Evaluation and comparison of identity style scales and Mental Health in Indian and Iranian Adolescents Males.

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Abstract: From the early centuries, Adolescence is mentioned as a period of challenges and opportunities for understanding oneself within the social context. A well-known note from more than 100 years ago describing adolescence as "storm and stress), is still addressed by psychologists. Adolescence is typically divided into three periods: early adolescence (ages 13-14), middle adolescence (ages15-18) and late adolescence (age 19 to adoption of adult roles), this research has been studied as a case study on Indian and Iranian teenager boys which considers some of their characteristics such as anxiety, identity and mental health , which describe these three characteristic and give information about them. Available scheme is a survey on mental health, anxiety and identity observation and also it's attributes in Iranian and Indian teenager boys that this order has comparatively accomplished. A used tool had been Berzonsky's identity questioner and has been applied by using variance analysis and T test in comparison with effective significance and insignificance parameters toward people's identity. Identity style is characteristic of an individual who at identity formation passively accepts models, is conscientious and concentrated on the aim. The individual adapts his behavior to norms and expectations of others, so he is oriented conformal. Result indicates that this statistical society's culture, gender, depression, anxiety ,normative identity ,number of siblings and their residency and also positive correlation between diffuse identity and thought problem would have effect on them.
[Hakimeh Aghaei, Waheeda Khan, Ahmad Reza Baghestani. **Evaluation and comparison identity style scales and Mental Health in Indian and Iranian Adolescents Males.** *Life Sci J* 2012; 9(4):3728-3734] (ISSN:1097-8135). http://www.lifesciencesite.com. 553

Keywords: Identity style, Mental Health , Male Adolescents

Introduction

Mental health is more than the mere lack of mental disorders. The positive dimension of mental health is stressed in whose definition of health as contained in its constitution: "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." Concepts of mental health include subjective well-being, perceived self-efficacy, autonomy, competence, intergenerational dependence and recognition of the ability to realize one's intellectual and emotional potential. It has also been defined as a state of well-being whereby individuals recognize their abilities, are able to cope with the normal stresses of life, work productively and fruitfully, and make a contribution to their communities. Mental health is about enhancing competencies of individuals and communities and enabling them to achieve their self-determined goals.

According to (Bacová, 1998) identity is a cognitive process in which an individual experiences the value of oneself identity formation through social environment. Although identity is not defined uniformly, several psychological approaches agree that development of personal identity is influenced by social and cultural environment, which surround personality. Identity structure is in this way formed in a dynamic process. Identity is the process of claiming membership in social world, standing for something, being known for whom one is. Once constructed, identity then forms the framework for adulthood. Identity is both process and product. It is an unfolding bridge linking individual and society, childhood and adulthood. To understand identity then, we must be able to think about its basis in the individual and its realization in adult purpose. Because identity forms the foundation of adult life, as a society we have a large stake in seeing that this takes place as optimally as possible. Many psychopathological disturbances observed among some adolescents are accompanied by disturbances in identity.

During adolescence the development to sense identity is crucial task (Erikson , 1959). Erikson's concept of identity has been as important a contribution to the social sciences in the second half of the 20th century as Freud's concept of the unconscious was to the first half of 20th century. With Eriksson's understandings of identity came in focus on the roles not only of one's biological and psychological foundations, but also of cultural

contributions to the ways in which one both shapes and is shaped by the surrounding milieu.

The field of identity research has expanded so much over the past three and a half decades that virtually every major textbook on adolescent development contains a significant section on identity development and a discussion of Erikson's writings. In addition, there are now at least four English – Language social science journals that include the word identity in their titles and focus upon the interplay between the individual and context in shaping the course of the human life cycle. What is identity and how does it change as well as remain the same over the course of one's life span? Research provides a synthesis of theory research and practical consequences of the identity – formation process during the years of adolescence and adult life and attempts answer these questions. Erikson's psychological approach to identity theory is an integration of historical, biological, psychological, and socio-cultural forces. Identity is a complex entity. Over the past 60 years, and understanding both of what identity means and how it evolves over the course of the life span have been the inspiration for many theoretical writing as well as numerous research investigations (Kroger, 2006).

For example, identity disturbances are evident in identity disorders and borderline personalities (American Psychiatric Association, 1987). While not explicitly writing of the identity crisis, Masterson's (1988) ideas on borderline adolescents are quite salient to identity disturbances found in this form of psychopathology. In summary, the presence of psychopathology in adolescence, particularly borderline and narcissistic disorders, is strongly implicated in identity formation. Borderline disturbances bear strong resemblance to identity diffusion in that some borderline adolescents simply drop out of the identity search and commitment process. Other borderline adolescents may be susceptible to making foreclosed commitments at the urging of strong authority figures. Narcissistic disorders also pose problems in identity formation of adolescents. It has been suggested that this group of adolescents is at risk for identity foreclosure. Self-exploration is too threatening to the narcissistic individual who rigidly defends the fragile sense of self.

In poor countries, mental illness tends to be grossly neglected by health systems. Diseases tend to get prioritized.. However, emotional distress and mental illness are embedded within and cannot be separated from language, and cultural, social and political context.. Those who are mentally ill are also subject to stigma, sometimes feared, and sometimes cared for in inhumane conditions. These crucial issues are not addressed directly but are highlighted in some of the case studies that accompany this chapter on the Global Health Watch website.

Mental health problems are wide-ranging and include depression, schizophrenia, anxiety, stress-related disorders and substance abuse. They may be mild and temporary or chronic and severely disabling and affect all ages. Mental health problems also include organic disorders such as dementia and mental retardation (but not epilepsy, which is sometimes wrongly seen as a mental disorder). Poor mental health can also result in poorer outcomes associated with other diseases such as cancer, HIV/AIDS, diabetes and cardiovascular disease (Prince, 2007).

The World Health Organization (2003) estimated that13 percent of the worldwide burden of disease is due to mental health problems, although 31 percent of countries do not have a specific public budget for mental health (Saxena, 2007). In addition, each year nearly a million people take their own lives. Rates are highest in Europe's Baltic States where around 40 people per 100,000 commit suicide annually. However, the incidence of suicide is widely under-reported because suicide is considered a sin in many religions, a taboo in many societies, and a crime in others.

Suicide is among the top three causes of death of young people aged 15-35 (WHO, 2002) and is one of the leading causes of death of young women in India and China. In spite of the burden of mental illness across the world, 40 per cent of countries have no mental health policies. Thirty-three countries with a combined population of 2 billion invest less than 1 per cent of their total health budget on mental health (WHO, 2005). More than two-thirds of the world's population (68 percent), the majority of whom are in Africa and South Asia, have access to only 0.004 psychiatrists per100,000 of the population, although these areas have an extensive network of traditional practitioners (WHO, 2005).

Material and Method

The issue of adolescent mental health can be seen from many overlapping angels. For the promotion of their positive mental health, it is, therefore, necessary to understand and empirically evaluate their ideation, ideals, value system and the significant person ideologies and social institute affecting them or appealing to them. The mental health of children foreshadows the mental health of future generation of adults. Child and adolescent mental health services are a small part of the responsibilities of health and local authorities but the implication of poor attention to children's and young people's mental health are not only their and their

families continual suffering, but also a continuing spiral of child abuse, juvenile crime, family breakdown and adult mental illness, aloof of which can lead to more child and adolescent mental health problem. The theme for mental health week for the year 2003 was "Emotional and behavioral problems of children and adolescents". 37% of the population in India in is under the age of 18 years (WHO, 2001). Identity represents the intersection of the individual and society. In framing identity, the individual simultaneously joins the self to society to the self. As a result, identity comes to serve not only as a guardian of the integration and continuity of self-experiences, but also as a mechanism for shared meaning –making that embeds the individual with those with whom life will be lived. Eriksson's (1950, 1968)rich exposition of this process made it possible not only to better understand the adolescent transition but also to break ground for the study of adult development. In adolescence, young people first confront the challenge of finding a place for themselves in the larger social world. As children move toward and into adulthood, society begins to take them more seriously as members. Identity is the process of claiming membership in social world, standing for something, being known for who one is. Once constructed, identity then forms the framework for adulthood. Identity is both process and product. It is an unfolding bridge linking individual and society, childhood and adulthood

The purpose of the present research was to study the, Identity style and Mental Health of Indian male adolescents. A total sample of 120 adolescents, 60 each from India and Iran, were randomly selected from the school of Delhi and Iran in the age range of 14-17 years. The tools used in the research were: Identity Style Inventory developed by Berzonsky (1997) Youth Self Report developed by Achenbach (1991). The analyses of the data was group means and SD's were calculated and t-test was applied to study the differences between groups on the dimension of Identity Style and Mental Health Pearson's product coefficient of correlation was also calculated to know the inter relation among the various dimensions of identity and mental health in the sample of Indian, Iranian, male adolescents.

Result

Inter correlation coefficients for male adolescents (Table.1) between various dimensions of identity style and mental health; and self- esteem and mental health indicate significant positive correlation between diffuse identity and thought problems. To elaborate further, more the adolescents avoid personal issues, procrastinate decisions until situational demands dictate their behavior and accommodate their identity in relation to the changing social demands, more thought problems are likely to be experienced. In other words, this identity style results in a fragmented and loosely integrated identity structure. Most characteristic of the diffuse/avoidant identity style is a low level of active information processing and problem-solving (Berzonsky,2001).

Table 1:Inter-correlation Coefficients amongst the various dimensions of Identity Style and Mental Health of Male adolescents (N=120)

Variables	Mental health (overall)	Anxious depressed	With-drawn depressed	Somatic problem	Social problem	Thought Problem	Attention Problem	Rule Breaking behavior	Aggressive behavior	Internalizing behavior	Externalizing behavior
Informational	0.02	0.06	0.42	0.03	0.01	0.05	0.06	0.10	0.00	0.04	0.14
Normative	0.02	0.05	0.04	0.07	0.02	0.05	0.10	0.09	0.04	0.12	0.02
Diffuse	0.00	0.13	0.18	0.06	0.07	**0.24****	.10	0.00	0.00	0.05	0.13
Commitment	0.01	0.01	0.14	0.1	0.10	0.06	0.07	0.12	0.05	0.06	0.01
Identity style (overall)	0.09	0.03	0.03	0.00	0.12	0.01	0.10	0.08	0.15	0.01	0.01

Inter- correlations amongst the various dimensions of identity style and mental health for the sample of male adolescents are shown in Table It indicates significant positive correlation of diffuse/avoidant identity style with the mental health dimension of thought problem $^{**}(p<0.01)$.

Table 2 indicates significant t- values between Indian male and Iranian male adolescents on four dimensions of mental health i.e. anxious depressed, withdrawn depressed, thought problem, and externalizing. That is, Indian male adolescents had significantly higher mean scores than Iranian male adolescents on the measure of diffuse (i.e. 48.62 > 40.90), commitment (i.e. 50.23 > 41.87), withdrawn depressed (i.e. 51.67 > 38.28), and externalizing (i.e. 49.93 > 42.80). However, Iranian male adolescents scored significantly higher mean scores as compared to Indian male adolescents on the dimensions of informational identity (i.e. 46.23 > 41.42), anxious depressed mental health (i.e. 51.13 > 40.45), and thought problem dimension of mental health (i.e. 51.40 > 30.12).

Table 2: Mean, SD and t- values on the measures Identity Style and Mental Health for Indian and Iranian Male adolescents (df=59)

Measures	Indian male Adolescents (N = 60)		Iranian male Adolescents (N = 60)		t-value
	Mean	SD	Mean	SD	
Identity					
Informational	41.42	12.01	46.23	11.33	2.26*
Normative	47.87	10.33	50.60	10.65	1.43
Diffuse	48.62	9.01	40.90	11.54	4.08*
Commitment	50.23	10.01	41.87	12.83	3.98**
Identity (Overall)	50.42	9.62	50.22	9.94	0.11
Mental Health					
Anxious Depressed	40.45	10.34	51.13	10.40	5.64*
Withdrawn Depressed	51.67	11.56	38.28	10.38	6.54*
Somatic Complaints	51.27	10.30	50.17	12.42	0.53
Social Problems	48.62	11.08	50.67	12.33	0.96
Thought Problem	30.12	10.94	51.40	10.42	5.79*
Attention Problem	49.20	10.53	49.33	10.02	0.57
Rule Breaking Behavior	49.92	9.57	52.25	9.36	1.35
Aggressive Behavior	50.12	11.25	50.25	10.83	0.06
Internalizing	50.15	10.54	51.23	10.37	0.57
Externalizing	49.93	9.58	42.80	7.55	4.53*
Mental Health (Overall)	49.58	9.72	49.98	10.28	0.22

* p <.05; ** p <.01

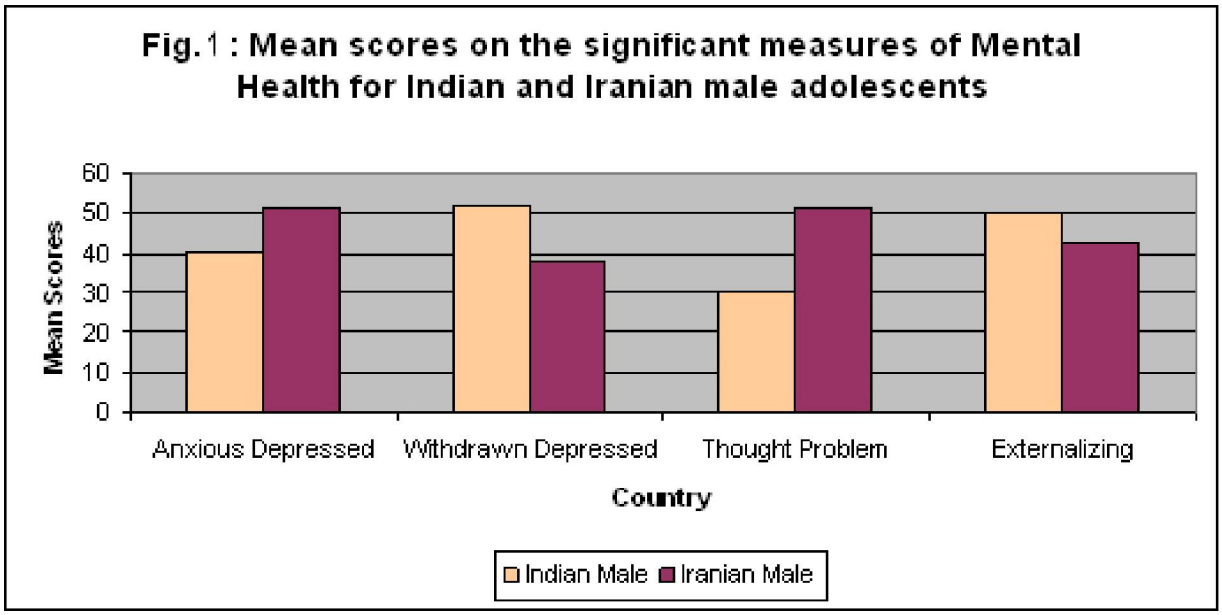

Figure 1: Mean score on the significant measures of Mental Health for Indian and Iranian male adolescents

The male adolescents from India and Iran exhibited significant differences on the dimensions of informational identity, anxious depressed, withdrawn depressed, thought problem, and externalization. Indian adolescents displayed significant higher mean scores than Iranian adolescents on identity style dimension of diffuse identity, and commitment identity; and mental health dimension of withdrawn depressed and externalization. That is, Indian adolescents generally avoid personal issues and

procrastinate decisions until situation demands so. They also adhere to a set of convocations, goals and values. They feel discomfort, distress and intensely crave for a substance when use of that substance is stopped.

Moreover, they generally exhibit more aggressive and rule breaking behaviors. Iranian adolescents showed more score on one dimension of identity style i.e. informational identity, and two dimensions of mental health i.e. anxious depressed and thought problem. That is, Iranian adolescents generally evaluate their worth, value, importance, or capabilities more than Indian adolescents. They seek out and evaluate information that is relevant for their identity before making committed decisions. However, they have a feeling of apprehension and fear characterized by physical, psychological and cognitive symptoms and have problem in concentrating or focusing thoughts over an issue or tasks in hand.

Discussion:

Depression in other age groups is linked with social isolation, alcohol and drug abuse and smoking (Hemenway, Solnick & Colditz 1993). Mood disorders can lead to an increased risk of accidents and injuries and poor physical and role function (Wells 1989).

Other factors such as learning through experience or observation also have an effect on health behavior. For example, it has been established that drug use before the age of 15 years is highly associated with the development of drug and alcohol abuse in adulthood (Jaffe 1995). Environmental influences, such as poverty or societal and cultural norms, also affect health behavior (WHO 2001).

A life-course approach helps in understanding social variations in health and mental health Exposure to experiences and environments accumulate throughout life, increasing the risk of adult morbidity and premature death if they are disadvantageous. Exposure to health-damaging environments during adulthood may accumulate on top of health disadvantage during childhood (Holland 2000). This approach takes into account the complex ways in which biological, economic, social and psychological factors interact in the development of health and disease. Such an approach reveals biological and social “critical periods” during which policies that will defend individuals against an accumulation of risk are particularly important. The policies of modern “welfare states” can be seen to contribute in many ways to present-day high standards of health overall in developed countries (Bartley, Blane & Montgomery 1997).

Mental health is fundamentally linked to physical health outcomes. Mental health status is a key consideration in changing the health status of a community. Health and behavior are influenced by factors at multiple levels, including biological, psychological and social. Interventions that involve only the individual, such as training in social skills or self-control, are unlikely to change long-term behavior unless family, work and broader social factors are aligned to support a change (Institute of Medicine 2001).

Health promotion is an approach to improving public health that requires broad participation. It may be understood as actions and advocacy to address the full range of potentially modifiable determinants of health, including actions that allow people to adopt and maintain healthy live and those that create living conditions and environments that support health (WHO 1998a). Mental health promotion is an integral part of health promotion theory and practice. The interventions can be applied at population, subpopulation and individual levels, and across settings and sectors within and beyond the health field (Walker, Moodie&Herrman, 2004)). The personal, social and environmental factors that determine mental health and mental illness may be clustered conceptually around three themes (Lehtinen, Riikonen & Lahtinen, 1997).

There are complex interactions between the determinants of health, behaviors and mental health at all stages of life. A body of evidence indicates that the social factors associated with mental ill-health are also associated with alcohol and drug use, crime and dropout from school. An absence of the determinants of health and the presence of noxious factors also appears to have a major role in other risk behaviors, such as unsafe sexual behavior, road trauma and physical inactivity. For example, a lack of meaningful employment may be associated with depression and alcohol and drug use. This may in turn result in road trauma, the consequences of which are physical disability and loss of employment (Walker, Moodie & Herrman 2004).

Kleinman (1999) describes the clustering of mental and social health problems in “broken communities” in shantytowns and slums and among vulnerable and marginal migrant populations: civil violence, domestic violence, suicide, substance abuse, depression and post-traumatic disorder cluster and coalesce. He calls for a research agenda and innovative policies and programmers “that can prevent the simply enormous burden that mental illness has on the health of societies resulting from the variety of forms of social violence in our era” (Kleinman 1999). The corollary is the need for the

development and evaluation of programmers that on the one hand control and reduce such clusters and on the other hand assist people and families to cope in these circumstances. In this context, Weisz (1993) and Ollendick (1996) found an association between cultures considered collectivistic and internalizing problems anxiety depressed, withdrawn depressed. (Escobar 2000) found that some evidence that a strong family orientation may be a protective factor against mental health problems. Berman, Weems and Petkus (2008) examined the expression, prevalence, and incremental validity of identity problem symptoms in adolescence. Identity problem symptoms predicted psychological symptom scores beyond identity status, and identity status accounted for substantially less variance in psychological symptom severity when controlling for identity problem symptoms. Additional research on the relationship between identity problems and psychological adjustment is needed and greater attention to the role of identity issues in clinical practice is warranted**.**

Aghaei and khan (2009) examined identity styles (informational, normative, diffuse- avoidant, commitment style) as a function of religion and gender on a sample of 120 (60 males & 60 females) with equal number of Hindu and Muslim students and showed that the identity construction is depended on gender and religion as normative identity style characteristic of conforming personalities, who acquire values: norms of authorities were dominantly. The informational and diffuse avoidant identity styles were least represented in these student. Gender also explained differences in commitment, indicating girls were high on identity commitment. The normative identity style positively influenced the identity commitment that means strength, stability of personality conviction about values, attitudes to itself and society as well.

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08/30/2012