EMOTIONAL INTELLIGENCE AMONG INDIVIDUALS WITH AND WITHOUT DEPRESSION: A COMPARATIVE STUDY

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Supervisor

DEDICATED

To my father (May God give him place in the Haven) my sweet mother, my sis Rehana and brother Manz who help me to reach at this place where my father wanted to see me.

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ABSTRACT

The present study was undertaken to explore the difference among emotional intelligence of individuals with depression and the individuals without depression. The sample of the study consists of 60 individuals (30 individuals with depression and 30 individuals without depression). The sample group was selected with equal gender differences from hospital and normal population from Rawalpindi and Islamabad. Matched group technique was used. To measure these differences, Urdu version of Emotional Quotient Inventory (EQ-i) first developed by BarOn was used. The scale comprises of 15 subscales. The Alpha Reliability Coefficient of EQ-i indicated high internal consistency i.e, .96 of the measure for the sample of the study. The results revealed the significant differences on emotional intelligence of the individuals with and without depression t-test ($t = 13.25$, $p < 0.01$) and ANOVA was computed. This finding showed individuals with depression had significantly high emotional intelligence as compare to the individuals without depression ($p < 0.01$). The results also showed that the men without depression significantly high emotional intelligence than men of individuals with depression at $p < 0.01$ level. The results also showed that the women without depression significantly high emotional intelligence than women of individuals with depression ($p < 0.01$). Significant differences do not exist between both genders in overall sample ($t = .76$), nonsignificant for individual with depression ($t = .30$). The results raveled that men without depression had significantly high emotional intelligence as compared to women without depression ($t = 2.7$) on $p < 0.01$ level. This study also revealed non significant difference between the individuals with high income and low income on emotional intelligence, overall sample showed non significant results ($t = .84$). The results showed significantly high emotional intelligence among high income individuals with depression than low income individuals on overall emotional intelligence scores ($t = 2.53$, $p < 0.01$). There was nonsignificant difference found between emotional intelligence in the individuals of different age levels from the group of individuals with depression but significant difference found in the group of individuals without depression on overall emotional intelligence scale ($t = 2.63$, $p < 0.01$).

INTRODUCTION

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Emotional Intelligence (EI) is the ability to sense, understand, and affectively apply the power and insight of emotions and these emotions are the human energy. It is also ability to acquire and apply knowledge from ones own emotions and the emotions of others. One can use the information about what he/she is feeling that help to make effective decisions about what to say or do. The EI is some what the ideal combination of emotionally important factors that are important for the purpose of leading a healthier, comfortable and successful life.

Here are some of the basic human emotional needs expressed as feelings. While all humans share these needs, each differs in the strength of the need, just as some of us need more water, more food or more sleep. One person may need more freedom and independence; another may need more security and social connections. One may have a greater curiosity and a greater need for understanding, while another is content to accept whatever is told to him.

The concept of EI is use to understand the interpersonal emotions as the reaction of any event and the interpersonal aspect according to the social settings. The physically healthy and emotionally intelligent person can identify his internal emotional condition and at times regulate it accordingly, it can also helping to understand socially acceptable behavior and utilize their competencies like intelligence and other skills appropriately in their fields. One of the major problems I have observed in schools is the treatment of all children as if their emotional and psychological needs were identical. The result is many children's needs are unsatisfied. They then become frustrated, as any of us do when our needs are unmet. They act out their frustration in various ways which are typically seen as "misbehavior." This is especially evident when children are expected to do all the same thing for the same length of time. The better we identify their unique needs and satisfy them, the fewer are problems. While the pathology is related to the disturbance, distortion, and imbalance condition of the connection of emotions. It may be related to the social issues like interpersonal and intrapersonal relationships (Cynthia, 1999).

The concept of the emotions is very old as from the area of Plato since then, scientists, educators, and philosophers have worked to prove or disprove the components of feelings in different aspects of life and experiences. There is an intelligence based on emotion, and people who have this capacity are less depressed, healthier, more employable, and have better social relationships (BarOn, 1992).

This study is based on the topic which is related to a social and emotional capabilities of human beings the term used for it is EI and its levels in clinically diagnosed patients with depression and normal individuals without depression. The fourth biggest mental disease of the world is depression that has made the people to think about the importance of this mental state (Cecile, 1999) which affects the normal abilities of an individual.

Emotional Intelligence

The emotions are the basic and important part of the human life as the Plato 2000 years ago said that "all learning has an emotional base". The emotions are the internal event that deals with wide range interactions of interpersonal to the intrapersonal affairs. That is composed of many functions dealt with internal or external events of physical interactions, cognitions, awareness and schemata's that are formed on the basis of any good or bad experiences about that particular situation (Bar-On, 1988).

EI isn't a new concept in psychology. One can find related ideas in work done over 60 years ago. For instance, Robert Thorndike wrote about "social intelligence" in the late thirties. In 1937, Robert and Stern reviewed the attempts to measure the social intelligence that dealt some competencies included to the EI; they also developed in 1926 Social Intelligence Test (Thorndike & Stein, 1937). In 1952 work on the intelligence quotient (IQ) and developed IQ tests nodded to the "affective capacities" as the important factor of the human intelligence whether related to the academics or the emotional competencies. In 1953, Doll worked on the social and emotional competencies in the human beings and also developed the scales for it, initially started on intellective intelligence.

In the early 1980s, Howard Gardner began to write about "multiple intelligence" and proposed that "intrapersonal" and "interpersonal" intelligences are

as important as the type of intelligence typically measured by IQ tests. This seems to be the first academic use of the term EI when in 1985 Wayne Leon Payne, a graduate student at an alternative liberal arts college in the USA, wrote a doctoral dissertation which included the term EI in the title (Hein, 2005).

In 1990 the work of two American university professors, John Mayer and Peter Salovey, was published in two academic journal articles. Mayer and Salovey were trying to develop a way of scientifically measuring the difference between people's ability in the area of emotions. They found that some people were better than others at things like identifying their own feelings, identifying the feelings of others, and solving problems involving emotional issues. The concept of EI is attributed to Peter Salovey *and* John Mayer in 1990. They define the EI as one of the factor of social intelligence that involves the ability to monitor one's own and others' feelings and emotions, to discriminate among them and to use this information to guide one's thinking and actions (Salovey & Mayer, 1990).

An EI includes a collection of personality traits, social skills and many other features of human behavior. As Lzard (1979) explains the interpersonal experiencing of certain emotions has been related to different anti- or pro-social behaviors in subject. Emotional awareness entails a variety of both interpersonal and an intrapersonal skills. They included perceptual insight, cognitive classification ability, emotional ability to recognize the importance of the emotions, and behavioral or interpersonal responses.

EI is the innate potential to feel, use, communicate, recognize, remember, learn from manage and understand emotions (Hein, 2005). He emphasizes that EI is an innate potential that depends on the ability to feel emotions, including the ability to remember feelings. Each child enters the world with a unique potential for these components of EI, emotional sensitivity, emotional memory, emotional processing and problem solving ability, emotional learning ability. The four branch model of EI describes four areas of capacities or skills that collectively describe many of areas of it. More specifically, this model defines EI as involving the abilities to accurately perceive emotions in one and others; use emotions to facilitate thinking; understand emotional meanings, and manage emotions. It is helpful to make a distinction in a person's innate potential versus what actually happens to that potential over their lifetime. This innate intelligence can be either developed or damaged with life

experiences, particularly by the emotional lessons taught by the parents, teachers, caregivers and family during childhood and adolescence. The impact of these lessons results in one's level of emotional quotient (EQ) in other words, the term, EQ represents a relative measure of a person's healthy or unhealthy development of their innate EI (Hein, 2005).

Every daily life events shows the importance of the emotion in the daily life. According to emotional and social intelligence is a multi-factorial array of interrelated emotional, personal and social abilities that influence our overall ability to actively and effectively cope with daily demands and pressures (Bar-On, 1988). He has been a pioneer in developing the concept of EI, and applying it and has developed an assessment tool of individuals' levels of EI.

For defining the term EI it is important to focused one-self and also on others feelings. EI requires that we learn to acknowledge and understand feelings – in ourselves and others – and that we appropriately respond to them, effectively applying the information and energy of emotions in our daily life and work. A more complete definition is 'EI is the ability to sense, understand and effectively apply the power and insight of emotions as a source of human energy, information, connection and influence (Cooper & Sawaf, 1997).

Daniel Goleman is the influential advocate of the value of developing EI; he said that EI is more important than the IQ. The feelings are natural and important for a healthy person to regulate at times and manage according to the conditions that are socially acceptable as he explains that EI does not mean giving free rein to feelings - letting it all hang out. Rather, it means managing feelings so that they are expressed appropriately and effectively, enabling people to work together smoothly toward their common goals (Goleman, 1995).

The human relation ships base upon the expressions of feelings inside that person as one of those leading the application of emotions in different situations. There are highlighted some of the core concepts about EI those are, the ability to understand and express emotions constructively, it is a set of non-cognitive abilities that influence your ability to get on in life. In addition, Geetu, in an article written with Reuven Bar-On, also talks about the broad area of emotional and social

intelligence (Bharwaney as cited in Bar-On, 2003). They both focus on the use of emotions in coping with daily demands. They point out those definitions of this broad area that involve one or more of the following abilities:

- To understand and express emotions constructively.
- To understand others' feelings and establish cooperative interpersonal relationships.
- To manage and regulate emotions in an effective manner.
- To cope realistically with new situations and to solve problems of a personal and interpersonal nature as they arise.
- To be sufficiently optimistic, positive and self-motivated in order to set and achieve goals.

These outlines explain basically the EI (BarOn & Parker, 2000).

Neurological Basis of EI

The competencies explained by the Goleman have long been recognized as adding value to performance; however, one of the functions of the EI framework is to reflect the neurological substrates of this set of human abilities. An understanding of these neurological substrates has critical implications for how people can best learn to develop strengths in the EI range of competencies.

From the perspective of affective neuroscience, the defining boundary in brain activity between EI and cognitive intelligence is the distinction between capacities that are purely (or largely) neocortical and those that integrate neocortical and limbic circuitry. Intellectual abilities like verbal fluency, spatial logic, and abstract reasoning-in other words, the components of IQ-are based primarily in specific areas of the neurological. When these brain areas are damaged, the corresponding intellectual ability suffers. In contrast, EI encompasses the behavioral manifestations of underlying neurological circuitry that primarily links the limbic areas for emotion, centering on the amygdala and it extend networks throughout the brain, to areas in the prefrontal cortex, the brain's executive center (Damasio, 1994).

Key components of this circuitry include the dorso-lateral, ventro-medial, and orbit frontal sectors of the prefrontal cortex (with important functional differences

between left and right sides in each sector) and the amygdala and hippocampus (Davison & Neal, 2002). This circuitry is essential for the development of skills in each of the four main domains of EI. Lesions in these areas produce deficits in the hallmark abilities of EI-Self-Awareness, Self-Management (including Motivation), Social Awareness skills such as Empathy, and Relationship Management, just as lesions in discrete areas of the brain selectively impair aspects of purely cognitive abilities such as verbal fluency or spatial reasoning (Mayer & Salovey, 1993).

Twelve patients with focal, stable, bilateral lesions of the ventromedial (VM) prefrontal cortex or with right unilateral lesions of the amygdala or right insular cortices were assessed with the EQ-i. Only patients with lesions in the somatic marker circuitry revealed significantly low EI and poor judgment in decision making as well as disturbances in social functioning, despite having normal IQs and the absence of psychopathology. These findings concur with the somatic marker hypothesis, which posits that deficits in emotional signaling (somatic states) lead to poor judgment in decision making, especially in the personal and social realms. Patients with lesions to the ventro-medial prefrontal cortex have defective somatic markers and tend to exercise poor judgment in decision making, which is especially apparent in the poor choices they often make in their personal lives and in the ways in which they relate to others.

There is a significant difference between the physical and memorial intelligence and the EI. Compelling evidence recently has surfaced; leading scientists to believe that Einstein's superior intellectual ability may have been related to the region of his brain that supports psychological functions (Dunn, as cited in Cynthia, 1999). The recent identification of these skills under the singular phrase EI, with an accompanying scientifically based, systematized approach to personal development is rapidly attracting attention within every social and organizational settings today (Cynthia, 1999).

Research shows that EI may actually be significantly more important than cognitive ability and technical expertise combined. In fact, some studies indicate that EQ is morethan as important as standard IQ abilities. Further, evidence increasingly shows that the higher one goes in an organization, the more important EQ can be. For those in leadership positions, EI skills account for close to 90 percent of what distinguishes outstanding leaders from those judged as average. EI defined as the

capacity for recognizing our own feelings and those of others, for motivating ourselves, and for managing emotions well in us and in our relationships (Goleman, 1995).

Theories of EI

Goleman in 1995, in Working with EI, has set out a framework of EI that reflects an individual's potential for mastering the skills. This model is based on EI competencies that have been identified in research at distinguishing outstanding performers. Focusing on EI as a theory of performance, a new version of that model, looks at the physiological evidence underlying EI theory, and reviews a number of studies of the drivers of performance and the factors that distinguish the best individuals from the average ones.

Goleman (1995) presents the current version of EI framework. Competencies nest in four clusters of general EI abilities. The framework illustrates, he identified the five domains of EQ. EI embraces and draws from numerous other branches of behavioral, emotional and communications theories, such as NLP (Neuro-Linguistic Programming), Transactional Analysis, and empathy. By developing our EI in these areas and the five EQ domains we can become more productive and successful at what we do, and help others to be more productive and successful too. The process and outcomes of EI development also contain many elements known to reduce stress for individuals and organizations, by decreasing conflict, improving relationships and understanding, and increasing stability, continuity and harmony. Following are some of the theoretical models that explain EI.

Salovey's model of EI. It is a type of social intelligence that involves the ability to monitor one's own and others' emotions, to discriminate among them, and to use the information to guide one's thinking and actions (Mayer & Salovey, 1993). EI (EI) subsumes Gardner's inter- and intrapersonal intelligences, and involves abilities that may be categorized into five domains: (1) Self-awareness: Observing oneself and recognizing a feeling as it happens (2) Managing emotions: Handling feelings so that they are appropriate; realizing what is behind a feeling; finding ways to handle fears and anxieties, anger, and sadness. (3) Motivating oneself: Channeling emotions in the service of a goal; emotional self control; delaying gratification and stifling impulses. (4) Empathy: Sensitivity to others' feelings and concerns and taking their

perspective; appreciating the differences in how people feel about things. (5) Handling relationships: Managing emotions in others; social competence and social skills (Mayer & Salovey, 1993).

Rather than use a self-reporting EI instrument, they developed a performance-based instrument that is similar to those found in the intelligence literature called the Multifactor EI Scale (MEIS) which is still being researched. Thus, from their framework, we see that EI is composed of mental abilities and skills. It is also a hierarchical structure with emotional management as the main factor and the other three parts playing the roles of general supporting processes.

Bar-On model of EI. Based on seventeen years of research by Dr. Reuven Bar-On (2000) and tested on over 33,000 individuals worldwide, the BarOn Emotional Quotient Inventory (EQ-i) is the first scientifically developed and validated measure of EI. EI reflects one's ability to deal with daily environment challenges and helps predict one's success in life, including professional and personal pursuits. A growing body of research suggests that EI, measured by Emotional Quotient (EQ), is a better predictor of "success" than the more traditional measures of cognitive intelligence (IQ). Theory of EI to date and renders an overall EQ score as well as scores for the following 5 components:

(1) *Intrapersonal Scales* that includes Self-Regard, Emotional Self Awareness, assertiveness, Independence, Self-Actualization (2) *Interpersonal Scales* includes Empathy, Social Responsibility Interpersonal Relationship (3) *Adaptability Scales* Reality Testing, Flexibility, Problem Solving. (4) *Stress Management Scales* Stress Tolerance, Impulse Control. (5) *General Mood Scales* (Optimism and Happiness).

These five components consist of following fifteen subscales that includes, Self-Regard (SR) is the ability to aware, understand, accept, and respect oneself; emotional self awareness (SA) is the ability to recognize and understand ones emotions; Assertiveness (AS) the ability to express feelings, belief and thoughts that defend once rights in a nondestructive manners; independence (IN) is the ability to be self directed and self control in once thinking and actions and to be to emotion dependency; Self Actualization, (SA) the ability to recognize and realized one's

potential and to do what one wants to do; Empathy (EM) ability to be aware of , understand, and appreciate the feelings, the feelings of others; Social Responsibility (RE) is the ability to demonstrate one self as a cooperative, contributing, and constructive member of one's social group; Interpersonal Relationship (IR) the ability to establish and maintain mutually satisfying the relationships that are characterize by emotional closeness, intimacy, and by giving and receiving affection; Stress Tolerance (ST) is the ability to withstand adverse conditions, stressful condition, and strong emotions without falling apart by actively and positively coping with stress; Impulse Control (IC) is the ability to resist or delay an impulse, drive or temptation to act, and to control once emotion; Reality Testing (RT) is the ability to assess the correspondence between what is internally and subjectively experience; Flexibility (FL) is the ability to adjusts one's feelings, thoughts and behaviors to changing situations; Problem Solving (PS) is the ability to identify and define personal and social problems and generate the effective solutions; Optimism (OP) is the ability to look at the bright side of life; Happiness (HA) is the ability to feel satisfied with one's life, to enjoy and express positive emotions. These subscales cover all types of person's emotional aspects that are included in this EQ-I (BarOn, & Parker, 2000).

While the validation studies of his instrument seem to be quite impressive so far, it is not clear as to whether the EQ-i measures any construct that is not already being captured with other Instruments.

Hein's model of EI. Hein (2000) explains that it is an innate ability which gives us our emotional sensitivity and our potential for learning healthy emotional management skills. This model includes (1) the ability to take responsibility for one's own emotions and happiness. (2) The ability to turn negative emotions into positive learning and growing opportunities. (3) The ability to help others identify and benefit from their emotions. Because the above attempt at a definition is still a bit cumbersome, here are two less complicated ways to look at it: The mental ability we are born which gives our emotional sensitivity and potential for emotional management skills that help us maximize our long term health, happiness and survival (Hein, 2005).

EI, personality, alexithymia, life satisfaction, social support, and health related measures were investigated in Canadian (N=500) and Scottish (N=204)

groups. EI was positively related to life satisfaction and social network size and quality. It was negatively associated with alexithymia and alcohol use. Additional analyses were carried out on a subgroup of Scots (N =99-111). The results indicated that the relationship between EI and social network size is stronger than the relationship between EI and personality. Social network quality, life satisfaction, alcohol use, number of doctor consultations, and health status are more strongly related to personality than EI (Austin, Saklofske & Egan, 2005).

This study examined social anxiety questions using structural equation modeling with self-report data from a large non-clinical sample (N = 2629). According to the results, EI was found to be highly related to social interaction anxiety, but not performance anxiety. A model permitting these three predictors to inter-correlate indicated that the EI factor was the dominant predictor of interpersonal adjustment, substantially reducing the unique contribution made by interaction anxiety. This pattern reflected the principal contributions made to interaction anxiety by the interpersonal and, particularly, intrapersonal domains of EI (Summerfeldt' Kloosterman, Antony, & Parker, 2005).

Classrooms are always filled with youngsters displaying a wide range of concerns and behavioral problems that often make learning in the classroom difficult and infection. Students are often found to suffer from poor self-awareness, low self esteem, lack of motivation, little self-discipline poor peer interaction, an inability to express feelings effectively, and sometimes, a significant amount of emotional pain such as feeling sad, unhappy, anxious, frustrated, and angry.

This study was conducted in five secondary schools in the state of Selangor, Malaysia, to examine students' overall level of EQ and the relationship between students' level of EQ and their level of negative affect (anxiety, anger, and frustration) towards specific school task and academic achievements. Research findings indicate that there is liner negative relationship between students' level of EQ and their level of negative affect towards specific school task, and positive linear relationship between EQ and academic achievement. The results indicate that students in high level of EQ and emotional regulation related to academic tasks, as they are less affected by negative affects such as anxiety, anger, and frustration in performing task in the classroom. This may also explains their average performance

in academic achievement. However, much focus is still needed to calculate the emotional aspects of school children and adolescence as emotion plays an important role in the well-being of a person and achieving success in life (Abdullah, Elias, Mahyuddin, & Uli , 2004).

The impact of EQ on school and learning was also mentioned by Schilling (1996) and she relates emotion to desire, and motivation which drive learning within school or without. Children who are emotionally competent have an increased desire to learn and to achieve their goals (Ciarrorchi, Forgas & Mayer, 2006).

Another study examined the connection between EI and criminal behavior in a sample of 56 parolees. Their EQ scores were lower than average. Hypothesized relationships between EQ and various personal characteristics were partially supported. Females scored higher on Interpersonal scores. There was a relationship between ethnicity and Total, Interpersonal, and Intrapersonal EQ. Intrapersonal EQ was associated with sexual abuse. Finally, Interpersonal EQ was related to the death of a parent. No associations of EI were found with age, education, marital status, being raised by mother or father, separation by divorce, or having been physically abused (Smith, 2001).

The relations between career decision-making self-efficacy, vocational exploration and commitment, and EI were investigated. The extent to which gender moderates the relationship between EI and career decision-making self-efficacy and between EI and vocational exploration and commitment was also examined. Findings revealed that it is measured by the empathy, utilization of feelings, handling relationships, and self-control factors was positively related to career decision-making, self-efficacy and that the utilization of feelings and self-control factors were inversely related to vocational exploration and commitment (Chris, 2003).

It was Investigated that the relationship between emotional and social competencies, as measured by the EQ-i, and the sales performance of 92 retail floor covering salespeople. There were significant positive correlations between annual income and the Self-Regard, self awareness, Assertiveness, happiness subscales. Significant negative correlations were found between income and the Stress Management cluster scores, and the Impulse Control subscale (Mulligan, 2004).

The high EI individual, relative to others, has less ability to engage in problem behaviors, and avoids self-destructive, negative behaviors such as smoking, excessive drinking, drug abuse, or violent episodes with others. The findings of this study showed the relationship between EI and smoking, an evidence of a protective link between EI and smoking-related factors is increasing. With the emerging trend within tobacco research towards positive and protective factors, these findings regarding the protective role of EI against smoking intentions was encouraging. Many adolescent smoking risk factors cannot be changed, such as ethnicity and socioeconomic status. However, EI appears to be a modifiable factor that can be improved i.e., it can be taught (Mayer & Salovey as cited in Trinidad, 2000) and thus may help to control future adolescent smoking behaviors.

This study examined the association between EI, anxiety, depression, and mental, social, and physical health in university students. The sample was made up of 184 university students (38 men and 146 women). El was evaluated by the Trait Meta-Mood Scale, which evaluates the three dimensions (Attention, Clarity, and Mood Repair). Anxiety was evaluated with the Trait Anxiety Questionnaire and depression with the Beck Depression Inventory. Mental, social, and physical health was evaluated with the SF-12 Health Survey. Results showed that high Emotional Attention was positively and significantly related to high anxiety, depression, and to low levels of Role Emotional, Social Functioning, and Mental Health. However, high levels of emotional Clarity and Mood Repair were related to low levels of anxiety and depression, high Role Physical, Social Functioning, Mental Health, Vitality, and General Health. This study confirmed the predictive value of Attention, Clarity and Mood Repair regarding the levels of anxiety, depression, and areas related to mental, social, and physical health in university students (Extremera & Berrocal, 2001).

In another research EQ-i used to examine the relationship between parents' and child's EI, as well as the relationship between child's EI and both internalizing and externalizing problem behaviors. A significant but low association was found between the mother's and father's EI level. However, only the mother's level of EI was significantly related to the child's. EI in children was found to be a moderate to strong predictor of both externalizing and internalizing problem behaviors (Parker & Reker, 1999). Another study is about the positive relationship between EI and marital satisfaction (Grieco, 2002).

Hogan (1972) employed the Hogan Empathy Scale; empathy is one of the factors in the EI explained by Bar-On in its model, empathy as an effort to compare the empathy scores of adult offenders and non offenders. To account for these findings, these authors speculated that high levels of empathy compensated for the socialization of the apparently pro-social college student group. The results obtained indicated that in spite of equivalency of socialization scores between the groups, the prisoners obtain lower scores on the measure of empathy. To account for this finding, the authors speculated that high levels of empathy compensated for the poor socialization of the apparently pro-social college student group (Izard, 1979).

Many problems in adjustment may arise from deficits in EI. People, who don't learn to regulate their own emotions, may become slaves to them. Individuals who can't recognize emotions in others, or who make others feel badly, may be perceived as coldish or uncultured and ultimately be not accepted. Other peculiarities of emotional deficits exist as well. Sociopaths, who are impoverished in their experience of emotion, seem to over-regulate mood in others for their own purposes. A far more common ailment may involve people who cannot recognize emotion in themselves and are therefore unable to plan lives that fulfill them emotionally. Such planning deficits may lead to lives of unrewarded experience lived by individuals who become depressed, even suicidal ideation (Izard, 1979).

EI was hypothesized to be a factor in successful life adjustment, among them the successful achievement of a well balanced life with little interference between work and family and leisure. Data from a sample of 153 respondents who were roughly representative of the population were obtained, including measurement of EI, life/work balance and other indices of adjustment and social/psychological skills, and salary. Both interference dimensions correlated strongly with EI in the hypothesized direction. It was positively related to salary both for men and women, and at different levels of educational achievement. Other in-dices of skill were also related to EI. On the other hand, those high in EI tended to be less concerned with economic success (Ciarrorchi, Forgas, Mayer, 2006).

Depression

The condition we label today depression has been described by a number of ancient writers under the classification of melancholia. A depressive disorder is an

illness that involves the body, mood, and thoughts. It affects the way a person eats and sleeps, the way one feels about oneself, and the way one thinks about things. A depressive disorder is not the same as a passing blue mood. It is not a sign of personal weakness or a condition that can be willed or wished away. People with a depressive illness cannot merely "pull themselves together" and get better. Without treatment, symptoms can last for weeks, months, or years. Appropriate treatment, however, can help most people who suffer from depression. Clinical depression is a lot more common than most people think. It affects 10 million Americans every year. One-fourth of all women and one-eighth of all men suffer at least one episode or occurrence of depression during their lifetimes. Depression affects people of all ages but is less common for teenagers than for adults. Approximately 3 to 5 percent of the teen population experiences clinical depression every year. That means among 100 friends, 4 could be clinically depressed (Beck, 1967).

The condition we label today depression has been described by a number of ancient writers under the classification of melancholia. The first description of melancholia was made by Hippocrates in the fourth century B.C; it also referred as swings similar to mania and depression. It was the historically defined depression. These accounts bear a striking similarity to modern description of depression the cardinal signs and symptoms used today in diagnosing it, that are disturbed mood (sad, dismayed, futile); self-castigations (the accursed, hatred of the gods); self-debasing behavior (wrapped in sack-cloth or dirty rags…he rolls himself, naked, in the dirt); wish to die; physical and vegetative symptoms (agitation, loss of appetite and weight, sleeplessness); and delusions of having committed unpardonable sins. In our present state of knowledge, we don't know that which component is primary, or whether they all are external manifestations of some unknown pathological process (Basle, 1974).

Depression may be defined in term of the following attributes:

1. A specific alteration in mood: sadness, loneliness, apathy.
2. A negative self concept associated with self-reproaches and self blame.
3. Regressive and self punitive wishes: desire to escape, and hide or die.
4. Vegetative changes: anorexia, insomnia, loss of libido.
5. Change in activity level: retardation or agitation.

These are the components of depression other than mood deviation. According to Saul depression affects the main functioning of a person severely. Social and emotional functioning was the gratification of depressives that many patients regard it as central feature that is affected because of their illness. Experiences that are primarily psychosocial such as achieving fame, receiving expressions of love or friendships, or even engaging in conversation, are similar exposed of their pleasurable properties. Even activities that are generally associated with biological needs or drives, such as eating or sexual experiences, are not spared and their give-get balance is upset (Saul as cited in Beck,1967).

Loss of emotional involvement in other people or the activities usually accompanies the loss of satisfaction. Loss of affection for the members of his family is often a cause for concerns to the patient and occasionally is a major factor in his seeking medical attention. In a study 64% of severely-depressed people reported loss of feeling or interest whereas only 16% of the non-depressed reported this symptom (Beck, 1967).

Increase in the period of crying spells are frequently observed. Among some patients who rarely cried when not depressed, were able to diagnose the onset of depression observing had strong desire to weep. Depressed patients frequently volunteer the information that they have lost their sense of humor. There was not in construction of a joke but they reported that they didn't feel laughing. Nussbauum and Michaux studied the responses to the humor with sever psychotic and neurotic depression patients; they found the positive correlation well between improvement to this disease and humorous stimuli (Izard, 1979).

Types of Depression

Depressive disorders come in different forms, just as is the case with other illnesses such as heart disease. It briefly describes three of the most common types of depressive disorders. However, within these types there are variations in the number of symptoms, their severity, and persistence (Beck, 1967).

Major depression is manifested by a combination of symptoms that interfere with the ability to work, study, sleep, eat, and enjoy once pleasurable activities even suicidal ideation. The symptoms of the major depression are sometime also referred

to the unipolar depression. Such a disabling episode of depression may occur only once but more commonly occurs several times in a lifetime. More severe symptoms mark the period as an episode of major depression (Beck, 1967).

Another type of depression is *Bipolar disorder*, also called manic-depressive illness. Not nearly as prevalent as other forms of depressive disorders, bipolar disorder is characterized by cycling mood changes: severe highs (mania) and lows (depression). Sometimes the mood switches are dramatic and rapid, but most often they are gradual. When in the depressed cycle, an individual can have any or all of the symptoms of a depressive disorder. Mania often affects thinking, judgment, and social behavior in ways that cause serious problems and embarrassment, the individual in a manic phase may feel elated, full of grand schemes that might range from unwise business decisions to romantic sprees. Mania, left untreated, may worsen to a psychotic state. It is not a character flaw or a sign of personal weakness (Davison & Neal, 2002).

Bipolar disorder usually begins in late adolescence (often appearing as depression during teen years) although it can start in early childhood or later in life. An equal number of men and women develop this illness (men tend to begin with a manic episode, women with a depressive episode) and it is found among all ages, races, ethnic groups and social classes. The illness tends to run in families and appears to have a genetic link. Like depression and other serious illnesses, bipolar disorder can also negatively affect spouses and partners, family members, friends and coworkers (Beck, 1967).

Bipolar I disorder is characterized by one or more manic episodes or mixed episodes (symptoms of both a mania and a depression), *Bipolar II disorder* is characterized by one or more depressive episodes accompanied by at least one hypomania episode. Others, they can be troublesome. *Cyclothymic disorder* is characterized by chronic fluctuating moods involving periods of hypomania and depression. However, these mood swings can impair social interactions and work. Many, but not all, people with cyclothymiac's develop a more severe form of bipolar illness.

Dysthymic Disorder is characterized by chronic depression, but with less severity than a major depression. The essential symptom for Dysthymic disorder is

an almost daily-depressed mood for at least two years, but without the necessary criteria for a major depression. Low energy, sleep or appetite disturbances and low self-esteem are usually part of the clinical picture as well. Although the long-term, the nature of this type of depression. People who have Dysthymic disorder will often report that they don't recall ever not feeling depressed, but they may be relatively functional in managing their life, although the symptoms are severe enough to cause distress and interference with important life role responsibilities (Davison & Neal, 2002).

The findings contradicted the generally held that in depression aggression becomes direct inward. This may be true for serve neurotic and psychotic cases (melancholia) but may not be typical of the milder depression of normal individuals. Although most psychoanalytic writers have stressed the role of ambivalence and inwardly directed aggression in depression, a few have argued that it has been overemphasized and old that basic depression, a simple fall in self-esteem without marked inward aggression, should be recognized.

The depressed person sees his environment as a source of defeat, deprivation, or disparagement that imposes a succession of obstacles and burden. A patient regards himself as deficient, inadequate, or unworthily-attributing his unpleasant experience to his physical, mental or moral defects. Furthermore, he anticipates that his current difficulties will continue indefinitely (Izard, 1979).

Theories of Depression

Medical research has contributed much to our understanding of depression. However, scientists do not know the exact mechanism that triggers depressive illness. Probably no single cause gives rise to the illness, and researchers continue to piece the puzzle together.

In the past, doctors believed that depression was the result of thoughts or emotions that were troubling for a person. More recently, experts realize that there can be several factors working together that will lead a person to become depressed. The three most important of these are biological, genetic, and psychological factors.

Biological theory. Depression is due to changes in the chemistry of the brain, such as fluctuations in the levels of important hormones. Studies have shown that genetic makeup plays a role in the etiology of depression, but no study has indicated that depression is solely based on a person's genes. Family, twin, and adoption studies have indicated that genetic factors are involved in the development of mood disorders (affective disorders). Potential genetic markers (that is, specific traits present on the genes) have been identified on specific chromosomes (Silberg as cited in Neal & Devison, 2002). Some of these markers are directly linked to neurobiological processes, believed to be related to the occurrence of major depression. Other body chemicals also may be altered in depressed people. Among them is cortisol, a hormone that the body produces in response to stress, anger, or fear. According to Schildkraut, he find out that in depressed people, however, cortisol peaks earlier in the morning and does not level off or decrease in the afternoon or evening. The over abundance of nor-epinephrine can also causes mania, (Halgin & Whitebourne, 2003).

Studies of the effects of antidepressant medications used to treat depression suggest that depression is characterized by low levels of both serotonin and nor epinephrine. Depletion of neurotransmitters is associated with feeling down and depressed. Neuro-psycho physiological explanation of biological theory explains (Basle, 1974).

Papez work in 1937 suggested that impact through the limbic system were responsible for generating emotional activity. And subsequent studies as well as PET investigations in 1992 by Drevets et.al., found that increased blood flow through the amygdala may be a trait marker for depressive disorders whether depression is manifested or not. He compared his findings to other neurophysiologic data available suggest that the functioning of a prefrontal-amygdala-medial dorsal thalamic circuitry is overactive in a depressed individual's brain. CT studies ventricular enlargement in unipolar as well as bipolar depression (Schlegal & Ketzschmar as cited in Basle, 1974).

Depression can also develop due to a physical illness, a reaction to a medication that you are taking, or as an outcome of substance abuse. In these cases, when the cause is successfully treated, the depression will end. Genetic causes are the result of what we inherit from our parents. If one or both of parents have a

vulnerability to depression, then it can be transmitted to child. Recent genetic research also supports earlier studies reporting family links in depression. For example, if one identical twin suffers from depression or manic-depressive disorder, the other twin has a 70 percent chance of also having the illness).

Psychodynamic theory explanation. Psychodynamic theory begins with Freud's (1917-1957) observational analogy between depression and mourning, whereby he noticed that in both cases, there is a strong sense of overwhelming sorrow, and that people in mourning often become depressed. He felt that when we lose an object of our love, we incorporate aspects of that person in a fruitless effort to regain at least parts of the person - yet often there are ambivalent feelings - we miss the person, but are angry at our loss. He suggested that this anger directed at a person whose play a part we have incorporated is anger directed at ourselves and is the source of depression at least symbolically (Halgin & Whitbourne, 2003).

Learning theory explanations. The learning theory of depression is basically that depressed people receive fewer rewards and more punishment than people who do not feel depressed. Thus, we may conclude on that statement that fewer things make a depressed person happy, and more things make a depressed person unhappy. This implies that depression may be a self-sustaining state. There is another theory of learned helplessness, in which individual's passivity and sense of being unable to act, and no control on his or her life. On the basis of his work on uncontrollable stress Seligman conclude that type of stress could provide model for at least certain form of depression.

Cognitive explanations. Cognitive theory suggests that a form of learned helplessness leading to frustration is the cause of depression. Aaron Beck says that inappropriate attributions and inferences directly contribute to depression and that depressed persons are particularly susceptible to make errors in thinking - in particular - logical errors that lead them to see things in an unfavorable manner by (1). To drawing a conclusion even though there is little or no evidence to support it. (2). Focusing on an insignificant detail of a situation while ignoring the more important features. (3). Drawing global conclusions about ability on the basis of a single fact or episode. (4). Committing gross errors of evaluation by magnifying small, unfavorable events, yet minimizing important large and favorable events. (5). Taking personal responsibility for events that are situational. It should be noted that a

given thought pattern may involve several of these distortions simultaneously (Halgin & Whitbourne, 2003).

Humanistic-existential theory. Viktor Frankel (1959) observed through his own experiences of the World War in a Nazi concentration camp, that depression results from a lack of purposeful living. This suggests that finding meaning or spirituality in our lives is important in ameliorating depression, as well as aiding us in confronting other forms of challenge in our lives (Neal & Devison, 2002).

Relationship between EI and Depression

A study by Starkstein & Robinson (as cited in Nelson & Israel, 2003) suggests that dysfunction of the frontal lobes (the executive and decision making area of the brain) may produce over inhibition of dorsal brain areas, thus abnormally reducing motor, instinctive, intellectual, and emotional output. These motor and emotional reactions, emotional regulations effects (EI) the daily functioning and relationships. Further studies in this area by Mayberg, suggest that recovery from depression will involve inhibition of the overactive ventral regions (amygdala/limbic system) and normalization of the front dorsal hypo function. These studies show the relationships between EI, depression and also its neurological bases.

The relevance of social relationships to the phenomena of depression among the aged was examined. The study was based on the reduced reinforcement hypothesis which predicts a low rate of social relationships (i.e. the loss of positive reinforcement) for those individuals who are prone to depression. This hypothesis was both tested and confirmed among the residents in homes for the aged in Berlin. The senior citizens who reported a low rate of social activities had higher depression scores than those reporting a higher rate of such social involvement. These results were confirmed for various indicators of social participation. A further variable influencing the rate of depression was identified as the self-rating of personal health (Hautzinger & Aktuelle, 1982).

Risk indicators of depression assess by studying depressive symptoms in social and personal domains of residents of residential homes. In a cross-sectional study risk indicators for depressive symptoms were functional impairment, loneliness, higher education levels, a family history of depression and neuroticism

are associated with depressive symptom. The risk indicators of depression found in residential homes are similar to those in the community (Eisses, et.al, 2004).

The results of a survey released as part of the National Depression Week 2002 campaign by Depression Alliance clearly show that many people with depression who have sought help from their employers are still being made ill through unrealistic workloads and bad management. The results launched that concentrated on depression and work, show that employers can no longer ignore a condition that is as dangerous as cancer and heart disease (Halgin & Whitbourne, 2003).

According to that study the people those, who are socially active and expose to the social stimuli has feelings of well being and satisfied than the people not involve in the social gatherings and not had more exposure to the social stimuli and has feelings of depression. This study shows the relationship between social activity and depression. The mean of sample age was 72.2 and the instruments were Self-Rating Depression Scale (SDS) was used to evaluate feelings of well-being or depression. This study show the social acceptableness of those people, who are without the depression (Yamashita, & Nippon, 1993).

The people's impulse controls break down during emotional distress. Some theories propose that distress impairs one's motivation or one's ability to exert self-control, and some postulate self-destructive intentions arising from the moods. Contrary to those theories, three experiments found that believing that one's bad mood was frozen (unchangeable) eliminated the tendency to eat fattening snacks, seek immediate gratification, and engage in frivolous procrastination. The implication is that when people are upset, they indulge immediate impulsive reactions to make themselves feel better, which amounts to giving short-term affect regulation concern over other self-regulatory goals (Myers, 1999).

According to Izard (1979), the mentally ill individuals are generally in pain, suffering from anxiety and mental anguish. They fell incapable of coping with their problems. Their symptoms reflect their inadequate efforts to deal with their distress.

They can not laugh off suffering, or can they use humor to experience any joy, is not a state of despair or low self-esteem but it is about the disturbed behavior.

A number of studies have attempted to relate subjects degree of anti-social behavior with their scores on the empathy scale constructed by Hogan (1969) reasoned that repeat offenders who more persistently engage in crime would be less empathic(a factor of EI) than less involved offenders. They reported that no offender (actually under graduated and first offenders) did differ significantly from repeat offenders but not from each other on the Hogan Empathy Scale. Efforts to replicate this finding with adolescent were unsuccessful. However, in that adolescent no offenders, first offenders, and repeat offenders did not significantly differ in their obtained empathy scores (Kendall, Deardorff & Finch, as cited in Izard, 1979).

Self esteem is often regarded as the key stone (Goleman, 1995). Self esteem can be regarded as individual's sense of his or her values or worth or the extent to which a person values, approves of, appreciates, praises or likes himself or herself. The large number of researches indicates that self esteem is positively related to high EI. The signs of depression have been listed many times, persistent sad mood, loss of interest in previously enjoyable activities, changes in appetite or sleep, poor school performance, withdrawal from family and friends due to low self esteem, recurrent thoughts of death that he/she are not able to face the difficulties of life (low self-esteem). These studies explain that there are relationships of EI and depression with self esteem, it is positively and depression is negatively correlated with high self esteem (Blascovich & Tomaka, as cited in Goleman, 1995).

Emotions are essential for the complete development of the behavioral pattern at any stage of life. EI helps a person to regulate and express his emotion accurately, which are the indication of psychological health. Misra (2002) also reveals that the person who is emotionally intelligent avoids extremities of emotions. EI has much to do with knowing when and how to express the emotions and feelings. Social competencies are an essential attribute of members of a progressive society. According to Batlette (2002) social competence is what allows organizing ourselves in groups and societies. Relationship between social competence and EI is a complex one. And according to him EI abilities develop our social skills. In the depressing Individuals show the extreme feelings of sadness low social competencies and social skills, which is contrary to the EI (Katayal & Awasthi, 2003).

Emotional awareness is not limited to cognitive and perceptual skills. It also involves the emotional responsiveness of the observer. In considering the relations of the cognition to affect and mood, we also should recognize the role of verbal labels and formulations in structuring and interpreting experience. If the information carried by emotional feelings is critical for judgment and decision making, being unable or unwilling to avail oneself of this information should have costs. Has documented the negative consequences of being unable to use affective feelings as feedback for making everyday judgment and decision. According to related consequences including judgmental biases and interpersonal difficulties that negatively correlated to the EI but is prevalent in depression (Damasio, 1994).

It is found that self reported difficulty in describing and identifying one's own emotions is associated with ambivalence about emotional expression as well as with more general depressions neuroticism, and distress. Thus, as neurological impairment of the ability to use affective information, confusion about the meaning of one's emotional experiences also has important consequences. This research focuses on the consequences for mood regulation, including the regulation of the both positive and negative mood. The assumption is the confusion about their own emotional experiences, argument by a higher then average intensity of emotion, leads to overwhelmed individuals to be more sensitive to the influence of moods and therefore more motivated to regulate such feeling states. Indeed, persons with this combination of triad report that they typically use an avoidance strategy when coping with stressful situations.

According to Clore (2000) three individual differences that should moderate emotion relevant information processing like clarity, attention and intensity. Emotional clarity is the ability to identify and describe specific emotion, feelings of good or bad. It means low clarity is associated with the neuroticism, vulnerability to distress and person become ambivalent about expressing emotions. Attention to emotion is related with public and private self consciousness, empathy, and neuroticism. Finally, emotional intensity concern with the magnitude with which one typically experience emotion. It is associated with the measure of arousal/ reactivity and measures of somatic and neurotic symptoms. These neurotic symptoms can distress the person. Likewise, beliefs about negative mood regulation were associated with depressive symptoms independently of intensity specifically; low self-efficacy

about negative mood regulation was associated with less effected coping (i.e., more depression) (Myers, & Salovey, 1993).

Neurotic and psychotic symptoms are also seen as detachments from reality; however, people with depression are not voluntarily but are pathological. They make mal adaptive attempts to cope with conflicts anxiety and depression. They are essentially psychologically defensive flights from threatening or painful reality. They therefore do not function for ego gratification or pleasure (Lzard, 1979).

Emotion avoidance and inhibition has been implicated as a common feature associated with borderline personality disorder. The study that has been recently conducted at the Duke based Cognitive Behavioral Research and Treatment Program. The study examined 127 participants to evaluate a developmental model in which chronic emotion inhibition mediates the relation between childhood emotional invalidation/abuse and adult psychological distress. Findings indicated that a history of emotion invalidation (i.e., a history of childhood psychological abuse and parental punishment, minimization, and distress in response to negative emotion) was significantly associated with emotion inhibition (i.e., ambivalence over emotional expression, thought suppression, and avoidant stress responses). Further, emotion inhibition significantly predicted psychological distress, including depression and anxiety symptoms. The second study examined a model in which inhibition of thoughts and emotion was predicted to mediate the relationship between the personality trait of negative affect intensity and acute psychological distress. Using structural equation modeling hypotheses were supported in both clinical and non-clinical samples, indicating its generalizability (Thomas, 2003).

A sample of 100 women between the ages of 18 and 78 participated in a study designed to investigate the relationship between EI, locus of control, and depression. EI and an internal locus of control were found to be protective against depression. Furthermore, EI is positively correlated with an internal locus of control and negatively correlated to external loci of control. The most significant negative predictor of depression was the Intrapersonal EQ scale (Lammana, 2001).

More recently, researchers Vasey & MacLeod have begun to address the question of emotional processing in pediatric affective disorders (Ciarrochi, Forgas & Myers, 2006) found in different sample like adults, anxious children its results

related to emotional disturbance (depression). Some studies suggest that depression may be associated with a bias toward negative emotional information whereas others propose that this bias is specific to anxiety. Recent studies in adults suggest that anxiety seems to be related to early attentional orienting toward threatening stimuli whereas depression seems to be related to sustained attention toward negative emotional information. The intensive case studies indicated that no single developmental trauma could account for the origins of sadness; rather, the source in the cumulative series of the individual's life experiences. In various self-esteem and self-acceptance seemed to have been impaired for happy men, hampering their potential for interpersonal intimacy and commitment to more psychosocial development crises (Erickson as cited in Lzard, 1979).

Rationale of the study

The purpose of this study is to compare EI among individuals with and without depression and also exploring differences on EI along with demographic variables like, gender, age, income, education and marital status. Although, many researches had done on above mentioned two variables in other countries and Pakistan (see for example Golman, 1995; BarOn, 1992; Kiani, 2003; Aslam, 2004; Farast, 2005; Akram, 2004). But in Pakistan not much research evidence is available on EI and depression together, but a few work evidences like EI and its relationship with academic achievement, conflict management and psychological well being are available. A lot of studies conducted on depression with various other variables have been conducted e.g. with marital status of working women, marital difference, conflict management, academic achievement and organizational stress (Kalil, 1999; Fatima, 2002; Younas, 2003; Munir, 2000) in Pakistan.

This study is dealing with variable the EI that is an important component related to the healthy emotional development in the every age of people. That component become more important in collectivistic culture like Pakistani culture because the social competencies play the firm role in relationships building and to continue them in large families where many families live together. It is not a new concept but clinically less frequently dealt, especially for research purposes with mental health like (psychological well being, self efficacy, and self esteem). This study is to explore the difference between EI scores among individuals suffering

from depression and comparing with another group of individuals without depression and how it differs in Pakistan as it is relatively new concept.

The EI is the intelligence based on emotion, and people who have this capacity are less depressed, healthier, and have better social relationships (BarOn, 1992). Therefore, it is hypothesized related to the main objectives of the study that EI will be high in individuals without depression, it means people who can comfortably deal with emotional situations, express and control their emotions on the right time can handle the depressive emotions like hopelessness, loss of interest in life activities or problem social relationships, and on the other hand people who cannot deal with their emotions and not meet the criteria of EI indulge in problem of emotional regulation, emotional expressions, and emotional competencies (Goleman, 1995).

Also in a Swedish report and an American study explains gender differences play a role in EI, in previous studies. Results indicated that women scored higher than men on EI (Norie, 1999) this difference were statistically significant. On the other side researches explains also men with depression shown significant lower score than female with depression (Cruz & Virgina, 2000). Another hypothesis formulate on the basis of another demographic variable that is income. Previous literature supported this hypothesis that higher level of income shows that there were significant positive correlations between annual income and the scale, especially intrapersonal subscale and general mood subscale (Mulligan, 2004). It was also hypothesized that age affects the EI of individuals, higher the age level individuals show more EI. According to Erez, Johnson, and Judge, (1995) with the age and experience emotional and social competencies are increased (BarOn, & Parker, 2000).

As the sample taken from clinical settings are those who are clinically diagnosed as the patients of depression and the matched group from normal populations on same demographic information's to compare the EI in both groups with and without depression and the relationship of the depression and EI. As this study is find out the difference among the emotionally depressed people. For this purpose, it is aimed to use the standardized Scale translated version (for the convenience of the sample) because of its highly reliable scale and has validity is also high (Dulewicz, Higgs, & Slaski, 2003).

The purpose of taking the match group from normal population is to eliminate the other variables that only concentrating on particular differences that are the main purpose of the study that is to find out the differences between EI of individuals with clinically diagnosed depression and the EI of individuals without depression diagnosis and not found in the life histories.

METHOD

Chapter II

METHOD

Objectives

Objectives of present research are to:

1. Study the difference in EI among individuals with depression and without depression.
2. Investigate the EI along various demographic variables (i.e., gender, age, income, marital status) among individuals with and without depression.

Hypotheses

1. Individuals without depression will have higher EI than the individuals with depression.
2. Women will be more emotionally intelligent than men.
3. Individuals with high income will be more emotionally intelligent than the individuals with low income.
4. Older individuals will have higher EI than the younger individuals.

Operational Definition

Emotional Intelligence. Emotionally intelligence reflects ability to deals with daily environmental changes and helps to predicts one's success in life, including professional and personal pursuits the ability to sense, understand and effectively response of emotions as a source of used information, connection that influence on the human life (BarOn, 2000). The research suggests EI measured by Emotional Quotient (EQ) having high reliability. High scores on the scale show more EI and low scores shows less EI in the present research. The EQ-i formed on the basis of BarOn's model of EI, that has 15 subscales including Self-Regard (SR); emotional self awareness (EA); Assertiveness (AS); independence (IN); Self Actualization, (SA); Empathy (EM); Social Responsibility (SRe); Interpersonal Relationship (IR); Stress Tolerance (ST); Impulse Control (IC); Reality Testing

(RT); Flexibility (FL; Problem Solving (PS); Optimism (OP); Happiness (HA). These subscales cover all types of person's emotional aspects that are included in this EQ-i. Individuals scored higher on these subscales which represents that they have higher emotional intelligence.

Depression. In the present research individual with depression means those individuals who have presently hospitalized or out patient in psychiatry wards and has been given clinical diagnosis of depression (either it's bipolar, cyclothymiacs or major depression) with out any co-morbidity. These are the diagnosis of all category of depression.

Individual without depression means those who are matched on the basis of different demographic characteristic of clinically diagnose individuals with depression but has never been given diagnoses of depression or any other mental illness in any point of their lives.

Sample

The sample consisted of 60 people from Islamabad. The people with depression were taken from two hospitals of Islamabad PIMS (Pakistan Institute of Medical Sciences) and Capital Hospital. The people without depression matched on same demographic variables that of individuals without depression from the normal population were taken from Rawalpindi / Islamabad and Murree. Matching was carried out to achieve a compatible group for comparison.

Purposive convenient sampling was carried out to select the individuals with depression while for the individuals without depression, purposive convenient sampling was carried out with the purpose of selecting matched group on demographic variables compatible for individual with depression. The matching for both groups was based upon the some specific demographic information like age, education, gender, monthly income, marital status and sibling. Correct matching of some of demographic information of both groups (depressive and non depressive) were not possible like number of children, age, monthly income and family members. Then the limits were specified below and above that information, for example the age, the limit for three years above and below actual age of individual

with depression were set for matching the individuals without depression. Same procedure was utilized with the other variables.

A Demographic Information Sheet (see Annexure - A) was attached with instrument in order to get information about demographic variables. Age range was 17 to 58 years and the mean age was 37 years. 16 were women and 14 were men. Family income was ranging from 5000 to above 13500. Marital status used only for demographic information, most of the subjects had married and unmarried marital status but only four of them were widow, widowers or divorced and additional information was also taken about the variables like occupation, mother, father, number of siblings and patient's birth order for selection of the matched group.

Sample was consisting of all types of depression (mild to sever). In clinical settings more discussions about the diagnosed disorder like the duration of suffering from disordered, the family history about the presence of mental illness and the type of the treatment used for the patient in the hospitals and about them as being here the rapport with them that they feel comfortable to understand my purpose of being with them, and they do not feel hesitant to respond according to their true feelings.

Instrument

BarOn Emotional Quotient Inventory (BarOn EQ-i) BarOn EQ-i consists of 133 items arranged carefully in the inventory. The inventory has five main components comprised of 15 subscales. The final version of the EA-i has a 5-pint self-rating response format (1 = *very seldom or not true of me*, 2 = *seldom true of me*, 3 = *sometimes true of me*, 4 = *often true of me*, and 5 = *very often true of me or true of me*). Numerous validity after reliability studies were carried out on the EQ=I over the years. Internal consistency coefficients for the EQ-i subscales based on seven population samples show the average Cronbach's alpha coefficient ranging from a low of .69 to a high of .86. Test retest reliability based on one study is .85 after one month and .75 after four months. Nine types of validity studies have been conducted in over the 17 years (content, face, factorial, construct, convergent, divergent,

criterion-group, discriminate, and predictive validity). The results show that EQ-i is a highly reliable and valid instrument (BarOn & Parker, 2000). It has fifteen subscales

1. *Intrapersonal Scales:* includes Self regard (items no. 10, 22, 36, 50, 62, 75, 89, 101, and 114), Emotional Self Awareness (items no. 6, 8, 21, 31, 46, 56, and 78), Assertiveness (items no. 20, 33, 59, 72, 85, 98, and 111), Independence (items no. 3, 17, 29, 43, 82, 95, and 107), Self-Actualization (includes items No. 5, 19, 32, 45, 58, 71, 84, 97, and 110).

2. *Interpersonal Scales:* Includes Empathy (items no. 16, 39, 46, 54, 63, 87, 105, and 109), Social responsibilities (items no. 14, 27, 41, 54, 63, 67, 80, 92, and 105), Interpersonal Relationship (items no. 9, 21, 28, 35, 49, 55, 61, 74, 88, 100, and 130).

3. *Adaptability Scales:* Includes Reality Testing (items no. 7, 31, 34, 47, 60, 73, 78, 86, 99, and 112), Flexibility (items no. 12, 25, 38, 52, 65, 77, 91, and 116), and Problem Solving (items no. 1, 13, 26, 40, 53, 66, 79, and 104)

4. *Stress Management Scale*: Includes Stress tolerance (items no. 4, 18, 30, 44, 57, 69, 83, 96, and 108), Impulse Control (items no.11, 24, 37, 51, 64, 76, 90, 103, and 115).
5. *General Mood Scales*: Includes Optimism (items no. 10, 18, 23, 48, 70, 94, 96, and 117), Happiness (items no. 2, 15, 28, 42, 55, 68, 81, 93, and 106).

62 items out of 117 items has reverse scoring, these were: 2, 3, 9, 11, 12, 15, 17, 19, 20, 21, 22, 24, 25, 27, 29, 31, 32, 34, 37, 38, 41, 43, 44, 45, 46, 47, 51, 52, 57, 58, 60, 61, 62, 64, 66, 68, 72, 73, 76, 77, 81, 82, 83, 86, 90, 91, 92, 98, 102, 103, 104, 107, 108, 110, 111, 112, 113, 115, 116, and117.

In this study Urdu translated version of BarOn Inventory (EQ-i), translated by Akhtar (2004) (see Appendix B) was utilized for the purpose of collecting the data. Urdu version was used for the convenience of the patients as they were not highly educated. The reliability coefficients of 117 items of Emotional Quotient Inventory (EQ-i) administer on the sample of 120 students. The high alpha value ($r = .92$) demonstrates that EQ-i is an internal consistent scale. The alpha reliability

coefficients of subscale of EQ-i with number of items are consistent. The results show that all the fifteen subscales of EQ-i have moderate alpha reliability coefficient ranging from as low as .46 (Assertiveness) to the high coefficient of .75 (Impulse Control). All the subscales of EQ-I show the high internal consistency.

Procedure

The sample was taken from hospitals and from the normal population (for match group). The clinical sample (individuals with depression) was taken from the hospitals. Those people who were already diagnosed as suffering from depression by physician; prior permission was taken to get the information from the Head of Department of each psychiatric department that was approached for this research. The questionnaires were administered to the patients of depression in both genders. First the cases were selected from the Psychiatric wards record and after that patient were contacted and rapport was built. Purpose of research was told them, and then necessary instructions were given to them about how to fill the questionnaire and were requested to report honestly. The questionnaire was administered individually. Each form took about an hour to be filled, during this time the patient were allowed to take short pause to complete it. Most of them were very cooperative and showed interest to fill it and also showed interest in the research topic.

A matched group of individual without depression and without any history of mental illness was chosen having same demographic information, for comparing the EI in individuals with and with out depression. In few cases, when the same matching groups were not found then the limits for specific variables were formed. They were instructed about the questionnaire and its options for the responses and told that their given information would be kept confidential and these will be used for only research purposes. They were acknowledged that how important is the information they had given and how much their information was useful for research and also in the field of clinical research.

RESULTS

Chapter III

RESULTS

The present study aimed at comparing EI of individuals with depression (n = 30) and individuals without depression (n = 30). In order to fulfill the objectives of the study, the data of individual with and without depression (N = 60) was statistically analyzed. The results obtained through the analysis of the study are given below in the form of tables.

Alpha Reliability Coefficient of EQ-I and Subscales.

Table show the alpha reliability coefficient of 117 items of EI Quotient (EQ-i) on the sample of 60 individuals.

Table 1

Alpha Reliability Coefficient of EQ-I and Subscales (N=60).

EQ-i	No. of items	Reliability
Total	117	.96
EA	8	.66
AS	7	.67
SR	9	.72
SA	9	.59
IN	7	.69
EM	8	.79
IR	11	.71
SRe	9	.61
PS	8	.63
RT	10	.59
FL	8	.72
ST	9	.69
IC	9	.68
HA	9	.74
OP	8	.81

Note. EA= Emotional Awareness; AS= Assertiveness; SR= Self regard; SA= Self Actualization; IN= Independence; EM= Empathy; IR= Interpersonal Relationship; SRe = Social Responsibility; PS = Problem Solving; RT = Reality Testing; FL = Flexibility; ST = Stress Tolerance; IC =Impulse Control; HA = Happiness; OP = Optimism.

Table 1 shows the alpha reliability coefficient of 117 items of EQ- i on the sample of 60 individuals. The high alpha value (r = .96) demonstrated that EQ-i is a highly reliable scale and has internal consistency. The Table 1 also shows the subscales of EQ-i with the number of items and their alpha reliability coefficients. The results show that all the fifteen subscales of EQ-i have high reliability ranging from as lower .59 Reality Testing to high coefficient of .81 Optimism. All subscales of EQ-i show internal consistency.

Differences in EI among Individuals With and Without Depression.

To explore differences on emotional difference on the basis of diagnosis (N = 60, Table 2) individuals with depression (n = 30) and individuals without depression (n = 30). To further study the differences among individuals with depression and without depression in detail independent sample t-test was computed separately for men (n = 28) and women (n = 32) and differences between both groups was as curtained gender in Table 3 and 4 respectively.

Table 2

Mean, Standard Deviation and t-values of Individual's with and Without Depression on EI Scale and Its Subscales (N= 60).

	Individuals with depression (n = 30)		Individuals without depression (n = 30)		
EQ-I	*M*	*SD*	*M*	*SD*	*t*
Total	310.27	14.64	419.07	42.51	13.25**
EA	20.93	3.61	25.47	3.61	3.7*
AS	18.60	2.43	22.77	3.05	5.8**
SR	24.43	3.59	31.20	5.49	5.6**
SA	23.07	2.80	32.17	4.76	9.0**
IN	18.37	2.54	23.43	3.10	6.9**
EM	23.40	2.65	30.60	3.35	9.2**
IR	29.40	3.77	41.00	6.01	8.9**
SRe	24.10	2.45	34.27	4.43	10.9**
PS	23.20	2.87	30.90	3.22	9.7**

Continue.....

EQ-I	Individuals with depression ($n = 30$)		Individuals without depression ($n = 30$)		
	M	*SD*	*M*	*SD*	*t*
RT	26.70	2.98	36.47	4.93	9.2**
FL	19.40	3.31	28.53	3.6	10.2**
ST	20.83	2.98	33.77	7.48	8.7**
IC	22.50	3.51	31.53	5.26	8.7**
HA	25.10	3.17	33.00	5.38	6.9**
OP	22.30	3.44	29.13	3.55	7.5**

Note. EA= Emotional Awareness; AS= Assertiveness; SR= Self regard; SA= Self Actualization; IN= Independence; EM= Empathy; IR= Interpersonal Relationship; SRe = Social Responsibility; PS = Problem Solving; RT = Reality Testing; FL = Flexibility; ST = Stress Tolerance; IC =Impulse Control; HA = Happiness; OP = Optimism.
df= 58. ***p* <0.01.

The results in the Table-2 show the differences in EI among individuals with and without depression that there is significant difference ($t = 13.25$, $df = 58$) among individuals without depression, which indicates that the mean score of individuals without depression is high ($M = 419.07$, $SD = 42.51$) as compare to individuals with depression ($M = 310.27$, $SD = 14.64$) on EQ-i. According to the subscales all shows the significant difference on EQ-i at $p < 0.01$. Result indicated that individuals without depression are high as compare to individuals with depression on EQ-i. This result proves that our hypothesis 1 is accepted.

Table 3

Mean, Standard Deviation and t-values of Men from Group of Individuals with Depression and Without Depression on EQ-i (n = 28).

EQ-i	Men with depression ($n = 14$)		Men without depression ($n = 14$)		
	M	*SD*	*M*	*SD*	*t*
Total	311.14	14.69	439.64	38.17	11.75**
EA	21.86	3.18	29.00	4.35	4.95**
AS	19.29	2.46	22.86	3.61	3.05**
SR	24.00	2.32	32.79	5.41	5.58**

Continue.....

EQ-i	Men with depression ($n = 14$)		Men without depression ($n = 14$)		
	M	*SD*	*M*	*SD*	*t*
SA	23.71	2.61	32.71	3.63	7.53**
IN	18.64	2.62	25.00	3.28	5.66**
EM	22.86	1.66	31.50	2.71	10.17**
IR	31.43	2.77	41.57	5.26	6.38**
SRe	23.50	3.01	35.64	4.18	8.82**
PS	22.29	2.61	31.93	3.56	8.16**
RT	26.14	2.44	36.07	5.73	5.96**
FL	21.50	2.77	29.57	3.06	7.32**
ST	21.93	2.67	37.64	9.45	5.98**
IC	22.29	2.23	32.36	4.16	7.97**
HA	22.79	2.19	35.36	4.25	9.83**
OP	22.43	2.47	30.71	3.75	6.90**

Note. EA= Emotional Awareness; AS= Assertiveness; SR= Self regard; SA= Self Actualization; IN= Independence; EM= Empathy; IR= Interpersonal Relationship; SRe = Social Responsibility; PS = Problem Solving; RT = Reality Testing; FL = Flexibility; ST = Stress Tolerance; IC =Impulse Control; HA = Happiness; OP = Optimism.
df= 28. **$p < 0.01$. * $p < 0.05$.

The results in the Table-3 show the differences in EI among men from both groups from individuals with and without depression ($t = 11.75$, $df = 28$), which indicates that the mean score of men from both groups of individual without ($M = 439.64$, $SD = 38.17$) are more emotionally intelligent as compared to men with depression ($M = 311.14$, $SD = 14.69$) on EQ-i. According to the subscales all shows the significant difference on scale at $p < 0.01$. Result indicated that men without depression are more emotionally intelligent than men from group individuals with depression on EQ-i.

Table 4

Mean, Standard Deviation and t-values of Women from Both Groups of Individuals with Depression and Without Depression on EQ-i (N = 32).

EQ-i	Women with depression (n = 16)		Women without depression (n = 16)		
	M	*SD*	*M*	*SD*	*t*
Total	309.50	15.03	401.06	38.60	8.84**
EA	20.13	3.86	22.38	4.83	1.45
AS	18.00	2.31	22.69	2.57	5.42**
SR	24.81	4.46	29.81	5.34	2.87**
SA	22.50	2.92	31.69	5.56	5.77**
IN	18.13	2.53	22.06	2.24	4.66**
EM	23.88	3.26	29.81	3.73	4.79**
IR	27.63	3.69	40.50	6.72	6.71**
SRe	24.63	1.78	33.06	4.42	7.08**
PS	24.00	2.92	30.00	2.68	6.05**
RT	27.19	3.39	36.81	4.26	7.06**
FL	17.56	2.61	27.63	3.91	8.55**
ST	19.88	2.99	30.38	2.13	11.45**
IC	22.69	4.41	30.81	6.10	4.31**
HA	27.13	2.42	30.94	5.53	2.52**
OP	22.19	4.18	27.75	2.79	4.42*

Note. EA= Emotional Awareness; AS= Assertiveness; SR= Self regard; SA= Self Actualization; IN= Independence; EM= Empathy; IR= Interpersonal Relationship; SRe = Social Responsibility; PS = Problem Solving; RT = Reality Testing; FL = Flexibility; ST = Stress Tolerance; IC =Impulse Control; HA = Happiness; OP = Optimism.
df =30. ***p*<*0.01.*

The results in the Table-4 show the differences in EI among women with and without depression (t = 8.84, df = 30), which indicates that the mean score of women from individuals without depression (M = 401.06, SD = 38.60) are more emotionally intelligent as compared to individuals with depression (M = 309.50, SD = 15.03) on EQ-i. According to the subscales all shows the significant difference on EQ-i at $p <$ 0.01except emotional awareness and optimism subscales of EQ-i. Result indicated

that women without depression are more emotionally intelligent than women from group individuals with depression on EQ-i. Both groups show the same results, on subscales empathy and optimism.

Gender Differences on EI among Individuals with and Without Depression.

To explore the gender differences on EI ($N = 60$) was divided into two groups men ($n = 28$) and women ($n = 32$) an independent sample t-test was computed (Table 5). Further, the same differences was observed within two groups i-e explore gender differences within the groups of individuals with depression ($n = 30$, Table 6) and the gender differences within the group of individuals without depression ($n = 30$, Table 7)

Table 5

Mean, Standard Deviation and t-values to Find Gender Difference on EQ-i and Its Subscales (N = 60).

	Men ($n = 28$)		Women ($n = 32$)		
EQ-i	*M*	*SD*	*M*	*SD*	*t*
Total	311.14	14.69	439.06	38.17	.76
EA	25.43	5.22	21.25	4.45	3.34*
AS	21.07	3.54	20.34	3.39	.81
SR	28.39	6.06	27.31	5.47	.72
SA	28.2	5.53	27.09	6.43	.71
IN	21.82	4.36	20.09	3.08	1.7*
EM	27.18	4.92	26.84	4.58	.27
IR	36.50	6.61	34.06	8.44	1.2
SRe	29.57	7.14	28.84	5.42	.44
PS	27.11	5.79	27.00	4.11	.08
RT	31.11	6.65	32.00	6.19	.53
FL	25.54	5.01	22.59	6.07	2.0

Continue.....

EQ-i	Men ($n = 28$)		Women ($n = 32$)		t
	M	*SD*	*M*	*SD*	
ST	29.79	10.51	25.13	5.91	2.1*
IC	27.32	6.09	26.75	6.67	.34*
HA	29.07	7.21	29.03	4.62	.026
OP	26.57	5.25	24.97	4.50	1.27

Note. EA= Emotional Awareness; AS= Assertiveness; SR= Self regard; SA= Self Actualization; IN= Independence; EM= Empathy; IR= Interpersonal Relationship; SRe = Social Responsibility; PS = Problem Solving; RT = Reality Testing; FL = Flexibility; ST = Stress Tolerance; IC =Impulse Control; HA = Happiness; OP = Optimism.
df= 58. **p< 0.01. *p< 0.05.

Table 5 is showing that there is non significant difference among the men and women on total scores and sub scales of the emotionally intelligence scale except four different subscales (Impulse Control, Stress Tolerance, Emotional Awareness and Independence) show the significant difference among both mean scores. In subscale Emotional Awareness (EA), Independence (IN), Stress Tolerance (ST) and Impulse Control (IC) also show that men scores higher on EI scale than the women at $p < 0.05$ significant level. Therefore our hypothesis 2 is mildly accepted.

Table 6

Mean, Standard Deviation and t-values of Gender Differences of Individuals with Depression on EI Scale and Its Subscales (n= 30).

EQ-i	Men ($n = 14$)		Women ($n = 16$)		t
	M	*SD*	*M*	*SD*	
Total	311.14	14.69	309.50	15.03	.30
EA	21.86	3.18	20.13	3.86	1.32
AS	19.29	2.46	18.00	2.31	1.4
SR	24.00	2.32	24.81	4.46	.61

Continue.....

EQ-i	Men ($n = 14$)		Women ($n = 16$)		t
	M	*SD*	*M*	*SD*	
SA	23.71	2.61	22.50	2.92	1.19
IN	18.64	2.62	18.13	2.53	.55
EM	22.86	1.66	23.88	3.26	1.05
IR	31.43	2.77	27.63	3.69	3.15*
SRe	23.50	3.01	24.63	1.78	1.26
PS	22.29	2.61	24.00	2.92	1.6
RT	26.19	2.44	27.19	3.39	.95
FL	2 1.50	2.77	17.56	2.61	4.0**
ST	21.93	2.67	19.88	2.99	1.97
IC	22.29	2.23	22.69	4.41	.30
HA	22.79	2.19	27.13	2.42	5.1**
OP	22.43	2.47	22.19	4.18	.18

Note. EA= Emotional Awareness; AS= Assertiveness; SR= Self regard; SA= Self Actualization; IN= Independence; EM= Empathy; IR= Interpersonal Relationship; SRe = Social Responsibility; PS = Problem Solving; RT = Reality Testing; FL = Flexibility; ST = Stress Tolerance; IC =Impulse Control; HA = Happiness; OP = Optimism.
df= 28. **p<0.01.

The results in the Table 6 that there is no significant difference (t =.30, df = 28) among men and women of individuals with depression. Result indicated that mean value of men and women have same type of emotionally intelligent on overall and subscale of EQ-i except Interpersonal Relation (IR), Flexibility (FL) and Happiness (HA). But on subscales Interpersonal Relationships (IR) and Flexibility (FL) men scores higher as compared to women at $p < 0.01$ significant level. But in contrast on subscale Happiness (HA) women score higher than men.

Table 7

Mean, Standard Deviation and t-values of Gander Difference from Individuals without Depression on EI (n=30).

EQ-i	Men without depression ($n = 14$)		Women without depression ($n = 16$)		t
	M	SD	M	SD	
Total	439.64	38.17	401.06	38.60	2.7**
EA	29.00	4.35	22.38	4.83	3.9**
AS	22.86	3.61	22.69	2.57	.15
SR	32.79	5.41	29.81	5.34	1.5
SA	32.71	3.63	31.69	5.65	.58
IN	25.00	3.28	22.06	2.25	2.8**
EM	31.50	2.71	29.81	3.73	1.4
IR	41.57	5.26	40.50	6.72	.48
SRe	35.64	4.18	33.06	4.42	.63
PS	1.93	3.56	30.00	2.68	1.68
RT	36.07	5.73	36.81	4.26	.40
FL	29.57	3.06	27.63	3.91	1.50
ST	37.64	9.45	30.38	2.13	2.99**
IC	32.36	4.16	30.81	6.10	.79
HA	35.36	4.25	30.94	5.53	2.42*
OP	30.71	3.75	27.75	2.79	2.47*

Note. EA= Emotional Awareness, AS= Assertiveness, SR= Self regard, SA= Self Actualization, IN= Independence, EM= Empathy, IR= Interpersonal Relationship, SRe = Social Responsibility, PS = Problem Solving, RT = Reality Testing, FL = Flexibility, ST = Stress Tolerance, IC =Impulse Control, HA = Happiness, OP = Optimism.
df= 28. **$p < 0.01$. * $p < 0.05$.

The results in the Table 7 that there is significant difference (t = 2.3, df = 28) among men and women of individuals without depression on over all results. Findings indicate that mean value of men without depression (M = 439.64, SD = 38.17) shows high score on EQ-i as compare to women without depression

(M = 401.06, SD = 38.60). According to subscales, there are non significant difference on EI scale except Emotional Awareness (EA), Independence (IN), Stress Tolerance (ST), Happiness (HA) and Optimism (OP) and these subscales show that men from group of individuals without depression show high EI overall and some specific domains than women.

Comparison of Income Levels Of Individuals On EI Scales.

To explore differences in EI with different income level groups (n = 60) was divided into two groups those with 5000-10,000 income (n = 41) and above 11,000 income (n = 19) an independent sample t-test was computed (Table 8). Further the same differences was observe within two groups i-e individuals with depression (n = 30, Table 9) and individuals without depression (n = 30, Table10) separately an independent sample t-test was computed.

Table 8

Mean, Standard Deviation and t-values on EI of Individuals With and Without Depression of Different Income levels (N = 60).

	Below 10,000 (n = 41)		Above 11,000 (n = 19)		
EQ-i	*M*	*SD*	*M*	*SD*	*t*
Total	359.98	63.94	374.79	62.27	.84
EA	23.02	5.29	23.58	5.19	.38
AS	20.17	3.29	21.79	3.60	1.7
SR	27.41	5.87	28.68	5.46	.79
SA	27.37	6.49	28.16	4.92	.47
IN	21.00	3.78	20.68	3.93	.29
EM	26.85	4.87	27.32	4.45	.35
IR	34.98	7.85	35.68	7.48	.33
SRe	29.10	6.24	29.37	6.40	.15
PS	27.00	4.85	27.16	5.20	.11
RT	31.05	6.53	32.74	6.00	.95

Continue.....

EQ-i	Below 10,000 ($n = 41$)		Above 11,000 ($n = 19$)		t
	M	SD	M	SD	
FL	3.54	5.64	24.89	6.01	.85
ST	26.66	9.14	28.68	7.42	.84
IC	26.68	6.62	27.74	5.84	.59
HA	28.85	5.90	29.47	6.10	.37
OP	25.00	4.48	27.26	5.47	1.6

Note. EA= Emotional Awareness; AS= Assertiveness; SR= Self regard; SA= Self Actualization; IN= Independence; EM= Empathy; IR= Interpersonal Relationship; SRe = Social Responsibility; PS = Problem Solving; RT = Reality Testing; FL = Flexibility; ST = Stress Tolerance; IC =Impulse Control; HA = Happiness; OP = Optimism.
$df = 58$. * $p < 0.05$.

The results in the Table-8 show that there is no significant difference ($t = 2.3$, $df = 28$) among individuals of 5000-10,000 income and income above 11,000 of individuals on over all scale and on subscales, mean value of both groups quit equally scores on EQ-i and its subscales, so hypothesis 3 is rejected.

Table 9

Mean, Standard Deviation and t-values on EI of Individuals with Depression of Different Income Levels ($n = 30$)

EQ-i	Below 10,000 ($n = 21$)		Above 11,000 (n = 9)		t
	M	SD	M	SD	
Total	306.19	13.09	319.78	14.24	2.53*
EA	20.86	3.81	21.11	3.30	.17
AS	18.19	2.52	19.56	2.01	1.43
SR	23.95	3.69	25.56	3.24	1.12
SA	22.62	2.94	24.11	2.26	1.35
IN	18.62	2.64	17.78	2.33	.82

Continue.....

EQ-i	Below 10,000 ($n = 21$) M	SD	Above 11,000 (n = 9) M	SD	t
EM	23.14	2.63	24.00	2.47	.80
IR	29.24	3.74	29.78	4.02	.35
SRe	24.10	2.59	24.11	2.26	.01
PS	23.19	2.96	23.22	2.82	.02
RT	26.10	3.10	28.11	2.26	1.75
FL	19.10	2.88	20.11	4.26	.76
ST	20.29	2.88	22.1	2.98	1.57
IC	22.14	3.42	23.33	3.77	.84
HA	24.90	2.83	25.56	4.00	.50
OP	22.00	3.39	23.00	3.64	.72

Note. EA= Emotional Awareness; AS= Assertiveness; SR= Self regard; SA= Self Actualization; IN= Independence; EM= Empathy; IR= Interpersonal Relationship; SRe = Social Responsibility; PS = Problem Solving; RT = Reality Testing; FL = Flexibility; ST = Stress Tolerance; IC =Impulse Control; HA = Happiness; OP = Optimism.
df= 28. * p< 0.05.

The Table 9 shows that there is significant difference (t = 2.53, df = 28) among individuals of 5000-10,000 income and income above 11,000 of individuals with depression on the overall EQ-i but there is no significant difference found on its subscales.

Result indicated that mean value of individuals of income 5000-10,000 (M = 306.19, SD = 13.09) score low as compare to the individuals of income above 11,000 (M = 319.78, SD = 14.24) on EI.

Table 10

Mean, Standard Deviation and t-values on EI of Individuals without Depression of Different Income Levels (n=30).

	Below 10,000 (n = 20)		Above 11,000 (n = 10)		
EQ-i	*M*	*SD*	*M*	*SD*	*t*
Total	416.45	43.27	424.30	42.72	.46
EA	25.30	5.75	25.80	5.71	.22
AS	22.25	2.69	23.80	3.58	1.33
SR	31.05	5.57	31.50	5.62	.20
SA	32.35	5.33	31.80	3.58	.29
IN	23.50	3.15	23.30	3.16	.16
EM	30.75	3.37	30.30	3.47	.34
IR	41.00	6.35	41.00	5.58	.00
SRe	34.35	4.26	34.10	5.00	.14
PS	31.00	2.73	30.70	4.19	.23
RT	36.25	4.29	36.90	5.17	.33
FL	28.20	3.69	29.20	3.55	.70
ST	33.35	8.68	34.60	4.50	.42
IC	31.45	5.77	31.70	4.32	.12
HA	33.00	5.44	33.00	5.56	.00
OP	28.15	3.13	31.10	3.67	2.29*

Note. EA= Emotional Awareness; AS= Assertiveness; SR= Self regard; SA= Self Actualization; IN= Independence; EM= Empathy; IR= Interpersonal Relationship; SRe = Social Responsibility; PS = Problem Solving; RT = Reality Testing; FL = Flexibility; ST = Stress Tolerance; IC =Impulse Control; HA = Happiness; OP = Optimism.
df= 28. * $p < 0.05$.

The results explain in the Table10 that there is non significant difference ($t = 2.3$, $df = 28$) among individuals of 5000-10,000 income and income above 11,000 of individuals without depression on over all EQ-i. And there is no significant difference between the individual's income 5000-10,000 and the individuals income above 11,000 of individuals without depression on all subscales except only one Optimistic (OP) (t = 2.29, $df = 28$). Result indicated that individuals of 5000-10,000 income (M = 28.15, SD = 3.13) scored low on emotionally intelligence scale as compared to individuals of 11,000 incomes ($M = 31.10$, $SD = 3.67$) on Optimism subscale of EQ-i.

Comparison of Different Levels of Ages of Individuals on EI Scale.

To explore the differences along age, sample (N = 60) was divided into four groups 17-25 (n = 20), 26-35 (n = 20), 36-45 (n = 10) and above 46 (n = 10). One way ANOVA was computed to explore differences among groups (Table 14). Same analysis was further explore within the group i-e individual with depression (n = 30, Table15) and individual without depression (n = 30, Table 16) and one way ANOVA was computed.

Table 11

Mean, Standard Deviation and F-values on EI of individuals With and Without Depression of Different Age Levels (N= 60).

	17 – 25 (n = 20)		26- 35 (n = 20)		36- 45 (n = 10)		46 + (n = 10)		
EQ-i	*M*	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*	*F*
Total	363.45	64.49	357.75	53.61	379.40	83.64	366.2	63.62	.25
EA	22.60	5.60	23.40	3.57	25.70	6.95	21.50	5.15	1.22
AS	19.90	3.49	20.30	2.90	22.70	4.57	21.00	2.67	1.64
SR	28.60	5.13	27.15	4.53	27.50	8.6	27.90	6.28	.21
SA	28.25	6.18	27.00	5.19	27.60	6.11	27.60	6.52	.13
IN	20.75	3.68	20.45	3.50	22.20	4.89	20.80	3.71	.48
EM	27.45	5.09	26.60	4.36	27.50	5.5	26.40	4.27	.19
IR	35.00	8.57	34.65	7.10	37.60	8.54	22.70	6.62	.39
SRe	29.20	5.83	29.15	6.15	29.30	7.86	29.10	6.45	.00
PS	27.40	4.95	26.45	4.62	26.60	5.89	28.00	5.01	.27
RT	30.75	6.48	31.20	5.61	34.10	7.62	31.50	6.62	.64
FL	23.30	6.04	23.55	5.63	26.50	5.13	23.60	6.11	.77
ST	26.25	6.50	28.30	11.39	26.8	8.32	27.90	7.09	.20
IC	27.00	6.74	26.60	5.79	28.60	6.62	26.30	7.10	.26
HA	30.10	5.29	27.45	5.89	30.50	7.00	28.70	6.1	.90
OP	26.05	4.58	24.65	4.93	25.60	6.74	27.30	3.13	.69

Note. EA= Emotional Awareness; AS= Assertiveness; SR= Self regard; SA= Self Actualization; IN= Independence; EM= Empathy; IR= Interpersonal Relationship; SRe = Social Responsibility; PS = Problem Solving; RT = Reality Testing; FL = Flexibility; ST = Stress Tolerance; IC =Impulse Control; HA = Happiness; OP = Optimism.
df = 3, 56. p >0.05.

In Table-11 shows that there is no significant difference in the different levels of ages of individuals with and without depression. The ANOVA was computed as results shows that there is less difference in scores of between these four different levels of individuals on EQ-i, so the hypothesis 4 rejected.

Table 12

Mean, Standard Deviation and F-values on EI of Individuals with Depression of different age Levels (n = 30).

	17 – 25 (*n* = 10)		26- 35 (*n* = 10)		36- 45 (*n* = 5)		46 + (*n* = 5)		
EQ-i	*M*	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*	*F*
Total	310.90	16.89	310.40	7.83	304.40	21.04	314.60	16.23	.39
EA	20.10	3.73	23.00	3.13	19.80	3.63	19.60	3.44	1.79
AS	17.40	1.51	18.50	1.96	19.60	4.39	20.20	1.30	2.01
SR	26.50	2.64	24.70	2.79	20.20	4.21	24.00	3.00	4.85
SA	23.3	3.27	23.40	2.22	22.40	2.51	22.60	3.78	.19
IN	18.50	3.24	18.00	1.70	18.20	2.77	19.00	2.83	.17
EM	23.80	3.08	23.40	2.55	22.60	1.82	23.40	3.21	.21
IR	28.20	2.15	30.00	4.45	30.60	6.02	29.40	2.30	.56
SRe	24.90	2.85	24.20	2.70	22.60	2.07	23.80	.45	1.00
PS	24.30	3.30	22.50	2.64	21.60	3.21	24.00	1.00	1.39
RT	25.70	3.23	27.20	3.50	27.20	2.59	27.20	1.64	.53
FL	18.30	2.54	19.20	3.36	22.40	2.97	19.00	4.00	1.95
ST	21.00	3.27	20.30	2.67	20.00	2.74	22.40	3.51	.68
IC	22.50	3.34	23.10	3.84	23.60	4.34	20.20	1.79	.97
HA	27.10	3.25	23.80	3.46	24.40	2.30	24.40	1.14	2.34
OP	22.80	3.88	21.10	3.07	20.60	2.07	25.40	2.51	2.61

Note. EA= Emotional Awareness; AS= Assertiveness; SR= Self regard; SA= Self Actualization; IN= Independence; EM= Empathy; IR= Interpersonal Relationship; SRe = Social Responsibility; PS = Problem Solving; RT = Reality Testing; FL = Flexibility; ST = Stress Tolerance; IC =Impulse Control; HA = Happiness; OP = Optimism.
df= 3, 29. *$p<0.05$.

The Table 12 shows that there is no significant difference on EI scale. In different levels of ages of individuals with depression, results shows that these four different levels of ages from individuals with depression was not affect on the EI in the of individuals with depression quite equivalent scores on EQ-i and its subscales.

Table 13

Mean, Standard Deviation and F-values on EI of Individuals Without Depression of Different Age Levels (n = 30)

	17 – 25 ($n = 10$)		26- 35 ($n = 10$)		36- 45 ($n = 5$)		46 + ($n = 5$)		
EQ-i	*M*	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*	*F*
Total	416.00	48.55	405.10	32.00	454.40	35.14	417.80	46.77	2.63*
EA	25.10	6.19	23.80	4.10	31.60	2.88	23.40	6.23	3.01**
AS	22.40	3.10	22.10	2.96	25.60	1.39	21.80	3.56	2.29*
SR	30.70	6.64	29.70	4.72	34.20	3.69	31.80	6.40	1.05
SA	33.30	5.27	30.40	4.8	32.40	3.51	32.60	4.78	.53
IN	23.00	2.24	22.60	3.70	26.20	2.67	22.60	3.83	.72
EM	31.10	3.08	29.40	2.55	32.40	2.30	29.40	3.2	.95
IR	41.80	6.91	39.30	6.45	44.60	2.02	39.40	2.30	.08
SRe	34.90	4.78	34.20	4.70	36.60	4.07	34.80	4.45	.33
PS	30.30	4.40	30.40	1.6	31.60	2.21	32.60	3.94	.37
RT	35.70	4.23	35.20	4.29	41.20	2.29	35.00	7.64	.88
FL	28.30	3.54	27.20	3.70	30.40	2.88	28.09	3.90	.65
ST	31.50	4.27	36.30	11.67	33.00	5.73	33.40	5.51	.66
IC	31.50	6.34	30.10	5.64	33.60	4.16	32.40	4.19	.52
HA	33.10	5.34	31.10	5.63	36.60	3.44	33.00	6.12	1.18
OP	29.30	2.41	28.20	3.74	30.60	5.94	29.20	2.59	.49

Note. EA= Emotional Awareness; AS= Assertiveness; SR= Self regard; SA= Self Actualization; IN= Independence; EM= Empathy; IR= Interpersonal Relationship; SRe = Social Responsibility; PS = Problem Solving; RT = Reality Testing; FL = Flexibility; ST = Stress Tolerance; IC =Impulse Control; HA = Happiness; OP = Optimism.
df = 3, 29. $p > 0.05$.

Above Table 13 shows that there is no significant difference in the scores found in the different levels of ages of individuals without depression. Results

reveals that these four different levels in ages of individuals from individuals without depression affect on over all EQ-i (t = 2.63, df = 3,29), nonsignificant difference on all subscales except Assertiveness (AS) (t = 2.29, df = 3,29) and Emotional Awareness (t = 3.01, df = 3,29) result found that the age level of 36 – 45 years of individuals without depression scored high on EQ-i than other groups of ages.

DISCUSSION

Chapter IV

DISCUSSION

This study aims at exploring the comparison of EI in individuals with depression (who had been given diagnosis of suffering from depression) and individuals without depression (who had never received diagnosis of any mental illness in their lives). The EI refers to the ability to control and express the feelings of emotions according to the need of time (Goleman, 1995). In the present study the target sample was individuals with depression who were the patients diagnosed as suffering from depression and its matched group that had been taken from the normal population with same demographic variables (age, gender, marital status, no. of children) to make sure that other confounding variables could be controlled, that might affect the results of the present study.

For this reason EI scale Urdu version of Emotional Quotient- Inventory (EQ-i) was utilized (Bar-On, 1997) translated by Akhter (2004). The alpha reliability was found to be 0.96 (see Table- 1) which shows the high reliability of scale. For its fifteen subscales it was ranging from .59 to .81 which also found to be satisfactory. It was first time used in clinical settings in Pakistan still showing internal consistency.

It was hypothesized that the individuals without depression would score high on EI than the individuals with depression. Findings indicated (see Table 2) that the individuals without depression showed more EI as compared to individuals with depression so the hypothesis was accepted and it was supported by the study (Bar-On & Parker, 2000). According to the Bar-On and Parker (2000), EQi and its all the subscales has negative correlation (r = -.76) with the depression as their study show that they use the Beck Depression Inventory (BDI) for the diagnosis of the depression.

Further, results revealed that men without depression scored high on EI scale than men with depression, (see Table 3) at $p < 0.01$ significant levels. Similarly, women without depression showed high score on EI than the women with depression except emotional awareness (see Table 4). The total scores and also the subscales showed significant difference at $p < 0.01$ significant levels.

The given results indicated that our first hypothesis is accepted and further analysis of the groups (individuals with and without depression) also showed that difference in both the groups explains the EI of individuals inversely related to the depression. As a study indicated that women with depression has less emotionally intelligent protective factors (hardiness) than the women without depression. The results shows resilience in the women has positive relationship with hardiness and protects the women for developing the depression (as a reflection of special resiliency to the depression) (Rhodewat & Zone, 1989).

Second hypothesis was about the gender differences on EI. Findings showed that there was nonsignificant difference between the mean scores of the men and women on over all EQ-i and its sub-scale except on subscales Emotional Awareness, Independence, Stress Tolerance and Impulse Control (see Table 5). Men show more assertiveness, self recognition about them, more independence and management according to the situations than women. Independence and assertiveness was observed in men may be because; men are more powerful and independent member in our society. Nonsignificant difference on remaining subscales and overall EQi may be because of emotional states through which all individual are suffering that might effect than EI, hence not showing over all gender differences.

Gender differences within the group of individuals with and without depression, separately; indicated (see Table 6) that there is nonsignificant difference among men and women with depression on total and subscales of emotional intelligent except Interpersonal Relationship, Flexibility and Happiness. Findings revealed that men with depression scored higher than women with depression on subscales Interpersonal Relationship and Flexibility of EI. An interesting finding was that women scored high on sub-scale Happiness of EQ-i than men. The mean scores on Interpersonal Relationship and Flexibility which explains that women's deficiencies in interpersonal skills and flexibilities explain why psychopathology stress problems is observed much more frequently in women as compared to men (APA, as cited in BarOn, & Parker, 2000). This showed that men with depression had more control on their emotional expressions and showed flexibility in their reactions. Women are scored higher than men on happiness may be because women are more emotionally expressive and have ability to regulate their emotions than men (Malateasta, Haviland & Cole, as cited in BarOn, & Parker, 2000) through catharsis.

Men without depression showed more EI than the women without depression. Finding indicated (see Table 7) that men scored significantly higher on overall EQi and its subscales Emotional Awareness, Independence, Stress Tolerance, Happiness, and Optimism than women. A study carried out by Roothman, Kirsten and Wissing (2003) found that EI, among other factors, was not found to differ significantly between sexes. May be the cultural differences or gender discrimination play a role in making difference.

The second hypothesis that the women are more emotionally intelligent than men was rejected. The results reveal that men show more EI than the women on overall sample. In both the groups of individuals (individuals with and without depression) the individuals with depression show nonsignificant results than individuals without depression. This shows that women from both groups show less EI than men. The difference in the results in both groups explains that presence of depression affects the results of individuals on EI.

To investigating third hypothesis, individuals with high income would be more emotional intelligent than the individual with low income. Result showed (see Table 8) that there is nonsignificant difference among individuals with high income and low income on total and subscales of EI. According to Beekie, (2004) the correlation between stratum level of salary (income) and overall EQ-i of individuals was positive. Findings indicate nonsignificant results because one reason is that, may be there was no big difference in the levels of income of sample and there was difference in sample size in each group too, that might have effected results of present study.

Further, results indicated that there is significant difference among individuals with depression having high and low income on overall scale (see Table 9). Individual with depression having high income showed high EI than individual with depression having low income on total score of EI scale. Nonsignificant difference was observed on subscale of EQ-i. Findings revealed that income is important factor in regulating emotions among the individuals suffering from depression, literature supports these results as a study (Brown & Harris, as cited in Kausar, 1999) showed that there was negative correlation between depression (emotional disturbance) and income levels.

In other group of individuals without depression, there was nonsignificant difference on EQ-i among individuals of both levels of incomes except Optimism (see Table 10). This shows that individuals without depression with high level of income wants to see and lead their lives positively than the low earning individuals. They have gathered hope for their future and try more.

The third hypothesis was rejected as shown in the results but further analysis according to the groups (individuals with and without depression) that shows depression has inverse relationship with income and that effects the results. These results show the individuals with depression have different scores on EQ-i than the individuals without depression and as its shows depression affects the EI of individuals.

The fourth hypothesis was older individual will have higher EI than the younger individuals. Finding indicated that there was nonsignificant difference among older individuals and younger individuals on total and subscales of emotionally intelligence scale (see Table 11). This shows that hypothesis is rejected that may be because of the small number of individuals falling in each group on which analysis was done.

Further findings indicated that there is nonsignificant difference among individuals with depression at different age levels (see Table 12). It reveals that the mean scores of individuals with depression of different levels of age shows that they have the same levels of EI. One reason is that may be there are small differences between age levels that made the findings nonsignificant.

Findings indicated that there is significant difference among older and younger individuals without depression on total and there is nonsignificant difference on subscales of EQ-i except Emotional Awareness and Assertiveness (see Table 13). These findings indicate that group between age 36-45 show high EI. Almost on all subscales the mean scores of this age group was high but significant difference was only found on Emotional Awareness and Assertiveness. This shows that the people of this age group have ability to know about their feelings and thoughts, express them and to defend themselves that heighten the self-esteem and protect from development of psychopathology (Bar-On & Parker, 2000) and this group seems to be more settled and energetic than rest of the groups.

Our fourth hypothesis that was older individual's show more EI than the younger individuals was rejected on overall sample. The individuals without depression show significant results on EI that shows there is difference in EI according to the different levels of group of individuals. Whether individuals with depression has nonsignificant difference that shows EI do not show difference with passage of age which is wrong according to the modern researches. So, this shows that EI is negatively correlated with depression.

Limitations and Suggestions

The present study aimed at exploring the EI among individuals among individuals with and without depression. Hypotheses were partially accepted but like other empirical study, generalizability of the findings of this research is limited according to the demand of the research.

The sample selection was not true representative because taken from a very limited area and the generalization of findings is not possible sample size was too small that might have affected the results of the research. A large sample size may yield to more fruitful findings.

The scale was large containing 117 items; it was lengthy for a patient suffering from depression (who also has not interest in the life activities). Some difficulties were found in the understanding of statement that may not reveal their true responses. Clinical settings can also act as confounding variable for the research.

It is suggested that in future research sample size should be increased and it will be better considered to different types of depression that may be helpful for deciding the therapeutic interventions in the clinical settings.

Conclusion

The present study explores the difference between the EI of individuals with and without depression. EI necessarily requires a degree of awareness of how emotion states impart our memories, thoughts, and judgments interpersonal and intrapersonal behaviors. We have also seen the positive and negative mood produce different thinking strategies, and as a result, positive mood often increase and

negative mood decreases memory, judgmental and thinking errors. The social situations we face impose strong motivational demands to act in required ways that override these slight mood effects. When people do not rely on open, constructive thinking to figure out what to do, mood states are much less likely to influence their responses. Individual who experience negative mood (depressive symptoms) report more and more severe physical symptoms and more negative attitudes and believes about their ability to manage their health. Hopefully, the work described here will contribute to understanding of the role of emotion and its awareness and control (EI) in social life and mental health.

REFERENCES

REFERENCES

Abdullah, M. C., Elias, H., Mahyuddin, R., & Uli, J. (2004). EI and academic achievement among Malaysian secondary students. *Pakistan Journal of Psychological Research,* 19 (3-4), 105 – 121.

Akhter, R. S. (2004). *EI and academic achievement among university students.* Unpublished M.Sc., Dissertation National Institute of Psychology, Quaid-i- Azam University, Islamabad Pakistan.

Aslam, F. (2004). *Relationship between EI and occupational stress among information technology professionals*. Unpublished M.Sc., Dissertation National Institute of Psychology, Quaid-i-Azam University, Islamabad, Pakistan.

Austin, E. J., Saklofske, D. H., & Egan, V. (2005). Personality, well-being and health correlates of trait EI. *Personality and Individual Differences, 38(3)*, 547-558.

BarOn, R (1988). *The development of an operational concept of psychological well-being*. Unpublished doctoral dissertation, Rhodes University, South Africa, Retrieved on November 12, 2006, from: http://www.mhs. com/healthcaredoes/ Eqi.pdf.

BarOn, R. (1992). *The development of the concept and test of EI.* Unpublished Manuscript. Tel Aviv: Reuven BarOn. Retrieved on December 12, 2006. from http:// www.eiconsorti m-org/research/eci-clusters.html.

Bar-On, R., & Parker, D. A. (2000). *A hand book of EI.* John Wiely & Sons, Inc San Francisco.

Bar-On, R., Tranel, D., Denburg, N. L., & Bechara, A. (2003). Exploring the neurological substrate of emotional and social intelligence. *Brain, 126(8)*, 1790-1800. Retrieved on December 2, 2006, from. http://www.brain. oxfordjournals.org/cgi/content/abstract/ 126/8/1790.

Bar-On, R. (2006). The Bar-On model of emotional-social intelligence (ESI). *Psicothema, 18,* supl., 13-25. Retrieved September 22, 2006, from http://www. eiconsortium.org/ research/baron_model_of_emotional_social_intelligenc.htm

Basle, P. K, (1974). *Depression in every day practice.* Williams and Wilkins Company Baltimore.

Beck, A. T. (1967). *Depression.* University of Pennsylvania.

Beekie, R. B. (2004). *The relationship between EI and sales performance: From intuition to research.* Unpublished PhD thesis, University of St. Thomas, Minnesota. Retrieved October 27, 2006, from http://www. mhs.com/ROE/EI ResearchByType.aspx - 217k

Cary, C., & Goleman, D. (1998). An EI-Based Theory of Performance. *TheEmotionally Intelligent at Workplace* retrieved December 2, 2006, from http://www.eiconsortium. org/research/ei_theory_performance.htm

Chris, B. (2003), The Role of EI in the Career Commitment and Decision-Making Process, *Journal of Career Assessment*, Vol. 11, No. 4, 379-392 (2003). Retrieved on October 10, 2006 from http://jca.sagepub.com/ cgi/content /abstract/11/4/379.

Ciarrochi, J., Forgas, J. P, & Mayer, J. D. (2006). Emotinal Intelligence in Everyday life (2nd ed.). Psychology Press. New York.

Cooper, R. K., & Sawaf, A. (1994). *Executive EQ: EI in leadership and organization.* New York: Grosset / Putnum.

Damasio, A. (1994). *Descartes error: Emotion, reason, and the human brain.* New York: Grosset Putnam. Retrieved on November 17, 2006 from: www.waisman. wise.edu/ symp _ damasio.html.

Dennis, T. (2000). *EI and smoking across ethnicity Adolescent tobacco use is a well-known public*; University of Southern California. Retrieved on November 3, 2006, from http://www.trdrp.org/ research/PageGrant.asp?grant_id =1892.

Davison, G., & Neal, A. (2002). *Abnormal Psychology*, (9th ed) Boston.

Dulewicz, V., Higgs, M., & Slaski, M. (2003). Measuring EI: Content, construct and criterion-related validity. *Journal of Managerial Psychology, 18(5)*, 405-420. Retrieved on October 5, 2006, http://www.charlie.2-minute-website. com/ site/ neilrankin. 2min/Definition-of-competency

Eisses, H. M; Kluiter, H ; Jongenelis, K;. Pot, A. M; Beekman, A.T; Ormel, J. (2004). Risk indicators of depression in residential homes. *Int J Geriatr Psychiatry. Journal:* 19(7):634-40. Retrieved on December 13, 2006, from http://www3.interscience.wiley.com/cgibin/abstract/109076547/ABSTRACT?CRETRY=1&SRETRY=0

Extremera, N., & Berrocal, F. (2001). *EI as predictor of the mental, social and physical health in the university students*. Universidad de Malaga Spain. Retrieved on 22 December, 2006, from . http:// www.nextreme ra@uma.es.

Fatima, S. A. (2002). *Relationships of complexity, depression and self esteem among college students.* Unpublished M.Sc., Dissertation. National Institute of psychology, Quaid-i-Azam University, Islamabad, Pakistan.

Farast, F. (2005), *EI and its relationship with psychological well being.* Unpublished M. Phill., Dissertation. National Institute of Psychology, Centre of Excellence, Quaid-i-Azam University, Islamabad, Pakistan.

Goleman, D. (1995). *EI: EI.* New York: Banton Books.

Grieco, C. E. (2002). EI, level of commitment, and network of social support as predictors of marital satisfaction. *Dissertation Abstracts International: Section B: The Sciences and Engineering, 62 (10-B)*, 4837. Retrieved on November 13, 2006, from http://www.eqtoday.com/ 02/emotional.php

Halgin, P. R., & Whitbourne, K. S. (2003). *Abnormal Psychology*, (4th ed). Boston.

Hautzinger, M., & Aktuelle, G. (1982). *The influence of depression, and family and friendship relations, on residents.* Mar;12(2):67-71. Retrieved on November 28, 2006, from http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?db=pubmed&cmd=Retrieve&dopt=AbstractPlus&list_uids=16877454&query_hl=7&itool=pubmed_DocSum.

Hein. S, (2005). *Introduction to EI* Centre for Applied EI. Retrieved November 19, 2006, from http://www.emotionalintelligence .co.uk /eitheory.htm.

Hogan, R., & Shelton, D. (1998). A scioanalytic perspective on job performance. *Human performance, 11, 129-144.*

Izard, E. C. (1979*). Emotions in personality and psychopathology* published by University of Delaware Newark, Delaware Jim, T. (2002). *Survey Shows That Unrealistic Workloads Are To Blame For Increasing Rates of Depression And Stress At Work.* Retrieved on November 11, 2006, from http://www.depressionalliance.org/docs/what_we_ offer/research.html.

Kalil, A. (1999). *Depression between married and unmarried working women.* Unpublished M.Phill., Dissertation. National Institute of Psychology, Centre of Excellence, Quaid-i-Azam University, Islamabad, Pakistan.

Katayal, S., & Awasthi, E. (2003). Gender differences in EI and its correlates. *Journal of personality and social psychology, Vol.*84; 3,594-607

Kausar, R. (1999). *Depression married and unmarried working women.* Unpublished M.Sc., Dissertation National Institute of Psychology, Centre of Excellence, Quaid-i-Azam University, Islamabad, Pakistan.

Kiani, S. (2003). *EI and conflict management in workplace.* Unpublished M.Phill., Dissertation. National Institute of Psychology, Centre of Excellence, Quaid-i-Azam University, Islamabad, Pakistan

Mulligan, R.D. (2004). Self-assessment of social and emotional competencies of floor covering salespeople and its correlation with sales performance. *The Sciences and Engineering,* 64 (9-B), 4664.

Munir, N. (2000). *Relationship between depression and gender discrimination against women in families.* Unpublished M. Phill., Dissertation. National Institute of Psychology, Centre of Excellence, Quaid-i-Azam University, Islamabad, Pakistan.

Mayer, J. D. (1990). *University of New Hampshire.* Retrieved Nov 24, 2006. from http://www.rachelgreen.com/emotional-intelligence.html

Myers, J. D., & Salvoey, P. (1993). The intelligence of EI. *Intelligence*, 17(4), 443-442.

Myers, J. D. & Salovey, P. (1997). *What is EI? Emotional development and implications for educators*. New York: basic. Retrieved on December 28, 2006 from http; //www.eqi. org/mayers.html.

Myers, S. (1999). *Emotional Distress Regulation Takes Precedence Over Impulse Control.* Retrieved on November 2, 2006, from, http://www.unh.edu/EI/ei%20 Reprints/EIreprints%201990-1999.htm

Nelson, W. R., & Israel, C. A. (2003). *Behavior disorder of childhood.* (5th Ed) Pearson Education.Inc, New Jersey.

Norie, N. (1999). *EI and its Relation to Gender and Culture*. Retrieved on 5 Oct, 2006, from, http://www.unh.edu/emotional_intelligence/ei%20Reprints/Eirep rints %201990-1999.htm.

Parker, J. D. A., & Reker, D. L. (1999, August). *EI, mood, and problem behaviours in children and adolescents*. Poster session presented at APA 107th annual convention, Boston, MA.

Roothman, B., Kirsten, D. K., & Wissing, M. P. (2003). Gender differences in aspects of psychological well-being. *South African Journal of Psychology, 33(4)*, 212-218.

Rowwe, D. (2003). Depression (3rd ed). Brunner-Routledg. New York.

.Salovey, P., & Mayer, J. D. (1990). *EI. Imagination, Cognition, and Personality*, 9, 185-211. Retrieved on November 3, 2006, from http://www.unh.edu/ emotional_intelligence/ei%20Measuring%20EI/eiMeasure%20who%20is%20e motionally%20intelligent.htm

Smith, II, J.E. (2001). EI and behavior: An exploratory study of people on parole. *The Sciences and Engineering, 61 (11-B)*, 6168. Retrieved on November 16, 2006. from http://www.mhs.com/ROE/EI ResearchByType.aspx

Summerfeldt' L. J., Kloosterman, P. H., Antony, M. M., & Parker, D. A. (2005). Social Anxiety, EI, and Interpersonal *Adjustment. Journal of Abnormal Child Psychology,* v33,(2), p165. Retrieved on October 28, 2006, from http://www.eric.ed.gov/ERICWebPortal/custom/portlets/recordDetails/detailmini.jsp?_nfpb=true&_&ERICExtSearch_SearchValue_0=EJ696986&ERICExtSearch_SearchType_0=eric_accno&accno=EJ696986

Thomas, R. L. (2003). The *Role of Emotion Inhibition in Psychological Distress, Duke University*. Retrieved on 25 November, 2006, from, http://www.eqi.org/history.htm.

Thorndike, S. T., & Stein. V. S. (1937). *Emotional competencies and social intelligence*. Retrieved on November 3, 2006, from,http://www.goliath.ecnext.com/coms2/ summary_0199-1538514_ITM - 29k.

Trinidad, D. (2000). *EI and smoking across ethnicity Adolescent tobacco use is a well-known public*; University of Southern California.. Retrieved on October 21, 2006from http://www.trdrp.org /research/ Page Grant asp? grant_id=1892.

Virgina, B. &., Cruz, R. (2000), Across contexts comparison of EI competencies: A discovery of gender differences. Retrieved on November 25, 2006, from http://www.jca.sagepub.com/cgi/content/ abstract/11/4/379

Yamashita, K., & Nippon, R. I. Z. (1993). *Feeling of well-being and depression in relation to social activity in normal elderly people.* 30(8);693-7. Retrieved on November 25, 2006, from, http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?db=pubmed&cmd=Retrieve&dopt=AbstractPlus&list_uids=8230783&query_hl=pubmed_DocSum.

Younas, A. (2003). *Relationship between locus of control and loneliness in clinically depressed out patients*. Unpublished M.Phill., dissertation. National Institute of Psychology, Centre of Excellence, Quaid-i-Azam University, Islamabad.

Appendix A

تعارف وہدایات

میں قومی ادارہ نفسیات، قائداعظم یونیورسٹی اسلام آباد میں ایم۔ایس۔سی کی طالبہ ہوں اور انسانی احساسات کے بارے میں تحقیق کر رہی ہوں۔ ہم سب احساسات اور جذبات رکھتے ہیں جو کے منفی بھی ہو سکتے ہیں اور مثبت بھی۔ ہم مختلف حالات میں کیسے جذبات محسوس کرتے ہیں، ہماری زندگی میں بہت آہم کردار ادا کرتے ہیں۔ اپنے احساسات وجذبات سے نبرد آزما ہونے کیلئے ہر انسان اپنے نقطۂ نظر رکھتا ہے۔ یہ نقطۂ نظر جاننے کے لیے آپ کو یہ سوالنامہ دیا جا رہا ہے۔

آپ سے گزارش ہے کہ دیئے گئے بیانات کو غور سے پڑھیں اور ان کی روشنی میں خیالات کا اظہار کریں۔ برائے مہر بانی کسی بھی بیان کو خالی نہ چھوڑیں۔

بہت کم صحیح	شاذ و نادر صحیح	کبھی کبھار صحیح	اکثر صحیح	ہمیشہ صحیح

دیئے گئے بیانات کا کوئی بھی جواب غلط یا صحیح نہیں ہے۔ لہاذا ہر سوال کا جواب دیں جیسا کے آپ زندگی میں محسوس کرتے ہیں۔ اس بات کا یقین رکھیں کہ آپ کے جوابات کو صیغۂ راز میں رکھا جائے گا اور یہ صرف تحقیقی مقاصد کے لئے استعمال کیا جائیگا۔ آپ کی رائے میرے تحقیقی مقاصد کے لئے بہت قیمتی ہے۔ میں آپ کے تعاون کی شکر گزار ہوں گی۔

ذاتی کوائف

عمر: _____

تعلیم: _____

جنس: _____

ازدواجی حیثیت: _____

پیشہ: _____

خاندان کی ماہانہ آمدنی: _____

والد: _____

والد کی عمر: _____

والدہ: _____

والدہ کی عمر: _____

بہن بھائیوں کی تعداد: _____

بہن بھائیوں آپ کا نمبر: _____

خاندان میں کسی کو یہ بیماری: _____

بیماری کو کتنا عرصہ ہوا: _____

طریقہ علاج: _____

علاج کو کتنا عرصہ ہوا: _____

Appendix B

نمبر شمار	سوالات	بہت کم صحیح	شاذ و نادر صحیح	کبھی کبھار صحیح	اکثر صحیح	ہمیشہ صحیح
.1	میں مشکلات پر مرحلہ وار قابو پاتا/ پاتی ہوں.					
.2	میرے لئے زندگی سے لطف اندوز ہونا مشکل ہے.					
.3	میں ایسی ملازمت کو ترجیح دوں گا/ گی جس میں مجھے کافی حد تک بتایا جائے کہ مجھے کیا کرنا ہے۔					
.4	میں پریشان کن مسائل سے نمٹنا جانتا/ جانتی ہوں.					
.5	میں اپنی زندگی کو بامعنی بنانے کی ہر ممکن کوشش کرتا/ کرتی ہوں.					
.6	میرے لئے اپنے احساسات کا اظہار کرنا کافی آسان ہے.					
.7	میں چیزوں کو خواب و خیال سے الگ رکھ کر حقیقت میں دیکھنے کی کوشش کرتا/ کرتی ہوں.					
.8	میں اپنے جذبات سے باخبر ہوں.					
.9	مجھے شفقت کا اظہار کرنے میں مشکل پیش آتی ہے.					
.10	میں اکثر حالات میں پُر اعتماد محسوس کرتا / کرتی ہوں.					
.11	اپنے غصے کو قابو کرنا میرے لئے ایک مسئلہ ہے.					
.12	میرے لئے کوئی نیا کام شروع کرنا مشکل ہے.					
.13	کسی مشکل صورت حال کا سامنا ہونے پر میں اس کے بارے میں ہر ممکن معلومات جمع کرنا پسند کرتا/ کرتی ہوں.					
.14	مجھے لوگوں کی مدد کرنا پسند ہے.					
.15	میرے لئے مُسکرانا بہت مشکل ہے.					
.16	مجھے دوسرے لوگوں کے احساسات کو سمجھنے میں دقت ہوتی ہے.					
.17	جب میں دوسروں کے ساتھ کام کرتا/ کرتی ہوں، تو میں خود سے زیادہ ان کے خیالات پر انحصار کرتا/ کرتی ہوں.					
.18	مجھے یقین ہے کہ میں مشکل حالات میں سُرخرو ہو سکتا/ سکتی ہوں					

نمبر شمار	سوالات	بہت کم صحیح	شاذ و نادر صحیح	کبھی کبھار صحیح	اکثر صحیح	ہمیشہ
.19	میں یقیناً نہیں جانتا / جانتی کہ میں کس چیز میں اچھا/اچھی ہوں۔					
.20	میں دوسروں پر اپنے خیالات کا اظہار کرنے سے قاصر ہوں۔					
.21	میرے لئے اپنے گہرے جذبات میں دوسروں کو شریک کرنا مشکل ہے۔					
.22	مجھ میں خود اعتمادی کی کمی ہے۔					
.23	میں اپنے زیادہ تر کاموں کے بارے میں پُر امید رہتا/رہتی ہوں۔					
.24	جب میں بولنا شروع کرتا / کرتی ہوں تو خاموش ہونا مشکل ہوتا ہے۔					
.25	اپنے آپ کو حالات کے مطابق ڈھالنا میرے لیئے عموماً مشکل ہوتا ہے۔					
.26	میں کسی مسئلے کو حل کرنے سے پہلے اس کا بغور جائزہ لینا پسند کرتا / کرتی ہوں۔					
.27	مجھے لوگوں سے فائدہ اٹھانے میں کوئی حرج نہیں محسوس ہوتا خاص طور پر اگر وہ اس کے مستحق ہوں۔					
.28	میں کافی حد تک ایک خوش مزاج انسان ہوں۔					
.29	میں ترجیح دیتا/دیتی ہوں کہ دوسرے میرے بارے میں فیصلہ کریں۔					
.30	میں بہت زیادہ گھبراہٹ کے بغیر مشکلات پر قابو پا سکتا / سکتی ہوں۔					
.31	میرے لیئے اپنے محسوسات کو سمجھنا مشکل ہے۔					
.32	گزشتہ چند سالوں میں میں نے بہت کم مقاصد حاصل کئے ہیں۔					
.33	جب مجھے دوسرے افراد پر غصہ آتا ہے تو میں اس کا اظہار کر سکتا / سکتی ہوں۔					
.34	میرے ساتھ کچھ ایسے (عجیب و غریب) واقعات گزرے ہیں جن کی وضاحت نہیں کی جا سکتی۔					

نمبر شمار	سوالات	بہت کم ☐	شاذ و نادر ☐	کبھی کبھار ☐	اکثر ☐	ہمیشہ ☐
.35	میرے لیئے دوست بنانا آسان ہے۔					
.36	میں خوب عزت نفس رکھتا/رکھتی ہوں۔					
.37	میری جلد بازی مسائل پیدا کرتی ہے۔					
.38	میرے لیئے چیزوں کے بارے میں اپنی رائے تبدیل کرنا مشکل ہے۔					
.39	میں بخوبی سمجھ سکتا/سکتی ہوں کہ دوسرے لوگ کیا محسوس کر رہے ہیں۔					
.40	جب کسی مسئلے کا سامنا ہو تو سب سے پہلے میں سوچ و بچار کرتا ہوں۔					
.41	دوسروں کو مجھ پر انحصار کرنا مشکل لگتا ہے۔					
.42	میں اپنی زندگی سے مطمئن ہوں۔					
.43	میرے لیئے اپنے طور پر فیصلہ کرنا مشکل ہے۔					
.44	میں مشکل صورت حال کو برداشت نہیں کر سکتا/سکتی۔					
.45	میں اپنے کام سے لطف اندوز نہیں ہوتا/ہوتی۔					
.46	میرے لیئے اپنے دلی جذبات کا اظہار کرنا مشکل ہوتا ہے۔					
.47	میری سوچ کو سمجھنا لوگوں کیلیئے مشکل ہوتا ہے۔					
.48	میں عموماً بہترین کی امید رکھتا/رکھتی ہوں۔					
.49	میرے دوست، مجھے اپنے بارے میں راز کی باتیں بتا سکتے ہیں۔					
.50	میں اپنے بارے میں اچھا محسوس نہیں کرتا/کرتی۔					
.51	دوران بحث لوگ مجھے اپنی آواز دھیمی کرنے کو کہتے ہیں۔					
.52	میرے لیئے نئے حالات میں اپنے آپ کو ڈھالنا آسان ہوتا ہے۔					
.53	جب میں کسی مسئلے کو حل کرنے کی کوشش کرتا/کرتی ہوں تو ہر ممکن راستہ سوچ کر بہترین فیصلہ کرتا/کرتی ہوں۔					
.54	میں رک کر ایک روتے ہوئے بچے کے والدین کو تلاش کرنے میں مدد کروں گا/گی خواہ مجھے اس وقت کہیں اور پہنچنا ہو۔					

نمبر شمار	سوالات	بہت کم صحیح	شاذ و نادر صحیح	کبھی کبھار صحیح	اکثر صحیح	ہمیشہ صحیح
.55	میرا ساتھ خوشی کا باعث ہوتا ہے۔					
.56	میں اپنے احساسات سے باخبر ہوں۔					
.57	میں محسوس کرتا/ کرتی ہوں کہ میرے لیئے اپنی پریشانی پر قابو پانا مشکل ہے۔					
.58	میں اپنی دلچسپیوں کے بارے میں اتنا/اتنی پر جوش نہیں ہوتا/ ہوتی۔					
.59	اگر میں کسی سے اختلاف کروں تو اس کا اظہار کر دیتا/ دیتی ہوں۔					
.60	میں اکثر اپنے خیالات میں گم ہو جاتا/ جاتی ہوں اور ارد گرد کی دنیا سے بے نیاز ہو جاتا/ جاتی ہوں۔					
.61	میں دوسروں کے ساتھ اچھی طرح نہیں چل سکتا/ سکتی۔					
.62	میرے لیئے اپنے آپ کو اس طرح قبول کرنا مشکل ہے جیسا / جیسی میں ہوں۔					
.63	مجھے اس کی پرواہ ہوتی ہے کہ دوسرے لوگوں کے ساتھ کیا ہوتا ہے۔					
.64	میں بے صبر ہوں۔					
.65	میں اپنی پرانی عادات کو بدل سکتا/ سکتی ہوں۔					
.66	مسائل کے حل کے دوران میرے لیئے بہترین حل کا انتخاب کرنا مشکل ہوتا ہے۔					
.67	اگر میں کچھ حالات میں قانون توڑ کر بچ سکوں تو میں ایسا ہی کروں گا/ گی۔					
.68	میں ذہنی دباؤ کا شکار ہو جاتا/ جاتی ہوں۔					
.69	میں مشکل حالات میں پرسکون رہنا جانتا/ جانتی ہوں۔					
.70	جب چیزیں مشکل ہو جائیں تب بھی میں عام طور پر کوشش جاری رکھتا/ رکھتی ہوں۔					

نمبر شمار	سوالات	بہت کم صحیح	شاذ و نادر صحیح	کبھی کبھار صحیح	اکثر صحیح	ہمیشہ صحیح
.71	جن کاموں میں مجھے لطف آتا ہے میں انہیں جاری رکھنے اور پروان چڑھانے کی کوشش کرتا/ کرتی ہوں۔					
.72	میرے لئے چاہتے ہوئے بھی "نہ" کہنا مشکل ہے۔					
.73	میں اپنے تصورات اور خیالات کی رو میں بہہ جاتا/ جاتی ہوں۔					
.74	میرے نزدیکی تعلقات میرے اور میرے دوستوں کے نزدیک بہت معنی رکھتے ہیں۔					
.75	میں جس قسم کا / کی انسان ہوں اس سے خوش ہوں۔					
.76	میری خواہشات اتنی شدید ہیں کہ انہیں قابو میں رکھنا مشکل ہے۔					
.77	عموماً میرے لیئے اپنی روزمرہ زندگی میں تبدیلیاں لانا مشکل ہے۔					
.78	باوجود اس کے کہ میں پریشان ہوں، مجھے آگاہی ہوتی ہے کہ میرے ساتھ کیا ہو رہا ہے۔					
.79	مشکلات کی صورت میں میں ہر ممکنہ حل سوچنے کی کوشش کرتا/ کرتی ہوں۔					
.80	میں دوسروں کی عزت کرنا جانتا/ جانتی ہوں۔					
.81	میں اپنی زندگی سے اتنا/ اتنی خوش نہیں ہوں۔					
.82	میں رہنمائی کرنے والوں سے زیادہ پیروی کرنے والوں میں سے ہوں۔					
.83	میرے لیئے ناخوشگوار چیزوں کا سامنا کرنا مشکل ہوتا ہے۔					
.84	میں ان چیزوں سے لطف اندوز ہوتا/ ہوتی ہوں جن میں مجھے دلچسپی ہے۔					
.85	میرے لیئے لوگوں کو اپنے خیالات کے بارے میں بتانا نسبتاً آسان ہے۔					
.86	میں مبالغہ آرائی کرتا/ کرتی ہوں۔					
.87	میں دوسروں کے احساسات کے بارے میں حساس ہوں۔					

نمبر شمار	سوالات	بہت کم صحیح	شاذ و نادر صحیح	کبھی کبھار صحیح	اکثر صحیح	ہمیشہ صحیح
.88	میرے دوسروں سے اچھے تعلقات ہیں۔					
.89	میں اپنی ظاہری جسمانی حالت سے مطمئن ہوں۔					
.90	میں جلد باز ہوں۔					
.91	اپنے طریقوں کو تبدیل کرنا میرے لیئے مشکل ہے۔					
.92	میرے خیال میں قانون پر عمل کرنے والا شہری ہونا اہم ہے۔					
.93	میں ہفتہ وار اور دیگر تعطیلات سے لطف اندوز ہوتا/ہوتی ہوں۔					
.94	وقتاً فوقتاً ناکامیوں کے باوجود میں کامیابی کی امید رکھتا/رکھتی ہوں۔					
.95	میں اکثر دوسرے لوگوں کا سہارا لیتا/لیتی ہوں۔					
.96	مجھے اپنی قابلیت پر یقین ہے کہ میں انتہائی پریشان کن معاملات کو حل کرسکتا / سکتی ہوں۔					
.97	میں جن چیزوں سے لطف اندوز ہوتا/ہوتی ہوں ان سے زیادہ سے زیادہ استفادہ کرنے کی کوشش کرتا / کرتی ہوں۔					
.98	دوسروں کا خیال ہے کہ مجھ میں اپنی بات منوانے کی کمی ہے۔					
.99	میں با آسانی خیالات کی دنیا سے نکل کر حقیقی دنیا میں واپس آ سکتا/سکتی ہوں۔					
.100	لوگوں کے خیال میں میں گھل مل جانے والا/والی (فرد) ہوں۔					
.101	میں اپنی شکل وصورت سے خوش ہوں۔					
.102	میرے لیئے اپنے احساسات کو بیان کرنا مشکل ہے۔					
.103	میرا غصہ بہت برا ہے۔					
.104	مسائل کو حل کرنے کیلئے مختلف طریقوں کے بارے میں سوچتے ہوئے عام طور پر میں اٹک جاتا/جاتی ہوں۔					
.105	میرے لیئے لوگوں کو اذیت میں دیکھنا مشکل ہے۔					
.106	مجھے لطف اندوز ہونا پسند ہے۔					

نمبر شمار	سوالات	بہت کم صحیح	شاذ و نادر صحیح	کبھی کبھار صحیح	اکثر صحیح	ہمیشہ صحیح
.107	مجھے ایسا لگتا ہے کہ لوگوں کو میری اتنی ضرورت نہیں ہوتی جتنی مجھے ان کی ہوتی ہے۔					
.108	میں بے چین ہو جاتا/جاتی ہوں۔					
.109	میں دوسروں کے احساسات کو ٹھیس پہنچانے سے گریز کرتا/کرتی ہوں۔					
.110	میں بہتر طور پر نہیں جانتا/جانتی کہ میں زندگی میں کیا کرنا چاہتا/چاہتی ہوں۔					
.111	اپنے حقوق کیلئے آواز اٹھانا میرے لیئے مشکل ہے۔					
.112	میرے لیئے چیزوں کو درست نقطۂ نظر میں رکھنا مشکل ہے۔					
.113	میں دوستوں کے ساتھ رابطہ نہیں رکھتا/رکھتی ہوں۔					
.114	اپنے اچھے اور برے پہلوؤں کو دیکھتے ہوئے میں اپنے بارے میں اچھا محسوس کرتا/کرتی ہوں۔					
.115	میں بہت آسانی سے غصے سے پھٹ پڑتا/پڑتی ہوں۔					
.116	اگر مجھے زبردستی گھر چھوڑنے پر مجبور کر دیا جائے تو میرے لیئے ماحول سے مطابقت اختیار کرنا مشکل ہوگا۔					
.117	کوئی بھی نیا کام شروع کرنے سے پہلے مجھے محسوس ہوتا ہے کہ میں ناکام ہو جاؤں گا/گی۔					