International Journal For Technological Research In Engineering
Volume 1, Issue 10, June-2014 *ISSN (Online): 2347 - 4718*

A STUDY OF MENTAL HEALTH OF WORKING AND NON-WORKING WOMEN WITH REGARDS TO AREA OF RESIDENCE

Ashabahen C. Tadvi
Hemachandracharya North-Gujarat University, Patan, Gujarat

I. INTRODUCTION

Advancement in all spheres of life and health awareness in general, people of today's world are more conscious about their health so as it is a well recognized fact that the ill-effect of health related problems on employees well-being is well-recognized by various organizations such as W.H.O., I.L.O. and other unions, that mental health seems to be equally important as physical health. An individual cannot be considered as healthy if he/she is not mentally healthy. However, more importantly, mental health also affects our physical and social health because the components of mental health not only affect emotional states but also our physiological and biological states as well. If an individual is continuously exposed to mental stressors then he/she is likely to develop the symptoms of physical disease states in three ways: the body's ability to fight infection is reduced, the chances to influence existing disease 54 increase and vulnerability to catch new diseases and illnesses are likely to increase.

Mental health may be described in terms of an individual's emotional and psychological well-being. The concept of mental health has greater relevance, which was first described by Clifford Whittingham Beers in 1908 with the term "Mental Hygiene". He constituted a National Committee for Mental Hygiene in 1909 and actively campaigned for the rights of the mentally ill people. William Glasser (1961) also described "Mental Hygiene" in his book entitled 'Mental Health or Mental Illness', wherein he took the dictionary definition of hygiene that is described as the establishment and maintenance of health, viz; mental health. Before 20th century, mental health was described in terms of the absence of mental disorder but later on it was examined that the absence of a recognized mental disorder is not necessarily an indicator of mental health and it has been considered in its more positive connotation. It is obvious that mental health is so vast that includes subjective well-being, perceived self-efficacy, autonomy, competence, inter-generalizational dependence and self-actualization of one's intellectual and emotional potential amongst others. It is not possible to cover every aspect in its domain while defining mental health comprehensively but it is however generally agreed that mental health is relatively much broader when it is compared with mental disorders.

According to the Surgeon General's Report, Mental Health refers to "the successful performance of mental function, jesting in proactive activities, fulfilling relationships with other people, ante ability. Depot changes and copes with adversity". On the end of the continuum" is differ mental illness, a term that "refers to all alterations in thought, mood, or behaviour (or some combination thereof) associated with distress and/or impaired functioning." In this perspective and the notion of a continuum one can see mental health on one end as successful mental functioning as compared to mental illness on other end as 'impaired functioning.' Indian women have been gradually coming out of traditional roles and entering into the male dominated areas. In recent years the role and stutus of the women have been changed tremendously. With increasing female education and more liberty for their rights and privileges, women's attitude towards their stereotyped role is changing. Their participation in education and work place has also led to their increased socio-familial roles. Women who work outside the home are required to make many socio-familial adjustments that may contribute more stress and anxiety. The problem of stress in women, particularly working women, is an important aspect on the process of social and emotional changes.

Women in India today have more opportunities to pursue their higher education and more and more women have started taking up the jobs outside their homes. Women are existing under cultural norms and values so the working women have to make an adjustment with the family members are expected to make such adjustments. So this in turn leads to a number of stress and strain among working women. WHO defines health as a state of 'complete physical, mental and social well-being, and merely the absence of disease or infirmity'. Mental health has been reported as an important factor influencing an individual's various behaviours, activities, happiness and performance. Mental pressure is a vital cause of the mental health problems which arise due to various conditions. If the mental condition is good, a women can take various responsibilities of a family and herself, understand the complications, try to solve them, plan for future and adjustment with others by becoming mentally strong. Mental health can be defined as the ability to make adequate social and emotional adjustments to the environment, on the plane of reality. In other words it is the ability to face and accept the realities of life. The interface between the work place and the family life is more stressful for the women who work outside the home and they have to perform both familial as well as professional roles. This in turn, leads to stress of a person and affects mental health.

Rastogi and Kashyap (2001) reported that significant negative relationship existed between occupational stress and mental health among married employed in teaching, nursing and clerical jobs. The sources of stress for working and non-working women are heavy workload, lack of co-operation from colleagues or neighbours and negative community attitude.

Ojha and Rani (2004) observed significant negative correlations between life stress and positive self-evaluation and between life stress and integration of personality among working and non-working women.

Thakar and Misra (1999) studied the role of social support in daily hassles and well-being amongst employed and unemployed married women. It was found that though the employed women experienced more hassles and received less support than their unemployed counterparts, they enjoyed better well-being. Employed women's higher well-being speaks of the relative deprivation of housewives role and their desire for opportunities to use their potential for self-actualization and self-gratification. Resources generated by employment (e.g. income, status) appeared adequate not only to cope with stresses emanating from multiple roles, but also to enhance wellbeing.

Khlat, Sermet and LePape (2000) examined the relation of family and work roles on women's health. Results showed that higher income was clearly associated with better health. Housewives and single mothers were more common at the bottom and middle of the income scale. Single mothers were clearly disadvantaged in terms of mental health condition, malaise symptoms and health related behaviour. Housewives were disadvantaged in terms of physical health conditions. Childless married working women at the top of the income scale and single women reported suffering from discomfort more than married working mothers.

Srivatsa (1995) compared role stress and mental health in 4 types of couples. A sample of 120 male partners in 3 types of dual career couples: both partners engaged in similar types of jobs, partners in different types of jobs, Females partners in part time job and who were husbands of full time housewives. Results showed that husbands of full time employed women experience higher role stress and manifest more symptoms of psychoneurosis compared to those whose wives were in part time jobs or full time housewives. The life style of the 4 types of couples had significant variance in their level of role stress and mental health. Role stress and mental ill-health were significantly correlated for all 4 categories of subjects. However, the intensity of the relationships was lower for the husbands of full time employed women.

Iwata and Suzuki (1997) examined the relationship between role stress at work and mental health status, and the moderating effect of social support over a sample of 256 bank employees. Findings showed that high coworker support was effective to keep mental health status at low to medium levels of role overload but became less effective at a higher level of role overload. This relationship was replicated for male clerks, but varied for female clerks and was not significant for male chief clerks or higher.

Frese (1999) studied the relationship between work stressors and psychological dysfunction amongst blue-collar male workers in metal industry. Stressors at work were ascertained by observations and a variant of peer rating. Psychological, physical and social stressors at work and leisure time stressors were ascertained. The dependent variables of dysfunction were psychosomatic complaints, depression, irritation/strain and (social) anxiety. Results showed that social stressors and socially oriented aspects of psychological dysfunction were affected more strongly.

Gardiner and Tiggemann (1999) studied the impact of working in both a male or female dominated industry on the stress levels and mental health of 60 female and 60 male managers. Results revealed that women reported more pressure from their jobs than men, with women in male dominated industries reporting the highest level of pressure from discrimination. There was no overall difference between women and men mental health. Both gender and gender ratio of the industry influenced stress and mental health and as such contributed to our understanding of the barriers to women working in senior management roles in male dominated industries.

Vinokur, Pierce and Buck (1999) examined the effects of work and family stressors and conflicts on mental health of Air Force women. The sample consisted of 525 Air Force women (mean age 32 yrs) from reserve and guard forces who were activated for service during operations Desert Shield/Storm. The main contributors to depression were job and family distress. Work-family conflict and family-work conflict had a bi-directional 61 influence on each other. Separate effects of marital and parental roles on mental health. Job and parental stressors have direct effects on work-family conflicts and that job and marital distress and family-work conflict have an independent adverse effect on mental health whereas job and parental involvement has a beneficial effect on distress, they have an adverse effect on work-family conflicts.

Kirkcaldy and Martin (2000) studied the occupational stress and health outcomes amongst 276 nurses. In general, nurses showed high scores on the stresses related to confidence and competence in role, home work conflict and scores related to mental health. Older nurses reported more stress and the younger nurses experienced better mental health. Finally, Type A emerged as a significant determinant of physical health.

Wong et al, (2001) examined the sources of stress and mental health of nurses in Hong Kong. The sample consisted of 269 nurses (Male-25 and Female-244) working in private, public and other hospitals. Results showed that more than one-third of the nurses could be considered as having poor mental health. While supervisory role produced the highest level of stress, organizational environment also created a substantial amount of stress for nurses.

II. OBJECTIVES OF THE STUDY

- To study and compare between working and non-working women with regards to their Mental Health.
- To study and compare between urban and rural areas women with regards to their Mental Health.
- To study interaction effect between women status and Area of Residence of women with regards to their Mental Health.

III. HYPOTHESES OF THE STUDY

- There will be no significant difference between working and non- working women with regards to

their Mental Health.

- There will be no significant difference between urban and rural areas women with regards to their Mental Health.
- There will be no interaction effect between women status and Area of Residence of women with regards to their Mental Health.

IV. SAMPLE

For the present study random sampling technique was used for the selection of the participants. The sample was consisted of 120. Sample was categorized as under.

A1 (Working)		A2 (Non-working)	Total
B_1 (Urban)	30	30	60
B2 (Rural)	30	30	60
Total	60	60	120

V. VARIABLES

In present study the nature of variable was given in the following table:

Name of Variable	Nature of Variable	Number of Variable	Level of Variable
Women status	Independent Variable	2	Working Non-working
Area of Residence	Independent Variable	2	Urban Rural
Mental Health	Dependent Variable	1	Mental Health

VI. TOOL

Mental Health Check List by Dr. Pramod Kumar

Mental health Check list by Pramod Kumar was used for data collection. Mental health Check list consists of 11 items - 6 mental and 5 somatic, presented in a 4-point rating format e.g. 'rarely', 'at items', often and 'always'.

A numerical value of 1,2,3 and 4 is assigned to the 4-response categories i.e. for 'rarely', 'at times', 'often', and 'always', respectively. The total score varies from 11 to 44, showing the highest to the lowest (poorest)mental health status of the person.

The split-half reliability, correlating the odd-even items (applying the Spearman-brown formula for doubling the test length) has been found to ·be 70(N=30) with an index of reliability ·of .83 (Garrett, 1961). The test-retest reliability is also been studied. It has been found to be .65 (N=30) with an index of reliability of .81. The retest was giving with a time interval of two weeks.

The r-value of .70 and .65 .reliability have been found to be significant. .01 level of confidence, showing that the test is reliable both in term of its internal consistency and stability of scores.

The face validity of the MHC appears to be fairly high as items were prepared by asking teachers of psychology to list all such symptoms which according to them showed poor mental health. The content validity was adequately assured as only those symptoms which showed 100 percent agreement amongst the judges regarding their relevance to the study of mental health were selected.

VII. PROCEDURE

Mental Health inventory by Check List by Dr. Pramod Kumar were administered simultaneously in individual setting after giving adequate instructions and establishing rapports. All the precautions were taken during the test administration as per manual also. Scoring of test was done as per manual of test.

VIII. STATISTICAL ANALYSIS

To find out main and interaction effect of women Status and Area of Residence on scores of Mental Health Two way analysis of variance was used.

IX. RESULT AND DISCUSSION

Table: 1 Showing Results of ANOVA on Mental Health of Various Groups

Source of Variation	Sum of Square	df	Mean sum of Square	f	Level of significant
Ass	11.408	1	11.048	1.87	NS
Bss	276.074	1	279.074	45.82	.01
AxBss	7.009	1	7.009	1.15	NS
Error	707.301	116	6.09		
Tss	1004.792	119			

Table: 2: Showing Means Scores of Mental Health of Variable-A (Women status)

	A1(Working women)	A2 (Non-working women)
Mean	11.65	12.26
N	60	60

Table: 3: Showing Means Scores of Mental Health of Variable-B (Area of Residence)

	B1 (Urban)	B2 (Rural)
Mean	14.36	10.50
N	60	60

Table: 4: Showing Means Scores of Mental Health of Variable-AxB (Women status x Area of Residence)

		A1 (working women)	A2 (Non-working women)
B1 (Urban)	Mean	12.93	14.03
	N	30	30
B2 (Rural)	Mean	10.36	10.5
	N	30	30

F ratio for Mental Health on women status (Ass) is 1.87, which is not significant. It means working women is significantly not differ on Mental Health as compared to non-working women. Table 2. Shows the mean scores of working women is 11.65 on Mental Health and mean scores of non-working women is 12.26 on Mental Health. It is clearly said that significant difference is not exists between

working and non- working women on Mental Health.

F ratio for Mental Health on Area of residence (Bss) is 45.82, which is significant at .01 level. It means urban women significantly differ on Mental Health as compare to rural women. Table 3 shows the mean scores of urban women is 14.36 on Mental Health and mean scores of rural women is 10.50 on Mental Health. It is clearly said that significant difference is exists between urban and rural women on Mental Health. Urban Women have better Mental Health as compare to rural women.

F ratio for Mental Health on women status and Area of residence (AxBss) is 1.15. Which is not significant. It means significant interaction effect is not exists between women status and Area of residence on Mental Health. Table 4 shows the mean scores of urban working women is 12.93, rural working women is 10.36, urban non- working women is 14.03 and rural non- women is 10.5 on Mental Health. It is clearly said that significant difference is not exists between women status and Area of residence on Mental Health.

X. CONCLUSIONS

1. Significant difference is not exists between working and non- working women on Mental Health.
2. Significant difference is exists between urban and rural women on Mental Health. Urban Women have better Mental Health as compare to rural women.
3. Significant difference is not exists between women status and Area of residence on Mental Health.

REFERENCES

[1] Frese, M. (1999). Social support as a moderator of relationship between work stressors and psychological dysfunctioning: A longitudinal study with objective measures. Journal of Occupational Health Psychology, 4(3), 179-192.

[2] Glasser, W. (1961). Mental Health or Mental Illness? Psychiatry for Practical Action, 1962, ISBN 0-06-091092-05

[3] Iwata, N. and Suzuki, K. (1997), Role stress-mental health relations in Japanese bank workers. A moderating effect of social support. Applied Psychology: An International Review, 46(2), 207-218.

[4] Khlat, M.; Sermet, C. and LePape, A. (2000). Women's health in relation with their family and work roles: France in the early 1990s. Social Science and Medicine, 50(12), 1807-1825.

[5] Kirkcaldy, B.D.; Shephard, R.J. and Furnham, A.F. (2002). The influence of Type A behaviour and locus of control upon job satisfaction and occupational health. Personality and Individual Differences, 33(8), 1361-1371.

[6] Ojha, S. and Rani, U., 2004, A comparative study of the level of life stress and various dimension of mental health among working and non-working Indian women. J. com. Guid. Res., 21(3): 297-303.

[7] Rastogi, R. and Kashyap, K., 2001, A study of occupational stress and mental health among married working women. J. Com. Guid. Res., 18(2): 189-196.

[8] Srivastava, A.K. (1995). Role stress and mental health of the male partners in dual-career couples. Psychological studies, 40 (1). 11-17.

[9] Thakar, G. and Misra, G. (1999). Daily hassles, well-being and social support: experiences of employed women in India. Psychological Studies, 44(3), 69-76.

[10] Vinokur, A. D.; Pierce, P.P. and Buck, C.L. (1999). Work-family conflicts of women in the Air Force: Their influence on mental health and functioning. Journal of organizational Behaviour, 20(6), 865-878.

[11] Wong, D.; Leung, S.; So, C. and Lam, D. (2001). Mental Health of Chinese Nurses in Hong Kong: The Roles of Nursing Stresses and Coping Strategies. Online Journal of Issues in Nursing, Vol. 5, No. 2, Manuscript 7.

