

Emotional Intelligence and Mental Health in Emerging Adulthood

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Abstract

Emerging adulthood involves rapid changes in education, identity, relationships, autonomy, and future roles. These transitions make adaptive emotional functioning particularly relevant to mental health. Emotional intelligence (EI) may support positive mental health by facilitating emotional awareness, understanding, regulation, interpersonal functioning, and coping. This study examined the association between EI and positive mental health among emerging adults and tested differences by age, sex, educational qualification, and place of residence. A cross-sectional correlational design was used with 200 emerging adults aged 18–25 years. Mental health was assessed using the Mental Health Status Scale and EI using the Emotional Intelligence Inventory. Pearson's correlations and independent-samples *t* tests were used. The results show that EI was positively associated with mental health, $r(198) = .323$, $p < .001$. Participants aged 21–25 years reported higher mental health, $t(198) = 2.00$, $p = .047$, $d = 0.28$, and EI, $t(198) = 3.21$, $p = .002$, $d = 0.46$, than those aged 18–20 years. Postgraduates reported higher EI than undergraduates, $t(198) = 2.08$, $p = .039$, $d = 0.30$, but did not differ in mental health. Gender and residence differences were not significant. EI is a meaningful correlate of positive mental health in emerging adulthood. Modest age and educational differences suggest possible developmental and experiential contributions to emotional competencies; however, longitudinal and intervention research is required before causal conclusions are warranted.

Keywords: *Emotional intelligence, positive mental health, emerging adulthood, young adults, and university students.*

Introduction

Emerging adulthood is a developmentally distinctive period during which individuals negotiate increasing autonomy while managing uncertainty in education, employment, identity, intimate relationships, and future roles. Arnett (2000) characterised this period, which broadly spans the late teens through the twenties, as one of exploration, instability, self-focus and possibilities. These features make emerging adulthood potentially growth-promoting, but they also expose young people to repeated demands for adjustments. University entry, changing peer networks, relocation, competitive examinations, financial concerns, family expectations, career decisions, and the formation or reorganisation of close relationships may occur within a relatively short period. Consequently, psychological resources that help young adults understand and manage emotional demands are highly relevant to mental health.

The mental health of university-age populations has become a major international concern. Contemporary evidence indicates substantial levels of depression, anxiety, and stress among university students, including in the post-pandemic period (Antón-Ruiz et al., 2026). Systematic reviews have also identified a broad range of psychosocial risk factors for poor mental health among undergraduates and emphasised the value of early identification and prevention (Sheldon et al., 2021). Importantly, mental health should not be reduced to the

absence of disorders. The World Health Organization (2022) conceptualises mental health as a state of well-being that enables individuals to cope with life stresses, realise their abilities, learn and work, and contribute to their communities. This positive functioning perspective is especially appropriate for non-clinical emerging adult samples because it captures adaptive functioning even in the absence of diagnosed psychopathology.

The present study approached mental health as positive psychological functioning rather than symptom burden alone. The Mental Health Status Scale used in this study assesses domains such as attitude toward the self, self-actualisation, integration, autonomy, perception of reality, and environmental mastery. This conceptualisation overlaps with longstanding eudaimonic approaches to psychological well-being, in which effective functioning involves self-acceptance, purposeful development, environmental competence, and autonomous regulation (Ryff, 1989). Such a framework is useful when the research question concerns resources that may support everyday adaptations.

Emotional intelligence (EI) is a psychological resource particularly relevant to this developmental period is emotional intelligence (EI). Salovey and Mayer (1990) initially described EI as involving the appraisal and expression of emotion, the regulation of emotion, and the use of emotion in adaptive action. The later ability model conceptualised EI as a set of capacities involving perceiving emotion, using emotion to facilitate thought, understanding emotional information, and managing emotions (Mayer et al., 2004, 2008). Other traditions conceptualise EI as trait-like self-perceptions or broader emotional and social competencies. These approaches are related but not interchangeable; the measurement method is important when interpreting findings (Joseph & Newman, 2010). The present study used a self-report inventory that captures personal, intrapersonal, and interpersonal emotional efficacy and is therefore best interpreted as perceived emotional competence rather than as a pure performance-based ability measure.

A coherent theoretical account linking EI and mental health can be built around emotion regulation. Emotions provide information about needs, threats, goals, relationships, and environmental requirements. Adaptive functioning depends not on eliminating negative emotions but on accurately identifying emotional states, understanding their meaning, selecting context-appropriate responses, and regulating their intensity or expression when necessary. Gross (2015) emphasised that emotion regulation is a dynamic process in which strategies differ in timing, function, and consequences. Individuals with stronger emotional competencies may be better able to label affective states, distinguish transient emotions from enduring problems, reappraise stressful situations, communicate their needs, inhibit impulsive reactions, and seek interpersonal support. These processes can support the components of positive mental health measured in the present study, including integration, autonomy, realistic perception, and environmental control.

Beyond intrapersonal regulation, the interpersonal component of EI may be particularly relevant in emerging adulthood. University students and young adults must increasingly manage reciprocal relationships with peers, teachers, employers, family members and intimate partners. Understanding emotional cues can facilitate empathy and communication, whereas emotion regulation can reduce escalation during interpersonal conflict. A sense of belonging may be one pathway that connects emotional competence to mental health. For example, Moeller et al. (2020) found that emotional intelligence and belongingness were meaningfully related to mental health outcomes in college students. These findings suggest that EI may influence mental health not only through intrapersonal regulation but also through the quality of social functioning.

The empirical literature broadly supports the EI–mental health association. Martins et al. (2010) reported a positive relationship between EI and health, with particularly meaningful associations for mental health. Sánchez-Álvarez et al. (2016) similarly found a positive meta-analytic association between EI and subjective well-being. In adolescents, EI has predicted psychological adjustment beyond personality and cognitive ability (Davis

& Humphrey, 2012), while prospective work has linked emotional clarity and repair to later adjustment (Salguero et al., 2012). More recent university research continues to support the relevance of emotional competencies. Acebes-Sánchez et al. (2025), studying 647 undergraduates, found that dimensions of trait EI statistically predicted mental health outcomes, with emotional clarity and repair playing prominent roles. A 2026 meta-analytic structural equation modelling study synthesising 257 studies further indicated that EI can be associated with mental health directly and through resilience and digital-addiction pathways (Karaköse et al., 2026). These findings reinforce the plausibility of EI as a psychological resource while also showing that the association is embedded in a wider network of coping, resilience, social, and behavioural processes.

In this context, the distinction between correlation and causation is crucial. Cross-sectional associations can show that people with higher EI report better mental health, but they cannot determine whether EI leads to better mental health. Better mental health may facilitate more effective emotional processing, or both variables may be influenced by personality, social support, socioeconomic conditions, family relationships, stress exposure, and other factors affecting emotional processing. Therefore, evidence of intervention is crucial. Systematic reviews indicate that psychosocial interventions can improve university students' mental health outcomes (Barnett et al., 2021; Muriago et al., 2026); however, the specific causal contribution of EI training requires appropriately controlled trials. Accordingly, this study treats EI as a correlate and potential resource rather than assuming a causal effect.

Demographic variation provides a second important line of enquiry. Emotional competencies may change across emerging adulthood as individuals accumulate interpersonal experience, face more complex role demands, and gain opportunities for self-reflection. Age differences may reflect developmental maturation, experience, or contextual exposure. Educational qualifications may also be associated with EI, as postgraduate students are typically older and have spent more time navigating academic and interpersonal demands than undergraduate students. However, age and educational level are often confounded, making causal interpretation difficult, particularly in cross-sectional analyses based on bivariate comparisons, as in this study.

Findings on gender differences in EI are inconsistent. Some studies report higher scores for women on emotional attention or empathy, while others find small or inconsistent differences depending on whether EI is measured as an ability, trait, or self-perceived competence. Joseph and Newman (2010) demonstrated the importance of the measurement model in interpreting EI findings. Recent work has also shown that the pathways from EI to well-being may differ by gender in some samples (e.g., Chen et al., 2026), but such differences should not be presumed to be universal or biologically fixed. Socialisation, reporting styles, cultural norms, and measurement characteristics may all contribute to this.

Place of residence is potentially relevant in India because urban and rural environments differ in terms of educational opportunities, access to services, family structure, social networks, and exposure to changing cultural expectations. However, the binary urban-rural distinction is broad and may conceal substantial within-group diversity. Therefore, residence may show little association with EI or mental health when more proximal factors such as socioeconomic resources, family support, and stress exposure are not measured.

The Indian context warrants focused attention to this issue. Emerging adulthood in India often unfolds within family systems in which autonomy develops alongside continuing interdependence and parental involvement. Educational competition delays economic independence, family expectations, and rapidly changing social environments, which may shape both emotional demands and mental health. Despite this relevance, the EI–mental health literature remains disproportionately based on Western samples, and Indian evidence is less extensive. Locally standardised measures may also capture culturally familiar expressions of emotional and psychological functioning that are not identical to the constructs assessed by Western instruments. Accordingly,

this study examined the association between emotional intelligence and positive mental health among Indian emerging adults and explored the differences by age, sex, educational qualification, and place of residence.

Method

Design

This study employed a quantitative, cross-sectional correlational design. This design was appropriate for estimating the direction and magnitude of the association between EI and mental health and for comparing mean scores across demographic groups in a relatively large student sample, providing an efficient first step before more resource-intensive longitudinal or intervention studies are conducted. Because no variable was manipulated and measurements were obtained at one point in time, causal inference is not warranted.

Participants

The analysed sample comprised 200 emerging adults aged 18–25 years. The final demographic counts reported in the five result tables were internally consistent and summed to $N = 200$ for each grouping variable: 93 participants were aged 18–20 years and 107 were aged 21–25 years; 89 were women and 111 were men; 114 were undergraduates and 86 were postgraduates; and 119 resided in urban areas and 81 in rural areas.

Sampling

A proportionate stratified random sampling procedure was employed to obtain a sample that adequately represented the major subgroups of the target population. Eligible emerging adults aged 18–25 years were identified from the accessible student population and were stratified according to educational level (undergraduate/postgraduate) and academic programme. Within each stratum, we selected participants proportionately to that stratum's representation in the enrolment records. Students who were currently on leave or receiving psychiatric treatment were excluded from the study. This approach was adopted to improve sample representativeness and reduce sampling bias while ensuring adequate variation in demographic characteristics such as age, sex, educational qualification, and place of residence. The final sample comprised 200 emerging adults, including 111 males and 89 females, 93 participants aged 18–20 years and 107 aged 21–25 years, 114 undergraduates and 86 postgraduates, and 119 urban and 81 rural residents.

Measures

Mental health was assessed using the Mental Health Status Scale developed by Gireesan and Samanda Raj (1988). The measure conceptualises mental health as positive functioning across six domains: attitude toward the self, self-actualisation, integration, autonomy, perception of reality, and mastery of the environment. The test manual describes a 72-item scale with 12 items per domain and reports acceptable split-half and test-retest reliability estimates for the domains, along with evidence of criterion-related validity.

Emotional intelligence was assessed using the Emotional Intelligence Inventory developed by Sushma and Thomas (2003). The self-report inventory contains 50 items, including positively and negatively worded statements rated on a five-point response scale. It yields indices of personal, intrapersonal, interpersonal, and overall EI scores. The source manuscript reports a Cronbach's alpha of .88 and corrected split-half reliability of .864 in the standardisation sample, together with evidence of concurrent validity. However, as a self-report inventory, the measure may be influenced by social desirability and shared method variance with self-reported mental health, which should be considered when interpreting the strength of associations.

A personal information schedule recorded demographic characteristics, including age, sex, educational qualifications, and place of residence.

Procedure

Prior to data collection, all necessary permissions were obtained from relevant institutional authorities. Participants who met the eligibility criteria were informed of the purpose and nature of the study, and informed consent was obtained prior to participation. They were assured that participation was voluntary and that their responses would be kept confidential and used only for research. The demographic information schedule, Mental Health Status Scale, and Emotional Intelligence Inventory were administered according to standardised instructions. Participants were given sufficient time to complete the measures, and their completed responses were subsequently coded, screened, and subjected to statistical analysis.

Statistical analysis

Pearson's product-moment correlation was used to test the association between EI and mental health variables. Independent-samples t-tests were used for two-group demographic comparison.

Results

Table 1

Pearson correlation between mental health and emotional intelligence among emerging adults (N = 200)

Variable	Emotional Intelligence
Mental Health	.323***

Note. *** $p < .001$.

A Pearson product-moment correlation showed a significant positive association between emotional intelligence and mental health ($r(198) = .323, p < .001$). Thus, emerging adults with higher emotional intelligence tend to report better mental health. The effect was small to moderate in magnitude, with the two variables sharing approximately 10.4% of their variance ($r^2 = .104$). Therefore, the hypothesis proposing a significant relationship between emotional intelligence and mental health was supported in this study.

Table 2

Mean, standard deviation, and independent-samples t-test results by age group

Variable	age	n	M	SD	t	p
Mental Health	18–20	93	78.42	11.90	2.00	.047
	21–25	107	82.52	16.40		
Emotional Intelligence	18–20	93	159.68	25.90	3.21	.002
	21–25	107	170.11	19.90		

Note: * $p < .05$. *** $p < .01$.

Participants aged 21–25 years ($M = 82.52, SD = 16.40$) reported significantly higher mental health scores than those aged 18–20 years ($M = 78.42, SD = 11.90, t(198) = 2.00, p = .047$). Similarly, participants aged 21–25 years ($M = 170.11, SD = 19.90$) demonstrated significantly higher emotional intelligence than participants aged 18–20 years ($M = 159.68, SD = 25.90; t(198) = 3.21, p = .002$). Thus, age group differences were statistically

significant for both mental health and emotional intelligence, with the 21–25-year group obtaining higher mean scores on both variables.

Table 3

Mean, standard deviation, and independent-samples t-test results by sex

Variable	sex	n	M	SD	t	p
Mental Health	Female	89	80.68	13.51	0.28	.777
	Male	111	80.08	15.83		
Emotional Intelligence	Female	89	162.64	23.78	-1.62	.106
	Male	111	168.08	23.33		

There was no significant sex difference in mental health between female ($M = 80.68$, $SD = 13.51$) and male ($M = 80.08$, $SD = 15.83$) participants ($t(198) = 0.28$, $p = .777$). Similarly, emotional intelligence did not differ significantly between female ($M = 162.64$, $SD = 23.78$) and male ($M = 168.08$, $SD = 23.33$) participants ($t(198) = -1.62$, $p = .106$). Thus, sex was not significantly associated with mental health or emotional intelligence.

Table 4

Mean, standard deviation, and independent-samples t-test results by educational qualification

Variable	education	n	M	SD	t	p
Mental Health	UG	114	79.25	14.27	-1.13	.259
	PG	86	81.58	14.63		
Emotional Intelligence	UG	114	161.14	25.36	-2.08	.039*
	PG	86	168.02	19.84		

Note: * $p < .05$

Undergraduate participants ($M = 79.25$, $SD = 14.27$) did not differ significantly from postgraduate participants ($M = 81.58$, $SD = 14.63$) in terms of mental health ($t(198) = -1.13$, $p = .259$). However, postgraduate participants ($M = 168.02$, $SD = 19.84$) reported significantly higher emotional intelligence than undergraduate participants ($M = 161.14$, $SD = 25.36$) ($t(198) = -2.08$, $p = .039$). Thus, educational qualifications were significantly associated with emotional intelligence but not with mental health.

Table 5

Mean, standard deviation, and independent-samples t-test results by place of residence

Variable	residence	n	M	SD	t	p
Mental Health	Urban	119	80.00	14.22	-0.36	.722
	Rural	81	80.74	14.65		
Emotional Intelligence	Urban	119	165.81	21.41	0.51	.613
	Rural	81	164.13	25.21		

There was no significant difference in mental health between urban ($M = 80.00$, $SD = 14.22$) and rural participants ($M = 80.74$, $SD = 14.65$; $t(198) = -0.36$, $p = .722$). Similarly, emotional intelligence did not differ significantly between urban ($M = 165.81$, $SD = 21.41$) and rural participants ($M = 164.13$, $SD = 25.21$; $t(198) =$

0.51, $p = .613$). Therefore, place of residence was not significantly associated with mental health or emotional intelligence in this study.

Discussion

This study examined the relationship between emotional intelligence and positive mental health among emerging adults and evaluated the differences by age, sex, educational qualification, and place of residence. After correcting the inferential discrepancies in the original tables, four findings were central. First, EI was significantly and positively associated with mental health. Second, participants aged 21–25 years reported higher EI and modestly higher mental health than those aged 18–20. Third, postgraduates reported higher EI than undergraduates, although the groups did not differ in terms of mental health. Fourth, sex and place of residence were not significantly associated with either of the outcomes.

The positive association between EI and mental health supports the study's primary theoretical proposition. Emotional competencies may facilitate adaptive functioning because they help individuals identify affective states, understand emotional causes and consequences, regulate responses, communicate effectively, and mobilise interpersonal support. These capacities plausibly map onto the positive mental health domains assessed in the study. For example, effective emotional regulation may support integration and environmental mastery; accurate perception of one's own emotional states may facilitate realistic self-appraisal; and interpersonal emotional competence may improve the management of social demands.

This finding is consistent with earlier meta-analytic evidence. Martins et al. (2010) reported a robust association between EI and health, particularly mental health, while Sánchez-Álvarez et al. (2016) found that EI was positively related to subjective well-being. The present result also converges with more recent university research. Moeller et al. (2020) linked emotional intelligence and belongingness to college student mental health, highlighting interpersonal integration as a possible pathway. Acebes-Sánchez et al. (2025) found that trait EI dimensions statistically predicted mental health outcomes in undergraduates, especially emotional clarity and repair. Most recently, Karaköse et al. (2026) synthesised 257 studies using meta-analytic structural equation modelling and reported that EI was connected with mental health both directly and through resilience and digital-addiction pathways. Taken together, these studies suggest that EI is not an isolated correlate but part of a broader system of emotional, interpersonal, and behavioural adaptation.

Simultaneously, the effect size in this study requires disciplined interpretation. A correlation of .323 indicates a small-to-moderate relationship with approximately 10.4% of shared variance. This is meaningful in psychological research but clearly shows that EI is only one component of mental health. The remaining variance may reflect personality, stress exposure, family functioning, socioeconomic resources, physical health, sleep, social support, academic pressure, prior adversity, and other unmeasured factors. Therefore, the results should not be interpreted as evidence that EI determines mental health outcomes.

The age findings are noteworthy. Participants aged 21–25 years scored higher on EI than those aged 18–20 years, with a small-to-moderate effect. This pattern is compatible with the possibility that emotional competencies develop through repeated interpersonal experiences, increasing autonomy, and exposure to complex educational and occupational demands. Emerging adulthood is not psychologically uniform; the early years may involve abrupt transitions from highly structured school and family environments, whereas later emerging adulthood may bring greater experience in managing relationships, decisions, and setbacks. Emotional learning could accumulate across this period.

The older group also reported significantly higher positive mental health, although the effect was small and the p -value (.047) was close to the conventional .05 threshold. This finding should be treated as provisional

rather than as evidence of a robust developmental increase. The older and younger groups may differ in terms of educational status, social experience, financial circumstances, or selection into postgraduate education. Without longitudinal data or multivariable adjustment, the study could not separate maturation from cohort and contextual effects.

Educational qualifications produced a more selective pattern of results. Postgraduates reported significantly higher EI than undergraduates, with a small effect; however, the groups did not differ in mental health. One interpretation is that postgraduate students have had more opportunities to develop emotional competencies through age, academic experience, collaborative work, decision-making, and repeated exposure to evaluative and interpersonal challenges. However, educational qualifications are strongly intertwined with age, and the present analysis does not isolate their independent contributions. Therefore, it would be inappropriate to conclude that postgraduate education increases the EI.

The absence of a significant sex difference in mental health is important, as in the present sample, women and men had almost identical mental health means, and the effect size was negligible. The EI was numerically higher among men, but the difference was small and non-significant. These findings underscore the measurement-sensitive nature of sex differences in EI. Ability tests, trait measures, and broad self-report inventories do not necessarily yield the same patterns (Joseph & Newman, 2010). Socialisation may influence emotional attention, expression, and self-reporting differently than actual regulatory ability. Accordingly, the present findings should be reported as sample-specific evidence of no statistically reliable gender differences rather than as proof that gender never matters.

The lack of urban-rural differences similarly suggests caution against broad demographic assumptions in the study. Urban and rural participants had nearly identical mental health and EI scores. Place of residence is a distal contextual marker and not a direct measure of psychosocial resources. Urban and rural emerging adults may overlap substantially in terms of educational exposure, digital connectivity, mobility, peer networks, and family support. However, meaningful inequalities may exist within both categories. Future research should measure more proximal contextual variables such as socioeconomic status, access to mental health services, family cohesion, perceived discrimination, social support, and educational opportunities.

The findings are relevant to contemporary concerns about university mental health. A 2026 systematic review and meta-analysis found a substantial post-pandemic prevalence of depression, anxiety, and stress among university students internationally (Antón-Ruiz et al., 2026). Although the present study measured positive mental health rather than psychiatric symptoms, the broader evidence underscores the need for preventive resources that strengthen adaptive functioning before severe distress develops. EI is a plausible target because emotional skills are potentially teachable and can be incorporated into psychoeducation, counselling, peer support, and life-skills programs.

Limitations

First, the cross-sectional design precludes causal inference and the establishment of temporal ordering. Second, both primary variables were assessed using self-reports, raising the possibility of shared method variance, social desirability, and self-perception bias. Third, the available documentation does not permit the independent verification of the stated simple random sampling procedure. Fourth, the study did not statistically control for potential confounders, and age and educational qualifications may overlap. Fifth, the broad urban-rural classification may be insensitive to more meaningful contextual variations. Sixth, the available source text contains an inconsistency in the reported scoring range of the Mental Health Status Scale. Because this range is incompatible with the documented 72-item structure and the observed scores, it was removed from this study. The

original scoring manual and raw dataset should be checked before the submission. Finally, current-sample reliability coefficients and assumption diagnostics could not be calculated without participant-level data.

Future research

Future research should address these limitations using longitudinal, multisite designs and larger, more diverse Indian samples. Multivariate analyses were conducted to determine whether EI remained associated with positive mental health after adjusting for age, education, personality, socioeconomic status, stress, social support, and family functioning. Mediation models were used to examine whether coping, resilience, belongingness, or emotion regulation explained this association. Experimental studies could test whether structured emotional skills interventions produce changes in both EI and mental health outcomes. Mixed-methods research may also clarify how emerging adults understand emotional competence within culturally specific family and educational contexts.

Implications

Within higher education, the findings support the importance of emotional competence as part of preventive mental health promotion. Younger students entering university may particularly benefit from transition-oriented programs that address emotional awareness, stress appraisal, communication, and help-seeking behaviours. The postgraduate EI advantage should not be interpreted as a deficit label for undergraduates; rather, it may indicate that emotional competence develops with experience and can be supported earlier than previously thought. Because sex and residence did not differentiate outcomes, universal programs with needs-based intensification may be more appropriate than demographic targeting based on assumptions.

Conclusion

Emotional intelligence is positively associated with positive mental health in emerging adults. Participants aged 21–25 years reported higher EI and slightly higher mental health than those aged 18–20 years, while postgraduates reported modestly higher EI than undergraduates did. Sex and place of residence were not significantly associated with either of the outcomes. The corrected statistical results provide a coherent evidence base and strengthen the internal rigor of this manuscript. EI appears to be a meaningful psychological correlate of adaptive functioning during emerging adulthood; however, its causal role remains unclear. With the verification of the original scale scoring, raw data analyses, and ethics documentation, this study can make a focused contribution to the literature on emotional competencies and mental health in an underrepresented cultural context.

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