The present research concentrates on a comparative study of the status of mental health, self-esteem, self-competence and social support experiences between individuals handicapped visually and normal ones. An attempt has been made to study the influence of the demographic variables on the dependent variables – overall subjective well-being, self-esteem and social support appraisals.

The review of literature has been organised by quoting relevant research and studies in relation to subjective well-being and mental health, self-esteem and subjective well-being, social support and subjective well-being, demographic variables and subjective well-being and studies on visual handicap.

Subjective Well-being and Mental Health

In psychological as well as popular parlance, the concepts that are used frequently when talking about well-being are welfare, adjustment, adaptation, balance, equilibrium, homeostatis, competence and health (Sinha 1990; and Nathawat, 1997). The expression quality of life is used as a measure of physical, mental and social well-being as perceived by each individual or group of individuals and of happiness, satisfaction, and gratification involving mainly such non-esoteric life
concerns as health, marriage, work, housing, financial status, educational opportunities, self-esteem, competence, creativity, belongingness, and trust in others. The measures generally cover overall satisfaction as well as satisfaction in the component areas. Similarly quality of life can be evaluated by taking a number of aspects of a person's life and assessing the person's subjective feelings of happiness or unhappiness about the various life concerns (Campbell and Converse 1970; Andrews and Withey, 1976; Zautra et al., 1977; Rhoads and Raymond, 1981 and Nagpal and Sell 1985). Andrews and Mckennel (1980) identified three basic components of quality of life judgments; positive affect, negative affect and a third set of cognitive influences. When people appraise their quality of life, they combine positive feeling states, negative feeling states and their thoughts (cognitions) about these feelings. Actions (behaviours) feelings (affect), values (cognitions) all interact to determine an individual's level of perceived well-being or quality of life. Hence, an individual's aspirations, standard of reference and immediate feeling states influence his quality of life.

Bubolz, et al., (1980) present a conceptual model that indicates that the interactions between the individual and the available resources in the environment are important determinants of quality of life. However, in evaluating their model they employ satisfaction rather than behavioural measures of quality of life. They propose an ecological model in which the individual (the human environed unit) interacts with
three interrelated environments. The three environments are the natural environment (climate), the human constructed environment (neighbourhood) and the human behavioural environment (activities). Physical measures are appropriate indices of quality of life of the physical environment and social indicators can be considered measures of the human constructed environment.

The concept of the quality of life became a topic of interest for social scientists in the 1960's within the context of the social policy research (Shin, 1980; Murrel et al., 1983; Scheusler and Fisher, 1985; McLennan et al., 1988). The initial interest was in objective, economic and social indicators of quality of life, such as age, sex, race, income, housing density, and environmental pollution levels. Subsequently, increased attention has been paid to the subjective experiences of quality of life. In order to distinguish the subjective domains, from the objective domains, terms such as subjective quality of life (SQOL) and perceived quality of life (PQOL) and subjective well-being have been in use. The most generally used term is subjective well-being (SWB).

Padilla and Grant (1985) propose that quality of life encompasses three domains - symptom control, physical well-being and psychological well-being. While the three domains are related, each provides information unique to its respective area.
In recent years psychologists have become increasingly concerned with the positive end of the psychological well-being spectrum. Instead of focusing solely on the factors that lead to disorders such as depression and anxiety, researchers have begun to examine the antecedents and consequences of happiness, self-esteem, optimism and other indicators of positive well-being. Subjective well-being has gained widespread interest, attention and prominence as an emerging research area in social science (Diener and Emmons, 1985; Lucas et al. 1996; and Suh et al., 1996). Subjective well-being (SWB), people's cognitive and affective evaluation of their lives has assumed great importance as indices of psychological well-being, (Zautra and Simons, 1978; and Evans et al., 1985).

Subjective well-being is measured from the individuals' own perspective. In the field of subjective well-being a person's belief about his or her well-being are of paramount importance. (Diener, et al., 1997).

Campbell et al., (1976), Andrews and Withey (1976), Flanagan, (1978), and Diener, Diener and Diener (1995) made the central points that having rights, material comforts and prosperity, health, work, active recreation, learning and creative expression, autonomy, individual freedom and equality are more important to subjective well-being in the modern world than in how many resources others have or how many resources one had in the past.
The factors of well-being include health and material conditions of the individual and the community (Fontana, et al. 1980; Hoffmann, 1988; and Sinha, 1990). Well-being implies that the environment provides the necessary inputs for the proper development of the skills and abilities through which the individual is able to satisfy his basic and psychological needs and thereby achieve a degree of adjustment. A state of maladjustment would denote absence of such conditions or the presence of such factors that prevent the satisfaction of the individual's needs and thereby militate against his well-being. Mental health and physical health are inexorably linked - sickness and disability can upset the delicate balance of the mind just as mental illness can affect physical health. Mental health implies a harmonious equilibrium between the environment in which we live and our inner selves. Man is a thinking being; inner experiences are linked to interpersonal group experiences. In other words, mental life is what makes people's life valuable. To be human is to think, feel, aspire, strive and achieve and to be social. Promoting health must, therefore, be concerned not only with preserving the biological element of the human organism, but also with enhancing mental life. There has been a growing acceptance of the view that psychological health is not merely the absence of psychological impairment, but rather a separate state making its own contribution to a person's overall well-being.

Subjective well-being (SWB) refers to how people evaluate their lives and includes variables such as life satisfaction, lack of
depression and anxiety and positive moods and emotions. Thus, a person is said to have a high subjective well-being if he or she experiences life satisfaction and frequent joy and only infrequently experiences unpleasant emotions such as sadness or anger. Contrariwise, a person is said to have low subjective well-being if he or she experiences little joy and affection and frequently feels negative emotions such as anger or anxiety. The cognitive and affective components of subjective well-being are highly interrelated. Subjective well-being is a new field of research that focuses on understanding the complete range of well-being from utter despair and agony to total life satisfaction and ecstasy. The three primary components of subjective well-being are: satisfaction, pleasant affect, and low levels of unpleasant affect. All the three factors postulate that a positive self-concept, a sense of autonomy, good social support and an internal locus of control are important predictors of well-being. Mental health also includes two separate but related factors subjective well-being and personal growth (Andrews and Withey, 1976; Campbell, 1976; Diener et al., 1977; Diener, 1984; Vinokur and Caplan, 1986; Sell and Nagpal, 1992; and Compton, et al 1996).

The indicators of well-being in an individual or a group of individuals have objective and subjective components (Campbell, 1976; Diener, 1984; Nagpal and Sell, 1985; and Nagpal, 1985). The objective components relate to such concerns as are generally known by the term “standard of living”, which includes level of education, status
of employment, financial resources, housing conditions, and comforts of modern living. The subjective well-being components consist of an individual's expectations and adaptations vis-a-vis perceived reality. The subjective indicators have the advantage over the objective indicators, that is, in dealing directly with the individual's sense of well-being.

Bradburn and Caplovitz (1965); Bradburn (1969); and Fontana et al., (1980) have distinguished between psychological impairment and psychological health in terms of positive and negative affect and their behavioural correlates. This model of psychological well-being originated from a serendipitous finding that people's reports of positive and negative affect were statistically independent of one another and it was further based on the finding that positive affect was related exclusively to harmonious interactions with others while negative affect was associated exclusively with interpersonally disruptive behaviour and or personally distressing experiences. For the implications of the conceptualization and measurement of psychological impairment and psychological health, both positive and negative affects should be included in order to obtain a complete account if people are to report on their own psychological well-being. Exclusive focus on negative affect will provide information regarding psychological impairment and will yield little indication of psychological health.
In recent years psychology has seen a resurgence of interest in affect. Research on emotions and several happiness scales suggests that positive affect and negative affect are strongly inversely correlated. However, work on subjective well-being indicates that over a longer period of time, positive and negative affect are independent across persons. The intensities of specific emotions across persons are also highly correlated. Thus, the intensity dimension help to explain the relative independence of positive affect and negative affect (Bradburn, 1969; Reich and Zautra, 1983; Diener et al., 1985; Diener and Iran-Nejad, 1986).

Beiser, et al., (1972) suggest that certain aspects of positive functioning are pervasive and recurrent themes in the literature of positive mental health. These include (1) freedom from psychiatric illness, (2) a sense of contentment, and (3) effective performance in major social roles.

The factors usually labelled positive affect (PA) include terms such as reflecting enthusiasm, zest for life, mental alertness, active, calm, relaxed, high level of determination and sociability. Negative affect (NA), in contrast, represents the extent to which a person feels upset, depressed, distressed, sad, lethargic, nervous, guilty, angry, scornful, disgusted, fear, contempt and impulsive. Negative affect is associated with psycho-physiological complaints and generally poor mental health. Hence, high negative affect individuals feel more self-dissatisfied and inadequate than their low negative affect counterparts.
The poor self-esteem and negative mood of high negative affect individuals seem to be linked in part to their tendency to dwell upon and magnify mistakes, frustrations, disappointments and threats (Bradburn, 1969; Westbrook, 1977; Watson and Clark, 1984; Emmons and Diener, 1986; Watson, 1988a; 1988b; Watson, et al., 1988; and Berry and Hansen 1996).

The model of mental health designed by Taylor and Brown (1988; 1994) highlights the fact that certain positive illusions are highly prevalent in normal thought and prediction of criteria traditionally associated with mental health. The criteria of mental health include contentment, positive attitude towards the self, the ability to care for and about others, openness to new ideas and people, creativity, the ability to perform creative and productive work, and the ability to grow and develop and self-actualize especially in response to stressful events. Thus, these illusions foster the criteria normally associated with mental health.

A theoretical model of psychological well-being that encompasses six distinct dimensions of wellness (autonomy, environmental mastery, personal growth, positive relations with others, purpose in life, self-acceptance) formulated by Ryff and Keyes, (1995) is thus supported as a multifaceted domain that includes six distinct components of psychological functioning. Two of the six theoretical constructs self acceptance and environmental mastery were highly correlated.
Emmons (1986) and Brunstein (1993) assumed that successful pursuit of meaningful goals plays an important role in the development and maintenance of an individual's psychological well-being. Goals are conceptualized in terms of personal strivings, which represent what individuals are characteristically aiming to accomplish through their behaviour or the purposes that a person is trying to carry out. Emmons (1986; 1991) suggests that what is critical for a person's well-being is not random positive and negative life events, but rather events that impinge upon a person's goals or commitments. Personal strivings represent the recurring, enduring goals that individuals seek in their everyday behaviours, and are defined as "what a person is typically or characteristically trying to do". Power and affiliation, strivings and everyday interpersonal life events most strongly influence well-being. Affiliation and intimacy relate positively to interpersonal events, and achievement strivings relate negatively to interpersonal events. The study by McAdams and Bryant (1987) employed a nation-wide sample of adults to examine the relation between intimacy motivation and six factors of subjective mental health and well-being: unhappiness, lack of gratification, strain, vulnerability, lack of self-confidence and uncertainty. The study offers modest support for a linkage between intimacy motivation on the one hand and subjective mental health and well-being on the other.

Psychological theories of subjective well-being can be distinguished in terms of whether they focus on a bottom-up versus top-
down approach to happiness (Brief, et al., 1993; and Fiest, et al., 1995). Bottom-up theories suggest that happiness is derived from a summation of pleasurable and unpleasurable moments and experiences. Objective life circumstances such as marriage, work and family should be the primary predictors of one’s overall happiness. Top-down theories maintain that individuals are predisposed to experience and react to events and circumstances in positive and negative ways. Global dimensions of personality in essence determine levels of subjective well-being.

Subjective well-being (SWB) consists of two components, long-term happiness and satisfaction with life. Happiness refers to average levels of positive and negative affect considered over a long-term period. Happy subjects recall more positive events because they have labelled more interpretive events as positive, whereas unhappy subjects may recall more negative events because they have labelled more of the events as negative. Individuals with high self-esteem, with a sense of control of their lives, and more optimism about the future are happier than individuals lacking these self-evaluations. Happy people take better care of their appearance so they may be more physically attractive, (Seidlitz and Diener, 1993; Colvin and Block, 1994; and Diener, Wolsic and Fujita, 1995).

Happiness is one thing everyone wants from life. In philosophy, in psychological theory and for the average individual, personal happiness is held generally to be the ultimate of all human endeavour.
Personal happiness as defined in psychological literature is much broader in scope than a temporary mood state. It is an overriding emotional sense of well-being and serves as a global index of life satisfaction, (Gurin et al., 1960; Fordyce, 1977; 1983; and Harry, 1976). Bradburn (1969) hypothesized that happiness is really a global judgment people make by comparing their negative affect with their positive affect, and attempts to enhance life must both reduce negative affect and increase positive affect.

Measures of positive and negative events were derived from a life-event inventory to test the predictions of an equilibrium model and a positive mental health model by Zautra and Simons (1979), Zautra and Reich (1980) and Schwarz and Clore (1983). Subjects who reported more negative events also reported more psychological distress and less positive adjustment. Positive events were associated with reports of positive adjustment. In the equilibrium model, life events are viewed as stressful based on the assumption that any underlying change results in disequilibrium. In the positive mental health model, a person is seen as having two needs: a need to avoid and or adjust to painful aspects of life including life change, a need to find positive experiences which provide a sense of well-being and life satisfaction. Positive life events may influence community well-being in a number of ways. The events may have direct effects on psychological well-being they may act indirectly by facilitating social interaction. These studies suggest that positive life events may offer some promise for
assessing the level of psychological well-being of communities as a whole. Investigations of positive life events may promote well-being in addition to identifying stressful events which increase the risk of pathology in a community.

Campbell (1976) developed three general measures of life experiences. The first measures index of satisfaction with life domains, the index obtained an assessment of satisfaction with life which is essentially a cognitive measure. The second measure, the index of general affect gave a reading of the affective quality of life directed more to the experience of a pleasantness-unpleasantness than of satisfaction-dissatisfaction. The third measure, the index of perceived stress included several questions concerned with sense of being rushed, worried about money and worries of a broader character. It was assumed that the three measures tapped into that attributes of human experience called sense of well-being. The major determiners of well-being are psychological rather than economic or demographic.

Flanagan (1978) used detailed information on individuals comprising representative national sample of 1,000, 30 year olds, 600, 50 year olds and 600, 70 year olds divided into male and female subgroups. The findings from these surveys indicated that most adults in the US reported that their needs and wants were well met in the areas most important to their quality of life. More than 95 per cent of both the men and women in these three age groups stated that their health and personal safety is important or very important to them. In each
group more than 80 per cent reported that their needs and wants in this area are well met. The two other factors that more than 80 per cent of each of the six groups reported as important to their quality of life were having and raising children and understanding oneself. More than 70 per cent of the men and 80 per cent of the women at all three ages reported close friends were important to their quality of life. The six areas showing the largest co-efficients with overall quality of life were material comforts, health, work, active recreation, learning and creative expression.

**Self-esteem and Subjective Well-being**

Self-esteem is the central focus of research examining human personality, it is a multifaceted phenomenon that governs people's thinking and behaviour in a variety of ways. James (1890) defined self-esteem as similar to a barometer that rises and falls as a function of one's aspirations and success experiences. There is a certain average tone to the self-feelings people maintain that is largely dependent on objective feedback that might contradict the self-concept. Thus, although momentary self-evaluations may be context dependent, people derive their overall sense of self-esteem by averaging feelings of themselves across a number of different social situations.

Self-esteem is a multidimensional variable and self-esteem as a dimension of self-concept refers to the global evaluation of one's own
characteristics and attributes. Self-esteem also has motivational force (Gecas, 1971; and Rosenberg, 1979).

Cohen (1959) defined self-esteem as the discrepancy between the ideal self one sets for himself and his actual self-conception. The consequences of low self-esteem would be feelings of inadequacy, and social inferiority and a consequent greater reliance upon others for support as well as for sources of self-evaluation.

People pursue self-esteem in two ways, one of which reflects a narcissistic personality style and the other which reflects the needs for approval and social acceptance, perhaps, a “conformist” personality style (Raskin et al., 1991a; 1991b). Narcissim is positively related to self-esteem. Existence of a narcissistic configuration of ideational and behavioural processes that involve managing hostility through grandiose self-representation and interpersonal strategies centering on dominance. Moreover, this configuration is central to many people’s experience of self-worth and well-being.

Self-esteem is viewed as a fluctuating self-attitude that most often resembles a baseline or standard self-evaluation, but that also encounters situational fluctuations from this baseline as a function of changing role expectations; performances, responses from others and other situational characteristics. In this manner, individuals may have generally favourable attitudes toward themselves, possess self-respect and consider themselves as persons of worth. Self-esteem has been
defined as the evaluation that the individual makes and customarily maintains with regard to the self as capable, successful and important (Coopersmith, 1967; Beck, 1967; Beck et al., 1979; Rosenberg, 1979; Campbell, 1981; and Demo, 1985). Self-esteem is the sense of contentment and self-acceptance that stems from the person’s appraisal of his own worth, significance, attractiveness, competence and ability to satisfy his aspirations. A more spiritual view is that self-esteem relates to satisfaction of needs, related to having, relating and being. The latter involves a feeling of having control over the directions of one’s life and a sense of contentment and fulfillment.

Chrzanowski (1981) referred to self-esteem as a self-reflecting, individual monitoring system pertaining to the feelings of personal worth. This ever present mirror of oneself carries the term self-esteem, self-regard, self-respect. In the broadest sense, self-esteem is a validly favourable image of oneself based on fair evaluation of one’s assets and liabilities. Included in the self-esteem is a feeling of personal dignity, personal merit, an appreciation of the basic stuff one is made of. Combined with it is an intouchness with feelings of integrity, acceptability and mastery. It is also the capacity to be aware of one’s personal needs and the freedom to gain appropriate satisfaction. Some aspects of self-esteem are rooted in a person’s native endowment. Intelligence, temperament, appearance, bodily structure are components to which self-esteem is grafted. Life experiences, culture, society and family and social environmental factors combine in molding the
available material. Self-esteem runs through a person's life, and may be influenced by a change in surroundings, by contact with certain people and also by the various segments, private and psychological in one's life. Self-esteem is usually defined as the liking and respect of oneself and it typically denotes a person's characteristic evaluation of himself and his accomplishments (Crandall, 1973; Yousuf and Saha, 1976).

Self-esteem is a comparatively straightforward idea, a global positive or negative attitude toward the self. Self-evaluation or self-esteem is typically treated as an unidimensional variable referring to the individual's overall feelings about himself. It is the individual's conception of himself in terms of various qualities and abilities, and these refer to the person's feelings of competence, effectiveness and personal influence and his feelings of personal virtue and moral worth respectively (Gecas, 1971 and Rosenberg and Pearlin, 1978).

In evaluating the role of the family in the development of the child's self-concept (Muhlenkamp and Sayles, 1986; Roberts and Bengtson, 1993, 1996; Diener and Diener, 1995; Felson, 1985; Gecas and Schwalbe, 1986; and Whitbeck et al., 1991), stated that self-esteem is a strong predictor of life satisfaction. Earlier parental affective ties contribute to self-esteem by promoting aspects of health, wealth and happiness over the life course. According to the reflected-appraisal process, children's perception of how well liked they are should be an important determinant of self-esteem. However, it may
also be that children with high self-esteem are more likely to assume that others like them. Reflected - appraisals seem to be more consequential for feelings of self-worth.

Efficacy-based self-esteem is dependent, in large part, upon the nature of the social contexts within which the individuals function, especially as this nature affects the organization of practical activities. Those features of contexts of actions that are held to be of the greatest importance in determining possibilities for efficacious actions and the formation of self-esteem are: (1) the degree of constraint on individual autonomy, (2) the degree of individual control, and (3) the resources that are available to the individual for producing intended outcomes. Each of us possesses a strong propensity to cast ourselves in the best possible light to accentuate the positive (Gecas and Schwalbe, 1983; and Owens, 1993).

Franks and Marolla (1976) distinguished inner self-esteem that derives from the experience of the self as an active agent of making things actually happen and realizing one's intents in an impartial world. This feedback comes in terms of the consequences of one's action upon the environment. Inner self-esteem is not given, it is earned through one's own competent actions. In contrast, outer self-esteem is bestowed by others and the concern which makes such input meaningful is with the approval and acceptance of particular others.
Tennen et al., (1987), and Tennen and Herzberger, (1987) demonstrated the importance of self-esteem in depressive attributional style in the normal and clinical populations, as well as potential differences in the relations among self-esteem, depression and attributional style in clinical versus normal samples. Self-esteem emerged as a reliable predictor of depressive attributional style for both college students and psychiatric in-patients. The self-esteem maintenance model predicted that self-esteem was the best predictor of depressive attributional style. For positive outcomes, self-esteem predicted the locus, stability and globality of the subject's attributions. In addition, self-esteem predicted feelings of helplessness and guilt. For negative outcomes self-esteem predicted the locus of subject's attributions as well as feelings of helplessness. Higher self-esteem subjects attributed positive but not negative outcomes to internal and stable causal factors. They also rated positive outcomes as being more important than negative outcomes and believed they had more control over positive outcomes. Lower self-esteem subjects were more evenhanded with respect to these findings. Although depression best predicted some of the negative outcome variables, self-esteem predicted the vast majority of conceptually relevant criteria. Stager et al., (1983) studied the determinants of self-esteem among labelled adolescents, the findings suggest that low self-esteem is not inevitable among labelled deviants. However, when the individual sees his or her label as similar to the self and also has a negative evaluation of that label self-esteem is more likely to be lowered.
DuBois et al., (1994) utilized structural equation modeling to test the role of self-esteem as a mediator of relationships between socio-environmental experiences and environmental/behavioural problems during early adolescence. The findings provide support for a mediational role of self-esteem in linkages between socio-environmental experiences and adjustment. The processes involving self-esteem also may be implicated in the effects that stressful events have on the emotional functioning of youth.

Mackie (1983) and Elliott (1996) examined the relative effects of women's labour force status, family responsibilities and welfare receipt on the development of their self-esteem in early adulthood, because housewifery is devalued work and occupation an achieved status, housewives were hypothesized to have lower self-esteem than women in labour force who had significantly higher self-esteem.

The term self-esteem denotes an intrapsychic cognition, it is an attitude that evaluates the self. The following researchers have made distinct and remarkable observations in individuals with high self-esteem and in individuals with low self-esteem by examining their background and personality characteristics (Jussim et al., 1986; Brown et al., 1988; Baumeister et al., 1989; Campbell et al., 1991; Setterlund and Niedenthal, 1993; Baldwin and Sinclair, 1996; and Roberts et al., 1996, Hunter et al., 1981, Baumeister et al., 1985 Elliott 1986, Robson 1988, and Wood et al., 1994). Individuals with high self-esteem by
definition believed they had numerous talents and abilities, any of which might be cultivated into excellence. High self-esteem entails confidence and one can repeat one’s success. They aspired to excel and sought opportunities to achieve success as their self-esteem was presumably based on a faith that they were quite competent in many other endeavours. They experienced robust good health. Individuals with high self-esteem present themselves in self-enhancing fashion, that is characterized by willingness to accept risks. They show greater confidence in their abilities; they are ambitious and aggressive in their approach. They exhibit a self-aggrandizing style of presenting oneself and they focus themselves as having outstanding good qualities. They possess problem-solving repertoire and evaluate themselves more favourably. In contrast, individuals with low self-esteem lack confidence in their own views, opinions and methods which makes them more willing to defer to someone else. They doubt their competence in many areas. They are cautious, prudent, conservative, and they avoid responsibilities and risks. They fear being a failure and they, therefore, avoid social comparisons. They present themselves in a self-protecting style and they protect themselves from dispute and rejection. They are grossly influenced by their daily events and this has a strong impact on their moods. They lack self-clarity and they have less stable and less certain self-concepts. They are less sure of their identity. They exhibit insecure adult attachment styles that are associated with dysfunctional attitudes. They suffer from depressive symptoms and have maladaptive contingencies of self-worth. They feel uncomfortable in becoming
close to others and they are constantly worried about abandonment and not being loved. They have a tendency to link success with acceptance and failure with rejection. Individuals with low self-esteem reported at a statistically significant level poor health, more daily pain, and greater disability, more somatization, more anxiety and depression and a greater external control orientation. They felt unhappy about themselves, they considered themselves as deficient, unworthy and inadequate. They tended to be low in self-acceptance, self-esteem and self-respect. Individuals with low self-esteem were oriented mainly towards self-protection, they used esteem-bolstering strategies, because they needed them more as they lacked self-confidence.

High self-esteem is one of the strongest predictors of subjective well-being. Many studies have found relationship between self-esteem and subjective well-being (Anderson, 1977 and Czaja, 1975). Self-esteem covaries with subjective well-being although this relation is stronger in individualistic societies where the 'self' stands out as more important (Diener and Diener, 1995). In collective cultures self-esteem and life satisfaction are typically related but not so strongly as in individualistic western nations. This finding suggests that self-esteem is only one component of life satisfaction the importance of which varies across cultures. They found mean within country correlations between life satisfaction and self-esteem by .44 and .43 for men and women respectively. Using daily reports of mood and self-esteem Diener and Emmons, (1985) found that self-esteem correlates (across
two studies) .46 and .34 with positive affect and .48 and .46 with negative affect. Taylor and Brown (1988) documented that people who have high self-esteem and self-confidence who report that they have lots of control in their lives and who believe the future will bring them happiness are more likely than people who lack these perceptions to indicate that they are happy at the present. Individuals high on self-esteem and with optimism about the future are happier than individuals lacking these self-evaluations.

Another concept which is relevant and integral to well-being is that of competence (Sinha, 1990). It is an offshoot and outgrowth of the concept of self-esteem. It is an individual's capacity to control and master the environment. It is the skill to deal with the environment in such a way as to satisfy his needs, as well as maintain a state of balance or equilibrium with himself and his environment. A sense of competence, a term coined by White, (1959, 1963) describes the feelings of confidence in one's abilities based on the successful mastery of one's environment. Sense of competence is an intrapsychic feeling of goodness that arises from the confidence that one builds to engage in further action based on one's success in the ventures already undertaken by the individual.

Lorsch and Morse (1974) were the first to use the concept of sense of competence in the organizational context by defining the sense of competence as the feeling of confidence that an individual has in his or her own task competence.
Self-esteem and self-competence are interrelated in the sense that both the concepts convey and imply the feelings of success, worth, mastery, confidence and an overall feeling of well-being and life satisfaction.

Social Support and Subjective Well-being

The concept of social support has been studied in myriad situations and contexts. This concept has come to occupy a prominent place in the lives of individuals and its health-enhancing qualities and the feelings of being cared for, loved and accepted cannot be under-estimated. The presence of aid and support from significant others in the form of emotional care, financial help, and instrumental aid is understood to play a vital role in improving and elevating the status of physical health as well as mental well-being of an individual.

The presence of social support depicts the appropriate representation of psychological assets or resources. Therefore, it is necessary to explain the concept of social support in detail.

In reviewing some of the colloquial and technical definitions of quality of life Andrews and Withey, (1976) noted that an individual's satisfaction with his social relationships occupies an integral part of this concept. These authors adopted Bateson's position of the centrality of social relationships for quality of life research by stating that "what people care most about is not episodes or things as such but the pattern and setting of their personal relationship - how they stand in
love, belonging, hate, respect, responsibility, dependency, trust and other similar abstract but nonetheless real relationship”. It is apparent that the social lives of people are perceived as key factors in understanding the quality of their lives. (Flanagan, 1978), as well as their physical and psychological health (Myer, Lindenthal and Pepper, 1975) and the manner in which they cope with personal and social change (Gurin, Veroff and Feld, 1960).

Several studies suggest the special importance of subjective aspects of support (perceived support or support satisfaction) in relation to well-being (Barrera, 1981; Hirsch, 1980; Procidano and Heller, 1983). Barrera (1981) concludes that ‘knowledge of people’s subjective appraisals of the adequacy of support is more critical to the prediction of their well-being than simply collecting information about the number of supporters or the quantity of supportive behaviours to which they have access’.

Donald and Ware (1984) concluded that subjective ratings of being ‘cared for’ and ‘loved and wanted by others’ are substantially related both conceptually and empirically to mental health. A deficient social support system may increase vulnerability to mental illness.

Smith and Hobbs (1966) and Hibbard (1985) observed that mental illness is not the private misery of an individual, “but it is intrinsically tied to the breakdown of natural resources of social support in the individual’s life involving family, job, friendship and religious
affiliations". The relationship between social ties and status of health indicated that having more social ties, being more trustful of others and perceiving more control are all related to having better health.

Social support is an exchange of resources between two individuals perceived by the provider or the recipient to be intended to enhance the well-being of the recipient (Mitchelle and Trickett, 1980; and Shumaker and Brownell, 1984). In its broadest sense, social support is the essence of being social, it is mutual nurturing and caring. According to the health sustaining functions of social support its overall function is to enhance the recipient's well-being, that is to enhance the physical and mental health of the individual. Support can meet people's needs for the contact and companionship of others and thereby mitigate the deleterious effects of isolation and loneliness. Through support people can obtain the feelings of belonging that satisfy their affiliative needs. The resources associated with this function could include expressions of caring, love, understanding, concern, intimacy, and an enhanced sense of belonging, e.g., the inclusion of the recipient in group activities.

Social support may best be understood as a metaconstruct referring to three subsidiary constructs; support network resources, supportive behaviours, and subjective appraisals of support (Vaux and Harrison, 1985; Cook and Campbell, 1979; Vaux et al., 1986; and Vaux et al., 1987). This metaconstruct constitutes several theoretically legitimate components including perception and beliefs that one is
supported. Certain kinds of relationship constitute social relationships like a saving account an individual can draw upon for affection, advice, assistance, etc., in times of need or simply gain comfort from their existence. Within these relationships certain kinds of interactions are likely to take place, e.g., physical comforting, listening empathetically, loaning money, giving advice, etc., but the nature, timing, quality and degree of their interactions may vary in any given relationship. Further, the existence of these relationships and the occurrence of these interactions are likely to lead the individual to feel supported, e.g., loved, cared for, esteemed, involved, capable. Presumably, support resources provide the contexts for supportive acts, both the acts and relationship themselves lead to appraisals of the adequacy of support. The subjective appraisal is an appraisal of supportive interactions and available resources. Subjective appraisals of support appear to be especially important in regard to psychological well-being. Barrera (1981); Hirsch, (1980); Procidano and Heller, (1987) observed that satisfaction with support or perceived adequacy of support has shown a stronger relationship to distress or well-being than the social support network measures.

The diversity of the measures of social support is matched by the diversity of conceptualization concerning its ingredients. Oritt, et al., (1985) and Sarason et al., (1983) defined social support as a set of behavioural interactions between an individual and other people during times of stress for the individual which serves to restore emotional and
instrumental equilibrium to the individual in the wake of a stressful event. The set of people who engage in these supportive interactions with the individual during times of stress is defined as support network. Observations in a variety of settings have highlighted the positive role played by social attachments in psychological adjustment and health. These types of observations have led to the idea that social support contributes to positive adjustment and personal development and also provides a buffer against the effects of stress.

Help-seeking is defined as any communication about a problem or troublesome event which is directed towards obtaining support, advice or assistance in time of distress. Help-seeking thus includes both general discussions about problems and specific appeals for aid. In addition, it encompasses requests for assistance from friends, relatives, and neighbours as well as professional helping agents (Gourash, 1978). People who solicit help are usually looking for comfort, reassurance and advice (Gurin et al., 1960; Shumaker and Brownell 1984). Interpersonal relations have long been considered central to the quality of an individual's life. As social animals, we require others to meet many of our needs. Evidence of the deleterious effects of isolation, and the loss of important people in our lives reinforces the conclusion that relationships are critical to well-being.

Social support has been broadly defined as the range of significant interpersonal relationships that have an impact on an individual's functioning (Caplan, 1974; and Hirsch, 1980). Social
support encompasses the set of presently significant others who are either a member of one's social network (i.e., family or friends) or affiliated non-mental health professionals (e.g. physician, clergy).

A social activity is said to have social support if it is perceived by the recipient of that activity as esteem enhancing or if it involves the provision of stress-related interpersonal aid (emotional support, cognitive restructuring, or instrumental aid (Sandler and Lakey, 1982; and Unger and Wandersman, 1985; and Heller et al., 1986;). One can consider supportive transactions as aids to effective coping which are processed and utilized by the individual as part of coping with stressful events.

Thoits, (1986) defines one function of social support as coping assistance. In this conceptualization, coping is what the individual does to meet environmental demands, while support is seen as what others do to help the individual cope with the problem. This view suggests that the impact of social support only influences health outcomes through its effects on coping.

Social support system is perceived availability of support resources and social support is an interpersonal transaction (Wethington and Kessler, 1986).

Much of the earlier work on social support treated it as an unitary factor. Later reviews of the concept have suggested that it is a complex phenomenon requiring analysis of its constituent elements (House,
The types of support illustrated are emotional support, which refers to the behaviour that fosters the feelings of comfort, and leads an individual to believe that he or she is admired, respected and loved and significant others are available to provide care and security. Cognitive support refers to information, knowledge and advice that help the individual to understand his or her world and to adjust to changes within it. Material support refers to the provision of goods and services that solve practical problems.

In a useful breakdown of five key components (Tardy, 1985) suggested that the best way to clarify differences in definition and approach to social support is to specify the directions (support can be given or taken), disposition (availability versus utilization of support resources), description of support versus evaluation of satisfaction with support, content (what form does the support take ?), and network (which social system or system provide the support ?). Social support can be conceptualized as actions that others perform when they render assistance to a focal person. The behavioural description of support referred to as "enacted" support, that is, measured by scales of perceived availability and even some measures of social embeddedness.

The social support system as defined by Kaplan et al., (1977); Thoits, (1982); and Cobb, (1976) is that subset of persons in the individual's total social network upon whom he or she relies for socio-emotional aid, instrumental aid or both. Instrumental aid has socio-
emotional overtones. Practical help from others assures the individual that he or she is cared about, loved and esteemed and that he belongs to a network of communication of mutual obligations. Various researchers in the field of psychology have underlined the need for social support for the well-being of individuals (Caplan, 1974 and Weiss, 1974). Leavy, (1983) concluded that, regardless of the research methods used, absence of social support is associated with increased psychological distress.

Fiore, Beck and Coppel (1983) defined five categories of support. Socializing: being with others in non-problem oriented interactions. Tangible assistance: concrete behavioural assistance or services with chores and tasks rendered beyond role expectations. Cognitive guidance: help which clarifies or furthers the subject’s understanding of problems. Emotional support: help which results in feeling cared about, understood, praised, and sympathized with. Self-disclosure: consists of the frank revealing of one’s thoughts, feelings, confidences and concerns. More broadly, social support may involve empathy, encouragement, information, material assistance, and expressions of sharedness (Mechanic, 1977; Aneshensel and Stone, 1982; Heller and Mansbach, 1984; Sandler and Barrera Jr., 1984; and Lin et al., 1985). A person’s sense of efficacy, as well as tangible and symbolic assistance, depends on the extent and strength of social networks. Strengthening such networks or assisting their development where they do not exist may be much more effective than individual
therapeutic approaches. There is growing evidence that the absence of group support makes people vulnerable to environmental assaults and to other adversities. Often, the mere knowledge that help is available if needed provides people with confidence to cope. Thus, having some to talk to about a worry or concern may reduce the emotional intensity of the worry. These kinds of relationships are most likely to be provided by strong rather than weak ties and homophilous rather than heterophilous ties and theses ties are more effective in promoting mental health. The degree of access to and use of strong and homophilous ties are indicators of social support. Support has direct, positive effects on psychological well-being by fulfilling a person’s needs for affiliation, belonging, respect, social recognition and affection. Stress and the lack of social support have direct effects on depressive symptoms. Thus, stress has greater adverse impact on those with limited as opposed to adequate sources of social support. Support is essentially a moderator of stress, a reactive social process.

Rook and Dooley (1985) proposed two quite different research traditions that deal with social support. The applied tradition explicitly and directly attempts to enhance well-being by modifying the quantity or quality of social support. The analytic tradition, in contrast, regards theoretical specifications of social support mechanism as an intervening step toward the goal of optimizing interventions.

Balance of support may reflect variations in levels of well-being across individuals. Those who are receiving more social support than
they are giving to others may be in greater need of help. Conversely, those who are providing more total social support than they are receiving across their social network might have greater well-being and should be less likely to show depression and symptomatology (Brown et al., 1986; Zea et al., 1995; and Jung, 1997). Psychological well-being may be influenced by an individual's ability to perceive the environment as supportive and to adopt beliefs and engage in behaviours conducive to competent functioning. Individuals who enjoy good social support are likely to be in a better position to develop active coping skills and internal beliefs of control because their relationships provide them with a sense of security. Support in family and work environment is differentially related to health of men and women (Holahan and Moos, 1982). The work environment is a considerably more important source of social support for men than for women. In contrast, the family environment provides an especially potent source of social support for unemployed women.

The oft-neglected loss is of a place in the social milieu. Such a place is assured for many people by their continuous association with a supportive social network. Such network affirms the function of an individual, both as objects of affection and as a contributory member of the life tasks of the group (Henderson, 1977; and Pilisuk and Minkler, 1980). Thus, social support is conceptualized as a basic human need that must be satisfied for an individual to enjoy a sense of well-being. Mental health is associated with having several good friends, abundant
contacts with persons in the primary group, and above all, not one but a number of attachment figures (Henderson, et al., 1978a, 1978b).

Social support implies positive social interaction. The frequency of positive supportive interactions with others is directly related to positive affect whereas the frequency of negative interactions with others is directly related to negative affect (Zautra, 1983; and Earls and Nelson, 1988). Negative social interactions have more potent effects on well-being than positive social interactions (Rook, 1984a; and Singh et al., 1995). Problematic ties with others were more significantly related to well-being than were supportive ties. Positive ties with others were significantly related to well-being only when they involved positive affect, (particularly comfort) and sociability rather than provision of support per se. While supportive relationships are useful in enhancing well-being, it is equally important to focus on the negative aspects of social relationships. Although undermining may be a less frequent phenomenon in the workplace, it is clearly predictive of negative mental and physical health consequences. Emotional support was negatively related to the strain variables of irritability, anxiety, depression and somatic complaints.

Strong resource persons will not be psychologically affected by even high levels of undesirable life events, and greater contact with close friends diminishes the effects of personal dispositions on individual well-being (Linn and McGranahan, 1980; Murrel and Noris, 1984; and Shinn et al., 1989). Support from four sources: the spouse,
supervisor, co-worker, and friends, neighbours and relatives was assessed. Well-being measures included both positively and negatively toned indices in the domains of family (family satisfaction, family distress) work (job satisfaction, job distress) and general well-being (overall satisfaction, poor mental health and poor physical health). Among the four sources of support, the spouse and the supervisor were the most valuable support, support from the spouse was the most important for family outcomes and support from the supervisor was the most important for job outcomes.

Lack of spouse support appears to be a “risk factor” in the mental health of young women with children. The results highlight the role of spouse-supportiveness in well-being and happiness experiences in women. Increased husband participation in family work may reduce potential strain and enhance well-being of wives (McLanahan et al., 1981; Gray et al., 1990; and Chandra et al., 1995).

**Demographic Variables and Subjective Well-being**

Campbell, et al., (1976) found that all demographic factors together accounted for less than 20 per cent of the variance in subjective well-being. Variables such as education, ethnic status and age often correlate at very low levels with reports of subjective well-being.
Age

Early studies found that young people were happier than old (Bradburn and Caplovitz, 1965; Gurin, et al., 1960). Campbell, et al., (1976) reported that satisfaction and the index of general well-being correlated positively with age whereas reports of being very happy decreased with age. Older people reported grater satisfaction in every domain except health.

Gender

Gurin, et al., (1960) reported that although women report more negative affect, they also seem to experience greater joys. Younger women are happier than younger men and older women are less, happier than older men (Medley, 1980; and Spreitzer and Snyder, 1974). With respect to gender, it is significantly related to subjective well-being with males having slightly higher subjective well-being than females (Haring, et al., 1984). The social class – subjective well-being relation is stronger for females than for males on composite and occupational relation measures, but the relation is stronger for males than for females on income measures.

Education

Ross and Willigen (1997) state that education is a root cause of individual well-being. It shapes people’s opportunities for employment, the kind of work they do, their income and economic
hardships, their social, psychological resources and their distress. The well-educated have consistently lower levels of psychological and physical distress than the poorly educated. Compared to the well-educated people, the poorly educated have higher levels of depression, anxiety, malaise, aches and pains and to a lesser extent anger. Poorly educated persons have low levels of enjoyment, hope, happiness, fitness and energy. Education affects both men and women, but it significantly affects women. Education shapes life changes, which affect subjective quality of life. Byrant and Marquez (1986); Campbell (1981) and Clemente and Sauer (1976), explored how educational status affects the criteria men and women use to evaluate their subjective well-being. The six-factor model of subjective mental health was used to operationally define subjective well-being. Specifically, college educated men expressed feelings of vulnerability and reactions of stress in more psychological terms such as feelings of nervous breakdown and anxiety, whereas grade-school and high school-educated men defined these judgements more exclusively in terms of physical symptoms. In addition, dissatisfaction and self-doubt were more indicative of uncertainty towards the future among college educated men than among either grade school or high school educated men. they argued that college may sensitize men to mental health issues and may thereby broaden their realm of psychological criteria that they consider relevant for their self-evaluations. Women, in contrast may already be sensitive to these issues due to sex-role socialization, higher education may have little structured impact on their subjective well-being and may instead
influence other aspects of adjustment. A man’s education is important to his psychological well-being only in that it increases his income and decreases perceived economic hardships, a woman’s education plays an independent role in her psychological well-being. Education appears to be the most important component of socio-economic status to women’s psychological well-being possibly because education helps a wife to successfully meet her responsibilities in the home. Successful fulfillment of male and female role obligations in the household affect psychological well-being (Ross and Huber, 1985; and Baruch and Barnett, 1986).

Employment

Kessler, et al., (1987), Campbell, et al., (1976) and Ross and Mirowsky, (1995) reported that employment correlates positively with health. Failure to keep a job may result in demoralization and neglect, and thus perhaps may lead to poor health as unemployment has health-damaging and devastating effects that can be considered clinically significant. The results generally support the argument that employment protects and fosters health.

Income

Diener, Dieners and Diener, 1995 hypothesised that income and human rights should correlate strongly with subjective well-being because they are likely to influence one’s ability to achieve diverse goals. Subjective well-being of a nation correlates with income, rights
and the degree to which basic rights are fulfilled for the majority of its citizens. People in poor nations show average subjective well-being scores close to or slightly below the neutral point. Countries that are wealthier possess greater freedom and human rights, and emphasis on individualism, and have citizens with higher subjective well-being. Wealth should predict higher subjective well-being because greater resources allow people to achieve some of their goals and also high income confers higher status. It appears that possessing a high income is the goal of a larger number of people throughout the world, because goal success is a predictor of subjective well-being (Emmons, 1986), it seems like those with greater income will possess greater subjective well-being.

**Religion**

Pollner (1985) and Clemente and Sauer (1976) state that the positive influence of religious certainty on well-being is, however, direct and substantial, individuals with stronger religious faith report higher levels of life satisfaction, greater personal happiness and fewer negative psychological consequences of traumatic life events. Spreitzer and Snyder (1974) found that religion had a significant effect on those under age 65 but surprisingly not on older respondents.

**Marriage**

A number of large-scale studies indicate that married persons report greater subjective well-being than any category of unmarried
persons (Andrews and Withey, 1976; Glenn and Weaver, 1979, 1981; Campbell, et al., 1976) although married women report greater stress symptoms than unmarried women, they also report greater satisfaction. Marriage was the strongest predictor of subjective well-being even when education, income and occupational status were controlled. Happy marriage seems virtually necessary for a high level of global happiness (Clemente Sauer, 1976; Lehman, 1983; Haring Hidore, et al., 1985; and Zollar and Williams, 1987). Marital happiness was a better predictor of global happiness for female subjects than it was for male subjects. Thus, marital status showed the most consistently significant relationship to well-being, the few currently married subjects were more satisfied with their lives as a whole as compared with other subjects.

Studies on Visual Handicap

In studying children with visual handicaps (Bowley and Gardner, 1980; Bhatnagar, 1990; Barua, 1996) reported two usual attitudes of parents to blindness in their children. The first arises out of their natural distress and an undesirable but misguided desire to shield the blind child from any kind of harm. He is constantly sheltered and protected from any kind of experience, which may prove difficult for him. His every wish is anticipated and he receives very little encouragement to fend for himself. He thus lives a passive kind of life. Such a degree of overprotection can thus only retard the development of the blind child. Sometimes the child is smothered with excess of
love and care. Such a situation may be potentially hazardous. They never let the child grow up and this makes him feel frustrated. The family of the disabled child undergoes feelings of guilt, resentment, confusion, despair, contradiction, helplessness and even segregation. Disabled children do experience a sense of rejection, as the feelings of inferiority, dependency and other psychological problems are the outcome of the attitude of society.

Blindness imposes its limiting consequences on the individuals interactive mechanism, social withdrawal either unilateral or bilateral when group membership is curtailed or denied by explicit and implied rejection. Blindness and the resultant mal-adjustment are generally labelled by the layman as 'misfortune' or the manifestation of divine wrath and the tendency usually culminates in the overt reactions of pity and over concern and covert responses in the form of attitudes prejudices and conditional value patterns prevalent in a given cultural complex (Verma, 1971; Woods, 1975). In short the physical, psychological and social functioning of the individual blinded is disrupted in degrees which are at variance to one another owing to differential experience and group influences. The handicapped individual is often beset with psychological problems owing to the feelings of inadequacy or helplessness as compared to other able bodied persons. These psychological problems make him a misfit for society, which leads to his alienation from society and consequently economic deprivation.
Blindness enforces a change in the role patterns of the disabled individual or a complete curtailment of former roles as the case may be. A loss of a given role or roles will necessarily reduce the functioning capacity of the person and thereby affecting his adjustment adversely.

The disability of visual handicap has been identified as a contributory factor in increasing dependence among the victims, it is likely to influence their locus of control. Singh (1984) reported that locus of control of visually handicapped and sighted subject did not differ significantly, but it was observed that the non-congenitally blind were less internal and differed significantly from their sighted counterparts. Differences in the mean score of congenitally and non-congenitally groups and congenitally matched control groups were not found to be statistically significant which suggests, that locus of control of congenitally blind and non-congenitally blind is not very different. In the same way congenitally blind did not differ significantly from their sighted counterparts. Comparing the non-congenital group with their sighted counterparts marked differences were noticed in the mean scores which was also found to be highly significant. This signifies that visual handicap which occurs in later life determines locus of control to a greater extent than congenital blindness. The overall findings suggest that living with congenital blindness is almost like usual life process of a sighted person. A person who loses sight in later life needs readjustment (Emerson, 1981) in his changed life due to imposed new demands as a result of blindness.
which can also be identified as a critical event and traumatic experience in the life of the non-congenitally blind. This may account for their increased dependency and low internal control.

Mehta and Chaudhary (2000) while studying visual handicaps in children reported that children with superior abilities have experienced academic failure due to their inability to read due to dyslexia a specific condition where there is difficulty in the interpretation of symbols in individuals commonly of average or above average performance intelligence quotient. The psychological trauma and loss of self-esteem in these children may at times incite a child with dyslexia to either partially or completely withdraw from his peer group or may lead him to resort to an overtly aggressive behaviour pattern. In a study on the personality changes in school children with refractive errors (Mehta, et al., 1992) reported that though intelligence was not affected in ametropia it definitely made the children either more demanding, impatient, over-reactive or resulted in their becoming timid or shy. The balance was only struck when the child learnt how to optimise his visual impairment and prevent it from turning it into a handicap.