THEORETHICAL ORIENTATION
CHAPTER - 2
THEORETICAL ORIENTATION

Before undertaking research in any field of social science, it is of paramount importance to explain clearly the concepts underlying the work. Defining and elaborating the concepts is an essential element in research and formulation of hypotheses. Statistical analysis of data and interpretation of the results is not possible unless the concepts are clear. The concepts used in the present study are as follows:

2.1 Quality of Life

There has been an increasing interest in the concept of the quality of life of people. The numerous problems faced by women call for an extensive research on their quality of life. There is perhaps no single group that illustrates better, the combined impact of poverty, stress, role conflicts on health and quality of life, than women.

Lyndon Johnson is credited with being the first person to use the phrase ‘Quality of life’ to express the view that having a good life was more than being financially secure. Since his speech at Madison Square Garden in 1964, this phrase has been globally used in a variety of contexts ranging from environment to health (Blan, 1977).

Different definitions have been proposed to explain the concept of quality of life. Quality of life has been considered as an abstract and complex response to physical and social forces which contribute to normal living.

The word ‘Quality’ is of Latin origin from the root word "Qualis" meaning “of what kind” (Webster, 1986). The same dictionary defines “Quality” as the “degree of excellence”, “a special distinguishing attribute” or “high social status”. Definitions of “life” include the course of existence or the manner of their living. Quality of life thus, represents a broad spectrum of human experiences. It ranges from the necessities of life...
Theoretical Orientation...

such as food and shelter, to those associated with achieving a sense and personal happiness.

Quality of Life is an area of study that has attracted a great deal of interest over the past ten years, particularly in the areas of health and social services, but increasingly in medicine, education, and others.

The study of Quality of Life is an examination of factors that contribute to the goodness and meaning of life, people's happiness, and also exploration of the inter-relationships among these factors.

The ideological thrust of quality of life study is to promote means for people, within heir environments, to live in ways that are best for them. The ultimate goal of quality of life study and its subsequent application to people's lives is to enable them to live quality lives i.e., lives that are both meaningful and enjoyable (Quality of Life Research Unit, University of Toronto).

It tends to cover a variety of areas such as physical and psychological complaints, feeling of well-being, personal functioning and general limitations (Blan, 1977). Different definitions have been proposed to explain the concept of quality of life. Quality of life has been considered as an abstract and complex response to physical, mental and social forces which contribute to normal living.

Campbell and Converse (1970), Andrews and Withney (1976), Najman and Levin (1981) considered quality of life as a composite measure of physical, mental, and social well-being as perceived by each individual and happiness, satisfaction, gratification involving life concerns like health, marriage, family, education, opportunities, financial situation, creativity and so on. So it refers to the overall satisfaction as well as the satisfaction in component areas.

According to McCall (1975), quality of life consists of obtaining the necessary conditions for happiness in a given society or region.

Rezsohazy (1978) defined quality of life by calling it “as ways of life and considered it as life style, as an overall behavior resultant of occasions occurring daily (at
Horquist (1982) defined quality of life in terms of satisfaction of needs in the physical, psychological, social, activity, material and structural realms. Besides, it has been considered as the capacity of an individual to realize his/her life plans or the difference, at a particular period in time, between the hopes and expectations of the individual’s present experience. Quality of life is a multifaceted construct that encompasses the individual’s behavioral, cognitive capacities, emotional well-being and abilities requiring the performance of domestic, vocational and social roles.

According to Diener et al. (1985), “life satisfaction refers to an individual’s personal judgment of well-being and quality of life based on his or her own chosen criteria”.

Dubey, Dwivedi, and Verma (1988), Kassa, Mastekassa, and Naess (1988) stated that quality of life means the degree of excellence of one’s life that contributes to satisfaction and happiness and benefits mental health.

Patrick and Erickson (1992) defined quality of life “as the level of well-being and satisfaction associated with events or conditions in a person’s life as influenced by disease, accidents or treatments”.

Meeberg (1993) identified four critical attributes of quality of life from a review of literature: (i) a feeling of satisfaction with one’s life in general, (ii) the mental capacity to evaluate one’s own life as satisfactory or otherwise, (iii) an acceptable state of physical, mental, social and emotional health as determined by the individual, and (iv) an objective assessment by another that the person’s living conditions are adequate and not life threatening.

World Health Quality of Life (QOL) was set up for health promotion in response to a request by the Ontario Ministry of Community and Social Services as a model and instrumentation for assessing QOL among persons with developmental disabilities. The project developed quickly and in 1994, the quality of life research unit was established.
According to Wilson and Clearly (1995), Health-related quality of life (HRQL) is an individual’s satisfaction or happiness with domains of life insofar as they affect or are affected by “health” as defined: Health status is an individual’s relative level of wellness and illness, taking into account the presence of biological or physiological dysfunction, symptoms, and functional impairment. Health perceptions (or perceived health status) are subjective ratings by the affected individual of his or her health status. Some people perceive themselves as healthy despite suffering from one or more chronic diseases, while others perceive themselves as ill when no objective evidence of disease can be found.

WHO (1995) defined quality of life as “An individual’s perception of his/her position in life in the context of culture and value system in which they live and in relation to their goals, expectations, standards and concerns. It is a broad ranging concept incorporating a complex way in which the person’s physical health, psychological state, level of independence, social relationships, personal beliefs and their relationships are adapted to the salient features of the environment”.

According to Spilker (1996), quality of life has emerged as a broad term describing this domain of measurement (e.g., patient’s experiences in such areas of function as mobility, mood, life satisfaction, sexuality, cognition and ability to fulfill occupational, social and family roles). The QOL construct may be viewed as a paradigm shift since it shifts the focus of attention from symptoms to functioning and establishes the primacy or at least the legitimacy of the patient perspective.

Ulisky (2001) opined that quality of life (QOL) is a measure of an individual’s physical, functional, emotional, and social well-being. He also maintained that what is important to one person in terms of QOL, might not be as important to another person.

Quality of life has combined the multiple meaning, consisting of objective and subjective factors and considers the evaluation of the individuals on the basis of his comfort. There are two views for meaning and measuring the quality of life, one is life satisfaction methods and second is adjustment methods.
Definition of quality of life according the Word Net Dictionary (2002) is “Your personal satisfaction (or dissatisfaction) with the cultural or intellectual conditions of life (as distinct from material comfort)".

According to Biology Dictionary (2002), it is a reference to the well-being of a patient. There are three major components of the quality of life, 1) health: disease and body functions, 2) socioeconomic status, and 3) functional status: physical, social, mental and sexual behavior, daily activities.

According to the Quality of Life Research Unit (2004), the quality of life is related to communities, families, and individual from a variety of population groups. The study of quality of life is an examination of factors that contribute to the goodness and well being of life, as well as people’s happiness. It also explores the inter-relationships among these factors. The ideological thrust of quality of life study is to promote means for the people, within their environments, to live in the way that is best for them.

Good health, sufficient income and a family are the three main factors contributing to a good life for the majority of Europeans. With the latter giving relatively more importance to having enough leisure time to enjoy life. Those aged 65 and over place more emphasis on having less children and good relations with neighbors than those under 25 who regard seeing friends and having a holiday as more important. The younger generation appears to have an increasingly harmonized perspective of what it takes to lead a good life.

Verwayen (1978) reported that The Organization for Economic Cooperation and Development, Paris, had initiated Social Indicator Development Program in some of the countries to measure quality of life on the assumption that similarities of well-being and methodological principles of these surveys will be constant for all the countries under study. The areas that had been selected for this intensive work were:

1. Healthfulness of life
2. Measurement of learning
3. Employment
4. Quality of working life
5. Time and leisure
6. Income, wealth, and material deprivation
7. Housing condition
8. Quality of the natural environment
9. Measurement of victimization
10. Inequality
11. Economic accessibility
12. Comprehensive survey
13. Methodological issues in data collection
14. Presentation of social indicators and statistics, and
15. Applicability of selected social concern and indicators to particular national contents.

Flanagan (1978) explained dimensions of quality of life as follows:

Table 3: Flanagan’s Domains of QOL (1978)

<table>
<thead>
<tr>
<th>Physical and material well-being</th>
<th>Material well-being and financial security</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Health and personal safety</td>
</tr>
<tr>
<td>Relations with other people</td>
<td>Relations with spouse having and rearing children</td>
</tr>
<tr>
<td></td>
<td>Relations with parents, siblings, or other relatives</td>
</tr>
<tr>
<td></td>
<td>Relations with friends</td>
</tr>
<tr>
<td>Social, community, civil activities</td>
<td>Helping and encouraging others</td>
</tr>
<tr>
<td></td>
<td>Participating in local and governmental affairs</td>
</tr>
<tr>
<td>Personal development, fulfillment</td>
<td>Intellectual development understanding and planning occupational role career</td>
</tr>
<tr>
<td></td>
<td>Creativity and personal expression</td>
</tr>
<tr>
<td>Recreation</td>
<td>Socializing with others i.e., passive and observational recreational activities</td>
</tr>
<tr>
<td></td>
<td>Participating in active recreation</td>
</tr>
</tbody>
</table>
Table 4: Domains of QOL (1989) according to Health Promotion (Department of Public Health Sciences, University of Toronto)

<table>
<thead>
<tr>
<th>Being</th>
<th>Who one is</th>
</tr>
</thead>
</table>
| Physical Being | physical health  
|             | personal hygiene  
|             | nutrition  
|             | exercise  
|             | grooming and clothing  
|             | general physical appearance |
| Psychological Being | psychological health and adjustment  
|             | cognitions  
|             | feelings  
|             | self-esteem, self-concept and self-control |
| Spiritual Being | personal values  
|             | personal standards of conduct  
|             | spiritual beliefs |
| Belonging   | Connections with one's environments |
| Physical Belonging | Hate, 1969, home  
|             | workplace/school  
|             | neighborhood  
|             | community |
| Social Belonging | intimate others  
|             | family  
|             | friends  
|             | co-workers  
|             | neighborhood and community |
| Community Belonging | adequate income  
|             | health and social services  
|             | employment  
|             | educational programs  
|             | recreational programs  
|             | community events and activities |
| Becoming    | Achieving personal goals, hopes, and aspirations |
| Practical Becoming | domestic activities  
|             | paid work  
|             | school or volunteer activities  
|             | seeing to health or social needs |
| Leisure Becoming | activities that promote relaxation and stress reduction |
| Growth Becoming | activities that promote the maintenance or improvement of knowledge and skills  
|             | adapting to change |

24
In measuring the quality of life some believed that the subjective factor in comparison to the objective factor can measure better the comfort of patients (Thapa and Rowland, 1989).

The extent of a person’s Quality of Life in the areas of Being, Belonging, and Becoming and their sub-domains is determined by two factors: importance and enjoyment. Thus, Quality of Life consists of the relative importance or meaning attached to each particular dimension and the extent of the person’s enjoyment with respect to each dimension. In this way, quality of life is adapted to the lives of all humans, at any time, and from their individual perspectives.

Sell and Nagpal (1992) identified eleven domains of quality of life which included positive and negative well-being, transcendence, family group support, social support, social contacts, expectation-achievement congruence, mental mastery, competence in coping, primary group concern and perceived health.

Quality of life, thus, may be considered as the degree of excellence with which an individual can face the various problems of life and acts in such a way that may result in satisfaction and happiness of an individual, and society as a whole. No doubt, it is a difficult area to define, as many of the factors may be ill-defined inter-related and to some extent interdependent also.

Quality of life has been seen as consisting of obtaining of the necessary conditions for happiness in a given society or region. Another method of trying to understand the concept of quality of life is to consider the many different measures of perceived life quality that have been developed, for instance family life, money, amount of fun, health, friends, sex life, social standards, time to do things and getting a good job. Investigators have stressed that quality of life can be evaluated by taking a number of aspects of a person’s life and assessing that person’s subjective feelings of happiness or unhappiness about the various life concerns. Jenkins (1992) suggested that quality of life research is now in the stage of conceptual development.
Besides, factors like socio-cultural milieu, perception about the stressful life event and the response to it, financial consequences of stressful life events, the available social support and personality of the person can influence his/her quality of life.

Quality of life can be affected by a number of significant positive and negative life events. The factors contributing to the quality of life of an individual may be broadly classified under two groups: (i) satisfactory conditions: These include factors like group cohesiveness, sharing of each other’s experience, helping attitudes, understanding and sharing each others problems, absence of conflicts among members, absence of mental or severe physical illness etc; (ii) satisfying conditions: These include factors like sense of belongingness, subjective feelings of physical, psychological, mental, social and spiritual well-being, absence of unhappy experiences within the family, etc.

Long-term unemployment is still the most detrimental factor for quality of life. Social integration and life satisfaction is improved when a high level of employment coincides with high quality jobs. Overall results support an integrated employment policy: higher employment rates, better quality jobs combined with family-friendly activities.

Unemployment has a negative effect on satisfaction. This suggests that it is not only the lack of income that matters to the unemployed but the lack of a job as such. The fight against unemployment is perceived to be one of the most important measures required to improve family life and boost fertility rates, surpassing all other traditional social assistance measures.

Although employed are more satisfied than unemployed, the quality of job is important because difficult working conditions have a detrimental effect on several areas of satisfaction. Those who work overtime, in high intensity jobs, or in jobs that are physically or psychologically demanding, report lower satisfaction levels than those who work under favorable conditions.

In the present study, quality of life was taken as consisting of a number of aspects of a person’s life satisfaction, job satisfaction, marital adjustment, physical health, psychological health, social relationships, and good income.
2.2 **Hardiness**

The concept of individual hardiness was originally developed by existential psychologists (e.g., Fromm, 1947; Allport, 1955; Kobasa and Maddi, 1977) to describe individuals who continuously rise to their life challenges and turn stressful experiences into opportunities for personal growth (Kobasa, Maddi, and Kahn, 1982). Kobasa et al. (1982) describe hardiness as significantly influencing how people cope with stressful events. Hardiness is a term that was first identified in the literature describing personal resilience in terms of the health status of individuals (Kobasa, 1979). Kobasa and her colleagues argued that the ability to be resilient increases individuals' chances for physical and psychological health. Resiliency, as defined by Bartone et al. (1989), involves the capability to recover after a stressful encounter and to make quick adjustments through coping. In this context, hardiness also describes the ability to cope. On the other hand, the absence of resilience may be characterized by increased levels of risk factors to physiological and psychological well being (Kobasa, Maddi, and Kahn, 1982; Banks and Gannon, 1988; McCubbin and McCubbin, 1992).

According to Kobasa (1979), hardy persons are considered to possess three general characteristics: (a) the belief that they can control or influence the events of their experience, (b) an ability to feel deeply involved in or committed to the activities of their lives, and (c) the anticipation of change as an exciting challenge to further development.

Hardiness also represents the ability of an individual to face difficult conditions with absolute courage (Bartone, Ursano, Wright, and Ingraham, 1989; Williams, Weibe, and Smith, 1992; Funk, 1992).

Emerging from the medical literature, the concept of hardiness was first identified by Kobasa as a resistance factor in the late 1970's. Initially used to examine the relationship between health and stress (Jennings and Staggers, 1994), Kobasa's (1979a, 1979b) preliminary findings revealed that individuals who experienced high levels of stress, but remained healthy had a different personality structure than individuals who experienced high levels of stress and became ill. The central domain of this personality structure, labeled hardiness, was subsequently defined as, "the use of ego resources necessary to appraise, interpret, and respond to health stressors" (Pollock, 1989).
Following this, the term continued to be employed by management theorists in their examination of the links between stress and health (Low, 1996). Although it continues to be employed most frequently in the contexts of medicine and illness (Pollock, 1989; Jennings and Staggers, 1994), researchers are beginning to conceptualize hardiness as a general health promoting factor (Bigbee, 1985), which enables individuals to remain both psychologically and physically healthy despite confrontations with stressful situations or experiences (Kobasa, Maddi, and Kahn, 1982).

Kobasa (1979a, b) found that there were two different patterns in the way executives responded to the stress. People in one group became increasingly symptomatic. They had more medical and psychological problems and symptoms and more visits to doctors. In contrast, the second group showed no difference in symptoms during this stressful period as compared to before its onset. Surprisingly, they seemed healthier and more robust. They essentially rose to meet the challenge. Kobasa referred to this second group as having a stress-hardy personality.

Hardiness is considered as the measure of one’s tendency to make relationship to oneself and one’s outside world. It is not mere rigidity or stress "endurance", but power to cultivate one’s way under difficult conditions and go through stressful events such as changing one’s value, social status, income, or one’s total life by understanding the emotion mental conditions and making a decision. It is necessary to have stress-overcoming personality trait for effective performance.

Theoretically, hardiness develops in early childhood and emerges as the result of rich, varied, and rewarding life experiences (Maddi and Kobasa, 1984). According to Kobasa (1979a), the effects of hardiness on mental health are mediated by the individual’s cognitive appraisal of a stressful situation and his/her repertoire of coping strategies. Specifically, hardiness alters two appraisal components: it reduces the appraisal of threat and increases one’s expectations that coping efforts will be successful (Tartasky, 1993). Hardiness has also been shown to be associated with the individual’s use of active, problem-focused coping strategies for dealing with stressful events (Kobasa, 1982; Gentry and Kobasa, 1984). These two mechanisms are, in turn, hypothesized to reduce the amount of psychological distress one experiences and to contribute to the long-term psychological well-being of an individual.
Hardiness alters the individual's cognitive appraisal process, such that individuals are able to reframe or reinterpret adverse experiences (Pollock, 1989; Williams et al. 1992; Tartasky, 1993).

Hardiness is concerned with a variety of resistance resources available to the individual who can neutralize the otherwise debilitating effects of stress (Kobasa 1979; Kobasa et al. 1982). The psychological component of hardiness is referred to specifically as "cognitive hardiness". Kobasa (1979) considered that people capable of handling highly stressful, conditions have personality traits consisting of commitment, control and challenge, based on existential personality theories (Kobasa and Maddi, 1977). Commitment is the tendency to involve oneself fully in one's total life space. Control, including responsibility, is the tendency to believe and act as if one can influence the course of events within reasonable limits. Challenge is based on the belief that change rather than stability is the normative mode of life, anticipated as an opportunity for personal growth (Orr and Westman, 1990).

As indicated previously, hardiness is comprised of three sub related concepts: control, commitment, and challenge (Maddi and Khoshaba, 1994). Control, which is measured by the absence of powerlessness that an individual feels (Bigbee, 1985), refers to the belief that one can control or influence occurrences in one's life, that personal efforts can modify stressors so as to reduce them into a more manageable state (Maddi and Kobasa, 1984; Bigbee, 1985; Pollock, 1989; Wagnild and Young, 1991; Tartasky, 1993; Huang, 1995), or that a contingency exists between one's actions and external events (Sullivan, 1993).

The second dimension, commitment, is reflected in the ability to feel actively involved with others and a belief in the truth, value, and importance of one's self and one's experience (Wagnild and Young, 1991; Tartasky, 1993; Huang, 1995). Adverse situations are ultimately seen as meaningful and interesting (Maddi and Kobasa, 1984). Individuals high on this dimension are committed to various aspects of their life including interpersonal relationships, family, and the self (Low, 1996). Measured or indicated by the absence of alienation (Bigbee, 1985), commitment is reflected in one's capacity to become involved, rather than feeling estranged. From an existential point of view, this dimension represents a fundamental sense of one's worth, purpose, and
accountability, which protects against weakness while under adversity (Bigbee, 1985; Pollock, 1989; Sullivan, 1993).

The third dimension, challenge, reflects the belief that change is not a threat to personal security, but an opportunity for personal development and growth (Maddi and Kobasa, 1984; Bigbee, 1985; Pollock, 1989; Wagnild and Young, 1991; Tartasky, 1993; Huang, 1995). Indicated by the absence of a need for security, it represents the individual’s positive attitude toward change and the belief that one can profit from failure as well as success (Brooks, 1994). Fears surrounding potential mistakes and the feelings of embarrassment which are frequently a consequence of making them, present an obstacle to overcoming challenges and, thus, personal growth (Brooks, 1994). These fears frequently lead to avoidance behavior which perpetuates the fear and prevents the individual from confronting and overcoming the challenge. Fostering challenge can also be accomplished by asking oneself, “What can I learn from this experience?” Alternatively, employing the “bedtime nuggets” exercise could be used to review the difficult events of the day and to explore what each means with respect to personal growth. Among adults, studies conducted by Williams et al. (1992) and Florian et al. (1995) have provided that the dimensions of commitment and control positively contributed to mental health by way of cognitive appraisal and active coping resources. Interestingly, Sullivan (1993) notes that Kobasa’s concept of challenge describes an individual who has developed flexible coping styles.

There is some evidence that hardiness does moderate the effects of stress upon health. However, there is also argument about exactly which components of the hardiness construct are responsible for this effect. Some studies suggest that the commitment and control aspects have a more significant moderating effect on the stress-health link than that of challenge. However, in contrast to this hypothesis, Contrada (1989) found that it was the challenge component of hardiness, as opposed to control or commitment, which correlated with blood pressure reactivity.

According to Maddi (2000), Hardiness is an outcome of an individual’s ability to navigate professional and personal changes in a way that fulfills his and his employer’s goals, strengthens his ability to turn adversity to advantage, thus it deepens professional and personal relationships.
Comparison of the two figures 2 and 3 by Kobasa (1982) reveals very different conceptions of the role of hardiness and its sub-components in the stress–illness relation. In the first case, hardiness reduces the impact of stressful life events by increasing the use of successful coping strategies. In the second case, hardiness in the form of the committed personality decreases strain directly. It has indirect effects by decreasing the use of unsuccessful coping strategies.

**Fig. 2: The Buffering Effects of Hardiness: Kobasa and Puccetti (1983)**

```
Stressful Life Events ——> Strain ———-> Illness
Personality Hardiness ———> Successful Coping
                            ———> Use of Social Resources
```

**Fig. 3: Direct and Indirect Effects of Hardiness: Kobasa (1982)**

```
Stressful Life Events ———> Regressive Coping ———> Strain ———> Illness
Hardy Personality
```

Hall (1986) suggested that personality hardiness and its three components (commitment, control and challenge) buffered against illness suggesting that the subjects who were low on both hardiness and fitness were more susceptible to reporting a history of illness than subjects high on one or both of the variables. No relationship was found between reports of stressful life events stressors and psychological responses.

Solcova and Tomanek (1994) explored possible pathways through which hardiness might buffer against stress. Results indicated that hardiness might have a positive impact on an individual’s ability to:

1) Coping to resources in the sense that hardy people have more self-competence
2) Cognitive appraisal in their every day life and
3) Coping responses because hardy persons employ a higher level of coping strategies than less hardy persons.

Hardiness is defined as a combination of adaptive personality traits that allow one to overcome stressful life events (Weich and McCallum, 1986).

A hardy individual is defined as “bold and courageous,” “inured to fatigue,” and “capable of withstanding adverse conditions” (Neufeldt and Guralnik, 1988).

Kennett et al. (1989) argued that hardy persons are hypothesized to display commitment or involvement in daily activities, perceived control over life events, and tendency to view unexpected change or potential threat as a positive challenge rather than as an aversive event. Non-hardy persons in contrast, are hypothesized to display alienation (lack of commitment), external locus of control, and tendency to view change as undesirable. They argued that in high stress condition, high hardy individuals endorsed more positive self-statements than did low hardy persons. Furthermore, highly hardy subjects reported more positive self-statements in the high stress condition than did high hardy subjects in the low stress condition. In contrast, low hardy subjects reported fewer positive thoughts in the high stress condition than in the low stress condition.

According to Maddi (1990), persons high in commitment think of themselves and their environment as interesting and worthwhile and thus can find something in whatever they are doing that piques their curiosity and seems meaningful. Persons high in control believe that they can, through effort, have an influence on what goes on around them.
And persons high in challenge believe that what improves their lives is growth through learning rather than easy comfort and security.

Nakano (1990) examined the effect of hardiness and Type A Behavior (TAB) on the relationship between stressful life events (SLE) and physical and psychological well-being in 78 Japanese men (aged 36-47 years). He found that hardy subjects were less likely to have physical symptoms and depression. There was a significant interaction between stressful life events and Type A Behavior (TAB).

Psychologists have been attempting to isolate the components of the stress-hardy personality ever since then (Funk, 1992). The belief that if the approach to life used naturally by stress-hardy individuals incorporates mental and behavioral skills which can be taught to others, over time, the regular use of these skills can become effective healthy habits that can replace less functional ones. This is the foundation of hardiness for hard times.

A study by Lawler et al. (1992) on hardiness in women suggested that hardiness and locus of control buffered the effects of illness. Hardy individuals have the ability to cope in a way that is adaptive once stress and/or adversity is perceived (Williams et al. 1992; Tartasky, 1993). They prefer to rely on active, transformational coping strategies which act to cognitively transform a potentially negative event into a growth producing experience (Bigbee, 1985; Funk, 1992; Florian et al. 1995). Less hardy individuals who are more likely to engage in distancing, avoidance, and emotionally-focused coping, individuals who score high on hardiness measures are more likely to engage in problem-focused, active, and support-seeking coping strategies (Pollock, 1989; Williams et al. 1992). These latter coping strategies, in comparison to emotionally-focused coping (distancing) have typically been regarded as adaptive, since individuals engaging in problem-focused coping generally demonstrate fewer indications of distress and maladjustment (Cooper et al. 1988; Breslin et al. 1995; Evans and Dunn, 1995).

Amerikaner et al. (1994) suggested that hardiness and social interest are distinct dimensions of functioning. Psychological health (PH) was related to cohesion and satisfaction within family, good communication with parents and promotion of social involvement.
Carson (1994) suggested that hardiness of family as reported by both wives and husbands (in his sample of study) was positively correlated with their perceptions of quality of life. Solcova and Sykora (1995) concluded that individuals with less anxiety and high hardiness displayed reduced psychological response when encountered with a stressful situation.

According to Rush et al. (1995), psychological hardiness had a direct negative impact on stress and a direct positive impact on satisfaction.

Huang (1995) examined the relationship between hardiness and stress, through a critical review of definitions, concepts, and measures of hardiness. Individual and family hardiness are stress resilience resources, comprising of 4 dimensions which include, control, challenge, commitment, and confidence. Hardy persons are more likely to stay healthy and perceive life changes as positive and challenging, through cognitive appraisal. Hardiness facilitates family adjustment and adaptation. The concept of family hardiness should be incorporated into family stress theory.

Walsh (1996) discusses the concept of resilience as the ability to withstand and rebound from crisis and adversity by having valuable potential for research, intervention, and prevention approaches aiming to strengthen couples and families. The author advanced a systematic view of resilience in ecological and developmental contexts for both individuals and family hardiness.

Bayazi’s (1997) study was based on the relationship of hardiness and coronary heart disease among 60 heart coronary disease patients and 60 healthy persons. He suggested significant relationship between hardiness, stress and coronary heart disease, in the two groups. The women and men patients in the two groups showed more stress and less hardiness as compared to health people. This showed that the men had low level of stress and high level of hardiness as compared to women.

Hardiness aids people in coping with their individual jobs (Manning, Williams and Wolfe, 1988; Westman, 1990; Berwick, 1992), their personal daily hassles (Lee, 1991; Solcova and Tomanek, 1994), and their alcohol and drug use (Maddi, Wadhwa, and Haier, 1996).
Sinclair and Terrick (2000) suggested that hardiness is best conceptualized as a multi level and multi dimensional construct in which different facets obtain different relationships with health and performance criteria.

Shirkan (2000) describes hardy individuals as having the ability to endure and prevail over stressful situations. They use effective coping strategies in dealing with stressful situation, engaging in what is called transformation coping, which means they have ability to use the appropriate cognitive and behavioral skills to reduce the effects of stress and illness.

Research by Hardiness Institute (2004) has revealed that employees in the organizations high on hardiness are higher on performance; possess better leadership qualities, good moral conduct, and health. Thus, hardiness as a personality combined has implication for the functional, psychological, physical well-being of an individual.

Psychological hardiness, according to Sharma (2004), is the resistance we have to stress, anxiety, and depression. It includes the ability to withstand grief and accept the loss of one's loved ones which is critical for survival.

Psychological hardiness and the ability to creatively adapt to challenges, besides increasing the life span, also positively impacts relationships, family life, and work. Vaillant (2004) noted that psychologically healthy people are more adaptive and flexible. They tend to have the following: stable family life, satisfying marriage, steady progression in their careers, and an absence of any disabling mental or physical illness.

The above discussion suggests that hardiness is related to mental health, low depression and anxiety, and higher adjustment.

2.3 Self-Efficacy

The construct of self-efficacy, which was introduced by Bandura, represents one core aspect of his social-cognitive theory (Bandura, 1977, 1997). Bandura (1977) has defined self-efficacy as “the expectation that one can successfully execute the behavior required to obtain desired outcomes in a specific situation”. Feeling self-efficacious is related to successful adjustment to a host of negative life events. Feelings of efficacy
have been shown to lead to greater effort, motivation and perseverance in the face of an impressive array of negative life events (Bandura, 1989).

In nutshell, according to Bandura (1994) self-efficacy means “people’s beliefs about their capabilities to produce designated levels of performance that exercise influence over events that affect their lives”. Self-efficacy beliefs determine how people feel, think, motivate themselves and behave. Such beliefs produce these diverse effects through four major processes. They include cognitive, motivational, affective, and selection processes.

Self-efficacy has been defined as an individual’s beliefs about his performance capabilities in a particular domain (Woolfolk, 2001). The researchers report that an individual’s sense of self-efficacy is also related to achievement of goals (Pajares, Britness and Valiante, 2000) and attributions (Chase, 2001 and Sherman, 2002) and self-regulation (Joo, Bong, and Choi, 2000).

According to Corsini’s Encyclopedia of Psychology (2000), “Efficacy beliefs are the foundation of human agency. Unless people believe that they can produce desired results by their actions, they have little incentive to act or to preserve in the face of difficulties”.

Self-efficacy judgment is both more task and situation specific and individuals make use of this judgment in reference to some type of goal.

Flammer (2001) opines that self-efficacy refers to the individual’s capacity to produce important effects. People, who are aware of being able to make a difference, feel good and therefore take initiatives. People who perceive themselves as helpless are unhappy and not motivated for actions. It has been proved that the psychological effects of helplessness are different depending on whether the helpless persons believe themselves to be helpless forever, whether being helplessness is unique, and whether related to a specific domain or to most domains of life. In the worse case, helpless people are, deeply sad about not having control; are not motivated to take initiatives or to invest effort and perseverance; cognitively blind for any alternative or better view of the state of the world and, devaluate themselves.

Person who believes in being able to cause an event can have a more active and self-determined life course. This “can do”-cognition mirrors a sense of control over one’s
environment. It reflects the belief of being able to control challenging environmental demands by means of taking adaptive actions. It can be regarded as a self-confident view of one’s capability to deal with certain life stressors.

Bandura’s conceptualization of self-efficacy encompasses two components, efficacy expectations and outcome expectations. Efficacy expectations refer to one’s conviction that he or she can successfully produce the behaviors that will lead to a desired outcome, while outcome expectations refer to one’s belief that a particular course of action will produce a certain outcome (Bandura, 1977a). Efficacy expectations have an effect on one’s choice of settings, behaviors, and persistence (Bandura, 1997b). Those with low efficacy expectations are likely to avoid situations in which they feel unable to cope. Instead, they will seek out situations in which they feel that they will be able to handle. Persistence in producing behaviors is also affected by efficacy expectations. Individuals who have high levels of efficacy expectations will be more likely to persist with behaviors when they become difficult and will therefore be more likely to execute the behavior successfully which in turn increases their efficacy expectations even more (Bandura, 1998). On the other hand, individuals with low levels of efficacy expectations will be more likely to cease production of behaviors once the behaviors become difficult, which will in turn reinforce their already low efficacy expectations (Strauser, 1995; Strauser, Waldrop, Hamsley and Jenkins, 1998; Strauser, Waldrop, and Jenkins, 1998).

The concept of self-efficacy is this situation-specific meaning that one will have a range of both high and low self-efficacy expectations at one time depending on specific situation, task, or behavior (Sadri and Robertson, 1993).

Schaler (1995) reported self-efficacy as people’s confidence in their ability to achieve a specific goal in a specific situation. If people believe that they are powerless, they are likely to act in the powerless way.

Self-efficacy theory may be viewed as one approach to the more general study of the application of social learning or social cognitive theory to vocational behavior (Krumboltz, Mitchel, and Jones 1976; Mitchel and Krumboltz, 1984; Lent, Brown, and Hackett, 1994).
According to Hackett and Betz (1981), self-efficacy is mediated by a person's beliefs or expectations about his/her capacity to accomplish certain tasks successfully or demonstrate certain behaviors. When individuals have low self-efficacy expectations regarding their behavior, they limit the extent to which they participate in an endeavor and are more apt to give up at the first sign of difficulty. Their efficacy beliefs serve as barriers to their career development. Low self-efficacy beliefs of women are thought to reflect the limited and disadvantaged position women have in the workplace and the limited range of career options presented to them.

It is a construct based on cognitive and behavioral concepts that Bandura (1977b) describes as an individual's perception of his or her skills and abilities and whether the skills/abilities produce effective and competent actions. Self-efficacy influences perceptions of actions and coping behaviors and the choice of environments and situations in which the individual will attempt to access. Bandura (1998) states that there is a reciprocal relationship between cognitive process and behavior change in self-efficacy theory.

According to Albert Bandura’s Social Cognitive Theory (1986), “self-efficacy is belief in one’s capability to organize and execute the courses of action required to manage prospective situations containing many ambiguous, unpredictable, and often stressful elements”. On the other hand feeling inefficacious, in contrast has been associated with giving up more easily, with making more internal attributions for failure and with greater autonomic arousal and catecholamine secretion (Bandura, 1982).

Bandura (1986) has identified four main sources that seem to have influence upon the development of self-efficacy. These include mastery experiences, vicarious experience, social persuasions, and emotional and physiological states. Mastery experiences, the result of purposive performance, are the most influential source. People’s interpretation of the effects of their actions, help them to create their efficacy beliefs. Success raises self-efficacy; failure lowers it. The second source of efficacy information is vicarious experience of the effects produced by the actions of others. This source of information is weaker than enactive attainment, but, when people are uncertain about their own abilities or have limited prior experience, they become more sensitive to it. The effects of modeling are particularly relevant in this context. The third source,
Theoretical Orientation...

social persuasions, involves exposure to the verbal judgments of others and is a weak source of efficacy information, but persuaders can nonetheless play an important part in the development of an individual's self-beliefs. In addition to this, emotional and physiological states such as anxiety, stress, arousal, and fatigue also provide information about efficacy beliefs.

Some of the other important factors influencing self-efficacy are discussed below:

(i) Familial Influence on Self-Efficacy: Beginning in infancy, parents and caregivers provide experiences that differentially influence children's self-efficacy. Home influences that help children interact effectively with the environment positively affect self-efficacy (Bandura, 1997; Meece, 1997). Initial sources of self-efficacy are centered in the family, but the influence is bidirectional. Parents who provide an environment that stimulates youngsters' curiosity and allows for mastery experiences help to build children's self-efficacy. In turn, children who display more curiosity and exploratory activities promote parental responsiveness. When environments are rich in interesting activities that arouse children's curiosity and offer challenges that can be met, children are motivated to work on the activities and thereby learn new information and skills (Meece, 1997). As children grow, peers become increasingly important. Parents who steer their children toward efficacious peers provide further vicarious boosts in self-efficacy. (ii) Transitional Influences: Periods of transition in schooling bring additional factors into play that affect self-efficacy. Eccles and her colleagues (Eccles, Midgley, and Adler, 1984; Eccles and Midgley, 1989) have reported that the transition to middle school brings several changes.

Strength of self-efficacy determines whether behavior will be initiated, how much effort will be expended, and how long it will be maintained in the face of obstacles or aversive experiences. Self-efficacy is not a passive trait or characteristic, but rather a dynamic aspect of the self-system that interacts with the environment and with other motivational mechanisms. Lent and Hackett (1987) stated “self-efficacy determines what we do with the skills we have”.

Benjamin and Stewart (1989) proposed the usefulness of the self-efficacy concept in understanding the factors that lead to welfare dependency and the connection between public assistance and participation in the workforce. These researchers theorized that the
mastery of behaviors needed for labor market success, including obtaining the appropriate educational credentials, has a direct effect on one's self-efficacy which, in turn, influences future choices about participation in the labor market. London and Greller (1991) pointed out that women can be blocked from career opportunities as effectively by their own beliefs and assumptions as they can by the discriminatory practices of others in the labor market.

There has been a great deal of research exploring the construct of self-efficacy as it relates to a number of clinical, social, and health behaviors (Maddux, 1995). A few studies have considered its relevance to the role strain literature (Matsui and Onglatco, 1992; Kahn and Long 1998).

According to theory and research (Bandura, 1995), self-efficacy has definitive influence on people's thoughts, feelings, and actions. In terms of feeling, a low sense of self-efficacy is associated with depression, anxiety, and helplessness. Such individuals also have low self-esteem and harbor pessimistic thoughts about their accomplishments and personal development. In terms of thinking, a strong sense of competence facilitates cognitive processes and performance in a variety of settings, including quality of decision-making and academic achievement. When it comes to preparing action, self-related cognitions are a major ingredient of the motivation process. Self-efficacy levels can enhance or impede motivation. People with high self-efficacy choose to perform more challenging tasks (Bandura, 1995). They set themselves higher goals and stick to them. Actions are reshaped in thought, and people anticipate either optimistic or pessimistic scenarios in line with their level of self-efficacy. Once an action has been taken, high self-efficacious persons invest more effort and persist longer than those who are low in self-efficacy. When setbacks occur, they recover more quickly and maintain the commitment to their goals. Self-efficacy also allows people to select challenging settings, explore their environments, or create new environments (Schwarzer, 1995).

According to Pajares (1996), people's beliefs in their efficacy have diverse effects. Such beliefs influence the choice of behaviors in which individuals will engage and the courses of action they will pursue. People engage in tasks in which they feel competent and confident and avoid those in which they do not. Self-efficacy beliefs also influence how much effort people will expend on an activity, how long they will
persevere when confronting obstacles, how resilient they will prove in the face of adverse situations, whether their thought patterns and emotional reactions are self-hindering or self-aiding, how much stress and depression they experience in coping with taxing environmental demands, and the level of accomplishments they realize.

A strong sense of efficacy enhances human accomplishment and personal well-being in many ways. People with a strong sense of personal competence approach difficult tasks as challenges to be mastered rather than as threats to be avoided, have greater intrinsic interest and deep engrossment in activities, set themselves challenging goals and maintain strong commitment to them, heighten and sustain their efforts in the face of failure, quickly recover their sense of efficacy after failures or setbacks, and attribute failure to insufficient effort or deficient knowledge and skills which are acquirable.

People with low self-efficacy may believe that things are tougher than they really are. Such a belief fosters stress, depression, and a narrow vision of how best to solve a problem. High self-efficacy, on the other hand, helps create feelings of serenity in approaching difficult tasks and activities. As a result of these influences, self-efficacy beliefs are strong determinants and predictors of the level of accomplishment that individuals finally attain.

Self-efficacy expectations determine whether an individual’s coping behavior will be initiated, how much task related effort will be expended and how long that effort will be sustained despite disconfirming evidence (Bandura and Cervone 1983; Bandura, 1997a).

Self-efficacy expectations, when viewed in relation to career, refer to a person’s beliefs regarding career-related behaviors, educational and occupational choice, and performance, and persistence in the implementation of those choices (Betz and Hackett 1997). They are reflected in an individual’s perception about his/her ability to perform a given task or behavior (efficacy expectation) and his/her belief about the consequences of behavior or performance (outcome expectation) (Hackett and Betz 1981).

According to Pajares (2002), of all the thoughts that affect human functioning, and standing at the very core of social cognitive theory, are self-efficacy beliefs. Self-efficacy beliefs provide the foundation for human motivation, well-being, and personal...
accomplishment. This is because unless people believe that their actions can produce the outcomes they desire, they have little incentive to act or to persevere in the face of difficulties. Much empirical evidence now supports Bandura’s contention that self-efficacy beliefs touch virtually every aspect of people’s lives whether they think productively, self-debilitating, pessimistically or optimistically; how well they motivate themselves and persevere in the face of adversities; their vulnerability to stress and depression, and the life choices they make. Self-efficacy is also a critical determinant of self-regulation.

Of course, human functioning is influenced by many factors. The success or failure that people experience as they engage in the myriad tasks that comprise their life naturally influences the many decisions they must make. Also, the knowledge and skills they possess will certainly play critical roles in what they choose to do and not do. Individuals interpret the results of their attainments, however, just as they make judgments about the quality of the knowledge and skills they possess.

Bandura’s (1997) concept of self-efficacy was used by Foster and Dion (2003) for examining if disposition to hardiness and women’s well-being are related to gender discrimination. They suggested that hardy women encountering both a laboratory simulation and hypothetical scenario of discrimination showed greater self-esteem and less negative effect than women low on hardiness. Well-being in hardy women may have been achieved through minimizing the pervasiveness of discrimination. Thus, minimizing the pervasiveness of discrimination may have been a threat-reducing tool for women high on hardiness.

According to Barnhardt (1997), self-efficacy refers to learners’ beliefs about their ability to accomplish a task. Self-efficacy forms the basis for self-esteem and motivation. Self-efficacious learners feel confident about solving a problem because they have developed an approach to problem solving through practice.

Bandura’s (1997) key contentions as regards the role of self-efficacy beliefs in human functioning is that “people’s level of motivation, affective states, and actions are based more on what they believe than on what is objectively true”. For this reason, how people behave can often be better predicted by the beliefs they hold about their capabilities than by what they are actually capable of accomplishing, for these self-
Theoretical Orientation...

efficacy perceptions help determine what individuals do with the knowledge and skills they have. This helps explain why people's behaviors are sometimes disjointed from their actual capabilities and why their behavior may differ widely even when they have similar knowledge and skills. For example, many talented people suffer frequent (and sometimes debilitating) bouts of self-doubt about capabilities they clearly possess, just as many individuals are confident about what they can accomplish despite possessing a modest repertoire of skills. Belief and reality are seldom perfectly matched, and individuals are typically guided by their beliefs when they engage the world. As a consequence, people's accomplishments are generally better predicted by their self-efficacy beliefs than by their previous attainments, knowledge, or skills. Of course, no amount of confidence or self-appreciation can produce success when requisite skills and knowledge are absent.

People's self-efficacy beliefs should not be confused with their judgments of the consequences that their behavior will produce. Typically, of course, self-efficacy beliefs help determine the outcomes one expects. Confident individuals anticipate successful outcomes. Students confident in their social skills anticipate successful social encounters. Those confident in their academic skills expect high marks on exams and expect the quality of their work to reap personal and professional benefits. The opposite is true of those who lack confidence. Students who doubt their social skills often envision rejection or ridicule even before they establish social contact. Those who lack confidence in their academic skills envision a low grade before they begin an examination or enroll in a course. The expected results of these imagined performances will be differently envisioned: social success or greater career options for the former, social isolation or curtailed academic possibilities for the latter.

The notion of perceived control also differs from self-efficacy. People who believe they can control what they learn and perform are more apt to initiate and sustain behaviors directed toward those ends than are individuals who hold a low sense of control over their capabilities (Bandura, 1997). Perceived control is generic; thus, it is meaningful to speak of perceived control over learning or performing and over outcomes. Further, perceived control is only one aspect of self-efficacy. Other factors that influence self-efficacy include perceptions of ability, social comparisons, attributions, time available, and perceived importance. People may believe they can control their use of
learning strategies, effort, and persistence, yet still hold a low sense of self-efficacy for learning because they feel that the learning is unimportant and do not want to invest time in it.

Apart from efficacy, there are also feeling of competence and self-satisfaction associated with the objectives that the individuals sets for themselves in their work in an environment that cannot be compared to another (Wicks, 1980; Johenson and Price, 1991; Ellis, 1993; Ekstedt and Jackson, 1997).

Individuals who perceive themselves as high self-efficacious activate sufficient effort, which if well executed, produces successful outcomes whereas those with low self-efficacy are likely to cease their efforts prematurely and fail on the task (Bandura, 1997; Bandura, 1986; Stajkovic and Luthans, 1998b).

Flammer (2001) prefers self-efficacy to helplessness as a concept. Self-efficacy beliefs provide us with security and pride. When we lack self-efficacy in important domains, we either strive for self-efficacy (by fighting, learning or training) or search for compensation.

Valiante (2004) believes that efficacy contributes more heavily to occupational preferences. Perceived efficacy is a robust contributor to career development. Self-efficacy characterized by spiritual improvement creates a setback and variations in the rate of progress.

Self-efficacy leads to greater self-satisfaction and interest. Employees with low sense of efficacy are stressed because they have limited opportunities to make full use of their talents.

Perceived self-efficacy affects how well individuals manage requirements and challenges of occupational pursuits (Bandura, 2005). Career choice and development is one example of the power of self-efficacy beliefs to affect the course of life paths through choice-related processes. The higher the level of people's perceived self-efficacy the wider the range of career options they seriously consider, the greater their interest in them, and the better they prepare themselves educationally for the occupational pursuits they choose and the greater is their success. Occupational structure is a good part of people's lives and provides them with a major source of personal growth.
From the above definitions, it is clear that persons high on self-efficacy feel that they can produce results and don’t perceive themselves as helpless. Employed women with their higher skills, in a variety of situations are likely to feel more in control of the situation than the unemployed women who are likely to be having more feeling of helplessness because of lower position and power. People with higher perceived self-efficacy to fulfill job functions consider a wide range of career options. Some people eliminate an entire class of vocation based on perceived self-efficacy.

**2.4 Self-Esteem**

Various psychologists have studied and discussed self-esteem which, in fact, constitutes an important aspect of personality. Most psychologists would probably agree on a general definition of self-esteem as a personal judgment of one’s own worth.

Studies have indicated that students who are unsure of themselves or who expect to fail inclined to stop trying and just give up. It means feeling good about yourself is being good. The more you like yourself, the more you act in likable ways, the more you believe, the more you are able to achieve. The National Association of self-esteem (NASE) defines Self-Esteem as “The experience of being capable of meeting life’s challenges and being worthy of happiness”.

Shavelson et al. (1976) offered an explanation of the self-esteem construct based on an analysis of the pertinent literature. According to their definition self-concept is: (a) organized (b) multifaceted (c) hierarchical, (d) stable (when considered as a general construct) and unstable (situational with age), (f) evaluative, and (g) differentiable from related constructs. According to them, self-esteem is believed to be at the top of the hierarchy and can be separated into academic and non-academic components. The latter is assumed to be further divisible into physical, emotional, and social aspects.

Another issue in the definition of self-esteem is whether it is best conceptualized as a stable personality trait or a context specific state. Most theories of self-esteem view it as a relatively stable trait, i.e., if one has high self-esteem today, one probably will have high self-esteem tomorrow. Around this stable baseline however, there are fluctuations. Although people generally may feel good about themselves, there are times when they
Theoretical Orientation...

may experience self-doubt and even dislike themselves. Experimental research has demonstrated that self-esteem is not a stable trait, but rather is likely to be affected by the immediate situation and the motives of the individual (Bednar, Wells, and Paterson, 1989).

Self-esteem is a person’s evaluation of his own self-worth. It is an element of the internal system that we all bring to any interpersonal communication situation (Bodaken and Sereno, 1975). Self-esteem refers to individual’s perception of his own self-worth, his feeling of self-respect, and self-confidence and the extent to which the individual holds positive or negative views about himself (Brockner, 1988).

According to Joubert (1990), self-esteem can be defined as a “person’s judgment of general self-worth that is a product of an implicit evaluation of self-approval or self-disapproval made by the individual”.

Moretti and Higgins (1990) argued that self-esteem is a cognitive judgment based on standards of worth and accessible information about how well an individual is meeting those standards. Current mood may be one source of information on which judgments of self-worth are based (Schwarz and Strack, 1999).

Fuller and Schaller (1990) reported self-esteem as a positive feeling of a person in association with his physical, mental, and social identity.

According to Leavy and Down (1995), self-esteem is a sociometer, which constitutes a psychological measure of one’s social connectedness. The initial assumption is that people have a deeply rooted or innate connection with others. Positive self-esteem relates to power of decision making, creativity, mental health, and self-worthiness.

Self-esteem is the disposition to experience oneself as being competent to cope with the basic challenges of life and of being worthy of happiness. It is confidence in the efficacy of our mind and in our ability to think. By extension, it is confidence in our ability to learn, make appropriate choices and decisions, and respond effectively to change. It is also the experience that success, achievement, fulfillment, happiness are right and natural for us. The survival-value of such confidence is obvious; so is the danger when it is missing.

According to Kazdin (2000), self-esteem refers to evaluation a person makes and maintains with regard to him or herself. It is the global evaluation reflecting our views of
Theoretical Orientation...

our accomplishments and capacities, our values, our bodies, others responses to us and
our possessions.

The root of our need for self-esteem is the need for a consciousness to learn to
trust itself, and the root of the need to learn such trust is the fact that consciousness is
volitional: we have the choice to think or not to think. We control the switch that turns
consciousness brighter or dimmer. We are not rational that is, reality-focused
automatically. This means that whether we learn to operate our mind in such a way as to
make ourselves appropriate to life is ultimately a function of our choices.

A person’s self-esteem is the extent to which that person believes he or she is
worthwhile and deserving individual (Adler, 1997; Moorhead and Griffin, 1999). The
term self-esteem sometimes is used interchangeably with terms such as self-confidence,
self-efficacy, and even self-concept (Borgatta and Montgomerg, 2000). Self-confidence
and self-efficacy refer to the extent that one can attain specific outcome. Although people
with high self-esteem often are self-confident, yet evaluative reactions to personal
outcomes vary greatly, and it is possible for people to be confident about attaining a goal
without feeling good about themselves in the process (Felson, 1992; Borgatta, and
Montgomerg, 2000).

According to Tesser (2000), “self-esteem is a global evaluation reflecting our
view of our accomplishments and capabilities, our values, our bodies, other’s responses
to us, and events, or occasions, our possessions”.

Deci and Ryan (1994) speak of contingent self-esteem as distinguished from true
self-esteem. Contingent self-esteem is like conditional love; one’s self-acceptance or self-
love is based on living up to one’s own and other’s expectations i.e., passing all the tests
of life. This tenuous, conditional self-esteem is not a secure foundation and is associated
with an external orientation, such as seeking money, fame, and attractiveness. On the
other hand, true self-esteem, according to Deci and Ryan (1994), involves a more secure,
solid sense of self and self-acceptance, regardless of what happens in the outside world
and is associated with intrinsic motivations, such as seeking relationships, self-
Improvement, and serving others. While, contingent self-esteem might even be gained by
being proficient at something one does not value but true self-esteem comes only when
one’s actions are highly valued and freely chosen or self-determined.
In respect to socialization of self-esteem, a novel and important functional account of self-esteem has been reported by Baumeister and Leary (1995). According to them, humans have a fundamental need to belong to a group and this need is rooted in evolutionary history (Baumeister and Leary, 1995), because most of human evolution, survival and reproduction depend on affiliation with a group. Those who belong to a social group are more likely to survive and reproduce than those who are excluded from group and left to survive on their own. Self-esteem functions as a monitor of the likelihood of social exclusion.

One basic distinction between people with high self-esteem and low self-esteem is related to the motivation (Baumeister et al. 1989). People with high self-esteem are concerned primarily with self-enhancement whereas those with low self-esteem are concerned primarily with self-protection. The self-enhancement motive emphasizes good feelings about oneself with the aim of increasing one’s self-esteem. Thus, people with high self-esteem look for areas in which they can excel and stand out. Whenever they fail at a task; they tend to set higher goals so that they can prove to themselves, that they possess exceptional skills, whereas people with low self-esteem are concerned with avoiding humiliation, embarrassment, and rejection. Thus, whenever they fail at a task, they tend to set more modest goals so that they do not lose further esteem through failure.

Nezlek et al. (1997) revealed that people with high self-esteem believe that their talents are unique and special but that their weaknesses are common and trivial. They are, therefore, more adept at defending their self-esteem from external threats. Thus, people with high self-esteem tend to discredit sources of negative feedback while readily accepting positive feedback. They are also more likely to show a self-serving bias, which refers to the tendency of individuals to take personal credit for success but blame failure on external circumstances. However, people with low self-esteem appear to be generally less able to put a positive spin on negative personal information. After receiving negative evaluation, individuals with low self-esteem are more likely to dwell on their weaknesses, while individuals with high self-esteem recruit thoughts about their strengths (Dodgson and Wood, 1998).

Self-esteem differences have been reported for a wide range of intrapsychic phenomena, including emotional reactions, cognitive processes and motivational states.
There is obvious difference in how individuals with high and low self-esteem feel about themselves. Researches have revealed that people with low self-esteem are more likely to report being depressed and anxious than those with high self-esteem (Campbell and Laskey. 1991). Some researches have used studies to examine whether high and low self-esteem people differ in their daily moods and emotions. In term of specific emotional states of impersonal emotions like happiness, the high and low esteem people have not shown any appreciable differences in expression but in case of self-relevant emotions like pride and shame they have exhibited appreciable differences in their reaction. People with high self-esteem are more likely to report pride, whereas, those with low self-esteem are more likely to report shame. However, this scenario is independent of actual events in the lives of people with high and low self-esteem (Campbell and Laskey, 1991). On the other hand, people with low self-esteem, like to hear good things about themselves just as much as do people with high self-esteem and both groups hope to be successful in life. However, people with high self-esteem are much more likely to believe in the positive feedback because it contradicts what they believe to be true about themselves (Swann, 1996). At the same time, Swann (1996) argued that people with low self-esteem are attracted to negative information because it validates and confirms their negative self-views.

Building self-esteem is considered by many psychologists and educators to be so vital to good mental health, education, and physical health that research interest in this area should stay high. However, in an excellent review of self-esteem research by Kohn (1994), there is little hard data showing that self-esteem is related to helping others, academic achievement, or good citizenship.

The signs of low level of self-esteem include frequency apologetic, defensive behavior, fear of failure, feeling of guilt, and tendency to blame others.

Psychologists believe that self-esteem is a part of mental health. They believe that self-esteem is a main center for social and emotional adjustment. An individual with high self-esteem evaluates himself positively and has good relationships. Low self-esteem causes mental diseases such as depression, anxiety, feelings of alienation and decrease in interpersonal relationship and exposure to high level of stress (Stein 1997). Therefore, the feeling of higher self-esteem is likely to be positively related to mental health.
Theoretical Orientation…

One aspect of self-esteem which is positive is that when individual meets the desired standards of achievement, he feels good about himself and is confident of mastering the chosen tasks in life. One feels good when one gains the respect of others for what he does. A sense of competence is the result of repeated experiences of positive feedback. However, when individuals cannot fulfill their esteem needs, they feel a sense of inferiority, helplessness and are discouraged. As a result, they rely on others for prestige, status, recognition, and reputation (Bee, 1939; Cohen, 1956; Rosenberg, 1965; Coopersmith, 1967; Gordon and Gergen, 1968; Elder, 1968; Sarah, 1977; Buss, 1978; Chzonowski, 1981; Harre and Lamb, 1983; Stratton and Hayes, 1996; Corsini, 1999).

According to Reasoner (2004), individuals with high self-esteem are characterized by tolerance and respect for others. Individuals who accept responsibility for their actions, have integrity, take pride in their accomplishments, are self-motivated, willing to take risk, capable of accepting criticism, are loving, seek the challenge of demanding goals, and take command and control of their lives. The term self-esteem includes cognitive, affective and behavioral elements. It is cognitive as one consciously thinks about oneself and considers the discrepancy between one’s ideal self, the person one wishes to be and the perceived self. The affective element refers to the feeling or emotions that one has when considering the discrepancy. The behavioral aspect of self-esteem is manifested in behavioral assertiveness, resilience, being decisive and respectful to others.

Thus, people with high self-esteem pay attention to information that says good things about them but ignore information that challenges a positive self-view. On the other hand, individuals with low self-esteem focus on their own thoughts, and feelings often dwelling on negative life events. They tend to be vigilant for information that confirms a negative self-view and ruminate on past failures embarrassments and setbacks in a non-productive fashion.

According to psychologists, low self-esteem in women is nothing more than the natural process of considering females as worthless and in adorable after a certain period of time. This realization causes many young women to make dramatic changes in their self-images and their behavior. Gilligan (1982) has called this process “hitting the wall”, which is made of blocks containing all the negative messages young women receive from
Theoretical Orientation...

the society about their bodies, their mind and their worth. Through this process, they begin to realize that the world functions in terms of power dynamics and that the women do not possess the power.

Buss (1978) while presenting a model of self-esteem stated that virtually everyone possesses a core of self-esteem that does not depend on current affection or achievement. Overlying this core is a more peripheral self-esteem which though fairly stable, does fluctuate with important life events such as affection, rejection, success and failure. The development of both positive and negative self-esteem depends upon its evolution. The model propounded by Buss and is presented in Figs. 4 and 5.

As has been depicted in Fig. 4, the variables of peripheral self-esteem tend to be stable when the individual receives affection from others which leads to personal achievement.

The core self-esteem has a permanent inborn depression which comes as a result of parental conditional love. Hence, the core of self-esteem comes from constitutional determinants and parental-child interactions of early childhood whereas, peripheral self-esteem consists of two parts arising from (a) different kinds of affections and (b) specific assets and accomplishments. This approach to self was based on evolutionary development perspective which leads us to split the self into two aspects sensory and cognitive. Sensory aspect is not dependant on the peripheral variables whereas the cognitive aspect depends on both the shared and unshared aspects of self. One basic assumption is that the cognitive aspect of self may be split into two parts viz, private and public selves. The private self develops more comprehensively and is much distinctive and covert in its development whereas the public self is dependent for its development on socialization. Self-concept is linked up with self-esteem but cannot be treated synonymously. The negative or positive characteristics associated with one’s image, determine the regard one has for oneself. It is this regard associated with oneself which is known as self-esteem.
Fig. 4. The model of Self-Esteem

The model of self-esteem: Buss (1978)

Fig. 5. The Buss’s approach to development of self-esteem

Source: Buss (1978)
Some key factors to judge whether or not young women have high self-esteem. The first key factor was connection to at least one adult in an explicit relationship. The second mitigation factor was achieving measure of success in school. Having a form of spiritual connection is as the third mitigation factor. Finally the fourth mitigation factor is living in a family environment where there is low level of stress.

Kramer (1993) argues that self-esteem is rooted in activity of serotoninergic neurotransmitter system (SNTS). He notes that pharmacological treatments that increase the activity of serotonin are associated with an increased sense of self-confidence and self-esteem. However, there have not been any systematic or rigorous tests of this hypothesis. The possibility that self-esteem has a biological component remains an important empirical issue (Kramer, 1993; Kendler et al. 1998).

General Self-esteem evolves through constant self-evaluation in different situations (Shavelson and Bolus, 1982). From a completely different perspective, some researchers have begun to explore the possibility that self-esteem is determined more by biology than by socialization. Although direct evidence is minimal, there is circumstantial evidence that some components of self-esteem are based in biology. Twin studies have suggested that self-esteem is moderately heritable with estimates ranging from 30 to 50 percent (Kendler et al. 1998). In addition, traits known to be associated with self-esteem, such as extraversion and neuroticism, have long been known to have genetic component.

The base of self-esteem is made in the childhood period by the family and subsequently affected by school and the environment. The reaction of need for others, worthiness, comparison with others, and identification with models are some important sources for the development of self-esteem in a person.

The factors that have been found to be essential for the nurturing self-esteem are self-responsibility, self-assertiveness, purposefulness, and integrity. Two factors that affect self-esteem are religious beliefs and spirituality. According to Islam religion, self-esteem increases the power of tolerance in humans when faced with problems.

Each component can be broken down into progressively smaller subcomponents. Performance self-esteem refers to one’s sense of general competence and includes
intellectual ability, school performance, self-regulatory capacities, self-confidence, efficacy and agency. People high on performance self-esteem believe that they are smart and capable (Borgatta and Montgomery, 2000). Social self-esteem refers to how people believe they are perceived by others. It is perception rather than reality that is critical here. If people believe that others especially, significant others, value and respect them, they experience high social self-esteem even if others truly dislike them or hold them in contempt (Felson, 1992). The influence of these reflected appraisals on self-esteem is an integral part of Cooley’s (1902) Looking Glass Self and has been implicated in the development of self-esteem by sociological theorists such as George Herbert Mead (1934). People low in social self-esteem often experience social anxiety and are high on public self-consciousness. They are highly attentive to their public images and worry about how others view them. Physical self-esteem refers to how people view their physical bodies and includes things such as athletic skills, physical attractiveness and body image as well as physical stigma and feelings about race and ethnicity (Borgatta and Montgomery, 2000).

Self-esteem has both cognitive and affective components. A number of researchers have examined the cognitive and affective reactions of these with high and low self-esteem. A consistent theme in the literature on self-esteem is that, self-esteem involves a cognitive bias in processing evaluative social information. In a world filled with ambiguities and uncertainties, people selectively construct their own reality through biased encoding, retrieval and interpretation of life events. Research on information processing styles shows that high self-esteem is associated with cognitive strategies aimed at enhancing self-appraisals and thinking of oneself in the most positive way.

Researchers have thought of self-esteem as multidimensional and have looked for different types or aspects of self-esteem such as self-power and self-worth (Gecas, 1982), inner and outer self-esteem general and academic self-esteem, self regard and confidence in social, and physical ability (Shavelson and Bolus, 1982).

Self-esteem has been looked at in different roles such as school self-esteem (Wylie, 1979) and parental competence (Gibaud-Wallston and Wandersman, 1978) and has been studied in different contexts such as in class, with family, friends, the opposite sex, and adults.
An important issue in the literature on self-esteem is whether self-esteem is best conceptualized as a unitary global trait or a multi dimensional trait with independent subcomponents. Global self-esteem is best conceptualized as a hierarchical construct with three major components (i.e., performance self-esteem, social-self-esteem, and physical self-esteem).