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FRONTIERS IN PSYCHOLOGY: INSIGHTS INTO BEHAVIOR, COGNITION AND MENTAL HEALTH

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PREFACE

Frontiers in Psychology: Insights into Behavior, Cognition, and Mental Health explores contemporary developments in psychological science, bringing together knowledge from diverse areas such as cognitive psychology, developmental psychology, social psychology, clinical psychology, neuroscience, and positive psychology. The aim of this work is to present current theories, research findings, and practical applications that deepen our understanding of human behavior and mental processes.

Psychology is the scientific study of the human mind and behavior, offering valuable insights into how people think, feel, learn, and interact with the world around them. As societies continue to evolve in response to technological advancements, cultural changes, and global challenges, understanding psychological processes has become increasingly important for promoting individual well-being and addressing complex social issues.

This book emphasizes the interconnected nature of behavior, cognition, and mental health. Human behavior is shaped by biological, psychological, social, and environmental influences, while cognitive processes such as perception, attention, memory, language, and decision-making play a central role in everyday functioning. At the same time, mental health has emerged as a global priority, highlighting the importance of prevention, early intervention, resilience, and evidence-based therapeutic approaches.

Designed for students, researchers, educators, practitioners, and anyone interested in psychology, this volume bridges foundational concepts with emerging research and real-world applications. Each chapter encourages critical thinking, scientific inquiry, and an appreciation of the diversity of human experiences across cultures and contexts.

It is hoped that this book will serve as a valuable resource for advancing knowledge, inspiring future research, and supporting informed practice in the field of psychology. By exploring the frontiers of psychological science, readers are invited to better understand the complexities of the human mind and contribute to the promotion of mental health and well-being in individuals and communities worldwide.

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CONTENTS

PART-1

Frontiers in Psychology: Insights into Behavior, Cognition, and Mental Health

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EMOTIONAL DEVELOPMENT: AN OVERVIEW

Abstract

The external and internal changes that occur during an emotional state drive a person's emotional behaviour. Increased heart rate, rapid breathing, sweating, hunger, changes such as lack of sleep, dryness of the throat, changes in the amount of Qi in the body can be observed. The body begins to behave in accordance with emotions. By understanding the nature of emotions, decisive behaviours can be understood more easily. This chapter examines the complex process of emotional development, outlining its progression from early infancy through later childhood. It analyses the biological, cognitive, and social determinants that influence the emergence and regulation of emotions. Central themes include the identification and expression of fundamental emotions, the advancement of emotional understanding and empathy, and the significance of caregiver interactions in fostering emotional competence. This chapter offers a comprehensive perspective on the evolution of emotional skills and their contribution to overall psychological well-being.

Keywords: Qi, Infancy, Emotional development, Cognitive

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I. INTRODUCTION

A child's social adjustment depends on cognitive development. Emotions can also contribute to a child's healthy adjustment when they learn appropriate forms of expression from their family environment. Emotions act as motivators in generating a variety of behaviours within a child. Different emotions influence the development of a variety of personality traits. Therefore, studying the nature and development of emotions is important in developmental psychology.

II. NATURE OF THE EMOTIONAL BEHAVIOUR

A child faces many stimuli in their environment, some of which are effective stimuli that can trigger emotional behaviour. A snake is a distressing stimulus for a child. When it appears in the environment and provokes a person, the emotion of fear may arise. Even the presence of a stimulus does not necessarily lead to emotion. This depends on the person's prior experience with the stimulus. For example, seeing a snake may evoke fear in some individuals, leading them to exhibit flight behaviour. While others may become angry, leading them to attempt to attack the snake. In contrast, snake charmers, who attempt to capture snakes and gather crowds to gain wealth, cannot evoke both fear and anger upon seeing a snake. In an emotional situation, a person's experience of a stimulus guides emotional behaviour. When various emotions are present, perception becomes more distorted. The way a person perceives stimuli in emotional situations such as anger, fear, love, and hatred differ from normal situations. This is a very complex aspect of human behaviour.

III. MEANING OF EMOTION

The word ‘Emotion’ is derived from the Latin word ‘Emovere’, which literally means to shake the body. Psychologists have considered both physical and mental processes involved in it. Psychologists believe that for the emergence of emotional behaviour, it is necessary for a person to achieve a state of arousal by perceiving the stimuli of the emotional environment. As soon as the state of arousal is consciously experienced, many external and internal changes start taking place in the body, which are the origin of emotional behaviour. On these grounds, psychologists have tried to define emotion in the following ways.

P.T. Young's (1973) attempt to define emotion proved to be more successful. The definition given by him clarifies the nature of emotion to a great extent. According to Young (1943), "Emotion is an acute disturbance of the individual as a whole, psychological in origin, involving behaviour, conscious experience and visceral functioning." On analysis of this definition, the following things become clear regarding emotion.

1. **Emotion is a state of acute disturbance**. In this state, a person's experiences and behaviour undergo rapid changes. In emotional states such as love, fear, and anger, a person feels stirred or excited.

2. **The state of disturbance is perceived within a being**. This state affects the individual's entire experience and behaviour. For example, when a person is angry, it is expressed through their entire experience and behaviour.

3. **Emotions originate psychologically.** An emotional stimulus is present in the environment, and its effect is felt on one of the individual's senses. It falls on the nervous

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system (organ) which produces a nerve impulse, reaches a specific part of the system, and produces a rash. On this basis, we feel anger on seeing an enemy and happiness on seeing a friend. Sometimes it also happens that remembering a friend makes us feel happy and remembering an enemy makes us feel anger. This psychological basis continues in the form of previous experience. Hence, even such disturbances which occur on psychological grounds are termed as emotions. Disturbances are also produced by administering an injection of adrenaline in the body, but the basis for the origin of this state of disturbance is not psychological.

4. **A state of disturbance cannot be called an emotional state** simply because there is consciousness of this state of disturbance. A person feels that they are in a particular emotional state. When a person is in a state of fear, they are conscious of experiencing fear. This conscious experience is studied through introspection. In this sense, emotion is considered a personal experience. If the anger is not too intense, a person can change their mental state during the anger state.

5. **Emotions also involve certain types of behaviour.** Specific types of behaviour are observed in specific emotional states. In anger, aggressive behaviour, abusive language, etc. can be observed. Similarly, in fearful emotions, behaviours like crying, screaming, shrieking, running away, etc. are observed. Similarly, each emotion has different types of external behaviour, which are studied through external observation. Fixed patterns of behaviour are seen in animals as compared to humans because human behaviour is influenced by many factors like experience, learning, culture, social values, etc.

6. **During an emotional state, many changes occur in an individual's internal bodily functions.** Excessive anger causes increased release of adrenaline. Sugar is released from the liver in large quantities and enters the bloodstream, causing increased blood pressure, increased heart rate, and increased breathing rate. Emotions produce changes in respiratory rate, blood pressure, nervous system function, sweat gland function, and digestion. These changes can be measured using various instruments.

IV. IMPORTANCE OF CHILDREN'S EMOTION

Children's emotions are crucial to their lives. Psychologists have acknowledged the extent of children's emotional behaviour.

1. Joy is added to the everyday experiences of children through emotions. Children get pleasure from curiosity, affection, joy etc. At the same time, by expressing emotions like anger and fear, the child becomes stress-free. Regarding the emotion of joy, Harlock (1978) has written that physically joy is nature's best medicine because it dispels tensions and relaxes the body. Psychologically, it is a wholesome emotion because it makes all experiences pleasant.

2. Studies have shown that when emotional responses are repeated repeatedly in children, they develop into habits. Often, those emotional responses that are pleasurable to the child become habits.

3. All the emotions and emotional responses of the child influence his social interactions.

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4. A child's outlook on life is influenced by emotions. For example, if a child is very angry, their adjustment may be impaired due to excessive anger.

5. Children use emotions for self-evaluation and social evaluation. It is possible to assess a child's behaviour and personality through their emotional expressions. Often, emotions are present in children. The intensity of emotions is used to evaluate a child's self. A child can assess their self-evaluation by observing how they express emotions in emotional situations.

6. Emotions make a child active. During an emotional state, the heart rate increases, muscle fatigue decreases, the liver releases more blood sugar, and the thyroid and adrenal glands release more fluids. All of this increases a child's activity. If this increased activity is not managed, the child becomes nervous.

7. If children's increased emotional activity is not expressed, they may develop speech impairments. Behaviours such as thumb sucking and nail biting may also develop.

8. Emotions cause physical changes. These changes can help us understand what a child is feeling and how.

9. When emotions arise in a child, there is a high possibility that the child's mental activities like learning, recall, reasoning, concentration etc. will be affected by these emotions.

10. Children's emotions influence their psychological environment, which in turn affects their behaviour. For example, a child who is quarrelsome or jealous may become irritated and upset by their parents and family members. In such a situation, the child does not receive the healthy family environment and parental affection they should receive.

V. FEELING

In psychology, the term emotion is used to describe a mental process that results in the feeling of pleasantness or unpleasantness. Therefore, we can say that emotion is an elementary affective mental process through which we experience pleasantness and unpleasantness. The emotional process has the following characteristics:

1. **Elementary affective process:** Emotion is a simple and elementary emotional process. Analysing this mental process is impossible. Just as sensation is the elementary aspect of the cognitive process, just as the simplest aspect of the emotional process is sensation, which cannot be analyzed, the feeling is the simplest aspect of the emotional process, which cannot be divided into other parts.

2. **Experience of happiness or sadness:** The same stimulus can cause a feeling of happiness in one person and a feeling of sadness in another person.

3. **Subjective process:** Emotion is a subjective process. Only a person can experience their own happiness or sadness. Another person cannot experience their happiness or sadness. The other person will only become aware of it if they themselves express their happiness or sadness.

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4. **Fluctuating process:** Emotion is a fluctuating process. A single emotion does not remain stable for long. One emotion follows another. Sometimes we experience happiness, sometimes sadness. Happiness is followed by sadness, and sadness is followed by happiness.

5. **Intensity of feeling:** Variations in the intensity of emotion are observed. The degree of happiness or sadness is not always the same. Parents may feel happy when their son succeeds in an exam, or they may also feel happy when their lost son is found, but there is a difference in the intensity between these two feelings.

6. **Duration:** According to Wundt, one of the properties of an emotion is its duration. An emotion can last for a short or long time. In fact, this depends on the intensity of the emotion. More intense emotions have a longer duration, while less intense emotions have a shorter duration.

7. **Isolation of feeling:** Feelings are always separate. It is impossible to feel happiness and sadness simultaneously. Mixed feelings are not possible. We cannot experience both happiness and sadness at the same time.

VI. DIFFERENCE BETWEEN FEELING AND EMOTION

Emotion is a simple and elementary emotional process. Analysing this mental process is impossible. Just as sensation is the elementary aspect of the cognitive process, when this happens as visceral functioning, it is called emotion. Therefore, some psychologists have said that "feeling is an unexpressed emotion, and emotion is an expressed emotion." Despite the close relationship between feeling and emotion, there are the following differences between them:

1. Feeling is a simple and elementary process. In contrast, emotion is a complex process. Just as the simple and elementary aspect of the cognitive mental process is sensation and the complex aspect is perception, similarly, the simple and elementary aspect of the affective mental process is emotion and the complex form is emotion.

2. There are only two types of emotions: pleasantness and unpleasantness. There are many types of emotions, such as anger, fear, love, happiness, etc. Thus, the scope of emotion is much broader and broader than that of sentiment.

3. Emotion involves only the experience of happiness and sadness; there is no bodily change. On the other hand, emotion involves conscious experience as well as external and internal physical changes. When a person is angry, they are conscious of their anger, while external and internal changes occur. Their face turns red, their voice becomes louder, they engage in aggressive behaviour, etc. These behaviours can be observed externally. Furthermore, blood pressure may increase, their heart rate may increase, and such internal changes can be measured with instruments. Thus, emotion involves only the experiential aspect, whereas emotion involves the experiential aspect as well as the behavioural and visceral aspects.

4. Central nervous system in emotion: The autonomic nervous system and glandular system remain active. Especially the cortex and hypothalamus of the central nervous system play a role in emotion. The sympathetic division of the autonomic nervous system also plays a

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major role in emotion. Among the endocrine glands, the adrenal gland plays a major role. As far as the physiological basis of emotion is concerned, only the cortex plays a role in its origin.

5. Emotion is both subjective and objective. Subjective emotion means that the emotional person is conscious of experiencing the emotion. An angry person (if they are extremely angry)
knows that he is angry and can even talk about his mental state at that time. No, other person can see this state of his. Emotion being objective means that the internal changes of the perceiving person can be observed and it can be ascertained which emotional state he is in. By observing the behaviour of an angry person, anyone can guess that he is angry. As far as emotion is concerned, it is completely subjective. A person can experience his happiness or sadness himself; another person cannot see it from outside.

6. Emotion is necessary for feeling to be present, but emotion is not necessarily present with emotion. In fact, emotion is the first stage of emotion. Therefore, emotion must pass through emotion. In other words, it is impossible for emotion to exist without feeling. On the contrary, it is possible for emotion to exist without emotion. The truth is that emotion exists only in the absence of emotion. Sensation has an independent existence only until it transforms into perception. Similarly, emotion exists separately only until it transforms into emotion.

7. Emotion is a state of acute disturbance. In this state, a person becomes highly agitated and their activity increases. When a person is in an angry state, they become extremely agitated and may resort to rambling or even attacking. On the other hand, such agitated behaviour is not observed in emotion.

8. Feelings are fickler and more transient than emotions. Feelings of happiness or sadness fade away after a while. However, emotions last longer. Even after the object that triggered the emotion is removed, it continues for some time. Seeing a bear creates an emotion of fear in children. Even after the bear is removed, the fear persists in the child for some time. Cannon observed in his experiment that seeing a dog generated emotions of fear and anger in a cat, due to which its digestion stopped. Even after removing the dog, the digestion stopped for 15 minutes, meaning the emotion continued for that long.

VII. MOTIVATION AND EMOTION

Leaper (1948) is credited with establishing emotion as a motivating force. He formulated the motivational theory of emotion. It is generally accepted that emotional behaviour is inconsistent and unbalanced. Such behaviours clearly differ from normal behaviour, but Leiper completely refuted this notion and argued that emotional state is a motivated state in which a person acts in a specific direction to achieve a specific goal. In the conscious state, a person receives additional energy when needed, allowing them to balance and adjust themselves. The emotional state organizes behaviour and this state persists until a certain rhythm is achieved. The many external and internal changes that occur during this state are not meaningless; instead, they play an important role in achieving goals and maintaining balance. Psychologists believe that emotions play an important role in maintaining balance and adjustment in an organism's response to any adverse environmental situation. Psychologists believe that the need to maintain balance in an organism arises from an adverse environmental situation, which is influenced by feelings. For example, seeing a snake may

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trigger a need for safety and survival in an individual. When this need is aroused, the individual's behaviour depends on their emotional experiences. Based on this experience, the individual determines whether to flee or attack the snake. The individual's behaviour will be based on the feeling of fear or aggression.

VIII. DIMENSIONS OF EMOTION

There are individual differences in emotions. Different people respond to the same emotional stimulus with different emotions. The type of emotion a person experiences in response to a stimulus depends on their learning. Each of us learns something differently, so our emotions toward that thing can vary. The same person can be a friend of Ram and an enemy of Shyam. Therefore, it is natural for Ram to feel happy and Shyam to feel angry upon seeing that person.

Not only do different people respond to the same stimulus with different emotions, but the expression of emotions also varies. In this regard, Sanford (1961) described several dimensions of emotion, of which the following are notable:

1. **Deep to shallow:** In this dimension of emotion, emotional expression is on a scale from deep to shallow. This shows that a person’s extent to which the emotion is serious or trivial. This degree of anger can vary from person to person, with one person experiencing more intense anger and another experiencing less intense or trivial anger.

2. **Intensity of emotion through this Strong-Weak message:** An emotion may be more powerful or intense in one person and less powerful in another. The same stimulus may elicit strong anger in one person, while it may elicit weak or attenuated anger in another. This characteristic is also found in other emotions.

3. **Rich-meagre:** This dimension of momentum shows that one person may experience an emotion in abundance, while another may experience a diminished amount. One person may experience immense joy upon hearing the news of their son's success, while another may experience only mild joy in the same situation. This is also seen in emotions such as anger, hatred, love, etc.

4. **Broad-narrow:** This dimension of momentum is related to its spread. This scale measures the extent of an emotion. It is natural for children to feel fear at the sight of a snake, but the extent of their fear can vary. Some children's fear may be more widespread, while others' may be less widespread.

5. **Restrained Expression:** This dimension scale indicates whether a person expresses an emotion freely or in a restrained manner. Everyone experiences the emotion of joy and expresses it through their behaviour. However, some people express joy openly, while others do not. This is also true for other emotions. This dimension has a greater impact on the behavioural aspect of the emotion.

6. **Controlled-impulsive:** This dimension or direction of emotion reveals how much or less control a person has over their emotions. It also reveals how controlled or uncontrolled a person's behaviour is during an emotional state. Emotional expression is more uncontrolled in uneducated and uncivilized individuals, while it is more controlled in educated and civilized individuals. An uncivilized person expresses their anger in a more

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uncontrolled manner, while a civilized person expresses their anger in a more controlled manner.

7. **Appropriate-inappropriate:** This emotional dimension reveals whether a person's emotions or emotional expressions are consistent or inconsistent. It also provides information about the degree of consistent or inconsistent expression. Experiencing the emotion of fear upon seeing a dangerous stimulus is consistent. On the other hand, experiencing the emotion of grief upon seeing a friend is inconsistent. Similarly, experiencing the emotion of happiness upon seeing a dead body, such as a funeral pile, is inconsistent, while not experiencing the emotion of happiness is consistent. It should be remembered here that emotions that are inconsistent for normal individuals may be consistent for a particular individual due to adaptation. The experience of happiness and the unique smile on the face of a gravedigger upon seeing a dead body is an adapted response.

Hurlock (1953) described the characteristics of young people's emotions, which indirectly provide insight into the dimensions of emotion. According to him, young people's emotions have the following characteristics:

- Intensity
- Control
- Consistency
- Prevalence
- Sentiment

According to him, the dimensions of emotions can be determined based on intensity. An individual's anger can be mild, intense, or intense. Therefore, this scale can indicate where a person falls on the scale in relation to their different emotions. Similarly, the degree of control of emotions is also measured. The stability dimension indicates the extent to which an emotion is stable within a person. The least stability is found at one end of the scale. The spread dimension indicates the extent of an emotion's spread. The emotion of anger can range from simple dissatisfaction to extraordinary rage. Similar emotions can characterize patriotism, loyalty, and so on.

It becomes clear that emotions have many dimensions, yet not much research has been conducted in this area. The reason is that the reliability of measuring these dimensions remains unresolved. Some psychologists have also argued that the emotional dimension can be broadly divided into two parts: one called the pleasant dimension and the other the unpleasant dimension. At one end of this scale, the pleasant elements are maximal. As one progresses, the amount of sadness increases, and finally, a neutral point is reached. Then, the area of the unpleasant dimension begins. As one progresses, the amount of sadness increases, and at the extreme end, the unpleasant elements are maximal. However, this dimension of emotion is not considered very scientific. Young (1943) stated that even if only these two aspects of emotion are recognized, the problem of proneness to emotion remains. The same individual may be more prone to the pleasant aspect of emotion than another.

IX. MODERN DEVELOPMENTAL PSYCHOLOGY

It can vary from person to person. A difference can be seen between a person's smiling and laughing in a happy situation. On seeing a stimulus, a child laughs more and openly than an adult. On hearing a joke, some people laugh out loud and some do so in a controlled manner.

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Similarly, it is not possible to understand the sad aspect of emotion. In this regard, Sanford's idea, which was discussed above, also shows a difference. Hence, understanding the true nature of emotion only through the happy and sad dimension seems more scientific.

X. STAGES OF EMOTIONAL DEVELOPMENT

Like many other personality traits, emotions develop through different stages. Each stage of emotional development has its own fundamental characteristics, as can be seen from the behaviours of both childhood anger and adolescence.

1. **Emotional development during infancy:** There is disagreement among psychologists on this matter. Freud believes that even the foetus experiences happiness and sadness before birth. Ottorank believes that the child experiences anxiety and panic as soon as it is born. Watson believes that emotions of fear, anger and affection are found in the child as soon as it is born. After his famous detailed studies, Vrijges told that at the time of birth the child experiences only excitement, other emotions develop later. A 6-month-old child starts experiencing happiness and sadness. The emotions of a one-year-old child start becoming complex.

2. **Emotional development in early childhood:** Emotions develop rapidly during this stage. A child's behaviour is most influenced by the emotions of fear and anger. Cummings, Iannotti, and Jaha Waxler (1985) found in their studies that children express anger when a toy breaks. For this, they express their anger by hurting or physically inflicting pain on other children. Apart from this, the unfulfilled desires of children are also a cause of anger.

   A child in this stage craves affection from everyone. He is delighted to see loved ones and displays behaviours that express his affection. Between one and three years of age, anger and affection predominate. After three years, curiosity develops. He becomes aware of everything in his environment, tries to learn about objects, people, events, etc. The child's questions may be consistent or inconsistent. Parents should encourage curiosity. The influence of gender on child aggression has been studied. Eleanor Maccoby and Carol Jaclin (1980) found that boys are more aggressive than girls. However, Hyde (1984) did not find any difference in the aggressive behaviour of both. Therefore, the influence of gender cannot be clearly accepted.

3. **Emotional development in late childhood:** This period begins around the age of 5 and lasts until the age of 11 or 12. A key characteristic of emotional development during this stage is that children begin to consider the pros and cons of their actions, and fear gradually decreases. Girls are more fearful than boys during this stage. Children display emotional behaviours such as spoiling games, gossiping, ridiculing, fighting, and breaking objects. Psychologists have conducted numerous studies to assess the impact of television depictions of violent behaviour. Studies have shown that television violence influences the aggressive behaviour of eight- and nine-year-old children, increasing their violent tendencies. During this stage, children express affection through physical touch, affectionate words, laughter, and smiles.

4. **Emotional Development in Adolescence**: This crucial stage in terms of emotional development spans from 11-12 years to 21 years. It is a stage of social awakening. Children begin to understand social constraints, family limitations, economic difficulties, and their own abilities, which control their emotional behaviour. During infancy, children

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are constantly under the influence of one emotion or another and display emotional behaviour, whereas during adolescence, children begin to gain control over their emotions. Stability of emotions is the most prominent characteristic of this stage. During this stage, children display their emotions differently than in other stages. Furthermore, differences are observed in the emotional behaviours of boys and girls. This stage brings about significant changes in the relationship between emotions. Along with this, intellectual and logical abilities also develop, due to which the child remains concerned about social rules, norms, and notifications.

XI. THEORIES OF EMOTIONAL DEVELOPMENT

An attempt has been made by psychologists to explain emotions based on which we could clearly understood it. Consequently, many ideas have emerged in this direction that help explain emotions. Here, the theoretical ideas of some important psychologists are presented.

1. Evolutionary Theory of Emotion

This theory suggests that emotions have an evolutionary origin. Naturalist Charles Darwin proposed that emotions evolved because they were adaptive and allowed humans and animals to survive and reproduce. Feelings of love and affection lead people to seek mates and reproduce. Feelings of fear compel people to fight or flee the source of danger. According to the evolutionary theory of emotion, our emotions exist because they serve an adaptive role. Emotions motivate people to respond quickly to stimuli in the environment, which helps improve the chances of success and survival.

Understanding the emotions of other people and animals also plays a crucial role in safety and survival. If you encounter a hissing, spitting, and clawing animal, chances are you will quickly realize that the animal is frightened or defensive and leave it alone.

2. James Lange's Theory

James Lange's idea was based on physical changes. Therefore, the theory propounded by him is called the Theory of Physiological Changes. According to the famous American psychologist, environmental stimuli in this theory create an emotional state in a person. It is a synthesis of the ideas of James and the famous Danish psychologist Lange. In this theory, emotional state produces physical changes in a person, and the resulting physical changes generate an emotional state, that is, physical changes occur before the emotional state is generated. If there are no physical actions or changes, then the emotional state will not arise. For example, upon seeing a snake, a specific emotional state is generated in a person, which makes the person run away. Due to this physical change or action, the person becomes frightened, due to which the emotion of fear is generated in him.

Many psychologists have harshly criticized this theory. Their experimental studies have proven that the origin of emotions is not based on physiological changes. Sherington, using experiments on dogs, and Cannon, using experiments on cats, have attempted to shake the foundation of this theory.

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3. Canon-Bards' Views

Canon - Bards hold the view that through the perception of emotional stimuli, emotional experiences and the actions of internal organs operate simultaneously and independently. Environmental stimuli stimulate receptors, which are then reported to the thalamus. This information is then passed from the thalamus to the cortex and to the effectors, which produce the emotional state. His ideas are based on the central nervous system, which is why his ideas are called the central theory of emotion.

4. Watson's Idea

Watson conducted many important studies, based on this, he presented the theoretical aspect of the development of emotions. He believes that three emotions - fear, anger, and love - are present in a child from birth. Watson considers these three emotions to be primary, fundamental, and innate emotions. Therefore, his view is called the theory of primary emotions. In his studies, Watson took newborn babies as subjects and succeeded in generating all three emotions by giving them various stimuli. Watson believes that other emotions develop from these three primary emotions.

This theory was harshly criticized by psychologists. Irwin (1930) argued that this idea could not last long in the psychological world and found in his studies that newborns are aroused only by excitement. They do not show signs of fear, anger, or love. Through his experiments, Sherman concluded that no emotions are present in a child at birth.

5. Prinz Theory

Prinz formulated the developmental theory of emotion (the genetic theory of emotion) based on his own behaviour. Like Sherman, he conducted numerous experimental studies. He believed that the newborn does not display emotions but is merely aroused by stimuli. As a primary emotion, the infant exists solely in an excited state. Clarity and specificity in these displays increase with maturity.

Prinz stated that almost all emotions are developed by the age of two. Age and experience continue to regulate and control their expression. Prinz's sequence of emotion development is shown in the following chart:

Stage	Order of origin of emotion
Birth	State of Excitement
Three months	Tribulation , Happiness
Six months	Anger, Hatred, fear
One year	Glee, Affection for elders
One-and-a-half-year	Jealousy, Affection towards children
Two years	Joy

Prinz believes that there is a definite sequence of emotional development. At birth, only arousal exists. This arousal manifests as distress and happiness at three months. By six months, distress gives rise to three emotions: anger, fear, and disgust. A one-year-old child develops joy and affection for elders. By the age of one and a half, jealousy also develops, while happiness also manifests affection for other children. Joyful emotions emerge at two

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years of age. All the above emotions reach maturity by the age of two, and their expression begins to undergo modification, change, and refinement based on learning.

6. Schachter-Singer Theory

Also known as the two-factor theory of emotion, the Schachter-Singer theory is an example of a cognitive theory of emotion. This theory suggests that physiological arousal occurs first, and then the individual must identify the reason for this arousal to experience and label it as an emotion. A stimulus leads to a physiological response that is then cognitively interpreted and labelled, resulting in an emotion.

Schachter and Singer's theory draws on both the James-Lange theory and the Cannon-Bard theory. Like the James-Lange theory, the Schachter-Singer theory proposes that people infer emotions based on physiological responses. The critical factor is the situation and the cognitive interpretation that people use to label that emotion. The Schachter-Singer theory is a cognitive theory of emotion that suggests our thoughts are responsible for emotions. Like the Cannon-Bard theory, the Schachter-Singer theory also suggests that similar physiological responses can produce varying emotions. For example, if you experience a racing heart and sweating palms during an important exam, you will probably identify the emotion as anxiety. If you experience the same physical responses on a date, you might interpret those responses as love, affection, or arousal.

7. Cognitive Appraisal Theory

According to appraisal theories of emotion, thinking must occur first before experiencing emotion. Richard Lazarus was a pioneer in this area of emotion, and this theory is often referred to as the Lazarus theory of emotion. The cognitive appraisal theory asserts that your brain first appraises a situation, and the resulting response is an emotion. According to this theory, the sequence of events first involves a stimulus, followed by thought, which then leads to the simultaneous experience of a physiological response and the emotion.

For example, if you encounter a bear in the woods, you might immediately begin to think that you are in great danger. This then leads to the emotional experience of fear and the physical reactions associated with the fight-or-flight response.

8. Facial-Feedback Theory of Emotion

The facial-feedback theory of emotions suggests that facial expressions are connected to experiencing emotions. Charles Darwin and William James both noted early on that, sometimes, physiological responses often have a direct impact on emotion, rather than simply being a consequence of the emotion.

The facial-feedback theory suggests that emotions are directly tied to changes in facial muscles. For example, people who are forced to smile pleasantly at a social function will have a better time at the event than they would if they had frowned or carried a more neutral facial expression.

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Table 1: Comparing the Eight Theories of Emotion

Theory	Summary
Evolutionary	Emotions have evolved to aid in survival
James-Lange	Emotions are the result of interpreting physical reactions
Cannon-Bard	Emotions and physical reactions occur simultaneously
Watson	Emotions are innate
Prinz	Emotions stem from learning
Schachter-Singer	Emotions stem from cognitive evaluations of physical reactions
Cognitive Appraisal	Emotions stem from our cognitive appraisals
Facial Feedback	Facial expressions influence emotional experiences

XII. MAJOR EMOTIONS OF CHILDHOOD

Feelings predominate in most of a child's behaviour. Suspicion emerges by the age of one. Several important emotions, such as anger, jealousy, affection, joy, etc., develop during childhood. Their stability is influenced by education and learning. The following is an explanation of the development of the major emotions of childhood and their impact on behavioural performance.

1. Fear

Fear is an unpleasant internal feeling that makes a person want to run away from the fear-inducing situation. Fear can cause children to cry, scream, tremble, respiratory and heart rate stop, and blood pressure rise. However, if children do not exhibit escape behaviour, fearful children during infancy and childhood are often speechless and confused in fearful situations.

Psychologists have considered unpleasant experiences as the main reason for the feeling of fear. Once the continuous experience of fear affects the digestive process of the child. When the child gets burnt, when a dog snatches away the bread, when the doctor gives an injection, the child develops hypersensitivity towards these. Second time when a situation of unpleasant feeling arises, people get scared of things and people. The child also gets scared based on imitation. Apart from this, imitation is a major reason for fear.

As children grow older, the expression of fear also changes. Experience reduces its intensity. Efforts should be made to keep children away from fear-inducing situations, otherwise they may develop timidity and submissiveness.

2. Anger

Anger is an emotion that gives rise to aggressive behaviour. Anger is characterized by rapid mental turmoil, making it a more intense emotion than fear and jealousy. Young children express this emotion by crying, breaking things, and hitting adults. Older children may exhibit behaviours such as running away, screaming loudly, hitting younger children, and refusing food.

According to Prinz, this emotion originates in a child as young as six months old, but it undergoes significant changes as they age. Due to social conditions, the child experiences less physical anger, but the intensity of anger increases psychologically, leading to frustration and conflict. The primary cause of anger in the veins is interference with the child's natural

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bodily functions. When the causes of anger change with age, social and family settings can also contribute to anger. This emotion adversely affects the child's health, making it difficult for the child to adjust. A healthy home environment can help control a child's anger to some extent.

3. Jealousy

Anger is the root cause of jealousy in a child. This emotion consists of two basic emotions: anger and fear. This complex emotion, combined with the two, develops in a child by the age of one and a half. A child's environment plays a significant role in the development of jealousy. Jealousy is seen in children with younger siblings because the child has trouble adjusting to their parents' overprotectiveness. Jealousy in these children typically subsides with the arrival of a newborn baby. The threat of limited authority and limited rights can lead to jealousy. Furthermore, discriminatory behaviour by guardians can contribute to jealousy. Parental attitudes are also a major cause of jealousy. For example, discrimination between sons and daughters naturally leads to jealousy in daughters. Jealousy in a boy or girl gives rise to direct behaviour like biting, scratching, pushing, fighting etc. whereas indirectly the jealous boy or girl shows his jealousy by urinating on the bed, sucking finger or thumb, and by destructive behaviour.

Studies have shown that girls are more likely to experience jealousy than boys. The eldest male child in the family tends to display more jealous behaviour than other children. Studies have also shown that intelligent children are more jealous than slower-witted children.

For the healthy adjustment of the child, the children should be kept away from situations in the family that generate jealousy.

4. Affection

A child displays affectionate behaviour acquired through the social environment. This behaviour begins to emerge at six months of age and develops with advancing age. The child first objects of affection to those who fulfil his desires, with his mother being the first. This is why a child first develops affection for elders and later begins to express affection for younger children. At the age of one and a half or two, he begins to meet other young children and even plays with them. At the age of four or five, a child, in addition to people, also shares his possessions with his cat, dog, etc., starts playing with other children and shows affection. Love develops in adolescence. The child starts showing affection towards the opposite gender. The child expresses this by smiling, coming closer etc.

5. Joy

Joy is the experience of pleasure. Whether a biological or social need is met, we experience it when it is fulfilled. Initially, signs of joy are observed in a child when they are fed or provided physical comfort. At three or four months of age, children experience joy when they see a familiar person or hear a voice, which can be gauged from their body language. As they get older, they experience joy when they are allowed to act according to their wishes. Joy is sometimes expressed in the form of a smile and sometimes in the form of laughter. Smiling is seen in children as early as three or four months of age. Children are delighted when their parents pick them up or show them a toy. Gradually, their tendency to establish contact with adults becomes evident. They now experience joy when they establish physical contact with

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parents or familiar individuals. Along with general pleasure, they also develop a curiosity motive and a motivation for exploration. Exploratory motives develop. When these motives are satisfied, they experience joy. By adolescence, boys and girls develop a variety of goals. They now experience joy when these goals are achieved.

Joy is expressed in the form of smiles and laughter in various situations. These situations can be broadly divided into two categories: (a) Joy is experienced when a person is able to satisfy their feelings of superiority, hostility, sexuality, etc., based on socially accepted behaviour. We often laugh and rejoice at a friend's silliness. Similarly, children enjoy teasing their peers. We often experience joy by listening to or reading sexual stories. In all these situations, the emotion of joy is generated by the satisfaction of desires that are not directly accepted by society. (b) Laughter is also experienced in situations where there is a sense of incongruity. This is evident in various jokes, stories, pranks, and anecdotes. In these cases, there is often a contradiction between how a person should behave and how they behave, which is what causes laughter. Similarly, in a joke or story, when events occur contrary to our expectations, we laugh.

When we experience joy, we laugh. Clearly, the circumstances that trigger the emotion of joy vary from childhood to adulthood. The circumstances that trigger this emotion vary during infancy, childhood, adolescence, and adulthood.

6. Hate

Hate is a negative emotion. Hate is the opposite of love. Generally, dislike is called disgust. If someone says they hate meat, it means they dislike meat. It should be remembered that dislike is not actually a lack of liking. There is a difference between not liking and disliking. As for the development of the emotion of disgust, it is based on frustration in sexual and non-sexual love. When a person experiences disappointment in the sphere of sexual or non-sexual love, the emotion of disgust can develop. If a wife does not receive sexual satisfaction from her husband, she may gradually begin to hate him. Similarly, if a husband does not receive sexual satisfaction from his wife, he may develop an emotion of disgust towards his wife, if his wife is his only source of sexual satisfaction. However, this can be influenced by cultural variation. Similarly, hatred can arise toward an object or person that hinders the attainment of a goal. Sometimes, the emotion of hatred arises out of jealousy or competition.

XIII. Emotional Maladjustment

Emotional maladjustment means that when a person is unable or incapable of adjusting to the needs of his environment, it is called emotional maladjustment (Emotional maladjustment is an inability to adjust to one's own emotional demands). A child lives in some psychological environment. If the child expresses his emotions according to the requirements of this environment, then it will be said that there is emotional balance (Equilibrium) because he expresses emotions only in the required amount according to the circumstances. But complete emotional balance is not found in any person. It has been observed that balance is found in the expression of some emotions of the child and imbalance is found in the expression of some emotions. There can be two situations of emotional imbalance:

1. Heightened Emotionality
2. Low Emotionality

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It is clear from the above description that the dimension or expansion of emotional expression is as follows

Low emotionality- + High Emotionality

Emotional Equilibrium

In both the high and low emotional imbalance states described above, a child's emotional expression will be abnormal rather than normal. Therefore, both increased emotionality and decreased emotionality are two aspects of emotional maladjustment. Both aspects are generally important.

A child or an individual can achieve emotional balance in three ways. The first way is that a child can control their environment only when they abandon their sad emotions and adopt happy emotions. However, a child can only do this at about 4.5 years of age, or happy emotions can be generated in them through training. Another important way to maintain emotional balance is to teach the child emotional tolerance. A child must possess both types of emotional tolerance. They should be able to control and tolerate their own heightened emotions and tolerate the extreme emotions expressed by others in the environment. A third important way to maintain emotional balance is that if a child's emotionality is less than normal or low, they can be trained to express their reduced emotions in an appropriate and normal manner. In many children, curiosity is found to be at a lower level than other emotions. This emotion can be extremely beneficial for them if channelled toward creativity or intellectual pursuits. It is essential not only for children but for every individual to express all their emotions, both happy and sad, in a balanced manner, because studies have shown that in a state of emotional imbalance, a child's behaviour and personality can become disorganized. Adjustment in various areas of life also becomes impaired in this state. Consequently, symptoms such as stress, conflict, and antagonism can arise in the child. Lowered emotionality means that the intensity and frequency of emotional experiences are lower than normal. Therefore, if this emotionality is to be studied in a child, it is necessary that the child has normal emotionality.

Emotionality should be identified. It is often observed that some emotions in children are expressed in a manner that is not appropriate to the situation and emotional stimulus because the frequency and intensity of this emotional expression is less than normal. For example, if a child is expected to express anger in a particular situation as per the situation, but instead of expressing anger, he remains calm or has less emotion than required, this type of reduced emotionality is also a sign of maladjustment in the child. The child can be trained to normalize this type of emotion.

Defining heightened emotionality, Hurlock (1978) wrote that "heightened emotionality means a frequency and intensity of emotional experience beyond what is normal." Understanding hyperemotionality also requires determining the normal emotionality of various emotions. Not all emotions develop to a normal degree in any child. Some emotions are developed than others. It is not possible for any child to have all emotions developed beyond normal. It is essential that in every child, one or some emotions develop to a greater extent than others. Sometimes, the intensity and frequency of their expression exceeds the socially accepted standards. Numerous studies have shown that hyper-emotionality is always accompanied by nervous tension. This nervous tension manifests differently in different children. Some children may respond to this tension by sucking their thumbs, while older children may engage in nail-biting behaviours, scratching their heads, giggling, or bursting

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into tears. When emotional tension is severe, it may also manifest as language disorders such as stammering or stuttering.

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THE IMPACT OF YOGA AND MEDITATION ON EMOTIONAL MATURITY AND WELL-BEING: FOSTERING POSITIVITY IN LIFE

Abstract

Yoga and meditation are increasingly recognized as effective mind–body interventions that promote emotional balance, psychological resilience, and overall well-being. The present study examines the impact of yoga and meditation on emotional maturity and well-being, emphasizing their role in fostering positivity and adaptive functioning. Drawing on empirical findings from intervention-based research and existing psychological literature, the study explores how these practices enhance emotional regulation, self-awareness, stress management, and interpersonal functioning. Quantitative findings indicate significant reductions in perceived stress and psychological morbidity, along with significant improvements in well-being following structured yoga and meditation practice. The findings support the role of yoga and meditation as cost-effective, culturally relevant interventions for enhancing emotional maturity and positive mental health.

Keywords: yoga, meditation, emotional maturity, well-being, stress, positive psychology

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I. INTRODUCTION

Emotional maturity plays a critical role in psychological well-being, interpersonal relationships, and overall life satisfaction. Individuals with higher emotional maturity demonstrate effective emotional regulation, resilience, empathy, and adaptive coping, whereas emotional immaturity is associated with heightened stress, interpersonal conflict, and psychological distress. In modern life, increasing occupational pressures, lifestyle-related stress, and reduced self-regulation have contributed to declining emotional well-being.

Yoga and meditation, rooted in ancient Indian traditions, offer holistic approaches to emotional and psychological development. Contemporary psychological research supports their efficacy in reducing stress, enhancing emotional regulation, and promoting well-being. However, limited research has integrated these practices specifically within the framework of emotional maturity. The present paper aims to bridge this gap by examining the impact of yoga and meditation on emotional maturity and well-being.

Yoga and Emotional Maturity Yoga integrates physical postures (asanas), breath regulation (pranayama), and relaxation, fostering psychophysiological balance. Psychological models suggest that yoga enhances emotional maturity by strengthening self-regulation and reducing autonomic arousal. Empirical studies report reductions in anxiety, irritability, and emotional reactivity following yoga practice, enabling individuals to respond to emotional challenges with greater stability and awareness (Sharma et al., 2015). Regular yoga practice increases body awareness and introspection, allowing individuals to identify emotional triggers and maladaptive responses. This enhanced awareness supports emotional responsibility, tolerance, and self-control—core components of emotional maturity.

Meditation and Well-Being Meditation practices, particularly mindfulness-based techniques, cultivate present-moment awareness and non-judgmental observation of thoughts and emotions. Neuropsychological evidence indicates that meditation enhances prefrontal cortical regulation of emotional responses, thereby reducing limbic reactivity and stress (Goyal et al., 2014). Meditation has consistently been associated with reductions in perceived stress, anxiety, and psychological morbidity. By improving emotional clarity and acceptance, meditation contributes to sustained well-being and psychological resilience.

Emotional Maturity and Interpersonal Relationships Emotional maturity encompasses empathy, emotional regulation, responsibility, and adaptive communication. Emotionally mature individuals are better equipped to manage interpersonal stress and maintain healthy relationships. Yoga and meditation foster qualities such as patience, compassion, and emotional awareness, which positively influence interpersonal functioning and social harmony.

II. REVIEW OF LITERATURE

A growing body of empirical research has examined the psychological and emotional benefits of yoga and meditation, particularly in relation to emotional regulation, stress reduction, and overall well-being. The following review highlights key studies that form the conceptual and empirical foundation for the present research.

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Study 1: Yoga and Psychological Well-Being
Sharma, Thakur, and Thakur (2015) conducted a systematic review examining yoga as a complementary intervention for stress management. The findings indicated that regular yoga practice significantly reduced stress, anxiety, and emotional instability across diverse populations. The authors concluded that yoga enhances emotional regulation by balancing autonomic nervous system functioning, thereby contributing to psychological well-being and emotional maturity.

Study 2: Meditation and Stress Reduction
Goyal et al. (2014), in a meta-analysis published in JAMA Internal Medicine, evaluated the effects of meditation programs on psychological stress and well-being. The results demonstrated moderate but consistent reductions in stress, anxiety, and depressive symptoms. The study emphasized that mindfulness-based meditation improves emotional awareness and acceptance, key components of emotional maturity.

Study 3: Yoga, Emotional Regulation, and Self-Awareness
Streeter et al. (2012) investigated the neurophysiological mechanisms underlying yoga practice and found that yoga increases gamma-aminobutyric acid (GABA) levels in the brain, which are associated with improved mood and emotional regulation. Enhanced self-awareness and reduced emotional reactivity were identified as significant outcomes of sustained yoga practice.

Study 4: Meditation and Neuroplasticity
Hölzel et al. (2011) explored the effects of mindfulness meditation on brain structure using neuroimaging techniques. The study revealed increased gray matter density in brain regions associated with learning, memory, emotional regulation, and perspective-taking. These changes suggest that meditation facilitates emotional maturity through improved cognitive and emotional control.

Study 5: Emotional Maturity and Well-Being
Singh and Bhargava (2018) examined the relationship between emotional maturity and psychological well-being among adults. Their findings indicated a strong positive correlation between emotional maturity and life satisfaction, emotional stability, and resilience. Emotionally mature individuals demonstrates better stress coping and interpersonal functioning.

Study 6: Yoga-Based Interventions and Mental Health
Field (2016) reviewed evidence on yoga as a therapeutic intervention for mental health conditions and found that yoga significantly reduces cortisol levels, improves mood states, and enhances emotional balance. The study highlighted yoga's effectiveness in promoting emotional regulation and reducing psychological morbidity.

Study 7: Mindfulness, Emotional Intelligence, and Interpersonal Relationships
Brown, Ryan, and Creswell (2007) examined mindfulness and its association with emotional intelligence and interpersonal functioning. The results suggested that mindfulness meditation enhances empathy, emotional clarity, and relationship satisfaction, thereby supporting emotional maturity and social well-being.

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Study 8: Yoga and Quality of Life
Ross and Thomas (2010) reviewed multiple studies on yoga interventions and quality of life outcomes. The review concluded that yoga improves emotional well-being, reduces perceived stress, and enhances overall quality of life. Participants consistently reported increased emotional stability and positive outlook toward life.

Study 9: Meditation, Emotional Balance, and Well-Being
Keng, Smoski, and Robins (2011) reviewed mindfulness-based interventions and reported significant improvements in emotional regulation, reduced rumination, and enhanced well-being. The authors emphasized that meditation fosters adaptive emotional responses, which are central to emotional maturity.

Study 10: Integrated Yoga and Meditation Practices
Pascoe, Thompson, and Ski (2017) examined the combined effects of yoga, meditation, and breathe regulation on stress and emotional health. The findings indicated that integrated practices produced stronger reductions in stress and emotional dysregulation compared to single-component interventions, underscoring the synergistic role of yoga and meditation in fostering emotional maturity and well-being.

Summary of Review of Literature
The reviewed studies consistently demonstrate that yoga and meditation contribute positively to emotional regulation, stress reduction, self-awareness, and psychological well-being. Neurophysiological, cognitive, and behavioral evidence supports the role of these practices in fostering emotional maturity and enhancing interpersonal relationships. However, despite substantial evidence supporting individual benefits, limited research has integrated emotional maturity explicitly as an outcome variable. The present study addresses this gap by examining yoga and meditation as holistic interventions for promoting emotional maturity and overall well-being.

III. METHODOLOGY

1. **Research Design:** The present study adopted a pilot pre–post intervention design with a comparison (control) group, aimed at examining the effect of yoga and meditation on perceived stress, psychological morbidity, and well-being. Given the exploratory nature of the study and the limited sample size, the research was treated as a case-series pilot investigation intended to examine trends and feasibility rather than population-level generalization.

2. **Participants:**The sample consisted of four adults (N = 4) aged 30–40 years, selected using purposive sampling. Participants were divided into:

3. **Experimental Group (n = 2)**
   - Participants: BS and AK
   - Received yoga and meditation intervention

4. **Control Group (n = 2)**
   - Participants: SA and AM
   - Did not receive any structured intervention
   - Continued routine lifestyle

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All participants were free from severe psychiatric illness and provided informed consent prior to participation.
Age Range: 30–40 years (early adulthood)

5. **Tools Used:**
   - Perceived Stress Scale (PSS-10; Cohen et al., 1983)
   - General Health Questionnaire–28 (GHQ-28; Goldberg & Williams, 1988)
   - PGI General Well-Being Scale (Verma & Verma, 1989)

These instruments were administered at pretest and posttest for the experimental group, and at comparable time points for the control group.

6. **Intervention Procedure:** Participants in the experimental group underwent a structured yoga and meditation intervention for a fixed duration. The intervention focused on:
   - Yogic postures (asanas)
   - Breath regulation (pranayama)
   - Mindfulness-based meditation practices

The control group did not participate in any structured yoga or meditation program during the study period.

Data Analysis: Given the very small sample size, results were analyzed using:
- Descriptive statistics (Mean and Standard Deviation)
- Within-case pre–post comparison
- Findings are interpreted cautiously, emphasizing direction and magnitude of change rather than inferential generalization.
- Inferential statistics (t-values) are reported illustratively to indicate strength of change but are not used to claim statistical generalization.

IV. RESULTS

Given the small sample size, the findings of the present study are exploratory in nature and should be interpreted as indicative trends rather than statistically generalizable results. Accordingly, the results focus on descriptive patterns and the direction of change observed in perceived stress, psychological morbidity, and well-being following the yoga and meditation intervention. Pretest and posttest comparisons were examined for the experimental group and contrasted with observations from the control group to understand the potential influence of the intervention. These patterns suggest a potential association between yoga and meditation practices and improvements in emotional maturity–related outcomes.

Table 1: Pre- and Post-Intervention Differences in Stress and Well-Being (Experimental Group, n = 2)

Variable	Pretest Mean (SD)	Posttest Mean (SD)	Direction of Change
Perceived Stress (PSS)	26.50 (0.71)	15.50 (0.71)	Decreased
Psychological Morbidity (GHQ-28)	22.00 (1.41)	13.00 (0.00)	Decreased
Well-Being (PGI-GWB)	13.00 (0.00)	19.00 (1.41)	Increased

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Note. Values are derived from pretest scores of BS and AK and their corresponding post-intervention assessments.

Control Group Observations (n = 2)

Participants in the control group exhibited no significant change between pretest and posttest evaluations for perceived stress, psychological morbidity, and well-being, indicating that scores were stable in the absence of intervention.

Interpretation of Results:

The experimental group demonstrated:
1. A significant reduction in perceived stress
2. A significant decrease in psychological morbidity
3. A significant improvement in subjective well-being

In contrast, the control group showed minimal or no change, suggesting that the observed improvements in the experimental group may be attributed to the yoga and meditation intervention.

V. DISCUSSION

The present study sought to explore the impact of yoga and meditation on emotional maturity–related outcomes, perceived stress, psychological morbidity, and well-being in a small sample of adults. The findings, although exploratory, demonstrate clear and consistent trends indicating reductions in stress and psychological morbidity alongside improvements in subjective well-being among participants who underwent the intervention.

The observed changes suggest that yoga and meditation may facilitate emotional regulation and psychological balance through enhanced self-awareness and stress modulation. These outcomes are consistent with previous research highlighting the role of mind–body practices in promoting emotional stability and adaptive coping. While the present findings cannot be generalized due to the limited sample size, they provide meaningful preliminary evidence supporting the psychological benefits of yoga and meditation.

Importantly, the stability of scores observed in the control group strengthens the inference that the positive changes noted in the experimental group are likely associated with the intervention rather than natural variation or external influences. This contrast underscores the potential value of yoga and meditation as feasible and accessible practices for enhancing emotional well-being.

From an applied perspective, the results highlight the relevance of yoga and meditation as low-cost, non-invasive strategies that may be particularly useful in preventive mental health and well-being promotion. The study also demonstrates the feasibility of implementing such interventions and assessing their psychological impact, thereby laying the groundwork for future large-scale and longitudinal investigations.

VI. CONCLUSION

The present exploratory study sought to examine the role of yoga and meditation in influencing emotional maturity–related outcomes, perceived stress, psychological morbidity,

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and overall well-being. Although conducted with a small sample and intended primarily as a pilot investigation, the findings provide meaningful preliminary insights into the psychological processes through which mind–body practices may foster emotional balance and positivity in life.

Across the intervention period, participants who engaged in yoga and meditation demonstrated consistent trends toward reduced perceived stress and psychological morbidity, along with noticeable improvements in subjective well-being. These changes were not observed in the control group, suggesting that the observed improvements may be associated with participation in the intervention rather than natural variation over time. While statistical generalization is not possible, the clear direction and consistency of these trends underscore the potential psychological value of yoga and meditation practices.

From a conceptual perspective, the findings align with existing theoretical and empirical literature indicating that yoga and meditation enhance emotional regulation, self-awareness, and adaptive coping. These mechanisms are central to the development of emotional maturity, which involves the capacity to respond to emotional experiences with awareness, responsibility, and balance. By facilitating psycho-physiological regulation and mindful engagement with internal experiences, yoga and meditation appear to support healthier emotional functioning and greater psychological resilience.

The study also highlights the practical relevance of yoga and meditation as accessible, low-cost, and culturally grounded interventions. Their non-invasive nature and adaptability make them particularly suitable for preventive mental health initiatives, educational settings, and community-based well-being programs. Even at an individual level, these practices may serve as valuable tools for enhancing emotional awareness and fostering a more positive orientation toward life.

Despite its exploratory nature and methodological limitations, the present study contributes to the growing body of research emphasizing holistic approaches to emotional and psychological well-being. The findings offer a foundation for future research employing larger samples, longitudinal designs, and mixed-method approaches to further examine the relationship between yoga, meditation, emotional maturity, and well-being. In conclusion, yoga and meditation hold promise as meaningful practices for fostering emotional maturity and enhancing overall well-being, warranting continued scholarly attention and systematic investigation.

VII. LIMITATIONS AND FUTURE DIRECTIONS

The primary limitation of the study is the small sample size, which restricts statistical generalization. Additionally, reliance on self-report measures may introduce response bias. Future research should employ larger samples, longitudinal designs, and mixed-method approaches to further examine the relationship between yoga, meditation, emotional maturity, and well-being.

VIII. PRACTICAL IMPLICATIONS

The findings of this exploratory study hold several important practical implications despite the methodological constraints. The observed trends suggest that yoga and meditation may serve as feasible, low-cost, and non-invasive strategies for promoting emotional balance and

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psychological well-being. Given their adaptability and minimal resource requirements, these practices can be readily implemented in a variety of real-world settings.

In educational contexts, incorporating yoga and meditation into curricula or student support programs may help foster emotional regulation, resilience, and well-being among learners. Such initiatives could be particularly beneficial in addressing stress and emotional challenges during transitional or high-pressure periods. In workplace and organizational settings, structured yoga and meditation sessions may contribute to stress reduction, improved emotional maturity, and enhanced interpersonal functioning, thereby supporting employee well-being and productivity.

From a clinical and counseling perspective, yoga and meditation may be used as complementary interventions alongside traditional therapeutic approaches. Mental health professionals can integrate these practices to support clients in developing emotional awareness, managing stress, and cultivating adaptive coping strategies. Their non-pharmacological nature makes them especially suitable for individuals seeking holistic approaches to emotional and psychological growth.

At the community and public health level, yoga and meditation programs can be leveraged as preventive mental health initiatives, promoting emotional maturity and well-being across diverse populations. Given their cultural relevance and broad acceptability, particularly in the Indian context, these practices offer a promising avenue for enhancing psychological health and fostering a more emotionally resilient society.

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INTERMITTENT FASTING AND ITS IMPACT ON INSULIN RESISTANCE: A COMPREHENSIVE REVIEW

Abstract

Insulin resistance is a central metabolic dysfunction underlying type 2 diabetes mellitus, metabolic syndrome, obesity, and cardiovascular disease. Lifestyle interventions, particularly dietary modifications, play a critical role in its prevention and management. Intermittent fasting (IF), characterized by alternating periods of eating and fasting, has gained increasing scientific and clinical attention for its metabolic benefits. This review aims to synthesize current evidence on the effects of intermittent fasting on insulin resistance, elucidate its physiological mechanisms, and evaluate its clinical applicability in insulin-resistant individuals. Findings suggest that intermittent fasting improves insulin sensitivity through enhanced metabolic switching, reduced inflammation, improved mitochondrial function, and modulation of adipokines. However, individual variability, adherence challenges, and safety considerations warrant cautious implementation. Future research should focus on long-term outcomes, population-specific responses, and standardized fasting protocols.

Keywords: Intermittent fasting, insulin resistance, metabolic health, glucose metabolism, lifestyle intervention

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I. INTRODUCTION

Insulin resistance refers to a diminished biological response of peripheral tissues—primarily skeletal muscle, adipose tissue, and liver—to insulin action. This condition precedes the development of type 2 diabetes mellitus and is strongly associated with obesity, dyslipidemia, hypertension, and chronic inflammation. With the global rise in sedentary lifestyles and calorie-dense diets, insulin resistance has become a major public health concern and a key driver of cardiometabolic disease burden worldwide (Samuel & Shulman, 2016).

Conventional management strategies for insulin resistance emphasize continuous calorie restriction, increased physical activity, weight loss, and pharmacological therapies when necessary. Although continuous energy restriction reliably reduces body weight and cardiometabolic risk factors, long-term adherence is frequently poor and weight regain is common (Harvie & Howell, 2017). These limitations have prompted investigation of alternative dietary strategies that change the timing of energy intake rather than the composition or continuous caloric load. Intermittent fasting (IF) —an umbrella term that includes time-restricted feeding (TRF), alternate-day fasting (ADF), the 5:2 regimen, and periodic prolonged fasting—has received considerable research attention as a feasible, low-cost, nonpharmacological approach to improve metabolic health (Anton et al., 2018).

A growing body of randomized controlled trials (RCTs) and mechanistic human studies suggests that intermittent fasting can improve indices of insulin sensitivity and related metabolic markers. Early, well-controlled trials of TRF and early time-restricted feeding (eTRF) reported clinically meaningful reductions in fasting insulin and improvements in insulin sensitivity independent of major weight loss (Sutton et al., 2018; Xie et al., 2022). For example, trials comparing early TRF to later eating windows observed improved peripheral insulin sensitivity, reduced fasting glucose, and reduced inflammation after relatively short interventions (Xie et al., 2022). Studies with shorter daily feeding windows (e.g., 6–8 hours) appear particularly effective at lowering fasting insulin and HOMA-IR compared with wider windows (Cienfuegos et al., 2020; Zhang et al., 2022).

Comparative trials of ADF versus continuous calorie restriction have produced suggestive evidence that ADF may produce equal or, in some trials, greater reductions in fasting insulin and HOMA-IR even when weight loss is similar between arms. A notable randomized trial reported larger improvements in insulin resistance with ADF compared with daily calorie restriction among overweight adults (Gabel et al., 2019). These findings imply that metabolic benefits of IF may derive from factors beyond simple energy deficit, such as repeated metabolic switching (glycogen → lipolysis → ketogenesis) and improved insulin receptor signaling during fasting periods.

Systematic reviews, meta-analyses, and umbrella reviews have generally supported the potential of IF to improve metabolic outcomes, while also highlighting heterogeneity across studies and remaining evidence gaps. Recent meta-analyses and umbrella syntheses report that IF is associated with reductions in fasting insulin, HOMA-IR, waist circumference, and certain lipids among adults with overweight or obesity, although effect sizes and certainty vary by IF regimen, study duration, and population characteristics (Sun et al., 2024; Chen et al., 2024). Several meta-analyses note that some improvements in insulin metrics may be mediated largely through weight loss, whereas other data indicate weight-independent benefits—particularly for protocols that enforce a restricted feeding window aligned with circadian biology (Panda, 2016; Longo & Mattson, 2014).

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Mechanistic studies provide biologically plausible explanations for these clinical effects. Intermittent fasting promotes metabolic switching that reduces reliance on glucose and insulin, increases fatty acid oxidation and ketone production, decreases visceral adiposity, attenuates systemic inflammation, and favorably modulates adipokines and mitochondrial function—each of which can enhance insulin signaling in liver and skeletal muscle (Longo & Mattson, 2014; Patterson & Sears, 2017). Time-restricted feeding may confer additional advantages by synchronizing food intake with endogenous circadian rhythms, thereby optimizing insulin secretion and peripheral glucose uptake (Panda, 2016).

Despite promising results, the literature contains several important limitations. Study designs are heterogeneous with respect to fasting protocol (duration and timing), comparator diets, study populations (healthy, overweight, insulin-resistant, or with established type 2 diabetes), medication use, and follow-up length. Many RCTs are short term (≤12 weeks) and underpowered for hard clinical endpoints; adherence and long-term safety data are sparse for several populations (e.g., persons taking insulin or sulfonylureas, pregnant or lactating women, and those with eating disorders) (Sun et al., 2024). In addition, inconsistencies in outcome reporting and the influence of concurrent lifestyle changes (exercise, sleep timing, and calorie intake) complicate causal inference.

Given the rising prevalence of insulin resistance and the incomplete adoption of continuous calorie-restriction strategies, a refined synthesis of high-quality clinical trials and mechanistic studies is necessary to (a) quantify the insulin-related benefits of specific IF protocols, (b) identify which subpopulations derive the greatest benefit, and (c) clarify safety considerations and practical implementation strategies. The present review therefore aims to integrate contemporary RCT evidence and mechanistic insights to inform clinical recommendations for intermittent fasting in insulin-resistant individuals.

1. Types of Intermittent Fasting

- Intermittent fasting encompasses several dietary patterns, including:
- Time-Restricted Feeding (TRF): Daily eating window of 6–10 hours, followed by fasting.
- Alternate-Day Fasting (ADF): Alternating days of normal eating and fasting or very low caloric intake.
- 5:2 Fasting: Five days of normal eating and two non-consecutive fasting days per week.
- Periodic Prolonged Fasting: Extended fasting periods (24–72 hours) practiced occasionally.
- Among these, time-restricted feeding has shown greater feasibility and adherence, particularly in insulin-resistant populations.

2. Patho-physiology of Insulin Resistance

- Insulin resistance develops due to multiple interrelated mechanisms, including:
- Excess free fatty acid accumulation
- Chronic low-grade inflammation
- Oxidative stress
- Mitochondrial dysfunction
- Altered gut macrobiotic

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- Hormonal deregulations
- These factors impair insulin signaling pathways, leading to decreased glucose uptake and increased hepatic glucose production.

3. Mechanisms Linking Intermittent Fasting and Improved Insulin Sensitivity

- **Metabolic Switching:** Intermittent fasting promotes a shift from glucose-based metabolism to fat and ketone utilization, improving metabolic flexibility and reducing insulin demand.
- **Reduction in Visceral Adiposity:**IF contributes to fat loss, particularly visceral fat, which is strongly linked to insulin resistance and inflammatory cytokine release.
- **Improved Insulin Signaling:**Fasting periods reduce circulating insulin levels, enhancing insulin receptor sensitivity and downstream signaling pathways.
- **Anti-Inflammatory Effects:**IF downregulates pro-inflammatory markers such as TNF-α and IL-6, which interfere with insulin action.
- **Circadian Rhythm Alignment:**Time-restricted feeding aligns food intake with circadian rhythms, optimizing glucose metabolism and insulin secretion.

4. Clinical Evidence on Intermittent Fasting in Insulin-Resistant Individuals

Clinical trials and observational studies indicate that intermittent fasting:

- Reduces fasting insulin levels
- Improves HOMA-IR scores
- Enhances glycemic control
- Promotes weight loss independent of calorie counting
- Improves lipid profiles
- Studies suggest comparable or superior outcomes to continuous calorie restriction, particularly when adherence is maintained.

II. PSYCHOLOGICAL AND BEHAVIORAL CONSIDERATIONS

Adherence to intermittent fasting (IF) is not determined solely by physiological tolerance but is strongly shaped by psychological, behavioral, and social factors. Eating patterns are embedded within cognitive, emotional, and social contexts; therefore, the effectiveness of IF among insulin-resistant individuals depends largely on motivational processes, stress regulation, eating-related cognitions, and environmental support systems (Antoni et al., 2017).

1. Motivation and Self-Regulation

Motivation plays a central role in the initiation and maintenance of intermittent fasting. Individuals who adopt IF for intrinsic reasons, such as perceived health benefits, improved energy levels, or metabolic control, demonstrate higher adherence compared to those motivated primarily by rapid weight loss or external pressures (Herman & Polivy, 2020). From a self-regulation perspective, IF may simplify dietary decision-making by reducing the number of daily eating opportunities, thereby lowering cognitive load and decision fatigue. This structure can enhance perceived control over eating behavior, which is associated with improved dietary adherence and self-efficacy.

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However, for some individuals, prolonged fasting periods may increase cognitive preoccupation with food, particularly in those with high dietary restraint or prior dieting failures. Such preoccupation can undermine self-regulatory capacity, leading to compensatory overeating during feeding windows (Polivy & Herman, 2020). These contrasting responses highlight the importance of assessing individual differences in motivation and self-control before recommending IF.

2. Stress, Emotional Regulation, and Cortisol Response

Psychological stress is a well-established contributor to insulin resistance through activation of the hypothalamic–pituitary–adrenal (HPA) axis and subsequent elevations in cortisol. Intermittent fasting may exert bidirectional effects on stress regulation. Some individuals report improved emotional clarity, mood stability, and reduced emotional eating, possibly due to enhanced insulin sensitivity and reduced glycemic variability (Anton et al., 2018). Improved metabolic stability may reduce hunger-driven irritability and reactive eating behaviors.

Conversely, fasting can act as a physiological and psychological stressor, particularly during early adaptation phases. Increased cortisol levels during prolonged fasting or inadequate caloric intake may exacerbate anxiety, irritability, fatigue, and sleep disturbances in susceptible individuals (Tomiyama et al., 2010). Chronic stress combined with rigid fasting rules may paradoxically worsen insulin resistance through neuroendocrine mechanisms. Therefore, IF protocols should be adapted to minimize psychological distress, particularly in individuals with high baseline stress or maladaptive coping styles.

3. Eating Behaviors and Risk of Disordered Eating

The impact of intermittent fasting on eating behaviors varies substantially across individuals. Some studies report reductions in binge eating tendencies and improved appetite awareness, potentially due to enhanced interoceptive sensitivity and hormonal regulation of hunger and satiety (Antoni et al., 2017). Structured fasting may help certain individuals break habitual snacking patterns and emotionally driven eating.

However, there is growing concern that IF may reinforce rigid dietary control and all-or-nothing thinking in vulnerable populations. Individuals with a history of eating disorders, chronic dieting, or body image disturbances may experience increased risk of disordered eating behaviors, including binge–restrict cycles, guilt associated with breaking fasts, and obsessive focus on food timing (Herman & Polivy, 2020). Clinical guidelines therefore emphasize careful psychological screening prior to recommending fasting-based interventions, particularly among adolescents, young adults, and individuals with prior psychopathology.

4. Social and Environmental Influences

Social context plays a critical role in adherence to intermittent fasting. Cultural norms surrounding meal timing, family eating patterns, work schedules, and social gatherings can either facilitate or hinder compliance. Individuals with strong social support and flexible environments demonstrate greater consistency with fasting schedules, whereas social pressure to eat during fasting windows often leads to non-adherence and associated distress.

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Work-related demands such as shift work, long commuting hours, or irregular schedules may disrupt circadian rhythms and reduce the feasibility of time-restricted feeding. In such cases, rigid IF protocols may increase psychological burden rather than confer metabolic benefit. Tailoring fasting schedules to align with individual lifestyle constraints is therefore essential for sustainable adherence.

III. CLINICAL IMPLICATIONS AND BEHAVIORAL SUPPORT

From a behavioral medicine perspective, intermittent fasting should be conceptualized as a structured lifestyle intervention rather than a prescriptive diet. Incorporating psychoeducation, goal-setting, self-monitoring, and cognitive-behavioral strategies can enhance adherence while reducing psychological risk. Interventions that emphasize flexibility, self-compassion, and metabolic health rather than weight-centric outcomes are more likely to promote long-term success.

Healthcare professionals should routinely assess eating attitudes, stress levels, sleep quality, and coping mechanisms prior to initiating IF. Ongoing monitoring is recommended to detect early signs of psychological distress or maladaptive eating behaviors. When implemented within a supportive, individualized framework, intermittent fasting may offer both metabolic and psychological benefits; however, when applied rigidly or without psychological consideration, it may undermine both mental well-being and metabolic outcomes.

IV. SAFETY AND LIMITATIONS

Despite its benefits, intermittent fasting may not be suitable for all individuals. Potential concerns include:

- Hypoglycemia in individuals on insulin or sulfonylureas
- Nutrient deficiencies if poorly planned
- Hormonal disturbances with prolonged fasting
- Increased stress response in certain populations
- Pregnant women, breastfeeding mothers, individuals with eating disorders, and those with advanced diabetes require medical supervision.

V. FUTURE IMPLICATIONS

Future research should prioritize:

- Long-term randomized controlled trials
- Population-specific studies (e.g., South Asian populations)
- Comparative effectiveness of different IF protocols
- Integration of behavioral and psychological outcomes
- Biomarker-based personalization of fasting regimens

VI. CONCLUSION

Intermittent fasting represents a promising, non-pharmacological dietary strategy for improving insulin sensitivity among insulin-resistant individuals. Accumulating evidence from randomized controlled trials, mechanistic studies, and meta-analyses indicates that intermittent fasting can favorably influence glycemic regulation, fasting insulin levels, and insulin signaling pathways. These benefits appear to arise not only from reductions in body

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weight and visceral adiposity but also from repeated metabolic switching, attenuation of chronic low-grade inflammation, improved mitochondrial efficiency, and better alignment of energy intake with circadian rhythms. Consequently, intermittent fasting offers metabolic advantages that extend beyond those typically achieved through continuous calorie restriction alone.

Importantly, the effectiveness of intermittent fasting is not uniform across individuals and is strongly moderated by psychological and behavioral factors. Motivation, stress reactivity, eating-related cognitions, and social context substantially influence adherence and sustainability. While many individuals experience improved appetite regulation, reduced food cravings, and enhanced perceived control over eating, others may encounter irritability, fatigue, heightened stress responses, or maladaptive eating patterns during fasting periods. These divergent responses underscore the necessity of individualized implementation rather than a one-size-fits-all approach.

From a clinical perspective, intermittent fasting should be viewed as a structured lifestyle intervention that integrates metabolic goals with psychological well-being. Appropriate screening for stress levels, eating behaviors, and prior dieting or eating disorder history is essential before initiating fasting protocols. Ongoing monitoring and behavioral support can mitigate potential risks, enhance adherence, and promote long-term metabolic benefits. Flexible fasting schedules that accommodate occupational demands, cultural eating patterns, and family routines are more likely to be sustained and psychologically tolerable.
Despite growing evidence supporting the metabolic benefits of intermittent fasting, several gaps remain. Much of the current literature is limited by short intervention durations, heterogeneous fasting protocols, and underrepresentation of high-risk and diverse populations. Long-term randomized controlled trials examining sustainability, safety, psychological outcomes, and cardio-metabolic endpoints are needed. Future research should also prioritize personalized fasting approaches that account for individual metabolic profiles, behavioral traits, and psychosocial contexts.

In conclusion, when thoughtfully prescribed and appropriately supervised, intermittent fasting can serve as a valuable adjunct to lifestyle-based management of insulin resistance. Its potential to improve insulin sensitivity through integrated metabolic and behavioral mechanisms positions it as a viable option within personalized nutrition and preventive medicine frameworks. However, maximizing its clinical utility requires careful individualization, interdisciplinary support, and continued empirical investigation.

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BEHAVIOR THERAPY AND COGNITIVE BEHAVIORAL THERAPEUTIC APPROACH

Abstract

Two of the most empirically supported psychological treatment methods in the contemporary mental health practice include behavior therapy and cognitive behavioral therapy (CBT). They are based on learning theory and cognitive psychology and focus on the connection between thoughts, behavior, emotions, and the environmental factors. Behavior therapy is more concerned with overt behaviors and the concepts of conditioning, whereas the cognitive behavioral therapy incorporates the use of cognitive restructuring to include maladaptive thought patterns to impact emotional distress and functional behavioral impairments. This chapter explores the history, theory, fundamental methods, way of application, strength and weakness of behavior therapy and cognitive behavioral therapy. The efficacy of their use in a generalized treatment of various psychological disorders is discussed and the current developments and future prospects are discussed. Collectively, these strategies constitute an evidence-based practice foundation of psychotherapy.

Keywords: behavior therapy, cognitive behavioral therapy, learning theory, cognitive, psychotherapy.

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I. INTRODUCTION

Behavior therapy and cognitive behavioral therapy (CBT) have played a huge role in determining the way psychological treatment should be in the last century. Such methods were developed as the alternatives to psychoanalytic traditions, they paid more attention to scientific rigor, measurable results, and practical intervention plans (Corey, 2021). Behavior therapy was based on the concepts of the learning theory, which emphasizes the acquisition and maintenance of maladaptive behavior. This framework was extended by cognitive behavioral therapy that introduced the role played by cognition in the functioning of emotions and behavior (Beck, 2011).

CBT is now considered a gold standard intervention on many mental health disorders such as anxiety disorder, depression, posttraumatic stress disorder (PTSD), and substance use disorder (Hofmann et al., 2012). This chapter gives a detailed review of behavior therapy and CBT, the theoretical basis, methods of treatments, clinical practice, and its future development.

II. THOROUGH GROUND OF BEHAVIOR THERAPY

Behavior therapy came up in the first half to mid-20th century as a reaction to the hegemony of psychoanalytic methods, which according to critics were not empirically validated (Skinner, 1953). Early behaviorists like Ivan Pavlov, John B. Watson and B. F Skinner focused on observable behavior and environmental factors that determined learning.

1. Classical Conditioning

Classical conditioning Classical conditioning is a phenomenon that was originally described by Pavlov (1927) in which neutral stimuli can induce conditioned responses when paired with unconditioned stimuli repeatedly. This was the dictum of phobias and anxiety disorders. The Little Albert experiment, done by Watson and Rayner (1920), proved that fear could be conditioned.

2. Operant Conditioning

The behaviorists, led by Skinner (1953), are interested in how behavior is formed and supported by consequences. Reinforcement enhances the chances of a behavior reoccurring whereas punishment reduces it. This was the basis of such therapeutic methods as token economies and contingency management.

3. Fundamental Tenets of Behavior Therapy

There are a number of assumptions based on which behavior therapy is based:

- It is through exposure to the environment that behavior is learned.
- The maladaptive behaviors are capable of being unlearned or altered.
- The emphasis is made on the now, not on the past.
- Treatment is an outcome-oriented therapy.

Behavior therapy makes it possible to objectively evaluate and can be systematically fostered (Miltenberger, 2016) by focusing on observable behavior.

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4. Behavior Therapeutic interventions.

- **Systematic Desensitization:** Wolpe (1958) developed systematic desensitization, which is applied in anxiety and phobias treatments. It is based on exposure to feared stimuli gradually and relaxation techniques.

- **Exposure Therapy:** In exposure therapy, clients are expected to face feared objects or situations and deal directly with them either in real life or when visualizing. The habituation and extinction of fear responses are caused by repeated exposure (Craske et al., 2014).

- **Operant Techniques:**Positive reinforcement, shaping and behavior modification programs are all operant based interventions. These are popular strategies in the educational and clinical aspects with children and people who have developmental disorders.

III. COGNITIVE THERAPY CAME INTO BEING

Although behavior therapy worked in most disorders, it was not a good explanation of the inner-workings of the mind. Cognitive therapy was discovered in 1960s mainly by Aaron T. Beck and Albert Ellis.

According to Beck (1976), distorted thinking styles that prolong emotional disorders include overgeneralization and catastrophizing.

Rational Emotive Behavior Therapy: Rational Emotive Behavior Therapy (REBT) was introduced by Ellis (1962), who stressed the importance of irrational beliefs in the emotional distress.

1. Cognitive Behavioral Therapy: The Integrative Approach.

Cognitive behavioral therapy combines behavioral interventions with cognitive restructuring interventions. CBT is grounded on the assumption that all aspects of thoughts, feelings and behaviors are interdependent, and emotional and behavioral change can be achieved by modifying maladaptive thought (Beck, 2011).

2. Core Assumptions of CBT

- Cognitive distortions are a factor that leads to psychological distress.
- Learners can be taught to recognize and to change dysfunctional thoughts
- The skills acquired during the therapy support the work of long-term coping and the prevention of relapse.

3. Cognitive Techniques in CBT

- **Cognitive Restructuring:**Cognitive restructuring is the process of determining the automatic thoughts and assessing their truthfulness and substituting it with a more neutral option (Beck et al., 1979).

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- **Socratic Questioning:**Guided questioning is used to make the clients analyze the evidence behind their beliefs and explore alternative interpretations.

- **Thought Records:**Clients are also required to document experiences, thoughts, feelings, and alternative reactions which is strengthening self-awareness and expertise building.

4. CBT Techniques Behavioral

CBT still has numerous behavioral interventions, including:

- Behavioral activation, which is administered in depression.
- Exposure and response prevention, especially in the case of obsessive-compulsive disorder.
- Social skills and problem-solving, skills training.
- Cognitive and behavioral techniques are beneficial when incorporated to improve efficacy of the treatment (Dobson and Dozois, 2019).

5. Applications of CBT

CBT has been used effectively in a wide group of people and disorders:

- Fear disorders (Hofmann et al., 2012)
- Depression (Cuijpers et al., 2013)
- PTSD (Resick et al., 2017)
- Drug abuse (McHugh et al., 2010)
- Accidental pain (Ehde et al., 2014) and chronic illnesses.
- CBT can also be applied in children, adolescents and couples/group therapy.

IV. EFFECTIVENESS AND EMPIRICAL SUPPORT

CBT is among the psychotherapeutic methods that have been studied the most. Its efficacy is always proven in a broadened variety of disorders, by means of meta-analyses (Butler et al., 2006). The reason is that it has a structured nature and is focused on acquiring skills, which leads to positive treatment outcomes and minimize the rates of relapse.

Strengths and Limitations

Strengths

- Strong empirical support
- Time constraint and economical.
- Teamwork and competency-based.
- Culturally applicable and flexible.

Limitations

- Needs the involvement of the clients.
- Not as effective with those who have severe cognitive impairments.
- Critics claim it can ignore more profound emotional or relationship problems.

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V. CONTEMPORARY DEVELOPMENTS

Third wave behavioral therapies have included: Contemporary Development
Recent developments are the third-wave behavioral therapies, including:

- **Acceptance and commitment Therapy (ACT).**
- **The Dialectical Behavior Therapy (DBT)**
- **Mindfulness-based cognitive therapy.**

These strategies are extensions of conventional CBT using acceptance, values, and emotional control (Hayes et al., 2011).

VI. FUTURE DIRECTIONS

There are further studies on technology-assisted CBT, online and app-based interventions that are underway in the future. Cultural adaptations together with individual testing regimes are also valuable growth fields.

VII. CONCLUSION

The approaches of behavior therapy and cognitive behavioral therapy have revolutionized psychological treatment because they have focused on empirically based, practical and effective interventions. As behavior therapy contributed to laying the foundation of the model by learning principles, CBT enhanced the model by incorporating the cognitive processes that resulted in emotional distress. Collectively, these methods are fundamental to evidence-based psychotherapy and keep on improving with the new research and societal demands.

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TEACHING ATTITUDE AND MENTAL HEALTH AMONG WOMEN TEACHERS: A QUANTITATIVE ANALYSIS

Abstract

Teaching attitude and mental health are critical determinants of teachers' professional effectiveness and well-being. Women teachers, in particular, face multifaceted challenges that may adversely affect both their psychological health and professional orientation. The present study examined the relationship between teaching attitude and mental health among women teachers and explored differences in mental health across levels of teaching attitude. A sample of 65 women teachers was selected through purposive sampling. The Teaching Attitude Scale by Nasrin and Biswas and the Women Teachers Mental Health Scale by Marbaniang and Bhutia were administered. Descriptive statistics and independent samples t-test were employed for data analysis. The findings revealed a statistically significant difference in mental health between women teachers with high and low teaching attitude. Additionally, women teachers with poorer mental health demonstrated lower teaching attitude. The study highlights the reciprocal association between teaching attitude and mental health and underscores the need for institutional interventions to promote teacher well-being.

Keywords: Teaching Attitude, Mental Health, Women Teachers, Teacher Well-being, Educational Psychology

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I. INTRODUCTION

Teaching is a profession that places sustained psychological demands on individuals due to continuous emotional involvement, cognitive effort, and interpersonal interaction. Teachers are required to respond to diverse student needs, institutional expectations, academic accountability, and administrative responsibilities, often under conditions of limited resources and time pressure. These demands make teaching particularly vulnerable to stress-related psychological challenges. Consequently, teachers' mental health has gained increasing attention as a crucial factor influencing professional functioning, instructional quality, and job satisfaction.

Mental health plays a central role in shaping how teachers perceive their professional role and respond to occupational stressors. Teachers with adequate psychological well-being are more likely to demonstrate emotional balance, adaptive coping, and professional engagement. In contrast, compromised mental health may reduce motivation, impair emotional regulation, and negatively affect classroom interactions, thereby influencing overall teaching effectiveness.

Women teachers often experience additional psychological strain due to the simultaneous management of professional responsibilities and socially prescribed domestic roles. In the Indian socio-cultural context, expectations related to care giving, family obligations, and emotional labor frequently coexist with professional demands, contributing to role overload and work–life imbalance. These factors increase the susceptibility of women teachers to stress, fatigue, and psychological distress.

Teaching attitude refers to an individual's overall orientation toward the teaching profession, encompassing beliefs about teaching, emotional responses to professional responsibilities, and patterns of classroom behavior. A positive teaching attitude is reflected in professional commitment, enthusiasm, and willingness to engage in instructional activities, whereas a negative teaching attitude may manifest as disengagement, dissatisfaction, and resistance to professional demands.

Although teaching attitude and mental health have been examined independently in previous research, empirical studies exploring their interrelationship among women teachers in the Indian context remain limited. The present study seeks to address this gap by examining the association between teaching attitude and mental health among women teachers and by analyzing how variations in one are reflected in the other.

II. REVIEW OF LITERATURE

Research on teacher well-being has consistently demonstrated that psychological health is a key determinant of professional effectiveness and occupational satisfaction. Studies have indicated that teachers experiencing high levels of stress and emotional exhaustion are more likely to report diminished job satisfaction, reduced professional commitment, and increased burnout. Poor mental health among teachers has also been linked to absenteeism, emotional disengagement, and reduced instructional quality.

Studies focusing on teaching attitude have emphasized its role in shaping classroom behavior, professional motivation, and instructional practices. Teachers with favorable attitudes toward teaching tend to exhibit greater enthusiasm, adaptability, and engagement, while those with

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unfavorable attitudes often experience dissatisfaction and emotional detachment from their professional role.

Gender-focused research has highlighted that women teachers frequently report higher levels of occupational stress compared to men. This difference has been attributed to work–family conflict, emotional labor, and gender-specific role expectations. Research conducted in the Indian context similarly suggests that women teachers face considerable psychological pressure due to the need to balance professional and domestic responsibilities.

Empirical evidence examining the relationship between mental health and occupational attitude suggests that individuals with better psychological well-being are more likely to maintain positive work attitudes. In educational settings, teachers with higher levels of mental health have been found to demonstrate stronger professional commitment and more favorable teaching attitudes. Conversely, psychological distress has been associated with reduced motivation and negative professional orientation.

Despite these findings, limited research has directly examined the interaction between teaching attitude and mental health among women teachers. This lack of focused investigation underscores the need for empirical studies that consider both constructs simultaneously within a gender-sensitive framework.

III. THEORETICAL FRAMEWORK

The present study is grounded in psychological and occupational theories that explain the interaction between mental health and professional attitude. Mental health and teaching attitude are viewed as interrelated constructs shaped by emotional functioning, cognitive appraisal, and socio-cultural context.

Psychological well-being theory suggests that positive mental health involves emotional stability, resilience, and effective coping. In the teaching profession, these qualities enable individuals to manage occupational stress and sustain professional motivation. Teachers with sound mental health are therefore more likely to develop positive teaching attitudes, while psychological distress may undermine professional engagement.

The cognitive–affective approach to attitude formation emphasizes that attitudes emerge from the interaction of beliefs and emotional experiences. Mental health influences how teachers interpret professional challenges and derive emotional meaning from teaching. Psychological distress may lead to negative appraisals of teaching roles, resulting in diminished teaching attitude.

The Job Demands–Resources model further explains how excessive demands and limited psychological resources can impair mental health and reduce work engagement. Women teachers often experience additional role strain due to gender-based expectations, as explained by role strain theory. Such strain may negatively affect mental health and, in turn, weaken teaching attitude.

Based on these perspectives, the study assumes a reciprocal relationship between mental health and teaching attitude among women teachers.

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IV. Methodology

1. **Objectives of the Study:** The present study was undertaken with the following objectives:
   - To determine the extent of teaching attitude among women teachers.
   - To assess the mental health status of women teachers.
   - To compare the mental health of women teachers exhibiting high and low levels of teaching attitude.
   - To examine variations in teaching attitude across different levels of mental health among women teachers.

2. **Hypotheses:** The following hypotheses were formulated for the study:
   - There exists a statistically significant difference in mental health between women teachers with high teaching attitude and those with low teaching attitude.
   - Women teachers experiencing poorer mental health are likely to exhibit lower levels of teaching attitude.

3. **Research Design:** The study employed a descriptive and comparative research design to examine the relationship between teaching attitude and mental health among women teachers.

4. **Sample:** The sample comprised 65 women teachers drawn from educational institutions using purposive sampling. The participants were selected based on their availability and relevance to the objectives of the study.

5. **Tools Used:** The following standardized instruments were used for data collection:
   - Teaching Attitude Scale developed by Prof. Nasrin and Komy Biswas
   - Women Teachers Mental Health Scale developed by Careen E. G. Marbaniang and Dr. Yodida Bhutia

6. **Statistical Analysis:** The collected data were analyzed using descriptive statistics, including frequency distribution, percentage analysis, mean, and standard deviation. An independent samples t-test was employed to examine differences in mental health between groups based on teaching attitude.

V. RESULTS

Table 1: Distribution of Women Teachers by Levels of Teaching Attitude (N = 65)

Level of Teaching Attitude	Frequency	Percentage
Extremely High	25	38.46
High	5	7.69
Average	20	30.77
Below Average	10	15.38
Low	5	7.69
Total	**65**	**100**

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Table 1 presents the distribution of women teachers across different levels of teaching attitude. The findings indicate that a substantial proportion of the participants exhibited a positive orientation toward the teaching profession. Nearly half of the women teachers (46.15%) fell within the high to extremely high teaching attitude categories, suggesting a generally favorable professional outlook among a considerable segment of the sample. This trend reflects a strong sense of professional commitment, motivation, and engagement with teaching responsibilities among these teachers.

A notable proportion of the sample (30.77%) demonstrated an average level of teaching attitude. Teachers in this category may display moderate levels of professional interest and involvement, potentially influenced by situational factors such as workload, institutional support, or personal circumstances. While this group does not reflect negative professional orientation, it indicates scope for enhancement through professional development and supportive interventions.

In contrast, a smaller yet significant proportion of women teachers (23.07%) were found to exhibit below average to low teaching attitude. This group may be experiencing professional dissatisfaction, emotional strain, or reduced motivation toward teaching. Such attitudes could be associated with occupational stress, role overload, or inadequate psychological and organizational support. Although this group represents a minority, its presence highlights the need for targeted measures to address factors contributing to reduced teaching attitude.
Overall, the distribution suggests variability in teaching attitude among women teachers, with a dominant inclination toward positive professional attitudes alongside a meaningful segment requiring attention. These findings underscore the importance of fostering supportive work environments and addressing psychological well-being to sustain and enhance teaching attitude among women educators.

Table 2: Distribution of Women Teachers by Levels of Mental Health (N = 65)

Level of Mental Health	**Frequency**	**Percentage**
Very Good	5	7.69
Good	5	7.69
Average	20	30.77
Below Average	20	30.77
Poor	15	23.08
Total	**65**	**100**

Table 2 presents the distribution of women teachers across different levels of mental health. The findings reveal that a relatively small proportion of the participants reported very good or good mental health (15.38%), indicating that only a limited number of women teachers experienced a high level of psychological well-being. A sizeable segment of the sample (30.77%) demonstrated an average level of mental health, suggesting moderate psychological functioning with the capacity to manage occupational demands under typical conditions.

Notably, more than half of the women teachers (53.85%) were found to exhibit below average to poor mental health. This pattern highlights the prevalence of psychological strain among women teachers, which may be associated with occupational stress, emotional labor, role overload, and work–life imbalance. The findings suggest that a significant proportion of

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women teachers may be functioning under conditions of psychological vulnerability, emphasizing the need for systematic mental health support and well-being initiatives within educational institutions.

Table 3: Mean Difference in Mental Health between High and Low Teaching Attitude Groups

Teaching Attitude Group	N	Mean	SD
High Teaching Attitude	30	3.87	0.82
Low Teaching Attitude	15	1.67	0.72

Table 3 results indicate a marked difference in mental health scores between women teachers with high and low levels of teaching attitude. Women teachers classified under the high teaching attitude group obtained a substantially higher mean mental health score ($M = 3.87$, $SD = 0.82$) compared to those in the low teaching attitude group ($M = 1.67$, $SD = 0.72$). This difference suggests that women teachers who hold a more positive orientation toward the teaching profession tend to experience better psychological well-being.

The higher mental health scores among teachers with high teaching attitude may reflect greater professional satisfaction, emotional resilience, and effective coping with occupational demands. In contrast, teachers with lower teaching attitude may experience reduced motivation, emotional exhaustion, and psychological strain, which could adversely affect their mental health. The observed difference highlights the close association between professional attitude and psychological well-being, supporting the view that teaching attitude plays a significant role in shaping mental health outcomes among women teachers.

Table 4: Independent Samples t-Test Showing Difference in Mental Health

Group Comparison	t-value	df	p-value
High vs Low Teaching Attitude	17.63	43	< .001

The independent samples t-test revealed a statistically significant difference in mental health between women teachers with high and low teaching attitude ($t = 17.63$, $df = 43$, $p < .001$). The magnitude of the obtained t-value indicates a substantial difference between the two groups, suggesting that teaching attitude is strongly associated with mental health among women teachers.

Women teachers exhibiting high teaching attitude demonstrated significantly better mental health compared to those with low teaching attitude. This finding implies that a positive professional orientation may contribute to emotional stability, psychological resilience, and effective coping with occupational stress. In contrast, lower teaching attitude may be linked to reduced professional engagement, emotional exhaustion, and heightened psychological strain, thereby negatively affecting mental health.

The acceptance of the hypothesis reinforces the theoretical assumption that teaching attitude and mental health are closely interconnected. These results underscore the importance of fostering positive teaching attitudes through supportive institutional practices and mental health interventions, particularly for women teachers who may face additional occupational and socio-cultural stressors.

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Table 5: Teaching Attitude across Levels of Mental Health (N = 65)

Mental Health Level	High Teaching Attitude	Average	Low Teaching Attitude	Total
Very Good	5	0	0	5
Good	4	1	0	5
Average	12	6	2	20
Below Average	3	5	12	20
Poor	1	2	12	15

Table 5 illustrates the distribution of teaching attitude across different levels of mental health among women teachers. The findings reveal a distinct pattern indicating that teaching attitude varies systematically with mental health status. All women teachers with very good mental health exhibited high teaching attitude, and the majority of those with good mental health also demonstrated high teaching attitude. This suggests that better psychological well-being is associated with a more positive orientation toward the teaching profession.

Among teachers with average mental health, most participants showed high to average teaching attitude, with only a small proportion displaying low teaching attitude. In contrast, women teachers with below average and poor mental health predominantly fell within the low teaching attitude category. This pattern indicates that compromised mental health may adversely affect professional motivation, commitment, and engagement with teaching responsibilities.

The findings provide empirical support for the assumption that poor mental health is linked to diminished teaching attitude. They further highlight the reciprocal relationship between mental health and teaching attitude, emphasizing the need for mental health support and well-being interventions to promote positive professional attitudes among women teachers.

VI. DISCUSSION

The present study examined the relationship between teaching attitude and mental health among women teachers and revealed a clear and consistent pattern across descriptive and inferential analyses. The findings collectively indicate that both teaching attitude and mental health vary considerably among women teachers and are closely interrelated.

The distribution of teaching attitude showed that while a substantial proportion of women teachers demonstrated high to extremely high teaching attitude, a meaningful segment exhibited average to low levels. This variability suggests that although many women teachers remain professionally committed and motivated, a notable proportion may be experiencing professional strain or disengagement. Similarly, the mental health profile revealed that more than half of the participants reported below average to poor mental health, highlighting the prevalence of psychological vulnerability among women teachers.

The comparison of mean mental health scores and the results of the independent samples t-test provided strong statistical evidence that women teachers with higher teaching attitude experience significantly better mental health than those with lower teaching attitude. This finding underscores the role of professional orientation as a potential protective factor for

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psychological well-being. Teachers who maintain a positive attitude toward teaching may possess greater emotional resilience, job satisfaction, and coping capacity, which buffer against occupational stress.

Further, the cross-tabulation of teaching attitude across levels of mental health demonstrated a clear gradient pattern. Women teachers with good and very good mental health predominantly exhibited high teaching attitude, whereas those with below average and poor mental health were largely concentrated in the low teaching attitude category. This pattern reinforces the reciprocal nature of the relationship between mental health and teaching attitude, suggesting that compromised mental health may weaken professional motivation and engagement, while positive mental health supports favorable professional attitudes.

Overall, the findings align with psychological and occupational well-being theories that emphasize the interaction between emotional health and work-related attitudes. The results highlight the need for educational institutions to prioritize mental health promotion and supportive work environments, particularly for women teachers who often face additional occupational and socio-cultural stressors. Addressing mental health concerns may not only improve teachers' psychological well-being but also contribute to sustaining positive teaching attitudes and enhancing educational effectiveness.

VII. CONCLUSION

The present study provides empirical evidence that teaching attitude and mental health are closely associated among women teachers. Women teachers exhibiting higher teaching attitude demonstrated significantly better mental health, whereas those experiencing poorer mental health showed lower levels of teaching attitude. These findings suggest that mental health and professional attitude function in a reciprocal manner within the teaching profession. Psychological distress may weaken professional motivation and engagement, while positive teaching attitudes may support emotional resilience and well-being. The results emphasize the need for educational institutions to prioritize mental health support and professional development initiatives aimed at fostering positive teaching attitudes. Addressing psychological well-being among women teachers is essential not only for their personal health but also for enhancing the overall quality of education.

VIII. IMPLICATIONS

The findings highlight the need for institutional initiatives aimed at promoting mental health and positive teaching attitude among women teachers. Schools and colleges should implement counseling services, stress management programs, and professional development activities focusing on psychological well-being.

IX. LIMITATIONS

- The sample size was limited to 65 women teachers.
- The study relied on self-report measures.
- The findings may not be generalized beyond similar populations.

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X. SUGGESTIONS FOR FUTURE RESEARCH

Future studies may include larger samples, employ co-relational or regression analyses, and incorporate qualitative approaches to gain deeper insights into women teachers' mental health and professional attitudes.

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HUMAN MENTAL HEALTH AND SALUTOGENESIS

Abstract

Human mental health is a dynamic state of psychological well-being in which individuals can realize their abilities, cope with normal life stresses, sustain satisfying relationships, and maintain productive functioning in daily roles. It is not merely the absence of mental illness but the presence of positive emotions, purpose, and adaptive coping. The salutogenic model, introduced by Aaron Antonovsky, shifts attention from the causes of disease to the origins of health, emphasizing resilience, resources, and positive functioning that enhance coping strategies, buffer stress, and promote mental well-being across the lifespan. It asks a central guiding question: How do some people stay well despite stress and adversity? Within this framework, stressors are understood as inevitable aspects of life; what varies is people's capacity to comprehend them, access resources, and find meaning in responding to them.

This chapter explores the interaction between stressors, personal resources (such as social support, optimism, self-efficacy, spirituality, and problem-solving skills), and environmental conditions (including family climate, school or workplace culture, and community supports) in shaping mental health outcomes. The concept of Sense of Coherence—comprehensibility, manageability, and meaningfulness—serves as a core construct explaining why some individuals adapt and flourish while others become overwhelmed. Emphasis is placed on preventive, strengths-based perspectives that build resilience, promote life skills, and enhance positive emotions, rather than approaches focused solely on risk and pathology. Applications to health promotion, education, counseling, and public mental health policy are highlighted to demonstrate the practical relevance of salutogenesis.

Overall, the mental health and salutogenesis

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viewpoint provides a holistic framework that recognizes the human potential for growth, adaptation, and flourishing even in challenging circumstances. By cultivating internal strengths and supportive environments, individuals and communities can move toward the health end of the ease–dis-ease continuum and achieve sustainable psychological well-being. This perspective increasingly informs research, practice, and policy worldwide today significantly.

Keywords: Mental Health, Human Resilience, Salutogenesis, Well-being.

I. INTRODUCTION

Mental health is not merely the absence of mental illness; it involves a state of emotional, psychological, and social well-being in which an individual realizes his or her abilities, can cope with normal stresses of life, work productively, and contribute to the community. In today's world, rapid social change, academic and work pressure, unemployment, family conflict, and exposure to trauma have increased psychological stress. Yet, many individuals facing such stressors continue to function effectively and maintain good mental health. This observation shifts attention from illness to the factors that protect and promote mental well-being.

The salutogenic approach, proposed by Aaron Antonovsky(1979), provides an important framework for understanding this phenomenon. Rather than focusing only on causes of mental disorders (pathogenesis), salutogenesis emphasizes the origins of mental health.

Salutogenesis is the association of two words sales and Genesis sales that is meaning of Health and Genesis means origin or starting point. Thus, salutogenesis literally means "the origin of health." Unlike the traditional focus on illness, the salutogenic approach asks the fundamental question. In other words, we can say that Salutogenesis is the study of the origins of health, focusing on factors that support human health and well-being. Health has often been understood mainly as the absence of disease, and most medical systems have traditionally focused on diagnosing and treating illness. This disease-centered approach is known as pathogenesis. However, many people are able to remain physically and psychologically healthy even when they are exposed to stress, hardship, or trauma.

Salutogenesis highlights the role of Sense of Coherence (SOC)—the feeling that life is comprehensible, manageable, and meaningful—as well as internal and external resistance resources such as social support, coping skills, optimism, and resilience. These factors help individuals understand stress, handle it effectively, and find purpose in life, thereby protecting mental health.

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"What keeps people healthy?"

It emphasizes strengths, coping abilities, personal and social resources, and the capacity to find meaning, coherence, and manageability in life. Salutogenesis views health as a continuum from ease to dis-ease, rather than a simple division between healthy and sick. It highlights that stress is a normal part of life, but one's ability to understand and manage stress plays a major role in maintaining well-being. Salutogenesis therefore represents a positive, holistic, and health-promoting orientation, complementing pathogenesis and contributing significantly to modern public health, psychology, mental health care, and health promotion.

"What are the factors that promote and support human health, despite the presence of stressors and adversity?"

According to Antonovsky, health is not a fixed state but a dynamic continuum between ease and dis-ease. Individuals constantly move along this continuum depending on their life circumstances, coping resources, and ability to manage stress.

Thus, the salutogenic perspective views mental health as a continuum and focuses on strengths rather than deficits, coping rather than breakdown, and well-being rather than only disorder. It forms the basis of modern positive mental health promotion, resilience building, and recovery-oriented mental health care.

II. MENTAL HEALTH

Mental health refers to a state of well-being in which an individual realizes their own abilities, can cope with the normal stresses of life, can work productively, and is able to contribute to their community. According to the World Health Organization (WHO), mental health is more than the absence of mental disorders; it is an integral part of health and well-being that underpins our individual and collective abilities to make decisions, build relationships, and shape the world we live in.
Good mental health enables individuals to:

- Experience a sense of inner peace and emotional balance
- Develop healthy relationships with others
- Handle adversity and recover from setbacks
- Set and achieve meaningful goals
- Maintain focus, clarity, and decision-making capacity

Mental health includes emotional, psychological, and social dimensions. These affect how individuals perceive themselves, manage emotions, deal with stress, relate to others, and engage in life's challenges. A mentally healthy person is resilient, possesses a sense of purpose, feels connected to others, and is able to navigate change effectively. Conversely, poor mental health can impair daily functioning and overall quality of life even in the absence of a formal mental illness diagnosis.

Promoting mental health involves creating environments—social, economic, and physical—that support well-being and empower individuals to lead fulfilling lives. It includes preventive strategies, early interventions, and access to care, as well as efforts to reduce stigma and promote mental health literacy in society.

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1. Mental Health Research

Mental health research has evolved significantly over the decades, expanding from a narrow focus on mental illness to a broader perspective that includes psychological resilience, well-being, and prevention. Early studies centered around understanding and treating mental disorders such as schizophrenia, depression, and bipolar disorder. As awareness of the complexity of mental health grew, researchers began to explore the biological, psychological, and social determinants of mental well-being.

2. Contemporary mental health research now includes

- Neuroscientific studies investigating brain function, neurochemistry, and genetic predispositions
- Psychological research examining cognitive-behavioral patterns, emotional regulation, and personality traits
- Sociological and cultural studies exploring how environment, culture, stigma, and community support impact mental health
- Intervention-based research testing the effectiveness of therapies, mindfulness techniques, digital mental health tools, and preventive education

Recent advancements also emphasize the importance of mental health across the lifespan, the intersection of physical and mental health, and the role of social justice and equity in access to care. The rise of positive psychology has contributed significantly to this field by focusing on strengths, flourishing, and human potential.

As mental health challenges become more visible globally, mental health research plays a critical role in shaping policies, clinical practices, and educational programs aimed at improving mental health outcomes and reducing the burden of mental illness.

III. SALUTOGENESIS

Salutogenesis represents a transformative approach in mental health, shifting focus from the treatment of illness to the promotion of well-being. Introduced by Aaron Antonovsky, this model is ground Mental health research has traditionally focused on the pathogenesis model, which seeks to understand the origins and mechanisms of mental illness. However, in contrast, the salutogenic model shifts the focus toward what keeps people healthy. Developed by medical sociologist Aaron Antonovsky in the late 1970s, this model is based on the question: "What are the origins of health?" rather than "What causes disease?"ed in the concept of the Sense of Coherence (SOC), a psychological framework that helps individuals understand, manage, and find meaning in life’s stressors.

A growing body of empirical research supports the salutogenic model and its relevance to mental health. Numerous studies across different populations and contexts have validated the Sense of Coherence (SOC) as a strong predictor of psychological resilience and emotional well-being.

1. Eriksson and Lindström (2006) conducted a meta-analysis of over 470 studies and concluded that SOC is significantly and positively associated with perceived health,

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quality of life, and well-being, and negatively associated with anxiety, depression, and stress.

2. A longitudinal study by Volanen et al. (2007) in Finland followed adolescents over three years and found that those with higher SOC levels demonstrated fewer mental health problems and greater satisfaction with life.
3. Super et al. (2016) examined Dutch cancer patients and found that a strong SOC was linked to better coping strategies, reduced psychological distress, and improved quality of life during and after treatment.
4. In a workplace context, Albertsen et al. (2010) found that employees with higher SOC reported lower burnout and better work engagement, even in high-stress environments.
5. Sagy and Antonovsky (1996) conducted cross-cultural studies that confirmed SOC as a universal construct, although cultural factors can influence its expression. Their findings emphasized that while the sources of resistance may differ across populations, the presence of a coherent outlook was universally beneficial for mental health.

IV. THEORETICAL FRAMEWORK OF SALUTOGENESIS

At the core of Aaron Antonovsky's Salutogenic model is the construct called Sense of Coherence (SOC), which determines an individual's capacity to respond to stress and maintain health. SOC is comprised of three interrelated components: Comprehensibility, Manageability, and Meaningfulness. These components interact to influence how a person perceives life events and mobilizes resources to handle them effectively.

1. Comprehensibility (Cognitive Component)

Comprehensibility refers to the extent to which an individual perceives internal and external stimuli as making logical sense. People with a high sense of comprehensibility see life events as ordered, consistent, and structured, rather than random or chaotic. This cognitive clarity enables individuals to anticipate future events and understand their surroundings with less anxiety. Example - A student facing exam pressure perceives it not as an overwhelming chaos, but as a predictable part of academic life, which can be managed with preparation and support.

2. Manageability (Behavioral Component)

Manageability is the extent to which individuals feel they have the resources at their disposal—whether personal strengths, social support, or institutional help—to meet the demands posed by stressors. It reflects confidence in one's ability to cope and the presence of external supports when internal resources are insufficient. Example- An employee dealing with a tight project deadline believes they can meet it due to their skills, supportive team, and access to necessary tools or guidance.

3. Meaningfulness (Motivational Component)

Meaningfulness is arguably the most critical of the three components. It pertains to the degree to which a person feels that life makes emotional sense and that its demands are worthy of commitment, involvement, and engagement. When individuals find purpose or personal significance in their experiences—even in adversity—they are more motivated to manage stress and overcome obstacles. Example - A caregiver tending to a terminally ill parent finds

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emotional purpose in the act of caregiving, which strengthens their resilience despite emotional and physical strain.

V. SALUTOGENESIS VS PATHOGENESIS:

Table 1: The Salutogenic and Pathogenic models represent two contrasting approaches to understanding health and disease:

Aspect	**Pathogenesis**	**Salutogenesis**
Focus	Origin and progression of disease	Origin and development of health
Core Question	"What causes illness?"	"What promotes health?"
Orientation	Problem-focused, deficit-based	Strength-based, resource-focused
Goal	Diagnosis and treatment of symptoms	Enhancement of well-being and resilience
Health View	Health is the absence of disease	Health is a dynamic continuum
Theoretical Basis	Biomedical model	Sense of Coherence (SOC) and Generalized Resistance Resources (GRRs)
Intervention Style	Clinical treatment, medication, symptom management	Empowerment, education, preventive care, life meaning
Application Settings	Hospitals, clinical psychiatry, pathology labs	Schools, workplaces, community health, preventive medicine

VI. INTERPRETATION AND IMPLICATIONS

1. The Pathogenic approach has been essential for identifying and treating disease. It is reactive and starts once symptoms appear.

2. The Salutogenic approach is proactive. It focuses on health promotion, resilience, and individuals' capacity to manage life stressors effectively—even in the presence of illness. In mental health, a pathogenic approach would focus on diagnosing and medicating depression. A salutogenic approach would also focus on enhancing coping skills, meaning-making, social support, and lifestyle changes to improve well-being—even during recovery.

VII. APPLICATIONS OF SALUTOGENESIS

1. **Clinical Psychology:** Salutogenesis is applied in therapeutic approaches such as positive psychology, solution-focused therapy, and resilience training.

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2. **Education:** Schools incorporate salutogenic principles to promote emotional intelligence and student well-being.

3. **Workplace Wellness:** Employers use SOC principles to reduce burnout, improve morale, and promote mental health.

4. **Public Health:** Salutogenesis informs health promotion strategies that focus on empowerment and well-being rather than just disease prevention.

VIII. LIMITATIONS AND CRITICISMS:

While the salutogenic model offers a valuable alternative to traditional disease-centered frameworks, it is not without limitations and criticisms. Understanding these challenges helps in applying the model more critically and effectively.

1. **Measurement Issues:** Measuring SOC relies heavily on self-report scales, which can be influenced by individual perception, cultural context, and response biases.

2. **Overemphasis on the Individual:** Critics argue that salutogenesis may place too much responsibility on the individual to cope or adapt, without adequately addressing societal issues like poverty, discrimination, and access to healthcare.

3. **Limited Clinical Use:** The model is often seen as too theoretical and broad, lacking specific clinical guidelines for implementation in diagnosis or treatment, especially in acute or severe psychiatric conditions.

4. **Empirical Challenges:** There is no single agreed-upon method for applying salutogenesis in practice, and interventions vary widely in design, scope, and results.

5. **Complexity of Application:** The effectiveness of salutogenic strategies often depends on context—such as culture, socioeconomic status, or environment—making universal application difficult.

IX. FUTURE DIRECTIONS

The salutogenic model, while promising, remains underutilized in many areas of psychology and health promotion. Future research and practice can expand its impact in the following ways:

1. **Longitudinal and Developmental Studies:** More longitudinal studies are needed to track how Sense of Coherence (SOC) develops and changes over a person's lifetime. Understanding critical life stages and experiences that influence SOC will help design better interventions for mental resilience.

2. **Integration with Digital Health:** With the rise of telehealth, AI, and mobile apps, there is a strong opportunity to integrate salutogenic principles into digital mental health tools. Apps that track emotional well-being, promote meaning-making, or offer positive coping strategies could enhance accessibility and engagement.

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3. **Cross-Cultural Research:** Future studies should focus on how cultural, linguistic, and societal factors influence SOC. This will help develop culturally sensitive tools and frameworks that maintain the core values of salutogenesis while respecting local contexts.

4. **Application in Policy and Systems:** There is potential for salutogenesis to inform public health policy, particularly in education, work-life balance, urban design, and community development. Policymakers can use the model to shift from reactive to preventive health strategies.

5. **Training and Education:** Expanding curricula in psychology, nursing, social work, and education to include salutogenic principles can empower future professionals to adopt a more holistic approach to health and well-being.

6. **Targeted Interventions for Vulnerable Groups:** Special focus should be given to developing salutogenic interventions for marginalized populations, such as refugees, the elderly, and individuals in low-resource settings, where stress is chronic and support may be limited.

X. INTERDISCIPLINARY COLLABORATION

Collaborations across fields—such as psychology, sociology, neuroscience, and public health—will enrich the evidence base and support the development of integrated models that better reflect the complex nature of human well-being.

XI. CONCLUSION

Salutogenesis represents a powerful and optimistic model of mental strength, emphasizing resilience, coherence, and positive adaptation. In a world increasingly burdened by stress, anxiety, and mental disorders, the salutogenic approach provides a hopeful framework for understanding and enhancing mental health.

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THE EFFECT OF DIGITIZATION ON DEPRESSION: A PSYCHOLOGICAL STUDY OF JAMSHEDPUR TOWN IN JHARKHAND

Abstract

Renovating analog evidence, processes, and services into digital formats that can be retrieved, saved, processed, and distributed electronically is known as digitization. Depression is a state of mental illness. It is characterised in cavernous, long lasting state of mind of dejection or despair. The objective of this study is to know the effect of digitalization on depression among college students. Subjects were selected on Stratified Random Sample techniques. The data were collected with the help of PDQ and Back Depression Inventory (BDI)**.** In this study it was found that Maximum sample had mild and moderate level of depression and digitalization had significant impact on depression**.**

Keywords: Digitalization, Depression, students.

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I. INTRODUCTION

Revamping analog substantiation, processes, and services into digital formats that can be recaptured, saved, reused, and distributed electronically is known as digitization. The way people, companies, and associations operate has changed as a result of this marvels, opening doors for increased productivity, availability, and creativity. Unnaturally, digitization is the operation of technology to optimize processes, easing smooth communication and data exchange between platforms and regions. Digitization has come essential to ultramodern life, from pall storehouse and motorized documents to sophisticated artificial intelligence operations.

Digitization has evolved across a number of fields and disciplines. Telehealth services and digital medical records have enhanced patient issues and availability in the healthcare assiduity. Digital coffers ande-learning platforms have normalized information in education, reaching indeed the most remote and distant places. In a analogous tone, businesses have espoused digital tools to ameliorate effectiveness and grease remote cooperation. But digitization has also brought about new challenges in addition to these advancements. Reduced interpersonal connections, cybersecurity pitfalls, and information load are some of the problems that can arise from anover-reliance on digital platforms.

Depression is a state of internal illness. It's characterised in cavernous, long lasting state of mind of dejection or despair. Depression can change an existent's thinking and also affects his/ her social geste and sense of physical well- being. It can affect people of any age group, including youthful children and teens. It can run in families and generally starts between the periods of 15 and 30 times. Women and senior people are more generally affected than men. There are several types of depression similar as major depression it's a change in mood that lasts for weeks or months. It's one of the most severe types of depression. Dysthymia(habitual depression) is a less severe form of depression but generally lasts for several times. Psychotic depression a severe form of depression associated with visions and visions(passions that are untrue or unsubstantiated). Seasonal depression, occuring only at certain time of the time generally downtime, also known as ' downtime blues'.

II. CAUSES

Depression is allowed to be caused by an imbalance of certain brain chemicals called ' neurotransmitters' that carries signals in brain which the body uses to control mood. Some of the common factors that may beget depression are genetics(heritable), trauma and high situations of stress, internal ails similar as schizophrenia and substance abuse, postpartum depression(women may develop depression after the birth of the baby), serious medical conditions similar as heart complaint, cancer and HIV, use of certain specifics, alcohol and medicine abuse, individualities with low tone- regard, trauma and high situations of stress due to fiscal problems, bifurcation of a relationship or loss of a loved one.

III. SIGNS AND SYMPTOMS

The signs and symptoms of depression include feeling of sadness and loneliness, loss of interest in conditioning formerly set up pleasurable, feeling of forlornness, worthlessness or inordinate guilt, fatigue or loss of energy, sleeping too little or too much, loss of appetite, restlessness and being fluently irked.

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Opinion: The croaker may diagnose depression grounded on the detailed history and sign and symptoms of the existent. numerous a times the existent is asked a series of questions to help screen/ check for depression symptoms. Specific examinations include physical examination of the individual similar as height and weight dimension. Examination of the vital signs similar as blood pressure, heart rate and temperature. Laboratory tests similar as blood tests to screen for alcohol/ medicines in blood. Cerebral evaluation of the existent's studies, passions and geste patterns.

IV. REVIEW OF LITERATURE

Kaihlanen et al. BMC Health Services Research (2022) conduct a research and found that the impact of the COVID-19 pandemic on digital health equity, the study focuses on vulnerable groups and their challenges in accessing digital health services. It identifies obstacles like technology access and low e-Health literacy, proposing recommendations for enhancing digital health equity. Qualitative analysis highlights the importance of user-friendly platforms and improving e-Health literacy to create a more inclusive digital health ecosystem.

R.R. Bond et al. (2023) found digital interventions in mental health services, the review underscores their potential benefits and challenges. Mobile apps and virtual reality offer promising avenues for improving psychological wellbeing and expanding access to support. Human-centered design principles and stakeholder involvement are critical for their success. Ethical considerations and quality assurance must be addressed to optimize digital interventions, which complement traditional mental health services by offering personalized support.

Yashita Ahluwalia, Yatan Pal Singh Balhara (2024) conduct a research for Ensuring Mental Well-being in the Digital World: Challenges and Approaches. This study investigates that the digital world, acting as a dual-force catalyst, has fundamentally reshaped the landscape of mental healthcare, presenting a spectrum of unparalleled opportunities and significant challenges. On one end of the spectrum, it unfolds unprecedented opportunities for accessing psychological resources, support, and innovative interventions that were once inaccessible or limited. This digital transformation has revolutionized the way practitioners and scholars perceive, approach, and address mental health challenges. Through the integration of digital technologies and the e-health domain in the mental health sphere, new possibilities have emerged to enhance mental health services, spanning from internet-based interventions to smartphone applications tailored to address the prevention, treatment, and aftercare of mental health problems.

V. RESEARCH METHODOLOGY

1. Objectives of the Study

The main objectives of the present study are:

- To measure the prevalence of depression.
- To examine the effect of digitalization on depression.

2. Research Questions

The main Research Questions of the present study are:

- What will be the prevalence of depression.

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- What will be the effect of digitalization on depression.

Sample: To determine the effect of the digitization on depression, a survey was conduct from the randomly selected college students who use different digital gadgets. A sample consist of 100 (**digital gadgets users=50 and digital gadgets non users=50**) participants from Jamshedpur town in Jharkhand. Sample was selected by Random Sampling technique method. Survey method of research was employed to study the effects of digitization on the depression.

Personal Information Tools: Keeping in view the main objective of the present research, a personal information sheet will be filled by the college students in which things like Name, Age, Education, types of gadgets use, Gender etc. will be included.

Back Depression Inventory: To measure depression, participants completed Back Depression Inventory (BDI), Beck et al. It is the most commonly used psychometric test intended to assess the presence and severity of depression. The inventory comprises series of questions (21) developed to measure the intensity, severity and depression.

Scoring: Each answer is scored on a scale value of 0 to 3. The scores on different items (expect items 20 and 21) corresponding to symptoms of depression is summed to give a single total score for the total items. Items 20 and 21 are not part of the total scale score. They are provided to help gather additional clinical information for the therapist. The manual contains general cut that cut-- off guidelines, although the authors recommend off scores should be based upon clinical decisions [total score 0 to 13 is considered minimal range, 14 to 19 is mild, 20 to 28 is moderate and 29 to 63 is severe (scores range from 0 to 63).

VI. STATISTICAL ANALYSIS

1. Graphical representation done where ever needed.
2. Analysis done by using SPSS.

- **Analysis and Result**
  Levels of depression among digital gadgets users and digital gadgets non users

The levels of depression among digital gadgets users and digital gadgets non users has been presented on Table-1.

Table 1: Levels of depression in total sample

Group	Low		Mild		Moderate		High	
	N	%	N	%	N	%	N	%
Total Sample (N=100)	8	8	35	35	45	45	12	12

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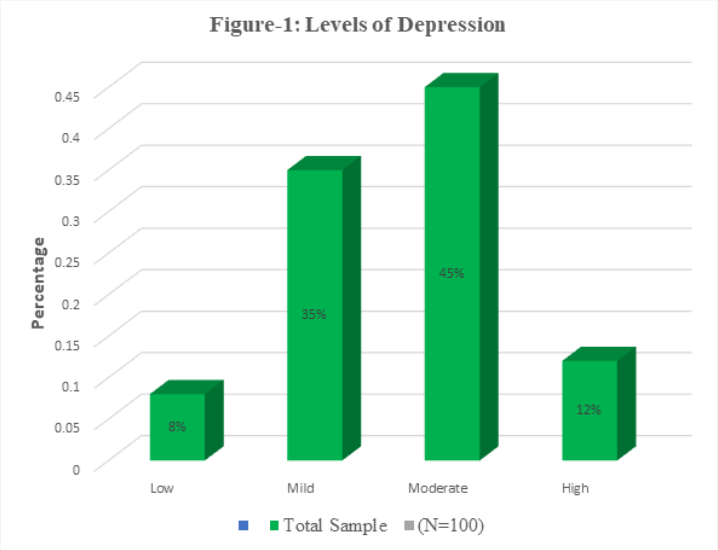

Figure 1: Levels Of Depression

Maximum samples ranged between mild and moderate level of depression. Few samples found in high and low level of depression.

- **Effect of digitalization on depression**
  The sample of the present study was selected from **digital gadgets users and digital gadgets non users of Jamshedpur town in Jharkhand**. The mean scores, SD and t-values are presented in Table-2.

Table 2: Mean Scores, S.D. and t values showing the Impact of digitalization on depression

Group	N	Mean	SD	t value
Digital gadgets users	50	21.27	6.89	5.74
Digital gadgets non users	50	16.79	6.83	

The mean score of **digital gadgets users was 21.27 and the mean score of digital gadgets non users** was 16.79. The t-value was 5.74, which was statistically significant at 0.01 level. This indicated that digitalization had significant impact on depression.

VII. CONCLUSION

- Maximum sample had mild and moderate level of depression.
- Digitalization had significant impact on depression.

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PART-2

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PSYCHOTHERAPY USING TAGORE'S PUJA PARJAYA SONGS

Abstract

This article discusses the foundations of devotional expression in Tagore's music and the historical context of Tagore's songs, especially his *Puja Parjaya* works. It is important to appreciate the psychological influence of Tagore, including areas in spiritual aesthetics. To understand the psyche of Tagore and the devotional foundation of his songs it is essential to delve deeper into his handling of themes of death, grief, and transcendence, a lot of which came from his personal experience of grief. Finally, the author being a psychotherapist, finds a lot of scope for research areas in including Tagore's songs, psychotherapeutically and suggests some specific areas in this direction. Rabindra Psychotherapy can also be a bridge between Western and Eastern Psychotherapy and the various facets of his songs can be tailor made to address individual psychotherapeutic needs.

Keywords: Grief; Puja Parjaya; Psychotherapy;Transcendence

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I. INTRODUCTION

There is a growing felt need to prepare a model of psychotherapeutic application of Tagore's poetry, particularly in the themes of handling psychological and transcendental issues, including death, grief, surrender, and other profound areas. These, would be very effective amongst people who appreciate and understand Tagore's songs and poetry. Rabindranath Tagore's work, particularly the devotional corpus of *Puja Parjaya* songs and the poems of *Gitanjali*, offers one of the most soulful, nuanced, and spiritually rich pathways for working with grief, loss, mourning, and existential suffering. Rabindranath Tagore's devotional songs form the spiritual core of Rabindra Sangeet, representing a refined synthesis of *bhakti,* philosophical introspection, and aesthetic universalism.

Unlike classical religious songs limited to ritual contexts, Tagore's devotional works express personal surrender, inner awakening, and humanistic spirituality. The devotional foundation of Tagore's *Puja* songs rests on the historical roots in Brahmo Samaj and Indian Renaissance spirituality. Tagore's aesthetic vision was founded on principles where beauty equaled spirituality, and thus one can notice a synthesis of Vedic introspection and *Vaishnava Padavali* emotionalism, yet transcending both through an emphasis on universal humanism. The musical structures seamless blend classical *raag-taal* with lyrical freedom.

Tagore grew up during the Bengal renaissance, a period marked by reform movements (Brahmo Samaj and Ramakrishna-Vivekananda). There was a decline in religious orthodoxy and a consequent rise in introspective, universal spirituality. This context shaped Tagore's non-ritual, inward-looking devotional outlook. This period also covers the influence of Brahmo Samaj, with its rejection of idol worship and emphasis on inner prayer (*antar-yajna*). The devotion was expressed through music, meditation, and moral upliftment. But, the most important facet in this period was Tagore's personal spiritual evolution, and his devotional expression evolved through early mystical influence from the Upanishads, nature spirituality in Shantiniketan, and humanistic spirituality during the later years (*Gitanjali* Period). Tagore was the primary composer of his around 2,200 songs, drawing primarily from Indian classical *raag*s, *Baul* tunes, and western influences. He integrated elements from Scottish, Irish, and English songs and his brother Jyotirindranath Tagore and Indira Devi Chaudhurani were notable amongst the composers. His work is characterized by deep individuality, blending Eastern and Western influences. Tagore drew inspiration from diverse musical cultures. There is extensive use of *Baul* and folk melodies from Bengal, *dhrupad-dhamar ang* for solemnity, western diatonic scales for harmonic colour. There were even Punjabi, Sufi, or Karnatic influences in some of his compositions. However, Rabindra Sangeet is not fusion music; it is synthesis, integration, and transformation. Tagore believed music must serve the word (*sabda*) and the emotion; hence, the *raag-taal* elements operate in harmony with the poetic intention.

Tagore's spirituality is non-dogmatic, experiential, universal, and deeply aesthetic. His devotional songs embody certain principles, like devotion as an inner dialogue where God is treated as a beloved or an inner guide and is the source of all creativity. There is also a remarkable union of beauty and spirituality, as he believed that the aesthetic experience is itself spiritual. His music uses nature imagery, evokes emotional states (longing, surrender, fulfillment), and unites *rasa* with Brahma consciousness.

Spiritual aesthetics is also emphasized in the recurring themes which range from surrender or *sharanagati, viraha* or longing, divine grace, inner waking, freedom from the ego, and the

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presence of divine immanence in nature which is evident as a form of emotional aesthetics (*Bhava-rasa).* His songs predominantly carry *Shanta rasa* (peace), *Bhakti rasa* (devotion), *Karuna rasa* (compassion), and *Adbhuta rasa* (wonder).

Tagore echoes the Upanishads more than the Rigveda. Also, Tagore absorbed the emotive richness of *Padavali* but transformed it into universal spirituality, avoiding mythological dependency. In terms of similarity, both focus on the formless devotion (*Nirguna nirakar Brahman*) and use nature as a divine manifestation and both use poetic and metaphysical language and highlight spiritual knowledge over ritualism. Tagore is philosophically aligned with Vedic spirituality but aesthetically distinct.

Tagore's *Puja Parjaya* is not merely another devotional genre; it is a new mode of spirituality emerging in modern India. The chief characteristics are that it is non-sectarian, yet deeply spiritual, as Tagore transcends religious boundaries, presenting devotion as a universal human disposition. There is a fusion of philosophical depth and lyrical simplicity as Tagore integrates Vedantic insights with accessible musical forms. There is also emphasis on inner transformation, as the treatment of devotion is linked to personal growth, ethical awakening, and creative liberation. With respect to aesthetic and emotional refinement, there is an interplay of music, poetry, and emotion that forms a unique spiritual atmosphere. Finally, it is a living devotional tradition, as Rabindra Sangeet continues to be sung in schools, ceremonies, concerts, and also in daily life, not as a ritual but as a personal expression of spiritual yearning. The treatment of devotion in Tagore was not sectarian. It is directed towards a formless, immanent divine. Bhakti appears as a direct, intimate dialogue with the divine and a spiritual longing for transformation. The surrender is to the moral forces within, rather than to a deity.

Humanism becomes central after Tagore's experiences in Shantiniketan and his extensive experience throughout the world. The divine to Tagore is reflected everywhere – in the human community, amidst the poor and the suffering, and amongst those striving towards harmony and freedom. Tagore was humane also in areas covering ethical responsibilities of the individual. The final two decades of Rabindranath Tagore's life represent an extraordinary flowering of musical spirituality. While his earlier devotional songs were rooted in *Brahmo* worship, *Vaishnava* lyricism, and an intimate emotional relationship with the divine, the late period shows a profound inward shift. Here, song becomes an instrument of silence, transcendence, and realization—a quiet contemplation of existence rather than an emotional appeal to God. The voice becomes less of a singer's expression and more of a soul's whisper. Tagore's late devotional songs often contain an atmosphere of minimalist spiritual awareness—not the emotional turbulence of longing, but a state of quiet, radiant acceptance. God is no longer approached through desire or supplication; instead, the divine is encountered as an everyday presence within quietude itself. Thus, the songs move from prayer to pure being. The treatment of silence as a spiritual state is noteworthy. Tagore moves from Brahmo formalism toward a universal, almost mystical spirituality. Songs become meditative reflections on consciousness, mortality, the soul's union with infinity, and the beauty of impermanence.

The most defining quality of late-period *Puja Parjaya* is divine solitude—a spiritual state where the soul encounters the infinite not through emotion but through silence. Solitude is treated as the highest form of spirituality. These songs reflect the Upanishadic idea that the divine is found in stillness, inner quietness, and the solitude of dawn and dusk with the final surrender of the ego. Tagore's solitude is not sadness—it is radiant emptiness. In the final

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years, Tagore experienced declining vitality, contemplation of impermanence, and the exhaustion of worldly engagements, which infused his music with a profound tranquility.

II. EFFICACY OF RABINDRA PSYCHOTHERAPY

The efficacy of using Rabindra Sangeet as a therapy is more because it uses simple, emotionally resonant melodies where the lyrics balance emotion and philosophy, that is ideal for meaning-making. The *raag*s selected by Tagore often mirror psychological states, and the songs evoke safety, containment, and gentle catharsis. They have a universal appeal and can be used across traditions, faith backgrounds, and psychological profiles. They are emotionally validating, spiritually non-coercive, intellectually rich, musically regulating, psychologically integrative, trauma-sensitive, and compatible with modern grief therapy. Tagore transforms grief into a form of inner music, which becomes therapeutic.

Grief is a universal experience that reveals the depth of human longing. For Tagore, sorrow is not an obstacle but a gateway to spiritual awakening. Pain is transformed through beauty, surrender, prayerful, and lyric illumination. His later works emphasize acceptance, transcendence, and inner silence. He turns it into a pathway towards self-transcendence, surrender, relational spirituality—a dialogue between human and divine, creative sublimation where pain is transformed into music, poetry, and insight, and inner expansion.

His music blends devotion, intimacy, surrender, inner illumination, and acceptance, making it uniquely suited for therapeutic use. Rabindra Sangeet is not merely sung; it is experienced. *Puja Parjaya* requires inner alignment, not just vocal skill. Emotional states shape musical interpretation. Psychotherapy using Tagore's songs involves the development of core skills involving *Sur-laya-tala* alignment, Bengali poetic diction, emotional phrasing (*bhava*), breath control for therapy, and counselling presence.

For the purpose of psychotherapy songs need to be mapped to specific therapeutic goals. The choice of songs could be grouped under categories such as cultural relevance, language and comprehension, use of imagery and symbolism, and the use of tempo and rhythm. As each individual is unique, there could be a therapeutically impact on the selection criteria of the songs which could impact various areas. We have seen that while the early Tagore songs are cathartic and expressive, the mature ones are dialogic and humanistic, and the late Tagore songs are deeply contemplative and silence oriented. Slow-moderate tempo songs with limited ornamentation can be very effective in clinical use. Lyrics can be carefully chosen, which supports safety, and the language should be conducive to the client's understanding. Although Tagore's songs have cross-cultural humanistic appeal, the individual context and the immediate perceptive analysis of the client's condition should be borne in mind. Finally, the therapeutic goal should have a cross-matching fit**.**

1. Tagore's Songs and Psychotherapeutic Healing

The careful choice of songs can be aimed at the transformation of the individual by a transition from clinging or attachment to surrender, isolation to belonging, meaninglessness to transcendence, and ego-bound entity to universal self. They are unique because of the following psychotherapeutic benefits:

- **Emotion Regulation:** Slow melodic structures, contemplative lyrics, and devotional grounding help soothe the nervous system, reduce grief-induced agitation, and allow safe expression of sorrow.

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- **Meaning Reconstruction:** Songs reinterpret loss as a journey. Offering, awakening, and a dialogue with eternity. This parallels meaning-centred grief therapy.
- **Cognitive Re-framing:** Death becomes not annihilation but completion, not punishment but return, not tragedy but a cosmic continuity.
- **Attachment Repair:** The Divine companion offers safe attachment, unconditional presence, and comfort for orphaned feelings. All these apply to inner-child work in grief therapy.
- **Creativity and Expressive Therapy:** Writing, singing, or interpreting Tagore allows catharsis, symbolic transformation, and integration of fragmented emotions. This can also be expressed through the use of dance and movement which can be applied therapeutically as it affects one's psycho-biological state.

Spiritual well-being: Promotes overall spiritual health and existential integration.

2. Psychotherapeutic techniques derived from Tagore's grief perspective

Certain of the following psychotherapeutic techniques can be very effective if they are tailor made to suit individual goals and needs.

- **Guided Song Listening:** Select early/mature Puja songs matching emotional state (for e.g., Bhairavi for catharsis, Pilu for intimate reflection). The therapist leads slow, reflective listening with attention to body sensations, emotions, and imagery.
- **Vocal Participation:** Call-and-response or humming of refrains encourages active emotional engagement. Breath synchronization with musical phrases promotes autonomic regulation.
- **Lyric-Based Narrative Work:** Clients reflect on or rewrite lyrics to personalize grief narratives. For example, replacing divine references with deceased loved ones can facilitate dialogue.
- **Imagery and Visualization:** Songs act as scaffolds for visualizing lost individuals or inner light. Late-period songs facilitate transcendent imagery, promoting acceptance and is very effective in hypnotherapy application.
- **Ritual and Symbolic Action:** Candle lighting, simple gestures, or offering elements during singing reinforce symbolic integration of grief.

3. Contraindications & Cautions

However, like any psychotherapy, psychotherapy using Tagore's songs would requires close clinical supervision, especially in cases where people suffer from active psychosis, mania, or uncontrolled dissociation. In some cases, evocative group singing can trigger decompensation. For people suffering from past trauma, the use of slow pacing and grounding can be very effective. Religious sensitiveness should be ensured by offering secularized adaptations, wherever appropriate.

In terms of cultural and ethical consideration, informed consent may be obtained prior to application for devotional materials, and client autonomy should be ensured. Wherever required, interdisciplinary coordination with psychiatrists and psychologists must be sought.

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III. POSSIBLE RESEARCH AREAS

There is strong philosophical, cultural, and preliminary empirical support for using Rabindranath Tagore's *Puja Parjaya* songs in psychotherapy. Several studies (Jadavpur University, NIMHANS collaborations, Vishwa-Bharati, and independent researchers) report reduced anxiety after Rabindra Sangeet listening, improved emotional clarity in adolescents, enhanced well-being in elderly populations, increased resilience and meaning-making, effective in depressive symptoms when combined with counselling. However, rigorous research, controlled trials, and standardized protocols are needed, and there are significant research gaps, as there is no standardized protocol, and no song-by-song classification yet. There is limited work on grief contexts and no integration with existential psychotherapy. This forms the justification for the proposed research.

In light of the above, there could be the following specific academic areas that can be applied in psychotherapeutic practices:

1. Tagore's devotional mode, or Bhakti, as an experiential therapy

This would cover areas like the impact of emotional disclosure (self-revelation), the divine as a safe-attachment figure, transcendence of ego-defence, humility and ego-relaxation, trust and emotional regulation, catharsis through surrender (using *Bhakti* as a therapy), and integration of grief and loss. Thus, *Bhakti* can serve as a mode of inner healing and a psychologically functional system in Tagore**.** Specific mechanisms through the application of rhythmic regulation through *raag* and *taal* structures that en-train breathing, soothe and actually downgrade the autonomous nervous system, and induce a trance meditative state. The lyrics can help repair shame and guilt and moving beyond self-blame. Specific study areas could be on *Vaishnava padavali* or the influence of *Baul* music.

2. Gitanjali as a psycho-therapeutic pilgrimage towards psychological wellness

Tagore's *Puja Parjaya* songs and *Gitanjali* form a psycho-spiritual therapeutic system, blending elements of emotional catharsis, reflective awareness, mindful singing, existential meaning-making, secure attachment, and treatment of compassion and surrender. The stages could cover the following: bewilderment of initial shock of pain followed by recognition of suffering, dialogue with the inner guide, and a deepening of self-enquiry. It is then followed by a breakthrough with a total surrender to the divine, culminating into integration and, acceptance. In this connection one could study the neuropsychobiological impact of therapy using Tagore's songs. Tagore moves beyond suppression, and he encourages naming sadness, crying, tenderness, accepting human limitation, and surrender of excessive control. Thus, slow melodic contours, sustained vowels, and simple rhythmic patterns in many *Puja* songs support parasympathetic activation.

3. Music therapy dimensions through the possible application of raags

The application of raags can be very therapeutic. Some of them can include the following: *Bhairav* (grounding, solemnity), *Bhairavi* (emotional release, tenderness), *Khamaj* (reassurance, warmth), *Piloo* (intimacy, vulnerability), B*himpalasi* (compassion, grief release), etc. The use of repetitive melodic contours has a definitive therapeutic neuro-biological impact, and the use of voice (tone, timbre, etc.) works as a therapeutic construct. Tagore's songs seem to focus on vocalization that emerges from the heart with focus on

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therapeutic impact areas such as breath regulation, autonomic calming, and emotional authenticity.

4. Comparative study of Rabindra psychotherapy vs. existing psychotherapies

While modern psychology rejects the idea that healthy grief requires detachment, Tagore's view was to continue grief in an altered form. Clients are encouraged to speak TO the lost one and not just ABOUT them. By comparing Tagore's approach with Eastern (*Vedanta, Buddhist, Bhakti,* and *Yogic* psychology) and Western (Freud, Jung, existentialist and humanistic) psychotherapeutic frameworks, we find that Tagore can certainly occupy a bridging space, synthesizing personal sorrow, philosophical acceptance, aesthetic expression, and spiritual transformation. This integration offers a powerful lens for therapeutic work today—including grief therapy, existential counselling, spiritually oriented psychotherapy, and others.

- **Advaita Vedanta:** Tagore draws deeply from Advaita Vedanta, which views death not as an annihilation but as a transition of the individual self into universal consciousness, dissolution of the ego-bound identity, and realization of the eternal Self (*atman).*
- **Buddhist psychotherapy**: Tagore absorbed Buddhist notions of impermanence, interdependence, and compassion for suffering beings. Songs such as *"Baje Baje Tomār Baje"* and *"Jiban Maraner Simanā Chhere"* reflect death as a gateway to compassion and grief as a universal condition. There is also a release of clinging.
- **Brahmo-Bhakti psychology:** Tagore's songs reflect this area, where grief is an intimate dialogue with the divine, pain is not rejected but offered, and where death is a moment of union (*yoga*). Songs like *"Ohe Dayamoy*," *"Prano Bhoriye Trisha Horiye*," and *"Tomar Khola Hawa"* demonstrate that vulnerability can become prayer, loss can become surrender and fear can turn into faith. Tagore references yogic inner states—stillness, expansion, and subtle perception. Death becomes a stilling of the restless waves of mind (*citta-vṛtti-nirodha*). It is a movement beyond fear (*Abhaya*) and a deepening of *praṇa*-based awareness.
- **Mindfulness and Contemplative Practice:** The late-period *Puja* songs emphasize silence, breath, and attention to the present moment, akin to mindfulness practices. Therapeutically, guided listening or slow chanting of songs like *"Tumi Robe Nirobe"* fosters interoceptive awareness and self-soothing.
- **Positive Psychology**: The use of music as mindfulness therapy (slow, repetitive *raag*-based singing improves emotional regulation and cognitive narrative re-framing (certain lyrics can guide users to reinterpret suffering in a positive framework), element of self-transcendence, grief integration, and cultivation of inner resilience.
- **Psychoanalytic Psychotherapy: Freud and Jung:** Grief is not merely intra-psychic—it is transpersonal and spiritual. Sublimation is not repression—it is transformation. Tagore is profoundly Jungian in spirit, where death is a threshold archetype (the "Shadow of the Self"), and the divine companion (Gitanjali) is the Self archetype, and dreams of union resemble individuation.
- **Existential psychotherapy**: Comparisons between Tagore and existentialists (Frankl, Kierkegaard, Heidegger, Yalom) indicate shared concerns like the search for meaning, confrontation with death, authenticity, human loneliness, and transcendence beyond fear. Tagore's songs help clients tolerate uncertainty, impermanence, mortality and the unknown.

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- **Narrative Therapy:** Narrative therapy frames clients' experiences as evolving stories, enabling meaning reconstruction. Tagore's song's structure grief as a story that moves from suffering to dialogue and surrender to integration. Thus, *"Amar Mukti Aloy Aloy"* exemplifies reframing suffering into illumination and insight.
- **Expressive Arts Therapy:** Tagore's integration of grief into musical and poetic expression aligns with arts-based therapies where vocalization, *raag* modulations, and rhythmic patterns regulate autonomic arousal; metaphors of light, offering, and surrender support symbolic processing influence poetic theology; and the minimal movement art choreography reinforces embodiment of grief and release.
- **Transpersonal and Existential Therapy:** Tagore's later works, emphasizing transcendence and the dissolution of the ego into universal consciousness, correspond with transpersonal approaches. Clients facing existential distress or terminal illness can benefit from Tagore-inspired reflective and musical practices, enhancing acceptance and meaning-making.
- **Grief psychotherapy:** Finally, the most effective area of psychotherapeutic application is in the areas of grief, bereavement and transcendence. The interesting subtopics could be grief as an experience of love, mourning as a dialogue with the divine, death as an aid in transformation, and the use of sorrow as a creative force. This topic could also be studied in terms of the three periods also. In this direction, model grief models of Kubler-Ross (stages of grief), Worden (tasks of grief) and Stroebe & Schut (dual process model), Klass (continuing bonds) or Neimeyer (meaning reconstruction) can be studied in relation to relevance with Tagore's treatment. Tagore's devotional songs easily align with these frameworks, enabling a uniquely trans-cultural therapy model. The different stages of grief can be mapped as under:

Grief Stage	**Song**	**Function**
Shock/Denial	*"Klanti amar khama koro"*	Containment, safety
Yearning	*"Tumi rabe nirabe"*	Attachment processing
Anger	*"Bipode more raksha koro"*	Catharsis within devotion
Meaning reconstruction	*"Jodi tor dak shune keu na ashe"*	Identity & agency
Acceptance	*"Maran re tuhu mama"*	Mortality acceptance

IV. REVIEW OF LITERATURE

The first work, a doctoral dissertation by Mahua Chakraborty (2018), covers extensive treatment of the concept of grief and death in the writings of Tagore. The author collates information about the influence of the death of people around Tagore and how grief and death have shaped his philosophy and outlook on life. It is very important to understand the psyche of Tagore before attempting to delve into his works, and in this regard the following books can contribute immensely.

Gitabitan by Sanjida Khatun (2018) covers in-depth analysis of 100 songs of Tagore, covering philosophical, literal, and spiritual context elements. It focuses on detailed facts like information about notations, date and time of composition, different versions of the songs, and publication details, as well as information about *raag, taal*, composer, etc. *Arupbina* by Arunabha Lahiri (2024) is another such book covering all the details, including annotation,

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history, and philosophy pertaining to the entire gamut of *Puja Parjaya* songs (617). This would be a handy book for all *Puja parjaya* song lovers. *Gitabitan er Sahaj path* (*Puja Parjaya*). Vol. 1 by Debasish Bhowmick is a detailed and scholarly disposition of a psychological evaluation of the first 300 songs by Tagore. The second volume, expected around June 2026, would cover the remaining 317 songs.

Thakur Barir Bhasacharcha by Debasish Bhowmick (2022) would help readers understand Tagore, as a lot of effort has been provided to understand the shaping of the literary genius right from the time before his birth to the period covered beyond Tagore's life. *Ganer Pichoney Rabindranath* by Samir Sengupta (2007) is another gift in this direction, where the author attempts to study the psyche of Tagore behind each of the compositions, collected from the writings and recordings of various people who were close to Tagore.

Gitabitaner Tathyabhandar by Purnendu Bikash Sarkar (2019) provides encyclopedic information in a tabular form about the complete works of Tagore in Gitanjali. They cover areas like, the category and subcategory, the details of the various publications with place and time, and details of the composer along with the *raag*, first recording, etc. *Rabindra Ganer Antaraley* by Purnendu Bikash Sarkar (2023) is another insightful work that gives an additional delight, as the book gives one the experience of listening to different versions of songs as well as recitation of some without musical notations (*swaralipi*) by scanning QR codes.

One of the books that is a must for all Tagore's lovers is *Baiseshy Shravan* by Nirmal Kumari Majalonobis (2022), written from a very intimate and personal association with Tagore. This book helps to unearth a lot of information on Tagore's psychological background behind various works, often from a personalized interaction from close associates of Tagore and also from scholars and academicians. *Mrittyushokatur Rabindranath o tar antaratmar protikriya* by Subrata Halder, (2016) which appeared in a journal publication should be read alongside Mahua Chakraborty's detailed work where pangs of separation and transcendence of pain are reflected.

Rabindrasangeeter Tribani Sangam by Srimati Indira Devi Chaudhurani (1947) covers a list and details of Bhanga Gaan by Tagore by including where both apply Tagore's words in other's Tunes as well as applying Tagore's tunes to others' songs. The first category covers both originating from Bengali and non-Bengali languages, like Marathi, Gujarati, languages from Madras, and Mysore, and also from some Punjabi Sikh Bhajans. The collection also includes English and Scottish sources of song and Tagore's songs too. *Gitabitan: Kalanukromik Suchi* by Prabhat Kumar Mukhopadhyay (2003) is a wonderful reference work for people who have an academic interest in the evolution of Tagore's songs with time and provides different versions of songs.

Young Tagore: The Making of a Genius by Sudhir Kakar, a psychoanalyst,x` is a powerful exploration of the psyche behind the making of the creative genius of Tagore. Tagore's own works, *Bektitva (2010), Swarobitan (1909),* and *Religion of Man (2005)* should be amongst the collections of any Tagore lover. Another book that helps one to understand from a philosophical perspective is one by Radhakrishnan, S. (2005), titled *The Philosophy of Rabindranath Tagore.* Two books on music therapy by Basudev Majumdar help one to have a general understanding of the application of music as a therapeutic device. The first book is *A New Horizon of Music Therapy (2023),* and Sangeet *Chitkitsaya Rabindrasangeet* (2005) are also worth exploring. *Bani tobo dhay (2024)* in 3 volumes by Sunil Mallick is another work

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the delves into the depths of Tagore's songs which can be read along with the 2-volume book, *Sahsra Dharay Rabindrasangeet* by Alok Mitra published in the same year.

V. CONCLUSION

Tagore's *Puja Parjaya* corpus provides a profound resource for psychotherapy, especially in contexts of grief, death, bereavement, and existential crisis. Tagore's unique synthesis of pain and beauty, sorrow and surrender, mortality and transcendence resonate with both Eastern spiritual philosophies and modern therapeutic frameworks. Through structured therapeutic use—singing, reflection, narrative work, and existential dialogue—*Puja Parjaya* songs can help clients regulate emotion, express loss, reconstruct meaning, and move toward acceptance and spiritual-expansive healing. Its implications extend across counselling, expressive arts therapy, palliative care, spiritual psychology, and intercultural psychotherapy.

Rabindranath Tagore transforms grief not into resignation but into radiant awareness—a therapeutic possibility of great relevance in today's world. Tagore's understanding of death and grief synthesizes Eastern acceptance with Western introspection and personal vulnerability with cosmic belonging. His *Puja Parjaya songs* act as therapeutic containers—spaces where sorrow is dignified, transformed, and elevated into a higher realization.

For psychotherapy, they offer a multidimensional model: emotional (affect expression), cognitive (re- framing), somatic (breath, melody), relational (divine–human dialogue) and spiritual (self-transcendence). Thus, Tagore provides not merely literature or music, but a profound psychotherapeutic philosophy capable of guiding modern grief work.

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PSYCHOLOGICAL PROFILE OF FEMALE PRISONERS: MENTAL HEALTH AND REHABILITATION PERSPECTIVES

Abstract

Female inmates represent a notably vulnerable demographic within correctional facilities, displaying significantly elevated rates of mental health issues relative to male inmates and women in the general populace. The psychological profile of incarcerated women is influenced by a complex interaction of trauma exposure, socio-economic adversity, substance use, altered familial roles, and systemic injustices. A significant number of women enter jail with pre-existing mental health disorders, which are frequently exacerbated by the stressors of incarceration, such as separation from children, loss of autonomy, stigma, and restricted access to psychological care. This chapter employs a hybrid methodology, combining empirical research findings with conceptual analysis, to investigate the mental health status of female convicts and the psychological elements contributing to their criminal pathways. It also examines rehabilitation in custodial environments, highlighting the significance of gender-responsive, trauma-informed, and therapeutic methods customized to address women's distinct psychological requirements. This chapter emphasizes mental health difficulties, risk factors, and rehabilitative measures, advocating for compassionate and effective correctional policies that foster psychological wellbeing, rehabilitation, and successful reintegration of female convicts into society.

Keywords: Female inmates,Mental health, Psychological assessment,Trauma; Rehabilitation,Forensic psychology

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I. INTRODUCTION

The globally population of incarcerated women has risen consistently in recent decades, attracting academic and legislative focus on their unique psychological and mental health requirements. Despite women constituting a lesser fraction of the overall prison demographic relative to men, comprehensive studies reveal that female inmates encounter significantly elevated rates of mental health issues. These concerns are not only incidental to incarceration but are fundamentally entrenched in women's life experiences preceding their engagement with the criminal justice system. Research consistently indicates that female inmates display markedly elevated rates of depression, anxiety disorders, post-traumatic stress disorder (PTSD), substance use disorders, self-harm, and suicidal ideation relative to both male inmates and women in the general population [1,2]. Significantly, numerous psychological challenges precede incarceration, indicating that imprisonment frequently exacerbates pre-existing vulnerabilities rather than originating them independently. This pattern underscores the necessity of framing female misbehavior within a comprehensive psychosocial and developmental context.

A significant body of research highlights that women's trajectories toward criminality are often influenced by cumulative adversities, such as childhood abuse, intimate partner violence, poverty, social marginalization, and unstable family situations. In contrast to conventional criminological frameworks that prioritize rational decision-making or antisocial characteristics, gender-responsive studies highlight the important influence of victimization and trauma on women's psychological functioning and criminal conduct. These events lead to emotional dysregulation, compromised coping skills, diminished self-esteem, and dependence on maladaptive behaviors, including substance use. Incarceration inherently presents further psychological pressures on women. The deprivation of autonomy, institutional oversight, stigma, and separation from children and family can amplify emotional pain and worsen pre-existing mental health issues. The interruption of caring and maternity responsibilities is very distressing for many incarcerated women and is significantly linked to experiences of despair, anxiety, and guilt [4]. Correctional facilities, primarily structured for male criminals, frequently neglect to address their gender-specific psychological requirements.

From a correctional psychology standpoint, comprehending the psychological profile of female inmates is crucial for successful rehabilitation and reintegration. Traditional prison-based therapies often employ gender-neutral strategies that neglect the effects of trauma, relationship requirements, and caring obligations. Evidence indicates that these tactics may be insufficient or potentially detrimental for female offenders [5]. Conversely, gender-responsive and trauma-informed frameworks prioritize safety, empowerment, emotional regulation, and relational healing as fundamental elements of rehabilitation. This chapter employs a hybrid methodology, combining empirical research with conceptual analysis, to investigate the psychological profiles of female convicts, emphasizing mental health issues and rehabilitation requirements. This chapter examines the relationship among trauma, mental illness, and incarceration experiences, emphasizing the necessity of formulating humane, evidence-based, and gender-responsive rehabilitation techniques that enhance psychological wellness and diminish recidivism.

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II. THE PREVALENCE OF MENTAL HEALTH ISSUES AMONG FEMALE INMATES

Research repeatedly indicates that female inmates endure a disproportionately elevated prevalence of mental health issues relative to male inmates and women in the general populace. The incidence of psychiatric problems in detained women indicates both pre-existing vulnerability and the psychosocial effects of imprisonment. Extensive epidemiological research reveals that a significant majority of female inmates satisfy the criteria for at least one identifiable mental condition. Systematic evaluations indicate that the prevalence of mental illness in incarcerated women is markedly greater than in community samples and surpasses that of male convicts [1][2]. The principal conclusions from empirical research are stated below:

1. Mood disorders (Depression)

Major depressive illness is frequently diagnosed among female inmates. Research indicates prevalence rates significantly exceeding those observed in the overall female population. Depression in incarcerated women is frequently linked to emotions of hopelessness, remorse, loss of maternal responsibilities, and institutional pressures [3].

2. Anxiety disorders

Anxiety disorders, such as generalized anxiety disorder and panic disorder, are significantly common among female convicts. Chronic uncertainty, fear of victimization, familial isolation, and insufficient emotional support exacerbate enduring anxiety symptoms throughout incarceration. [3][4].

3. Post-Traumatic Stress Disorder (PTSD)

PTSD is notably common among female inmates due to significant histories of childhood abuse, sexual violence, and intimate partner violence. Studies reveal that the prevalence of PTSD among incarcerated women is significantly greater than in male convicts, underscoring the important influence of trauma on women's psychological profiles. [5][6]**.**

4. Substance use disorders and associated conditions

Substance abuse is prevalent among female inmates and often coexists with mood and trauma-related illnesses. Alcohol and substance consumption frequently serve as maladaptive strategies for alleviating emotional distress and trauma-related symptoms. Comorbidity substantially complicates diagnosis, treatment, and rehabilitation outcomes [7].

5. Self-injury and suicidal tendencies

Female inmates demonstrate significantly elevated rates of self-injury and suicide attempts in comparison to their male counterparts. Empirical research indicates that self-injurious conduct in incarcerated women is strongly associated with emotional dysregulation, unresolved trauma, depression, and insufficient access to mental health care [8].

Despite the high prevalence of psychiatric issues, many female inmates continue to receive inadequate or no treatment. Correctional systems often lack gender-sensitive mental health

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screening and intervention services, resulting in unmet psychological needs and declining mental health outcomes. [2][9]. These data collectively indicate that institutions house a significant population of women with complex and interconnected mental health conditions. The high prevalence of psychiatric disorders among female inmates underscores the essential need for trauma-informed, gender-responsive mental health treatment and rehabilitation initiatives within correctional institutions.

III. PSYCHOLOGICAL RISK FACTORS AND TRAUMATIC HISTORIES

The psychological profile of female prisoners is significantly influenced by a combination of psychological risk factors and histories of trauma that usually occur prior to jail. Research repeatedly indicates that women's trajectories toward criminality markedly differ from those of men, with victimization, relationship trauma, and social poverty serving as crucial factors. Women's criminal activity is frequently rooted in cycles of abuse, psychological suffering, and survival techniques, rather than being predominantly motivated by antisocial traits.

1. Childhood Maltreatment and Neglect

A prominent psychological risk factor among female inmates is exposure to childhood maltreatment and neglect. Empirical research demonstrates that a significant percentage of jailed women disclose experiences of physical, emotional, or sexual abuse during their formative years. Adverse childhood experiences hinder typical emotional and psychological development, resulting in challenges in emotional regulation, a compromised self-concept, and increased susceptibility to mental health issues in adulthood [1][2].
Early trauma is significantly correlated with the subsequent onset of depression, anxiety disorders, post-traumatic stress disorder (PTSD), and substance dependency. From a psychological standpoint, childhood trauma heightens stress sensitivity and diminishes adaptive coping abilities, thereby increasing the likelihood of maladaptive behaviors, including criminal actions.

2. Domestic Violence and Sexual Assault

Intimate partner violence and sexual victimization constitute significant risk factors in the lives of incarcerated women. Studies consistently indicate that numerous female inmates have participated in abusive relationships marked by compulsion, control, and recurrent violence. Such experiences frequently lead to persistent terror, conditioned helplessness, and trauma-associated symptoms including hypervigilance, emotional desensitization, and intrusive recollections [3].

Criminal activity often arises within abusive relationships, encompassing acts such as self-defense, partner coercion, or economic necessity. Psychological theories of trauma assert that sustained interpersonal violence diminishes autonomy and decision-making, heightening women's susceptibility to engagement with the criminal justice system.

3. Substance Dependence as a Dysfunctional Coping Mechanism

Substance use disorders are prevalent among female inmates and are often associated with exposure to trauma. A multitude of ladies indicate utilizing alcohol or drugs as maladaptive coping strategies to alleviate emotional distress, traumatic recollections, anxiety, and depressive symptoms. This pattern illustrates a self-medication phenomenon, wherein

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narcotics provide transient relief from psychological anguish but ultimately intensify mental health issues [4].

Substance dependence markedly elevates the probability of engaging in criminal behaviors, such as drug offenses, theft, and sex work. The simultaneous presence of trauma, mental illness, and substance dependence results in intricate clinical profiles necessitating comprehensive psychosocial interventions instead of punitive measures.

4. Socio-Economic Disadvantage and Social Marginalization

Socio-economic poverty serves as a significant psychological stressor for female inmates. Poverty, homelessness, inadequate education, unemployment, and insufficient social support systems heighten exposure to chronic stress and impede access to mental health care. These systemic inequities disproportionately impact women, especially those from underprivileged groups [5].

From a psychological perspective, prolonged socio-economic adversity fosters feelings of pessimism, diminished self-efficacy, and a perceived lack of control, which may elevate participation in survival-oriented criminal behavior. Social marginalization serves as both a direct and indirect risk factor for engagement in the criminal justice system.

5. Disrupted Familial and Caregiving Responsibilities

A significant number of incarcerated women serve as primary caregivers before their incarceration. Separation from children and family members is a significant psychological stressor, frequently linked to great guilt, anxiety, grief, and depressive symptoms. Research demonstrates that apprehensions regarding children's welfare are a primary source of mental turmoil for detained women [6].

The interruption of caregiving duties adversely impacts mental health during incarceration and hampers post-release adjustment and reintegration. Psychological theories of attachment emphasize that involuntary separation from dependents can intensify trauma symptoms and undermine emotional stability.

6. Psychological Mechanisms Leading to Criminal Behavior

The interplay of these psychological risk variables establishes unique gender-specific trajectories into criminal behavior. Trauma, substance dependence, relational abuse, and socio-economic poverty interact dynamically, resulting in cumulative psychological vulnerability. In contrast to conventional criminological models that concentrate on antisocial characteristics, these routes highlight survival, coping mechanisms, and adaptation to extended adversity [7].

Comprehending these trauma-informed pathways is crucial for formulating effective recovery strategies. Mitigating underlying psychological risk factors by trauma-informed and gender-responsive therapies is essential for decreasing recidivism and fostering enduring psychological rehabilitation in female inmates.

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IV. MENTAL HEALTH NEEDS OF FEMALE INMATES IN CORRECTIONAL SETTINGS

Female inmates have intricated and diverse mental health requirements that markedly differ from those of male inmates and women in the broader community. Studies repeatedly indicate that jailed women enter correctional facilities with significantly elevated rates of pre-existing mental health disorders, such as depression, anxiety disorders, post-traumatic stress disorder (PTSD), substance use disorders, and co-morbid conditions. The psychological ramifications of incarceration exacerbate these demands, rendering female inmates a notably susceptible demographic inside correctional systems.

A primary mental health requirement for female convicts is the prompt identification and ongoing psychological evaluation. A significant number of women are either undiagnosed or misdiagnosed owing to insufficient mental health evaluations at admission and inadequate subsequent assessments. Research demonstrates that signs of trauma, despair, and anxiety are frequently normalized or disregarded in prison settings, resulting in unaddressed psychological suffering and a decline in mental health over time (Fazel & Baillargeon, 2011; WHO, 2014). Thorough mental health evaluation upon entry, accompanied by regular reassessment, is crucial for recognizing changing psychological requirements during incarceration.

A crucial requirement is trauma-informed mental health care. A significant percentage of female inmates had backgrounds of physical abuse, sexual assault, marital violence, and childhood trauma. These experiences influence emotional regulation, interpersonal dynamics, and coping mechanisms. Conventional rehabilitative methods that depend on control, punishment, and strict discipline may unintentionally retraumatize women, intensifying PTSD symptoms and emotional turmoil. Trauma-informed methodologies that prioritize safety, trust, empowerment, and emotional support are essential for mitigating the psychological effects of prior victimization (Bloom, Owen, & Covington, 2003; Messina et al., 2007).

Access to evidence-based psychological interventions represents a fundamental mental health requirement. Female inmates necessitate organized therapeutic treatments, including cognitive-behavioral therapy (CBT), trauma-focused therapy, substance use treatment, and group-based psychosocial therapies. Research indicates that mental health services in prisons are frequently restricted, unreliable, or focused on crisis intervention rather than rehabilitation. The shortage of qualified mental health experts, overcrowding, and institutional priorities centered on security often impede women's access to continuous psychological therapy (Fazel et al., 2016). Rectifying these deficiencies is crucial for enhancing mental well-being and mitigating the risks of self-harm and suicide.

Female inmates exhibit significant need of emotional support, social connectivity, and maternal mental well-being. A significant number of incarcerated women are moms and major caretakers before their imprisonment. Separation from children is linked to significant grief, guilt, anxiety, and depressive symptoms. The lack of familial interaction and social support exacerbates psychological anguish. Mental health interventions that focus on maternal identity, parenting issues, and familial ties are essential for fostering emotional stability and facilitating rehabilitation (Covington, 2007).

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There is an increasing necessity for the continuity of mental health care during re-entry and reintegration. The shift from incarceration to community poses a significant risk for relapse, psychological decline, and recidivism. In the absence of structured aftercare, numerous women forfeit access to mental health assistance upon discharge. Research underscores the need of cohesive correctional and community mental health systems that guarantee continuity of care, medication management, and psychosocial support throughout reintegration (WHO, 2014). The mental health requirements of female prisoners surpass mere symptom care and necessitate comprehensive, gender-responsive, and trauma-informed strategies inside correctional environments. Meeting these needs is crucial for safeguarding psychological welfare while incarceration, as well as for enabling rehabilitation, decreasing recidivism, and fostering effective reintegration into society.

V. REHABILITATION AND THERAPEUTIC INTERVENTIONS

The rehabilitation of female inmates necessitates a holistic, gender-sensitive, and trauma-informed strategy that caters to the intricate psychological, emotional, and social requirements of incarcerated women. In contrast to conventional correctional programs that prioritize punishment and behavioral management, effective rehabilitation for female inmates centers on addressing psychological trauma, refining emotional regulation, and augmenting coping abilities to facilitate long-term societal reintegration. Research consistently indicates that therapy approaches designed for women's lived experiences produce superior mental health results and diminish recidivism rates.

1. Trauma-Informed Care

Trauma-informed care serves as a fundamental framework for the rehabilitation of female inmates, considering the significant incidence of childhood trauma, sexual victimization, and intimate relationship violence in their backgrounds. This methodology acknowledges the widespread influence of trauma on mental health and behavior, prioritizing safety, trust, empowerment, and emotional regulation. Essential elements comprise:

- Establishing emotionally and physically secure treatment settings within correctional facilities
- Refrain from actions that could re-traumatize women (e.g., extreme isolation, coercive control)
- Educating correctional and mental health personnel to identify trauma responses
- Promoting survivor autonomy and involvement in treatment planning
- Trauma-informed care has demonstrated efficacy in alleviating symptoms of PTSD, anxiety, and emotional dysregulation in incarcerated women, while enhancing participation in rehabilitation programs.

2. Cognitive Behavioral Therapy (CBT)

Cognitive Behavioral Therapy is among the most used and well supported interventions in correctional environments. Cognitive Behavioral Therapy (CBT) is especially efficacious for female inmates when modified to target trauma, depression, substance abuse, and dysfunctional cognitive patterns. The therapeutic objectives of Cognitive Behavioral Therapy (CBT) encompass:

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- Recognizing and reformulating incorrect beliefs concerning self-esteem, guilt, and despair.
- Improving emotional regulation and stress management abilities.
- Mitigating impulsivity and self-injurious behaviors.
- Enhancing problem-solving and decision-making skills.
- Research demonstrates that CBT treatments tailored for women markedly alleviate depression symptoms and enhance psychological adaptation during incarceration.

3. Dialectical Behavior Therapy (DBT)

Dialectical Behavior Therapy is particularly advantageous for female inmates with emotional instability, self-harm behaviors, and borderline personality characteristics. Dialectical Behavior Therapy (DBT) amalgamates cognitive-behavioral methodologies with mindfulness and emotional acceptance approaches. The fundamental components of DBT comprise:

- Mindfulness techniques to enhance emotional awareness
- Strategies for distress tolerance to navigate crises without resorting to self-harm
- Strategies for regulating emotions to mitigate mood instability
- Skills for enhancing interpersonal effectiveness to strengthen relationships
- Studies have shown that Dialectical Behavior Therapy (DBT) diminishes self-harm, suicidal thoughts, and emotional instability among jailed women.

4. Substance Use Rehabilitation Programs

Substance abuse constitutes a significant mental health issue among female inmates and is frequently associated with trauma and emotional distress. Integrated substance use treatment approaches tackle both addiction and the underlying psychological suffering. Successful interventions comprise:

- Substance abuse counseling centered on trauma
- Training for relapse prevention
- Psychoeducation regarding addiction and mental health
- Group treatment centered on emotional support and accountability
- Gender-responsive substance use programs correlate with reduced relapse rates and enhanced post-release outcomes.

5. Mindfulness and Stress-Reduction Strategies

Mindfulness-based interventions, such as meditation, yoga, and stress-reduction programs, are being implemented in correctional facilities to enhance the psychological well-being of female inmates. Advantages encompass:

- Decreased anxiety, despair, and emotional reactivity
- Enhanced impulse regulation and self-awareness
- Improved management of incarceration-related stressors
- These therapies are economically efficient and especially beneficial in resource-constrained correctional facilities.

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6. Parenting and Family-Centric Interventions

A substantial number of incarcerated women serve as primary caregivers, and their separation from children constitutes a major source of psychological hardship. Parenting programs seek to enhance maternal identity and emotional fortitude. Essential elements comprise:

- Parental competency development
- Emotional assistance for grieving associated with separation
- Initiatives promoting effective communication with youngsters
- Such therapies have demonstrated efficacy in alleviating depression and enhancing motivation for recovery.

7. Psychoeducation and Life Skills Development

Psychoeducational programs augment self-awareness and enable women to navigate mental health difficulties effectively. These programs emphasize:

- Awareness of mental health
- Emotional literacy
- Strategies for coping and managing stress
- Development of vocational and life skills
- Psychoeducation fosters autonomy, self-efficacy, and enduring psychological stability.

VI. GENDER-RESPONSIVE REHABILITATION MODELS

Gender-responsive rehabilitation programs acknowledge that women's trajectories into criminality, their psychological requirements, and their experiences in correctional environments markedly differ from those of men. Conventional correctional systems, primarily structured for male offenders, frequently neglect the intricate mental health requirements, trauma backgrounds, and social roles of female inmates. Gender-responsive strategies seek to rectify this disparity by integrating psychological, social, and relational elements that are fundamental to women's experiences.

Gender-responsive rehabilitation is focused on trauma-informed and strengths-based approaches, prioritizing safety, empowerment, and comprehensive care over mere punishment. Studies have consistently demonstrated that these strategies are more efficacious in enhancing mental health outcomes, institutional adaptation, and post-release reintegration for jailed women.

1. Fundamental Principles of Gender-Responsive Rehabilitation

Gender-responsive models are informed by many fundamental ideas that differentiate them from traditional correctional programs:

- **Acknowledgment of trauma histories**
  The majority of female inmates have endured various sorts of trauma, encompassing childhood abuse, sexual violence, and intimate partner violence. Gender-responsive models emphasize trauma-informed care, guaranteeing that interventions avoid

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retraumatizing women while fostering emotional safety and trust.

Interpersonal orientation
The psychological growth and coping mechanisms of women are frequently influenced by their relationships. Consequently, rehabilitation programs prioritize healthy connections, interpersonal skills, and social support over an exclusive focus on individual illness.

- **Comprehensive and cohesive care**
  Mental health therapy is amalgamated with substance abuse treatment, physical healthcare, parenting assistance, career training, and educational programs to address interrelated needs.

- **Empowerment and self-efficacy**
  Instead than perpetuating emotions of helplessness, gender-responsive programs seek to enhance self-esteem, personal agency, and decision-making abilities.

- **Cultural and contextual awareness**
  Programs are modified to address socio-cultural backgrounds, poverty, stigma, and institutional inequities encountered by women.

2. Principal Gender-Responsive Rehabilitation Frameworks

Numerous recognized models have guided gender-responsive practices in correctional psychology:

- **Trauma-Informed Care Model**
  Trauma-informed rehabilitation acknowledges trauma as a fundamental structuring event in the lives of several incarcerated women. These models prioritize emotional safety, autonomy, collaboration, reliability, and empowerment. Therapeutic environments are designed to minimize coercion and institutional practices that could elicit trauma responses.
  Trauma-informed therapies have demonstrated efficacy in alleviating symptoms of PTSD, depression, emotional dysregulation, and institutional misconduct among female inmates.

- **Relational-Cultural Model**
  The relational-cultural model prioritizes development through connection instead of autonomy. Rehabilitation programs utilizing this model concentrate on enhancing social skills, resolving relational trauma, and cultivating supportive peer relationships within correctional environments. This method is especially beneficial for women who have endured abandonment, betrayal, and violent relationships.

- **Gender-Responsive Cognitive-Behavioral Interventions**
  Cognitive-behavioral therapy (CBT) is a fundamental correctional intervention, while gender-responsive modifications integrate trauma awareness, emotional control, and relationship settings. These treatments confront maladaptive cognitive habits while recognizing the influence of victimization, socioeconomic status, and substance abuse on behavior.

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- **Integrated Substance Abuse and Mental Health Initiatives**
  Due to the elevated prevalence of co-occurring illnesses in female inmates, integrated treatment strategies concurrently address chemical dependence and mental health issues rather than treating them in isolation. These programs prioritize coping strategies, relapse prevention, emotional regulation, and trauma rehabilitation.

- **Interventions focused on Parenting and Family**
  A significant number of incarcerated women are mothers, and their separation from their children constitutes a primary source of psychological distress. Gender-responsive rehabilitation encompasses parental education, family therapy, and initiatives that enhance maternal identity and caregiving competencies. These therapies have been associated with less depression and enhanced motivation for rehabilitation.

3. Advantages of Gender-Sensitive Rehabilitation

Empirical research demonstrates that gender-responsive models correlate with:

- Alleviated symptoms of depression, anxiety, and PTSD
- Decreased incidence of self-harm and disciplinary violations
- Augmented emotional regulation and coping mechanisms
- Increased participation in treatment programs • Improved post-release adaptation and diminished recidivism

These results underscore the necessity of transitioning from gender-neutral correctional procedures to frameworks that specifically include the psychological reality of female inmates.

4. Consequences for Correctional Policy and Practice

Executing gender-responsive rehabilitation necessitates institutional dedication, personnel training, and policy modification. Correctional personnel must receive training in trauma-informed and gender-sensitive methodologies to foster therapeutic environments instead of punitive ones. In the absence of institutional support, even meticulously crafted programs are likely to be useless.

Gender-responsive rehabilitation models signify a pivotal progression in correctional psychology, providing humane, evidence-based strategies that cater to the mental health requirements of female inmates while fostering long-term recovery and social reintegration.

VII. CHALLENGES AND BARRIERS TO IMPLEMENTATION

Despite growing recognition of the mental health needs of female prisoners and the effectiveness of gender-responsive rehabilitation models, multiple challenges continue to hinder their effective implementation within correctional settings. These barriers operate at structural, institutional, psychological, and socio-cultural levels, often resulting in inadequate mental health care and limited rehabilitation outcomes for incarcerated women.

One of the primary challenges is the **lack of adequate mental health infrastructure within prisons**. Many correctional institutions, particularly in low- and middle-income countries, are not equipped with sufficient mental health professionals, including psychologists, psychiatrists, psychiatric social workers, and trained counselors. As a result, mental health

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services are often limited to crisis management or pharmacological interventions, while long-term psychotherapeutic and rehabilitative care remains largely unavailable. This shortage disproportionately affects female prisoners, whose psychological needs are often more complex due to histories of trauma and abuse.

Another significant barrier is the **gender-neutral design of prison systems and rehabilitation programs**. Most correctional frameworks have historically been developed based on male offender populations, leading to policies and programs that fail to address women's specific psychological experiences. Gender-blind approaches overlook factors such as trauma histories, caregiving responsibilities, reproductive health concerns, and relational needs, thereby reducing the effectiveness of rehabilitation efforts for women. Without gender-sensitive adaptation, even well-intentioned mental health programs may fail to engage female prisoners meaningfully.

Stigma surrounding mental illness represents an additional challenge within correctional environments. Female prisoners often face dual stigma—both as offenders and as individuals with mental health problems. Fear of discrimination, social labeling, or punitive consequences discourages many women from disclosing psychological distress or seeking mental health support. Within prisons, mental illness may be misunderstood or minimized, leading to underreporting of symptoms and delayed intervention.

Institutional constraints such as **overcrowding, security priorities, and rigid prison routines** further impede the delivery of therapeutic interventions. High inmate populations, limited space, and emphasis on discipline over care restrict opportunities for individual counseling, group therapy, or trauma-focused interventions. Security-driven practices may also limit privacy and confidentiality, which are essential for effective psychological treatment, particularly for trauma survivors.

A critical barrier lies in the **lack of continuity of care** during and after incarceration. Mental health and rehabilitation programs often operate in isolation from community-based services, resulting in disruption of care upon release. Female prisoners with ongoing mental health needs may struggle to access treatment post-release due to poverty, social stigma, lack of housing, and limited community resources. This discontinuity increases the risk of relapse, reoffending, and psychological deterioration.

Finally, **policy-level gaps and insufficient funding** pose substantial obstacles to sustainable implementation of rehabilitation programs. Mental health services in prisons are frequently underfunded and underprioritized within criminal justice systems. Limited allocation of resources restricts staff training, program development, and evaluation of intervention outcomes. Without strong policy commitment and intersectoral collaboration between correctional, health, and social welfare systems, gender-responsive mental health care for female prisoners remains fragmented and inconsistent.

Addressing these challenges requires systemic reform, including investment in prison mental health infrastructure, staff training in trauma-informed and gender-responsive practices, reduction of stigma, and strengthened links between prison and community mental health services. Overcoming these barriers is essential to ensure that rehabilitation efforts move beyond punitive containment toward meaningful psychological recovery and social reintegration for female prisoners.

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VIII. CONCLUSION

Female inmates represent one of the most psychologically susceptible groups within the criminal justice system, possessing mental health requirements that are unique, intricate, and profoundly influenced by pre-incarceration experiences of trauma, victimization, and socio-economic marginalization. This chapter emphasizes that the psychological profile of jailed women is influenced not just by criminal activity but also by a series of cumulative adversities, including childhood maltreatment, intimate partner violence, substance use, disturbed caregiving responsibilities, and ongoing social disadvantage. The significant incidence of melancholy, anxiety disorders, post-traumatic stress disorder, substance use disorders, and self-harm among female inmates highlights the insufficiency of conventional, gender-neutral correctional methods that emphasize punishment rather than psychological treatment.

The data also illustrates that incarceration frequently aggravates pre-existing mental health disorders due to environmental stresses including isolation, loss of autonomy, stigma, and separation from children. Addressing these problems necessitates a transition to gender-responsive and trauma-informed rehabilitation frameworks that recognize women's lived experiences and psychological realities. Therapeutic methods, including trauma-focused cognitive behavioral therapy, substance abuse treatment, mindfulness-based approaches, and relational and attachment-oriented therapies, possess considerable promise for enhancing psychological well-being and facilitating rehabilitation. The successful execution of these interventions is sometimes obstructed by systemic impediments, such as insufficient mental health infrastructure, a scarcity of educated personnel, institutional limitations, and poor continuity of care post-release.

A thorough and humane correctional response must integrate mental health care as a primary element of rehabilitation rather than as a supplementary service. Policymakers, prison administrators, and mental health experts must cooperate to create evidence-based, gender-responsive programs that emphasize psychological recovery, social reintegration, and sustained wellness. By tackling the fundamental psychological risk factors and mental health requirements of female inmates, correctional institutions can facilitate individual rehabilitation, decrease recidivism, enhance public health outcomes, and foster a more equitable and efficient criminal justice system.

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PERSONALITY TRAITS, IDENTITY FORMATION AND SELF CONCEPT

Abstract

'Personality' has its roots in the Latin term Persona, which translates to 'Mask.' In essence, personality refers to the consistent set of traits that define an individual's identity. Nature vs. nurture debate: traits influenced by genetic makeup (genotype) and environment (phenotype).Studies on twins show genes contribute but do not fully determine personality. Traits linked to cognitive and social anxiety, aggression, impulsivity, and personality traits like belligerence and cynicism. Personality derives from behavioural traits, temperament, and character. Temperament involves unconscious automatic reactions. Character involves conscious self-awareness and plans. Five major traits: Openness to Experience, Conscientiousness, Extroversion, Agreeableness, Emotional Stability. Each trait described with contrasting poles (e.g., inventive vs. cautious for openness). Personality traits are pre-dispositions to respond to stimuli. Three types of traits: Cardinal Traits, Central Traits, Secondary traits that shaping personality. Differentiates source traits (fundamental) and surface traits (observable).Identified 16 personality factors through factor analysis. Personality development theory combines three dimensions like Extroversion vs. Introversion, Neuroticism vs. Stability, and Psychoticism vs. Socialization.

The notion of identity signifies what defines a person or an entity, encompassing the characteristics that influence individuals, along with family dynamics, historical events, and social and political environments. The idea of identity is generally recognized as the components that delineate a person or object, shaping their characteristics, family dynamics, and the historical and socio-political backdrop. Identity constitutes another fundamental element of personality

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that contrasts with character by focusing on self-dimensions One of the most long-lasting theories of development was introduced by psychologist Erik Erikson. Erik Erikson's theory of identity development suggests that it relates to one's sense of self, known as ego identity. This ego identity develops through eight distinct psychological stages throughout a person's life. Each of these eight stages presents a challenge, such as the conflict between Trust and mistrust or Identity and Role confusion. The eight psychological stages contribute to the formation of our personality and abilities. Erikson's theory describes psychological growth from the early stages of life to adulthood. Successfully navigating these conflicts leads to positive traits such as hope and integrity, while failing to do so may result in feelings of guilt. James Marcia's theory, the diffusion status describes a person who lacks any commitment. Such an individual is unable to define the course of their life. The foreclosure status refers to a person who has not gone through any significant crisis but has made commitments regarding their identity. The third status, moratorium, represents an individual who is engaged in thoughtful exploration, questioning, and searching for answers. This type of person has yet to reach a commitment. Finally, the identity achievement status signifies that an individual has committed to a specific identity and is actively working to resolve their identity crisis.

Self-concept is an understanding that pertains to the way one views oneself. It encompasses an individual's emotions, perceptions, attitudes, beliefs, and values that reflect their self-image, capabilities, and social position. Factors such as a person's physical appearance, self-presentation, attire, grooming, abilities, and values all impact their self-concept Symonds describes self-concept as the way an individual responds. Symonds outlines four aspects of self-concept theory. They are:

(i) The way an individual views himself.

(ii) The beliefs the individual holds about

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himself.
(iii) The value the person places on himself.
(iv) The different actions the individual employs to boost or protect his self-image.
The significance of self-concept arises from its crucial role in shaping personality. Self-esteem is linked to social effectiveness, as it affects a person's emotions, thoughts, learning, self-worth, interactions with others, and ultimately, their behaviour.

Keywords: Personality, Identity, Self-Concept, Temperament, Character, Big Five Personality Traits, Cardinal Traits, Central Traits, Secondary Traits, Erik Erikson, James Marcia, Ego Identity, Self-Esteem, Personality Development, Behavioural Traits, Emotional Stability, Extroversion, Introversion, Neuroticism, Socialization.

I. INTRODUCTION

'Personality' that derives from Latin word Persona means 'Mask'. Actually, Personality is the stable set of characteristic that responsible for a person's identity. Personalities are outside of our control but personality strongly influence our attitudes, expectations and assumptions others thus influenced our behaviour. Personality traits can define as the structure and predisposition , inside person that explain characteristics, thought pattern behaviour and emotion. Personality Traits capture that what people are like and what people can do. Trails are recurring regularities and trend in a person. Traits are the building blocks of personality. It is also expressed through the person's behaviour. Personality traits patterns can be one or few behaviours affects, cognitive desire or all of this . Personality traits are also associated and related with this, but can further be explain in more advance terms. It is a non-contextual factors that shape the person and their activity. Traits are also expressed through the person's behaviour. Personality traits-relatively stable patterns of thoughts, feelings and behaviour that distinguish one person from an-other-play a essential role in shaping individual's attitudes behaviour and well-being.

II. FORMATION OF PERSONALITY TRAIT

From Nature and Nuture debate study that is not limited to the study of personality traits. Now question is how much individual's Personality is genetic? It cann't be traced the exact amount of heritability is influenced it actually broadly accepted idea that traits are caused or influenced by certain genetic makeup genotype. Then the way that the traits are being expressed is the phenotype. Study on genes and personality were characterized by comparing identical and fraternal twins. So that the genes are not the whole contributing for variation of personality, genes are mattered. Interesting findings to psychic anxiety, cognitive social anxiety, and socialization, inhibition of aggression and impulsivity information processing and the correlation between personality like charisma, belligerence, cynicism, obsessive compulsive behaviour with genotype and the phenotype have been found.

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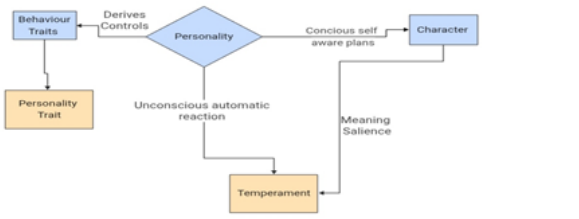

Figure 1: Relationship Between Personality and Personality Trait

III. Individual Comparison behind Personality Trait

The differences and similarities among individuals represent the primary discussion in the realm of personality trait psychology. Initial research that focused on trait comparison among individuals emerged during the early study of trait psychology. This area of inquiry has been utilized to explore a wide range of aspects of human behavior, encompassing academic pursuits, personal relationships, professional environments, as well as various interpersonal and intrapersonal interactions. Historically, these comparisons primarily concerned psychiatric populations. In contemporary times, however, the focus has shifted to exploring stable emotional and behavioural patterns in healthy individuals. To grasp the impact of personality traits on psychologically healthy individuals, researchers are examining how extremely high levels of neuroticism may be linked to an increased risk of heart disease. Studies on personality traits are largely connected to the Big Five personality model. This model encompasses five factors that account for most of the variations found within the complete list of personality attributes. These include extraversion, agreeableness, conscientiousness, neuroticism, and intellect or openness to experience, although there exist numerous additional personality traits. Some researchers contend that many other personality differences can be illustrated by these five factors, which feature two distinct poles.

Table 1:

Openness to experience	Inventive/ Curious Vs Consistent	This is a degree those who can be open to new experience and intellectually curious.
Conscientiousness	Efficient Vs Careless	It is the degree which a individual can be planner a dependable responsible and organized person.
Extroversion	Extrovert Vs Introvert	These degrees to which a person can active sociable talkative & assertive.
Agreeableness	Compassionate Vs Analytical	Individual who are good natured flexible, trusting and liked by others.
Emotional Stability	Secure Vs Sensitive	This is a degree where a person can be confident and emotionally secure.

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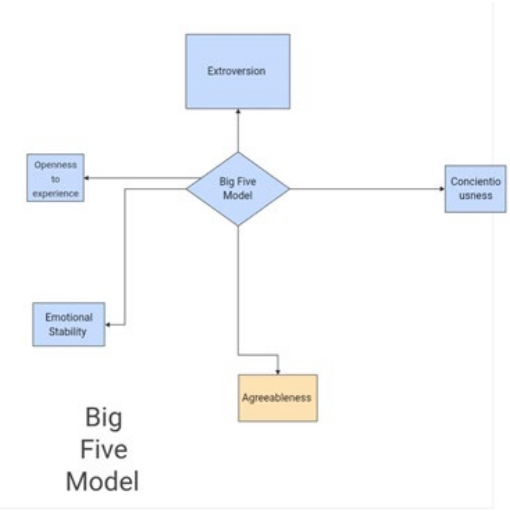

Figure 2: Big Five Model of Personality trait

IV. ALLPORT TRAIL THEORY OF PERSONALITY

Allport views personality characteristics as an active arrangement that reacts in the same or similar ways to various forms of stimuli. As per Allport's theory, there are three categories of traits that make up our personality. They comprise -

1. Cardinal Traits
2. Central Traits
3. Secondary Traits.

1. **Cardinal Traits:** It is a type of dominant traits of individual's personality. Allport's cardinal trait are rare. i.e. a majority of very few individuals dominated by cardinal trait some of them personality composed of multiple traits For example:- Mother Teresa for altruism.
2. **Central Traits:** It is a second hierarchial traits that responsible for shaping our personality. Those traits are Intelligent, loyal, dependable and aggressive etc.
3. **Secondary Traits:** It's a situational traits that can be numerous in number and are responsible for behaviours inconsistent to an individual's to usual behaviour

V. RAYMOND CATTELL'S THEORY OF PERSONALITY TRAITS

Personality traits is a basic structural units of the personality that have relatively permanent reaction tendencies

R. Cattell identified classified traits in two ways that are Fundamental or Source Traits and surface Traits or observable trait of personality. He also identified between common traits and unique trait traits.

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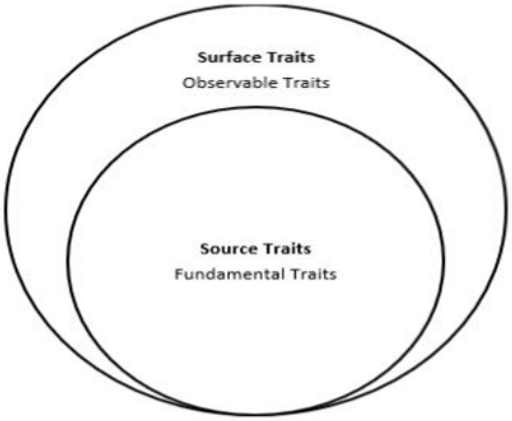

Figure 3:

A typical attribute is one that all individuals have to varying extents, such as sociability or cognitive ability. Cattell introduced 16 dimensions that define a person's character. He utilized factor analysis to determine these 16 personality characteristics. That're

Table 2 :

Factors	Low Score	High Score
A	Reserved	Impersonal
B	Less intelligent	Thinker /More Intelligence
C	Ego and Strength	Neuroticism
E	Submissive	Assertive
F	Serious	Happy -go- Lucky
G	Expedient	Conscientious
H	Shy	Sensitive
I	Tough – Minded	Tender -Minded
L	Trusting	Suspicious
M	Practical	Imaginative
N	Forthright	Shrewd
O	Placid	Apprehensive
Q1	Conservative	Experimenting
Q2	Another dependent	Self – Sufficient
Q3	Undisciplined	Disciplined
Q4	Relaxed	Tense Minded

VI. EYSENCK'S TRAIT THEORY OF PERSONALITY

Hans Eysenck used factor analysis for basic factors of personality trait which included introversion vs extroversion and emotionality vs stability. After he added third dimension to his model that is Psychoticism vs Socialization.

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1. **Extroversions Introversion :** It I refers external or internal stimulation. Individual those who are extrovert they prefer companion when they are in stress and they are social seek adventures

2. **Neuroticism versus stability:** Individuals exhibiting high levels of neuroticism often display characteristics such as instability, moodiness, emotionality, and poor adjustment. In contrast, individuals who are stable generally demonstrate a calm demeanour.

3. **Psychoticism versus socialization:** Individuals who score high on psychoticism tend to be impulsive, aggressive, and self-centred. On the other hand, those who are more socialized typically show traits of empathy, altruism, and conformity to social norms.

VII. IDENTITY FORMATION

The term Identity refers to the frequently portrayed as what makes a person or a thing is that shapes individuals characteristics, dynamics of family and historical factor social and political context. Identity that encompasses the relationship, memories, experiences and values which formed from individual's self sense . This amalgation creates a sense of those who one is over time even as new facets are developed and incorporate into their identity. Individual's name, age, location and their culture and hobbies are some aspects of the identity . Very few example of what constructs our entire identity. An individual don't tends to notice or even care about, is how their identity is truly formed. Identity formation is a process which individuals developed their sense of self often influenced by combination of internal and external factors. Identity process that encompasses various stages.

The notion of identity is generally perceived as the factors that characterize an individual or a thing, affecting their qualities, the complexities of family ties, and the historical as well as social-political contexts. Identity encompasses an individual’s relationships, memories, experiences, and beliefs that stem from self-perception. This combination creates an ongoing realization of who a person is throughout their lifetime, even as fresh aspects are introduced and fused into their self-concept. An individual’s identity encompasses various aspects such as their name, age, place of residence, culture, and hobbies, which represent only a few of the elements that contribute to their overall identity. Many people tend to be oblivious or apathetic regarding how their authentic identity is formed. The development of identity is a process where individuals refine their self-image, often influenced by a blend of personal and external factors.

1. Identity formation from personality trait :

Identity is an another core pillar of personality, that differs from character in that it focuses on dimension of self. identity shapes our internal sense of self. Identity is the also part of personality that helps us organize and understand our perceptions experience and interactions with others. Identity involves how we see ourselves, how we perceive others, and how we interpret.

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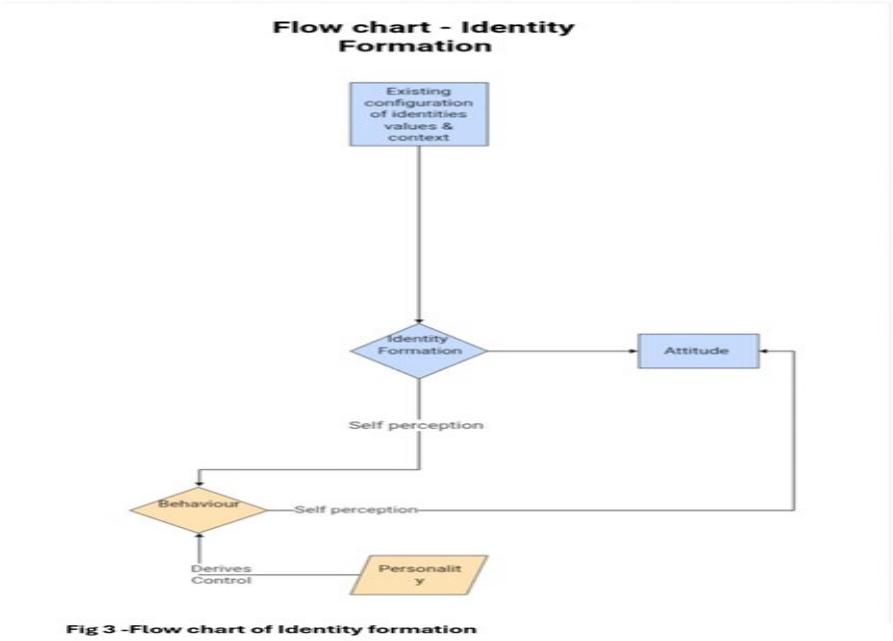

Fig 3 -Flow chart of Identity formation

Figure 4:

We derive our personal characteristics from our existing circumstances and experiences. The flow chart depicting the formation of identity illustrates our fundamental personality traits and highlights their significant effects on specific categories of identity. The process of establishing our identity commences in childhood, becomes more pronounced during adolescence, and is confronted with physical development, sexual growth, and upcoming career decisions. During this phase, adolescents work towards assimilating their previous traits and experiences into a unified identity.

VIII. IDENTITY THEORY

Two identity theory
1. Role identity Theory
2. Social identity Theory

1. Role Identity Theory

Erik-Erikson Theory: One of the most enduring theory of development was proposed by psychologist Erik Erikson. Erik Erikson coined a term ego identity which conceived as an enduring and continuous sense of who person is. Ego identity which helps to merge all the different versions of oneself the career self parent self and the sexual self into individual whole cohesive.

Erik Erikson's identity development theory posits that refers to sense of self (ego identity). This ego identity forms through eight psychological stages across the lifespan. This eight psychological stage present a conflict such as Trust vs mistrust identity vs Role confusion. Eight stages of psychological stage that shapes our personality and competence. Erikson theory outlines psychological development from infancy to adulthood . Erikson's theory

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successfully resolving those conflicts that leads to virtues like hope and integrity while failure can result in guilty. From Erik Erikson theory- eight psychological stages are

Table 3:

Erikson's Psychosocial Stages

Stage	Basic Conflict	Virtue	Description
Infancy 0–1 year	Trust vs. mistrust	Hope	Trust (or mistrust) that basic needs, such as nourishment and affection, will be met
Early childhood 1–3 years	Autonomy vs. shame/doubt	Will	Develop a sense of independence in many tasks
Play age 3–6 years	Initiative vs. guilt	Purpose	Take initiative on some activities—may develop guilt when unsuccessful or boundaries overstepped
School age 7–11 years	Industry vs. inferiority	Competence	Develop self-confidence in abilities when competent or sense of inferiority when not
Adolescence 12–18 years	Identity vs. confusion	Fidelity	Experiment with and develop identity and roles
Early adulthood 19–29 years	Intimacy vs. isolation	Love	Establish intimacy and relationships with others
Middle age 30–64 years	Generativity vs. stagnation	Care	Contribute to society and be part of a family
Old age 65 onward	Integrity vs. despair	Wisdom	Assess and make sense of life and meaning of contributions

Marcia discusses four specific identity statuses that adolescents can fall into, determined by their identity development process.

IX. JAMES MARCIA'S THEORY OF IDENTITY DEVELOPMENT

In James Marcia's theory, the Diffusion status applies to those who lack any commitments, leaving them unable to define their life direction.

Next, Foreclosure describes a status where an individual has not faced any crises yet, but they have made commitments regarding their identity.

The third status, Moratorium, refers to a phase where a person is actively contemplating, questioning, and searching for answers. This individual has yet to reach a commitment.

Finally, Identity Achievement is a status where the person has made commitments to a distinct identity and is working through their identity crisis.

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Table 4 :

IDENTITY FORECLOSURE LOW exploration efforts. Have acknowledged the possibility of switching professions but lack the drive to begin searching for new employment. HIGH dedication to the idea of a different career identity**.**	**IDENTITY MORATORIUM** LOW commitment to the prospect of a new career identity. HIGH level are knowledge about possible options and engagement in exploring new opportunities.
IDENTITY DIFFUSION LOW exploring towards considering a new career. LOW exploring new options and to motivate overwhelmed or unaware of number of possibilities.	**IDENTITY ACHIEVEMENT** HIGH level is new career identity HIGH exploration in job market to accepting of a new career and taking positive action.

X. SELF CONCEPT THEORY

Self-concept is a perception that refers to the view of to himself.Self concept refers to the individual's feelings, perception, attitude beliefs and values that denote individual's perception, abilities and his status. Self concept is influenced by person's personal appearance, physical self, dress and grooming by ability and values.

Symonds Self Concept theory:

Symonds describes self-concept as how a person responds to their own identity.
Symonds presents four theories related to self-concept. They include-

1. The way a person views their own identity.
2. The opinions that an individual holds about themselves.
3. The worth that an individual assigns to themselves.
4. The methods a person employs through various behaviors to improve or protect their self-image.

The significance of self-concept arises from its considerable role in shaping personality. Self-worth is linked to social skills, as it affects a person's emotions, thoughts, learning processes, self-value, interactions with others, and ultimately, their behavior. Individuals who possess a positive self-concept generally show a greater acceptance of others. They also demonstrate a higher level of acceptance towards their own shortcomings.

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