Chapter - 1

INTRODUCTION
AND
REVIEW OF LITERATURE
Anxiety: An overview

An increase in female employment in public and private sectors at different job positions other than home in Indian society has occurred during the last few decades, especially in urban areas, witnessing that the women are getting their long overdue share and job opportunities in shouldering responsibilities with men in diverse fields. With the pace of growth and modernization, urbanization and industrialization and emergence of new necessities, women began to work outside to gain economic independence and to contribute for her family as a bread earner. Although the concept of career women with due recognition was accepted much earlier in the developed as well as developing western countries and now almost in all the countries. It appears from the findings of a study conducted in Ontario which reported that the percentage of employed married women increased from 15.0% in 1951 to 50.6% in 1978 and out of them 40% were mothers of children under 16 years of age (Ontario Ministry of Labour, 1978). It is evident from the historiography that Indian society had been male dominant since very beginning and women had to play the role of housekeeper and they occupy a lower position in the family as well as in the society as compared to men because of rigid adherence of cultural norms, customs and stereotypes. Women were not supposed to get higher education and do any job other than home affairs so as a result of it they developed the feeling of being rejected, inferiority complex, low need achievement and low self esteem so they tried least to come up despite having all sort of potentialities to succeed in every sphere of life. But the rapid change in the attitudes, traditional values, life style, competitiveness and industrialization are some of the important factors that have brought out tremendous changes in the whole environment. It is imperative to mention that the
status of Indian women has viz-a-viz changed although the attitude towards employed women is no way different from that of housewives. People in our society agree with the idea of career women but on the other hand they are not willing to excuse them from performing their duties as housewives too. A woman working outside of home has to manage her home with her job when she fails to maintain a balance between the home and job assignments, she seems to develop the feeling of guilt because of non adherence of societal norms. She feels torn between the conflicting demands of family and career when she faces difficulty in performing her duties effectively, more often feels tense and living in the stage of continuous tension that creates anxiety which in turn also seems to affect her mental health status. It needs to highlight that though employment gives more opportunities and choices in many important respects, for most, a right to work does not necessarily mean a better status because doing jobs also increases their physical burden and it may strengthen their family responsibilities, they are also expected to finance sibling’s education, marriage and many other expenses (Pushpa, 1981). A housewife has to do all the works in the home without any complaint and salary but when she does not get the positive feedback from the family members e.g. appreciation for her work or affection and proper care, the problems like stress, anxiety, depression and many other mental health problems seem to arise.

It is an undeniable fact of modern life that experiencing anxiety is very common in today’s fast-paced, high-tech, activity packed society. Anxiety has been considered by the authors for centuries but it is strange is that although anxiety was and is always with the people and they have always faced it and felt it inside themselves but they still do not have a good understanding of its nature (Thack et al., 2005). Anxiety is a multisystem retort to a perceived threat or danger that every
individual experiences at some point of his/her life that "is characterized by a diffuse, unpleasant, vague sense of apprehension, often accompanied by autonomic symptoms, such as headache, perspiration, palpitations, tightness in the chest and the mild stomach discomfort" (Kaplan & Sadock, 1996).

Hallam (1992) stated that anxiety is a word used in everyday conversation, and refers to a complex relationship between a person and his situation. It may refer to; the behavior of a person, appraisal of the response and their effect, his intentions towards a situation and, his evaluation of the resources available for dealing with it. The origin of the word ‘anxiety’ is from the Latin word ‘Anxietas’ which commonly means experience of varying blends of the uncertainty, agitation and dread. It is an intrinsic part of the condition of being human, a natural response, built into the human design, to certain environmental and psychological factors.

Anxiety is the signal of danger which mobilizes the human organism’s resources at all levels of functioning in the interests of conservation, defense, and self preservation. Goldstein (1939,1951) viewed anxiety as the signal that catastrophe is imminent, and catastrophe is the state in which all integrated behavior collapses and only anxiety remains. It is also the sign of incompetence which in larger quantities leads to further disturbance and degeneration of functioning. Anxiety occurs when an individual is interrupted in the course of executing a desired behavior sequence and has no alternative course of action available. The result of this interruption is an emotional helplessness and disorganization which we call ‘anxiety’ (Mandler & Watson, 1966). Anxiety is associated with intense subjective distress, social impairment, and medical and psychiatric comorbidity. Anxiety is defined as the conscious and reportable experience of intense dread, and foreboding, conceptualization as internally derived and unrelated to external threat.
Alpert and Haber (1960) pointed out that anxiety may facilitate or impair performance in evaluative situations depending on its nature. For May (1950) anxiety is "the apprehension cued off by a threat to some value which the individual holds essential to his existence as personality." According to Nijhwan (1972), "anxiety is one of the most pervasive psychological phenomenon of the modern era, refers to a "persistent distressing psychological state arising from inner conflict."" Turner and Barrett (2002) defined anxiety as "lack of tranquility, doubt, lack of confidence and incapacity to overcome the situations."

Jacobs and Jacobs (2004) defines anxiety as "Characterized by an overwhelming sense of apprehension; the expectation that something bad is happening or will happen; class of mental disorders characterized by chronic and debilitating anxiety (e.g. generalized anxiety disorder, panic disorder, phobias, and post-traumatic stress disorder)"

In general anxiety can be defined as a constant unpleasant emotional and mental state characterized by sense of apprehension, fear, lack of confidence that can be engender when any psychological and physical threat is presented.

Anxiety may evoke several emotional responses, such as excessive fear or worry and may cause to sense of apprehension, nervousness or jumpiness. The experience of transiting and adjusting to new environment and meeting various demands can be anxiety provoking. An individual's negative life experiences increases anxiety (Cohen, Butt & Bjorck, 1987). However, according to Lazarus (1991) anxiety can provide both a healthy adaptation and at the same time a tendency for a pathological situation. An optimal amount of anxiety (Simpson, Parker &
Harrison, 1995) can mobilize human beings to respond rapidly and efficiently while excessive amounts of anxiety may foster poor response or sometimes inhibit response. Anxiety can affect adaptive behaviors like subjective well-being, social function, performance and resilience. Unless individuals with high anxiety deal with their anxiety effectively, anxiety may lead to depression (Cole et al., 1998).

An individual experiencing anxious feeling is likely to develop fear. When these feelings begin to arouse disruption in one's regular life continuously then these feelings may lead to anxiety disorder. Women often put off such feelings of anxiety until they are too much to bear can cause everyday functions to become harsh, scary and too hard to perform. Everyone of us in one way or the other is affected by some kind of anxiety within their lifetime. Anxiety disorders are not only common in one society or country rather they are ubiquitous across human cultures (Kessler et al., 1994; Regier et al., 1993; Weissman et al., 1997).

According to Spielberger (1983), anxiety can be either short term or a long term phenomenon. Short term anxiety known as state anxiety is an unpleasant emotional arousal in face of threatening demand. It is an actual anxiety reaction toward certain situations and responsibilities (Julkunen, 1992), a cognitive appraisal of threat is prerequisite for experience of this emotion (Lazarus, 1991). On the other hand trait anxiety reflects a stable tendency to respond with anxiety in the anticipation of threatening situation. Trait anxiety includes seeing the world as a dangerous and hostile place (Coleman & Broen, 1972).

Anxiety can be accompanied by physical effects such as sweating, shortness of breath, trembling, hot flashes and the fear of losing control (Bourne, 1990) and many
more such as increased blood pressure and pulse rate, blood flow to the major muscle
group is increased and immune and digestive functions are inhibited. External signs
may include pale skin, papillary dilation. Emotional symptoms may include feelings
of apprehension or dread, trouble concentrating, feeling tense or jumpy, anticipating
the worst, irritability, restlessness, and feeling like mind’s gone blank.

Anxiety is a general term for several disorders that cause nervousness, fear,
apprehension and worrying. These disorders affect how one feels and behaves, and
they can manifest real physical symptoms like heart palpitations, fatigue, chest pain,
headaches, choking, stomach aches etc. Mild anxiety is vague and unsettling, while
severe anxiety can be extremely devastating, having a serious impact on daily life.
People often experience a general state of worry or fear before confronting something
challenging and these feelings are easily justified and considered normal. Anxiety is
considered as a problem when symptoms interfere with a person’s ability, sleep or
otherwise functions. Anxiety generally refers to a psychological and physiological
state characterized by cognitive, somatic, emotional and behavioral components
(Seligman, Walker & Rosenhan, 2001). These components combine to create an
unpleasant feeling that is typically associated with uneasiness, fear or worry. It is a
mood condition that occurs without an identifiable triggering stimulus. Negative
cognitions are frequently found in individuals with anxiety (Ingram, Miranda &
Segal, 1998). One of the most prominent negative cognitions in anxiety is the sense of
uncontrollability. It is typified by a state of helplessness due to a perceived inability to
predict, control, or obtain desired results (Barlow & Lehman, 1996). Anxiety can be
differentiated from fear in such a way as fear-producing stimulus is either not present
or not immediately threatening, but in anticipation of danger, the same arousal,
vigilance, physiologic preparedness, and negative affects and cognitions occur. Different types of internal or external factors act as triggers to produce the anxiety symptoms of panic disorder, agoraphobia, post-traumatic stress disorder, specific phobias, and generalized anxiety disorder, and the prominent anxiety that commonly occurs in major depression.

There are major psychological theories of anxiety- psychoanalytic and psychodynamic theory, behavioral theories and cognitive theories (Thorne et al., 1999). In the view of Freud (1924) founder of psychodynamic theory, anxiety was “something felt”, a fundamental, unpleasant affective (emotional) state or condition. Freud observed it in his patients of anxiety neuroses and found that “it was characterized by apprehension or anxious expectation, all which is covered by the word nervousness and different discharge phenomenon”. Psychodynamic theories have focused on symptoms as an expression of underlying conflicts (Rush et al., 1998; Thorn et al., 1999) though there are no empirical studies in support of these psychodynamic theories, they are amenable to scientific study (Kandel, 1999). Existential philosophers regard moral and religious dilemmas as the cause of anxiety. Many of the ideas about anxiety discussed by the existential philosophers e.g. Kierkegard (1944), Jaspers (Schilpp, 1957), Heidegger (1949) and Sartre (1956) have found wide acceptance in psychology as well. Kierkegard (1944) distinguished between two different kinds of anxiety. The first is especially evident in children, is the apprehension associated with “a seeking after adventure, a thirst for the prodigious, the mysterious.” The second is the anxiety concerned with the choices that one faces as a function of his responsibilities as a person. It is the second of these that is most significant in his philosophy and in the existential approach to anxiety that he put forward.
Anxiety involves a combination of life experiences, psychological traits, and/or genetic factors. The anxiety disorders are so heterogeneous that the relative roles of these factors are likely to differ. Excess discharge of the locus of ceruleus with the acute stress response was a major contributor to the etiology of anxiety (Coplan & Lydiard, 1998). Cognitive factors, especially the way people interpret or think about stressful events, play a critical role in the etiology of anxiety (Barlow & Lehman, 1996; Thorn et al., 1999). Many modern psychological models of anxiety incorporate the role of individual vulnerability, which includes both genetic (Smoller & Tsuang, 1998) and acquired (Coplan et al., 1997) predispositions.

Functional imaging studies in anxiety disorders, such as PET studies of brain activation in phobias (Rauch et al., 1995), are also beginning to investigate the precise neural circuits involved in the anxiety disorders.

Anxiety differs from arousal in several ways (Barlow, 1988; Nutt, Bell & Malizia, 1998). First, with anxiety, the concern about the stressor is out of proportion to the realistic threat. Second, anxiety is often associated with elaborate mental and behavioral activities designed to avoid the unpleasant symptoms of a full-blown anxiety or panic attack. Third, anxiety is usually longer lived than arousal. Fourth, anxiety can occur without exposure to an external stressor.

There are many neurotransmitter alterations in anxiety disorders. In keeping with the broader view of anxiety, at least five neurotransmitters are perturbed in anxiety: serotonin, norepinephrine, gamma-aminobutyric acid (GABA), corticotropin-releasing hormone (CRH), and cholecystokinin (Coplan & Lydiard 1998; Rush et al., 1998). It is not clear why females have showed higher rates in most of anxiety
disorders than males, although some theories have suggested a role for gonadal steroids. Many studies witnessed that women may ruminate more about distressing life events compared with men, suggesting that a cognitive risk factor may predispose them to higher rates of anxiety and depression (Nolen-Hoeksema, Larson & Grayson 1999). Reddy and Chandrasekar (1998) reported that anxiety and depressive disorders were significantly more common in women.

Hauenstein (1977) found that hypertension was less prevalent in married, employed women, but that when the woman is excessively committed to the work role, the prevalence rate of hypertension rises. In that case, there was an increased rate of hypertension. Nandi et al. (1977, 1980) stated that the feeling of insecurity led to high stress and neurosis.

Waldron (1978) found that the coronary prone behavior pattern was more common among full time employed women than among housewives and part time employed women. The findings revealed that full time employed women have higher blood pressure. On the contrary, Haynes and Feinleib (1980) reported that working women did not have significantly higher incidence rate of CHD than housewives but women reported significantly more symptoms of emotional distress than men.

Walker and Walker (1980) examined 345 adult women to determine whether anxiety was related to employment status, number of children and age of children. Women were categorized as not employed, employed part time or full time employed and also in terms of number and ages of children. The results indicated that women who were not employed have slightly higher levels of anxiety than employed women and significant relationship was found between age of children and anxiety. Trait
anxiety was highest in women with children between 2 and 5 years of age and lowest in women with children older than 5 years.

Silver et al. (1980) examined type A behavior, anxiety, depression and neuroticism of a group of 105 men and 78 women between the age of 25 to 68 going for coronary angiography and found that women scored significantly higher on anxiety and depression than men. For patients with valve-related disorders also women had higher scores on anxiety.

Cooper (1981) pointed out that most of the working women experience high stress levels because they puts a bad effect on their lives and it creates stress in their personalities.

Kessiler and McRae (1982) surveyed a national sample of 1,086 married white couples and found employed wives have lower scores on measures of anxiety and depression. Cleary and Mechanic (1983) also reported that employed married women had slightly less stress than housewives.

Gupta and Murthy (1984) analyzed role conflict and coping strategies of Indian women. The results showed that the role conflict was a reality for both types of women, but it was higher among women with heterogenous workload (i.e. working women) than the homogenous workload (i.e. housewives).

Shenoy (1987) concluded from his study that married working women were significantly less distressed than housewives in spite of experiencing occupational stress. Parry (1987) also reported that employed women were less likely to report psychological symptoms, anxiety, depressive symptoms as compared to non-employed women.
Rosenfield (1989) stated that the high rate of depression among housewives is partly accounted for by the fact that the housewife role usually combines high responsibility and workload with low power which is effective combination for depression and anxiety.

Kapur and Shah (1991) and Davar (1999) concluded that women have a significantly higher rate of psychiatric morbidity. This higher psychiatric morbidity is found to be consistent across urban/rural background, religious and caste affiliation and socio-economic class. Depression has been found to be the most prevalent disorder in women all over the world and in India too (Nandi et al. 1980; Kapur & Singh, 1983; Nolen-Hoeksema, 1987). Reviewing studies from across the world, Desjarlais et al. (1995) also found comparable results of the studies conducted in Nigeria, Mexico, Uganda and Brazil.

Chen and Lin (1992) conducted a study on 274 working women and 167 housewives to examine daily life demands, social support, life satisfaction and health in Taipei city. Results revealed that working women experience more hassles in daily life demand whereas housewives feel higher levels of life satisfaction. Symptomatic scale was administered to measure health dimensions eg., somatization, depression and anxiety. The Mean value for both groups was very low though it was higher on all dimensions in the group of working women yet the difference was not significant. The only significant difference between two groups was in the depression dimension.

Mukhopadhyay, Dewanji and Majumder (1993) studied the impact of out-of-home employment on anxiety levels of mothers measured by the Anxiety Scale Questionnaire. A group of working mothers from Calcutta (India) was compared with
a socioeconomically similar group of non-working mothers with respect to their anxiety level, in terms of the total anxiety score and its various personality components. The possible relationships between anxiety score and age of these mothers as well as their children were studied. The findings indicated that non-working mothers had higher anxiety levels than their working counterparts with respect to the total anxiety score as well as its components, although the differences were statistically insignificant. The anxiety scores of non-working mothers showed increasing values with increasing age of children. This trend was absent among the working mothers. The age of these mothers was not related to their anxiety level.

Such roles of women as carrying out household duties, motherhood and wife cause some situations as overloading of role and role conflict and may become a reason of stress (Klarreich 1990, Ertekin 1993, Atkinson 1994). Anxiety and depression are more common in women according to literature available from developed country (Fitcher et al, 1996). Housewives were found to have much more stress and depressive symptoms in most of the researches (Crepet et al. 1993, Bromberger & Matthews 1994). It was reported that the role of ‘housewife’ and ‘motherhood’ have been associated with high levels of distress mainly because of they are high in demand and low in control (Davar, 1999).

Cilli et al. (1997) examined psychological symptoms and factors affecting psychological symptoms in 76 married working women and 68 housewives who were at least secondary school graduates selected from the center Konya. They were given a form questioning socio-demographic characteristics and psychological symptoms were measured through SCL 90-R. Result showed the age of both group did not make meaningful difference and anxiety, phobia, paranoia and psychosomatic sub-scale
points and average of symptoms were significantly higher in housewives and in both groups psychological symptoms were closely related to total family income.

Munir and Jackson (1997) studied the role of social support and need for support on anxiety among 61 women, graduate students and reported that high anxiety in women were a function of high need for support and separately of low social support.

Mumford et al. (1997) carried out an epidemiological study on anxiety and depression in rural Punjab and Pakistan. They found that the prevalence rate of anxiety and depression was higher in women and the rate of these disorders in women increased steadily with age (18-50). Married women in unitary families had higher levels of emotional distress than those extended or joint families, whereas single women fared better in unitary families and worse in extended families.

Thakar and Misra (1999) studied the role of social support in daily hassles and wellbeing experiences of women. 196 employed and 54 unemployed women served as Ss. Considering the complexity of social support, 3 measures of social support were used. It was found that the employed women experienced more hassles and received less support than their unemployed counterparts, they enjoyed better wellbeing. Employed women’s higher wellbeing speaks of the relative deprivation in housewives’ role and desire for opportunities to use their potentialities for self-actualization and self generalization. Resources generated by employment (eg. Income status) appear adequate not only to cope with stresses emanating from multiple roles but to enhance well being.
Rani and Yadav (2000) investigated the effects of managing dual role (mother and professional) on the anxiety level of women. The sample consisted of 30 middle class working women in different occupation and 25 non working women (control group) aged between 30-45 years. All the subjects were selected from Haryana. Anxiety was measured through Sinha’s Comprehensive Anxiety Scale. It was found that non working women had higher anxiety scores as compared to working mother.

Many studies showed that anxiety also causes further problems as high prevalence of sexual dysfunction had been reported in women with anxiety disorders (Aksaray et al. 2001; Figueria et al. 2001; Bodinger et al. 2002). Dunn, Croft and Hackett (1999) reported that women with moderate to high scores on a self report measure of anxiety were significantly at higher risk for a number of sexual problems.

Bhusan (2003) examined the sense of security- insecurity and feeling of social anxiety in the working class Indian women. The sample consisted of 30 working women (mean age 32.6 years) who were teachers in the non-government junior colleges and 30 non-working women (mean age 33.83 years) who were housewives. Both the samples were randomly selected and matched on age, educational qualifications and family type. The results revealed that working women feel more secured as compared to their non working counterparts and working women had relatively and significantly low social anxiety than the non-working matched control group.

Anxiety and depression are also related with control. The people with low control either at work or at home had an increased risk of developing depression and anxiety whether men or women (Griffin, 2003).
Sanlier and Arpaci (2007) examined the relationship between stress and working status of working and non working women. 540 participants were selected randomly from Turkey and each participant was taken face-to-face interview. Results indicated that the working women had higher levels of stress as compared to non working counterparts that was found associated with the working status of Turkish women.

Hashmi, Khurshid and Hassan (2007) conducted a study on sample of 150 married women (75 working and 75 non working women) from Multan, Islamabad and Bawalpur through convenient random sampling technique age ranges from 18 to 50 years. Working women were doctors, lectures and bankers. They concluded that both have to face depression in their married life and working women were significantly having high stress than housewives.

As reported by Akimaya (2008) the most important factor related to depression was interpersonal conflict in women where as for men it was related to professional matters.

Aleem and Danish (2008) conducted a study to assess and compare marital satisfaction and anxiety on a group of 60 single and dual career women whose age group ranged from 25-45 years selected randomly through purposive sampling. The housewives were considered as single career where as working women were considered as dual career women. A 30 items Marital Satisfaction Scale by Amrithraj and Prakash (1985) and Sinha Comprehensive Anxiety scale by Sinha (1965) was administered on the sample to examine their level of anxiety. They found that marital satisfaction among working women hardly gets disturbed due to their multiple role
but the thought processes seemed to be disturbed that is manifested in the higher anxiety among them. The results indicated that dual career women were found to be suffering from significantly higher level of anxiety than single career women. They reported that working status of women had profound effect on their thought process, feelings and emotions probably due to the dual responsibilities of family, society and job. Sheikh & Bhusan(2002) obtained almost similar findings that the way women are perceived and evaluated by others seems to generate social anxiety in them.

Dogar et al. (2010) assessed the rate of anxiety and depression on 339 patients suffering from various medical diseases from 2005 to 2007. They reported that the anxiety and depression was more common in housewives.

Desai et al. (2011) studied the effect of personal resourcefulness and marital adjustment on job satisfaction and life satisfaction of working women in India measured through socio economic status scale, general health questionnaire, self-esteem inventory, life satisfaction scale, perceived stress scale, marital adjustment scale, the self-control schedule, and job satisfaction questionnaire. They took sample of 300 women that was divided into three groups; working women, home-based working women, and homemakers. The home-based working women were found least stressed, most well adjusted, and the most satisfied with their careers among the groups studied. Their ways of perceiving and handling stress were found to be more effective than those used by women in the other two groups.

Sidik et al. (2011) reported that the prevalence of anxiety among women was similar in Malaysia to that found in other countries.
Lilhare and Borkar (2011) compared stress and anxiety level of 200 clerical working women and shift hour duty working women (100 clerical working and 100 shift hour duty working women). The findings revealed that the working women performing clerical and shift hour duties did not have significant difference on the measure of anxiety.

Adhikari (2012) conducted a study to ascertain the effect of working conditions of mothers along with the dimensions of certain psychosocial variables like anxiety and depression in comparison with non-working conditions. To accomplish the goal the total number of 60 mothers (30 working mothers and 30 non-working mothers) with age range of 35 to 45 years were randomly selected from Southern part of Kolkata considering age, marital status, educational level, family pattern (nuclear family) and interestingly all of them were from Hindu-Bengali family. The working mothers were various post holders in different government and non-government organizations whereas non-working mothers were only housewives/homemakers. The data was collected by administrating the questionnaires- Information blank, State-trait Anxiety Inventory (STAI) by Spielberger et al. (1970) and Beck Depression Inventory (BDI) by Beck, Word, Mendelson & Erbaugh (1961). The results revealed that working mothers showed higher level of state anxiety which was statistically significant but in case of trait anxiety there exits significant difference at both .05 and .01 levels as working mothers showed higher level of anxiety than that of non working mothers. It was observed that degree of depression was also significantly higher in case of working mothers than their counterparts. It was also observed from this study that in general, state & trait both anxieties were more prominent in case of working mothers than in that of the mothers who stayed at home (non-working).
Irfan et al. (2012) investigated the effect of anxiety level on the life satisfaction among working and non-working married women. The sample consists of randomly selected 90 married women (45 working and 45 non-working women). Working women were selected from Nationalized banks from Patiala. The age of the sample ranges from 25 to 36 years. The average age of the sample is 30.5 years. Satisfaction with Life Scale (Diener, 1985) and State Trait Anxiety Test (Psy.com services, 1993) was administered on both groups of women. Two way Anova was applied to analyze the data. The results of the study revealed that working and married females were found low on anxiety with higher life satisfaction in comparison to the non-working married females. They perceived their life as challenging and secure. They felt comfortable with their life situations. Whereas, the non-working married females were less satisfied with their lives and their anxiety level was also higher than the anxiety level of working females.

Bhadoria (2013) examined level of anxiety and depression among working and non working women living in Gwalior city (India). The results showed that working women were lower in level of anxiety significantly.

Some studies also examined the relation of age, working status, education with anxiety and found contradictory results. As Gaitz and Scott (1972) stated on the basis of their study that age seems to be one of the best predictors of anxiety and older people had higher anxiety scores. Sastry (1990) studied anxiety, sex role orientation and age. The sample selected for the study was from the urban, middle class, individuals in Ahmadabad city. The sample consisted of 200 subjects with the age range of 20-45 years. The results related to age and anxiety revealed that 20 to 30 years age group had a significantly higher anxiety score compared to the 31 to 45
years age group. Leger (2004) found that most working women who experience depression and generalized anxiety disorder were between the age group 35-55 years. The study conducted by Singh (1997) on a sample of 40 working and non-working women revealed that age and working condition of women have significant influence on anxiety whereas Porkiani et al. (2009) did not find significant relationship among anxiety, age, type of employment and work record and significantly negative relationship with education.

In recent years, several studies have examined the relationship between self concept and anxiety. Many researchers found out a significantly negative relationship between various components of self and anxiety (Dishman et al. 2006; Gursoy, 2006; Fathi- Ashtiani et al. 2007; Berg, 2009) but most of them are done on adolescents. However a few studies have been done in the context of career women and housewives. Therefore it becomes essential to study self concept of women as it is an integral part of human personality and affect other aspects of one’s life too.

**Self Concept:**

The concept of ‘Self’ is probably one of the most admired ideas in psychological and educational literature among the various popular concepts which is considered as a key to success. It is important to mention that self-concept is a central theme around which a large number of the major aspects of personality are organized. The concept of self had a diversity of meaning, due to its part in multidisciplinary heritage. Philosophy and Theology have emphasized the self as the locus of moral choices and responsibility. Clinical and Humanistic psychologist have stressed the self as the basis of individual uniqueness and neurosis.
Self-concept is individuals’ perception of their abilities, behavior and personality on the whole. It refers to an individual’s beliefs and understanding about himself that are developed from the experiences that the person gains through the interaction with others in the society and are concerned with personality traits, abilities, physical features, values, goals and social roles. If people have a positive attitude towards their own self and confidence in themselves then they may get success in every sphere of life. Self-concept is the way people think about themselves. It is unique, dynamic, and always evolving. This mental image of oneself influences a person’s identity, self-esteem, body image, and role in society. As a global understanding of oneself, self-concept shapes and defines who we are, the decisions we make, and the relationships we form. It is perhaps the basis for all motivated behavior (Franken, 1994).

Self-concept has been the center of interest for many researchers in the discipline of psychology, as well as other disciplines. It is a fundamental concept in psychological theory, holding a central position in psychoanalytic (e.g., Kohut, 1977) and humanistic (e.g., Rogers, 1959) theories. The basis for this interest began with Cooley and Mead (Hampson, 1988) and continued with Freud and his followers: Erikson, Horney, Rogers, Kohut and Maslow. These theorists attributed a central role to self in personality and its development (Dweck, 2000). Self-concept is defined as a person’s perception, emotion and attitude toward one’s own self (Marshall, 1989; Plucker & Stocking, 2002; Wall, 1986). These perceptions, emotions and attitudes change in relationship to positive (Marshall, 1989) and negative reactions (Giant & Vartanian, 2003) of significant others in the person’s environment. Positive reactions (i.e.rewarding) within time cause development of self values in a child (Marshall, 1989).
Most researchers acknowledged the development of self-concept as both social and environmental that is developed through interaction significant with others and by the evaluation of personal experiences (Fontana, 1977; Keenan, 2002). Burns (1982) suggests that the four main theories dealing with the development of self-concept are those of James, Cooley and Mead, Erikson and Rogers.

The origin of self-concept theory and substantial research is presumed to have been formalized by James in 1890 (Bracken, 1996; Hattie, 2000; Tamini, Khan & Mohammadyfar, 2009).

James (1890) viewed that the ‘self’ is made up of the subjective self and an objective self. He described the subjective self as ‘I’ and the objective self as ‘Me’, where ‘I’ is a consciousness of existence and ‘Me’ is the individual characteristics that makes a distinction between individuals (James, 1890; Mussen et al., 1984). James suggested that the objective self is made up four components: the spiritual self, the material self, the social self and the bodily self (Burns, 1982) and that there is a hierarchical order of the self starting at the lowest order with the ‘material self’ followed by the ‘social self’ with the ‘spiritual self’ being the highest level (Bracken, 1996).

The relationship between the individual, other people and society at large was central to the work of Mead (1913) and Cooley (1902) who is known as ‘symbolic integrationists’ (Pollard & Filer, 1996). Symbolic integrationists believe that humans respond to the individual meanings that their environment has for them and that these meanings are made through social interaction, further modified by individual interpretation (Burns, 1982). Individuals who construct their self-concept this way are constantly evaluating how they perceive others to be evaluating them.
Cooley’s ‘looking glass theory of self’ postulates that self-concept is heavily influenced not only by the feedback that an individual receives from others, and particularly significant others, but by what that individual believes others think of him (Burns, 1982; Lawrence, 2002). Mead agreed with James that the ‘self’ could be divided into ‘I’ and ‘Me’ (Fontana, 1995; Mead, 1913). Mead believed that the development of the ‘self’ is a social process in which an individual learns the complex set of shared symbols that make up a culture (Burns, 1982). Through this, not only are “objects, actions and characteristics defined, but the individual is also defined” (Burns, 1982).

Like Cooley and Mead, Erikson also emphasized the social and cultural factors of development (Keenan, 2002). Erikson did not like the terms ‘self-conceptualization’, ‘self-image’ or ‘self-esteem’, rather he talked of ‘Identity’ (Burns, 1982; Crain, 1992). Erikson also differed to Mead and Cooley in the perspective of process of identity formation as the interaction between three systems, the ‘somatic’ or biological process, the ‘ego’ or reasoning process and the ‘societal’, the process of integration into society (Keenan, 2002). Erikson argued that identity formation is a life long process that continues through old age (Keenan, 2002). Erikson proposed eight stages of development that progressed in an orderly sequence. At each stage, the individual is faced with a unique crisis and it is how well the crisis is resolved that determines the nature of further development (Burns 1982; Crain, 1992; Keenan, 2002).

Carl Rogers and George Kelly’s view of self-concept development is usually described as ‘humanistic’ or ‘phenomenological’ (Burns, 1982) because it is concerned with the individual’s personal, subjective, view of the world (Fontana,
Rogers argued that self-concept development takes place through the interaction between two concepts: the ‘organism’ and the ‘self’ (Fontana, 1995).

Raimy (1943) was the first person who defined the self-concept as “the more or less organized perceptual object resulting from present and past self observation... (i.e.,) what a person believes about himself. The self-concept is the map which each person consults in order to understand himself, especially during moment of crises or choice”.

Rogers (1951) described self concept as” an organized configuration of the perception of the self which is admissible to awareness. It is composed of such elements as the perception of one’s characteristics and abilities; the percepts and concepts of the self in relation to others and the environment; the value qualities which are perceived as associated with experiences and objects, and goals and ideals which are perceived as having positive or negative valence.”

Jersild (1960) has explained it that “it is a composite of a person’s thoughts and feelings, strivings and hopes, fears and fantasies, his views of what he is, what he has been, what he might become and his attitudes pertaining to his worth.”

Allport (1961) viewed self concept as “something of which we are immediately aware. We think of it as the warm, central private region of our life. As such it plays a crucial part in our consciousness (a concept broader than self), in our personality (a concept broader than consciousness) and in our organism (a concept broader than personality). Thus it is some kind of core in our being.” According to Hilgard et al. (1979) self-concept refers ‘to the composite ideas, feelings, and attitudes people have about themselves’.
Hamachek (1981) stated that Self-concept “is the set of perceptions or reference points that the subject has about himself; (...) the set of characteristics, attributes, qualities and deficiencies, capacities and limits, values and relationships that the subjects knows to be descriptive of himself and which he perceives as data concerning his identity” (Machargo, 1991). The self is an active agent and self concept is the view that this active agent “has of himself as a physical, social and spiritual and moral being” (Gecas, 1982) while Burns (1982) argued that self-concept is “composed of all the beliefs and evaluations you have about yourself.”

Some researchers described self-concept as an organized collection of beliefs and self-perceptions about oneself, including one's attitudes, knowledge and feelings regarding abilities, appearance and social relationships. The self is a framework that determines how we process information about ourselves, including our motives, emotional status, self-evaluations, abilities and much else besides (Klein, Loftus & Burton, 1989; Van Hook & Higging 1988). Self-concept is also defined by Purkey (1988) as the sum of a complex, organized, and dynamic system of learned beliefs, attitudes and opinions that each person holds to be true about his or her personal existence.

Shavelon and Bolus (1982) explained self-concept as one's judgments of his own self. The referred judgments include one's beliefs, feelings, attitudes and values.

Franzoi (1996) said that “the self concept is the sum of individuals’ beliefs about their own attributes such as their personality traits, cognitive schemas, and their social roles and relationships”. In the words of Byrne (1996) “Self concept can be described as the beliefs, feelings and memories a person has of himself.”
Sedikides and Skowronski (1997) proposed that the self evolved as an adaptive characteristic. The first aspect of emerge was “subjective self awareness”, secondly “objective self awareness”, and the third level of functioning is “symbolic self awareness.”

Baumeister (1999) defined self-concept as “the individual’s belief about himself or herself, including the person’s attributes and who and what the self is”.

Lawrence defined self-concept as “the sum total of an individual’s mental and physical characteristics and his/her evaluation of them” (In Pollard, 2002).

Bukatko and Daehler (2001) defined self concept as the combination of perceptions and values that an individual believes to be true of their own self. Woolfolk (2001) stated about self concept that it is the value that an individual places on his or her own characteristics, qualities, abilities and actions.

According to Thompson (2003) “self concept is a multidimensional construct, including the dimension of self worth. Self-concept includes an individual’s overall perception of their psychological and physiological being, where as self-esteem is the judgment of worth an individual assigns to his or herself.”

Michener et al. (2004) explained self-concept as “the organized structure of cognitions or thoughts that we have about ourselves. It includes the perceptions we have of our social identities and personal qualities, as well as our generalizations about the self based on experiences.”

Thus, there are various views regarding self concept but a general agreement is made that self concept is the knowledge of a person about his own abilities,
personality characteristics, social relationships and their role and position in the society. Self concept can either be positive (high) or negative (low). Positive or high self concept is important because it leads to sense of self worth, self-confidence, self respect, positive self evaluation, self esteem and self acceptance (Arthur, 1992). High self concept enables an individual to execute at superior level and utilize the learning experiences in the most favorable manner. On the other hand, low self-concept leads to frustration and involves in self-hatred (Lebar, 1999). Different views are proposed besides these two dimensions regarding whether self-concept reflects multiple or a single unity structure (Campbell et al., 2003). A common idea is that self is a multidimensional construct which consists of very different cognitive and affective components. On the other hand, consent has been reached that self is a unitary structure which depicts global ideas such as self-esteem and self-clarity (Nowak et al., 2000; Rogers, Kuiper & Kirker, 1977).

Rogers (1959) considered that self-concept has three different components i.e. ‘Self-image’ that refers to the view a person have about oneself, ‘Self-esteem’ or self-worth meant for how much value a person place on oneself, and ‘Ideal self’ is the self that a person would like to be.

When there is a corresponding relationship between the real self and ideal self, a person is generally happy and satisfied, while discrepancy between real self and ideal self often results in sadness and dissatisfaction and this is likely to affect how much a person value oneself. Therefore, there is an intimate relationship between self-image, ego-ideal and self-esteem. A person’s ideal self may not be consistent with what actually happens in life and experiences of the person. Hence, a difference may exist between a person’s ideal self and actual experience. This is called incongruence
that leads to generate anxiety in individuals. Roger’s basic principle is that people have a tendency to maximize self-concept through self actualization. He believed that for a person to achieve self-actualization, he/she must be in a state of congruence.

MacCandless (1970) said that self-concept is comprised of three main components structure, function and quality.

1. Self-concept structure;
   a. Numb and flexible
   b. Coordinated
   c. Simple and complex

2. Self-concept functional aspects;
   a. Self-evaluation of right or wrong
   b. Prediction of right or wrong
   c. Prediction of success or failure
   d. Related to multifunctional such as self-endorsement, self-actualization and self-efficacy
   e. One’s behavior is based on internal motivation or external expectation.

3. Three concepts of quality;
   a. beautiful or ugly
   b. self-acceptance and self-denial e.g. to what extent one can live comfortably with the sense of his well-being is not in a good condition.
According to Burns (1982) self concept implies positive self esteem and vice versa. He described three main elements of self concept:

(i) The identity of the subject or self image, referred to as the perception or mental representation of him/herself the cognitive aspect of self concept. Burns uses the terms ‘descriptive’ for self-image.

(ii) Self esteem which is related to the value individuals attach to the particular manner in which they see themselves. Self-esteem is the evaluative aspect of the self-concept that corresponds to an overall view of the self as worthy or unworthy (Baumeister, 1998).

(iii) A behavioural component, that reflect how self concept influences and conditioned the subject’s behaviour.

Gecas (1982) described three motives that are often associated with the self concept that are self efficacy, self esteem or self enhancement and self consistency.

The development of the self-concept and the enhancement of self-esteem are now considered to be a major outcome of education (Fontana, 1995). Self-concept is seen as being a major determinant of one’s learning and behaviour (Burns, 1982). Lewis (1990) contended that the development of the concept of self has two aspects viz., existential and categorical self. Existential self refers to ‘the most basic part of the self-concept; the sense of being separate and distinct from others and the understanding of the steadiness of the self’. The individuals generally realize that existential self exists as a separate entity from others and that they continue to exist over time and space. This awareness of the existential self begins due to the relation people have with the world. Second one is Categorical self, that develops after
realizing that he or she exists as a separate experiencing being, hence, thereafter he/she becomes aware that he or she is also an object in the world, which can be experienced and has properties (such as age, gender, size or skill, etc.). Self-concept consists of three fundamental self-representations: the individual self, the relational self, and the collective self. The individual self is achieved by differentiating from others (i.e., the individual self contains those aspects of the self-concept that distinguishes the person from other persons as an exclusive assortment of traits and characteristics that distinguishes the individual within his or her social context). This form of self-representation relies on interpersonal comparison processes and is associated with the motive of protecting or enhancing the person psychologically (Brewer & Gardner, 1996; Markus, 1977; Sedikides, 1993).

The relational self contains those aspects of the self-concept that are shared with relationship partners and define the person's role or position within significant relationships. The relational self is based on personalized bonds of affection. Such bonds include parent-child relationships, friendships, and romantic relationships as well as specific role relationships such as teacher-student or clinician-client. This form of self-representation relies on the means of reflected appraisal and is associated with the motive of protecting or enhancing the significant other and maintaining the relationship itself (Brewer & Gardner, 1996; Hazan & Shaver, 1994; Reis & Shaver, 1988).

The collective self contains those aspects of the self concept that differentiate in-group members from members of relevant out groups. The collective self is based on impersonal bonds to others derived from common (and oftentimes symbolic) identification with a group. These bonds do not require close personal relationships
among group members. Turner et al. (1987) defined briefly the collective self as a "shift towards the perception of self as an interchangeable exemplar of some social category and away from the perception of self as a unique person". The collective self relies on intergroup comparison processes and is associated with the motive of protecting or enhancing the in group (Brewer & Gardner, 1996).

Self concept can be viewed in terms of two major dimensions: identities and self esteem. Identities refer to the content of one’s perception and beliefs about oneself whereas self esteem refers to how one evaluates or feels about oneself.

Lawrence (In Pollard, 2002) suggests that self-concept can be divided into three areas of development: self-image, ideal self and self-esteem.

Generally, identity, self-worth, and self esteem are considered to be the evaluative components of self concept. Self-concept is an individual’s perception of self, including self-esteem, body image, and ideal self. A person’s self concept is often defined by self description such as “I am a mother, a nurse, and a volunteer.” It is essential for an individual to maintain a healthy self-concept for overall physical and mental wellness. Three basic components of self-concept are the ideal self, the public self, and the real self. The ideal self is the person would like to be, such as a good, moral, and well-respected person. Sometimes, this ideal view of how an individual would like to be conflicts with the real self (how the person really thinks about himself, such as “I try to be good and do what’s right, but I’m not well respected”). This conflict may motivate an individual to make changes toward becoming the ideal self. However, the view of the ideal self needs to be realistic and obtainable otherwise the person may experience anxiety or be at risk for alterations in
self-concept. **Public self** is what an individual thinks others think of him and influences the ideal and real self. The compatibility among these three components is essential for maintaining positive self-concept and good mental health. A positive self-concept is an important part of a person’s happiness and success. Individuals with a positive self-concept have confidence in their selves and they can achieve the aspired targets. Achieving their goals reinforces their positive self-concept. A person’s self-concept is composed of evolving subjective conscious and unconscious self-assessments. Physical attributes, occupation, knowledge, and abilities of the person will change throughout the life span, contributing to changes in one’s self concept.

Self concept connotes a broader representation of the self that includes cognitive and behavioural aspects as well as evaluative and effective ones (Blascovich & Tomaka, 1991). Various researches have observed change in self concept in terms of depth and certainty (Baumgardner, 1990; Campbell, 1990; Campbell et al., 1996; Garg, 1992; Kernis et al., 1993).

Self-concept encompasses three major qualities as suggested by Purkey (1988) that it is

- learned,
- organized,
- dynamic

Self-concept is learned indicates that no one is born with a self-concept. It is a process that emerges in the early stages of life and is shaped and reshaped by experiences through adolescents to adulthood by the people who influence us. It is
also assumed that any experience which is inconsistent with one's self-concept may be perceived as a threat to the self concept and the more of these experiences there are, the more rigidly self-concept is organized to maintain and protect itself. When a person is unable to get free of perceived inconsistencies, anxiety and emotional problems arise.

Self-concept is organized indicates that each person retains innumerable perceptions regarding his personal existence and each perception is harmonized with each other. It is usually stable and organized which gives consistency to the personality and helps individual to resist change.

Self-concept is also dynamic in nature, it might be assumed that continuously active guidance system not only shapes the ways a person views oneself, others, and the world, but it also serves to direct action and enables each person to take a consistent "attitude" in life. Since, self-concept development is considered as a continuous process so there is regular integration of new thoughts and eviction of old ideas throughout life. Dynamic nature of self-concept continuously guards itself against loss of self-esteem; unfortunately, its loss produces feelings of anxiety.

Demo (1992) concluded that self concept is characterized by both stability and change over a life course and environmental stability plays an important role in self concept stability.

**Factors affecting self concept:**

According to Myrick (1987), self-concept and self-worth are the results of how individual communicate and interact with one another. When individual self-concept is developed, multiple attitudes and self-personalization appear to be part of
learning process. Evidently, individual self-concept develops and matures as the product of environmental experiences (Lebar, 1999). There are various factors that may affect self-concept of an individual. According to Hattie (1992) high self-concept i.e., realistic or somehow positive self-appraisals, has a number of correlates. Some correlates that have been more strongly associated with higher self-concepts are: internal locus of control, desirable home environments, supportive and attentive communication style, versatile and deep processing study skills. Burns (1979, 1982) reported that a positive self-concept can be equated with positive evaluation, self respect, self-esteem, and self-acceptance, whereas a negative self-concept becomes synonymous with negative self-evaluation like self-hatred, inferiority, feelings of personal worthlessness and absence or low self-acceptance. Self-concept can be affected by an individual’s life experiences, heredity and culture, stress and coping, health status, and developmental stage.

**Life Experiences:**

Self concept is developed and influenced through various life experiences including success and failure. Experiences in which the individual has accomplished a goal and achieved success will positively reinforce the development of a healthy self concept. Difficult experiences or failures may negatively impact an individual’s self-concept unless he/she has established coping strategies to deal effectively with these challenges to their self-concept. Coping strategies are learned as a person encounters and deals with various situations in life.
Heredity and Culture:

An individual is usually grown up by learning and integrating his/her family's heredity and culture into his/her life. Heredity and culture shape and influence a person's self concept and this process begins from the birth. Individuals who have incorporated their heredity and culture into their life tend to have a healthier self-identity and self-concept.

Stress and Coping:

Everyone experiences stress at some level in every day life. Common stressors include problems regarding financial, work, relationship, and health. Every Individual reacts and deals with stress in different ways depending on his past experiences and success and failure with dealing with stress. Individuals who learn and use effective coping strategies to deal with stress will most likely develop a positive self-concept. People who become overwhelmed with stress may feel hopeless and powerless, leading to a feeling of low self-confidence and self-esteem.

Health Status:

People have a tendency to take their good health for granted. When they become ill, their altered health status can change their self-identity and self-concept. Amendment in body image can result from such health issues as amputation, cancer, mastectomy, trauma, or scarring, anxiety, conflict and many other problems.

Developmental Stage:

Growth and development of a person begins from birth and continues into adulthood. Typically a person will achieve specific developmental tasks as one passes
through each stage of life. The successful accomplishment of each task will influence and reinforce the development of a healthy self-concept. Individuals who experience developmental delays or situations in life that prevent or delay the accomplishment of developmental tasks can have an altered or negative self-concept. Negative self-concept may also develop due to continuous experience of failure in a child life. In this case, failure can be defined as unsuccessful to satisfy their parents or themselves. A continuous failure in child life get him feel that they are useless. Whereas, a positive self-concept is developed if a child sees failure as an opportunity for him to improve himself in every aspect of life or in decision-making. Another significant aspect that contributes in the development of negative self-concept is depression. People who suffer from depression tend to think and response negatively towards everything including evaluating themselves. They can be super sensitive to what other people say about them or act towards them. Moreover, internal self-critic is another important aspect that influences the process of the development of self-concept. Internal self-critic is needed to evaluate every action and decision that a person takes in his/her life. It functions as a regulator in every action and behavior of a person, so that he/she can be accepted by the society around or can adapt well within the society (Yahaya, 2008).

Purkey (1988) stated that individuals contain within themselves relatively boundless potential for developing a positive and realistic self-concept. This potential can be realized by people, places, policies, programs and processes that are intentionally designed to invite the realization of this potential.

The self concept is an extremely significant phenomenon as it permits the individual to make decisions and personalize his reactions. It also provides a
framework that determines how we process information about ourselves, including our motives, emotional states, self evaluation, abilities and much else besides (Klien et al., 1989; Van Hook & Higgins, 1988).

Thus, it becomes essential to understand about women’s concept of self as Messias et al. (1997) stated that occupying multiple roles is thought to increase the women’s chances to learn, to develop self-efficacy and self-esteem, to build social network and open access to informational, instrumental and emotional support, and to buffer life’s stresses and strains.

Mackie (1983) compared self-conceptions of full-time housewives and women in the labor force and found that the self-esteem of working wives was significantly higher than that of housewives. Stokes and Peyton (1986) also reported that fulltime home makers held more conservative values and a more traditional view of women’s roles had lower self esteem than women who work outside the home. On the contrary Tabatabaei (1993) revealed that employment status did not have a significant effect on the self-esteem and mental health of the sampled group.

Butler, Hokanson and Flynn (1994) showed that employed women had higher self esteem and thus lower in comparison with housewives.

Bala (1998) investigated the relationship between social self concept and employment status of employed and unemployed Indian women (150 in each group) age ranges from 22-48. The results revealed that employed women were higher on social self concept than to the unemployed women.

Sachdeva and Malhotra (2001) reported that working status enhances self esteem of women and enhanced self esteem works as moderator of stress in working women.
Kumthekar (2004) examined 137 working and 99 non working women age range from 25 to 45 years and found that there was no significant difference between the self concept of working and non working women. There was also no significant difference found among women working at different occupational level.

Sadeghi and Vasudeva (2006) conducted a study on 250 married employed and 250 married unemployed women in the age range of 24-41 years, with educational qualification of 10+2 and above and having at least one school going child using stratified convenience sampling technique. General Self-Efficacy Scale (GSE) and Coopersmith Self-Esteem Inventory (CSEI) were chosen for collection of data. Results indicated that professionally employed women were significantly higher on self-efficacy and self-esteem than unemployed and non-professionally employed women. But non-professionally employed and unemployed women did not differ significantly on self-efficacy and self-esteem.

Jan and Ashraf (2008) reported that self-esteem has enormous influence on mental health of women. Self-esteem comprises self-worth and self-image, which affects women's adjustment in various spheres of life. This study examined the relation of age, family income, and family type with self-esteem among women. In this context, 100 women were selected through multistage sampling method, administering questionnaire, and 'self-esteem scale for women' (SESW) on them. The study reveals highly significant relation of family type with self-esteem in personal life of women. Significant differences were also found among women in joint, nuclear and extended families, concerning their self-esteem in family relations, career life, and overall self-esteem. Family income has also shown significant association with women's self-esteem in family relations.
Hasnain, Ansari and Sethi (2011) found non working women had better self esteem than working women.

Devi, Sridevi and Rani (2011) conducted an examination to study the level of self-concept among professional women and the correlation between various demographic variables like age, experience and income on self-concept. A total sample of 180 women professionals belonging to six different occupations from the twin cities of Hyderabad and Secunderabad was chosen. The age ranged from 25 to 45 years and above with experience ranging from 2 years to 18 years. The self-concept scale developed by Mukta Rani Rastogi was administered individually to each of the subjects. Results showed that professional women experienced significantly greater self concept and self concept increases with age, experience but it was not related with income.

Self concept is a psychological construct that affects thoughts, emotions and also other behaviours (Byrne, 1996; Harter, 1990; Marsh, 1990). It was noted in some studies that self esteem is related to anxiety negatively as it increases in employed women, their anxiety decreases (Robert & Helson, 1997; Thomas et al., 1999). Pahlewanzadeh (1997) concluded as the person fails to achieve self esteem she may experience anxiety, mental breakdown, suspicion of herself and feel of lack of competence in life and confirmed negative relationship between self esteem and anxiety.

Sanford and Donovan (1985) concluded that women are usually characterized by poor self belief and vulnerability to anxiety and depression. According to Brenda, Cheryl and Shannon (2003) what a person experiences with low self esteem is that when everything is according to his wishes he gets anxious.
Lack of self belief makes a person his worst enemy and he will always suffer from anxiety and uneasiness (Mindi et al., 2006).

Porkiani et al. (2009) studied the relationship between anxiety and self esteem in employing women and the relation of self esteem factors and anxiety on women in Iran. It was found that self belief and anxiety of employed women have statistically negative and significant relationship. The results also revealed that there was a statistically negative significant relationship between self esteem and obvious anxiety.

The importance of self-concept stems from its influence over the quality of a person’s behavior and his/her method of adjustment to life and situation. It determines an individual’s adjustment in all the spheres of life as if the person is having positive view of himself then it will be easy for him to adjust in a new environment. Ybrandt (2007) explained that a positive self concept is the most important factor for adjustment and as a safeguard against typical problems that may affect behaviours (internalized and externalized). Bala and Laxmi (1995) also reported that perceived self concept as well as social self concept was positively correlated with marital adjustment for both employed and unemployed women. Thus, study of adjustment also becomes essential while looking for anxiety level and self concept of women.

**Adjustment : concept and relevant research overview**

Women have to perform many responsibilities all together, especially married working women have to play dual role as daughter-in-law, mother and housewife in the family and as an employee at their work place. Being subjected to the dual demands of home and work they are predisposed to face the catastrophe of adjustment in different areas such as home, emotion, health, social and so on. The problem of
adjustment is becoming a critical phenomenon that immersed in our complex and
civilized society. Adjustment refers to the extent to which an object fits the purpose
for which it is intended. In simple words it is a process that makes a balance between
the demands of environment and needs and interests of an individual. It is an active
process by which the daily programs run smoothly without being affected. It occurs as
the individual lives in his family situation, advances educationally, pursues vocational
outlets, and engages in social relationships. His adjustment is helped as he acquires
new experiences, accepts ideas and behaviour with which he may not agree, conforms
to the ways of the members of the group or to the customs of society and strives to
attain self realization. Adjustment is a static equilibrium between an organism and its
physical and social surroundings in which there is no stimulus change evoking a
response. Further no need remains unsatisfied and all the continuative functions of the
organism are proceeding normally. In broader sense adjustment refers to the
psychological processes through which human beings manage or cope with the
demands, challenges, and frustrations of everyday life.

Symonds (1939) defined adjustment as “a satisfactory relation of an organism
to its environment. Culturally, it is the process of conformity to the cultural norms of
the society.”

Smith (1955) stated that “a good adjustment is one which is both realistic and
satisfying. At least in the long run, it reduces to a minimum the frustrations, the
tensions and anxieties which a person must endure.”

Gates et al. (1955) defined adjustment as “a continuous process by which a
person varies his behaviour to produce a more harmonious relationship between
himself and his environment.”
Schneider (1955) emphasized that the "social adjustment signifies the capacity to react effectively and wholesome to social realities, situations and relations so that the requirements for social living are fulfilled in acceptable and satisfactory manner."

According to English and English (1958) "adjustment is a process of harmonious relation to the environment wherein one is able to obtain satisfaction for most of one's needs and to meet fairly well the demand, physical and social put upon one."

In the words of Boring, Langfeld and Weld (1962), "adjustment is a continual process by which a living organism maintains a balance between its needs and the circumstances that influence the satisfaction of these needs."

Lehner and Kube (1964) observed that "personal adjustment is the process of interaction between ourselves and our environments. In this process we can either adapt to the environment or alter it. Satisfactory personal adjustment depends on successful interaction."

Eysneck et al. (1972) described it as "a state in which the needs of the individual on the one hand and the claims of the environment on the other hand are fully satisfied or the process by which this harmonious relationship can be attained."

Jersield (1978) defined adjustment as "a continual process by which a person varies his behaviour to produce a more harmonious relationship between himself and his environment."

Thus it can be said that adjustment is a continuous process by which an individual makes an adequate relation with his/her environment and fulfill his basic
needs in a reasonably satisfied manner. In other words, it is the process by which a person varies his/her behaviour to produce a more harmonious relationship between himself and the environment in which he/she lives. It has also been defined as the individual’s successful adaptation to and interaction with his environment.

Interaction between an individual and the environment is an integral part of living. At the outset the environment involves principally the members of one’s family. As the person interacts with those people he consciously acquire from them certain methods of adjusting, methods which are modified to suit particular needs. As the person grows older he interacts with larger groups of people and acquires additional methods for adjusting. During this process of interaction and often without being aware of what is being done, people experiment with methods that they have observed in others and so evolve the behaviour patterns that constitute their specific pattern of adjustment.

The extent to which an individual is able to achieve successful life adjustment prominently depends on the environmental stimuli to which he is successively exposed during his life span, especially during his childhood and adolescent years and his inherited and acquired power to make whatever changes within himself that shall serve as the bases of constructive thinking, feeling and doing. Poor environmental conditions and/or deficient potentially are more than likely to encourage the development of maladjustments that can be harmful both to the individual himself and to those other persons whose lives are affected by his demonstrated attitudes and behavior.

An individual who is unable to overcome the obstacle in his path to achieve or who is rejected by the members of his group may become inadequately adjusted.
Complete rejection or repeated failure in achieving the goals is likely to be conducive to maladjustment.

An individual’s degree of successful adjustment in various spheres is perhaps strongly related to his/her past experiences, environmental influences and personal strengths. An individual hold the power to select, and to apply to himself the environmental elements and the experiences that may seem to him to be best suited to satisfactory adjustment. At the same time, however, the operation in a person’s life of scientifically evolved principles of cause and effect cannot be disregarded.

Adjustment is the process by which a living organism maintains a balance between its needs and the circumstances that influence the satisfaction of those needs. The essential aspects of the adjustment process are the existence of a motive, circumstances leading to its thwarting, resulting in varied responses, which may eventually lead to the discovery of a solution. It is an accepted part of our cultural pattern for persons to be thwarted and to make adjustments that result in achievement. This process enables an individual to learn certain ways of behavior through which he enters into a relationship of harmony with his environment. Thus, he tried to lead a life that is acceptable to the society. In its simplest form the term adjustment means that we should accommodate ourselves in order to fit certain demands of our environment. It also deals with how we make such accommodations and how successful we will be in finding solutions of our problems.

Adjustment is a process, which is expected to lead to a happy and contented life of every person. It creates a balance between needs and the capacity to meet these needs, persuades persons involved to change ways of life according to the demands of
the situation, and gives strength and ability to bring desirable changes in the conditions of the environment.

Adjustment refers to the individual’s behaviour delaying with or mastering demands that are made upon him by his/her environment. It is emphasized that adjustment is a learned behaviour, not an innate quality and is a continuous and indispensable process which is necessarily determined by the norms of the society and the environment with which the person is associated.

As it is known that adjustment is a process of continuous interaction, since both the organism and its environment is not static. It is a dynamic aspect concerning to any individual as the environment differs adjustment also differs. Adjustment may be viewed from two dimensions. First, adjustment may be viewed as an achievement or how well a person handles his conflicts and overcomes the resulting tension. Second, adjustment may be looked upon as a process or how a person adjusts to his conflicts.

Various researchers viewed adjustment or maladjustment from different perspectives. Psychoanalytical theorists discussed that the human personality had three components the id, ego and superego. The maladjustment occurs when a person’s upbringing has resulted in the development of a weak ego that is not able to mediate between the id’s demands for gratification and the superego’s demands for moral conduct. A well adjusted personality is one in which childhood development has allowed all the three components in some harmony. But the Neo Freudian argued that the sign of good adjustment is the full development of the individual’s social potential to form warm and caring relationship with others. Behavioural theorists
explained adjustive and maladjustive behaviours in terms of the learning process. According to them people engage in certain behaviours because they have learned through previous experiences, to associate these behaviours with rewards but these behaviours either have not been rewarded or punished, they stopped engaging in those behaviours. Thus all behaviours either adjustive or maladjustive are learned.

The mental hygienists took a more personal view of the adjustment process and consider it to be the need for a person adjusting to himself, understanding his strength and limitations, facing reality and achieving a harmony within himself. They put emphasis on the achievement of self acceptance, freedom from integral conflicts, self realization and developing unifying set of values which makes life full of meaning and purpose.

Social aspect of adjustment requires that the individual should achieve a reasonable compromise between his drive of self realization and the demands of the society in which he lives. He should establish a satisfying contact with other members of his group. He should have a socially oriented outlook towards life.

Clinical psychologists consider an organized behaviour to be adjusted behaviour and therefore freedom from fears, phobias, anxiety, obsessions, hostilities, complexes, stress and other pathological symptoms are the criteria against which adjustment can be evaluated.

Personality psychologists define adjustment on the basis of self concept, self picture of the individual which should be in accord with reality.

Adjustment is subjective and continuous process that varies from culture to culture but there are some certain features which possibly will be remaining similar
across different cultures and individual might be regarded well adjusted. A well adjusted person is aware about his own strengths as well as limitations. He has a sense of worth for himself and respect for his actions. He also respects other members of the society. His level of aspiration is neither too low nor too high in terms of his own strengths and abilities. He does not try to reach for the stars and also does not repent over selecting an easier course for his advancement. His basic organic, emotional and social needs are almost fully satisfied or in the process of being satisfied. He does not suffer from emotional cravings and social isolation. He has a feeling of security and maintains self esteem. He is not rigid in his attitude or way of life. He can easily accommodate or adapt himself to change circumstances by making necessary changes in the behaviour. He is not overwhelmed by adverse circumstances and has the will and the courage to resist and fight odds. He has a realistic approach to look to the world around him. A simple but important generalization is that a well adjustment person lives comfortable with himself (Shaffer & Shoben, 1956).

Different researchers have conducted studies on working and non working women as working women have to adjust themselves at home as well as at work place. The confusion arises due to incapability on the part of a woman to strike equilibrium between the old role and the new role. The role conflicts to which generally the Indian working women are exposed due to entry into jobs are above all ‘inter-role conflict’ (Mies, 1980). There is evidence that inter role conflict is associated with lower family and marital adjustment (Barling, 1986; Pleck, Staines & Lang, 1980; Suchet & Barling, 1986). Some studies carried out to see the relation with perception, role playing, employment, education, adjustment etc. Adjustment is also affected or determined by many other factors such as income, family support.
Lack and Mack (1949) conducted a study on marital adjustment of non-working and employed women and found that there was no significant difference between the marital adjustment of working and non-working women. On the contrary, some of the researchers confirmed that working and non-working women did not differ significantly on marital adjustment (Brar, 1997; Kapur, 1970; Singh, 1984; Singh, 1987).

Pareek (1954) found that poor economic condition and lack of education adversely affected marital adjustment. Mahajan (1966) reported that women even when in highly paid jobs, highly skilled and technical jobs, cannot get over from their consciousness about their duties and obligations towards parents, husband and children and can't avoid thinking that they have not been able to do justice to their household duties, especially towards children. This creates problems of inner conflict, tension etc.

Hops et al. (1972) reported that working married women can not properly adjust with their married life because they have many other tasks to perform at a time.

Heckman (1977) observed that the overload strain is a significant issue for dual career women in assessing problem areas for dual career couples. It was found that the women reported more problems in more areas than did men. They concluded that the continued existence of role conflict and overload strain are often at the expense of the women's personal identity and career aspirations.

Surti and Bhatt (1979) found significant difference between marital and family adjustment of women living in joint and nuclear families. Correlation between marital
and family adjustment of the daughter-in-laws in joint and nuclear family showed significant differences.

Houseknecht and Macke (1981) focused on highly educated women to investigate the relationship between female employment and marital adjustment. The data was drawn from a sample of 663 women who received high-level graduate degrees from a large mid western university. The findings showed that the marital adjustment of working women was higher than that for nonworking women. The results also revealed that it was not employment status per se which was important in determining marital adjustment but rather the extent to which family experiences accommodate the wife's employment.

Stella (1983) interpreted that poor communication in couples results in low level of marital adjustment. Moore et al. (1984) failed to find significant differences on marital adjustment amongst working and non working women.

Marshal (1985) declared that marital satisfaction was positively related to joint authority sharing of men and women in middle and upper middle class families.

Kumar and Rohtagi (1985) studied relationship of anxiety, neuroticism security with adjustment in married life. They found that the high adjusted couples were more relaxed (lower anxiety), emotionally more stable (lower neuroticism) and had a tendency to feel more secure in comparison to the low adjusted couples.

Upmanyu and Chauhan (1987) conducted a study on the marital adjustment of working and non working women and their attitude towards marriage. The analysis of the results indicated that working women have a positive attitude whereas non
working women have negative attitude towards marriage. Working women showed better marital adjustment as compared to non working women.

Bal (1988) selected 72 married couples for determining marital adjustment of dual earner couples in relation to marriage style. A comparison of working and non working wives and husbands revealed that working and non working status of women does not affect adjustment level of wives and husbands but it was observed that working and non working women significantly differed on marital and family adjustment for different marriage span.

Kumar, Joysinha and Patel (1989) attempted to examine the relationship of marital adjustment and mental health in married couples. The results indicated that the highly adjusted husband and wives possessed better mental health status as compared to the low adjusted husbands and wives.

Saxena (1990) studied the pattern of adjustment of retired working and non working women and found that retired working and non working women have been seen to have different adjustment patterns.

Richardson and Kittery (1991) conducted a study on educated working women and found that double responsibility which married working women expressed that they face difficulties in meeting demands of both professions and family there was a clash of personal interests between the spouses, which have experienced by a majority of the respondents.

Nathawat and Mathur (1993) compared marital adjustment and subjective well being in Indian educated housewives and career women. Results showed that working women have better marital adjustment and subjective well being than the housewives.
Working women also scored higher on general health, life satisfaction and self esteem and lower on hopelessness, insecurity and anxiety as compared with their counterparts.

Noroozi (1994) reported that employed women in contrast to women who were not employed have better marital adjustment.

Pandey (1996) examined the effect of profession on the social and marital adjustment of working and non working women. It was found that working and non working women significantly differed on social and marital adjustment from each other. The findings revealed that social and marital lives were affected adversely by the profession of women.

Marital adjustment may be a part of social adjustment for women as Fujihara (1998) found in an investigation which was conducted on 153 married couples. The findings showed that marital adjustment was significantly correlated with subcategories of social adjustment namely, household adjustment (except the spouse), external family adjustment, work adjustment, social leisure adjustment and general adjustment.

Aminabhavi and Kulkarni (2000) examined the marital adjustment of working women and housewives. The sample comprised of 50 working women and 50 housewives aged from 23 to 55 years. The marital adjustment inventory developed by C.G. Deshpandey (1988) was employed to measure the marital adjustment. The results showed that working women have significantly higher marital adjustment than the housewives. It was also observed that women of adult group and who belonged to nuclear families also have higher marital adjustment than their counterparts.
Jain and Gunthey (2001) examined the adjustment problems of 240 working and non-working women and found that non-working women had better understanding, more marital satisfaction and fulfillment of expectation whereas working women perceive little personal responsibilities for marital outcomes. Working women were found to have more hazards, less support and more psychosocial adjustment problems as compared with their counterparts.

Rogers and May (2003) also reported that working class women are generally more satisfied with their lives and marriage than non-working women. Kausar (2003) investigated the personality traits and socioeconomic status as predictors of marital adjustment in working women discovered that the difference between marital adjustment of working women of low, middle and high socioeconomic background was not statistically significant thus, it can be deduced that marital adjustment of working class women was not dependent on their socioeconomic background, rather the personality trait of the woman was a factor in her marital adjustment.

Singh, Thind and Jaswal (2006) compared the marital adjustment of families with employed and non-employed women across different educational levels. The sample was comprised of 300 families selected from Ludhiana (Punjab). The findings revealed that employed wives who are educated up to post graduation or graduation and their husbands were significantly more socially adjusted than the non-employed and educated wives. It was also observed that non-employed wives who were educated post graduation or above seem to be emotionally more dependent on their husbands.
Hashmi (2007) had done a study on marital adjustment, stress and depression among working and non working married women. The samples were consisting of 150 married women out of which 75 working and 75 non working women. The result showed that working married women could not contribute significantly for the well being of the family.

Kumar (2007) conducted a comparative study of adjustment between rural and urban working women in Kashmir and found that rural working women and urban working women differ significantly on their overall areas of adjustment.

Sinha and Sanyukta (2008) investigated the adjustment problems of working and non working women. The group consist of 200 women (100 in each group) selected randomly. The results indicated that working women have less adjustment problems as compared to nonworking women.

Dubey (2009) conducted a study on a sample of 100 working and 100 non working females selected from rural and urban areas of Saran district. It was found that working and non working women did not differed significantly on marital adjustment.

Chaudhari and Patel (2009) investigated marital adjustment among females of urban and rural area of Mehsana (Gujarat) selected through the purposive random sampling. The results indicated that there was insignificant relationship between marital adjustment and place of residence. It was also found that working status did not play an effective role in marital adjustment.

Kumari (2011) assessed the effect of socio-economic status on marital relationship and family resource management of the working women. It was found
that income was positively correlated with the level of marital satisfaction. The results showed that high income group has higher satisfaction as compared with the middle and low income group.

Markoweski and Greenwood (1984, Cited by Hosein Qhafari, 2005) reported significant positive relationship between social adjustment and marital adjustment, it means that the people who were successful in life were more adjusted in their social relationship.

Aminjafari et al. (2012) studied the marital adjustment in employers' dual career and single career families and found that the single career family couples (single earner) had higher marital adjustment as compared to the dual career family. Sexual activity, pain and comfort, work capacity, social support, physical environment, positive feelings and opportunities for acquiring new information and skills were found to play significant roles in marital adjustment score prediction among the twenty five quality of life factors.

Mangaleswaran (2012) studied the married women working as police personnel in Tiruchirappalli (India). The findings showed that almost in all dimensions and overall adjustment problems, the respondents had high level of adjustment problems though there was no significant difference among the various nativity of respondents with regard to the dimensions of adjustment problems, namely, health, emotional, self, home, social adjustment problems and overall adjustment problems. It was also observed that respondents from rural, urban and semi-urban were having an equal level of adjustment problems in all the dimensions, including the overall adjustment problems.
Goel and Narang (2012) studied the marital adjustment, mental health and frustration reactions of middle aged males and females from Delhi (India). The sample was comprised of 150 males and 150 females (n=300) working as bank employees, doctors and lecturers, within the age range of 40-55 years. It was seen that females showed high level of recreational adjustment as compared to males but males were having better group oriented attitude than females. The results revealed that there was insignificant sex differences found in marital adjustment of middle aged males and females. Significant sex differences were found only in recreational adjustment.

Jamabo and Ordu (2012) examined marital adjustment of 300 working and non working class Nigerian women selected through multi stage random sampling. The results revealed that both working and non working class women did not exhibit any difference in their marital adjustment. The level of education and income also not found to be affected marital adjustment of both groups. Kumar & Sharma (2012) also reported that working and non working women did not differ with respect to marital adjustment.

Tiwari and Bisht (2012) conducted a study on 100 women (50 working and 50 non working) in the age range of 20-40 years to measure the marital adjustment. The findings indicated that non working women were better at marital adjustment. It was also found that marital adjustment was better in the later years of marriage as compared with the early years. Women from nuclear families were found to have better marital adjustment than women from joint families.

Goel, Narang and Karodia (2013) studied the marital adjustment and mental health in middle aged couples (40-55 years) living in Delhi (India). The sample comprised of 200 working couples which were bank employees and doctors (100
doctors and 100 bank employees) age ranges from 40-55 years from Delhi (India). It was seen that in bank employees, autonomy was positively correlated with family adjustment, positive self evaluation and financial adjustment. In middle aged doctors, autonomy was positively correlated with family adjustment and social adjustment; whereas integration of personality was found correlated with role distribution. On the other side, perception of reality was negatively correlated with recreational adjustment and role distribution. A significant interactive affect of job and age, was found on marital adjustment, mental health of middle aged couples.

Thoker (2013) compared the adjustment problems of retired working and non-working women living in rural and urban background. 200 retired working and non-working women were selected by using purposive cum stratified sampling technique. It was found that retired working and non-working women differ significantly on adjustment problems. Retired working women seemed to have more adjustment problems as compared to non-working women. Further, it was found that locality has significant impact on adjustment problems of retired working and non working women, rural group was found more adjusted than urban group.

**Mental Health: meaning and review of literature:**

Health is an indispensible feature in human being and it should be taken on priority to maintain optimum level of physical, psychological and social health by every individual. Health, an important aspect of life, has been defined in terms of the absence of disease and more specifically the physical disease as considered in the past but this definition does not cover the other aspects of health because health can not be only referred to physical health rather it includes other aspects of health such as
biological, emotional, mental, spiritual and social. Therefore while defining health one should consider all these aspects of health. The physical aspect refers to the perfect functioning of the body and it is the overall conditioning of living organism at a given time. The social aspect refers to the ability to relate and communicate with others and to make adjustment to different social situations. Social component of health includes the level of social skills which a person possesses and social functioning. Positive social interaction can be seen both as a means of achieving health and as a part of health itself. Spiritual health may involve a religious belief, or it may simply relate to that sense of being part of a larger environment or world. Review of literature on health suggests that health has been defined in various ways according to the customs and cultures of different nations. The preamble of WHO (1946) charter defined health as “a state of complete physical, mental and social well being, not merely the absence of disease or infirmity.” In the words of Bhatia (1982) “health is a state of being hale, sound or whole in body and mind.” Health may be described as a potentiality—the ability of an individual or a social group to modify himself or itself continually, in the face of changing conditions of life not only, in order to function better in the present but also to prepare for the future. Health is being studied by the researchers of various disciplines from biological, psychological and social perspectives. The biological approach aims to explain all behaviours and experiences in terms of physical bodily processes. Psychological approach includes many perspectives like psychodynamic, behaviouristic, cognitive to understand health problems and this approach takes into account the emotions, thoughts, motivation, aspiration level etc. in the study of behaviours. Social approach defines health within a socio cultural context that includes family, school and society. Now-a-days Biopsychosocial approach is used widely to study health problems as this approach
considers all the three aspects while studying health. Biopsychosocial approach studies behaviour not only through biological perspective but it also looks at psychological factors, social phenomenon and the interaction of all these factors to understand health and illnesses.

Mental health is an integral part of health and sound health is an indicator of a person’s better mental health. It has been defined that health is “not merely the absence of illness; rather it is a physical, social, mental and spiritual well-being, a state which has been identified as an attribute of positive mental health” (Berg 1975; Jahoda 1958). The mental health problems of mild to severe degree can arise at any stage in the life of an individual resulting from the interaction of factors like biological, family, personality characteristics, social environment and so on. Thus the study of women’s mental health becomes essential as they are the nucleus of every family.

It appears from the research literature that the emergence of mental health is closely related to the growth of mental hygiene in U.S.A. and to the development of psycho-therapeutic practice and personality research. The subject of mental hygiene concerns with the origin or causes of mental problems or disorders with a view to find ways and means of preventing them and if they occur, to find ways and means to effect, as much cure as possible, by proper diagnosis but the criteria of mental hygiene is huge than mental health as mental hygiene refers to all the activities and techniques which encourage and maintain mental health. The term “mental health” began to replace “mental hygiene” in the 1930’s and by the late 1940’s it was assumed to occupy an independent status with a growing and enthusiastic social movement operating on its name.
As an illustrative construct "mental health" gained its first adherents at the beginning of the 20th century. Mental health is a broad but still a vague concept. Its precise and comprehensive explanation and evaluation is undoubtedly a difficult task as there is no absolute mental health standard against which the mental health of an individual may be measured. There is an extensive conceptual indistinctness with regard to the construct of mental health. It is a dynamic concept which is purely related to the cerebral functioning of a person, and it also stands for his emotional effective states, the relationships he establishes with others, and a quite general quality that might be called his equilibrium in his/ her socio-culture context.

Attempts were also made during last few decades to define and operationalize mental health (Bradburn & Captovitz, 1965; Kornhasuer 1965; Quinn, Seashore & Mangione 1971; Karl 1974). They defined mental health in different ways such as the overall of personal success, personal satisfaction, and personal effectiveness on socially considerate behavior. Mental health is a term used to describe either a level of cognitive or emotional well being or an absence of a mental disorder (Ross 1999; Libby & Theroux 2005; Gimeno et al. 2007).

Mental health is not only the avoidance of serious mental illness rather it is the springboard of thinking and communication skills, learning, emotional growth, resilience and self esteem of the individuals. It is concerned with how people look at themselves, their evaluation, their challenges and problems and exploration of choices. This includes handling stress, relating to other people, and making decisions.

The WHO committee, formed in 1950, reviewed the various definitions of mental health and observed "mental health is influenced by both biological and social
factors. It is not a static condition but subjects to variations and fluctuations of
degrees; which enables the individual to achieve a satisfactory synthesis of his own
potentially conflicting, instinctive drives; to form and maintain harmonious relations
with others; and to participate in constructive changes in his social and physical
environment.”

Menninger (1945) defined mental health “as the adjustment of human beings
to the world and to each other with a maximum of effectiveness and happiness.....It
is the ability to maintain, even temper, an alert intelligence, socially considerate
behavior and a happy disposition.”

Later on Hadfield (1950) defined mental health in terms of a dynamic state
which is not static, it is the functioning of the whole organism towards an end, it is a
harmony of movement being active and living.

Bernard (1957) stated that “mental health is a normal state of well being, a
positive but relative quality of life. It is a condition which is characteristic of the
average person who meets the demands of life on the basis of his/ her own capabilities
and limitations, mental health is not only absence of illness but it is an active quality
of individual’s daily effective living.”

In the words of Clausen, Merten and Nirbert (1966) “a mentally healthy
individual maintains a good adjustment with social situation and engage in some or
other project intended to benefit society.”

Bhatia (1982) viewed mental health as the ability to balance feelings, desires,
ambitions and ideas in one’s daily living. It means the ability to face and accept the
realities of life.
Kaplan and Sadock (1993) defined mental health “as a condition of well being and the feeling in person when can come to terms with society and personal situation and social features are satisfying him/her.”

Dennerstein et al. (1993) stated mental health in terms of “the capacity of the individual, the group and the environment to interact with one another in ways that promote subjective well being, the optimal development and use of mental abilities (cognitive, affective and relational), the achievement of individual and collective goals consistent with justice and attainment and preservation of conditions of fundamental equality.”

According to Diener and Diener (1995) “mental health refers to how people evaluate their lives and includes variables such as life satisfaction, lack of depression and anxiety, and positive moods and emotions.”

According to the Surgeon General's Report (1999) mental health is “….state of successful performance of mental function resulting in productive activities, fulfilling relationships with people, in the ability to adapt, to change and to cope with adversity.”

It emerges from the various definitions that the mental health is more than the absence of mental disorders rather it is a state of well being in which an individual holds the ability to balance emotions, to interact with others, to make adjustments even in adverse situations effectively and to contribute to the society and community. Mental health refers to the full and harmonious functioning of the total personality which gives almost full satisfaction to the person.
Mental health has two important aspects; individual and social. The individual aspect connate that individual is internally adjusted self-confident, adequate and free from internal conflicts and tension or inconsistencies. He is skillful enough to be able to adapt new situation but he achieves this internal adjustment in a social setup. Society has certain value systems, customs and traditions by which it governs itself and promotes the general welfare of its members. It is within this social framework that the internal adjustment has to be built up. Only, then an individual becomes a person who is acceptable as a member of society.

The concept of mental health has been explained in diverse perspectives by different psychologists. These views are different but some of them are similar in some ways that form a model. These different views can be categorized in the following models;

Medical Model: The medical model of mental health emphasizes the role of various organic conditions that affect brain functioning and may further lead to mental disorder.

Psychoanalytic Model: Psychoanalytic model gave much emphasis on the stress creating situations that cause anxiety in an individual. When a stressful situation is presented before a person it creates anxiety in him and if the individual is capable of handling the situation effectively, his anxiety can be eliminated but if the stressful situations are not resolved then the anxiety continues, the individual adapt various defense mechanism that affect his mental health. The psychoanalytic model also consider early childhood experiences that may lead to mental ill-health.
Behaviouristic Model: According to Behaviouristic model faulty learning does affect mental health of an individual. When people are not able to learn essential adaptive behaviour or competencies their mental health gets affected. Maladaptive behavior is learned by the individual like other skills from his/her environment.

Humanistic-Existential Model: This model emphasized the role of blocked or distorted personal growth as the major factor that influences mental health. According to this model if the individual is denied the opportunities for personal growth and self fulfillment then the person will be in the state of anxiety and despair and may experience frustration which usually leads to maladjustment.

Interpersonal Model: This model gives importance to the interpersonal relationship among people as the root of mental health. When people do not have satisfactory interpersonal relationship with one another, their mental health gets affected.

The dual factor theory emphasized the concept of mental health in two broad groups i.e. the positive mental health and negative mental health which again may be seen as consisting of different inter-related factors. (a) factors contributing to mental ill health- their health does not lead to positive mental health, though the presence of these factors indicate mental disorder or ill health; (b) factors whose presence leads to positive mental health but their absence does not lead to mental disorders.

Criteria of mental health may differ from culture to culture and country wise but mentally healthy people are characterized by certain characteristics such as proper insight and understanding of themselves through self-knowledge and self evaluation. They accept themselves according to their own motives, emotions, capacities and
intellectual peculiarities, handicaps and failure. They have learned how to adapt themselves in such a way as to find reasonable level of happiness and effectiveness in their living. They do not expect to be able to do everything perfectly, nor do they underestimate their powers. They perform their duties with responsibilities of various jobs (like home, office, college and society) as everyday challenge in the perspectives of their strengths and weaknesses. They use the gaps between their ideals and their accomplishments. They make efforts to shape their environment if it is possible; if not, they adjust to it. Mentally healthy persons are characterized by social adaptability to get along with people and to attain and maintain harmonious relationships in the family, community, school workshop or office. A mentally healthy person has a state of mind that enables him to experience the greatest amount of happiness and to attain the maximum efficiency with the minimum amount of strain or conflict. They, however, do not have the anxiety to live or clinging attitude that every thing must happen as suits to his/her design. Their desires and satisfactions are equally synchronized into well integrated personalities. They feel comfortable about themselves and their abilities. They are able to stay with a job, to live effectively within the values and customs of their society and to adjust to new and emergency situations.

Some of the psychologists have also documented a number of distinctive features of mental health like Jahoda (1958) has mentioned six aspects of positive mental health after reviewing psychological literature on mental health that includes the attitude of an individual towards his own self, growth, development or self actualization, integration, autonomy, perception of reality and environmental mastery.
Kornhauser (1965) identified six dimensions of mental health. These dimensions were derived empirically from an industrial setting. These dimensions are: manifest anxiety and emotional tension, feeling of self esteem, feeling of hostility towards other people, sociability and friendship, overall satisfaction with life and personal morale.

Hilgard, Atkinson and Atkinson (1971) stated that a mentally healthy person maintain a philosophy of life which gives direction to his life keeping in view the demands of the changed situations and circumstances.

Karl (1973) suggested four different criteria on the basis of which one's mental health can be assessed. The criteria are functional effectiveness, wellbeing, mastery and competence and psychiatric signs and symptoms.

Schultz (1977) noted seven criteria of sound mental health i.e. extension of sense of self; warm relation of self to others, emotional security, realistic perception, skills and assignments, self objectification and unifying the philosophy of life.

The prevalence rate of affective disorders is taught to be much higher in women than men (Kulkarni, 2008). There are various factors that may affect a person's mental health like hereditary factors such as chromosomal aberrations, faulty genes, genetic predisposition to specific mental disorders. Constitutional liabilities like physique, physical handicap and vulnerability to stress. Physical deprivation greatly affects mental health and functioning of the physique and the mind of the organism.

Mental health is also affected by numerous psychosocial factors that include mental deprivation, deprivation in home, early psychic trauma, pathogenic family
pattern, the disturbed family, inadequate family, marital instability and so on. Mental health of women is also affected by sex roles that are defined by the societal norms and traditions. The construct sex role has been derived from sex theory is defined as "behaviors, expectations, and role sets defined by society as masculine or feminine which are embodied in the behavior of the individual man or woman and culturally regarded as appropriate to males or females" (O'Neil, 1990). The sex roles are defined differently for males and females in every society. Women get many characteristics like docility, submissiveness, low self-esteem and passivity through the feminine socialization process and these sex roles influence the mental health of a woman as Baruch and Barnett (1975) reported a high degree of sex role socialization in females as negatively related to autonomy, self esteem, and adjustment. Many of the issues that damage the physical health of women, such as poverty, inadequate nutrition and unsafe water, also contribute to poor mental health (Swetart, 2001).

There are studies that depict the factors associated with mental health such as role overload is associated with an increase in symptoms of ill health (Gove & Geerken, 1977; Woods & Hulka, 1979). Gove (1972,1973) suggested that married women experience higher rates of mental disorders than married men. Carstairs and Kapur's (1976) conducted study at Kota did not find any significant relation between marital status and symptom rate. Nandi et al. (1975), Sethi et al. (1972,1974) and Thacore et al. (1975) did not presented disaggregated data on sex and marital status. It was evident from these studies that symptom rate was found to be linked more with being married than with being single. Dube (1970), Verghese et al. (1973), Chakraborty (1990; 1996) found higher level of distress rate in married women as compared to men and higher distress rate in single women as compared to single men.
When comparing employed women to women who are not working (including non-working housewives and the unemployed women), employment had not been found to be related to poor health (Repetti, Matthews & Waldron, 1989). Rather many researchers concluded that employment among women had been found to be related to better health (Adelmann et al., 1990; Arber, Gilbert, & Dale, 1985; Jennings, Mazaik, & McKinlay, 1984; Roos et al., 2005; Waldron & Herold, 1986; Waldron & Jacobs, 1988) and lower rates of depression (Hall & Johnson, 1988).

The findings of the study conducted by Passannante and Nathanson (1985) revealed that Wisconsin women in the labor force had a lower death rate than Wisconsin housewives. Furthermore, unemployed British single mothers (Baker, North, & The ALSPAC Study Team, 1999), unemployed British working class mothers (Parry, 1986), and unemployed American women on welfare (Chandler et al., 2005; Corcoran, Danziger, & Tolman, 2004) were found to show more mental health problems (including depression) than those who were employed. On the contrary some studies found that the double burden of being employed and maintaining primary responsibilities for the family and home, have shown that employed women have similar or even higher rates of psychiatric symptoms than housewives (Haavio, 1986).

Women who work full time, especially those in managerial and professional jobs (Bartley, Popay & Plewis, 1992; Hall, 1992; Rosenfield, 1989; Walters et al., 1996), and who have dependent children (Arber, Gilbert & Dale, 1985; Hall, 1992) also report more ill-health and depressive symptoms than their part-time or childless counterparts.
Nye (1963) reported after interviewing 2,300 women that employed women were slightly more satisfied with their work than housewives.

Ferree (1976) concluded that employed women saw themselves as more competent, independent, self-directed and they have higher self esteem than housewives. Burke and Weir (1976) observed that working women had better mental health than the housewives. Booth (1977) replicated Burke & Weir with data and found contradictory results that employed women were no more mentally healthy than housewives.

Employed women exhibited fewer symptoms of psychological distress than full-time homemakers (Pearlin 1975; Radloff 1975; Rosenfield 1980). Study conducted by Waldron (1980) also found that housewives reported more chronic illnesses than employed women and were more likely to rate their health as poor or fair compared to the employed women.

Cleary and Mechanic (1983), Kandel, Davies and Ravies (1985), Parry (1987), Sogaard et al. (1994) and Warr and Parry (1982) found that employed women have better mental health than homemakers.

Ross, Mirowsky and Huber (1983) interviewed a national sample of 680 couples and found that employment status was not related to the wives’ level of depression. In Shehan’s (1984) study of mothers of preschool children where half of the women were employed but there was no significant difference was found between the levels of depression of employed women and housewives. Kandel, Davies and Ravies (1985) reported that employed women had lower level of depressive symptoms.
Keith and Schafer (1983) interviewed 135 dual earner husbands and wives and found that work orientation, feelings of being a provider, and financial stress were associated with lower levels of depression but the hours the married women worked was positively related to depression. The overall relationship between employment and mental health was minimal.

Hibbard and Pope (1985) conducted a study to look into the characteristics of employment which were related to positive health among women. Aspects of employment which account for differences in health status between employed women and those not in the labor force were also studied. The subjects were 1140 adult females, aged 18 through 64. Medical record data covering seven years of inpatient and outpatient services was linked with survey data on the respondents. For all ages, women employed in jobs with a higher degree of social support and integration had better health than women in jobs with little social support and integration through work. The findings suggest that the social support and integration gained through work is a salient aspect of employment which contributes to health status differences between employed women and those not participating in the labor force.

Halfon, Kodama and Arbejt (1991) designed a study to examine the effect of work on women's health and reported that the health status of housewives was found clearly worse than that of employed men and employed women by all health indicators and employed women had more hospital episodes than employed men.

Lennon and Rosenfield (1992) found that women employed in jobs involving high levels of autonomy reported better psychological health compared to women
who were homemakers or women whose paid employment had little work-related autonomy.

The review of studies conducted on women by Dennerstein et al. (1993) indicates greater prevalence of depression, phobias, obsessive – compulsive disorder, somatic disorders and panic disorders among women. Sears and Galambos (1993) reported that multiple roles confer benefits to women’s physical and mental health.

Romito (1994) found that while employment tends to be associated with better physical and mental health in mothers but its effects were inconsistent when mothers of babies or young children were specifically examined. Lennon (1994) found that fulltime housework involves more autonomy, more interruptions, greater physical efforts, more routine, fewer time pressures and less responsibility for matters outside one’s control than paid work. Employed wives appear to benefit from having less routinized work than homemakers. As a result of the different configurations of their work characteristics, employed wives and homemakers experience average similar levels of depressive symptoms. Bird and Ross (1993) also reported the same findings.

Walters, Lenton and Mckeary (1995) used Canadian data and reported that employed women when compared with full-time homemakers, were more likely to rate their health positively and less likely to indicate activity limitations.

Bisgrove and Popkin (1996) observed that positive effects of work in the informal sector were greater for women from low-income Households.

Chadwick and Garrett (1996) conducted a study to ascertain the relationship of employment and religiosity with mental health. A mail questionnaire survey was conducted on a sample of 3000 women between the ages of 20 and 60 in the year
Mental health was measured by Depression Scale developed by the Center for Epidemiologic Studies (Weissman et al., 1977) and self esteem was measured through Rosenberg Scale (Rosenberg, 1979). They found that employment outside the home has a rather modest relationship to mental health as measured by depression, self esteem and general well being. Women who have worked full time for a large percentage of their life reported greater depression. Employed women experience more depression and have less positive feelings about their well being. On the other hand percentage of adult life working part time and being currently employed are positively related to feelings of self esteem. The results indicated that current employment was negatively related to well-being and positively related to self-esteem. It seemed the housewife, but the pressures of work and home life and the prospect than the pressures will continue in the future are also associated with a little lower sense of well being and higher level of depression.

Singh and Arora (1997) examined the relationship between social support, mental and physical health of 200 married nurses in the age range of 35-40 years. The measures of social support, mental health, self esteem and physical health were administered individually. Results revealed that perceived actual and expected social support scores were found significantly negatively correlated with mental and physical health and self esteem scores, it was also observed that husbands and colleagues having high actual support was found to be associated with better mental and physical health.

Mukhopadhyay (1997) reported that working women play dual role in family and work place. They experience a sustained stress to cope with both conditions and hence their mental well-being gets affected.
Rout, Cooper and Kerslake (1997) carried out a pilot study to know that employment has positive or neutral effects on women’s health. The study examined whether these positive effects could also be found in employed mothers by comparing working mothers with non-working mothers on measures of mental health, self-esteem, and mother role satisfaction and also assessed the stress as experienced by these mothers and examined the coping strategies used by them. 200 questionnaires were distributed and 101 were returned giving a 50.5% return rate of which 78% were working mothers and 22% non-working mothers. The findings showed that working mothers had better mental health and lesser degree of depression than the non-working mothers. The most frequently reported source of stress for working mothers was not having enough time to do everything, whereas for non-working mothers lack of social life was a major stressor.

Nandi et al. (1997) conducted a door to door field survey in two villages to assess mental morbidity of the elderly population aged 60 and above. The sample comprised of 183 people (85 male and 98 female). They found that women had a higher rate of morbidity than men.

Lai, Chan and Luk (1998) carried out a study to see the impact of unemployment on psychological health on a group of 86 unemployed and 79 employed women. The results revealed that unemployed women were found more disturbed than their steadily employed counterparts.

Refaat and Dandash (1999) investigated the impact of work as a determinant of women's care of their own health and observed that health indicators were in general low to moderate among the study group. The working women had different
characteristics and they were more likely to care for their own health than those who were not working ones. This study showed that work has a positive impact on women's care but conditioned by having few children. In other study significant difference was found in mental health of working and non-working women (Bhati & Gunthey, 1999).

Nandi et al. (2000) used household schedule, Case Detection Schedule and Case Record Schedule to assess the changes in the mental health status of an Indian rural community after 10 year. It was found that the rate of morbidity was higher in women than men in the base year (1972) and this trend did not change significantly after 20 years.

Aminabhavi and Kulkarni (2000) in their study found that working women have significantly sound mental health than housewives. Women from nuclear family and joint family did not differ significantly and the mental health of women with children was found not to differ significantly as compared to the women having no children.

Jain and Gunthey (2001) administered Mental Health Checklist (Kumar, 1991), The Marital Adjustment Questionnaire (Kumar & Rastogi, 1985) and The Problem Checklist (Joshi, 1989) to determine the level of mental health in relation to dual role conflict on a sample of 120 working and 120 non-working married women, age ranges from 25-45 with comparable educational status. The results showed that working women and non working women differed significantly on mental health problems.
Rastogi and Kashyap (2001) investigated occupational stress and mental health of women working in teaching, nursing and clerical professions. Occupational stress and mental health questionnaires were administered on a sample of 450 married working women (150 in each group). The results revealed that women in nursing profession had higher stress and poorer mental health as compared to the women in other two professions. Out of these three categories of participants, teachers were found to have soundest mental health in comparison to nursing and clerical staff. It was found that occupational stress and mental health had negative relationship.

Sharma and Yadav (2001) examined the impact of job stress on women’s mental health. The sample consisted of 120 women with low (non-working), moderate (job requiring 4 hours per day) and high (job requiring 8 hours or more per day) job stress who served as subjects. The results showed that the part time working women were found to better on their mental health index and therefore the study points out the participation of women in light jobs should be encouraged.

Santana, Loomis and Newman (2001) carried a cross-sectional study to test the hypothesis whether work burden, the simultaneous engagement in paid work and unpaid family housework can be a potential risk factor for psychiatric symptoms among women. 460 women were randomly selected from a poor area of the city of Salvador, Brazil aged between 18 to 70 years old who reported having a paid occupation or were involved in unpaid domestic activities for their families were included in the study. During an initial household visit, socio-demographic data, such as age, marital status, race, religion, education level, migration history, and income, were obtained from a family informant for each family member. Individual interviews were carried out to collect data on the characteristics of their current work, defined as
paid activities performed outside their household, and housework done for their own families. To assess mental health status, a psychiatric symptoms Questionnaire for Psychiatric Morbidity among Adults (QMPA) widely used in mental research in Brazil was administered to a well-informed member of the family, usually the mother, who provided data for every family member. QMPA is designed to be used by non-medical personnel, comprises 43 questions about symptoms of anxiety/somatization, irritability/depression, cognition/sensory-perception and previous treatment for mental disorders. Based on the answers to the questions, recorded as yes=1/no=0 with reference to relevant symptoms perceived during the past year, scores were calculated by summing positive responses. Results showed that major correlates of high QMPA scores were work burden variables. Married women with pre-school children and a double work shift were almost twice as likely to have high QMPA scores as those who were unmarried and have no pre-school children or double work shift. Being married or having pre-school children was also associated with high QMPA scores only when associated with work burden.

Nia (2002) conducted a survey in Tehran (Iran) in 1998 to see the impact of work on mother’s health on a sample of working and non-working mothers (710 working mothers and 355 non-working mothers). In this study three main explanatory factors were examined (socio-demographic, work and work related, and social life context variables) alongside a range of mental and physical health outcome variables. The results showed statistically insignificant difference between working and non working women in Tehran unlike the Western countries where women’s paid work is associated with better health.
Claro and Bedregal (2003) conducted a study on mental health status of 139 teachers from 12 schools of Chile. The results indicated that emotional problem was detected in 28.6% and mental health problem in 32% of the respondents. Age and number of working hours were identified as two risk factors for mental health problems.

Artazcoz et al. (2004) conducted a study in Spain to ascertain whether inequalities in health exist among housewives and employed women and the relationship between family demands and health differs by employment status. The sample was drawn from all women aged 25-64 years who were employed or full time homemakers and married or cohabiting from 1994 Catalan Health Survey. Four health indicators (self-perceived health status, limiting long-standing illness, chronic conditions and mental health) and two health related behaviors (hours of sleep on and leisure-time physical activity) were analyzed. Family demands were measured through household size, living with children under 15 and elderly. It was found that female workers had better health status than housewives, although this pattern was more consistent for women of low educational level. The health related behaviours were less favorable for workers mainly for those of low educational level. Family demands showed a negative effect in most health indicators and health related behaviours among workers of low educational level but had little or no negative association was found in workers of high educational level or in full time homemakers. Among women of low educational level, both workers and housewives, living with elderly had showed a negative association with poor health status and health related behaviours.
Noorbala et al. (2004) conducted a mental health survey in Iran on a sample of adult people. Results showed that women suffer from relatively higher risk of mental disorders as compared to men. The risk of mental disorders showed that working only within the home had a more serious impact on psychiatric morbidity. Depression and anxiety symptoms were more prevalent than somatization and dysfunction.

Immaculada et al. (2004) conducted a cross sectional survey to examine the mental health in the working population by gender and professional qualifications and to identify psychological risk factors and employment conditions related to mental health of the population. This was a cross sectional survey conducted using the data from the Barcelona Health Survey (2000) included 2322 men and 1836 women aged from 46 to 64 years. Results showed that poor mental health ranged from 8% among men working in non manual jobs to 19% in the women working in manual occupations. Women are more likely to report poor mental health status than men although sex differences were greater among manual workers. Psychological risk factors were associated with mental health, demands was associated in all groups, autonomy only in non manual jobs and social support in the most highly qualified working women.

Singh and Singh (2006) assessed the mental health status of middle aged female school teachers. Results indicated that anxiety level, somatic symptoms and depression level was low in 64%, 54% and 92% cases respectively. Social dysfunction was moderate in 80 per cent cases, which proved the presence of psychosocial stress in large number of the subjects.

Honkonen et al.(2007) examined the association between employment status and specific DSM-IV depressive, anxiety and alcohol use disorders in a group of 3440 employed, 429 unemployed and 820 economically inactive persons age ranges from
30-64. They found that the risk of mental disorders was higher among unemployed and economically inactive people as compared with the employed women. On the basis of obtained results they concluded that employment is beneficial for mental health.

Azar et al. (2008) examined QOL of a sample of 250 married employed women (175 professional and 75 non professionals) and 250 married unemployed women age range of 24-41 years selected through stratified convenience sampling technique from Iran. The results revealed that professional employed women were significantly higher on quality of life, physical health, psychological health, social relationship, and environment than nonprofessional women. Non-professional employed women were found significantly lower on quality of life, social relationship, and environment than unemployed women. Non-professional employed women did not differ significantly on physical health and psychological health than unemployed women.

Amirthagowri and Thiyagarajan (2008) reported that working women with school level education were affected significantly with more familial problems related to income and status and family support than their counterparts (women with collegiate education).

Kholasezadeh et al. (2012) conducted a cross sectional study to compare the mental health of housewives and working women in Yazd County (Iran) in 2010 on a sample of 300 women selected through cluster sampling technique. The group of working women was divided into three subgroups on the basis of their jobs (i) physicians and nurses (ii) teachers (iii) employees of agriculture, transportation and
health center offices who were selected randomly (50 respondents) from each subgroup whereas 30 housewives were selected from six health centers randomly. SCL-90 was administered to assess the mental health of the respondents. The data analyzed using chi-square and it was concluded that working women had better mental health than housewives. A significant positive relationship was found between the education level and mental health of housewives but no association was found for working women. There was a significant association found between type of job and mental health. Results of this study also showed that there was no significant association between number of children and mental health.

Nishikitani et al. (2012) conducted a cross-sectional survey in Japan on 1344 women. It was found that working women were more likely to have health anxiety and health dissatisfaction and have sleep problems than the housewives.

Dudhatra and Jogsan (2012) investigated the mental health problems and depression level among working and non-working women. The sample of the study was comprised of 80 working and non-working woman (40 in each group) selected from Rajkot (Gujarat). Mental health was measured by Bhatt & Geeda (1992) while the tool for depression was used developed by Beck (1961). The results revealed that non-working women had higher mean score 73.92 as compared to the working women 68.80 and the higher mean scores indicate that non-working woman have a good mental health than the working woman. The t-value of mental health was found statistically significant and also working and non-working women differed significantly in terms of the level of depression. The mean value of both groups revealed that the depression of non-working women was lesser than the working women.
Mankani and Yenagi (2012) assessed the status of mental health of the working and non-working women. The sample consisted of 90 working and 90 non-working women of rural and urban area which was selected through random sampling from Dharwad (Karnataka). The study emphasized on the influence of socio economic status on mental health of the working and non-working women. Mental health inventory by Jagdish and Srivastava (1983) and socio economic status scale by Aggrawal et al. (2005) was used to assess the mental health status and socio economic status of the selected respondents or sample. The results revealed that the working women had better mental health when compared to non-working women. It was also found that the demographic factors such as age, education, income and number of children had a positive and significant relationship with working women and family size had negative but significant relationship with mental health of the working women.

Gupta et al. (1987) found that women from nuclear family had poorer mental health than women from joint family whereas Raghunath (2012) found no association between age, education status, marital status, religion, type of family, children in family, individual income, family income, and menopausal status with mental health in his study conducted on middle aged women participants.

**Significance of the study:**

Women in Indian society are traditionally supposed to be the nucleus of the family around which the family members live their life with the bondage of love, affection and customs. They were thoughtfully pressurized to confine themselves to domestic environment and play a passive role as sisters, daughters, daughters-in-law,
housewives and mothers. But the last two-three decades witnessed increased pace of urbanization and modernization in all spheres that brought out a major change in the attitude of Indian women as they are coming forward in the field of education and searching of various employment opportunities to gain economic independence for fulfilling their needs, hopes and aspirations. In the recent time more and more Indian women are getting opportunities to become literate and independent. As per Census (2011) report based on national survey on women regarding the education showed that 65.46% of women as compared to 82.14% of men are literate in Indian society. Delayed age of marriage, awareness and eagerness of higher education, academic achievements, and higher employment rates brought out spectacular change in women’s attitudes, values, inspirations, feelings and about their role in their family as well as in the society. In this context transformation in the pattern of women’s participation within the family has been shifted in recent past years amongst both urban and rural women. Indian women of all social classes have entered into professional as well as non-professional occupations claiming to be equal shareholders. The married as well as unmarried women both are availing opportunities to come up in the job market but they might show their different role in their job positions. While the entry of unmarried women into professional occupations may be relatively less problematic, but in the case of married working women who have multiple roles to fulfill, is different because women working outside the home often faces various types of problems and receive different treatments living in the nuclear as well as joint families. There are contradictory role expectations from working women while she is at work and at home. On professional front she is expected to be committed, dynamic, competitive, straightforward, non-sentimental and act in a "business like" manner and while at home, they are expected to be sweet, soft,
sensitive, adaptable, gentle, caring, unassertive and domesticated (Misra, 1998). These contradictory expectations from women seem to put them in the state of confusion, tension and create many other problems related to adjustments, mental health problems like depression, stress, frustration, conflict, feeling of restlessness and so on. Iowa (2002) reported that depression is the found to be most prevalent psychiatric condition which affects the women more as compared to men. Dickerson (2004) found that modern women face enormous pressure to adhere to certain life opportunities. Experiencing anxiety is a common occurrence – a normal reaction of the body to stressful situations. But sometimes women suffer from mild to severe level of anxiety because of their multiple roles as pointed out by Sorensen and Verbrugge (1987) that “women’s multiple responsibilities and attendant role conflicts have negative consequences on the level of anxiety and their adjustment which will further impact their satisfaction.”

Kaplan and Sadock (2000) found that anxiety and depressive symptoms are common in women. The present study is being conducted on Indian women. The findings of previous researches have shown that career women had better mental health (Kholasezadeh et al. 2012) and have lower level of depression (Kandel et al., 1985; Radloff, 1975; Repetti & Crosby 1984).

The researcher determined to study self concept as it was extremely valuable and must be protected and enhanced (Grubb & Grathwohl, 1967; Belk, 1988). People having positive view of their self might show relatively lesser degree of anxiety after facing failure in their lives whereas people with negative self underestimate their capabilities and they are always worried in the hassles of daily life and may develop feeling of worthlessness. Thus, it becomes essential while assessing the level of
anxiety to know about women’s self concept as it is the dominant feature of one’s personality which influences human behavior. It has been seen that self-concept and self-esteem decrease trait and state anxiety levels (Greenberg et al. 1992; Gursoy, 2006; Ortiz, 1982). Bala and Laxmi (1995) found that perceived self concept was positively correlated with marital adjustment in both groups of employed and unemployed women as well as social self was also correlated positively with marital adjustment in both groups of women. Azar and Vasudeva (2006) reported that professionally employed women were found to be significantly higher on self esteem and self efficacy than non professionally employed women. Self concept is also related to better adjustment as it has an effect on the behavioural pattern in which individual reacts to various situations that determines his/ her personality and the quality of mental health.

Nathawat and Mathur (1993) reported that working women have better marital adjustment and subjective well being. Aminabhavi and Kulkarni (2000) found that working women were significantly higher on marital adjustment than housewives on the contrary Jain and Gunthry (2001) reported that nonworking women had better understanding, experience high marital satisfaction and fulfillment of expectations whereas working women were found to have higher level of mental hazards and more psychosocial adjustment problems. Other researches showed that employment and motherhood may result in low levels of marital adjustment (Gove & Peterson, 1980; Staines et al., 1978).

Positive self concept leads to better adjustment that enhances the mental health of individual. Mental health problems should not be understood only as presence of diagnosed mental disorders, but they are also viewed through the person’s own
perception of having poor mental health. A majority of people experience mental health problems at different times in their lives. It is ironical though the women are the earning member of the family but the mental distress of women remained unacknowledged within families (Isaac & Kapur, 1980), especially 'Indian families do underestimate mental distress levels in women' (Davar, 1999). Rout et al. (1997) found in their study that working mothers had better mental health and reported less depression than non working mothers. Holeymanvar and Itagi (2011) noted in their study that influence of stress on health status of housewives was 10 times more than that of working women. Kholasezadeh et al. (2012) found that there is a significant relationship between type of job and working women's mental health. Claro and Bedregal (2003) reported that age and number of working hours were identified as two risk factors for mental health. Andrade et al. (1999) found that working wives experience more confidence in coping than non working wives they conclude that employment benefit women. Cultural differences, socio economic status and subjective assessments also affect mental health. Individuals having good mental health are well adjusted to society, are able to relate well to other, and basically feel satisfied with themselves and their role in the society.

It has been found out by several investigators that those women who strongly accept either the professional or domestic roles have showed relatively less role conflict than those who fall in between the two (Adebayo, 2006; Rozario et al., 2004). Coleman and Antonucci (1983) found that homemakers had lower scores on general physical health, self-esteem and greater anxiety in relation to their employed counterparts. All the available literature motivated to the present researcher to make an attempt to conduct a study on Indian women to examine "the level of anxiety, self
concept, adjustment and mental health problems of housewives and career women” and also investigated the potential factors of these dissimilarities among housewives and career women.

Objectives:

1. To examine whether housewives and career women differ on anxiety, self concept, adjustment and mental health,

2. To determine whether anxiety affect adjustment and mental health of women,

3. To determine the influence of self concept and its dimensions on anxiety, adjustment and mental health of housewives and career women,

4. To determine the influence of mental health and its dimensions on adjustment of housewives and career women,

5. To determine the role of demographic variables like age, family type and qualification on the level of anxiety, self concept, adjustment and mental health of women

Hypotheses:

1. There will be significant difference between the level of anxiety of housewives and career women,

2. There will be significant difference between self concept of housewives and career women,

3. There will be significant difference between adjustment of housewives and career women,

4. There will be significant difference between mental health of housewives and career women,

5. Anxiety will affect adjustment and mental health of women significantly,
6. Self concept will influence anxiety, adjustment and mental health of housewives and career women,

7. Mental health will significantly influence the adjustment of housewives and career women,

8. There will be no significant influence of demographic variables like age, family type, and qualification on the level of anxiety, self concept, adjustment and mental health of women.
Chapter -2

METHODOLOGY
Methodology

Research methodology occupies prominent place in every scientific enquiry because it makes research endeavor in any discipline, more objective and scientific. A social science researcher has to be more careful in planning research in search of scientific knowledge so a scientific research program has to be organized, controlled, pragmatic and critical analysis of the presumed proposition to be taken into account about the hypothetical association among the variables. Research techniques, procedure and methods form the body of research methodology. It plays a very crucial role in every field of research that involves systematic and sound procedures in order to accomplish objectivity in results. Thus, it is essential to carefully choose an appropriate research design, sampling technique and selection of standardized measures, following sound procedure for collecting data and analyzing the data by the means of appropriate statistical techniques keeping in view the research design and objectives to carry out research work effectively and systematically.

The present endeavor aims to study the level of anxiety, self concept, adjustment and mental health problems of housewives and career women. To fulfill these objectives following methodology was adopted to meet out the requirements of this small piece of research.

Research design:

There are number of approaches developed, many design have been created to execute a research. Researches are designed to proceed in an orderly manner. They are carried on to control variances and to answer pertinent questions (Lindquist, 1956). Research design stands for advance planning of the methods to be adopted for
collecting relevant data and techniques to be used in the data analysis. Research design is invented to enable the researcher to answer research questions as validly, objectively and accurately as possible. Results and conclusion of any research depends on the research design used for the study. Thus, the selection of an appropriate research design becomes essential as faulty design results in misleading the findings. Research design facilitates the smooth sailing of various research operations that make any research work as efficient as possible and provide maximum information with minimum expenditure of time, effort and money. It is a very difficult task to put a particular study in a particular group as there are different types of research design that decides the structure of any research work. The selection of research design is guided through goals of research, variable under investigation and nature of data itself.

The present research is a type of correlational research and it is comparative in nature. Correlational research is being conducted to establish or to explore the nature and degree of relationship between two or more aspects of a situation/variables. The major purpose of this design is to describe the degree of relationship between two or more variables and discover either they are positively or negatively associated with each other.

Participants:

It is not possible for any researcher to cover the entire population of interest for the purpose of study, for this reason a representative sample from the population is used that makes the study more reliable. The investigator distributed 650 questionnaires to the participants chosen by the technique of purposive random sampling. The main criteria for selection of the respondents were that the respondents
should be married. The subjects chosen for the present study met the following inclusion/exclusion criteria:

**Inclusion Criteria:**

- Women aged more than 24 years and less than 56 years,
- Women who were working in insurance companies, IT and banks,
- Women who at least qualified their graduation.

**Exclusion Criteria:**

- Women aged less than 25 years and more than 55 years,
- Women who were not graduated.

Incomplete questionnaires were rejected and only those questionnaires were selected for the research purpose that fulfilled the inclusion and exclusion criteria. Finally the sample was comprised of 400 participants. The sample was divided into two groups; 200 housewives/homemakers and 200 career women. The sample was drawn mainly from Aligarh city but there were some subjects who belong to different cities especially in the case of career women.

The self-structured information sheet schedule was used both for career women and housewives to collect the information regarding age, education, type of family, children, duration of marriage and duration of job. The participants belonged to nuclear as well as joint families. There were 46.8% subjects from nuclear family and 53.2% subjects had joint family system. In case of career women 51.5% from nuclear family and 48.5% belonged to joint family whereas in the group of