, T. J. (1985). *The experience and expression of anger*. Sage Publication.
26. Spielberger, C. (1999). *State-Trait Anger Expression Inventory-2 Professional Manual*. Lutz, FL: Psychological Assessment Resources, Inc.
27. Walker, Richardson, D.R. (2000). Aggression among older adults. *Aggressive Behavior*. 26 (2): 145-154.
28. Wenze, S.J., Gunthert, K.C., & Forand, N.R. (2006). Influence of dysphoria on positive and negative cognitive reactivity to daily mood fluctuations. *Behaviour Research and Therapy*, 45, 915–927.
29. Wig, N. N., & Verma, S. K. (1973). PGI Health questionnaire, (N-1): A simple neuroticism scale in English. *Indian Journal of Psychiatry*, 15, 80-88.
30. World Health Organization. (1951). *Annual Report of the Director-General to the World Health Organization and to the United Nations*. Geneva: World Health Organization.