A Comparative Study Of Psychological Adjustment Among Heterosexual and Homosexual Male Youth"

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Certificate

This is to certify that the present piece of Thesis titled, "A Comparative Study Of Psychological Adjustment Among Heterosexual and Homosexual Male Youth" is the bonafide research conducted by Ms. P.C Lalhmingsangi under my supervision. He worked methodologically for his dissertation being submitted for the Doctor of Philosophy in Psychology under the Mizoram University.

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DECLARATION

I, P.C.Lalhmingsangi, hereby declare that the subject matter of this Thesis is the record of work done by me, that the contents of this Thesis did not form basis for the award of any previous degree to me or to the best of my knowledge to anybody else, and that the Thesis has not been submitted by me for any research degree in any other University or Institute.

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INTRODUCTION

Sexual Orientation - refers to the gender of the person(s) that someone is attracted to, emotionally and physically, i.e., gay, lesbian, bisexual, heterosexual, and others Kazdin (2000). sexual orientation ranges along a continuum from exclusively heterosexual to exclusively homosexual (APA 2013), it is usually discussed in terms of three categories: heterosexual (having sexual and romantic attraction primarily or exclusively to members of the other sex), homosexual (having sexual and romantic attraction primarily or exclusively to members of one's own sex), and bisexual (having a significant degree of sexual and romantic attraction). Persons with a homosexual orientation are sometimes referred to as gay (both men and women) or as lesbian (women only). Same-sex sexual attractions and behavior can occur in the context of a variety of sexual orientations and sexual orientation identities (Diamond, 2006; Hoburg et al., 2004; Rust, 1996; Savin-Williams, 2005).

Sexual Orientation is different from sexual behavior because it refers to feelings and self concept. Persons may or may not express their sexual orientation in their behaviors (APA 2000). Language is dynamic; it grows, changes, and develops. This is particularly true with the language of diversity and the terms (labels) used to identify ourselves and others. Identification of our self and others vary for everyone. Accordingly, different term is to identify sexual orientation of self and others, most commonly used terms are as follows:

Transgender - originally referred to people who changed their social role (gender role expression or presentation) to live fully in the gender role different from that assigned at birth, and did so without changing their bodies through surgery or medication. Currently the term *transgender* has been expanded, and may refer to all individuals who experience internal conflict with their physical sex, and/or their assigned gender role. Thus, the term *transgender* may now apply to any person who struggles internally over gender identity or whose physical characteristics and gender expression differ from their gender as assigned at birth. The key difference is that the term now includes the full range of gender identity concerns, from internal distress through medical and surgical change (APA 1968). Transgender people are often harassed, socially excluded, subjected to discrimination, abuse, violence and

murder(Davidson, 2012; Giordano, 2012) In the United States, transgender people are less likely than others to have health insurance, and often face hostility and insensitivity from healthcare providers (Mallon, 2009).

Transsexual *refers* to people that change their primary social gender roles *and* their physical bodies. They make use of medication and surgery to bring their bodies into harmony with their inner sense of gender identity. Transsexual youth believe they have a gender identity different from the sex they were born with. They often manifest this belief beginning in childhood through an expressed desire to be a person of the opposite gender, repudiation of their genitalia, gender nonconformity and cross dressing (APA 1980). The DSM III notes that transsexuals frequently experience "considerable anxiety and depression, which the individual may attribute to inability to live in the role of the desired sex" (APA 1980). This depression combined with a poor self esteem can easily result in suicidal feelings and behavior in transsexual youth.

Lesbian is a term most widely used in the English language to describe sexual and romantic desire between females. This is one of the oldest and most positive terms that labels the affection or sexual preference or orientation of women towards other women, and has a continuing affection, emotional, romantic, and/or erotic preference for someone of the same sex. Some lesbians prefer to call themselves "lesbian" and used this word (lesbian) as a concept to differentiate women with a shared sexual orientation, is a 20th-century construct. Throughout history, women have not had the freedom or independence to pursue homosexual relationships as men have, but neither have they met the harsh punishment in some societies as homosexual men. Instead, lesbian relationships have often been regarded as harmless and incomparable to heterosexual ones unless the participants attempted to assert privileges traditionally enjoyed by men. As a result, little in history has been documented to give an accurate description of how female homosexuality has been expressed. When early sexologists in the late 19th century began to categorize and describe homosexual behavior, hampered by a lack of knowledge about lesbianism or women's sexuality, they distinguished lesbians as women who did not adhere to female gender roles and designated them mentally (BBC News Europe, 2008&2009)

Homosexuality refers to the practice of same sex behavior. Homosexuality is a very controversial topic and issues in many years back and till today. The word homosexual refers to both men and women having sexual and romantic attraction primarily or exclusively to members of one's own sex. The degree to which the romantic relationships of same-sex couples are similar to those of other-sex couples has been the subject of some discussion (Herek, 2006; Kurdek, 2005). The word '*homosexual*' (whether it refers to both men and women 'Gay' while 'lesbian' refers to women only) has its roots in the Greek language, where 'homo' means 'the same or similar'.

According to the formal definition by Merriam Webster, (July 2004) the term "Homosexual" is defined as "of relating to or characterized by a tendency to direct sexual desire toward another of the same gender". Freud said, "Homosexuality is assuredly no advantage, but it is nothing to be ashamed of, no vice, no degradation, it cannot be classified as an illness…" (Freud,1935 as cited in Bayer,1987). Nevertheless, the American Psychiatric Association included homosexuality under the grouping of sociopath personality disturbances in the first edition of the Diagnostic and Statistical Manual of Psychiatric Disorders (DSM-I, American Psychiatric Association, 1952). By the time of the second edition of the DSM (DSM-II, American Psychiatric Association, 1968), the diagnosis of homosexuality was moved under the general heading of sexual deviations. Research was emerging in the 1950s, demonstrating that homosexuality, per se, did not constitute a mental disorder. The pioneering work of Evelyn Hooker (1957) demonstrated that homosexual males were similar to heterosexual males on tests of psychopathology.

'***Gay'*** *(interchangeably used with Homosexual)* is originally used to refer to feelings of being "carefree", "happy", or "bright and showy"; The word "Gay" arrived in English during the 12th century from Old French *gai*, most likely deriving ultimately from a Germanic source (Etymiology Dictionary). The word had started to acquire associations of immorality by 1637 and was used in the late 17th century with the meaning "addicted to pleasures and dissipations. Gay/homosexual refers to men and women whose social identity or sexual orientation is based on their primary erotic, affection, and romantic attraction to members of their own sex, and "lesbian" refers to women who are gay (Gonsiorek, & Weinrich, 1991). "Sexual minority" is used to refer collectively to gay, lesbian, and bisexual people to both men and women). As

such, they face the daily stress of being members of a stigmatized group (DiPlacido, 1998).

Men term was created in the 1990s by epidemiologists in order to study the spread of men, who have sex with men (abbreviated as MSM,). MSM are male persons who engage in sexual activity with members of the same sex, regardless of how they identify themselves; many men choose not to (or cannot for other reasons) accept social identities of gay or bisexual. (UNAIDS 2008; Greenwood, Cseneca; Mario Ruberte, 2004; Operario , Burton, Underhill , Sevelius , 2008; Operario , Burton ,April 2000). Also, the emergence of 'Gay Culture' in western societies during the 20th century encouraged the belief that people are either 'gay' (homosexual) or 'straight' (heterosexual).

Lesbian Gay Bisexual Transgender (or GLBT) is used as a self-designation by what was formerly known as the "gay community". It refers collectively to "lesbian, gay, bisexual, and transgender" people, which itself started replacing the phrase "gay community" beginning in the mid-to-late 1980's. The term 'LGBT' is intended to emphasize a diversity of "sexuality and gender identity-based cultures" and is sometimes used to refer to anyone who is non-heterosexual instead of exclusively to people who are homosexual, bisexual, or transgender (Keith, 2007., Shankle, 2006).

Heterosexual is a man who forms primary loving and sexual relationships with women or a woman who forms primary loving and sexual relationships with men; a women who has a continuing affection, emotional, romantic, and or erotic preference for men (or vice versa).The term 'Hetero' comes from the Greek word hetero's, meaning "other party" or "another' used in science as a prefix meaning "different'' hetero" (Houghton Mifflin 2012), and the Latin word which has a meaning of "for sex" (that is, characteristic sex or sexual differentiation). The word *"heterosexual"* was first listed in Merriam-Webster's New International Dictionary as a medical term for "morbid sexual passion for one of the opposite sex"; however, in 1934 in their Second Edition Unabridged, it is defined as a "manifestation of sexual passion for one of the opposite sex; normal sexuality".

Heterosexuals usually (but not necessarily) engage in overt sexual relationships with people of the other sex. Heterosexuality is romantic and/or sexual attraction or behavior between members of the opposite sex or gender. As a sexual orientation,

heterosexuality refers to "an enduring pattern of or disposition to experience sexual, affection, physical or romantic attractions to persons of the opposite sex"; it also refers to "an individual's sense of personal and social identity based on those attractions, behaviors expressing them, and membership in a community of others who share them". The term is usually applied to human beings, but it is also observed in all mammals. Heterosexuality, bisexuality and homosexuality together make up the heterosexual-homosexual continuum (Wilkholm, 2004). Some reject the term "heterosexual" as the word only refers to one's sexual behavior and does not refer to non-sexual romantic feelings.

"*Straight*" is originated as a mid-20th century gay slang term for heterosexuals, ultimately coming from the phrase "*to go straight*" (as in "straight and narrow"), or stop engaging in homosexual sex. One of the first uses of the word in this way was in 1941 by author G. W. Henry. As a result, the terms *straight* is sometimes preferred when discussing a person of this sexual orientation. Some object to usage of the term "*straight*" because it implies that non-heteros are crooked. (Watson & Skinner 2004).

The mechanisms for the development of a particular sexual orientation remain unclear, but the current literature and most scholars in the field state that one's sexual orientation is not a choice; that is, individuals do not choose to be homosexual or heterosexual (Frankowski 2004). Currently, there is no scientific consensus about the specific factors that cause an individual to become heterosexual, homosexual, or bisexual – including possible biological, psychological, or social effects of the parents' sexual orientation. However, the available evidence indicates that the vast majority of lesbian and gay adults were raised by heterosexual parents and the vast majority of children raised by lesbian and gay parents eventually grow up to be heterosexual(APA 2006). Heterosexual" and "homosexual" became the most widely accepted terms for sexual orientation (Karl Maria 2007, Psychopathia Sexualis 2007)

Heterosexuality and homosexuality are terms often used in European and American cultures to encompass a person's entire social identity, which includes self and personality. In Western cultures, some people speak meaningfully of gay, lesbian, and bisexual identities and communities. In other cultures, homosexuality and heterosexual labels do not emphasize an entire social identity or indicate community affiliation based on sexual orientation (Zachary & Michael 2002)

In Sexual Behavior in the human male, Kinsey, Pomeroy, and Martin (1948) laid the empirical foundation for contemporary research on sexual identities and behavior. Kinsey et al. demonstrated with the heterosexual-homosexual rating scale, i.e., the ‘‘Kinsey Scale,’’ that a significant percentage (37%) of males had engaged in ‘‘at least some overt homosexual experience to the point of orgasm’’ at some point in their lives and argued that human male sexuality cannot be divided into discrete categories (e.g., heterosexual vs. homosexual).While the work of Kinsey and colleagues began a discourse on the diversity of sexual meanings and sexual behaviors, Gagnon and Simon (1973) moved the study of sexuality from the biological to the social. As early symbolic interactionists and social constructionists, Gagnon and Simon proposed that one’s sexuality was constructed around social realms. Therefore, sexual experiences could not be separated from ‘‘economic, religious, political, familial, and social conditions’’ (Plummer, 2005). Simon and Gagnon (1986) posited the concept of sexual scripts, which states that sexual behavior is learned rather than biologically inherent, i.e., sexual experiences become coded into an individual’s sexual routine and, thereby, direct much of one’s sexual behavior. Social/sexual components are learned at specific age periods and through significant agents (parents, peers, and media). The social understanding of sexual choice continued to be realized in the works of Plummer (1975), Foucault (1980), and Weeks (1985), all of whom departed from a biological base in favor of constructing one’s sexuality within a social and historical framework.

Factors of homosexuality: The peculiar nature of homosexual desire has led some people to conclude that this urge must be innate: that a certain number of people are "born that way," that sexual preferences cannot be changed or even ended. Many controversial statements about the causes of homosexuality have been raised inviting some possible answers. The first, homosexual behavior is a bad habit that people fall into because they are sexually permissive and experimental as it is their chosen lifestyle and the result of self-indulgence and an unwillingness to play by society rules. The second view is "biological" and holds that such desires are genetic or hormonal in origin, and that there is no choice involved and no "childhood trauma" necessary. Which of these views is most consistent with the facts? Which tells us the most about homosexual behavior and its origins? The answer seems to be that homosexual behavior is learned.

The followings confirmed and supported learned behavior that:

1) No researcher has found provable biological or genetic differences between heterosexuals and homosexuals that weren't caused by their behavior (Cameroon, 1985) while the absence of such a discovery doesn't prove at inherited sexual tendencies aren't possible, it suggests that none has been found because none exists.

2) People tend to believe that their sexual desires and behaviors are learned their feelings and behavior were the result of social or environmental influences (Kinsey, 1948). The Family Research Institute (1983) collected a random sample of 147 homosexuals, 35% said their sexual desires were hereditary. Interestingly, almost 80% of the 3,400 heterosexuals in the same study said that their preferences and behavior were learned

3) There is evidence that homosexuality, like drug use is "handed down" from older individuals. The first homosexual encounter is usually initiated by an older person. How this happens is suggested by a nationwide random study from Britain: 35% of boys and 9% of girl said they were approached for sex by adult homosexuals. Likewise, a study of over 400 London teenagers reported that "for the boys, their first homosexual experience was very likely with someone older. The finding suggested that the homosexuality is introduced to youngsters the same way other behaviors are learned - by experience (Cameroon et al, 1989).

4) One's first sexual experience - was a strong predictor of adult homosexual behavior, both for males and females (Kinsey, 1998) as there was a strong relationship between those whose first experience was homosexual and those who practiced homosexuality in later life (Bell, 1973).

5) Kinsey reported "less homosexual activity among devout groups whether they be Protestant, Catholic, or Jewish, and more homosexual activity among religiously less active groups." (Kinsey et al, 1948). Recently, it has been discovered that, relative to white males, twice as many black males are homosexual and 4 times as many are bisexual. Perhaps it is related to the fact that 62% of black versus 17% of white children are being raised in fatherless homes.

6) In a large random sample (Camerron et al, 1989) 88% of women currently claiming lesbian attraction and 73% of men claiming to currently enjoy homosexual sex, and

most of them have been sexually aroused by, had sexual relations with, and even fallen in love with someone of the opposite sex. Nationwide random samples (Roberts and Turner, 1991) of 904 men were asked and reported that they had sex with women. The switching and experimentation demonstrated in these two studies identifies homosexuality as a preference, not inevitability.

7) There are many ex-homosexuals**,** those who have continued in homosexual liaisons for a number of years and then chose to change not only their habits, but also the object of their desire, almost 2% of heterosexuals reported that at one time they considered themselves to be homosexual (Cameroon et al, 1989). Sometimes this alteration occurs as the result of psychotherapy; (Bieber et al, 1962) in others it is prompted by a religious or spiritual conversion. It is clear that a substantial number of people are reconsidering their sexual preferences at any given time.

Gender identity is the inward and individual experience of being male or female, or ambivalence about maleness or femaleness, sexual identity referring to an individual's conception of themselves, behavior referring to actual sexual acts performed by the individual, and orientation referring to "fantasies, attachments and longings.'' (Reiter 1989). People with a homosexual orientation can express their sexuality in a variety of ways, and may or may not express it in their behaviors (APA 2010). People who have a homosexual sexual orientation that does not align with their sexual identity are sometimes referred to as 'closeted' and this may lead to discordance and result in sexual identity conflict. Evidence suggests that people who identify with a gender different than the one they were assigned at birth may do so not just due to psychological or behavioral causes, but also biological ones related to their genetics, the makeup of their brains, or prenatal exposure to hormones (Heylens, et.al 2012). Adults with GID are at increased risk for stress, isolation, anxiety, depression, poor self-esteem and suicide (Davidson, 2012).

Gender Role Conflict is defined as a psychological state in which one's gender role results in negative consequences for oneself or others (O'Neil, 1981a, 1981b). Gender role conflict occurs when the internalization of rigid, sexist, and restrictive cultural messages about what it means to be a man results in personal restriction, devaluation, or violation of self and others (O'Neil, Helms, Gable, David, & Wrightsman, 1986). Englar-Carlson (2006) asserted that men typically experience gender role conflict

when they try to meet or fail to meet gender role norms of masculinity; violate or deviate from gender role norms; experience discrepancies between their real and ideal self-concepts, based on gender role stereotypes; personally restrict, devalue, or violate themselves or others because of gender role norms; and experience personal restrictions, devaluations, or violations from others.

According to Freud (1905) phallic stage, sexual feelings for the opposite sex parent occur at this stage (and deals with Oedipus / Electra complex basically erotic attachment to parent of opposite sex, but since these feelings are not acceptable it may result in hostility) and feel some hostility to same sex parent. The failure to resolve conflict can cause a person to be afraid or incapable of close love; he also postulated that fixation could be a root cause of homosexuality.

Homosexuals are rarely confused about their gender identity with lesbians believing they are women and gay males believing they are men. There are indications that individuals may be predisposed to their sexual orientation from an early age. A gay or lesbian orientation in adolescence is not just a phase the youth is going through. Bell, Weinberg, and Hammersmith found that sexual orientation is likely to be formed by adolescence even if the youth is not yet sexually active, Huckleberry House found that, when given a choice, adolescents demonstrate a greater degree of conviction than confusion in identifying their sexual orientation, with 75 percent self-reporting as heterosexual, 15 percent homosexual, 5 percent bisexual, and only 5 percent confused or undecided (Huckleberry, 1982). Youth are more likely to underreport a homosexual orientation because of difficulties in accepting themselves and the fear of a hostile response. Jay and Young (1977) found that 56 percent of the lesbian respondents in their survey had previously identified as bisexual while only 16 percent currently did so. Forty-six percent of the gay males had previously identified as bisexual while only 20 percent currently did so.

Individuals are ‘becoming gay’’ in social interactions by adopting homosexuality as a way of life (Plummer 1975). For instance, Troiden (1998) explains that becoming gay ‘‘involves the decision to define oneself as homosexual, the learning of homosexual roles, and the decision to live one’s adult life as a practicing homosexual’’. According to Plummer (1975), boys first go through the sensitization stage in which they deal with social, emotional, and genital same-sex

experiences. Then, when boys reach to the adolescence, signification and disorientation take place. In this stage, boys question whether they may be gay or not. The coming out stage occurs when boys begin to internalize homosexuality as a way of life during the middle to late adolescence. Lastly, stabilization takes place when they develop their comfort with their homosexuality and commitment to homosexuality as a way of life.

According to Cass (1979, 1984), gay identity formation consists of six stages. Cass assumes that individuals start to question whether they may possess the same-sex attraction or not. This is the first stage named, identity confusion. In the second stage of identity comparison, individuals start to assume that they are likely to be gay by comparing themselves to heterosexuals. Then, in the identity tolerance stage, individuals begin to name themselves as gay although they may be still uncomfortable with their non-heterosexuality. The fourth stage is identity acceptance that individuals adopt non-heterosexuality as identity and a way of life while they furthermore interact with other gays. The fifth stage called identity pride occurs when gays begin to embrace their identity and a way of life. Lastly, identity synthesis takes place when gays are comfortable with disclosing their sexual identity to anyone. In this stage, they also begin to perceive that sexual identity is just one aspect of their multiple identities. Negotiating non-heterosexual identities, however, can become very problematic in a society that stigmatizes homosexuality (Plummer 1981).

Simon and Gagnon (1967) have said that homosexuality has been historically characterized by rhetoric of sin and rhetoric of mental health. Dank (1971) was concerned with the process of coming out in the gay world. Based on his research finding, Dank (1971) learns that becoming gay only takes place in an environmental condition in which the cognitive category of gay identity exists. In particular, the accessibility to informational knowledge about gays and homosexuality play a major role in the communication process of self-identifying as gay. In this view, a man possessing the same-sex attraction in a societal environment in which the cognitive category of gay identity is not present and/or is negatively viewed by others experiences the difficulty dealing with his sexuality. The stigmatization of homosexuality (e.g., sin and mental illness) can become the source of conflicts in one's process of adopting homosexuality as a way of life. Thus, the recent growing circulation of homosexuality as a way of life co-creates and co-shapes the gay

community in which one will claim his group (or community) membership to themselves and to others (Dank, 1971).

Due to the stigmatization many youth engage in heterosexual behavior in an effort to change their orientation. This often turns out to be a losing battle. Jay and Young found that 83 percent of the lesbians and 66 percent of the gay men in their survey had previously engaged in heterosexual sex (Jay and Young, 1977). Bell and Weinberg (1978) similarly found that 87 percent of lesbians and 68 percent of gay males interviewed had prior heterosexual experiences. Two studies with gay male youth found that at least 50 percent had prior heterosexual experiences (Ramafedi1985, Roesler& Deisher, 1972). Jay and Young add that 55 percent of the lesbians and 46 percent of the gay males reported feeling negative about these experiences.

Youth is generally the time of life between childhood and adulthood (Macmillan 1981). The age in which a person is considered a "youth", and thus eligible for special treatment under the law and throughout society varies around the world. Age between “15-29” is defined as “Youth” according to the commonwealth (Commonwealth Secretariat, (2011). An individual's actual maturity may not correspond to their chronological age, as immature individuals can exist at all ages. *Youth* is also defined as "the appearance, freshness, vigor, spirit, etc., characteristic of one who is young". *Youth* is a term used for people of both sexes, male and female, of a young age (Youth dictionary retrieved Nov 6 2012). Youth is the stage of constructing the Self-concept. The self-concept of youth is influenced by several variables such as peers, lifestyle, gender and culture (Thomas, 2003). It is this time that a person’s has to make the right choices and if not, it will affect their future. Young people are disproportionately the victims of violence as well, which can have negative consequences for both physical and mental health (Boney-McCoy & Finkelhor, 1995; Singer, Anglin, Song, & Lunghofer, 1995).

Adolescent is also used to explain the meaning of youth. From its beginnings at the turn of the century, the scientific study of adolescent development has always had as part of its implicit and explicit agenda as the goal of describing, explaining, predicting, and ameliorating problematic behavior (Dornbusch et al, 1991). Adolescence is not a period of “normative disturbance,” and accumulating evidence

that the majority of teenagers challenges the period without developing significant social, emotional, or behavioural difficulties (Steinberg 1999). Adolescence has long been characterized as a time when individuals begin to explore and examine psychological characteristics of the self in order to discover who they really are, and how they fit in the social world in which they live. Especially since Erikson's (1968) theory of the adolescent identity crisis was introduced and viewed adolescence as a time of self-exploration. Most individuals explore and integrate their sexual identity into their personal identity during adolescence (Erikson, 1950, 1968). Sexual identity development can be especially arduous for youths who discover that they may be gay, lesbian, or bisexual. Their sexual identity development, which is known as the "coming-out process," is expected to influence a wide range of adaptation (e.g., psychological functioning) and health-related (e.g., sexual acts) behaviors. They are also twice as common among youths reporting sexual behavior with the same sex as compared with peers reporting sexual behavior exclusively with the other sex (Faulkner & Cranston, 1998).

The American Psychiatric Association notes in the 1980 edition of the Diagnostic and Statistical Manual of Mental disorders (DSM III) that "there is a general consensus that spontaneous development of a satisfactory heterosexual adjustment in individuals who previously had a sustained pattern of exclusively homosexual arousal is rare". One potentially serious consequence of this heterosexual experimentation is pregnancy involving young lesbians or gay males that either occurs accidentally or in an effort to "prove" a heterosexual orientation.

Therefore, removing of homosexuality as a disease is not an indication of that prejudice against lesbian, gay, bisexual and transgender individuals is merely an historical phenomenon. Violence against homosexual youth and adults is still a present reality. D'Augelli (1998) summarized data from a number of surveys and research studies demonstrating that lesbian, gay, and bisexual youth were more likely to be victimized within their families and in the community. Violence against lesbian, gay, and bisexual youth takes the form of verbal harassment by peers, threat of physical violence, physical attack, rape, incest and destruction of personal property. Fifty-two percent of the women that participated in the National Lesbian and Gay Health Foundation study (Bradford, Ryan, & Rothblum, 1994) reported that they had been physically assaulted. Lesbian, gay, bisexual and transgender youth and adults are

a stigmatized minority group. As such, they face the daily stress of being members of a stigmatized group (DiPlacido, 1998).

Homosexual relationships and acts have been admired as well as condemned throughout recorded history, depending on the form they took and the culture in which they occurred, Ford and Beach demonstrate that homosexual behavior occurs in many societies and is not always condemned (Williams, 1986). Condemnation of homosexual acts (and other non-procreative sexual behavior) as "unnatural," which have been received official condemnation is congruent with most of the religious faith, and has continued through the present day. In some places, such as the New Haven colony, male and female homosexual acts were punishable by death (Katz, 1976). According to Freud (1905) all human beings were innately bisexual and that they become heterosexual or homosexual as a result of their experiences with parents and others. But there are no empirical studies or peer-reviewed research that support theories attributing same-sex sexual orientation to family dysfunction or trauma (Bell et al., 1981; Bene, 1965; Freund & Blanchard, 1983; Freund & Pinkava, 1961; Hooker, 1969; McCord et al., 1962; D. K. Peters & Cantrell, 1991; Siegelman, 1974, 1981; Townes et al., 1976)

Homosexuality is mostly a taboo subject in Indian civil society and for the government. Section 377 of the Indian Penal Code makes sex with persons of same gender punishable by law (Shyamantha 2013). Public discussion of homosexuality in India has been inhibited by the fact that sexuality in any form is rarely discussed openly. In recent years, however, attitudes towards homosexuality have shifted slightly. In particular, there have been more depictions and discussions of homosexuality in the Indian news media. India is among countries with a social element of a third gender. But mental, physical, emotional and economic violence against LGBT community in India prevails. Lacking support from family, society or police, many gay rape victims stay silent (Times of India 2013). On 11 December 2013, homosexuality was criminalized in India by a Supreme Court ruling (Shyamantha 2013).

Wellbeing has been defined from two perspectives. The clinical perspective defines well-being as the absence of negative conditions and the psychological perspective defines well-being as the prevalence of positive attributes. Positive psychological

definitions of wellbeing generally include some of six general characteristics. The six characteristics of well-being most prevalent in definitions of well-being are: the active pursuit of well-being; a balance of attributes; positive affect or life satisfaction; prosocial behavior; multiple dimensions; and personal optimization. Gough et al (2007) defined well-being as 'What people are notionally able to do and to be, and what they have actually been able to do and to be'. According to Angner (2008), even the philosophical literature refers to the 'simple notion' of well-being (i.e. 'a life going well') in a variety of ways, including a person's good, benefit, advantage, interest, prudential value, welfare, happiness, flourishing, eudaimonia, utility, quality of life, and thriving.

Psychological well-being is usually conceptualized as some combination of positive affective states such as happiness (the hedonic perspective) and functioning with optimal effectiveness in individual and social life (the eudaimonic perspective) (Deci & Ryan 2008). As summarized by Huppert (2009): "Psychological well-being is about lives going well. It is the combination of feeling good and functioning effectively". By definition therefore, people with high Psychological Well being report feeling happy, capable, well supported, satisfied with life, and so on; Huppert's (2009) review also claims the consequences of Psychological Well being to include better physical health, mediated possibly by brain activation patterns, neurochemical effects and genetic factors.

Subjective Well-Being (SWB) was defined by Deiner (2009) as the general evaluation of one's quality of life. The concept has been conceptualized as the three components: (1) a cognitive appraisal that one's life was good (life satisfaction); (2) experiencing positive levels of pleasant emotions; (3) experiencing relatively low levels of negative moods (Deiner, 2009). Furthermore, well-being has been defined as "Playing an active role in creating their well-being by balancing different factors, developing and making use of resources and responding to stress (Bradshaw *et al.* 2007).

Quality of life has also been defined "as the satisfaction of an individual's values, goals and needs through the actualization of their abilities or lifestyle" (Emerson, 1985).This definition is consistent with the conceptualization that satisfaction and wellbeing stem from the degree of fit between an individual's perception of their

objective situation and their needs or aspirations (Felce & Perry, 1995). The World Health Organization defines Quality of life as "an individual's perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns. It is a broad ranging concept affected in a complex way by the person's physical health, psychological state, personal beliefs, social relationships and their relationship to salient features of their environment"(Oort, 2005).

According to Ryff and Keyes (1995), psychological well-being is based on several dimensions: self-acceptance, personal growth, purpose in life, environmental mastery, autonomy, and positive relationships with others. These dimensions cover much of the same domain as sources of meaning (Wong, 1998). According to Keyes (1998), social well-being consists of five dimensions: social integration, social contribution, coherence, actualization, and acceptance. Complete mental health includes emotional, social, and psychological well-being (Keyes & Magyar-Moe, 2003) in addition to the absence of mental illness symptoms (Keyes & Lopez, 2002). Numerous studies have linked meaning in life with positive affect and life satisfaction (Chamberlain & Zika, 1988; King., Hicks., Krull & Del Gaiso, 2006; Ryff, 1989; Zika & Chamberlain, 1992). When things are going well and people are enjoying pleasant, engaging, and successful activities, positive emotions are probably sufficient to sustain a high level of subjective well-being. Research has clearly demonstrated the health benefits of positive affect (Fredrickson, 2001; Lyubormirsky, 2007). However, when people are going through very difficult times, meaning, rather than positive emotions, becomes more important in maintaining some level of well-being (Frankl, 1985; Wong, 2010, 2011).

Adolescence is an important transitional period marked by new social, academic, and vocational challenges in the lives of young people. Recently, experts in the field of adolescent development have begun to recognize that in addition to being a time of high risk for problem behaviors, adolescence is also a time of great opportunity for most young people (Lerner & Galambos, 1998). Therefore, in addition to studying the risk factors for negative outcomes among youth, greater attention should be paid to the protective factors that enable most adolescents to succeed in developmental tasks and go on to become productive adult members of society. The degree to which an adolescent is able to succeed at developmental tasks over the course of junior and

senior high school is likely to play an important role in their developing sense of self. Over time, repeated successes in academic, interpersonal, or other important domains are apt to enhance a young person's sense of mastery, self-esteem, and sense of psychological well-being. Conversely, repeated experiences with failure may lead to low self-esteem, poor self-confidence, feelings of hopelessness and distress, and other problems related to psychological adjustment.

Gender role conflict refers to identity confusion, means that those who are not fully aware of their gender identity regarding to female or male. It is expected that gay men as compared to their non gay counter experience more gender role conflict and that conflict may affect their psychological well being. Studies have typically found gender role conflict to be negatively related to psychological well-being (Blazina & Watkins, 1996; Cournoyer & Mahalik, 1995; Good & Mintz, 1990; Good et al., 1995; Mahalik, Cournoyer, DeFranc, Cherry, & Napolitano, 1998; Sharpe & Heppner, 1991). But no emperical evidence regarding to gender role conflict was found. Theorist assumed that progression through the stages toward an achieve identity was associated with a linear increase in positive self concept (Marcia 1980, Phinney and Alipuria 1990).

Homosexual men may face difficulties due to being more likely to display gender atypical behavior than heterosexual men. Development of sexual identity in middle childhood and early adolescence is a natural process. However, it is more stressful for homosexual youth. Homosexual male also face bullying in the schools and society. In this regard, some results suggest that those subjects who have been victims of bullying and are culturally stigmatized are more likely to suffer mental health problems and experience a variety of symptoms leading to post-traumatic stress due to the unremitting nature of the suffered bullying (Leymann & Gustaffson, 1996).

Homosexual experience difficulties when it comes to accepting their sexual orientation (Friedman, 1991; George & Behrendt, 1988; Pilkington & D'Augelli, 1995). Additionally, some studies carried out with homosexuals have proved that the combined effect of bullying and difficulties in accepting one's sexual orientation is related to the onset of a number of mental health problems (Rivers, 2004). Therefore in order to avoid rejection and hostility, homosexual youths are pressured to hide their sexual identities. This fact compounds the anticipated normal developmental concerns

of youths, and can create unique problems for the homosexual youths. Homosexuality can place them at risk for social stigmatization, isolation, depression, suicide, abuse, and rejection by their families and friends. Anyone struggling with identity may confront the problem of announcing that identity to potentially hostile others (cf., Erikson, 1968; Marcia, 1994). Gay identity is particularly well suited to an exploration of articulating and publicizing identity. Degree of outness has been found to correlate positively with SWB (Luhtanen, 1996) and may be an important factor in physical health as well (e.g., Cole, Kemeny, Taylor, & Visscher, 1996, but cf., Cole, Kemeny, & Taylor, 1997).

Kurdek, (1988) carried out with gay and lesbian couples have shown that friends and partners provide further social support, social support has not only positive effects on psychological well being but also a protective function against the negative effects of stressful life events (e.g. Cohen & Wills, 1985; Henderson, 1992; Lin & Peek, 1999; Schwarzer & Leppin, 1992; Turner & Turner, 1999). Hershberger & D'Augelli (1995) found that the best predictor of mental health among homosexual people was self-acceptance, as well as that such self-acceptance was associated with the support provided by families but only for those who had experienced low bullying levels. Rivers (2006) found higher rates of depression, anxiety and hostility among former victims as compared to non formal victims, bullying can have a negative effect on psychological well being.

Homosexual men may struggle with unique problems attending their sexual orientation e.g., being at odds with society's prescribed view, social condemnation, increased isolation, diminished support, and acceptance, still issues of success, power, and competition; emotional disclosure; affectionate expression; and work–family conflict have as much relevance for the gay as for the non-gay experience . As they were under a lot of pressures, their psychological well being were affected in a negative ways. Meyer (2003) mention that in decreased concealment of sexual identity, opportunity for in-group identification, and greater access to social support foster acceptance of homosexual and bisexual identity that, in turn, is strongly linked to psychological well-being .

Recent studies have suggested that life satisfaction is reciprocally effected by personality traits and psychological variables of life events and social support (Diener,

1996; Lu, 1999). Most researchers agree that, although life satisfaction fluctuates over time (Diener et al. 2003), in the long run, even exhilarating or traumatic events do not change it drastically. One explanation for that is that personality explains most of the variability in life satisfaction, and, as personality traits and dispositions tend to be stable over time, they create stability in levels of life satisfaction (Diener et al. 1999). Researchers refer to diverse aspects of personality when discussing life satisfaction. Some focus on locus of control (Spector et al. 2001, Wardle et al. 2004), others on self esteem (Diener and Fujita 1995), depression (Hong and Giannakopoulos 1994), introversion and extroversion (Harrington and Loffredo 2001), or trust (Lucas and Fujita 2000). Fewer researchers refer to instrumental and expressive traits as related to life satisfaction.

Homosexual men reported more psychological distress than heterosexual men, despite similar levels of social support and quality of physical health," the researchers reported. In speculating about the reasons for the higher level of psychological problems, the researchers offered the commonly proposed theory that social discrimination could be a source of the problem. Bailey (1999) in a prominent prior study also suggests that the higher level of mental disorders could be because homosexuality might constitute a "developmental error.” However, the researchers did note that "homosexual men may have lifestyles that make them vulnerable to psychological disorder. As research indicates, compared to their heterosexual counterparts, homosexual men and lesbian women are more prone to suffer from mental health problems, including an increased risk of depression and substance abuse disorders (Meyer, 2003). Turning to alcohol and other substances may be a form of relief from this tremendous stress (Anderson, 1996; Gochros &Bidwell, 1996). Homosexual men who hide their sexual orientation isolate themselves from gay communities. Consequently, their isolation for fear of disclosure leads to reduced social support, loneliness and an increased risk of depression (Oetjen & Rothblum, 2000).This feelings of rejection can affect their psychological well being.

Some international research studies on the impact of victimization on the psychological wellbeing of gay men and lesbian women have shown the consequences to range from minor reactions such as headaches, restlessness and sleep disturbances to more long-term reactions such as depression, post-traumatic stress disorder, increased substance (alcohol and drug) use, as well as suicidal ideation and

suicide attempts (Herek, Gillis, Cogan & Glunt, 1997; Hershberger & D'Augelli, 1995; Mays & Cochran, 2001; Otis & Skinner, 1996; Ryan & Rivers, 2003). Contrary to many studies indicating the link between victimization and psychological well-being, (Waldo,Hesson-McInnis and D'Augelli 1998) found no direct link between victimization and psychological distress. They did, however, find that victimization leads to lowered self-esteem, which, in turn, increases psychological distress. Self-esteem was therefore found to mediate the impact of victimization on psychological distress.

Gay men and lesbians may have lifestyles that make them vulnerable to psychological disorder. Such lifestyles may include increased use of drugs and alcohol. Prejudice in society against gay men and lesbians leads to greater psychological distress and higher use of services than in the heterosexual population (Savin-Williams, 1994). Until the past 25 years, homosexuality was considered to be a deviation from normal development that was accompanied by psychological symptoms (King & Bartlett, 1999). There is no evidence, however, for other developmental or physical abnormalities in gay men and lesbians that would lend support to the view that it is a developmental error (Bailey, 1999).

Distress refers to psychological suffering. It also refers to a state of adversity in which there is great peril or affliction. Distress also refers to great physical pain. There is a longstanding acceptance that psychological distress (PD) in the form of anxiety, sadness, irritability, self-consciousness and emotional vulnerability is strongly correlated with physical morbidity, reduced quality and duration of life, and increased use of health services (Lahey, 2009). There is evidence to suggest that social stress is associated with gender among LGB persons. Szymanski (2005) found that heterosexism, sexism, and internalized heterosexism are associated with psychological distress in lesbians and bisexual women, and that the interaction of heterosexist and sexist events further contributes to levels of psychological distress. Hughes et al. found that African American lesbians reported more indicators of psychological distress than African American heterosexual women. Lastly, a more recent study examined levels of psychological distress and common problems reported in an exclusive group of African American lesbians and bisexuals (Mays, Cochran, & Roeder, 2003). Although they did not directly compare heterosexuals with LGBs, Mays et al. reported that over one-third of African American lesbians and

bisexuals (38%) reported psychological distress, a percentage that exceeds population norms for African American females (26%) in the general public. Given the differences between heterosexual and LGB African American women, Hughes et al. suggested that future research investigate the potential relationships between specific risk factors associated with multiple minority status and psychological distress.

Studies have shown that gay people tend to experience psychological distress in relation to their homosexual orientation (D'Augelli, 2002; D'Augelli et al., 2002; D'Augelli & Hershberger, 1993; DiPlacido, 1998; Lock & Hans, 1999; Rosario, Rotheram-Borus, & Reid, 1996). Sources of distress include confusion arising out of their repeated reexamination of their sexual orientation, discrimination and social isolation with their deviation from normative sex-role behaviors and sexuality, struggles about whether or not to reveal their lifestyles, and uncertainty about the extent they can be affectionate to their partner in public. Other studies have also suggested that homosexual identification at a very young age may be associated with adjustment problems such as emotional distress, substance use, school failure, and peer rejection (D'Augelli, 2002; Floyd & Stein, 2002: Pilkington & D'Augelli, 1995; Rosario, Rotheram-Borus, et al., 1996). In other words, psychological distress of gay people mainly comes from discrimination, a sense of differentness, and a lack of social support. . Research suggests that discrimination based on minority group membership can increase risk for psychological distress through a variety of processes (Huebner, Nemeroff, & Davis, 2005; Mays & Cochran, 2001; Sandfort et al.,2001). These include direct experiences of victimization and rejection; however, even more subtle perceptions of discrimination may be related to increased psychological distress (e.g., Kessler, Mickelson, & Williams, 1999).

Due to the stigma surrounding, sexuality has placed a burden on individuals who do not self-identify as heterosexual (i.e., collectively referred to as “sexual minorities”; (Meyer 2003). Sexual minority youth experience greater psychological distress than heterosexual youth (Mays and Cochran 2001; Meyer, Dietrich & Schwartz 2007) and more victimization, especially related to their sexual identity (e.g., verbal taunts, physical threats, physical violence (Palfrey & Durant; 1998, Rivers & D’Augelli 2001).

According to Foreman (1999), within each society an estimated 5±10% of the population is engaging in same-sex sexual relations. In Bostwana's study the levels of well-being of Gay, Lesbian and Bisexual (GLBs) appeared to be influenced by both positive internal acceptance and the negative external acceptance of GLBs in society. The findings indicated that distress of varying degrees was experienced by 64% of the GLBs in this study. The majority of Botswana's GLBs experience levels of distress because of social isolation, criminalization of same sex behaviors, and unmet health care needs.

Depression is a state of low mood and aversion to activity that can have a negative effect on a person's thoughts, behavior, feelings, world view, and physical well-being (Salmans &Sandra, 1997) Depressed people may feel sad, anxious, empty, hopeless, worried, helpless, worthless, guilty, irritable, hurt, or restless. They may lose interest in activities that once were pleasurable, experience loss of appetite or over- eating, have problems concentrating, remembering details, or making decisions, and may contemplate or attempt suicide. Insomnia, excessive sleeping, fatigue, loss of energy, or aches, pains, or digestive problems that are resistant to treatment may also be presented (nimh.nih.gov 2012).

Depression is a serious illness that negatively affects how people feel, think, and act; depression is a common disease. Currently, depression is the fourth most common cause of disability worldwide. It is estimated that by the year 2020, depression will be the second most common cause of disability in the developed world, and the number one cause in the developing world (APA 2000 & Culbertson 1997). Depression can cause life miserable and can be a huge amount of suffering. It is a major reason for people taking time off work, causes great problems in peoples' home lives, and can lead to death from suicide or from self-neglect (Australian statistics 1995). It has been claimed that entire countries are facing a loss in productivity because of depression (Francis and Grey 2002). Suicide is a significant mortality risk factor for men of all ages and races. Men are around 3 to 4 times more likely to kill themselves than women in all age categories. The mortality rate for men by suicide is four times the rate of women but women are hospitalized for attempted suicide at 1.5 times the rate of men.

Men are not invincible. They do suffer from depression. According to the National Institute of Mental Health (NIMH), about six million American men suffer from depression every year. Researchers believe that typical depressive symptoms may not represent men's depression (APA 2010). Their expression would manifests as increase in fatigue, irritability and anger and loss of interest in work and hobbies. In order to mask these symptoms, men tend to use drugs, alcohol or would self medicate. Alcoholism or excessive alcohol consumption significantly increases the risk of developing major depression (Falk, Yi & Hilton 2008, Boden & Fergusson 2011). Men also try to hide it with overwork or exposure to harm by risky behaviour. It is an established fact that men commit suicide more often than women. Men are said to be notorious in expressing their emotions and probably have the ingrained belief that it is a sign of weakness and does not conform well to their gender role.

Depression is considered by many to be a "women's disease," therefore, it does not fall into the realm of "normal" diseases that men are expected to have. For men who identify with traditional notions of masculinity it would be threatening to his sense of self to be diagnosed with a "feminine disorder" such as depression. As a result, men experiencing symptoms consistent with the definition of depression are less likely to seek help. Due to this reason of labeling men are more likely to mask their depression with substance use or risk taking behaviors (Cochran & Rabinowitz, 2003; Diamond, 2005; Kantor, 2007).

According to the research of Dr Apu Chakraborty, Homosexual people tend to experience more mental health problems than heterosexual people. He believes that discrimination may contribute to the higher risk .Whether or not discrimination is the cause, mental health problems have previously been found to be higher among homosexual people. In 2008, Professor Michael King and his team at University College London, UK, carried out a review of 28 papers on the subject. All were published between 1966 and 2005, and included a total of 214,344 heterosexual and 11,971 homosexual people. Their analysis revealed twice the rate of suicide attempts among lesbian, gay and bisexual people. The risks of depression and anxiety disorders were at least one and a half times higher, as was alcohol and other substance abuse (Michael King, 2008). Most of the results were similar in both sexes, but women were particularly at risk of alcohol and drug dependence and men at a higher risk of suicide attempts. The researchers say, "There are a number of reasons why gay people

may be more likely to report psychological difficulties, which include difficulties growing up in a world orientated to heterosexual norms and values and the negative influence of social stigma against homosexuality (Michael King & Nazareth, 2006).

The increased risk of contemplating suicide and actually harming oneself in gay and bisexual people has previously been reported in the USA (Fergusson *et al*, 1999; Herrell *et al*, 1999; Russell & Joyner, 2001) and requires much greater attention, particularly in adolescents (Muehrer, 1995). No study has examined whether gay and lesbian people have elevated rates of completed suicide, but there are indications from medical examiners' reports of suicides in males that this may be the case (Bagley, 1992).

Gay youth have frequently internalized a negative image of themselves. They are the only group of adolescents that face total rejection from their family unit with the prospect of no ongoing support. Many families are unable to reconcile their child's sexual identity with moral and religious values. Remafedi found that half had experienced negative parental response to their sexual orientation with 26 percent forced to leave home because of conflicts over their sexual identity (Ramafedi 1985). Family problems are probably the most significant factor in youth suicide. Youth derive their core sense of being cared about and belonging from their families. Gay youth may make suicide attempts after being rejected by their families. Gay and lesbian youth reported a higher incidence of verbal and physical abuse from parents and siblings than other youth (Huckleberry 1982). The National Gay Task Force found that more than 33 percent of gay males and lesbians reported verbal abuse from relatives because of their orientation and percent reported physical abuse as well (Los Angeles 1986 & Larkin Street 1984). Due to this harassment from the family and if it becomes too much to bear for gay youth may lead to suicide attempt. Gay youth become fearful and withdrawn; they used to feel totally alone often suffering from chronic depression, despairing of life that will always be as painful and hard as the present one.

Homosexual men have a higher prevalence of mood, anxiety and substance-use disorders than heterosexuals of the same sex (Cochran, Mays and Sullivan, 2005). Skidmore, Linsenmeier and Bailey (2006) similarly state that, unlike heterosexual men, homosexual men have increased rates of depression and other anxiety disorders.

Depression can result from a number of factors, including biological, psychological and social factors. Although the biological causes of depression are not disregarded, we focused on the socio-cultural stressors that could result in an increased vulnerability to depression. Vulnerability of depression can be seen by physical symptoms. These symptoms include some of the somatic symptoms of depression, such as insomnia or oversleeping, appetite gain or loss, headaches and loss of energy. Thoughts of suicide were also interpreted as indicative of vulnerability to depression. Studies have found higher rates of depression and loneliness among male homosexuals, as well as "more paranoia and psychosomatic symptoms." Further, 18% of white homosexual males (like the 18% of lesbians) reported attempting suicide at least once, compared to a much lower rate among heterosexual respondents. Another factor in suicide attempts would be the compulsive or addictive elements in homosexuality (Pincu, 1989) which could lead to feelings of depression when the lifestyle is out of control (Seligman, 1975)

Some researchers suggest that distress are more common among homosexuals, distress is not the result of homosexuality itself, but the result of the way society treats homosexuals. Research supports a relationship between homosexuality and personal distress (rates of depression, substance abuse and suicidality). One important and carefully conducted study found suicide attempts among homosexuals were six times greater than the average (Remafedi et al, 1998). There is now clear evidence that mental health problems are indeed associated with homosexuality. Homosexuals and bisexuals are at least two-three folds more likely to manifest mood disorders, anxiety disorders, and substance use disorders compared to heterosexuals.

Gay men and lesbian women experience stress that is often linked to their membership of a stigmatized social minority (Vincke & Van Heeringen, 2002). Increased stress from various sources, including criminal victimization and lack of support, may also lower self-esteem, which causes an increased risk of mental health problems, including depression (Zea *et al*., 1999). As a result of these factors, gay men and lesbian women may suffer from minor to severe depression. Similarly, a fear of victimization can result in non-disclosure of sexual orientation, which, in turn, diminishes opportunities for appropriate support and heightens vulnerability to depression (Buzzella, Beals & Peplau, 2003). This may result in the excessive use of

alcohol and/or drugs to alleviate the stress, but which instead accentuate the depression.

According to the studies, depression and negative events of stress is closely related. Some gay men and lesbian women are faced with more stress than the general population because of the social stigma associated with having a minority sexual orientation. Therefore, gay men and lesbian women have been found to have a higher prevalence of mood, anxiety and substance use disorders than heterosexuals of the same sex (Cochran *et al*., 2003). In a survey conducted in the USA by McKirnan and Peterson (1993, in Anderson, 1996) among gay men and lesbian women (n = 3 400), it was found that the participants who reported more negative affectivity, including depression, were more likely to abuse alcohol to reduce tension. This correlation between stress and alcohol abuse was strong among both gay men and lesbian women, just as among the heterosexual population (Anderson, 1996). The link between negative affectivity and marijuana use, cocaine use and other drug problems was consistent, but low (Anderson, 1996).

Researchers have attempted to identify the risk factors for depression among gay men and lesbian women (Cochran, Mays & Sullivan, 2003; D'Augelli, Grossman, Hershberger & O'Connell, 2001; Luhtanen, 2003; Mays & Cochran, 2001; Otis & Skinner, 1996; Zea *et al*., 1999). The most consistently reported factors are: self-esteem, social support, self-disclosure of sexual orientation, victimization, and alcohol and drug use. According to Crocker (1999, p. 90) self-esteem refers to 'personal and global feelings of self-worth, self-regard, or self-acceptance'. Self-esteem is therefore an indication of the degree to which one values oneself, happy and has confidence in oneself. High self-esteem is indicative of a positive self-concept, while low self-esteem indicates a negative self-concept. In the USA, several studies among gay men and lesbian women have shown that self-esteem and depression are strongly related, with higher self-esteem resulting in lower levels of depression (D'Augelli *et al*., 2001; Luhtanen, 2003; Otis & Skinner, 1996; Zea *et al*., 1999). Although these studies differ considerably in terms of sample and the scales used in measuring depression/mental health, the relationship between self-esteem and depression/mental health is consistent. Low self-esteem is a risk factor for depression and higher self-esteem results in a decreased vulnerability to depression.

Gay and lesbian youth bear an increased risk of suicide, substance abuse, school problems, and isolation because of a "hostile and condemning environment, verbal and physical abuse, rejection and isolation from family and peers" (Gibson, 1989). Numerous studies have shown that lesbian, gay, and bisexual youth have a higher rate of suicide attempts than do heterosexual youth. Jay and Young (1977) found that 53 percent of gay males and 33 percent of lesbians surveyed believed their suicide attempts involved their homosexuality. Bell and Weinberg (1978) report that 58 percent of gay males and 39 percent of lesbians felt their first suicide attempts were related to the fact that they were homosexuals. Suicide attempts by gay and lesbian youth are even more likely to involve conflicts around their sexual orientation because of the overwhelming pressures they face in coming out at an early age. Bell and Weinberg found that initial suicide attempts related to homosexuality more frequently involved acceptance of self and conflicts with others for gay males, Self acceptance may be especially critical for young gay males who tend to have homosexual experiences and are aware of their orientation at a somewhat earlier age than lesbians (Jay and Young, 1977, Bell, Weinberg and Hammersmith, 1981). Conflicts with others may be more salient for young gay males "identified" as homosexuals. The earlier a youth is aware of a gay or lesbian orientation, the greater the problems they face and more likely the risk of suicidal feelings and behavior. Remafedi observes that younger gay adolescents may be at the highest risk for dysfunction because of emotional and physical immaturity, unfulfilled developmental needs for identification with a peer group, lack of experience, and dependence on parents unwilling or unable to provide emotional support (Ramafedi, 1985).

Age also matters because adolescence and early young adulthood can be a tumultuous and distressing time. The teenage years are generally a period of identity confusion and turmoil (Erikson, 1968). Although studies seem, overwhelmingly, to report greater mental health problems among gay compared with heterosexual men, many rely on adolescent and college aged participants (Bagley and Tremblay, 2000: Faulkner and Cranston, 1998; Fergusson et al, 1999; French et al, 1998; Morris et al, 2001; Safren and Heimberg, 1999). Numerous studies of mental disorder among adults, indeed the majority of those included in a meta-analysis by Meyer (2003), examine lifetime incidence, and hence do not fix the time of the disorder. Reported disorders may have occurred years earlier, possibly even during adolescence or early

young adulthood rather than later in adulthood. Other studies that examine one-year incidence of disorders (or recent symptoms) combine adolescents, young adults, and middle-aged adults together in the same sample without taking age into account (see review by Meyer 2003). This leaves open the possibility that inclusion of adolescents and college students in the adult samples increases the magnitude of differences related to sexual orientation (or even accounts for observed differences altogether).

Depression is more likely to be associated with anxiety than any other disorder. Just over half the people with an affective disorder or depressive disorder also reported an anxiety disorder. The co-morbidity of depression and anxiety is evident in both primary care and specialized mental health settings. Anxiety is an uneasy, fearful feeling is the hallmark of many psychological disorders. Anxiety may be defined as a general feeling of apprehension about possible danger, **(**Carson Butcher, & Mineka, 1998)

Anxiety is experienced as an inner state in which an individual anticipates some dreadful things happening that is not entirely predictable from his/her actual circumstances. When an individual cannot deal with the demands of desires (including sex and love) and reality, anxiety follows. Although anxiety is often adaptive in mild and moderate degrees, it is maladaptive when it becomes chronic and severe, as we generally see people diagnosed with anxiety disorders under the Diagnostic and Statistical Manual of Mental Disorders-IV (DSM-IV) published in 1994 (Barlow. 1988). In generalized anxiety disorder, distress and uneasiness are persistent, painful, and spread across multiple situations. Such anxiety can make people thoroughly miserable and even upset their health.

Aggression refers to a range of behaviors that can result in both physical and psychological harm to oneself, other or objects in the environment. The expression of aggression can occur in a number of ways, including verbally, mentally and physically. Aggression, in its broadest sense, is behavior, or a disposition, that is forceful, hostile or attacking. It may occur either in retaliation or without provocation. Aggression differs from what is commonly called assertiveness, although the terms are often used interchangeably among laypeople, e.g. an aggressive salesperson (Akert et al, 2010)

Aggression is difficult to measure, however. First, individuals often deny or conceal their aggressive behavior (e.g., James, McIntyre, Glisson, Green, Patton, LeBreton, et al., 2005). Second, aggressive acts are often unethical or consequential. Hence, researchers need to apply techniques that circumvent these complications. Aggressive individuals tend to espouse a variety of distorted assumptions, all intended to justify their behavior. (James, McIntyre, Glisson, Green, Patton, LeBreton, et al., 2005) For example, aggressive participants more likely to believe that other individuals are motivated to harm, not help. For instance, they assume surveillance systems are merely an excuse to bother employees.

There is evidence Males are historically believed to be generally more physically aggressive than females (Maccoby & Jacklin, 1974), men commit the vast majority of murders (Buss, 2005) . Theory and research suggest that antigay assailants motivated by gender role enforcement endorse traditional beliefs about the male gender role. These beliefs reflect adherence to a variety of separate norms, including: (a) Status, which reflects the belief that men must gain the respect of others, (b) Toughness, which reflects the belief that men are physically tough and inclined to be aggressive, and (c) Anti-femininity, which reflects the belief that men should avoid stereotypically feminine activities (Thompson & Pleck, 1986). Parrot (2008) posited that men who experience stress associated with threats to their masculine identity may be at heightened risk to engage in aggression toward sexual minorities. Indeed, men's tendency to experience gender-relevant stress, termed masculine gender role stress, leads them to "experience stress when they judge themselves unable to cope with the imperatives of the male role or when a situation is viewed as requiring 'unmanly' or feminine behavior". In contrast to masculinity ideology, which reflects the internalization of cultural norms regarding masculinity, masculine gender role stress refers to the negative effects that result from adhering to these prescribed standards of masculinity. Accordingly, men who report high levels of masculine gender role stress are posited to display increased anger or aggression in situations that involve behavior inconsistent with traditional male gender role norms as being in the presence of two gay men (Eisler & Skidmore, 1987).

According to the findings of the study, forthcoming in the journal Personality and Individual Differences, homosexual men score higher for empathy and show significantly lower levels of physical aggression than heterosexual men. Aggression is

directed to and often originates from outside stimuli, but has a very distinct internal character. Researchers often need to assess the level of aggression that individuals exhibit-defined as behavior with intent to harm a person (e.g., Baron & Richardson, 1994; Berkowitz, 1993; Geen, 1990). Although many forms of aggression have been differentiated, researchers often divide these acts into two main categories (e.g., Anderson & Carnagey, 2004): sometimes known as affective and predatory. Affective aggression, also called reactive, defensive, and hostile, refers to aggressive behavior that is elicited by a sense of threat, even fear. This form of aggression is impulsive, devoid of careful planning. In contrast, predatory aggression, also called instrumental, premeditated, and proactive, is more deliberate and calculated. Using various techniques and experiments, scientists have been able to explore the relationships between various parts of the body and aggression. Buss and Perry (1992) developed a scale that assesses the extent to which individuals exhibit aggressive behavior. This measure of trait aggressiveness comprises three subscales. The first subscale represents the degree to which respondent's exhibit anger. A typical item is "When frustrated, I let my irritation show". The second subscale concerns the extent to which respondents express aggressive remarks, called verbal aggression. A sample item is "When people annoy me, I may tell them what I think of them". The third subscale refers to the degree to which participants perceive other individuals as hostile. An example is "When people are especially nice, I wonder what they want.

Physical aggression includes behaviors that threaten or cause physical harm, such as threats of bodily harm, physical fighting and violent crimes such as robbery, rape and homicide (Loeber & Hay, 1997; Yonas., O' Campo., Bureke., Peak & Gielen, 2005). In contrast, social aggression encompasses various forms of non-physical aggression, such as indirect and relational aggression, in which behaviors are focused on damaging social relationships rather than inflicting or threatening physical harm (Archer & Coyne, 2005). Socially aggressive behaviors include gossiping (Xie, Swift, and Cairns & Cairns 2002) excluding or alienating someone socially (Xie Swift et al, 2002) and trying or threatening to damage someone's social standing within a group (Crick & Grotpeter, 1995). Both types of aggression are common among youth in non-metropolitan areas (Farrell., Kung., White & Valois, 2000). Generally, aggressive behaviors progress from less to more severe over the course of adolescent development (Loeber & Hay, 1997; Tolan et al, 2000)

Gay men as compared to straight men, rarely participate in violent behavior. Usually more gentle and refined, most of them queers prefer to love men rather than fight them. Gay men usually have a feminine feature (queers unmanliness) which is a great virtue. Gladue and Bailey (1995) examined levels of physical and verbal aggression and interpersonal competitiveness among heterosexual and homosexual males (using a comparatively larger sample of 82 heterosexual males and 74 homosexual males). No significant differences were recorded for either verbal aggression or competitiveness; homosexual males reported significantly lower levels of physical aggression. Therefore homosexual males are reported to be less physically aggressive than heterosexual males (Ellis, Hoffman, & Burke, 1990; Gladue & Bailey, 1995).

Some Gay men may be sissies and more prefer feminine behavior rather than fights. Previous aggression studies have not, however, compared all forms of direct aggression, indirect aggression and empathy among these populations. Empathy is a significant factor to consider since it both mitigates the expression of aggression (Kaukiainen, Björkqvist, Lagerspetz, Österman, Salmivalli, Rothberg, & Ahlbom, 1998**)** and differs between heterosexual and homosexual males (Salais & Fischer, 1995). This study therefore evaluated levels of direct and indirect aggression and empathy among homosexual (n = 91) and heterosexual (n = 91) males. Data was collected from an Internet-based sample of the two groups using self-report psychometric measures in order to reduce social desirability effects. Homosexual males reported significantly lower levels of physical aggression and higher levels of empathy but report similar levels of indirect aggression, and other forms of direct aggression, to heterosexual males. According to the findings of the study, forthcoming in the journal Personality and Individual Differences, homosexual men score higher for empathy and show significantly lower levels of physical aggression than heterosexual men. However they do show similar levels of non-physical and indirect aggression, which is the ability to inflict pain while avoiding identification and counter-aggression, for example by spreading malicious gossip.

Verbal aggression is a message behavior, which attacks a person's self-concept in order to deliver psychological pain (Infante, 1995) .Verbal aggression, was defined as cursing, yelling, and screaming at others. Verbal aggression is used for escape from demanding or difficult situations, relief from stress, and avoidance of

demanding or difficult situations. The behavior appears to be maintained through positive reinforcement. (Ebbesen, Duncan and Konecni, 1974) suggested that verbal aggression could be reinforced and maintained in such a manner. Since the most common form of verbal aggression was cursing, the method of identifying and avoiding the antecedents proved very successful. Infante (1995) used a similar method with young students. When replicating this program it may be appropriate to focus on the positive behavior rather than the negative. Instead of documenting the frequency of verbal aggression it may have been better to document the frequency of successful avoidance of verbal aggression. In this way we would help to internalize the strategy to maintain the behavior, as well as having a more positive and constructive program. In general, much research has suggested that males use more physical aggressive than females, while females use more verbal aggression than males (Hanish et al, 2012). Therefore, homosexual men due to their feminine features are expected to use more verbal aggression than heterosexual men but no significant difference were found in verbal aggression among homosexual and heterosexual male (Gladue & Bailey 1995).

Homosexual adults are frequent targets of verbal harassment and threatened physical violence (Berrill, 1992). Due to their feminine features they may also face discrimination in the work force (Croteau & Von Destinom, 1994; Krieger & Sidney, 1997; Levine & Leonard, 1984). For example, homosexual people are four times as likely as heterosexuals to report being fired from a job because of perceived discrimination (Mays & Cochran, 2001). Further, non-heterosexual men earn 11–27% less than heterosexual men with similar qualifications (Badgett, 1995), probably because of discrimination against homosexuality.

Most of the gay men were labelled as sissy boys as they have feminine features which cause inner conflicts. According to Freud, fear represents a retreat from oedipal rivalry and competition. Indeed, homosexual boys may face a particular and complex oedipal conflict. However, modern re-theorization of homosexuality would suggest possibilities beyond simple oedipal retreat. For example, Isay (1989) has reinterpreted male homosexual development through his consideration of a homosexual boy's oedipal desire for his father, and Silverman (1992) has pointed to the various ways in which male homosexual desire may be tethered to a boy's identification with his mother. Such oedipal configurations may, in part, account for gay conflict with

aggression. For example, it seems likely that a homosexual boy's aggressive feelings may conflict with his wishes to be cared for by men or his aggressive feelings may threaten his efforts toward self-control, as he attempts to conceal his sexual desire. Regarding this belief that aggression underlies masculine development, Person (1986) has pointed out that, "The fundamental sexual problem for boys is the struggle to achieve phallic strength and power vis-a-vis other men"

Gay men have feminine features and their behavior is also more similar to female rather than male**.** Bird's (1996) conceptualization of masculinity and gender provides a useful method for viewing sexual identity maintenance. In her work on masculinity among heterosexually identified men, she discussed how heterosexually identified men used emotional detachment, competition, and rejection of femininity to maintain their ‘‘maleness’’ and heterosexuality. Avoiding emotional attachment and withholding expressions of intimacy serves to delineate and reinforce identity boundaries (Chodorow, 1978). Furthermore, a sense of competition and sport facilitates hierarchical relationships that reinforce separation and distinction between ‘‘feminine’’ and ‘‘masculine’’ (Gilligan, 1982). Although gender nonconformity and sexual orientation appear to be related, not all lesbians and gay men are gender nonconforming. For example, not all gay men report that they were feminine boys (Bailey & Zucker, 1995). In addition to its relationship with gender nonconformity, sexual orientation has been linked to measures of psychological distress (Cochran &Mays, 2000a, 2000b; Fergusson, Horwood, & Beautrais, 1999; Paul et al., 2002).

The researchers noted that "experience with aggression, minor or otherwise, is exceedingly common among young adults, as are observations of aggression and the occurrence of interactions that they judge could have led to aggression. They found that 1 in every 3 men between the ages of 18 and 30 and 1 in 5 women in that age category are the target of physically aggressive behavior on an annual basis. Prevalence studies show that violent criminal behavior is occurring at earlier ages (U.S. Department of Justice, 1990) and aggression among youth are usually high. Interpersonal aggression and violence are major public health problems that contribute substantially to morbidity and mortality rates in the United States, particularly among youth (Koop & Lundberg, 1992). A recent study of over 4,500 youth attending high school found that 43% of respondents reported hitting or threatening to hit someone in the past year, 14% reported attacking someone, and

13% reported carrying a hidden weapon (Ellickson, Saner, & McGuigan, 1997). Young people are disproportionately the victims of violence as well, which can have negative consequences for both physical and mental health (Boney-McCoy & Finkelhor, 1995; Singer, Anglin, Song, & Lunghofer, 1995). Inner-city African-American youth from low-income families are the group most vulnerable to injury or death due to violence-related causes (Christoffel, 1990; Hammond & Yung, 1993).

The peer group is another important social influence factor that is related to delinquent behavior in adolescents (Paetsch & Bertrand, 1997; Snyder, Dishion, & Patterson, 1986). Through social learning processes, association with a deviant peer group is likely to foster attitudes and beliefs that promote aggressive behaviors, as well as provide opportunities to learn and practice these new behaviors (Akers, Krohn, Lanza-Kaduce, & Radosevich, 1979). Studies have shown that high levels of involvement with delinquent peers can lead aggressive boys to higher levels of serious delinquency during adolescence (O'Donnell, Hawkins, & Abbott, 1995), especially for those boys who were only moderately aggressive to begin with (Vitaro, Tremblay, Kerr, Pagani, & Bukowski, 1997). In some cases, adolescents may increase levels of aggressive behaviors in order to gain approval and acceptance among peers (starting fights over what appear to be trivial issues). Thus, adolescents within delinquent peer groups may observe more impulsive behaviour and angry outbursts, perceive that these behaviors are highly valued, and develop attitudes favourable towards anger expression, risk-taking, and aggression.

Mizoram is one of the North east state in India. Christianity is the religion practiced in Mizoram. In Christianity belief, practice of homosexuality is a sin and robustly forbidden in the society. Gay life style was almost negligible in Mizo traditional society as it was a social taboo. With the advent of modern technology especially media communication Mizo youth are very much inflated by fashion and love plays. Within a short period the mizo youth imitate the lifestyles and adopting the new mode of life which is deeply influenced by the western culture. The Mizo as a society are inhibit and conservative, they also established a non-governmental organization called the Young Mizo Association with a major role of preserving and protecting the Mizo youth from illegal behavior .

Although men having sex with men (MSM) is a social taboo, the numbers of revealing their identity as homosexual (MSM) have increased rapidly during the past 3 years. Since the impression of MSM in Mizoram does not coincide with the belief in Christianity, their identity is difficult to access. As a result they are living in the community with a hidden burden and fear of discrimination. Because of this fact they are elusive and it is not possible to access them through directly. Therefore, the only effective ways to access them and reach out to them is through the NGOs.

The notion with regards to MSM in Mizoram by the general population varies, some accept them as they are but some opposed them strongly. But in general they are accepted as righteous so long as they are actively involved in the church. Their status and line of interest too is different, some of them hold high positions in Government and in the community, most of them engage themselves as beauticians, dancers, singers, and open shop and are interested in flower arrangement, and fashion designing.(FXB)

MSM in Mizoram can be classified into 4 groups, viz, blooming, beautiful, touchable and hidden. Blooming is those MSM, who are not ashamed of their identity and act exactly like women in the public and they are moderately active in sex. Beautiful are those MSM, who dress like a men but talk and act mostly like a woman and they are highly active in sex. Touchable are those MSM, who never act and dress like women but prefer another man for sexual intercourse and Hidden are those MSM who hide their identity in public. They slept around where ever they could.(FXB).

The study endeavors to determine the difference of homosexual and heterosexual regarding to their psychological adjustment on depression, aggression, psychological well being and satisfaction with life among male youth. There are many theories about the development of sexual orientation. There is no definite evidence that homosexuality is genetically transmitted. The incidence of homosexuality, bisexuality, and heterosexuality has been a topic of great debate (e.g., see Bailey, 1995). In one recent large-scale sex survey, Laumann, Gagnon, Michael, and Michaels (1994) reported that slightly over 6% of the men and over 4% of the women surveyed reported some degree of same-sex desire, whereas under 3% of the men and under 2% of women actually labeled themselves to be "gay" or "bisexual." However, some researchers believe that genes code for childhood temperaments, such as the level of activity, aggression, etc. predisposes the person to prefer social and sexual activities with persons of a particular gender to the other. Gender conformation tends to follow later during adolescence. This is also called the exotic becomes erotic (EBE) theory. Some researchers have reported its association with prenatal hormones and certain neuro-anatomical features. However, the exact causal factors related to homosexuality are still unclear.

There is no previous study on the issues of homosexuality among the Mizo’s. However there is a common notion in the Mizo society that MSM (mens having sex with men) is more vulnerable and prone to psychological problems as compare to heterosexual. Homosexual men are just like any other men in that although they share similarities, in reality they each have their own individual personality. Six personality variables (social anxiety, trait anxiety, locus of control, sensitization, depression, and self concept) were correlated with variables relevant to a positive gay identity (J.Patrict Schmitt, Lawrence A Kurdek, 1987). Dr. Rick Fitzgibbons, a psychiatrist and member of the Catholic Medical Association, says there is evidence that homosexuality is itself a manifestation of a psychological disorder accompanied by a host of mental health problems, including "major depression, suicidal ideation and attempts, anxiety disorders, substance abuse, conduct disorder, low self-esteem in males and sexual promiscuity with an inability to maintain committed relationships." But on the other side, the American Psychological Association, which is known for its support of homosexual "marriage," ignored the evidence he presented

that homosexuality presents significant danger to psychological health. (lifesitenews, 2005).

Personality has been conceptualized by many as the study of human nature (Buss, 2005). Homosexual Men are at substantially higher risk for some forms of emotional problems; including suicidality, major depressions, and anxiety disorder, conduct disorder, and nicotine dependence (Bailey, 1999). Individuals who discover that they possess same‐sex loving feelings may experience internal conflict because of a heterosexual socialization (Cass, 1979), and subsequently struggle with the fear of being "found out" (Newman and Muzzonigro, 1993). This internal process, very often conflicting, can have a "crippling" effect on individuals who are attempting to develop a positive homosexual identity (Cass, 1979; Coleman, 1982; Dupras, 1994; Newman and Muzzonigro, 1993).

In many countries they outlaw homosexuality. In some countries homosexual behavior is punishable by life imprisonment. In the Mizo Society, the Mizo's laid a strict order in dress code that men should wear pants and female should wear skirts. But now a day's things have change even the male are also unashamed to imitate the female dress code in public. While under British rule in 1909, superintendent of the Lushai Hills HWG Cole issued a statute (Order No. 3 of 1909. 10) criminalizing homosexuality. "In future, all homosexuals who are clearly of the male sex are to abandon wearing women's clothes and are to live as men and will pay revenue and do coolly (porter) work. Chiefs are bound to report all cases of unnatural offences that come to their notice whether or not any complaint has been made to them. Failure to do this will be severely punished," the order stated. After the statute was implemented in the Lushai Hills, homosexuals were often treated as outcasts.

Due to this stigmatization gay men have significantly greater prevalence rates of substance abuse and dependence compared with heterosexual men (Meyer, 2003). *Expectation of stigma* is defined as experiences that produce the gay/homosexual man's anticipation that he will be rejected and discriminated against by society because of his sexual orientation (Meyer, 1995, 2003). Due to the stigmatization homosexual men can have a variety of negative consequences (e.g., minority stress) throughout the life span (D'Augelli & Patterson, 1995; Meyer, 1995, 2003). Stigma, prejudice, and discrimination stemming from negative societal attitudes toward

homosexuality lead to a higher prevalence of mental health disorders among lesbians, gay men, and bisexuals compared to their heterosexual peers (Meyer 2003).

In a review of published studies comparing homosexual and heterosexual samples on psychological tests, Gonsiorek (1982) found that, although some differences have been observed in test results between homosexuals and heterosexuals, both groups consistently score within the normal range. Gonsiorek concluded that "Homosexuality in and of itself is unrelated to psychological disturbance or maladjustment. Homosexuals as a group are not more psychologically disturbed on account of their homosexuality (Gonsiorek, 1982, 1991; Riess, 1980).

Accepting oneself as gay/homosexual is an important aspect of psychological well-being for homosexual men and lesbians (Leserman, DiSantostefano, Perkins, & Evans, 1994; Miranda &Storms, 1989). With regard to the possible selves of gay/homosexual individuals, goals that emerge out of one's gay identity ought to be important contributors to well-being. The degree to which gay individuals invest in goals that are rooted in gay identity ought to be related to the experience of positive wellbeing. Thus, we predicted that the salience of the gay/homosexual best possible self would relate to heightened subjective well being among gay/homosexual men and lesbians thinking about unavailable opportunities may serve as a source for envy, regret, and rumination (Lyubomirsky & Nolen-Hoeksma, 1995; Tangney & Salovey, 1999). Thus, again, thinking a great deal about one's best possible straight self was expected to relate to lowered levels of well-being for gay people. Social well-being encompasses the extent to which individuals feel they make valued social contributions, view society as meaningful and intelligible, experience a sense of social belonging, maintain positive attitudes towards others, and believe in the potential for society to evolve positively. The achievement of social well-being defined by this construct overlaps with outcomes suggested by models of sexual identity formation in LGB (Lesbian, Gay, Bisexual) persons: a rejection of the belief that the world is divided into "bad" heterosexuals and "good" homosexuals; a decreased sense of anger, alienation, and frustration; and an increased sense of belonging to the world at large and of being more than "just" a lesbian or gay man (Cass 1996; Eliason, 1996).

Ross (1988) in a cross-cultural study found most gays/homosexual was in the normal psychological range. However some papers did give hints of psychiatric differences between homosexuals and heterosexuals. One study (Riess, 1980) used the MMPI, that venerable and well-validated psychological scale, and found that homosexuals showed definite "personal and emotional oversensitivity." The data from some studies suggest that non-heterosexuals may be at somewhat heightened risk for depression, anxiety, and related problems, compared to exclusive heterosexuals (Cochran, Mays & Sullivan, 2003). Nurius (1983) proposes that depression in homosexuals is not because they are ashamed of being homosexual, but because they must keep their sexual orientation to themselves.

Acculturation describes as the amount of culture-related values, beliefs, affects, customs, and behaviors, adapted or endorsed by a minority group to the norms of the majority/host culture (Ward, 1996). It considered a broad context and focused on possible environmental and individual variables affecting change over time, or the outcomes of the acculturation process on individual psychological well-being (Ward, 1996). The acculturation model (Berry., Kim., Minde & Mok, 1987) proposed five important moderating factors: the nature of the larger society; the type of acculturation group; modes of acculturation; demographic and social characteristics of the individual; and psychological characteristics of the individual. Five different acculturation groups that can be identified on the basis of the nature of their contact with the host culture: immigrants, refugees, native people, ethnic groups, and sojourners. The acculturation adaptation process experienced at the bicultural and multicultural environment can be influenced by a number of factors that operate on the personal and societal levels (Berry, 1997). Sandhu (1994) pointed out two psychological problems due to acculturation: (i) intrapersonal, which have roots within the self and includes personality traits, (ii) interpersonal, that include environment and cultural milieu or surroundings (Powell, 1875) agreed that dominant cultures could acculturate to weaker ones: “Conquering tribes take the language of the conquered.” Mizoram had experience acculturation from traditional society to modern society within a short period of hundred years, witnessing all the acculturation footprint of negative and positive changes from dominant culture of British and Indian. Being the young and minority culture group, Mizo are highly vulnerable to all

stronger/ higher culture group of their fashion, life styles, food habits, practices and so on.

With the scrapping of Article 377, the homosexual/Gay in Mizoram had seen a ray of hope. But church and social leaders opposed the Delhi HC verdict and favoured the 1909 British order. Rev. Zosangliana Colney, Executive who was a secretary of Mizo Synod said "Legalizing homosexuality is directly against the ethics of Christianity and the Bible. Mizoram Synod's social front was working on the issue of homosexuality in the state. "We will soon come out with a comprehensive statistics," Homosexuality became a fad in Aizawl following the invasion of western culture among the Mizo youths in the early Eighties (Times of India, 2009)

Besides many studies focusing on the psychological perspective of homosexual and heterosexual men, some researcher also represents a unique look at mental health in gay and heterosexual men from a developmental perspective. Gay and heterosexual men are compared at two age levels, early young adulthood (ages 18–24) and later young adulthood to mid-life (25–48). In addition, age-related changes in mental health, shame, and guilt are examined among gay and heterosexual men during and across each time period using a cross-sectional design. Problems in mental health are expected to diminish with adult development. Chronic shame and guilt underlie mental health problems among heterosexual individuals (Quiles and Bybee, 1997) and bear examination among gay individuals as well. In this study, a lessening of these potentially harmful feelings with development is expected to account, in part, for the expected age-related decline in mental health problems.

Different approaches to disclosing/ concealing sexual identity are examined in relation to age, chronic shame and guilt, and mental health among gay men. An all-male sample is utilized because men are at elevated risk for many of the mental health problems examined in this study such as suicidality, anxiety, and hostility. These are serious mental health issues that contribute to elevations in men’s mortality rates. In 2002, for example, 80% of all the suicides in the United States involved men, half of whom were aged below 45 (Minin˜o et al. 2006). Gay compared to heterosexual men are more than twice as likely to attempt suicide and are also at greater risk for anxiety disorders. The relationship of sexual orientation to these variables is not so clear among women (Meyer, 2003). Men are also more violence-prone than females

throughout the life-span (Mash and Wolfe, 2002). As men are at particular risk for suicide and hostility (Mash and Wolfe, 2002; Meyer, 2003), measures used for tapping these types of symptoms are included. In addition, indices of mental health, such as emotional instability and emotional unresponsiveness, which received less attention in previous studies, are included as they may change in response to maturation and evolution of better coping skills.

In addition to age, individual difference variables that may underlie mental health are also examined. Meyer (2003) identifies concealment of sexual identity as one of the primary reasons why gay individuals may experience mental health problems. Individuals may hide their sexual identity out of shame and guilt or because they fear they will be stigmatized, ostracized, disowned, fired from a job, or even physically attacked (Meyer 2003). The inner experience of concealment, however, can become a ‘‘private hell’’ (Major and Gramzow, 1999). Concealment serves to cut off channels of support from gay or sympathetic supporters. Attendant lies, cover-ups, and hiding secrets can lead to harmful, ongoing feelings of guilt and shame, serving to further undercut mental well-being. Some investigators report more symptoms of poor mental health among gay compared to heterosexual individuals (Bagley and Tremblay 2000; Faulkner and Cranston 1998; Fergusson et al. 1999; French et al. 1998; Lock and Steiner, 1999; Morris et al, 2001; Safren and Heimberg, 1999). Further, a recent meta-analysis of more than a dozen studies seems to confirm that gay individuals are at greater risk of developing a mental disorder (Meyer, 2003).

While social scientists have long recognized that sexual identity formation and maintenance is an important area of research (Plummer, 1981; Troiden, 1988), some have argued that sexual identity research is synonymous with the study of homosexuality (Epstein, 1994; Namaste, 1994); thus, few research studies have addressed the question of how heterosexual identities are formed and maintained (Eliason, 1995). Further, the cultural influences of sexual identity formation and maintenance are poorly understood (Johns & Probst, 2004). Given that heterosexually identified MSM do not identify as homosexual, gay or bisexual, their identity, and particularly the maintenance of their identity, tends to be understudied.

Some evidence does support the hypothesis that gender nonconformity may be associated with increased risk for psychological problems, at least for gay men. Bailey and Zucker (1995) reviewed several studies finding an association between childhood gender nonconformity and adult psychological distress in gay men. Psychological problems in adulthood associated with recalled childhood gender nonconformity include lower self-esteem, higher rates of mood and anxiety disturbances, and suicidality (Harry, 1983a, 1983b; Weinrich, Grant, Jacobson, Robinson, & McCutchan, 1992, Weinrich, Atkinson, McCutchan, & Grant, 1995). Gender nonconformity may also be associated with increased risk for suicide attempts in gay adolescents (Remafedi, 1999). The rejection that many lesbians and gay men may have faced as children because of their gender nonconformity could plausibly affect their development in important ways (e.g., Beard & Bakeman, 2000; Landolt et al, 2004). For example, Friedman and Downey (1999, 2002) described a complex process whereby stigmatization of childhood gender nonconformity may become linked to adult psychological distress for some gay men. They argued that gay men are especially likely to experience, and to be negatively affected by, stigmatization of childhood gender nonconformity. This stigmatization of their femininity, most often by other males, may become internalized and tied to their homosexual identity, causing some to develop internalized homophobia with an additional element of "gender-values self-condemnation" (Friedman & Downey, 1999, p. 327). They further argued that a similar process does not happen for gender nonconforming heterosexual men.

The theoretical foundations and empirical findings concerning to sexual orientation correlates to some psychosocial variables such as life satisfaction, well being, depression and aggression that emerged in the target population.

OBJECTIVES:

The study aimed to elucidate the cause and effect relationship, in addition to the co-relational inferences, by way of incorporating two–way classification of variables of 'type of sexual orientation' and 'age' (independent measures) on the sub-scale/sub-factor measures of depression, aggression, life satisfaction, subjective

wellbeing (dependent measures). The present study is concerned with the following objectives:

(1) To determine that the behavioral measures would find replicability in the project population - the Mizo youth.

(2) To determine that higher aggression, higher depression with lower life satisfaction and lower subjective wellbeing during first age group (15-21 years), then second age group will follow.

(3) To determine that homosexual group would manifest higher aggression and higher depression with lower life satisfaction and lower subjective wellbeing than heterosexual group

(4) To study the interaction effects of the 'type of sexual orientation' and 'age' differences are exploratory in nature, but are expected in conformity to the independent effects of the main variables on measures of the dependent variables.

HYPOTHESES:

To meet the objectives of the study the following hypotheses are set forth for the study:

I. Significant difference would be observed in dependent variables in relation to sexual orientations (homosexuality and heterosexuality), and age groups (two age groups: 15-21years and 22-28years).

2. Depression would be manifested in life satisfaction and psychological wellbeing among the groups of subjects.

3. Aggression will influence life satisfaction and psychological well being among the heterosexual groups of subjects but it is exploratory in nature.

4. Homosexual subjects are expected to have higher depression scores than heterosexual subject.

Sample: Three hundred and twenty (320) subjects were selected out by following purposive random sampling procedures from the different parts of Mizoram. Only Mizo male youth were included to serve as participants for the present study. Initially, 230 Mizo male youths were initiated for screening and to represent the homosexual Mizo youths and were selected from different registered drop-in Centres located in Aizawl and Lunglei; some were identified through clients of the selected drop-in centres and Link-workers specially serving MSM in different part of Mizoram. Only those who have showed high scores on Kinsey homosexual rating scale (subscale of the Kinsey Heterosexual – Homosexual Rating Scale) were selected for the samples. On final count, only 160 Mizo male youths were selected for the representative of Mizo male homosexual participants with due care of the equal representation of the two age groups (15-21 and 22-28). After the final selection of the representative of the Homosexual oriented samples, the selection of their counterpart – heterosexual samples were selected to match the homosexual oriented sample on ground of background information of the participants such as age, birth order, educational qualifications, employment status of the parents, the family structure (nuclear and joint), size of the family, space and other facilities available to each member of the family were recorded with the objective to obtain truly representative sample for study; and also cross confirmation of their biological sex; and also to control any possible confounding variables. Only Mizo male homosexual youth were included as female homosexual observable were less in number and having high inhibition to share their life experiences, the researcher being female may effect in their choice of friend as female homosexual are more favour male friend. The two age groups 15- 21 and 22- 28 were selected for the studies as the younger age were in the stage of identity tolerance stage, here individuals begin to name themselves as gay although they were still uncomfortable with their non-heterosexuality whereas the other age group were in the stage of identity pride, they begin to embrace their identity and a way of life (Plummer 1981).The age group range was 15 to 28, and was purposefully design with high expectation that they were more open to share their sexual orientation and life experiences as compared to older age range.

To meet the objective of the research scheme, as envisioned in the foregoing, a factorial design with two-way classification of variables is proposed. In essence, the overall considerations of the experimental design may be diagrammatically presented in Figure-1:

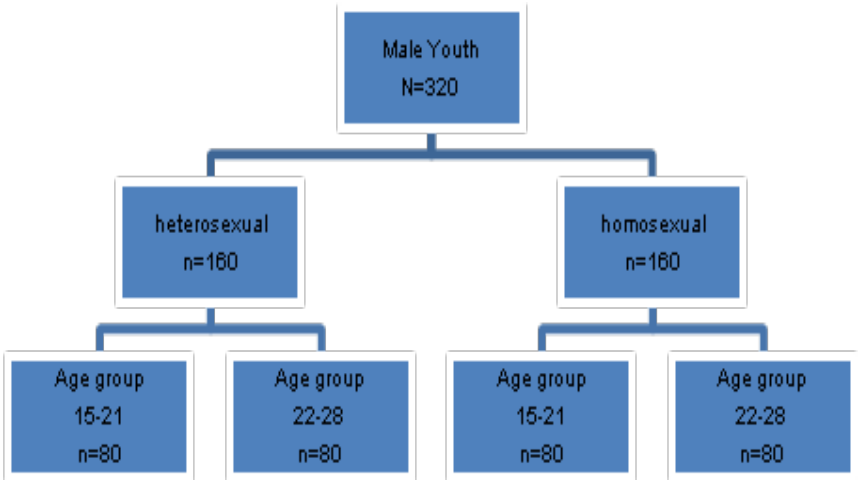


Figure – 1: showing the 2 x 2 factorial designs of the present study.

***Design of the study*:**

The study incorporates two way classifications of variables of 'sexual orientation' (heterosexual and homosexual), and 'age-group' (15-21, and 22-28). Under each cell of the main design (2 Sexual orientation x 2 Age-group) an equal proportion of participants, 80 Mizo male Youth in each, shall be included for psychoactive evaluation of the behavioral measures for study. 160 Mizo male youth who were having heterosexual orientations and 160 Mizo male youth who were having homosexual orientation were screen out by employing Kinsey Heterosexual-Homosexual Rating Scale for the final inclusion in the samples.

Psychological tools and Procedure:

To meet the objectives of the present study for the comparison of homosexual and heterosexual orientated Mizo youth, the following psychological measures were incorporated: (1) Kinsey Heterosexual-Homosexual Rating Scale (KRS; Kinsey et al., 1948) ; (2) *Well-being* Scale (Veit & Ware, 1983; Heubeck & Neill, 2000) (3) Satisfaction with life scale (Ed Diener, Robert A. Emmons, Randy J. Larsen and Sharon Griffin 1985).; (4) Becks Depression Inventory-11(Aaron T. Beck, Robert A.

Steer and Gregory K. Brown 1996). (5) Aggression (Buss, A. H., & Perry, M.1992) and (6) Demographic Profiles: The demographic profiles.

(1) ***Kinsey Heterosexual-Homosexual Rating Scale (KRS; Kinsey et al., 1948)***. The KRS is a 7–point, Likert style scale used to assess sexual orientation along a continuum such as exclusively heterosexual with no homosexual, predominantly heterosexual, only incidentally homosexual, predominantly heterosexual, but more than incidentally homosexual, equally heterosexual and homosexual, predominantly homosexual, but more than incidentally heterosexual, predominantly homosexual, only incidentally heterosexual, exclusively homosexual Participant has to report their behavioral experiences and sexual arousal from "exclusively heterosexual" to "exclusively homosexual." The "Kinsey Scale," was developed by Alfred Kinsey and his colleagues to asses their sexual orientation for psychological evaluation and research purpose.

(2) ***Psychological Well-being*** **Scale (GWS; Veit & Ware, 1983; Heubeck & Neill, 2000)** consists of 20 items where items 5,7,9,11,13,14,16,17,19,20 measure Psychological Distress (PD) and items 1,2,3,4,6,8,10,12,15,18 measure Psychological Well-Being (PWB) . The scale consists of 20 items and measures in a 6 point scale. In items that measure Psychological Distress (PD) the scores are reversed whereas in items that measure Psychological Well- Being, the scores are scaled in a positive direction where higher scores reflect positive well-being.

(3) ***The satisfaction with Life Scale (SWLS: Diener, Emmons, Larsen& Griffin, 1985):*** It consists of 5 items. The scale consists of 1-7 point scale ranging from 1 (strongly disagree) , 2 (disagree) , 3 (slightly disagree) , 4 (neutral) , 5 (slightly agree), 6 (agree), 7 (strongly agree). The Satisfaction with Life scale is scaled in a positive direction and there are no reverse scores.

(4). Becks Depression Inventory (BDI-11: Aaron T. Beck, Robert A. Steer and Gregory K. Brown1996): The BDI-II is scored by summing the ratings for the 21 items. Each item is rated on a 4-point scale ranging from 0 to 3. The maximum total score is 63. Special attention must be paid to the correct scoring of the Changes in Sleeping Pattern (Item 16) and Changes in Appetite (Item 18) items. Each of these items contains seven options rated, in order, 0, 1a, 1b, 2a, 2b, 3a, 3b, to differentiate

between increases and decreases in behavior or motivation. If a higher rated option is chosen by the respondent, the presence of an increase or decrease in either symptom should be clinically noted for diagnostic purposes.

(5) Aggression Questionnaire (Buss, A. H., & Perry, M.1992): This 29-item, Likert type scale measures participants' disposition toward physical aggression, verbal aggression, anger, and hostility. Although the full measure will administered, only the physical aggression subscale was analyzed. Participants rate how each item describes them on a scale of 1 (extremely uncharacteristic of me) to 5 (extremely characteristic of me). The AQ has been shown to have high validity and reliability ($\alpha = .80$), which was consistent with the present sample ($\alpha = .83$). It was included in the questionnaire battery to ensure that assignment to various conditions yielded an equal distribution of dispositional physical aggression throughout the experimental conditions.

(6). ***Demographic Profiles:*** The background information of the participants such as age, birth order, educational qualifications, employment status of the parents, the family structure (nuclear and joint), size of the family, space and other facilities available to each member of the family, affordance of mass media / communication, reasons of participation in the current sexual orientation and all other necessary information to be included looking the objective of the study; and to obtain true representative samples as per designed of the present study with an expectation to supplement information and also for cross validation of the information.

Procedure:

The recognized and self accepted homosexual populations of Mizoram were selected from different registered drop-in Centres located in Aizawl and Lunglei; some were identified through clients of the selected drop-in centres and Link-workers specially serving MSM in different part of Mizoram. From 230 participants, 160 homosexual oriented were screened out by employing Kinsey Heterosexual-Homosexual Rating Scale (KRS; Kinsey et al., 1948), only those who were identified as extremely homosexual and their matching heterosexual oriented were included for participants of the present study. Selected participants were initiated individually for psychological evaluation through selected psychological scales. The original psychological scales were in English while the target population is not well verse with English, and had to translate into Mizo language; for methodological concern the

translated Mizo Kinsey Scale was backed translate into English and reliability was α . 76.

All the participants received booklet containing the demographic information like age, birth order, educational qualifications, employment status of the parents, the family structure (nuclear and joint), size of the family, space and other facilities available to each member of the family, affordance of mass media / communication, reasons of participation in the current sexual orientation etc. were recorded in maintaining anonymity of the participants. The psychological constructs measured employed are1) Kinsey Heterosexual-Homosexual Rating Scale (KRS; Kinsey et al., 1948); (2) Well-being Scale (Veit & Ware, 1983; Heubeck & Neill, 2000) (3) Satisfaction with life scale (Ed Diener, Robert A. Emmons, Randy J. Larsen and Sharon Griffin 1985).; (4) Becks Depression Inventory-11(Aaron T. Beck, Robert A. Steer and Gregory K. Brown 1996). (5) Aggression (Buss, A. H., & Perry, M.1992) and (6) Demographic Profiles. All the psychological measures are translated into Mizo, the mother-tongue of the target population by employing ABBA technique to check the psychometric adequacy for the population under study.

After rapport was established and careful explanations of instructions for completing the psychological measures in each session, participants were anonymously requested to fill out the booklet including the background demographics sheets with assured confidentiality so as to minimize the potential influence of social desireable response sets, each session lasted for approximately one hour. After recollection of the booklets, the researcher checked out carefully for any missing response on the booklet.

Statistical Analyses:

Firstly the psychometric adequacy of scores on the series of various measures was analyzed by employing Descriptive statistics, Cronbach Alpha for Reliability indices, and item analyses based on – Item total coefficient of correlation and statistical assumption were also checked.

1) Bivariate correlations were worked out to elucidate the relationships among various measures to form bases for further analyses to bring a light to the target objective.

2) Levenes test was employed to determine the homogeneity of variance.
3) 2x2 analyses of variance was employed for the effect of sexual orientation and age on the dependent variables (Distress, well being, Satisfaction with life scale, Depression, Physical aggression, Verbal aggression, Anger and Hostility).
4) Post hoc multiple mean comparisons (Scheffe) was employed to highlight the instances of multiple mean difference for the significant independent effect of Sexual Orientation and Age on the dependent measures.
5) Multiple regression analysis was computed to examine the prediction of variables.

The quantitative primary data collected was processed with the help of computer and analyzed with statistical packages. The Statistical Product and Service Solutions (SPSS) were employed in conjunction with Microsoft Office Excel (2007). The psychometric adequacy of all the behavioral measures is determined. The data are then presented with Descriptive statistics (Mean, SD, Skewness and Kurtosis). The inferential statistics principally included Correlation, Post Hoc mean comparison, ANOVA and multiple regressions with careful check of their assumptions.

The results were computerized and analyzed with statistical software in accordance with the objectives set forth for this study. The overall analyses of results are presented and discuss in the chapter to follow, Chapter – IV.

The present study entitled “A comparative study of psychological adjustment among heterosexual and homosexual male youth” among Mizo. Firstly, the descriptive statistics were computed including the mean, standard deviation, Skewness, kurtosis, Alpha, linearity of the Scales/ Sub Scales in checking the normal distribution of scores for the scales and subscales of the behavioral measures (1) Well-*being* Scale (Veit & Ware, 1983; Heubeck & Neill, 2000); (2) Satisfaction with life scale (Diener et al, 1985).; (3) Becks Depression Inventory-11(Beck et al, 1996). (4) Aggression (Buss & Perry, 1992). Secondly, Pearson’s bivariate correlation on scales /subscales of the behavioural measures for the whole sample were calculated to indicated significant relationship of variables for further analysis in predicting cause and effect among variables. Thirdly, 2X2 ANOVA with post-hoc multiple mean comparison was employed to illustrate the independent and interaction effect of the independent variables on selected dependent variables for the whole samples. Finally, multiple regression analysis was employed to determine Multicolinearity indices of Durbin–Watson statistic, Tolerance and Variance Inflation Factor (VIF) were employed. This was done to detect the presence of autocorrelation in the residuals (prediction errors) to make conclusion of the cause and effect relationship.

320 (three hundred and twenty) subjects were selected out by following purposive random sampling procedures from the different parts of Mizoram. Initially, 230 Mizo male youths were initiated for screening for the true representative of homosexual Mizo youths by applying Kinsey homosexual rating scale, 160 Mizo male youths were selected for the representative of Mizo male homosexual participants with due care of the equal representation of the two age groups (15-21 and 22-28 age group). After the final selection of the representative of the homosexual oriented samples, the selection of their counterpart – heterosexual samples were selected to match the homosexual oriented samples through multi stage sampling procedure. Demographic profiles was carefully recorded for cross confirmation of their biological sex; and also to control any possible confounding variables. The two age groups were 15-21 and 22-28 were selected to fulfill the objectives of the study, and were purposefully designed with high expectation of easier handling for psychometric evaluation as compared to older age range.

In view of the foregoing, the outcome of the study to highlight 'A comparative study of psychological adjustment among heterosexual and homosexual male youth' are presented in stepwise manner on selected variables : (1) Well-being Scale (Veit & Ware, 1983; Heubeck & Neill, 2000) (2) Satisfaction with life scale (Ed Diener, Robert A. Emmons, Randy J. Larsen and Sharon Griffin 1985).; (3) Becks Depression Inventory-11(Aaron T. Beck, Robert A. Steer and Gregory K. Brown 1996). (4) Aggression (Buss, A. H., & Perry, M.1992)

Psychometric properties of the behavioral measures:

The parametric statistical analyses of Descriptive statistics, Cronbach Alpha, normality, linearity, additively and homogeneity were checked with an objective to justify the appropriate statistical treatment for further analyses of specific item, missing responses, outliers and those responses outside the sampling frame as well as deviated responses from the distributed data are excluded for statistical analyses. The descriptive statistics of the scales/Subscales of the behavioral measures are presented in Table – 1.

Results (Table – 1) shows the mean, standard deviation, Skewness, kurtosis, Alpha, linearity of the Scales/ Sub Scales of the behavioral measures of (a) Well-being Scale (Veit & Ware, 1983; Heubeck & Neill, 2000), (b) Satisfaction with life scale (Ed Diener, Robert A. Emmons, Randy J. Larsen and Sharon Griffin 1985), (c) Becks Depression Inventory-11(Aaron T. Beck, Robert A. Steer and Gregory K. Brown 1996), and (d) Aggression (Buss, & Perry 1992) for the whole sample.

Results (Table-1) revealed substantial consistency over the level of analyses that ascertained applicability of the scales/subscales of the behavioral measures of all the whole samples. Thus, the scales/subscales was retained for further analyses as it fulfilled the statistical assumption of additivity, linearity, normality and homogeneity tests (Glass, Peckham, & Sandras, 1972; Tomarken & Serlin, 1986; Rogan & Keselman, 1977).

Table 1: Descriptive Statistics of the Scales/Subscales, of the Behavioral measures of mean, Standard deviation, Skewness, Kurtosis, Linearity and Alpha (PWB, PD, SWLS, BD1, PA,VA , Anger and hostility) for the whole samples.

Sources of Variables	**Mean**	**Standard Deviation**	**Skewness**	**Kurtosis**	**Linearity**	**Alpha**
Distress	39.08	5.23	.07	.91	.44	.57
Wellbeing	42.96	4.03	.04	.79	.04	.59
SWLS	18.38	4.53	.02	.93	.99	.64
BDI	45.36	5.91	.07	.66	.42	.72
Physical Aggression	29.12	6.01	.02	.58	.56	.87
Verbal Aggression	16.78	4.47	.16	.75	.55	.87
Anger	22.48	5.11	.04	.94	.47	.86
Hostility	25.50	5.09	.09	.82	.86	.84

Reliability indices emerged to be robust at each level of analysis (for the whole sample). Cronbach Alpha for the internal reliability of the scales/sub scales of Well-being Scale (Veit & Ware, 1983; Heubeck & Neill, 2000), Satisfaction with life scale (Ed Diener, Robert A. Emmons, Randy J. Larsen and Sharon Griffin 1985), Becks Depression Inventory-11(Aaron T. Beck, Robert A. Steer and Gregory K. Brown 1996), and Aggression ((Buss,& Perry 1992) showed the reliability ranging from .57 - .87 in Table-1. Thus the scales and sub scales of the test portrayed the trustworthiness of the test scales for measurement purposes in the project population of Mizo Youth. The scale constructed and validated for measurement of theoretical construct for a given population are need to be check again its reliability and validity as it might be more reliable and valid to another cultural setting (Berry, 1974; Eysenck & Eysenck, 1983; Witkin & Berry, 1975) as the cultural practices and norms are different according to derived-etic approach assumption (Pootinga, 1989), due to the influence of differential social desirability and response (Van de Vjver & Leung, 1997)

Result (Table -1) shows the preliminary psychometric check of the behavioral measures of the present study, and revealed considerable consistency over the level of analyses that determined the applicability of the scales of the behavioral measures : of (a) Well-being Scale (Veit & Ware, 1983; Heubeck & Neill, 2000), (b) Satisfaction

with life scale (Ed Diener, Robert A. Emmons, Randy J. Larsen and Sharon Griffin 1985), (c) Becks Depression Inventory-11(Aaron T. Beck, Robert A. Steer and Gregory K. Brown 1996), and (d) Aggression ((Buss, A. H., & Perry, M.1992).

Relationship of the Behavioural Measures

After determining that the data generally met the requirements, the Bivariate correlations between the scales / sub scales of the behavioral measures were computed in Table-2. The Bivariate correlations were worked out between Sexual orientation (heterosexual and homosexual) and Age Group (15-21 and 22-28) on the scores of the behavioral measures well-being, satisfaction with life scale, Becks depression inventory-11, aggression which was presented in Table -2.

Table - 2: Bivariate Correlation between the scores of the scales/subscales (PWB, PD,SWLS, BDI-11, Physical Aggression, Verbal Aggression, Anger & Hostility) for the whole samples.

	VARIABLES	PD	PWB	SWLS	BDI	PA	VA	AG	HS
Correlations	PD	1	-.68**	-.68**	.18**	-.42**	.41**	-.32**	-.32**
	PWB		1	.75**	-.19**	.43**	-.23**	.27**	.25**
	SWLS			1	-.13*	.45**	-.36*	.29**	.31**
	BDI-11				1	.14*	.19	-.18**	-.15**
	PHYSICAL					1	-.22**	.17**	.16**
	VERBAL						1	-.14*	-.19**
	ANGER							1	.84**
	HOSTILITY								1

** Correlation is significant at the 0.01 level (2- tailed)
*Correlation is significant at the 0.05 level (2- tailed

Results of the Bivariate correlation between the scales/subscales of the behavioral measures were computed and presented in Table – 2, that revealed:

The behavioral measures between the scales/subscales were significantly correlated with each other. The result Table-2 clearly revealed that Psychological Distress indicated positive relationship at .01 level with Depression (r=.18**) and verbal aggression (r=.41**), at the same time wherein emerge negative relationship

with psychological Well being (r=-.68**), Satisfaction with life scale (r=-.68), Physical aggression (r =-.42**), anger (r =-.32**) and hostility (r=-.32**). Numerous studies concerned the relationship between depression and distress. Life stress, vulnerable and depression are related to each other, stress can lead to vulnerabilities and vulnerabilities can lead to stressors overtime to produce depression. Depressive symptoms may generate negative life events (Hammen 2005)

Table -2 indicates that psychological well being is significantly correlated with life satisfaction (r=.75**), physical aggression (r=.43**), anger (r =.27**) and hostility (r=.25**) where as negative significant correlation with depression (r=-.19**) and verbal aggression (r =-.36**).People who are satisfied with their life, feeling happy, well supported usually reports high score on psychological well being (Huppert's 2009).

Depression, anxiety and hostility can have a negative effect on psychological well being (Rivers 2006). Mascaro (2006) found that a sense of personal meaning as measured by the Personal Meaning Profile (PMP; Wong, 1998) was negatively related to depressive symptoms, depression and hopelessness, and positively related to meaning fulfillment, hope, and internal locus of control. A Dutch translation of the PMP administered to cancer patients was found to be positively correlated with psychological well-being and negatively correlated to distress (Jaarsma, Pool, Ranchor, & Sanderman, 2007). Simms (2005) found that mental health and well-being consists of five main factors: personal meaning, subjective well-being, personal growth, hardiness, and positive relationship.

The result Table – 2 also proved that satisfaction with life scale is found to indicate significant positive relationship with most of the scales/subscales of the behavioral measures, except Becks depression inventory (r =-.13*) and verbal aggression (r= -.36*) where in there emerge negative relationship. Numerous studies also have linked meaning in life with positive affect and life satisfaction (Chamberlain & Zika, 1988; King., Hicks., Krull & Del Gaiso, 2006; Ryff, 1989; Zika & Chamberlain, 1992).

The inter correlation matrix (Table -2) revealed that correlation between the physical and verbal aggression were in the negative direction (r= -.22**) where as the scores of physical aggression has a positive correlation with the scores of anger

(r= .17) and hostility (r= .16**).Table 2 shows that verbal aggression is negatively correlated with anger (r= -.14*) and hostility (r= -.19**) while the scores on anger have significant positive relationship with hostility (r= .84**). Anger or hostility is commonly highlighted in sub typing approaches to the classification of depression. (Paykel 1971).

. Mean and standard Deviation values of Sexual orientation (heterosexual & homosexual) and Age group (15-21&22-28) on the behavioural measures are shown in (Table 3). To illustrate the mean differences for the significant independent effect of Sexual Orientation and Age group was presented in the following figure 2 to 4.

Table -3: Mean and Standard Deviation values for 'Sexual orientation' and 'Age' on the behavioral measures for the whole samples.

Sexuality	**Age**	**Statistics**	**PWB**		**SWLS**	**BDI**	**Aggression**			
			Distress	**Well – being**			**Physical**	**Verbal**	**Anger**	**Hostility**
Hetero	15-21	***Mean***	***35.15***	***44.15***	***20.27***	***47.30***	***34.89***	***13.19***	***22.33***	***25.36***
		SD	2.92	2.92	1.90	7.06	4.94	4.46	3.84	4.21
	22-28	***Mean***	***35.13***	***47.71***	***23.79***	***42.87***	***31.13***	***16.49***	***26.42***	***29.40***
		SD	3.20	3.204	2.22	4.428	3.69	3.15	4.53	4.33
Heterosexual Total			**35.14**	**45.93**	**22.03**	**45.09**	**33.01**	**14.84**	**24.38**	**27.38**
Homo	15-21	***Mean***	***45.09***	***38.23***	***13.63***	***48.49***	***27.31***	***19.81***	***21.98***	***25.46***
		SD	3.09	3.09	1.91	3.49	4.44	3.06	3.98	3.96
	22-28	***Mean***	***40.94***	***41.74***	***15.84***	***42.79***	***23.14***	***17.61***	***19.20***	***21.76***
		SD	3.22	3.22	2.81	5.72	3.67	4.27	5.23	4.77
Homosexual Total			**43.01**	**39.98**	**14.73**	**45.64**	**25.23**	**18.71**	**20.59**	**23.61**

Figure - 2: Mean scores of sexual orientation of the whole samples on the dependent measures.

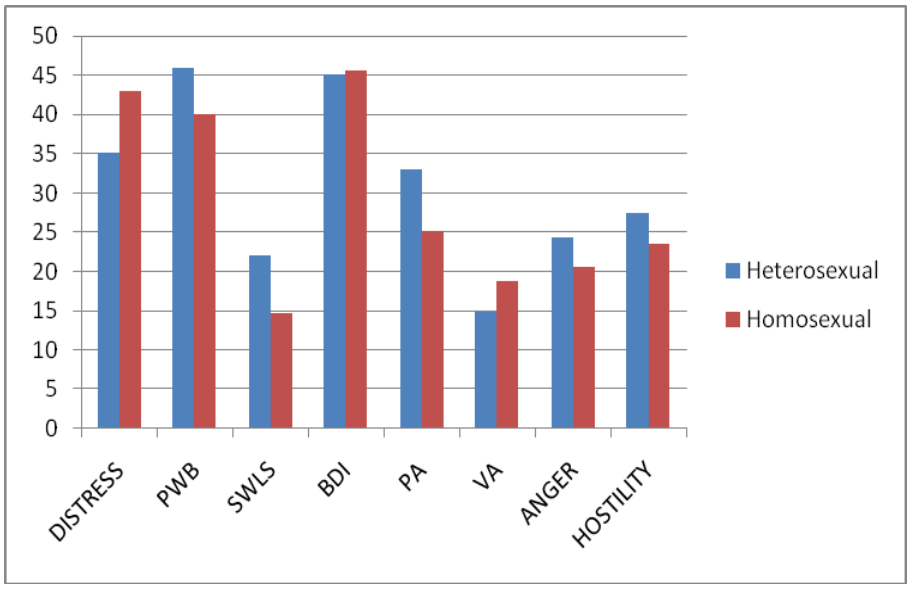


Figure - 3: Mean scores of sexual orientation and age group of the whole samples on the dependent measures.

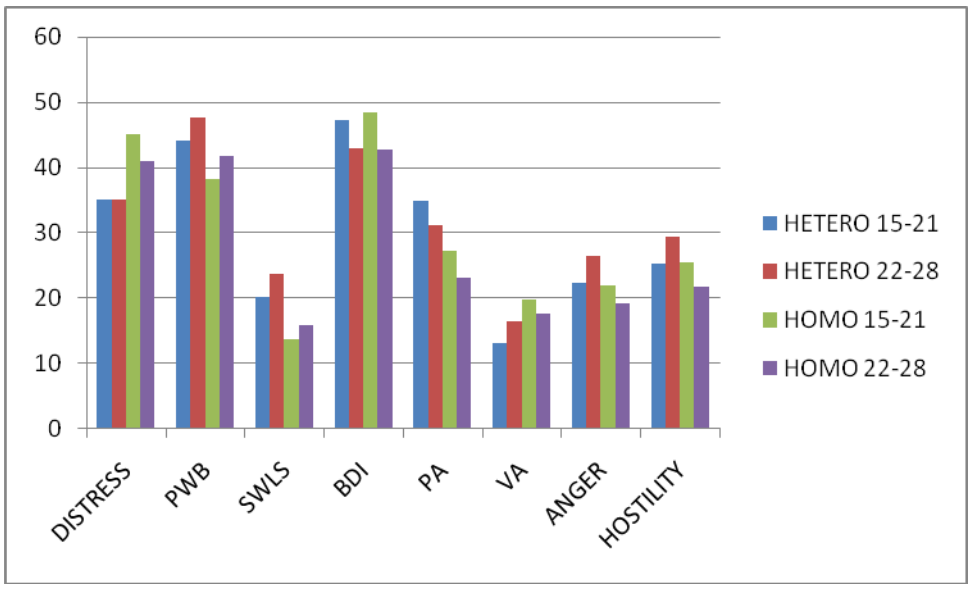


Figure - 4: Mean Scores of heterosexual age Group difference of the whole samples on the dependent measures.

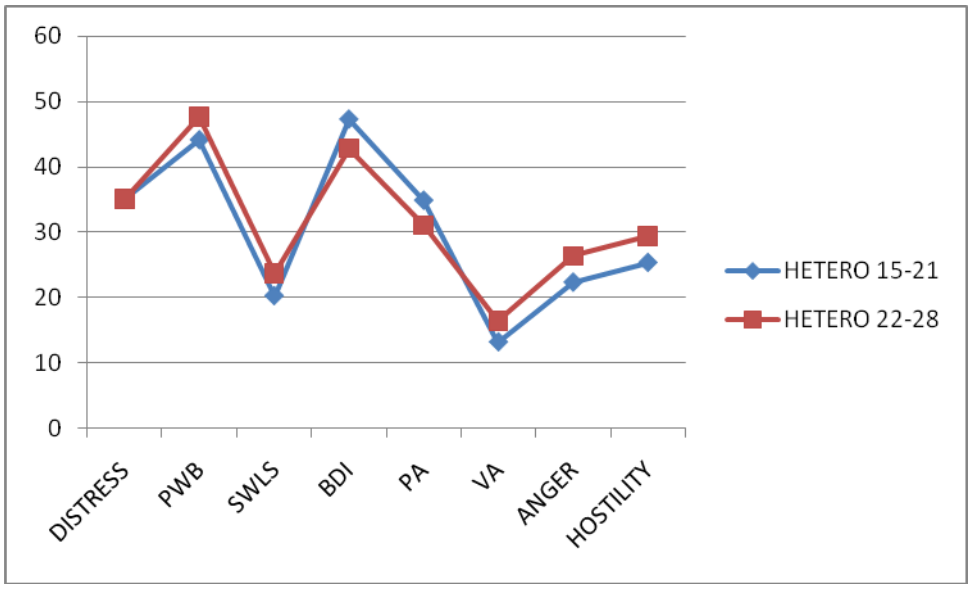
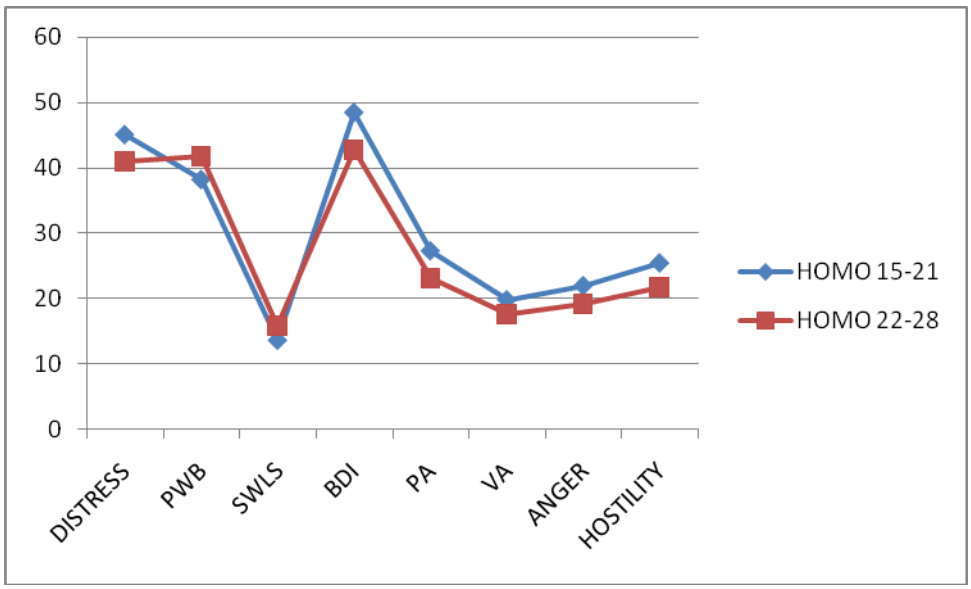


Figure - 5: Mean Scores of Homosexual Age Group difference of the whole samples on the dependent measures.



The results Table 3 confirmed that homosexual male score higher in distress (M=43.01) as compared to heterosexual male (M=35.14). The scores of high distress are expected to reverse with psychological well being (Veit & Ware, 1983; Heubeck

& Neill, 2000). Results of mean score conformed to the earlier studies, heterosexual mean score (M= 45.93) on well being is higher than homosexual mean score (M=39.98).

Heterosexual male seems more satisfied in their life with a higher mean score in satisfaction with life scale (M=22.3) as compared to homosexual male mean score (M= 14.73). Heterosexual behavior is acceptable and believed that its consequences are consistent has been associated with greater life satisfaction (Klonowicz 2001; Lachman and Prenda 2004). The results Table 3 also revealed, heterosexual male mean score is higher in physical aggression (M=33.01), Anger (M=24.38) and hostility (M=27.38) than homosexual male score of physical aggression (M=25.23), anger (M=20.59) and hostility (M=23.61). While homosexual men scored (M=18.71) higher than heterosexual male (M=14.81) on verbal aggression. The result was in line with the stereotypes of gay men are feminine, outspoken, sociable, talkative, and concerned about appearance (Madon 1997). Other studies have found that gay men have increased rates of depression, anxiety disorders, and suicidal behavior compared with heterosexual men (Bancroft, Janssen, Strong, & Vukadinovic, 2003; Fergusson et al., 1999; Remafedi, French, Story, Resnick, & Blum, 1998; Sandfort, de Graaf, Bijl, &Schnabel, 2001) but our results show that in depression, the score of heterosexual and homosexual is quite similar, not much difference is shown as expected.

2X2 ANOVA for the effect of Sexual orientation and Age on the dependent variables

2X2 factorial design (2 Sexual Orientation x 2 Age Group) was employed to highlight the independent effects on the dependent measures. The 2x2 ANOVA {2 Sexual Orientation (Heterosexual and Homosexual male) x 2 Age group (15-21& 22-28)} on test scores of Well-being, Satisfaction with life scale , Becks Depression Inventory-11, Aggression with Levene's Test of Equality of error Variances for the independent effect of Sexual Orientation and Age on the behavioural measures was employed.

Table – 4a: Levene's test of equality of error variances for the independent effect of Sexual orientation and Age group on the behavioral measures for the whole samples.

Variable	F Statistics	df1	df2	Sig.
Distress	.505	1	318	.135
Wellbeing	.598	1	318	.440
Swls	.000	1	318	.988
Bdi	.642	1	318	.423
Physical	.350	1	318	.555
Verbal	.358	1	318	.550
Anger	.531	1	318	.467
Hostility	.032	1	318	.858

Table – 4b: Analysis of Variance for the effect of Sexual orientation, Age, Sexuality X Age on the standardized scales of the behavioral measures for the whole samples.

Dependent Variable	**Sources of variation**	**Sum of Squares**	**Df**	**Mean Square**	**F**	**Sig.**	Partial Eta Squared
PD	Sexual orientation	4961.25	1	4961.25	511.9	.00	.62
	Age	348.61	1	348.61	35.9	.00	.10
	Sex X Age	340.31	1	340.31	35.1	.00	.10
PWB	Sexual orientation	2832.20	1	2831.20	666.9	.00	.68
	Age	1001.11	1	1001.11	235.73	.00	.43
	Sex X Age	.05	1	.05	.91	.00	.00
SWLS	Sexual orientation	4263.20	1	4263.20	839.27	.00	.73
	Age	655.51	1	655.51	129.06	.00	.29
	Sex X Age	33.80	1	33.80	6.66	.01	.02
BDI	Sexual orientation	24.20	1	24.20	.85	.35	.003
	Age	2050.31	1	2050.31	71.73	.00	.19
	Sex X Age	32.52	1	32.52	1.14	.29	.004
PHYSICAL AGGRESSION	Sexual orientation	4843.83	1	4843.83	271.90	.35	.003
	Age	1260.08	1	1260.08	70.73	.00	.19
	Sex X Age	3.40	1	3.40	.19	.29	.004
VERBAL AGGRESSION	Sexual orientation	1201.25	1	1201.25	83.77	.00	.21
	Age	24.20	1	24.20	1.69	.19	.005
	Sex X Age	605.00	1	605.00	42.19	.00	.12
ANGER	Sexual orientation	1147.61	1	1147.61	58.51	.00	.16
	Age	35.11	1	35.11	1.79	.18	.006
	Sex X Age	945.31	1	945.31	48.19	.00	.13
HOSTILITY	Sexual orientation	1136.28	1	1136.28	60.67	.00	.16
	Age	2.28	1	2.28	.12	.72	.00
	Sex X Age	1197.38	1	1197.38	63.94	.00	.17

To indicate that there is a difference between the variables as assumed by the 2x2 ANOVAs, Levene's test was applied. Levene's test is a homogeneity test, it shows homogeneity of variance for the independent effect on the behavioural measures were not significant in all levels of analyses showing the fulfillment of parametric statistical assumption for further analyses. Thus, 2x2 Anova of variance for the effect of sexual orientation and age on the dependent measures was employed for the whole samples under study.

Results (Table - 4b) revealed significant Independent effects of Sexual orientation, Age; Sex X Age in all the analyses for test scores on (i) Psychological Distress with effect size on sexuality is 62% (ii) Psychological Distress with effect size on age is 10% (iii) Psychological distress with effect size on Sex X Age is 10%.

The results of the present study (Table - 4b) conformed to the earlier studies which revealed sexual orientation has been linked to measures of psychological distress (Cochran &Mays, 2000a, 2000b; Fergusson, Horwood, & Beautrais, 1999; Paul et al., 2002). According to the minority stress theory (Lick et al, 2013; Meyer, 1995; Meyer, 2003), mental health disparity are usually the result of stigmatization from the society that devalues minority sexual orientation confirming that gay people tend to experience psychological distress in relation to their sexuality orientation (D'Augelli, 2002; D'Augelli et al., 2002; D'Augelli & Hershberger, 1993; DiPlacido, 1998; Lock & Hans, 1999; Rosario, Rotheram-Borus, & Reid, 1996).

The results of Table-4b revealed the significant Independent effects of Sexual orientation, Age, Sex X Age in all the analyses for test scores on (i) Psychological Well Being with effect size on sexuality is 68% (ii) Psychological Well Being with effect size on Age is 43%.

Researchers initiated that younger age tend to have higher well-being scores than the middle aged, and the old aged (Blanchflower & Oswald, 2008; Clark & Oswald, 1994). Other researchers also found the existence of a strong relation between psychological well-being during adolescence and the quality of a best-friendship (Elkins and Peterson 1993). Studies have typically found gender role conflict to be negatively related to psychological well-being (Blazina & Watkins, 1996; Cournoyer & Mahalik, 1995; Good & Mintz, 1990; Good et al., 1995; Mahalik, Cournoyer, DeFranc, Cherry, & Napolitano, 1998; Sharpe & Heppner, 1991).

Identification of sexual orientation has been found to correlate positively with SWB (Luhtanen, 1996) and may be an important factor in physical health as well (Cole, Kemeny, Taylor, & Visscher, 1996, but cf., Cole, Kemeny, & Taylor, 1997). The results of Table-4b revealed the significant Independent effects of Sexual orientation, age, Sexual orientation x Age in all the analyses for test scores on (i) Satisfaction with Life Scale with effect size on Sexual orientation is 73% (ii) Satisfaction with Life Scale with effect size on Age is 29% (iii) Satisfaction with Life Scale with effect size on Sex X Age is 02%.

Sexual orientation shown significant effect size on Depression is 00%, Age = 19% and Sex x Age = 004%. These findings revealed that sexual orientation has no effect at all on depression. But the effect of sexual orientation on depression has been found in numerous studies. Bell and Weinberg found that black gay males and lesbians attempted or seriously considered suicide at a rate less than white homosexual but greater than black heterosexuals. However, they found that a higher percentage of suicide attempts by black homosexuals took place during their youth. 36 percent of black lesbians compared to 21 percent of white lesbians and 32 percent of black gay males compared to 27 percent of white gay males attempted suicide before age 18. Physical aggression on sexual orientation has also no effect at all; Physical aggression with effect size on age is 19%.

The results of Table-4b revealed the significant Independent effects of Sexual orientation, Age; Sex X Age in all the analyses for test scores on Verbal Aggression with effect size on sexual orientation is 21% (ii) Verbal Aggression with effect size on Age is 005%. (iii) Verbal Aggression with effect size on Sexual orientation x Age is 12%. Results (Table -4b) also revealed significant Independent effects of Sexual orientation, Age, Sex X Age in all the analyses for test scores on Anger with effect size on sexuality is 16%; effect size on age is 006%; and effect size on Sexual orientation x age is 13%. This result shows that anger has contributed minor effect on sexual orientation.

The findings of Table-4b indicated that there is a significant independent effects of sexual orientation, Age, sexual orientation x age in all the analysis for test scores on Hostility with effect size on sexual orientation is 16% , with effect size on age is 00%; and also effect size on sexual orientation x age is 17%. Individual

struggling with identity may confront the problem of announcing that identity to potentially hostile others (cf., Erikson, 1968; Marcia, 1994). According to Freud (1905) phallic stage, sexual feelings for the opposite sex parent occur at this stage (and deals with Oedipus / Electra complex basically erotic attachment to parent of opposite sex, but since these feelings are not acceptable it may result in hostility) and feel some hostility to same sex parent. Therefore, sexual orientation has contributed an effect of 16% on hostility.

Table – 5a: Post hoc multiple comparison for the significant effect of Sexual 0rientation and Age on the dependent measures of psychological well being, Satisfaction with life scale and depression for the whole samples

Psychological Well-Being	**Sexual ort**	Mean	35.15	35.13	45.09	40.94
	Hetero(15-21)	*35.15*	X	-.03	-9.94*	-5.79*
DISTRESS	Hetero(22-28)	*35.13*		X	-9.96*	-5.81*
	Homo(15-21)	*45.09*			X	4.5*
	Homo(22-28)	*40.94*				X
	Sexual ort	Mean	*44.15*	47.71	38.23	41.74
PWB	Hetero(15-21)	*44.15*		3.56*	5.93*	2.41*
	Hetero(22-28)	*47.71*		X	9.49*	5.98*
	Homo(15-21)	*38.23*			X	-3.51*
	Homo(22-28)	*41.74*				X
SWLS	Sexual ort	Mean	*20.27*	*23.79*	*13.63*	*15.84*
	Hetero(15-21)	*20.27*		-3.51*	6.65*	4.44*
	Hetero(22-28	*23.79*		X	10.16*	7.95*
	Homo(15-21)	*13.63*			X	2.21*
	Homo(22-28)	*15.84*				X
BDI-11	Sexual ort	Mean	47.30	42.87	48.49	42.79
	Hetero(15-21)	*47.30*		4.43*	-1.19	4.51*
	Hetero(22-28)	*42.87*		X	-5.61*	.09
	Homo(15-21)	*48.49*			X	-5.70*
	Homo(22-28)	*42.79*				X

*The mean difference is significant at the .05 level

The result (Table 5a) clearly revealed the Post hoc multiple comparisons for the significant Effect of Sexual orientation and Age on the dependent measures of psychological well being, Satisfaction With life scale and depression for the whole samples.

In psychological distress homosexual male score higher rank than heterosexual male. The result supported the earlier findings prejudice in society against gay men and lesbians leads to greater psychological distress and higher use of services than in the heterosexual population (Savin-Williams, 1994). The results Table 5a indicated that homosexual 1st age group 15-21 shows higher mean score (M=45.09) than heterosexual 1st age group 15-21 (M=35.15) and 2nd age group 22-28 of heterosexual (M=35.13) (M3-M1=9.94 p>.05; M3-M2 =9.96 p>.05). And homosexual 2nd age group 22-28 (M3-M4 = 4.5 p>.05) on distress.

Research also suggests that discrimination based on minority group membership can increase risk for psychological distress through a variety of processes (Huebner, Nemeroff, & Davis, 2005; Mays & Cochran, 2001; Sandfort et al., 2001). These include direct experiences of victimization and rejection, however, even more subtle perceptions of discrimination may be related to increased psychological distress (e.g., Kessler, Mickelson, & Williams, 1999) psychological distress may be partly due to stigmatization of gender nonconformity, and/or a decrease in social support (Beard & Bakeman, 2000; Friedman & Downey, 1999, 2002; Landolt et al., 2004) . Bailey and Zucker (1995) reviewed several studies finding an association between childhood gender nonconformity and adult psychological distress in gay men.

The results (Table 5a) clearly depicted that heterosexual 2nd age group score higher in Psychological well being mean (M=47.71) than other age group of heterosexual 1st age group, and homosexual 1st and 2nd age group (M2-M1=3.56 p>.05; M2-M3=9.49 >.05; M2-M4=5.98 p>.05) The results (Table 5a) also revealed that heterosexual 2nd age group (22-28) score is higher than other age group. Therefore, heterosexual is more satisfied in their life as compared to homosexual male youth.

In Table - 5a In depression test homosexual 2nd age group 22-28 shows higher mean score (48.49) as compared to other age group (M3-M4=5.70 p>.05; M3-M1= 1.19; M3-M2= 5.61 p>.05) .

Jay and Young (1977) found that 53 percent of gay males and 33 percent of lesbians Surveyed believed their suicide attempts involved their homosexuality. Bell and Weinberg (1978) report that *58* percent of gay males and 39 percent of lesbians felt their first suicide attempts were related to the fact that they were homosexuals. Suicide attempts by gay and lesbian youth are even more likely to involve conflicts around their sexual orientation because of the overwhelming pressures they face in coming out at an early age. Skidmore, Linsenmeier and Bailey (2006) have found that, unlike heterosexual men, homosexual men have increased rates of depression and other anxiety disorders.

The results (Table 5b) of post hoc multiple mean comparison clearly revealed significantly mean score for heterosexual and homosexual male youth with age group of 15-21 and 22-28 on the dependent measures of aggression. In physical aggression heterosexual age group 15-21 score (M=35.89) mean score is higher than other age group (M1-M2= 3.76 p>.05; M1-M3= 7.58 p>.05; M1-M4= 11.75 p>.05). This result supports other findings homosexual males are reported to be less physically aggressive than heterosexual males (Ellis, Hoffman, & Burke, 1990; Gladue & Bailey, 1995).

Homosexual men to be less masculine or more feminine compared to heterosexual men, while for women the opposite pattern is found (Finlay & Scheltema, 1991; Lippa, 2002; Lippa & Arad, 1997; Pillard, 1991; Sandfort, 2005). Due to their feminine behaviour the mean score of homosexual 1st age group (19.81) is higher in verbal aggression as compared to other age group(M3-M1=-6.63 >.05p; M3-M2=-3.33 p>.05; M3-M4=-2.20 p>.05). While heterosexual mean score is higher in anger and hostility as compared to homosexual male.

Table – 5b: Post hoc multiple comparison for the significant effect of Sexual orientation and Age on the dependent measures of Aggression sub scales (physical aggression, verbal aggression, anger and hostility) for the whole samples.

Aggression	**Sexual orientation**	Mean	34.89	31.13	27.31	23.14
Physical Aggression	Hetero(15-21)	*34.89*	X	3.76*	7.58*	11.75*
	Hetero(22-28)	*31.13*		X	3.81*	7.99*
	Homo(15-21)	*27.31*			X	-4.18*
	Homo(22-28)	*23.14*				X
Verbal Aggression	Sexual ort	Mean	13.19	16.49	19.81	17.61
	Hetero(15-21)	*13.19*	**X**	3.30*	-6.63	-4.43*
	Hetero(22-28)	*16.49*		X	-3.33*	-1.13*
	Homo(15-21)	*19.81*			X	-2.20*
	Homo(22-28)	*17.61*				X
Anger	Sexual ort	Mean	22.33	26.42	21.98	19.20
	Hetero(15-21)	*22.33*	X	4.10*	.35	3.13*
	Hetero(22-28	*26.42*		X	4.45*	7.23*
	Homo(15-21)	*21.98*			X	-2.78*
	Homo(22-28)	*19.20*				X
Hostility	Sexual ort	Mean	25.36	29.40	25.46	21.76
	Hetero(15-21)	*25.36*		-4.04*	.10	3.60*
	Hetero(22-28)	*29.40*		X	3.94*	7.64
	Homo(15-21)	*25.46*			X	3.70*
	Homo(22-28)	*21.76*				X

*The mean difference is significant at the .05 level

Table - 6a: R, R2 change statistics and Durbin Watson Statistics in the prediction of Aggression on Distress for the whole samples.

Predictors	R	R2 Change	F Change	Df	Sig	Durbin-Watson
PA	.42	.17	67.09	1/318	.00	.73
VA	.41	.17	65.43	1/318	.00	.85
AG	.32	.09	35.93	1/318	.00	.69
HS	.31	.97	84.01	1/318	.00	.66

Table - 6b: Beta values and collinearity statistics in the prediction of Aggression on Distress for the whole samples.

Predictors	Beta	T	Sig	Collinearity Statistics	
				Tolerance	VIF
PA	-.42	-8.19	.00	1.00	1.00
VA	.41	8.09	.00	1.00	1.00
AG	-.32	-5.99	.00	1.00	1.00
HS	-.31	-5.83	.00	1.00	1.00

Figure -6: Histogram depicting the prediction of Aggression on Distress for the whole samples.

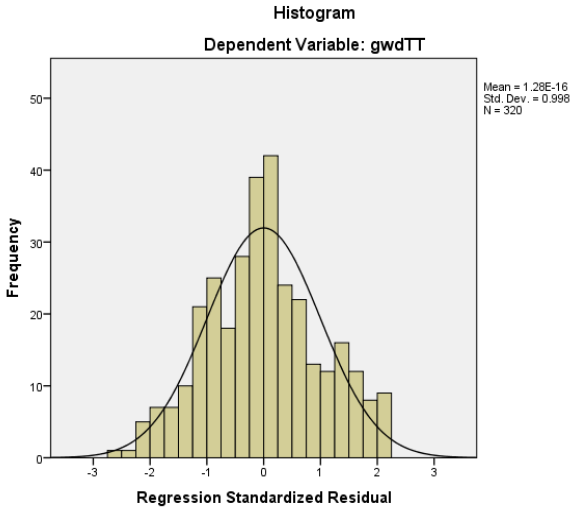
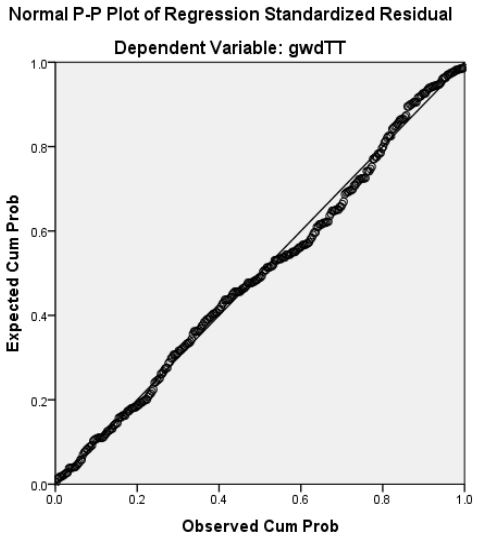


Figure -7: Plot Graph depicting the prediction of Aggression on Distress for the whole samples.



The multiple regression analyses for the prediction of Aggression on Psychological distress are statistically significant. The R, R2, and the change statistics with Durbin Watson are presented in Table -6a, the Beta values and collinearity statistics are presented in Table-6b, and the graphs depicting normality and the homogeneity of the regression slope are presented in Figure- 5&6, respectively.

The Durbin Watson statistics and the collinearity diagnostics 6a&b supported by the normality and the homogeneity of the regression slopes (Figure-6&7) warranted the interpretability of the outcomes of the multiple regression. The results of table-6a revealed that hostility as predictors explained 97% variances on the scores of psychological Distress. Other Scales physical, verbal and anger has not much contributed as a predictor on the scores of psychological distress. The smallest value of Durbin Watson statistics on Aggression subscales indicated that successive error terms are very close in value to one another, which cause an alarm, but since the collinearity statistics of tolerance valued 1.00, the more likely that it is statistically significant.

Due to the stigma surrounding, sexuality has placed a burden on individuals who do not self-identify as heterosexual (i.e., collectively referred to as “sexual minorities”; (Meyer 2003). Sexual minority youth experience greater psychological distress than heterosexual youth (Mays and Cochran 2001; Meyer, Dietrich &

Schwartz 2007) and more victimization, especially related to their sexual identity (e.g., verbal taunts, physical threats, physical violence (Palfrey & Durant; 1998, Rivers & D'Augelli 2001).

Table - 6c: R, R2 change statistics and Durbin Watson Statistics in the prediction of Aggression on Psychological Well Being for the whole samples.

Predictors	**R**	**R2Change**	**FChange**	**Df**	**Sig**	**Durbin-Watson**
PA	.43	.18	70.43	1/318	.00	.53
VA	.23	.05	17.72	1/318	.00	.49
AG	.27	.07	24.32	1/318	.00	.51
HS	.24	.06	20.33	1/318	.00	.48

Table – 6d: Beta values and collinearity statistics in the prediction of Aggression on Psychological Well Being for the whole samples.

Predictors	**Beta**	**T**	**Sig**	**Collinearity Statistics**	
				Tolerance	**VIF**
PA	.43	8.39	.00	1.00	1.00
VA	-.23	-.21	.00	1.00	1.00
AG	.27	4.93	.00	1.00	1.00
HS	.25	4.51	.00	1.00	1.00

Figure -8: Histogram depicting the prediction of Aggression on well being for the whole samples.

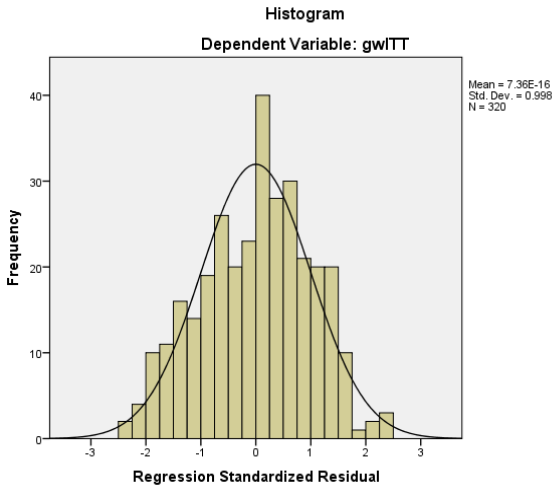
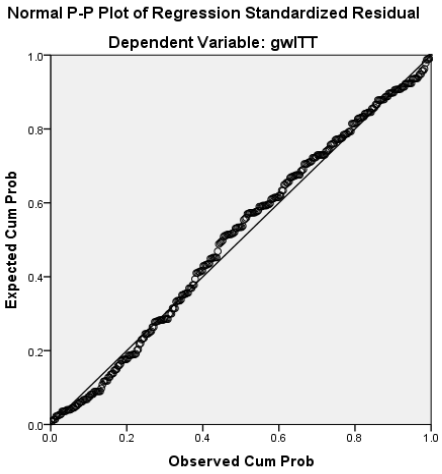


Figure -9: Plot graph depicting the prediction of Aggression on well being for the whole samples.



The regression Model in Table-6c represents the R, R2, change Statistics and the Durbin Watson. The result Table – 6c revealed the aggression scales of physical aggression contributed 8% of variance on the scores of Psychological well being. While the other scales of aggression has a contribution which has no effect at all on the scores of Psychological Well Being. To support the result, Durbin Watson and the collinearity diagnostics is highlighted with the graph of normality and the homogeneity of the regression slopes(Figure 8&9)

Table - 6e: R, R2 change statistics and Durbin Watson Statistics in the prediction of Aggression on Depression for the whole samples.

Predictors	**R**	**R2Change**	**FChange**	**Df**	**Sig**	**Durbin-Watson**
PA	.14	.02	6.29	1/318	.01	.25
VA	.09	.01	2.57	1/318	.11	.27
AG	.18	.03	10.79	1/318	.00	.33
HS	.15	.02	7.72	1/318	.00	.31

Table - 6f: Beta values and collinearity statistics in the prediction of Aggression on Depression for the whole samples.

Predictors	**Beta**	**T**	**Sig**	**Collinearity Statistics**	
				Tolerance	**VIF**
PA	.14	2.51	.01	1.00	1.00
VA	.14	2.51	.01	1.00	1.00
AG	-.18	3.29	.01	1.00	1.00
HS	-.15	-2.78	.00	1.00	1.00

Figure -10: Histogram depicting the prediction of Aggression on Depression for the whole samples.

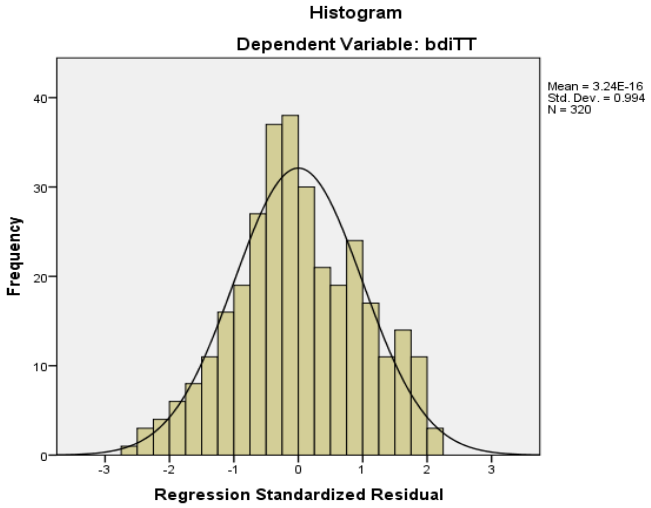
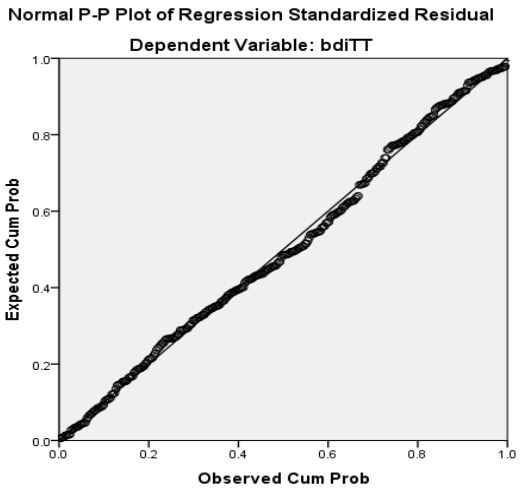


Figure - 11: Plot graph depicting the prediction of Aggression on Depression for the whole samples.



The Durbin Watson statistics and the collinearity diagnostics (Table-6e&f) supported by the normality and homogeneity of the regression slope (Fig- 10&11) warranted the interpretability of the outcomes of the multiple regression. The result Table-6e revealed that the predictors of aggression explain 2% variance on the scores of depression, verbal explains 1%, anger explains 2% and Hostility explains 3%. This result of regression clearly shows that the Prediction of aggression contributed on the scores of depression is very less.

The overall findings met the objectives of the study and can be summarized in the light of the outcome of the analyses of comparison among heterosexual and homosexual male highlighted mean significant differences in sexual orientation, significant correlation between dependent variables, and also among the selected comparison groups on dependents variables.

Considerable amount of studies highlighted sexual orientation among heterosexual and homosexual and their difference regarding to mental health. Some investigators report more symptoms of poor mental health among gay compared to heterosexual individuals (Bagley and Tremblay 2000; Faulkner and Cranston 1998; Fergusson et al. 1999; French et al. 1998; Lock and Steiner, 1999; Morris et al, 2001; Safren and Heimberg, 1999). One study used the MMPI, that venerable and well-validated psychological scale, and found that homosexuals showed definite "personal and emotional oversensitivity." (Riess,1980).The data from some studies suggest that

non-heterosexuals may be at somewhat heightened risk for depression, anxiety, and related problems, compared to exclusive heterosexuals (Cochran, Mays & Sullivan, 2003). This finding supported the theoretical expectation (hypothesis) set forth for the study that significant difference would be observed in dependent variables in relation to sexual orientations (Homosexuality and heterosexuality),

The teenage years are generally a period of identity confusion and turmoil (Erikson 1968). One of the research studies revealed that 46% of gay youth report having lost a friend as a result of disclosing their sexual orientation (Marsiglio 1993). Therefore same-sex loving feelings may experience internal conflict because of a heterosexual socialization (Cass, 1979), and subsequently struggle with the fear of being "found out" (Newman and Muzzonigro, 1993).Gay youth may realistically fear the consequences of disclosing their sexual identity to others.' from the mid-twenties onward, the Rates of substance abuse, violent crime, as well as antisocial and high risk behavior are high among young men, peaking during late adolescence and young early adulthood and falling during their twenties (Mash and Wolfe 2002). Our objectives set forth for the study that significant difference would be observed in dependent variables in relation to two age groups (15-21) and (22-28). Findings from the present study indicate the 1st age group (15-21) showed poor mental health as compared to 2nd age group (22-28). Sexual orientation of two age groups showed no differences than expected by chance emerged.

Studies have suggested that depression will influence in life satisfaction and psychological wellbeing among the groups of subjects. It is expected that gay men as compared to their non gay counter experience more gender role conflict and that conflict may affect their psychological well being. Studies have typically found gender role conflict to be negatively related to psychological well-being (Blazina & Watkins, 1996; Cournoyer & Mahalik, 1995; Good & Mintz, 1990; Good et al., 1995; Mahalik, Cournoyer, DeFranc, Cherry, & Napolitano, 1998; Sharpe & Heppner, 1991) Consequently, their isolation for fear of disclosure leads to reduced social support, loneliness and an increased risk of depression (Oetjen & Rothblum, 2000) and affect their psychological well being. The results Table- 2 of correlation clearly support our hypothesis that depression is negatively correlated with psychological wellbeing and life satisfaction.

Homosexual people tend to experience more mental health problems than heterosexual people (Dr Apu Chakraborty). The increased risk of contemplating suicide and actually harming oneself in gay and bisexual people has previously been reported in the USA (Fergusson *et al*, 1999; Herrell *et al*, 1999; Russell & Joyner, 2001). Our result findings indicate that comparison among homosexual and heterosexual men on depression shows marginal difference, although homosexual men is more expected to be depressed than heterosexual. In our result findings, it appears quite similar which support other findings (Jane, Eric & Elizabeth 2009).

To sum up the result clearly explained a comparison among heterosexual and homosexual male youth on the dependent measure like distress, well being, satisfaction with life scale, depression, physical aggression, verbal aggression, anger and hostility. The whole results revealed that significant difference have been clearly highlighted between the mean scores of sexual orientation (heterosexual and homosexual) and two age group (15-21 and 22-18).

The present study was designed to reveal a comparative study of Psychological adjustment among heterosexual and homsexual on Psychological well being, Satisfaction with life scale, Becks depression, Aggression among male youth. Keeping in view the objectives of the study 320 (three hundred and twenty) subjects were selected out by following purposive random sampling procedures from the different parts of Mizoram. Initially, 230 Mizo male youths were initiated for screening for the true representative of homosexual Mizo youths by applying Kinsey homosexual rating scale, 160 Mizo male youths were selected for the representative of Mizo male homosexual participants with due care of the equal representation of the two age groups (15-21 and 22-28 age group). After the final selection of the representative of the homosexual oriented samples, the selection of their counterpart heterosexual samples were selected to match the homosexual oriented samples through multi stage sampling procedure Demographic profiles was carefully recorded for cross confirmation of their biological sex; and also to control any possible confounding variables. The two age groups were 15-21age and 22-28 ages were selected to fulfill the objectives of the study, and were purposefully designed with high expectation of easier handling for psychometric evaluation as compared to older age range.

Only Mizo male youth were included to serve as participants for the present study. Initially, 230 Mizo male youths were initiated for screening and to represent the homosexual Mizo youths and were selected from different registered drop-in Centres located in Aizawl and Lunglei; some were identified through clients of the selected drop-in centres and Link-workers specially serving MSM in different part of Mizoram. Only those who have showed high scores on Kinsey homosexual rating scale (subscale of the Kinsey Heterosexual – Homosexual Rating Scale) were selected for the samples. On final count, only 160 Mizo male youths were selected for the representative of Mizo male homosexual participants with due care of the equal representation of the two age groups (15-21 and 22-28).

Psychological tools used:

To meet the objectives of the present study, the researcher had employed the following psychological tools which were mentioned below:

(1) Kinsey Heterosexual-Homosexual Rating Scale (KRS; Kinsey et al., 1948). The KRS is a 7–point, Likert style scale.Participant has to report their behavioral experiences and sexual arousal from "exclusively heterosexual" to "exclusively homosexual." The "Kinsey Scale," was developed by Alfred Kinsey and his colleagues to assess their sexual orientation for psychological evaluation and research purpose.

(2) *Psychological Well-being Scale* (GWS; Veit & Ware, 1983; Heubeck & Neill, 2000) The scale consists of 20 items and measures in a 6 point scale. In items that measure Psychological Distress (PD) the scores are reversed whereas in items that measure Psychological Well- Being, the scores are scaled in a positive direction where higher scores reflect positive well-being.

(3) The satisfaction with Life Scale (SWLS: Diener, Emmons, Larsen& Griffin, 1985***):*** It consists of 5 items. The scale consists of 1-7 point scale ranging from 1 (strongly disagree) , 2 (disagree) , 3 (slightly disagree) , 4 (neutral) , 5 (slightly agree), 6 (agree), 7 (strongly agree). The Satisfaction with Life scale is scaled in a positive direction and there are no reverse scores.

(4) Becks Depression Inventory (BDI-11: Aaron T. Beck, Robert A. Steer and Gregory K. Brown1996): The BDI-II is scored by summing the ratings for the 21 items. Each item is rated on a 4-point scale ranging from 0 to 3. The maximum total score is 63. If a higher rated option is chosen by the respondent, the presence of an increase or decrease in either symptom should be clinically noted for diagnostic purposes.

(5) Aggression Questionnaire (Buss, A. H., & Perry, M.1992): This 29-item, Likert type scale measures participants' disposition toward physical aggression, verbal aggression, anger, and hostility.

Preliminary Psychometric Analyses on the Behavioral Measures

The Parametric statistics analyses of Descriptive Statistics, Cronbach Alpha for Reliability indices, and Item analyses based on - item total coefficient of correlation were checked with an objective to decide the appropriate statistical treatment for further analyses of the raw data. In the analysis of specific item, missing responses, outliers and those responses outside the sampling frame as well as extremely deviated responses from the distributed data are excluded for statistical analysis.

The subject wise scores on the specific items of the behavioral measures of (a) Psychological Well-being Scale (GWS; Veit& Ware, 1983; Heubeck& Neill, 2000) (b) The satisfaction with Life Scale (SWLS: Diener, Emmons, Larsen& Griffin, 1985):, (c)). Becks Depression Inventory **(**BDI-11**:** Aaron T. Beck, Robert A. Steer and Gregory K. Brown1996) (d) Aggression Questionnaire **(**Buss, A. H., & Perry, M.1992)were prepared separately for sexual orientation and Age group, and analyzed in step wise manner for each cell of the design(n=80).

Results (Tables -1) showed the mean and standard deviation and reliability indices (Cronbach – alpha) of the scales/subscales of the behavioral measures, and the mean standard deviation and the reliability analyses, computed for sexual orientation and age revealed consistency over the level of analyses that determined applicability of the scales/subscales of all the behavioral measures.

Relationship of the Behavioral Measures:

Bivariate correlation between scales /subscales (Distress, well being, and satisfaction with life scale, Becks depression, physical aggression, verbal aggression, anger & hostility) for the whole samples were presented in Table – 2. The bivariate correlation matrix (Table -2) indicated the relationships among the scales/subscales of the behavioural measures accounting for the samples of the Mizo youth. The bivariate correlation in Table 2 indicated that depression has a negative correlation with life satisfaction and Psychological well being which is supported by our hypothesis. . The result Table – 2 also proved that psychological well being is found to indicate significant positive relationship with satisfaction with life scale where in emerge negative relationship with distress and depression.

Mean and standard Deviation values of sexual orientation (heterosexual &homosexual) and Age group (15-21 & 22-28) on the behavioural measures are shown in (Table 3). Homosexual male score higher in distress (M=43.01) as compared to heterosexual male (M=35.14). Heterosexual male seems more satisfied in their life with a higher mean score in satisfaction with life scale (M=22.3) as compared to heterosexual male mean score (M= 14.73). The results Table 3 also revealed heterosexual mean score is higher in physical aggression (M=33.01), Anger (M=24.38) and hostility (M=27.38) than homosexual male score of physical aggression (M=25.23), anger (M=20.59) and hostility (M=23.61). Earlier studies also found

homosexual males are reported to be less physically aggressive than heterosexual males (Ellis, Hoffman, & Burke, 1990; Gladue& Bailey, 1995). The results also confirmed that homosexual mean score of verbal aggression is (M=18.71) higher than the mean score of heterosexual (M= 14.84). Males use more physical aggressive than females, while females use more verbal aggression than males (Hanish et al, 2012).

2X2 ANOVA for the effect of Sexual orientation and Age on the dependent variables :

Levene's test of equality of error variances (Table -4a) for the independent effect of sexual orientation and age on the behavioural measures were not significant in all levels of analyses on the behavioural measures showing the fulfillment of parametric statistical assumptions for further analyses, then analysis of variance was computed.

2x2 Analysis of variance were computed for the effect of sexuality and age on the standardized scores of the behavioural measures presented in Table – 3b. Results of the 2 X 2ANOVA {2 sexual orientation (heterosexual and homosexual) and two age group (25-21 & 22-28)} revealed there is a significant effects of sexual orientation and age group on the behavioural measures. The effect size of sexual orientation was observed on: Distress 62 %. ($p>.01$); Well being 68% ($p>.01$); Swls 73% ($p>.01$); while other behavioural measures has small effect on the independent variable.

The post hoc Analysis of variance:

The post hoc analysis of variance (Table -5a) for the effect of Sexual orientation and Age group on the standardized scores of the behavioural measures (Distress, Well being, Satisfaction with life scale and Depression) indicate that homosexual 1st age group (15-21) shows higher mean score on distress (M=45.09) as compared to other age group (M3-M1=-.9.94*; M3-M2= -9.96*; M3-M4= 4.5*). Heterosexual 2nd age group (22-28) score on wellbeing is the highest mean score (M=47.71) than other age group (M2-M1=3.56*; M2-M3=9.49*; M2-M4=5.98*). The score of well being also influence the score of satisfaction with life scale; heterosexual 2nd age group is more satisfied in their life as compared to other age group. In depression mean score the 2nd

age group (22-28) of homosexual score (M=48.49) which is slightly higher than other age group (M3-M1= -1.19; M3-M2=-5.61*; M3-M4=-5.70*)

Results of the post hoc mean comparison of Table- 5b revealed the significant effect of mean difference among Sexual orientation and age group on the dependent measures of physical aggression, verbal aggression anger and hostility. Heterosexual male 1st age group (15 -21) shows significantly higher mean score on physical aggression (M=34.89*) than other age group (M1-M2= 3.76*; M1-M3= 7.58*; M1-M4= 11.75*). On the scores of verbal aggression homosexual 1st age group mean score (M= 19.81) which is higher than the scores of other age group (M3-M1=-6.63*; M3-M2=-3.33*; M3-M4=-2.20*). Heterosexual 2nd age group score highest mean on anger and hostility as compared to other age group.

The results clearly depicted that, the 1st age group (15-21) shows significantly higher mean scores of the dependent variables than the second age group (22 – 28) on distress, depression and physical aggression with a lower scores of psychological well being and satisfaction with life scale which supported our theoretical assumption of the present study.

Mean difference for the significant independent effects of sexual orientation and age on the behavioural measures of the whole samples were presented in Figure – 2 to 5.

Predictability of the selected variables by applying multiple regressions:

The multiple regressions in the prediction of Aggression on Distress for the whole samples are presented in Table -6a and are statistically significant. The result supported by the normality and homogeneity slope revealed that the scores of hostility as predictors explained 97% variances on the scores of psychological Distress. The result Table – 6c revealed the aggression scales of physical aggression contributed 8% of variance on the scores of Psychological well being. The histogram and plot graph depicting the selected variables were presented in the Figure- 6 to 11.

In conclusion of the overall results of analyses incorporated in the present study to determine a comparative study of psychological adjustment among heterosexual and homosexual male youth conformed to the empirical basis sufficiently. Substantial analyses based on – Item total coefficient of correlation and

the relationship of the specific items of the specific scale, reliability index (cronbach alpha) and the relationship between the scales and the sub scales of behavioural measures. The result shows that there is a significant difference in dependent variables in relation to sexual orientations and age groups. Heterosexual male youth had shown significantly greater mean score on well being, satisfaction with life scale, physical aggression, anger and hostility while homosexual male youth exhibited greater mean score on distress, depression and verbal aggression. Depression scores of homosexual compared to heterosexual emerged margin variation. Other studies also seem to confirm that gay individuals are at greater risk of developing a mental disorder (Meyer 2003). In addition to age the results show that the 1st age group compared to 2nd age group had significantly greater mean score on distress, depression, physical and verbal aggression. On the whole the findings of the study provided the component empirical bases that are sufficient enough in conformity to the theoretical expectations as set forth for the conduction of the study.

Limitations and suggestion for further Research:

Although the present study revealed robust results, but it was not free from limitations. The present study among male homosexual is a sensitive issue in the Mizo's society. Many of the subjects were inhibited, as they were afraid of revealing their identity as the practice of homosexuality because of a social taboo in the Mizo's society. Due to this issue, the sample size was restricted to small size, and to obtain homogenous group to control the extraneous variable age group of only 15-28 age were taken (not the other age group). Therefore, it may not be well representation of the whole Mizo homosexual and heterosexual male youth for making generalization. Many other variables were excluded though they are susceptible to have effect on sexual orientation, due to the time limitation. The researcher felt that qualitative method such as open interview would strengthen the finding of the result, but that required longer time and could not be done in this study.

Suggestions for further research:

Based on the limitation of the present study, it was suggested that further extended studies to illustrate the difference between heterosexual and homosexual on personality, intelligence, and other psychological variables for better understanding of sexual orientation in highlighting its cause and effect at individual and societal level.

It would be an ideal larger sample size than the present study, at least an acceptable level for adaptation of the selected scales; and also to have better representation of the selected population for methodological consideration. Inclusion of gender effects (Lesbian and women), ecological effect, acculturation and media effect and socio economic status in the independent variable would enrich the finding on sexual orientation for making suggestion for intervention. With all of the limitation, the present study clearly highlighted the difference between heterosexual and homosexual orientation on wellbeing, distress, satisfaction with life skill, depression, physical aggression, verbal aggression, anger and hostility; the scale employed would find replicability in the selected population for further studies; the findings also suggested that urgent attention of the social scientist to conduct intensive research in this area to be able to give advice to the policy making for ‘dysphoria’ population which are in the dilemma in all over the globe.

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Appendix - I

DEMOGRAPHIC INFORMATION SHEET

Please indicate your responses to the following questions by circling the numbers against each question wherein applicable.

1 **Personal Information**

1. Name :
2. Date of Birth : Date____ Month_____ Year____ Age ____as on_____
3. Gender : Male/Female
4. Present Address :
5. Permanent Address :
6. Educational Qualification:
   a) Matriculate.
   b) Under-graduate.
   c) Graduate

II **Family**

1. Structure : Nuclear / Joint
2. Number of family members :_____
3. Number of Siblings : _____
4. Birth Order :_____
5. Mother's age :_____
6. Father's age : _____
7. Parental Structure : Intact/ Single/ Step parents

III**Income**

1. Source:

a) Father : ____
b) Mother : ____
c) Others : ____

2. Total monthly income of family:

a) Below Rs 1000 : ____
b) Rs 10000 – Rs 20000 : ____
c) Above Rs 20000 : ____

IV. Do you feel comfortable with your identity?

a) Yes……..

b) No……

V. Do you feel stigmatization because of your sexual orientation?

a) Yes……

b) No……

VI. Do you enjoy coming out (as Gay)?

a) Yes……

b) No ……

VII. Do you feel any discrimination from your friends or family?

a) Yes……

b) No…...

VIII. Do you believe that you are born this way (biological effect)?

a) Yes……..

b) No……..

IX. Do you think that Tv or internet influence your behaviour?

(a) Yes……..

(b) No……..

Appendix - II

Kinsey Heterosexual-Homosexual Rating Scale
(KRS; Kinsey et al., 1948).

Which of the following 7 statements best describes your past sexual experiences? Please rate yourself in terms of overt actions only, not in terms of psychological or sexual arousal. Read ALL responses before indicating your answer. Circle only ONE response.

1. All sexual experiences have been with females. No physical contacts with other males have resulted in erection or orgasm.

2. Most sexual experiences have been with females, but infrequent physical contacts with other males have resulted in erection or orgasm.

3. Most sexual experiences have been with other females, but quite a bit of sexual contact with other males have occurred. However, sexual experiences with females are more numerous.

4. Equal sexual contact has occurred with males and females.

5. Most sexual experiences have been with males, but a fair amount of sexual experience with females has also occurred.

6. Most sexual experiences have been with males, but infrequent physical contacts with females have resulted in erection or orgasm.

7. All sexual experiences have been with males. No physical contacts with females have resulted in erection or orgasm.

Which of the following 7 statements best describes your psychological reactions? Please rate yourself in terms of sexual arousal only, not overt experiences. Read ALL responses before indicating an answer. Circle only ONE response.

1. All sexual arousal occurs in response to female sexual contact or fantasies involving sexual contact with females.

2. Most sexual arousal occurs in response to female sexual contact or fantasies involving sexual contact with females. However, infrequent male sexual contact or fantasies involving sexual contact with other males has resulted in sexual arousal, but these reactions are weaker than the sexual arousal that results from female sexual contact.

3. Most sexual arousal occurs in response to female sexual contact or fantasies involving sexual contact with females, but definite sexual arousal also occurs in response to male sexual contact or fantasies about sexual contact with males. However, sexual arousal to females is stronger.

4. Equal sexual arousal occurs in response to sexual contact or fantasies with males and females.

5. Most sexual arousal occurs in response to sexual fantasies or contact with males, but a fair amount of sexual arousal to females has also occurred.

6. Most sexual arousal has occurred in response to sexual contact or fantasies with males. However, infrequent sexual arousal has occurred in response to female sexual contact or fantasies involving sexual contact with females.

7. All sexual arousal occurs in response to male sexual contact or fantasies involving sexual contact with male

Appendix - III

GENERAL WELL-BEING
(PWS; Veit & Ware, 1983; Heubeck & Neill, 2000).

These questions are about how you feel, and how things have been with you mostly during the past month. For each question, please circle the number for the one answer that comes closest to the way you have been feeling.

(1) How happy, satisfied, or pleased have you been with your personal life during the past month?

1. Extremely happy, could not have been more satisfied or pleased
2. Very happy most of the time
3. Generally satisfied, pleased
4. Sometimes fairly satisfied, sometimes fairly unhappy
5. Generally dissatisfied, unhappy
6. Very dissatisfied

(2) How much of the time, during the past month, has your daily life been full of things that were interesting to you?

1. All of the time
2. Most of the time
3. A good bit of the time
4. Some of the time
5. A little of the time
6. None of the time.

(3) How much of the time, during the past month, did you feel relaxed and free of tension?

1. All of the time
2. Most of the time
3. A good bit of the time
4. Some of the time
5. A little of the time
6. None of the time

(4) During the past month, how much of the time have you generally enjoyed things?

1. All of the time
2. Most of the time
3. A good bit of the time
4. Some of the time
5. A little of the time
6. None of the time

(5) Did you feel depressed during the past month?

1. Yes, to the point that I did not care about anything for days at a time
2. Yes, very depressed almost every day
3. Yes, moderately depressed on several occasions
4. Yes, quite depressed at least a couple of times
5. Yes, a little depressed now and then
6. No, never felt depressed at all

(6) When you got up in the morning, during the past month, about how often did you expect to have an interesting day?

1. Always
2. Very often
3. Fairly often
4. Sometimes
5. Almost never
6. Never

(7) During the past month, how much of the time have you felt tense or 'high-strung'?

1. All of the time
2. Most of the time
3. A good bit of the time
4. Some of the time
5. A little of the time
6. None of the time

(8) How much of the time, during the past month, have you felt calm and peaceful?

1. All of the time
2. Most of the time
3. A good bit of the time
4. Some of the time
5. A little of the time
6. None of the time

(9) How much of the time, during the past month, have you felt downhearted and blue?

1. All of the time
2. Most of the time
3. A good bit of the time
4. Some of the time
5. A little of the time
6.Noneofthe time

(10) How much of the time, during the past month, were you able to relax without difficulty?

1. All of the time
2. Most of the time
3. A good bit of the time
4. Some of the time
5. A little of the time
6. None of the time

(11) How often, during the past month, did you feel that nothing turned out for you the way you wanted it to?

1. Always
2. Very often
3. Fairly often
4. Sometimes
5. Almost never
6. Never

(12) During the past month, how much of the time has living been a wonderful adventure for you?

1. All of the time
2. Most of the time
3. A good bit of the time
4. Some of the time
5. A little of the time
6. None of the time

(13) How often, during the past month, have you felt so down in the dumps that nothing could cheer you?

1. All of the time
2. Most of the time
3. A good bit of the time
4. Some of the time
5. A little of the time
6. None of the time

(14) During the past month, how much of the time have you been moody or brooded about things?

1. All of the time
2. Most of the time
3. A good bit of the time
4. Some of the time
5. A little of the time
6. None of the time

(15) How much of the time, during the past month, have you felt cheerful, light-hearted?

1. All of the time
2. Most of the time
3. A good bit of the time
4. Some of the time
5. A little of the time
6. None of the time

(16) During the past month, how often did you get rattled, upset, or flustered?

1. Always
2. Very often
3. Fairly often
4. Sometimes
5. Almost never
6. Never

(17) During the past month, have you been anxious or worried?

1. Yes, extremely so, to the point of being sick or almost sick
2. Yes, very much so
3. Yes, quite a bit
4. Yes, some, enough to bother me
5. Yes, a little bit
6. No, not at all

(18) During the past month, how much of the time were you a happy person?

1. All of the time
2. Most of the time
3. A good bit of the time
4. Some of the time
5. A little of the time
6. None of the time

(19) How often during the past month did you find yourself having difficulty trying to calm down?

1. Always difficult
2. Very often
3. Fairly often
4. Sometimes
5. Almost never
6. Never any difficulty

(20) During the past month, how much of the time have you been in low or very low spirits?

1. All of the time
2. Most of the time
3. A good bit of the time
4. Some of the time
5. A little of the time
6. None of the time

Appendix - IV

The satisfaction with Life Scale (SWLS: Diener, Emmons, Larsen& Griffin, 1985)

Using the 1 - 7 scale below, indicate your agreement with each item by circling the appropriate number for that item. Please be open and honest in your responding.		**Strongly Disagree**	**Disagree**	**Slightly Disagree**	**Neutral**	**Slightly Agree**	**Agree**	**Strongly Agree**
1	In most ways my life is close to my ideal.	1	2	3	4	5	6	7
2	The conditions of my life are excellent.	1	2	3	4	5	6	7
3	I am satisfied with my life.	1	2	3	4	5	6	7
4	So far I have gotten the important things I want in life.	1	2	3	4	5	6	7
5	If I could live my life over, I would change almost nothing.	1	2	3	4	5	6	7

Appendix - V

Becks Depression Inventory-II
(BDI-11: Aaron T. Beck, Robert A. Steer and Gregory K. Brown1996)

BDI-II
Instructions: This questionnaire consists of 21 groups of statements. Please read each group of statements carefully, and then pick out the one statement in each group that best describes the way you have been feeling during the past two weeks, including today. Circle the number beside the statement you have picked. If several statements in the group seem to apply equally well, circle the highest number for that group. Be sure that you do not choose more than one statement for any group, including Item 16 (changes in sleeping pattern) or Item 18 (changes in appetite).

1. Sadness
0 I do not feel sad.
1 I feel sad much of the time.
2 I am sad all the time.
3 I am so sad or unhappy that I can't stand it.

2. Pessimism
0 I am not discouraged about my future.
1 I feel more discouraged about mu future than I used to be.
2 I do not expect things to work out for me.
3 I feel my future is hopeless and will not get worse.

3. Past Failure
0 I do not feel like a failure.
1 I have failed more than I should have.
2 As I look back, I see a lot of failures.
3 I feel I am a total failure as a person.

4. Loss of Pleasure
0 I get as much pleasure as I ever did from the things I enjoy.
1 I don't enjoy things as much as I used to.
2 I get very little pleasure from the things I used to enjoy.
3 I can't get any pleasure from the things I used to enjoy

5. Guilty Feelings
0 I don't feel particularly guilty.
1 I feel guilty over many things I have done or should have done.
2 I feel guilty most of the time.
3 I feel guilty all of the time.

6. Punishment Feelings
0 I don't feel I am being punished.
1 I feel I may be punished.
2 I expect to be punished.
3 I feel I am being punished.

7. Self-Dislike

0 I feel the same about as ever.
1 I have lost confidence in myself.
2 I am disappointed in myself.
3 I dislike myself.

8. Self-Criticalness

0 I don't criticize or blame myself more than usual.
1 I am more critical of myself than I used to be.
2 I criticized myself for all of my faults.
3 I blame myself for everything bad that happens.

9. Suicidal thoughts or Wishes

0 I don't have any thoughts of killing myself.
1 I have thoughts of killing myself, but I would not carry them out.
2 I would like to kill myself.
3 I would kill myself if I had the chance.

10. Crying

0 I don't cry anymore than I used to.
1 I cry more than I used to.
2 I cry over every little thing.
3 I feel like crying, but I can't.

11. Agitation

0 I am no more restless or wound up than usual.
1 I feel more restless or wound up than usual.
2 I am so restless or agitated that it's hard to stay still.
3 I am so restless or agitated that I have to keep moving or doing something.

12. Loss of Interest

0 I have not lost interest in other people or activities.
1 I am less interested in other people or things than before.
2 I have lost most of my interest in other people or things.
3 It's had to get interested in anything.

13. Indecisiveness

0 I make decisions as well as ever.
1 I find it more difficult to make decisions than usual.
2 I have much greater difficulty in making decisions than I used to.
3 I have trouble making any decisions.

14. Worthlessness

0 I do not fell I am worthless.
1 I don't consider myself as worthwhile and useful as I used to.
2 I feel more worthless as compared to other people.
3 I fell utterly worthless.

15. Loss of Energy

0 I have as much energy as ever.
1 I have less energy than I used to have.
2 I don't have enough energy to do very much.
3 I don't have enough energy to do anything.

16. Changes in Sleeping Pattern

0 I have not experienced any change in my sleeping pattern.
1a I sleep somewhat more than usual.
1b I sleep somewhat less than usual.
2a I sleep a lot more than usual.
2b I sleep a lot less than usual.
3a I sleep most of the day.
3b I wake up 1-2 hours early and can't get back to sleep.

17. Irritability

0 I am no more irritable than usual.
1 I am more irritable than usual.
2 I am much more irritable than usual.
3 I am irritable all the time.

18. Changes in Appetite

0 I have not experienced any change in my appetite.
1a My appetite is somewhat less than usual.
1b My appetite is somewhat greater than usual.
2b My appetite is much greater than usual.
3a I have no appetite at all.
3b I crave food all the time,

19. Concentration Difficulty

0 I can concentrate as well as ever.
1 I can't concentrate as well as usual.
2 It's hard to keep my mind on anything for very long.
3 I find I can/t concentrate on anything.

20. Tiredness or Fatigue

0 I am no more tired or fatigued than usual.
1 I get more tired or fatigued more easily than usual.
2 I am too tired or fatigued to do a lot of the things I used to do.
3 I am too tired or fatigued to do most of the things I used to do.

21. Loss of Interest in Sex

0 I have not noticed any recent change in my interest in sex.
1 I am less interested in sex than I used to be.
2 I am much less interested in sex now.
3 I have lost interest in sex completely

Appendix - VI

Agression Questionnaire

(Buss, A. H., & Perry, M.1992)

Instructions: Using the 5 point scale shown below, indicate how uncharacteristic or characteristic each of the following statements is in describing you. Place your rating in the box to the right of the statement.		**extremely uncharacteristic of me**	**somewhat uncharacteristic of me**	**neither uncharacteristicnor characteristic of me**	**somewhat characteristic of me**	**extremely characteristic of me**
1	Some of my friends think I am a hothead	1	2	3	4	5
2	If I have to resort to violence to protect my rights, I will.	1	2	3	4	5
3	When people are especially nice to me, I wonder what they want.	1	2	3	4	5
4	I tell my friends openly when I disagree with them.	1	2	3	4	5
5	I have become so mad that I have broken things.	1	2	3	4	5
6	I can't help getting into arguments when people disagree with me.	1	2	3	4	5
7	I wonder why sometimes I feel so bitter about things.	1	2	3	4	5
8	Once in a while, I can't control the urge to strike another person.	1	2	3	4	5
9	I am an even-tempered person.	1	2	3	4	5
10	I am suspicious of overly friendly strangers.	1	2	3	4	5
11	I have threatened people I know.	1	2	3	4	5
12	I flare up quickly but get over it quickly.	1	2	3	4	5
13	Given enough provocation, I may hit another person.	1	2	3	4	5
14	When people annoy me, I may tell them what I think of them.	1	2	3	4	5
15	I am sometimes eaten up with jealousy.	1	2	3	4	5
16	I can think of no good reason for ever hitting a person.	1	2	3	4	5
17	At times I feel I have gotten a raw deal out of life.	1	2	3	4	5
18	I have trouble controlling my temper.	1	2	3	4	5
19	When frustrated, I let my irritation show.	1	2	3	4	5
20	I sometimes feel that people are laughing at me behind my back.	1	2	3	4	5
21	I often find myself disagreeing with people.	1	2	3	4	5
22	If somebody hits me, I hit back.	1	2	3	4	5
23	I sometimes feel like a powder keg ready to explode.	1	2	3	4	5
24	Other people always seem to get the breaks.	1	2	3	4	5

25	There are people who pushed me so far that we came to blows.	1	2	3	4	5
26	I know that “friends” talk about me behind my back.	1	2	3	4	5
27	My friends say that I’m somewhat argumentative.	1	2	3	4	5
28	Sometimes I fly off the handle for no good reason.	1	2	3	4	5
29	I get into fights a little more than the average person.	1	2	3	4	5

Appendix - VII

DEMOGRAPHIC INFORMATION SHEET
(MIZO)

Please indicate your responses to the following questions by circling the numbers against each question wherein applicable.

I Personal Information

1. Name :

2. Pianni leh thla : Date____ Month_____ Year____ Age ____as on_____

3. Nihna : Male/Female

4.Veng :

5. khua :

6.Lekha Zirthlen
Matriculate:
Under-graduate:
Graduate :
.

IIFamily

7. Chhungkua awmdan : Inpui/Indan

8. Chhungkua chengzat : _____

9. Unau neihzat : _____

10. A engzat na : _____

11. Nu kum : _____

12. Pa kum : _____

13. Nu leh pa : pahrawn/ nuhrawn/inthen

IIIIncome

2. Lakluhna:

d) Pa ber : ____

e) Nu ber : ____

f) Midand : ____

3. Total monthly income of family:

d) Rs 1000 hnuailam : ____

e) Rs 10000 – Rs 20000 : ____

f) Rs 20000 chunglam : ____

IV. Tunah i awmdan hi nuam I tih tawk em?

(a)Aw……..

(b) Aih……

V. I nihna (Gay) vang hian hmusit I tawk thin em?

(a)Aw……

(b)Aih……

VI. I awmdan (Gay) hi nuam I tih em?

(a)Aw……

(b) Aih…….

VII. I chhungte emaw thiante atangin hmusit I tawk thin em?

(a) Aw……..

(b) Aih……..

VIII. Tuna I awmdan (gay) hi I pianpui ve reng ni in I hria em?

(a) Aw……..

(b) Aih…….

IX. Tuna I awmdan (Gay) hi mi tih (TV or INTERNET) I hmu vanga tih ve I ni em?

(a) Aw…….

(b) Aih…….

Appendix -VIII

Kinsey Heterosexual-Homosexual Rating Scale
(KRS; Kinsey et al., 1948)

Heng thu pasarih (7) zinga hian a eng ber khian nge hun kaltawh a mipat hmeichhiatna I tawn hriat hrilhfiah ber ? Khawngaihin pawnlama I hmanchhuah\ chetchhuah dan chauh teh la, I ngaituahna chhungril emaw tisa chakna suangtuahna lam ni lovin. Ngun takin a chhanna tur hi chhiar chhuak theuh la. Pakhat chauh thai bialin chhang ang che.

1. Mipat hmeichhiatna ka lo hmantawh thinna hi chu hmeichhia ah chauh a ni a. Mahni mipat pui te nena taksa intawk/ inchul hi chuan eng tisa chakna mah min pe lo.

2. Mipat hmeichhiatna ka hmantawh na tlangpui hi chu hmeichhia ah a ni a, mahse mahni mipat pui han tawk/sik ve zeuh hian nuam tihna ka nei ve thin.

3. Mipat hmeichhiatna ka hman tawh tamna ber hi chu hmeichhia ah a ni a, mahse achang hian mipa dang han ngaihsak zawk hi ka nei ve thin. Engpawh chu nise, mipat hmeichhiatna hi chu hmeichhia nen ka hmang nasa fe zawk a ni.

4. Ka lo tih thin tawh ah chuan Mipa leh hmeichhia ka ngaihmelh leh it dan hi chu in ang deuh reng a ni.

5. Mipat hmeichhiatna ka hman pui thin hi chu mahni mipat pui te nen a ni ber a, mahse hmeichhia pawh ka hman pui teuh tho a ni.

6. Mipat hmeichhiatna hi mahni mipat pui nen ka hmang thin a, mahse hmeichhia han nawk vel hian tisa chakna a chawk chhuak tho thin.

7. Mipat hmeichhiatna ah ka tawn hriat zawng zawng hi chu mahni mipat pui ah a ni a. Hmeichhia nen a han in nawk vel hian tisa chakna min thlen ngai lo.

Heng thu pasarih 7 zingah hian eng hian nge I rilru ngaituahna hrilhfiah chiang ber? Khawngaihin I suangtuahna a tisa chakna I neih thin chauh teh la. A taka I tih thin dan ni lovin. A chhanna I pek hmain ngun takin chhiar chhuak phawt la. Pakhat chauh chhangin thai bial ang che.

1. Ka tisa chakna hi hmeichhia ka chul vel hian a chhuak deuh ber a, tisa chakna hmanpui tur kan suangtuah vel pawh hi hmeichhia tho ani thin.

2. Ka tisa chakna chhuahna chhan thin ber hi chu hmeichhia ka chul vel hian a ni deuh ber a, tisa chakna hmanpui tur kan suangtuah vel pawh hi hmeichhia tho ani thin. Mipa avang pawhin a chhuak tho thin na a, a nasa lo zawk fe ani.

3. Ka tisa chakna chuahna chhan thin ber hi chu hmeichhia ka chul vel hian a ni deuh ber a, tisa chakna hmanpui tur kan suangtuah vel pawh hi hmeichhia tho ani thin. Mipa nena han in sawngbawl vel pawh hian ka chakna a ti chhuak tho thin na a, hmeichhia nen a hman hi ka chak zawk daih a ani.

4. Ka tisa chakna phuhruk tur emaw ka suangtuahna a ka han hisap kual vel hian, mipa leh hmeichhia hian ang khat rengin min ti zauthau thin.

5. Ka suangtuahna a tihsa chakna chuahna chhan thin ber hi chu mipa ka chul vel hian a ni deuh ber a, tisa chakna hmanpui tur kan suangtuah vel pawh hi mipa tho ani thin. Hmeichhia nena han in sawngbawl vel pawh hian ka chakna a ti chhuak tho thin na a, mipa nen a hman hi ka chak zawk daih a ani.

6. Ka suangtuahna a tisa chakna chuahna chhan thin ber hi chu mipa ka chul vel hian a ni deuh ber a, tisa chakna hmanpui tur kan suangtuah vel pawh hi mipa tho ani thin. A chang chang chuan hmeichhia nena han in sawngbawl vel pawh hi nuam ka ti ve tho thin.

7. Ka suangtuahna a tisa chakna hrikthlak nana ka duh ber leh ka hisap thin chu mipa a ni thin.

Appendix – IX

Psychological Well-being Scale
(GWS; Veit & Ware, 1983; Heubeck & Neill, 2000)

Heng zawhna awmzia chu nangmah I inhriat dan leh thla hmasa kalta a I nun a thil thleng ni a I hriat te a zawt che a. Zawhna tina hian rinbial (circle) pakhat theuh I rilru awmdan nia I hriat ber kha khawngaihin thaibial ang che.

1. Thla hmasa kalta a khan I nuna eng ang chiaha hlim leh, lungawi leh lawm nge inih le?
    1. Hlim takzet, khabak chuanga hlim leh lawm awm thei lovang.
    2. Engtik lai pawh khan ka hlim a ni ber mai.
    3. Ka hlimin ka lungawi tlangpui.
    4. A changchuan ka lungawi thawkhata, a changchuan ka lungngai thin.
    5. Ka lungawilo tlangpui, hlimlo.
    6. Ka lungawi lo ngawih ngawih.

2. Thla hmasa a khan eng ang chiah a tam nge I nitin nuna thil chakawm leh Itui ngawih ngawih nah I tawn?

    1 .Engtik lai pawh in

    2. Hun tam zawk

    3. Hun tha tam zawk

    4. Hun thenkhat

    5. Hun tlemte

    6. Eng huna mah

3.Eng zata tam nge thla hmasa khan I hahdam ngawih ngawih leh hrehawm ti lova I awm?

    1. Ka hun zawng zawng

    2. Hun tam zawk

    3. Hun tha tam zawk

    4. Hun thenkhat

    5. Hun tlemte

    6. Eng huna mah

4. Thla hmasa kalta khan eng zata tam chiah nge I nuam tih zawng tak I tih tlangpui?

1. ka hun zawng zawng
2. Hun tam zawk
3. Hun tha tam zawk
4. Hun thenkhat
5. Hun tlemte
6. Eng huna mah

5. Thla hmasa kalta khan lungngaih ngawih ngawih chang I nei em?

1,Aw,a changchuan nilengin engmah ngaituah peih miah lo in ka awm thin.

2.Aw, nitin deuh thawh hian ka lungngai ngawih ngawih thin

3.Aw,chhan hrang hrang a vang hian ka lungngai thin

4.Aw, rilru hrehawm ngawih ngawih hi chu vawi tam tak ka nei

5.Aw,tunah leh nakina pawh rilru hahna hi chu la awm zel ang.

6.Aih, engtik lai mahin ka lungngai ngai lo tlangpui.

6. Thla hmasa khan zing I thawh in eng zata tam nge vawin chu ka van hmang nuam dawn tak em I tih thin?

1. Ka hun zawng zawng
2. Hun tam zawk
3. Hun tha tam zawk
4. Hun thenkhat
5. Hun tlemte
6. Eng huna mah

7. Thla hmasa khan eng zata tam nge awmnuam lo leh hrehawm tung/hah tung a I awm?

1. Ka hun zawng zawng
2. Hun tam zawk
3. Ka hun tha tam zawk
4. Hun thenkhat
5. Hun tlemte
6. Eng huna mah

8. Thla hmasa khan eng zat a tam nge rilru hahdam tak leh hlim veng veng a I awm?

1. ka hun zawng zawng
2. Hun tam zawk
3. Hun tha tam zawk
4. Hun thenkhat
5. Hun tlemte
6. Eng huna mah

9. Thla hmasa khan engzat a tam nge rilru beidawng ngawih ngawih leh ngaina hreloa I awm?
   1. Ka hun zawng zawng
   2. Hun tam zawk
   3. Hun tha tam zawk
   4. Hun thenkhat
   5. Hun tlemte
   6. Eng huna mah

10. Thla hmasa khan engzat a tam nge harsatna nei miah lova rilru hahdam ngawih ngawih a I awm?
   1 .ka hun zawng zawng
   2. Hun tam zawk
   3. Hun tha tam zawk
   4. Hun thenkhat
   5. Hun tlemte
   6. Eng huna mah

11. Thla hmasa khan engtia zingin nge engthil mah hi I duhdan anga thleng lo a I hriat.
   1 .Engtik laipawhin
   2. Thleng ngun
   3. Thleng zing thawkhat
   4. A chang changin
   5. Thlenglo tlangpui
   6. Thleng ngai lo top

12.Thla hmasa khan eng anga tam nge thil hlimawm dangdai tak I tawn hriat.
   1. ka hun zawng zawng
   2. Hun tam zawk

3. Hun tha tam zawk
4. Hun thenkhat
5. Hun tlemte
6. Eng huna mah

13.Thla hmasa khan enga zing nge ngui ngawih ngawih a engthil mahin chawkphur thei lo che a I inngaih?

1. Ka hun zawng zawng
2. Hun tam zawk
3. Hun tha tam zawk
4. Hun thenkhat
5. Hun tlemte
6. Eng huna mah

14. Thla hmasa khan eng ang a tam nge thil ho te a rilru nguai leh phur loh deuh I neih.?

1. Ka hun zawng zawng
2. Hun tam zawk
3. Hun tha tam zawk
4. Hun thenkhat
5. Hun tlemte
6 .Eng huna mah

15. Thla hmasa khan eng ang chiah a tam nge hlim veng veng leh rilru zangkhai taka I awm?

1. ka hun zawng zawng
2. Hun tam zawk
3. Hun tha tam zawk
4. Hun thenkhat
5. Hun tlemte
6. Eng huna mah

16. Thla hmasa khan eng anga zing nge buainuaih,thinrim emaw sen awp awp khawp a I awm?

1. Engtik laipawhin

2. Thleng ngun
3. Thleng zing thawkhat
4. A chang changin
5. Thlenglo tlangpui
6. Thleng ngai lo top

17. Thla hmasa khan hlau thawn ngawih ngawih le phi ruai in I awm thin em?
    1. Aw, nasa lutuk, damlo emaw damlo tluk hial in
    2. Aw, nasa khawpmai
    3. Aw, nasa ve thawkhat
    4. Aw, tamtak, min tibuai khawp chu
    5. Aw, tlemte chu
    6. Aih, nei ngailo

18. Thla hmasa khan eng anga tam nge mihlim thei takni a I in hriat?
    1. ka hun zawng zawng
    2. Hun tam zawk
    3. Hun tha tam zawk
    4. Hun thenkhat
    5. Hun tlemte
    6. Eng huna mah

19. Thla hmasa khan eng a tam nge hun harsa tak tawka nagmah inbengdaih I tum?
    1. Engtik lai pawn a harsa
    2. Thleng ngun lutuk
    3. Thleng ngun thawkhat
    4. A chang chang in
    5. Thleng lo ang a ni
    6. Harsatna thleng ngai lo top

20. Thla hmasa khan eng anga zing nge ngui ngawih ngawih leh thlarau chau vek khopa I awm?
    1. Hun zawng zawng

2. Hun tam zawk
3. Hun tha tam zawk
4. Hun thenkhat
5. Hun tlemte
6. Eng huna mah

Appendix - X

Satisfaction with Life Scale

(SWLS: Diener, Emmons, Larsen& Griffin, 1985)

1 - 7 tehna hmang hian a hnuaia thu te hi I ngaihdan mil ber ah I thai dawn nia.		**Pawmlo hulhual**	**pawmlo**	**Pawm vak lo**	**hrelo**	**Pawm deuh**	**pawm**	**Pawm lutuk**
1	Ka nun hi kawng tam taka ka duhthusam	1	2	3	4	5	6	7
2	Ka nun dan hi a tha ka ti tawp.	1	2	3	4	5	6	7
3	Ka nundan ah hian ka lungawi tawp.	1	2	3	4	5	6	7
4	Ka nuna a tan a thil pawimawh leh ka mamawh nia ka hriat hi chu ka la nei tlangpui ani.	1	2	3	4	5	6	7
5	Ka nun hi a bula tangin tan tha le dawn ta ila, thlak danglam tur a awm ka hrelo.	1	2	3	4	5	6	7

Appendix – XI

Becks Depression Inventory-II

(BDI-11: Aaron T. Beck, Robert A. Steer and Gregory K. Brown1996)

He zawhna buatsaihah hian thuhlawm (group) hmun 2 a then a nei a. A thute hi khawngaihin uluk takin chhiar la, tichuan group tin atang hian eng thu hlawm ber hian nge tun kar hnih hung chhung emaw vawiin ni thleng a I rilru leh ngaihtuahna a deh dan emaw khawih dan ber pakhat (1) I thlang chhuak dawn nia. I thuhlawm (sentence) pakhat thlanchhuah zel sira number hi I thai bial zel dawn nia. Group khat a sentence te hian nangmah ah an kawh dan emaw hnamhnawih dan a in ang tlangpui a nih chuan, chumi group a number tam ber chu I thai bial dawn nia. Group khat ah sentence pakhat chiah bak thlang lo tur in I fimkhur dawn nia, Item 16 (mutdan ziarang) emaw Item 18 (Ei leh in chakna inthlakdanglamna) te tiam in.

Hriattur

1. Lungngaihna/ Nguina
   - 0 Ka lungngai ngai lo.
   - 1 Ka hun tamzawk ah hian ka lungngai in ka ngui
   - 2 Engtik lai mai pawh hian ka lungngai in ka ngui.
   - 3 Ka lungngai in ka ngui/hlimlo lutuk hi tuar har ka ti.

2. Beidawnna/ Beidawng zawng a thil thlirna
   - 0 Ka hun lo la awm tur ah hian ka beidawngin ka lungngai ngai lo.
   - 1 Ka hun lo la awm tur atan hian tun hma zawng aiin ka lunghnual in ka beidawng
   - 2 Engmah hi ka tan hian beiseiawm in ka hrelo.
   - 3 Ka hun lo la awm tur hian beisei a tibo in, a chhiat zual ka ring.

3.Hun kal tawha hlawhchhamna
   - 0 Mi hlawhchham ni in ka in hria ngailo.
   - 1 Ka hlawhchham tur aia tam hi ka hlawhchhamtawh/ hlawhtlinglo tawh.
   - 2 Ka hun kal tawh ka han thlir hian, hlawhchhamna tam tak ka hmu.
   - 3 Keimah hi mi hlawhchham leh mi tlinglo hulhual mi niin ka in hria.

4. Hlimna/Lawmna hlohna
   - 0. Nuam ka tih zawng thil ka tih zawng zawng ah hian hlimna/lawman tam tak ka hmu.
   - 1 Tun hma angin thil nuam ka tih zawng te ka tih in ka hlim lo.
   - 2 Tun hma a nuam ka lo tih thin te khan tuna chuan hlimna min pe tlem tawh.
   - 3 Nuam ka lo tih zawng zawng thin te khan eng hlimna mah min pe tawh

5. Mahni inthiamlohna
   - 0 Mahni inthiamlohna ka nei hran ngailo.
   - 1 Ka thil lo tih tawh emaw lo tih awm ngei ngei ka tih lo te a khan mahni inthiamlohna ka ngah khawp mai.
   - 2 Ka hun tam zawk ah hian mahni inthiamlohna in ka khat thin.
   - 3 Engtik hunlai mai pawh hian mahni inthiamlohna rilru hi ka nei.

6. Hremna / Sawisakna lam hawizawng
   - 0 Hremna/sawisakna tuar ni in ka in hria ngai lo.
   - 1 Hremna/sawisakna/tihduhdahna la tuar maithei turin ka in hria.

2 Hremna/tihduhdahna tuar turin ka in beisei/ in ring.
3 Hremna/tihduhdahna hnuaia awm ni in ka in hria.

7. Mahni insitna
0 Keimah ah hian engtiklai maipawh hian ka lungawi.
1 Mahni inrintawkna tlachham in ka in hria.
2 Keimah awmdan ah hian ka lungawi thloh lo.
3 Keimah leh keimah hi ka insit in ka inngei.

8. Mahni insawiselna/ Indemna
0 Keimah hi ka in sawiselin indemna hranpa ka nei lo.
1 Mahni indemna/sawiselna ka nei fo.
2. Ka thil tih sual zawng zawng ah te hiam mahni indemna/selna ka nei.
3 Thil thalo thleng reng reng ah hian keimah in demna / selna ka nei.

9. Mahni intihhlum duhna/ tumna rilru
0 Mahni intihhlum tumna rilru engmah/ vawikhatmah ka la neilo.
1 Mahni intihhlum duh maina rilru chu ka pu tawha, mahse tih hlawhtlin ka duh kher lo.
2 Mahni intihhlum duh maina rilru ka pu fo.
3 Hun remchang chu awm /nei ila chuan mahni intihhlum mai duhna ka nei.

10.Tahna/ Lungchhiatna
0 Lungchhiatna/tahna/ mittui tlakna ka nei zen zen lo.
1 Rin ai takin lungchhiatna ka tawng fo.
2 Thil ho te ah pawh hian ka mittui a tla in, ka lungchhe fo mai.
3 Tah chhuah hawm hawm ka chak/duh a, mahse ka thei lo.

11. Philina/ Awm hle hle theihlohna
0 Phili emaw awm hle hle theihloh ka nei hranlo.
1 Phili emaw awm hle hle theihloh ka nei ve fo mai.
2 Ka buai in ka phili sek mai thin a, awm hle hle pawh hi harsa ka ti thin.
3 Ka phili chung zel mai a, chuvangin thil eng emaw tal tiin emaw ka buai reng a ngai thin.

12. Tuina hlohna
0 Mi dang chungah emaw thil engpawh ah hian tuilohna ka nei hranpa lo.
1 Tun hma aiin mi chungah emaw thil dangah emaw tuilohna ka nei hma tawh.
2 Ka thil tuina zawng zawng thin te kha midang chungah emaw thil dangah emaw ka hloh zo vek tawh.
3 Engkim mai ah hian tuina leh chakna neih harsa ka ti.

13.Thutlukna siam kawnga harsatna
4 Thutlukna siam hi harsa ka ti ngai lo.
5 Dan naran in thutlukna siam hi harsa ka ti tlat thin.
6 Tun hma zawng aiin thutlukna siam fel harsa ka ti.

7 Thutlukna engpawh mai hi siam harsa ka ti.

14. Hlutlohna

8 Mi hlu lo ni hian ka inhria ngai lo hrim hrim
9 Tun hma zawng ai khan hlu lo tlat a in ngaih na ka nei.
10 Midang ai hian hlu lo bik niin ka in hria/ngai.
11 Tlaktlailo leh hlu lo bik ngawih ngawih hian ka in hria.

15. Chakna leh tha hlohna

12 Chakna ngah leh zamtha tak mi ka ni.
13 Tun hma zawng ai in ka chakna leh thathona hi tlahniam ta in ka in hria.
14 Chakna thahrui leh phurna ka nei tlem hle.
15 Engpawh han ti tur hian chakna leh phurna ka neilo.

16. Mutdan ziarang

0. Ka mut dan leh mutmu tuah kawngah danglamna leh harsatna ka nei lo.
1a Dan pangngai aia tam/rei mah mut chang ka nei.
1b Dan pangngai aia tlem/tawi mut chang ka nei.
2a Dan naranin rei tak ka mu thin.
2b Dan naranin muthilh ka harsat/mu tlem.
3a Nileng deuh thaw ka mu thin
3b Darkar 1-2 Vel ka han harh a , ka muhil leh mai theilo thin.

17. Thinur hmana

0.Mi pangngai aia thin ur hma bik ka ni in ka hria lo.
1.Ka thinur hma in ngeiawm chang ka nei fo.
2.A tlangpui in mi thinur hma leh thinchhe mi ka ni.
3. Engtiklai mai pawh hian ka thin hi a ur in a rim tauh reng mai.

18. Ei leh in chakna inthlak danglam

0 Ei leh in chakna hunbi inthlak ka neilo.
1a Ei leh in ka chakna a tla hniam.
1b Ei leh in ka chakna a zual in a pung.
2a Tunhma aiin ei leh in lamah harsatna ka neiin,ka tla hniam.
2b Tunhma aiin ka ei leh in a tui.
3a Ei leh in chakna ka neilo
3b Ei leh in chakna ka nei huam huam reng mai.

19. Rilru ding taka ngaihtuahna hman lama harsatna

0.Rilru leh ngaihtuahna fim tak leh ding taka kaltirna lamah harsatna ka neilo.
1.Nidang aiin ngaihtuahna leh rilru ding taka hman harsa ka ti.
2.Thil pakhatah ka rilru leh ngaihtuahna ding taka kal tir harsa ka ti.
3.Engmah ah hian ka rilru leh ngaihtuahna te ding takin ka kal tir theilo.

20. Chauhna/ Hah ngawih ngawih na/ Kulchona

0. Dan naran in chauhna leh kulchona ka nei hran lo.
1. Chau ngawih ngawih/ kulcho a awm fo chang ka nei.
2.Hna/ thil tam tak khawih tur hian tha ka neilo in ka chau ngawih ngawih fo

tawh mai.

3.Thil eng ang pawh ti tur hian ka chau ngawih ngawih in, ka kulcho ti tih reng mai.

21.Hmeichhiat Mipatna lama tuina hlohna

0.Hmeichhiat mipatna lama tuina leh harsatna ka hloh tun hnai maiah ka hrelo.

1.Hmeichhiat mipatna kawngah tuina ka nei vak hranlo.

2.Tun ah hian hmeichhiat mipatna lam hawizawng ah tuina ka neilo.

3.Hmeichhiat mipatna kawngah tuina leh ngaihtuahna pakhatmah ka nei lo.

Appendix - XII

Aggression Questionnaire
(Buss, A. H., & Perry, M.1992)

Instructions: Tehna 5 hmang hian imizia lo emaw I mizia emaw sawifiah na a awm a.Khawngaihin I nihna a dik ber a I inhriat chhung a hian I thai don nia.		**Ka mizia lo tawp ani.**	**Ka mizia lo a ni tlangpui**	**Ngaihdan nei lo**	**Thena chuan ka mizia ni reng**	**Ka mizia tawp a ni.**
1	Ka thian thenkhat chuan mi thinchhe tak niiin min ngai	1	2	3	4	5
2	Ka dikna humhim turin tharuma beih ngai ta se ka tih ka ring..	1	2	3	4	5
3	Mi ka chunga an that viau hian mak ka ti thin a, engnge ka lakah an beisei ang aw ka ti thin	1	2	3	4	5
4	Ka ngaihdan anihloh chuan tlang takin ka ngaihdan anih loh thu ka hrilh ang	1	2	3	4	5
5	Ka thinur hian mi a ang main thil ka tichhe thin.	1	2	3	4	5
6	Ka ngaihdan an pawmloh hian ka in sum thei thin lo.	1	2	3	4	5
7	Engemaw chang a rilrusual ka put tlat thin hi mak ka ti thin.	1	2	3	4	5
8	Thin ur vanga midang kut thlak mai duh na hi ka nei ve tawh	1	2	3	4	5
9	A chang chuan thin chhe tak ka ni thin..	1	2	3	4	5
10	Hriat ngailoh an fel viau hian ka ring hlel thin...	1	2	3	4	5
11	Mi dang hi ka tihreawm thin tih ka hria.	1	2	3	4	5
12	Ka thin hi a rim phut a mahse a reh leh vat thin.	1	2	3	4	5
13	Min tihthin ur viau chuan ka khawih mai duh ka ring.	1	2	3	4	5
14	Min min tih lungawiloh chuan, an mahni ka ngaihdan ka hrilh mai ka ring	1	2	3	4	5
15	A chang chuan mi thikna in ka khat thin.	1	2	3	4	5
16	Mi dang kut thlak tur khawp khawp na chhhan tur ka hrelo .	1	2	3	4	5
17	A chang chuan ka nuna thalo ber lai hi ka ti lang chhuakin ka hre thin.	1	2	3	4	5
18	Ka thinchhiatna thup hlei thei lo thin	1	2	3	4	5
19	Ka beidawn hian awm hle gle theilo in ka ti lang thin.	1	2	3	4	5
20	A chang chuan mite hian ka hnunglamah min nuihzatin ka hre thin.	1	2	3	4	5
21	Midang te hnialkalh reng ni hian ka in hre thin.	1	2	3	4	5
22	Tu in emaw kut min thlak chuan ka beilet ve nghal ang..	1	2	3	4	5
23	A chang chuan thinurna puakdar reng thei pai ni hian ka in hre thin	1	2	3	4	5
24	Midangfte hi chu insum thei tak niin ka hre thin.	1	2	3	4	5
25	Midangin min fuihpawrh nasat avangin kan ti thin in ka hria	1	2	3	4	5
26	Ka thiante hian ka hnunglama min rel thin tih ka hria	1	2	3	4	5
27	Ka thiante te hian mi hnial hrat min ti.	1	2	3	4	5
28	A chang chuan ka thin chhe lutuk hian a chhan awm chuanglo in thil ka paihdarh vak thin	1	2	3	4	5
29	Mi tam tak ai chuan ka intihbuaina ah hian ka tel tam zawk.	1	2	3	4	5

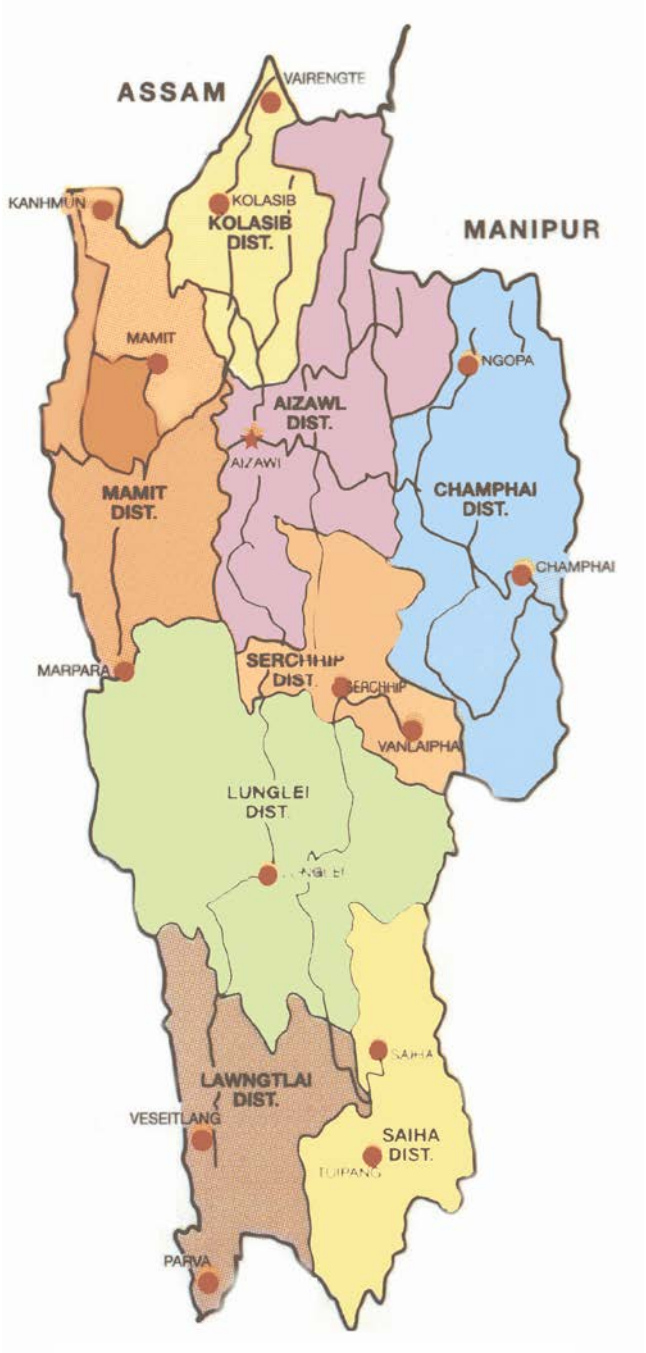
Appendix- XIII

MAP OF INDIA

(Showing the location of Mizoram State)

Appendix – XIV

MAP OF MIZORAM STATE


ASSAM
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NGOPA
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SAIHA
LAWNGTLAI DIST.
VESEITLANG
SAIHA DIST.
TUIPANG
PARVA

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PARTICULARS OF THE CANDIDATE

Name of the Candidate	: Ms. P. C.Lalhmingsangi
Degree	: Doctor of Philosophy
Department	: Psychology
Title of Dissertation	: "A Comparative Study Of Psychological Adjustment Among Heterosexual and Homosexual Male Youth"
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Approval of Research Proposal

1. BPGS : 29.04.2011
2. School Board : 16.05.2011
3. Registration No.& Date : MZU/Ph.D/385 of 29.4.2011
4. Academic Council : 1.07. 2011
5. Extension (If any) : Nil

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