CHAPTER IV

DISCUSSION AND CONCLUSION
Environment and social system influence human behavior. Hence social cognitive theory posits that economic condition socio-economic status and educational, family structure do not affect human behavior directly but they affect to the degree that they influence people's aspirations, self-efficacy belief, personal standards, emotional states and other self regulatory influence (which include evaluation of one's own self, self concept, self esteem and values and also self efficacy. Our present findings implicates that meaning and satisfaction in life is related to working environment and socio economic status.

A micro analysis reveals that working women have a better psychological mindedness to perceive stressfulness of life events. Their socio-economic status also facilitates their generalized as well as domain specific self efficacy. The exposure to work environment increases adaptability among women. Housewives do have an environment which is perplexed with personal and family stress. Financial pressure is high with middle SES groups. Quality of life model proposed by N.R. De (1984) finds its utility in the findings of this study even after 25 years. That implicates that the Indian social ethos has remained the same over the years. Life begins at the far side of despair satisfaction in life and initiative towards personal growth cannot be experienced in a social vacuum; it can only happen in a psychosocial environment. Irrespective of whether one is employed or not employed satisfaction is experienced and this experience is qualified by our personal perception, attitudes and values on life. Socio-economic environment, nature of the work, condition of workplace, people around one's home and workplace inter-personal relationships at home and workplace, transactions of women with others, life orientations and above all personality of women may affect their self efficacy and social readjustment coping strategies. In our society people think that working women experience greater degree of stress than housewives because, at home they also work and they accomplish high
degree of responsibility. The VAB model explains our behavior. It suggests that our values and attitudes influence our behavior both at home and our workplace.

Most Indians do not work for personal accomplishment and achievement. They work more for their family and place more emphasis on affiliation needs rather than needs related to goal accomplishment. Therefore when they fail to accomplish needs of the family they cannot adjust with home, due to their occupation, they feel guilty, they are more stressed; that affect their efficacy.

A long hour of work at the workplace is definitely strenuous for both genders. But it is observed that the impact is more upon women than men because of the orthodox social definition of a women’s role. According to a survey released by market research from Nielsan, Indian women were the most stressed in the world.

As many as 87% said they were stressed and pressured for time, which they attributed to managing multiple roles and inadequate money for discretionary spends. So socio-economic status is also a factor that has an impact on adjustment and subjective wellbeing. Another 82% said they did not have time to relax, and 64% felt stressed or overworked most of the time. “She often has additional stress to deal with in the form of an angry spouse, disappointed children, and other family members,” says Nirmala Menon founder Interweave consulting a Bangalore based firm offering diversity management solution. The general expectation that a woman’s first duty is as wife and mother burdens working women with subconscious guilt and pressure. On top of this, they sometime also have to deal with gender-based workplace biases. (Source-Economic Times, 3rd July)

The findings of the present study lend support to established sociological and social psychological theories of work motivation and social behavior. Some recent psychological research findings do support the findings of the present study (Kaur 2007, Mishra 2008, Khizana, 2009 Nagri, 2009). A critical analysis of the data reveals that working women do experience a difference in their quality and intensity of perception compared to housewives on certain psychosocial facets such as life stress, satisfaction, and domain specific self-efficacy. It implicates that further multifactorial design of research might unravel deeper dynamics of such perceptions.

A substantial amount of studies evidenced that a low sense of self-efficacy is associated with depression, anxiety, and helplessness. A strong sense of personal efficacy is related to better health, higher achievement, control, and more social integration.

The present study shows self-efficacy is significantly related to meaning of life, satisfaction in life, subjective happiness.

A positive sense of self-efficacy contributes to psychological wellbeing as well as performance accomplishment.

Generalized efficacy expectancies may be linked to physical health through effects on health behaviors (Waller & Bates, 1992), and may also
influence cognitive appraisal and coping processes, thereby buffering the
effects of stressors on health-damaging physiological activity (Jerusalem & Schwarzar, 1992). The vast majority of self-efficacy studies have
focused on situation-specific efficacy expectancies. However, there is
some work examining individual differences in generalized efficacy
expectancies in relation to health behavior and adaptation to disease. For
example, higher generalized self-efficacy assessed prior to heart surgery
has been linked to better quality of life 6 months following surgery
(Schwarzer & Schroder, 1997). Generalized self-efficacy also has been
found to correlate positively with emotional adjustment and quality of
life in patients with epilepsy (Gramstad, Iverson & Engelsen, 2001).

Perceived competence has been shown to predict health promoting
behavior, in some cases even more strongly than health locus of
control (Pender, Walker, Sechrist & Frank-Stromborg, 1990). It also has been
shown to mediate the effects of social and psychological factors on
depression and life satisfaction in patients with rheumatoid
arthritis (Smith et al., 1991). Self-mastery has been associated with
fewer self-reported health problems and better self-assessed physical
health (Marshall, 1991), as well as with better health-related quality of
life (Kempen, Jelicio & Ormel, 1997). Mastery and generalized self-
efficacy have both predicted lower levels of psychological distress in older
adults, and also have partially mediated the effects of chronic medical
conditions on distress (Ormel et al., 1997). Finally, perceived coping self-
efficacy has been shown to predict better health behaviors (Schwarzer & Renner, 2000) and improved physiological
responses to stressors (Bandura, Taylor, Williams, Mefford & Barchas,
1985; Wiedenfeld et al., 1990).

Several constructs have been proposed to conceptualize individual
differences in generalized expectancies for positive versus negative
outcomes, including dispositional optimism, optimistic explanatory style,
and trait hope. Although these constructs are closely related, each has unique features and reflects a somewhat different form or aspect of optimism.

**Dispositional Optimism**

Dispositional optimism refers to a generalized expectation that good things, as opposed to bad, will happen in the future. Of the social-cognitive constructs discussed in this chapter, dispositional optimism is the most general in that it involves expectations about future outcomes without specific regard for how these outcomes come to pass. This contrasts with both locus of control and generalized self-efficacy which, as we have seen, both involve expectations about the causes of outcomes.

Dispositional optimism was introduced by Scheier and Carver (1985) as a component of behavioral self-regulation theory, which conceptualizes goal-directed behavior in terms of a feedback system involving ongoing assessment of goal attainment. Within this framework, when a discrepancy is perceived between a goal and current conditions, expectancies regarding the prospects for a reduction in the magnitude of the discrepancy are an important determinant of subsequent efforts to attain the goal. Individuals who are optimistic therefore are expected to initiate active, engaged forms of coping in such situations, whereas those who are pessimistic are expected to disengage or to use avoidant forms of coping.

The instrument most commonly used to assess dispositional optimism is the Life Orientation Test (LOT: Scheir & Carver, 1985).a self-report questionnaire. Items inquire about general expectations for positive and negative future events. More recently, a revised version of the LOT was developed (LOT-R: Scheier, Carver & Bridges,
Evidence for the reliability and validity of both versions of the LOT was reviewed by Scheir et al. (1994)

A major criticism of the dispositional optimism construct involves its relationship with neuroticism or negative affectivity. The LOT is moderately correlated with neuroticism, in some cases showing a stronger association than it does with other measures of optimism (Smith, Pope, Rhodewalt & Poulton, 1989). Further, a number of associations between optimism and reports of physical symptoms were substantially reduced or eliminated when neuroticism or negative affectivity were controlled statistically (Robbins, Spence & Clark, 1991; Smith et al., 1989). Suggesting that these effects may be attributable to neuroticism rather than optimism. However, studies using other, more objective outcome measures have demonstrated effects of optimism that are independent of neuroticism or negative affectivity (e.g. Scheir et al., 1989, 1999).

Although the LOT was originally believed to measure a single dimension, factor analyses (Marshall, Wortman, Kusulas, Hervig & Vickers, 1992; Robin-Whelen, Kim, Maccallum & Kiecolt-Glacer, 1997) indicate two related but separable factors, optimism, and pessimism, corresponding to positively and negatively worded items. These subscales are typically only moderately correlated, and in addition, have been differentially associated with health outcomes (Lai, 1994; Mahler & Kulik, 2000; Schulz, Bookwala, Knapp, Schier & Williamson, 1996). These findings suggest that pessimism may not simply be the absence of optimism, through there is no consistent pattern regarding the differential health effects of optimism and pessimism when measured separately. What is clear is that global expectations for good and bad outcomes are not mutually exclusive. Apparently, a person can be optimistic about certain goals or outcomes, and pessimistic about others, and these expectancies may influence health in different ways.
Dispositional optimism and pessimism have been found to predict a number of physical health outcomes. For example, optimism was associated with a reduced risk of per-operative myocardial infarction, better physical recovery, and lower rates of re-hospitalization in patients undergoing heart surgery (Scheir et al., 1989, 1999). In one of the first studies to examine health effects of optimism and pessimism separately, pessimism interacted with age to predict 8-month mortality among younger cancer patients (aged 30-59), but not older cancer patients (aged 60 and over) (Schulz et al., 1996). In contrast, optimism was not related to mortality in this study. Dispositional optimism also appears to be predictive of adaptation to disease. Longitudinal studies have found that optimism predicts lower levels of distress in HIV+ and HIV- gay men (Taylor et al., 1992), and in patients undergoing breast cancer surgery (Carver et al., 1993). Optimists also report better quality of life than pessimists following heart surgery (Scheir et al., 1989).

Potential mechanisms for these associations are thought to involve coping activity. The more active, engaged coping strategies of optimists may modulate psychological and physiologic responses to stressors that influence physical health (Carver et al., 1993; Scheier et al., 1989). In support of this notion, optimism has been associated with lower diastolic blood pressure in healthy adults (Raikkonen, Matthews, Flory, Owens & Gump, 1999), with lower diastolic blood pressure reactivity to stress (Williams, Riels & Roper, 1990). Behavioral factors represent an additional pathway by which optimism may influence physical health. In patients with heart disease, optimism has been associated with health promoting behaviors related to diet and exercise (Shepherd, Maroto & Pbert, 1996). Optimism has also been associated with less substance abuse among pregnant women (Park, Moore, Turner & Adler, 1997), and with reduced likelihood of dropout from an alcohol treatment program (Strack, Carver & Blaney, 1987).
Optimism has been conceptualized as an explanatory style (Peterson & Seligman, 1984) related to the attributional reformulation of learned helplessness theory (Abramson, Seligman & Teasdale, 1978). When individuals encounter controllable circumstances, they ask why. Their attributions regarding the nature of the causes of events influence expectations about the future and subsequent helplessness. The causes of negative events are evaluated along three dimensions: internality, the degree to which a person perceives the cause as involving characteristics of the self; stability, the degree to which an individual perceives the cause as remaining constant over time; and globality, the degree to which an individual perceives the cause as having influence across different situations. Overall, an individual who tends to attribute negative events to external, unstable, and specific causes is characterized as having an optimistic explanatory style, whereas an individual who tends to attribute negative events to internal, stable, and global causes is characterized as having a pessimistic explanatory style.

There are two major approaches to measuring explanatory style. The first is the Attributional style Questionnaire (ASQ: Peterson et al., 1982), a self-report instrument that inquires about the perceived causes of six hypothetical negative events. Respondents are asked to imagine that each event has happened, to identify its one major cause, and to rate the cause in terms of internality, stability, and globality. The more recently developed expanded attributional style Questionnaire (EASQ: Peterson & Villanova, 1988) includes 24 negative events, and no longer inquires about positive events. The second major approach to assessing explanatory style is the Content Analysis of Verbatim Explanation (CAVE) technique (Peterson, Luborsky & Seligman, 1983), which involves content coding of verbal material, and then identify casual explanations based in part on phrases such as 'because' or 'as a result of'. Causes are then rated for internality, stability, and globality. The reliability and validity of both of these assessment strategies have been
reviewed by Peterson and Seligman (1987) and by Peterson, Maier, and Seligman (1993).

Individual differences in explanatory style appear related to various indicators of physical health. Longitudinal studies have found that a pessimistic explanatory style predicts self-reported illnesses (Lin & Peterson, 1990; Peterson & Seligman, 1987) and doctor visits (Peterson & Seligman, 1987) similarly, a 35-year study using the CAVE techniques found that individuals with a pessimistic explanatory style experienced poorer physician assessed physical health over time (Peterson, Seligman & Vaillant, 1988). A pessimistic explanatory style is believed to promote feelings of helplessness and lack of efficacy. These feelings may in turn influence behavioral and physiologic activity through difference in coping strategies, much as is thought with dispositional optimism. With regard to health-damaging mechanisms, a pessimistic explanatory style has been shown to predict poorer immune functioning (Kame-Siegel, Rodin, Seligman & DWYER, 1991) as well as decreased likelihood of engaging in adaptive illness behaviors (Lin & Peterson, 1980).

Another construct related to optimism is hope. As conceptualized by Snyder et al. (1991), hope is a generalized, stable disposition consisting of two major components: agency, which refers to a sense of determination regarding the successful attainment of past, present, and future goals; and pathways, which refers to perceived availability of plans or strategies for attaining goals, Snyder et al. (1991) compare agency to self efficacy, whereas the pathways notion bears a similarity to outcome expectancies. Like dispositional optimism, hope is thought to influence the selection and attainment of goals, with goal attainment partially mediated by coping activity. However, the interaction of efficacy expectancies and outcome expectancies distinguishes this construct from others such as dispositional optimism or generalized self-
efficacy, which involves only one or the other type of expectancy. Snyder and Colleagues assert that the reciprocal relationship between agency and pathways is a more powerful predictor of behavior than either efficacy or outcome expectancies alone.

Trait hope is assessed with the Hope Scale (Snyder et al., 1991), a self-report questionnaire comprising four items that assess general beliefs about agency, and four items that assess general beliefs about pathways. As measured by this scale, trait hope has been shown to be related to but separable from similar constructs such as optimism, self-esteem, and generalized self-efficacy (Magaletta & Oliver, 1991; Snyder et al., 1991).

The notion of self-efficacy is of central importance within Bandura's social cognitive theory. Self-efficacy refers to the beliefs that individuals have concerning their ability to cope with a particular task or situation and achieve the desired outcome. In the words of Bandura (1977)self-efficacy judgments of what one can to do with the skills one possesses'. Self-efficacy is claimed to predict several aspects of behavior. According to Bandura.

Given appropriate skills and adequate incentives,...efficacy expectations are a major determinant of people's choice of activities, how much effort they will expend, how long they will sustain effort in dealing with stressful situations.

An individual's sense of self-efficacy in any given situation is determined by four main factors:

1. The individual's previous experiences of success and/or failure in that situation.
2. Relevant vicarious experiences (e.g., if you see someone else cope successfully with a situation, this may increase your self-efficacy beliefs).

3. Verbal (or social) persuasion. Your feelings of self-efficacy may increase if someone argues persuasively that you have the skills needed to succeed in that situation.

4. Emotional arousal. High Levels of arousal are often associated with anxiety and failure, and can serve to reduce feelings of self-efficacy.

Social situations can also be viewed as tasks involving the ability to conduct oneself in an appropriate manner. As you might expect, those with low social self-efficacy experience high levels of social anxiety. These negative feelings, in turn lead the individual to avoid social situations. As a result, there is little opportunity to learn new and better social skills. It is also true that levels of self-efficacy differ in different social situations. One undergraduate may perform very comfortably in a party setting but be a bundle of nerves when asked to talk in front of a class; another student may show exactly the opposite pattern.

People with low social self-efficacy make different attributions than do high-efficacy individuals about the outcomes of social interactions, as shown by Alden(1986). This experimenter found that feedback inconsistent with a person's perceptions of his or social abilities was interpreted as externally caused. For example, when someone with high social self-efficacy received negative feedback after a social exchange, the unfavorable outcome was attribute not to deficient social skills but to something about the situation. Negative feedback for those low in social self-efficacy, however, was interpreted in terms of lack of ability. You can think of these results as involving self schemas relevant
to social self-efficacy; when information fails to fit our schema, we reinterpret it to make it fit.

Factors that Influence Self-Efficacy

Feelings of self-efficacy can be changed. A psychology major who originally feels confident being able to cope with the statistical requirements of this field may later decide that his or her skills simply don't include data analysis. Conversely, a friendly and informative statistics course can raise a student's level of understanding and feelings of efficacy in this area. In effect, the student will find that previously incomprehensible material has become understandable; the situation thus can be mastered through direct, successful experience (Bandura, 1986).

Social comparison can also affect self-efficacy (Bandura, 1986). For example, when a person does well on a task relative to the performance of other people, the perception of self-efficacy rises. A more direct social influence occurs when someone who is believable convinces you that your performance is good. In studies of bogus feedback, another person inflates or deflates one's feedback about task performance (Bandura, 1986). This is most effective in a situation in which the person has no prior conceptions about his or her abilities. When a child ties a shoelace for the first time, an adult who praises or criticizes the performance can have a major impact on feelings of self-efficacy involving this skill.

Self-efficacy can also be raised whenever a person's success in a given activity is clearly defined and available for recall. In various sports, coaches often exhort their teams by invoking images of outstanding performances and the fruits of success. The strong image of the desired behavior can increase an athletes' feelings of self-efficacy and hence improve performance. In the former Soviet Union, sports psychologists...
went a step farther and showed athletes videotapes of their best performances, sometime edited to make the performance look better than it had actually been (Feltz, 1982). Again, self-efficacy and performance improved.

The present study followed a 2x2 factorial design of research focusing on perception of life stress, psychological adjustment, and self-efficacy of women. It intended to find out the differential dynamics relating to these variables among women at work places and housewives from two levels of socio-economic states, i.e., high and middle. Major findings revealed certain similarities as well as differences between housewives and working women across two levels of socio-economic status. Working women seem to have a better psychological perception and adjustment to perceive stressfulness of life events. Their socio-economic status also facilitates their generalized as well as domain-specific self efficacy. It is assumed that their exposure to the work environment and their observational learning experiences increases adaptability. Financial pressure seems to be higher among middle SES groups. Compared to high SES groups. Irrespective of whether one is employed or not employed, satisfaction is perceived and experienced and this experienced is characterized by our personal perceptions, values, attitudes in life. The interrelationships among different variables are stronger among high SES working women compared to the other three subgroups.

There are certain limitations of this research. The kind of work environment selected may affect the results meaningfully. The personality dynamics of the participants/respondents may also influence the interrelationship among the variables. However the study, to a great extent, facilitates insight and understanding about an important section of the present society where more and more women are joining the work
force and, at the same time; wish to maintain harmony, happiness, and subjective wellbeing at their home and family.