LIFE STRESS AND COPING RESPONSE IN RELATION TO MENTAL HEALTH. A COMPARISON BETWEEN URBAN AND RURAL WOMEN.

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LIFE STRESS AND COPING RESPONSE IN RELATION TO MENTAL HEALTH. A COMPARISON BETWEEN URBAN AND RURAL WOMEN.

A Dissertation
Submitted to the University of Dhaka in partial fulfillment of the requirements for the degree of Master of Philosophy in Psychology.

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APPROVAL SHEET

This is to certify that I have read the dissertation entitled "Life Stress and Coping Response in Relation to Mental Health. A Comparison Between Urban and Rural Women" submitted by Zahanara Fahim, in partial fulfillment for the degree of master of Philosophy in Psychology, and that this is an original study carried out by her, under my supervision and guidance .

Dated: Dhaka
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ABSTRACT

The purpose of the present study was to investigate life stress and coping response in relation to mental health of women in urban and rural setting. Education, age, income and certain other socio-demographic variables have also been explored.

For the present study 200 respondents from urban and rural setting was used as the sample of the present research. Urban sample (100 women) of the present study was randomly selected from six thanas of Dhaka city and the rural samples (100 women) were selected from the three villages of Noakhali district.

The original version of the "How stressful is your life?" (Cohen, 1999) translated into Bangla by Fahim (2001) was used to measured life stress of the respondents. The translated and adapted version of the coping scale (Huque, 2004) originally developed by Folkman and Lazarus (1980) was used to measure coping behavior of the respondents. Mental health of the respondents was measured by the Bangla version of General Health Questionnaire (GHQ-12) adopted by Sorcar and Rahman (1989). A bio-data form was also used to gather respondents' socio-demographic information.

One-way ANOVA was used to see if life stress, coping strategies and mental health of women vary with residential status. Significant difference in life stress as a function of residential status of the respondents was found. Rural women had higher life stress than urban women. Significant residential status difference in the use of wishful

thanking, social withdrawal and acceptance coping strategies were found in the present study. Urban respondents used more wishful thinking, social withdrawal and acceptance coping strategies than their rural counterparts.

Findings of ANOVA also showed significant difference in the use of social withdrawal coping strategy between respondents of 3 different age groups. Up to the age group of 18 to 24 years social withdrawal coping strategy was adopted more than the other two groups. Results also revealed that life stress varied with the occupation of the respondents. Students in the present study experienced more life stress than housewives and service holders. Significant difference was found in mental health with family type. Respondents living in joint families had better mental health than those living in single families.

Correlation coefficient showed significant positive relation between adoptive coping strategies, age and mental health. Significant negative correlation was found between life stress and mental health. The correlation matrix showed the intercorrelation among the several variables under study. Highly significant positive correlation was found between adaptive coping strategies and income, nonadaptive coping strategies and education, and between income and education. Significant negative correlation was found between income and life stress, education and age, and between education and life stress.

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Chapter –1
Introduction

Stress, and ways of coping with it, have long been central topic of interest to psychologists. All of us face stress in our lives. Some health psychologists believe that daily life actually involves a series of repeated sequences of perceiving a threat, considering ways to cope with it, and ultimately adapting to the threat, with greater or lesser success. Although adaptation is often minor and occurs without our awareness, adaptation requires major effort when stress in more severe or longer lasting. Ultimately, our attempts to overcome stress can produce biological and psychological responses that result in health problems.

Often the most immediate reaction to stress is biological. Exposure to stressors generates a rise in certain hormones secreted by the adrenal glands, an increase in heart rate and blood pressure, and changes in how well the skin conducts electrical impulses.

On a psychological level, high levels of stress prevent people from adequately coping with life. Their view of the environment can become clouded (e.g., a minor criticism made by a friend is blown out of proportion). People under a lot of stress also become less able to deal with new stressors. The ability to contend with future stress, then, declines as a result of past stress.

Stress is a normal part of life- and not necessarily a completely bad part. For example, without stress, we might not be sufficiently motivated to complete the activities we need to accomplish. However, it is also clear that too much stress can take its toll on both physical and psychological health. The efforts to control, reduce, or learn to tolerates that lead to stress are known as coping. We habitually use certain coping responses to help ourselves deal with stress. Most of us cope with stress in a characteristic manner employing a coping style that represents our general tendency to deal with stress in a specific way.

The social and emotional support that people provide each other helps in dealing with stress in several ways.

Every body maintain their life in their own way. We find many difficulties in our life. We face many stressful situation and also have to cope with it. Those people who are mentally and physically healthy they can face all the problem in their life. But mentally unhealthy people fall in difficulty to face their problem.

Research studies have shown that better mental health has been found to be associated with the use of more adaptive, engaged coping activities such as problem solving and cognitive restructuring, whereas poor mental health has been found to be associated with the use of more maladaptive, disengaged coping activities such as problem avoidance and social withdrawal (Chang, 1995; Long and Sangster, 1993; Scheier and Carver, 1985,1992).

Since mental health is no less important than physical health and sometimes mental disturbances can be more damaging for people at their workplace, family, etc, mental health professionals are currently taking great interest in the field of assessment, prevention and intervention to promote mental health. However, in the context of Bangladesh, little attention has been devoted to it, until very recently.

Bangladesh is one of the worst poverty stricken countries of the world where nearly 40 percent of the population fall below poverty line (UNDP, 2003). A vast majority of this poverty stricken
population (about 46.3 million) live in the rural areas and about 50 percent of the rural population are landless (UNDP, 1994). Bangladesh is backward in almost all indices of development viz, education, income, employment, health care etc. Women in Bangladesh constituting half of its population are worse off than men in all indicators of human development. Nutrition index show that females receive 88 percent as against 100 percent of the male. Wage

index also show gender disparity as females score 48 as opposed to 100 of the male. Few studies conducted so far on mental health has revealed that people of low socio-economic group had significantly poorer mental health than that of middle and high socio-economic groups (Begum and Mahmuda, 1997). Females belonging to low SES had poorer mental health than males (Begum and Mahmuda, 1997; Jahan, 1996; Khaleque and Sorcar , 1992; Sorcar and Rahman, 1993). Most of the women in Bangladesh dependent on others. At the beginning women are dependent on their parents, after marriage they are dependent on their husband and their family and at the old age they are dependent on her children.

There is probably so far known to data no research has been conducted in Bangladesh which has concentrated particularly on women, their life stress, how they cope with their problems and their mental health conditions. Therefore, present study was designed to investigate perceived stress, coping strategies and mental health of rural and urban woman in Bangladesh. The following paragraphs would offer a discussion on stress, coping strategies and its effect on women's mental health.

1.1:The concept of stress.

Psychological stress has been conceptualized in three ways-

1. Stress as a stimulus:

One approach focuses on the environment, describing stress as a stimulus. This can be seen in people's reference to the source or cause of their tension as being an event or set of circumstance- such as having " a high- stress job". Events or circumstances that we perceive as threatening or harmful, thereby producing feelings of tension, are called stressors. Researchers who follow this approach study the impact of a wide range of stressors; including.

A. Catastrophic events, such as tornadoes and earthquakes,

B. Major life events, such as the loss of a loved one or a job, and

C. Chronic circumstances, such as living with severe pain from arthritis.

Research also shows that routine hassles may have significant negative effects on our mental and physical health (Folkman and Lazarus, 1988). These daily hassles include misplacing things, struggling with rising prices, traffic jam and so forth. Routine hassles at home, school and at work might be fairly benign individually but collectively they could create great strain. For people to consider an event to be stressful, they must perceive it as threatening and must lack the resources of deal with it effectively (Folkman et. al.; 1986).

2. Stress as a response:

The second approach treats stress as a response, focusing on people's reaction to stressors. An example of this approach is when people use the word stress to refer to their state of tension. The response has two interrelated components- the psychological and physiological components. The psychological components involves behavior, thought patterns and emotions, as when we "feel nervous". The physiological components involves heightened bodily arousal- such as pounding heart, dryness of month, feeling of tightness in the stomach and perspiration. The person's psychological and physiological response to a stressor is called strain.

3. Stress as a process:

The third approach describes stress as a process that includes stressors and strains, but adds an important dimension: the relationship between the person and the environment (Cox, 1978; Lazarus and Folkman, 1984a,1984b; Lazarus and Launier,1978; Mechanic, 1976). This process involves continuous interactions and adjustments – called transactions – between the person and the environment with each affecting and being affected by the others. According to this view, stress is not just a stimulus or a response, but rather a process in which the person is an active agent who can influence the impact of a stressor through behavioral, cognitive and emotional strategies.

Defining stress:

To define stress ideas from several sources have been borrowed (Cox, 1978; Lazarus and Folkman, 1984b, Mechanic, 1976; Singer and Davidson , 1986; Trumbull and Appley, 1986). Stress is the condition that results when person-environment transactions lead the individual to perceive a discrepancy- Whether real or not between the demands of a situation and the resources of the person's biological, psychological or social systems. This definition has four components which will be discussed briefly below.

1. Stress taxes the person's biopsychosocial resources for coping with difficult events or circumstances. An example of stressful encounter that strain our biopsychosocial resources is participating in a competitive athletic event, being injured in an accident or becoming nauseated before performing a play, exam or an interview.

2. The phrase "demands of a situation" refers to the amount of our resources the stressor appears to require.

3. When there is a poor fit, or a mismatch, between the demands of the situation and the resources of the person, a discrepancy exists. This generally takes the form of the demands taxing or exceeding the resources. But the opposite discrepancy may also occur- that is, our resources may be underutilized- and this can be stressful, too. A worker who is bored by a lack of challenge in a job may find this situating stressful.

4. In our transactions with the environment, we assess demands, resources and discrepancies between them. These transactions are affected by many factors, including our prior experiences and aspects of the current situation.

Appraising Events As Stressful:

Transactions that lead to the condition of stress generally involve an assessment process that Richard Lazarus and his co-workers call cognitive appraisal (Cohen and Lazarus, 1983; Lazarus and Folkman , 1984b; Lazarus and Launier, 1978). Cognitive appraisal is a mental process by which people assess two factors:

i) Whether a demand threatens their well- being and
ii) The resources available for meeting the demands.

These two factors form distinction between two types of appraisal – primary & secondary.

Primary and secondary appraisal:

Primary appraisal is an initial evaluation of whether an event is -
a) Irrelevant to you,
b) relevant but not threatening,
c) Stressful ,

When we view an event as stressful, we are likely to make a secondary appraisal.

Secondary appraisal refers to our ongoing assessment of the resources we have available for coping and options for dealing with the stress.

Thus our primary appraisal would determine whether we saw an upcoming job interview as stressful. Our secondary appraisal would determine how stressful the interview appeared in light of our assessment of our ability to deal with the event.

A number of studies have shown that stress and our appraisals of stressful events are highly subjective (Brett, 1990). Some people are more prone than

others to feel threatened by life's difficulties. This reality was apparent in a study by Lundberg (1976), who compared neurotic subjects against control subjects in regard to their perception of the stressfulness of various life events. They found that neurotic subject's ratings of how "upsetting" various stressful events would be were consistently higher than the control subjects ratings of the same events.

Factors related to stress Appraisals:

Appraising events as stressful depends on two types of factors- those that are related to the person and those that are related to the situation (Cohen and Lazarus, 1983; Lazarus and Folkman, 1984b).

1) Personal factors.

Personal factors include intellectual, motivational and personality characteristics. One example has to do with self esteem: people who have high self- esteem are likely to believe they have the resources to meet demands that require the strengths they possess. If they perceive an event as stressful, they may interpret it as a challenge rather than a threat (Cohen and Lazarus, 1983). Another example relates to motivation: the more important a threatened goal, the more stress the person is likely to perceive (Paterson and Neufeld, 1987). Another important personal factor is a person's belief system. According to Albert Ellis (1987) many people have irrational beliefs that increase their stress and they appraise almost any sort of inconvenience as harmful or threatening.

2) Situational factors :

Situational factors involve demands, life transitions, timing, ambiguity, desirability and controllability factors. Events that involve very strong demands and are imminent tend to be seen as stressful (Cohen and Lazarus, 1983; Paterson and Neufeld,1987). Life transitions tend to be stressful (Moos and Schaefer, 1986; Sarason and Sarason, 1984). Life has many major events that mark the passing from one condition or phrase to another, and they

produce substantial changes and new demands in our lives. These events are called transitions, and include:

- Starting day care or school
- Moving to a new community
- Reaching puberty, with accompanying biological and social changes
- Starting college, especially away from home
- Entering a carrier
- Getting married
- Becoming a parent
- Death
- Retirement, etc.

The timing of a life transition can affect the stress it produces. People expect some events, such as marriage or retirement, to occur at certain times in the life span (Neugarten & Neugarten, 1987). Deviations from the expected timetable are stressful. Events that happen too early or too late often leave the person without the support of compatible peers (Lazarus and Folkman, 1984b). Also, the person may interpret being off schedule as a failure, and this is stressful.

Ambiguity- a lack of clarity in a situation can have an effect on stress appraisals. But the effect seems to depend on the type of ambiguity that exists. Role ambiguity occurs when the information about a person's function or task is unclear or confusing (Quick and Quick, 1984). Harm ambiguity occurs when the likelihood of harm or the availability of resources to meet situational demands is unclear.

Another factor that influences stress appraisals is the desirability of the situation. Undesirable events are more likely to be appraised as stressful than are desirable ones (McFarlane et.al., 1980; Sandler and Guenther, 1985; Suls and Mullen, 1981; Vinokur and Selzer, 1975).

One other aspect of the situation that affects the appraisal of stress is its controllability- that is, whether the person has the real or perceived ability to modify or terminate the stressor. People tend to appraise an uncontrollable event as being more stressful than a controllable event, even if they do not actually do anything to affect it (Miller, 1979; Suls and Mullen, 1981; Thompson, 1981).

There are two types of control

- Behavioral control
- Cognitive control

In behavioral control, we can affect the impact of the event by performing some action. For example, you are experiencing intense pain from a headache. If you have the ability to reduce the pain, you are less likely to be stressed by the headache than if you do not have this ability.

In cognitive control, we can affect the impact of the event by using some mental strategy, such as by distracting our attention from the stressor or developing a plan to overcome a problem.

Sources within the person:

One way stress arises form within the individual is through illness. Being ill places demands on the person's biological and psychological systems, and the degree of stress these demands produce depends on the seriousness of the illness and the age of the individual, among other things.

Another way stress arises within the person is through the appraisal of opposing motivational forces, when a state of conflict exists. Conflict is a major source of stress. The pushes and pulls of the conflict produce two opposing tendencies: approach and avoidance. These two opposing tendencies characterize three basic types of conflict (Lewin, 1935; Miller, 1959).

1.Approach / Approach conflict arises when we are attracted toward two appealing goals that are incompatible. Although individuals generally resolve an approach / approach conflict fairly easily, the more important they perceive the decision to be, the greater the stress it is likely to produce.

2.Avoidance / Avoidance conflict occurs when we are faced with a choice between two undesirable situations. People generally find avoidance / avoidance conflicts difficult to resolve and very stressful.

3.Approach / Avoidance conflict arises when we see attractive and unattractive features in a goal or situation. This type of conflict obviously are most unpleasant, stressful and difficult to resolve.

Source in the family:

The behavior, needs, and personality of each member of a family have an impact on and interact with those of the other members of the family system, sometimes producing stress.

Interpersonal conflict can arise from financial problems, from inconsiderate behavior or from opposing goals. Of the many sources of stress in the family, we will focus on three: adding a new family member, divorce and illness and death in the family.

An addition to the family

A new child in the family is a joyful event, but it also brings stress – particularly to the mother, of course during pregnancy and after the birth. But an addition to the family is stressful to other family members too. The arrival of a new baby can also be stressful to other children in the family (Honig, 1987; Rutter 1983). This stress seems be particular strong among children

who are very young, say, 2 or 3 years old, and who may want to share their parents with the new brother or sister.

Divorce:

A divorce produces many stressful transition for all members of the family as they deal with changes in their social, residential and financial circumstances. Amato (1994) studied the impact of divorce on psychological well being of men and women in India and United States. The results showed that Indian women experience more problem than men and also suffer more hardship than U.S. women. Three factors are responsible for this pattern: Indian women's economic dependence on men, Indian cultural beliefs about women and marriage, and the patriarchal organization of the Indian joint family. Psychological well being of these women were significantly poorer than U.S. women.

Family illness, Disability and Death :

Having a sick member in a family is stressful for the other members. The family faces many difficult decisions and must learn about the illness and how to care for the sick. Medical expenses add burden to the families' stress. Marten et. al. (2000) studied the psychological well being of the family members with schizophrenia. The results indicated that family members are significantly distressed as a result of having family member with schizophrenia. In another study Liao et. al. (2000) studied the psychological well being of women who had experienced menopause before the age of 40 years. The results showed high levels of depression and perceived stress and low levels of self esteem and life satisfaction among these women compared to general population.

Disability is another source of family stress. Having a physically ill or disabled member in the family restricts the family time and personal freedom and produces

very important changes in interpersonal relationships (Leventhal, Leventhal and Van Nguyen, 1985, Michela, 1987, Skelton & Dominian (1993).

Death is also another factor in the experience of stress. Loss of a parent during childhood years may be one of the most traumatic events for a child. An adult whose child or spouse dies suffers a tremendous loss (Kastenbaum and Costa, 1977; Kosten, Jacobs, and Kasl, 1985). In a study . Edelstein (1984) found bereaved mother reported losing important hopes and expectations for the future.

Sources in the Community and Society :

The contacts people make outside the family provide many sources of stress. Since the present study focused on adult women population, sources of stress experienced by women will be discussed- Much of their stress is associated with their occupations and a variety of environmental situations.

Job Stress :

The topic of job stress has received considerable research attention during the last decade and has emerged as an important issue of health concern. It has been observed that an increasing number of women are feeling and reporting stress in their working life. In America The National center for Health statistics (1985) found that more than half of the 40,000 workers they interviewed reported feeding either "a lot stress" or "moderate stress" in the last 2 weeks. The factors which make job stressful are:

1. Task demand **:** The demands of the task can produce stress in two ways. First, the workload may be too high. Studies have found that excessive workloads are associated with increased rates of accidents and health problems (Mackay and Cox, 1978; Quick and Quick, 1984). Second, some kinds of activities are more stressful than others. For example, repetitive jobs that underutilize the worker's abilities can produce stress.

2. Responsibility **:** Jobs that involve a responsibility for people's lives can be very stressful. Medical personnel have heavy workloads and must deal with life or death situations frequently, so their job is stressful.

3. Poor interpersonal relationship **:** People's stress on the job increases when their boss or a co-worker is socially abrasive, being insensitive to the needs of others or condescending and overly critical of the work other individuals do. (Quick & Quick, 1984).

4. Perceived inadequate recognition or advancement**:** Workers feel stressed when they do not get the recognition or promotion they believe they deserve (Cottingtion, Mathews, Talbott and Kuller, 1986; Quick & Quick, 1984).This is particularly not only for our country but all over the world.

5. Job loss **:** People experience stress when they lose their jobs or think their jobs are threatened. They feel a sense of insecurity and this is stressful. Studies have shown that unemployment is associaed with psychological and physiological signs of stress, such as in people loss of self esteem and heightened blood pressure (Olafsson & Sevensson, 1986).

Environmental Stress:

Although the perception of stress is a highly personal matter, many kinds of stress emanate from the environmental circumstances that we share with others. Ambient stress consists of chronic environmental conditions that, although not urgent, are negatively valued and place adaptive demands on people (Holahan, et.al., 1990). Features of the environment, such as excessive noise, heat and pollution can threaten our well being and leave their mark on our mental and physical health. Research has revealed that people exposed to excessive noise at work experience more headaches, nausea, and moodiness than others (Cohen, Glass & Phillips,1977). Evidence suggests that excessive heat may impair task performance and increase the likelihood of aggressive behavior (Fisher, 1993). In a study conducted in Dayton, Ohio, Rotten

and Frey (1984) found that psychiatric emergencies increased when air pollution was high.

Crowding is another source of environmental stress. Research conducted on the effects of residential density have found an association between high density and aggression, poor task performance and social withdrawal (Cohen, et.al., 1977)

Gender and Socio-cultural differences in Stress:

Studies have shown that stress depends on a persons gender and socio-cultural group membership. With respect to gender differences, women generally report having experienced a greater number of major stressors than men do (Greenglass & Noguchi, 1996) Although this difference may result partly from women's greater willingness to say they have felt distressed, it probably also reflects real variations in experiences. For instance in today's two income households, the total daily workload is particularly heavy for mothers because they still do most of the chores at home (Frankenhaeuser, 1991).

According to Jick & Mitz (1985) there are differences in the stressors to which the two sexes are subjects. For example, sexual harassment is a stressor for many working women. Other stressors can be more subtle in the job situation but no less distressing. Sex harassment is associated with many negative consequences like decreased morale and increased absenteeism, decreased job satisfaction (Gruber, 1992), job loss (Coles, 1986; Crull, 1982, Loy & Stewart, 1984) and deteriorating relationship with co-workers (Gutek, 1985; Loy & Stewart, 1984). Such studies illustrate that harassment represent a serous risk to employee's psychological well being. Sneider and Swan (1997) examined sexual harassment experiences, coping responses, job related and psychological outcomes. The study presents evidence that sexual harassment even at relatively low frequencies exerts a significant negative impact on women's psychological well being as well as job attitude and work behavior Sorcar and Rahman (1993) conducted as study in Bangladesh on occupational stress and mental health of women engaged in different occupation. The

perceived occupational stress was found significantly higher for bank and garment employees as compared to school teachers and more of unmarried women than the married, reported higher stress. However, although some studies have been conducted in the developing countries like ours on working women, relatively little information is obtained regarding the mental health of women in general.

Being a member of a minority group or being poor appears to increase the stress people experience (Johnson, et. al. 1995; Young and Zane, 1995). Research in western countries have shown that individuals with these socio-cultural statuses report having experienced a disproportionately large number of major stressors (Gottlieb & Green, 1987).

1.2: Assessing stressful life events:

Assessment of the impact of stressful event has been the focus of several recent clinical investigations (Miller, 1989). The aim of assessment is to gain detailed information about the nature, sources and severity of life stress.

Researchers have developed different scales for assessing psychological stress, some of these are The Social Readjustment scale SRS (Holmes & Rahe, 1967), The Life Experiences Survey LES (Sarason, Johnson & Seigal, 1978), The PERI Life Event Scale (Dohrenwend, Knasnoff, Askenrasy and Dohrenwend,1978). The unpleasent Events schedule UES (Lewinsohn, Mermelstein, Alexander and Macphillamy, 1985) etc.

In the present study life stress of women in urban and rural areas was measured by the Bangla version (Fahim, 2001) of the "How stressful is your life?" scale originally developed by Cohen(1999).

1.3:The concept of coping :

Individuals of all ages experience stress and try to deal with it. It is a normal part of our life- and not necessarily a completely bad part. For example without stress, we might not be sufficiently motivated to complete the activities we need to accomplish. It is also clear that too much stress can take its toll on both physical and psychological health. We face many stressful situation and also have to cope with it. These responses to stress tend to be largely automatic and controlling them depends on the coping responses that we make to stressful situations. Thus our mental and physical health depend on our ability to cope with stress.

What is coping?

Because the emotional and physical strain that accompanies stress is uncomfortable, people are motivated to do things to reduce their stress. These "things" are what is involved in coping.

Lazarus and Folkman (1984b) defines coping as the cognitive & behavioral activities by which a person attempts to manage a stressful situation as well as the emotions that it generates. The word manage in the definition is important. It indicates that coping efforts can be quite varied and do not necessarily lead to a solution of the problem. Although coping efforts can and should be aimed at correcting or mastering the problem, they may also simply help the person alter his on her perception of a discrepancy, tolerate or accept the harm or threat, or escape or avoid the situation (Lazarus & Folkman,1984 b, Moos and Schaefer, 1986).

1.4 : Coping Strategies :

Research on the structure of coping has found it to be a multidimensional phenomenon that includes a number of diverse as well as overlapping processes (Folkman and Lazarus , 1980; Stone and Neale, 1984; Tobin, Holroyed, Reynold, and wigal, 1989). People have enormous number of ways for coping with stress. One

approach to coping divides it into emotion focused coping strategies and problem focused coping strategies (Lazarus & Folkman, 1984a).

Emotion Focused coping : It is aimed at controlling the emotional response to the stressful situation. People can regulate their emotional responses through behavioral and cognitive approaches. Some example of behavioral approaches are using alcohol or drugs, seeking emotional social support from friends or relatives and engaging in activities, such as watching T.V. that distracts one's attention from the problem. Cognitive approaches involve how people think about stressful situation, such as denying unpleasant facts. People tend to use emotion- focused approaches when they believe they can do nothing to change the stressful conditions (Lazarus and Folkman, 1984b). An example is the death of a loved one. Other example can be seen in situations in which individuals believe their resources are not and cannot be adequate to meet the demands of the stressor.

Problem focused coping : It is aimed at reducing the demands of the stressful situation or expanding the resources to deal with it. It may lead to changes in behavior or to the development of a plan of action to deal with stress. Everyday life provides many examples of problem- focused coping, including quitting a stressful job, devising a new schedule for studying, choosing a different career to pursue and learning new skills. People tend to use problem- focused approaches when they believe their resources or the demands of the situation are changeable (Lazarus and Folkman, 1984b). Example of problem focused strategies are problem solving, confrontive coping, social support, cognitive restructuring etc.

Many individuals use both problem- focused and emotion- focused coping when adjusting to a stressful circumstance. For example in one study individual said they used both problem-focused and emotion-focused coping strategies in 98 percent of the stressful encounters they face (Folkman and Lazarus, 1980).

Lazarus and Folkman's concept of problem- focused and emotion- focused strategies correspond to Tobin, et. al., (1989) concept of problem engagement (adaptive) and disengagement (maladaptive) coping, Emotion engagement (adaptive) and disengagement (maladaptive) coping strategies. Studies have reported engagement (adaptive) strategies tend to be associated with better adaptation and adjustment than disengagement (maladaptive) strategies (Tobin et. al, 1989). But there are times when emotion- focused coping is adaptive. For example, denial is one of the protective psychological mechanisms that enables people to cope with the painful feelings that occur when the reality of death or dying becomes too great. But in other circumstances, denying or avoiding a problem, rather than dealing with it is maladaptive.

1.5: Relevant Research on coping strategies :

Research evidence suggests that the nature of coping strategies adapted varies according to variables such as, age, gender and socio cultural factors.

Age and coping strategies :

Some studies have examined changes in methods of coping from adolescence to old age. One study used interviews and questionnaires to compare the daily hassles and coping methods of middle- aged and elderly men and women (Folkman, Lazarus, Pimley & Novacek, 1987). The middle aged men and women used more problem focused forms of coping, whereas the elderly subjects used more emotion focused approaches.

In their study of coping strategies in young, middle aged and older adults, Folkman et.al., (1987) found that older adults were less likely than young and middle-aged adults to employ confrontation and aggression. Rather than becoming highly emotional when faced with stressful circumstances, older adults tended to cope by using denial, repression, and other passive strategies (Felton and Revenson, 1987;

Folkman et. al., 1987) Confronting stress with detachment and humor is more characteristic of older than young adults (Vallient, 1977). Compared with older adults, young adults and adolescents employ denial and other defense mechanisms more often (Blanchard- Fields and Irion, 1988; Blanchard-Fields and Robinson, 1987).

A study of Australian secondary students (Frydenberg and Lewis, 1993) found that the older pupils were more likely to blame themselves and use tension reduction techniques while younger students reported greater use of work- related strategies.

Gender and Socio-cultural differences in coping:

Studies of gender difference in coping have generally found that men are more likely to report using problem- focused strategies and women are more likely to report using emotion- focused strategies in dealing with stressful events. But when men and women were similar in occupation and education, no gender difference were found (Greenglass and Noguchi, 1996). These results suggests that societal sex roles play an important role in the coping patterns of men and women.

Girls were more likely to adopt coping strategies involving seeking social support, wishful thinking, and tension reduction but less likely to turn to sport than their male peers (Frydenberg and Lewis, 1993). Similar finding were found in studies of Canadian, German, Israeli and Vs students (seiffge-krenke, 1993).

The findings of Billings and Moos (1981) that individuals with higher incomes and educational levels reported greater use of problem focused coping than those with less income and education. Social experiences of disadvantaged people might have lead them to believe they have little control over events in their lives. Gottlieb and Green (1987) in their study on disadvantaged individuals which also included more minority group members found they experienced more stress and coped with them less effectively than other people.

Cultural differences in coping with stress was examined between 111 Asian American studies and 111 Caucasian American students in a study conducted by Chang (1996). Asian American were found to used significantly greater problem avoidance and social withdrawal strategies than Caucasian American students.

The present research focused on 11 coping strategies. A brief description of the subscales used in the study is given below.

1.Problem Solving (adaptive).

Tobin et. al., (1989) defined problem solving as cognitive and behavioral activities that attempt to change the stressful situation for the better. According to D 'Zurilla and Nezu (1982) it is an adaptive way of coping with problematic situations encountered in the course of every day living.

According to this view, problem solving is primarily a conscious, rational effortful and purposeful coping process that enhances and persons ability to deal effectively with a wide range of stressful situation. (e.g. "I work on solving the problems in the situation.").

2. Cognitive Restructuring (adaptive).

Tobin et. al., (1989) defined cognitive restructuring as cognitive reappraisals that alter the meaning of stressful situation to make it less threatening. In Tobin et. al's model it is a problem engagement strategy, where as Lazarus and Folkman (1984) view this technique as an emotion- focused strategy. (e.g. " I convince myself that things aren't quite as bad as they seem".).

3. Confrontive Coping (adaptive).

Confrontive coping is a problem- focused strategy where an individual take assertive action often involving anger or risk taking to change the situation. (e.g. "I speak foul language or get annoyed in such situations".).

4.Express Emotion (adaptive).

Express emotion is an emotion- focused strategy which aims at managing one's emotional reactions to a stressful situation by releasing and expressing feelings (e.g. "I let my emotions/feelings out".).

5. Social Support (adaptive).

According to Folkman and Lazarus (1988) this strategy can be problem or emotion-focused. It aims at managing one's emotional reactions to a stressful situation by seeking emotional support from others. People not only try to get comfort and encouragement from others by describing one's worries, but also try to acquire informational support. (e.g. "I discuss with others about how I feel.").

6. Problem Avoidance (non-adaptive).

Problem avoidance strategies are responses that individuals use keep stressful circumstances out of awareness so they do not have to deal with them (e.g. "I avoid thinking or doing anything about the problem.").

7.Wishful Thinking (non-adaptive).

It is an emotion- focused strategy where an individual thanks wishfully about the situation. (e.g. " I hope a miracle would happen".).

8. Social withdrawal (non-adaptive).

Social withdrawal is an emotion- focused strategy where one makes cognitive efforts to detach oneself from the situation or create a positive outlook. (e.g. "I avoid being with people.")

9. Self- Criticism (non-adaptive).

People sometimes become highly self-critical when confronted with stress (especially frustration and pressure). It is a tendency to engage in negative self-talk, to attribute failures to personal shortcomings and making unduly pessimistic projections about the future. A good deal of evidence suggest that self-criticism or self-blame are not

very healthy ways to cope with stress (Revenson and Felton, 1989; Vitaliano et. al.,1990). (e.g. " I blame my self".)

10. Religion (adaptive).

People sometimes pursue more informal ways of coping with stress. One such strategy according to Folkman and Lazarus (1988) is 'Turning to religion' (emotion-focused). In Muslim community prayers are regarded as a kind of meditation which helps release tension. (e.g. " I put my trust in God".).

11. Acceptance (non –adaptive).

It is an emotion –focused strategy where people acknowledges one's own role in the problem while also tries to put things right (e.g,"I accept everything or learn to line with I").

Research has shown that coping strategies, that is adaptive and non-adaptive has considerable impact on mental health. Better mental health is related to adaptive coping strategies and poor mental health is related to non adaptive coping strategies.

1.6. Mental Health:

WHO defines " health as a state of complete physical, mental and social well being and not merely the absence of disease or infirmity. The enjoyment at the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief or economic and social condition (1994)". Mental health includes subjective well being, perceived self efficacy, autonomy, competence, intergenerational dependence and self actualization of one's intellectual and emotional potential, among other (WHO-2001). Although many criteria of this definition of mental health are introduced from outside researches (e.g. maturity, autonomy) in psychology, subjective well being is the determinant of mental health. Subjective well being includes mental health, quality of life

and social gerontology. In 1960, Gurin et. al., studied subjective well being under the banner of "mental health". It is individual's own perspective/ feeling about his/her own life activities which range from negative to positive mental states.

Mental health is evaluated by assessing individual's lives such as satisfactions, emotions and his/ her psychological well being (e.g. absence of any psychological or affective symptoms like depression, anxiety). According to Ostrom (1969), Diener and Fujita (1994) subjective well being (mental health) comprises people's evaluations, both affective and cognitive. Ryff and Keyes (1995) proposed six aspects of well –being, self acceptance, positive relation with others, autonomy, environmental mastery, purpose in life and personal growth. This explanation is consistent with WHO'S definition of mental health.

Clinical perspectives of mental health.

Clinicians certainly may be interested in the social causes of mental illness, their immediate concerns are with its treatment. From a public health perspective, the treatment of mental illness requires the identification of people in the community who need treatment and of the particular disorders for which treatment is needed. Just as in other clinical specialties, mental health workers seek to distinguish cases from noncases. Cases are represented by those whose mental problems meet the criteria of distinct diagnostic categories, which serve as the basis for deciding on a treatment regimen. For example, the regimen for people diagnosed as schizophrenic would not be employed for those classified as having bipolar depression. Thus the categorization of patients is entirely in keeping with the treatment imperatives that operate in psychiatry as a medical specialty.

Sociological perspective of mental health.

Sociologists have multiple stakes in the study of mental health. First, they may be drawn to the field out of humanistic concerns and the wish to contribute to the alleviation of suffering, not unlike the concerns of those in the healing professions. However, although the interests of sociologists may overlap with those of clinicians and representatives of other disciplines, a sociological approach to mental health is distinctly different. In particular, social scientists are more likely to be concerned with the social and environmental conditions that broadly contribute to mental health problems and less likely than clinicians to be concerned with the amelioration of specific disorders by direct interview in the lives of individuals.

Health and well being are general out comes usually evaluated in stress research. Particularly as reflected in psychological functioning. Despite its common usage, the construct of mental health has resisted clear definition. Moreover, the social contexts from which mental health might arise have generally been over looked. Thus, attempts of specify the indicators of mental health have traditionally emphasized such individual qualities as self-actualization, maximization of potential, the possession of self esteem and so on(Allport, 1995; Jahoda, 1958; Maslow, 1954). It would be difficult to argue about the desirability of such qualities or their appropriateness as indicators of mental health. However, these qualities should not be regarded as some how resulting solely from the efforts, motivations and circumstances at the individuals in whose personalities they reside. The attributes that serve as marker of mental health do not develop within a social vacuum.

It is not easier to define and measure mental illness than to define mental health. To being with, illness is not the opposite to health, nor can one be assumed to exist in the absence of the other. Although one who is mentally ill can hardly be judged as simultaneously healthy, one who is not ill is not healthy is not necessarily ill. Partly because of the multiple perspective of the various discipline that are concerned with mental illness, it has been difficult

to resolve the ambiguities surrounding the meaning and nature of mental illness. Three such perspectives are distinguished here those brought to bear by clinicians, including but not limited to psychiatrists: those employed by researchers into social stress: and those found among those whose work is oriented toward symbolic interaction and social construction.

Social constructionist perspectives.

Stress researchers are likely to accept the reality of mental illness, questioning only how it is best defined and measured, another perspective questions the very reality of mental illness. Other social constructionists. primarily symbolic interactionists, argue that mental illness is a construct invented not to control unacceptable behavior but to explain its incomprehensibility (Horwitz, 1982a; Rosenberg, 1992).

The central point is that conceptions and measures of mental health can not easily be Judged as right or wrong. Rather, they are evaluated in terms of how appropriate they are to the purposes of the social scientists or practitioners using them. There is nothing intrinsic to mental health or illness that dictates the definition and meaning of these constructs. The way they are conceived depends on such consideration as (a) whether those who have a stake in mental health are involved in therapeutic interventions or research and (b) the clinical, behavioral or social theories that guide their work.

1.7:Research on Mental Health.

Mental health researchers are interested in the factors that influence cognitive and affective mental health from the respondent's perspective. Both demographic and psychological factors should be considered and all consistent relations must be understood in the context of theories that explain the processes underlying mental health judgments. Mental health is not a single construct . Instead, it comprises multiple separable components. People

are said to have high mental health if they feel satisfied with the conditions of their lives. A person with high self- esteem can cope with their stress, they see themselves as more intelligent and better able to get along with others that the average person. Their mental health is also better. Low self- esteem person can't face all the stressful situation in their life. They feel mentally unhealthy because of the disability to cope with their life stress. Some of the example are given below.

Stress and mental health :

Chronic and prolonged stressful experiences generate many types of psychological problems and mental disorder. Studies indicated that, stress may contribute to poor academic performance (Lloyd et.al., 1980), insomnia (Hartmann, 1985), nightmares (Cernovsky, 1989), sexual difficulties (Malatesta and Adams, 1984), drug abuse (Lester et. al., 1994), and unhappiness (Heady and Wearing, 1989). Stress has been found to trigger the onset of psychological disorders, including depression (Gruen, 1993), eating disorder (Strober, 1989), schizophrenia (Spring, 1989). Most theories of schizophrenia assume that stress is instrumental in triggering schizophrenia. High stress precipitates the onset of anxiety disorder (Lester et. al., 1994;Blazer et. al.,1987), men who experienced high stress were 8.5 times more likely to develop this disorder then men under low stress. Johnson and Roberts, 1995; Kendler et. al., 1995 found strong link between stress and mood disorder. Stress have detrimental consequences on people's mental health and physical health.

Sex differences and mental health:

A frequently cited study of Broverman et. al.,(1970) indicates that clinicians tend to see the average man as more emotionally healthy than the average women.

The data reported by Broverman et.al., (1970), Abramowitz (1976), Gomes and Abramowitz(1976), McKee and Sherriffs (1957, 1959) suggest that expectations regarding appropriate behavior are probably more stringent for males than for females.

In a recent overview of the literature on depression, Weissman and Klerman (1977) concluded that women had higher rates of depression than men and that there difference were not artifactual. They reviewed evidence bearing on the possibility that the higher rates of depression among women could be due to genetic factors. Women's social status, the experience of more severe life events or various endocrinological factors including premenstrual depression. They concluded that higher rate of depression among women was primarily due to their disadvantaged social status and emphasized the link between marriage and depression. Ruback et. al., (1996) found that females perceived crowding to be more irritating than males.

Socio-cultural differences in Mental Health:

Ample evidence indicated that cultural and some personal factors may be associated with mental health. In a study on rural males and females of low socio- economic status (Begum and Hossain, 1992) women were found to have significantly lower need achievement than men.

Easterlin (1974) in his review of thirty cross sectional studies conducted within countries found wealthier person to be happier than poor persons. Institutionally raised children were also found to score lower on intelligence and self concept than those raised in home environment (Haque and Islam, 1995). Low self concept has been found to be associated with low socio-economic status for both boys and girls (Haque and Begum,1984).

Studies on female industrial worker belonging to low SES (Khaleque and Sorker 1992; Sorcar and Rahman , 1993) reveal that they experience poorer

quality of life, more stress, and poorer mental health. Longer working hours and more frequent shift rotation are found to be associated with their poorer subjective health and family problems causing stress.

Women in general and poor women in particular also differ from others in their perceptions, attitudes and values. In a study on self perception (Ahmed and Begum, 1988) women of low SES were found to perceive their status lower than those of other socio-economics groups. In another study women of low income group(monthly income <$70) were found to label themselves as moderately poor (Khanam,1995). This indicates their realistic perception of own status in society. Campbell et.al.,(1976)in his study found that unemployed people were the unhappiest group.

1.8: Rationale of the study:

Bangladesh is known all over the world as one of the worst stricken countries with a vast population of 133.4 million inhabitants (World Bank data, 9th April,2003). The country is also one of the most densely populated countries with our 800 persons per square kilometer and an adverse population-resource ratio. Majority of the people in Bangladesh depend mainly on agriculture, small, and cottage industries and manual labor for their livelihood. Poverty again is not equally experienced across gender. The rate of illiteracy for women is 75.8 percent as against 54.5 percent for men (UNDP 1994).

A particular section of the people of Bangladesh who are worst affected by socio- cultural attitudes and values and have been pushed to an extreme end of poverty are women often designated by the social scientists as the poorest of the poor. The traditions of the countries have denied them of equal status with men in society. These tradition nourish some built in beliefs, prejudices, discrimination, stereotyped gender roles and above all acceptance of patriarchy in social and cultural spheres.

In Bangladesh discrimination against women starts at birth. When a boy is born, the parents give azan, a public call for prayers, but when a girl is born it is simply whispered into her ear. From then on boys receive preferential treatment and girls are taught to be self-sacrificing. Girls usually eat last and least ; they do not get priority in going to school and getting health care as their brothers do. When they grow up they are married off as early as 15 or 16 years of age(although the official age at married in 18 years) and from then on they become subject to their husband-looking after home and bearing and rearing children. When they become old they usually live the rest of their life with their son. In general women have little control over the decisions which affects their lives. At home most decision are taken by men.

Women have different responsibility, perform different activities, hold different jobs and often have different pay. In the working world of women, family and work are strictly interrelated. Women in industrial societies generally hold a paid occupation outside the house, but still have most of the responsibility for the care of the family and the house. Although women work longer hours then men per day(Farouk and Ali,1977),they are paid less than men for the same work in many cases of employment.

In agricultural societies, women work in the field to grow food and manage all the other activities directly related to the well being and survival of the family. Evidences show that women experience stress and strain which result from the role conflict in balancing dual responsibilities (Nelson et. al.,1990).Research in Bangladesh also indicate that working women perceive higher role conflict as compared to nonworking women(Begum and Tasneen,1984).As opposed to majority of the study some studies also indicate that mental health of dual career women is better than house wives(Shams,1985).Sorcar and Rahman (1993) concluded a study in Bangladesh on occupational stress and mental health of women engaged in different occupation. The perceived occupational stress was found

significantly higher for Bank and Garments employee as compared to school teachers and more of unmarried women than the married reported higher stress.

A legal factor contributing to the lower status of women is inheritance law. Where a daughter is only entitled to half a son's share of her father's property. All of these socio-cultural variables make women powerless and because of their powerlessness they are not only deprived of education, health care etc, which are among their fundamental rights but also of access to production resources, namely, land, credit, technology information and the like.

Women experience stress and strain which affect both physical and mental health. In Bangladesh the aspect of health of women has remain almost ignored. No national survey to assess the quality of life or mental health of both urban and rural women known to data has been undertaken. Only few studies have been conducted on these constructs. Hence an extensive survey to assess mental health of women of urban and rural areas was urgently needed.

Therefore, the study strives to investigate life stress, coping strategies and mental health of women in urban and rural areas. Findings of the study will provide a clear picture of the conditions of women, especially in rural areas where women are deprived of all basic needs of life. The courses offered in this field could be enriched by introducing the issue from the context of Bangladesh.

It is hoped that this study will help us to improve mental health of women by teaching them effective or adaptive ways of coping with stress. The finding of the study are also expected to contribute to the knowledge of planners, policy makers and practioners to chalk out a meaningful action scheme for the psychological intervention of the women in Bangladesh.

1.9: Purpose and objectives of the study:

The main purpose of the present study was to investigate life stress and coping response in relation to mental health of women in urban and rural setting.

Objective of the study:

The objectives of the present study were:

1. To examine whether life stress, coping strategies and mental health of women varies with residential status.

2. To investigate whether life stress and mental health varies with occupational, marital status and family type of the respondents.

3. To examine whether there was any significant age difference in life stress and coping strategies of the respondents.

4. To see whether there was any relationship between mental health of the respondents with adaptive coping strategies, nonadaptive coping strategies, income, education, age and life stress.

METHOD

CHAPTER II
METHOD

This chapter describes the sample, study design questionnaires used and field work procedures of the present study.

2.1: Sample .

Urban sample (100 women) of the present study was randomly selected from six Thanas of Dhaka city and the rural sample (100 women) were selected from three villages of Noakhali district. The total number of women and the name of the Thanas and villages from where they were selected are given in table 1.

Table 1: Number and percentage of study sample according to residential status.

Type of residence	**Thana/ Village**						**Number of respondents**
Urban	Dhanmondi Thana	Uttara Thana	Motijheel Thana	Ramna Thana	Tejgoan Thana	Mirpur Thana	
	18(9)	15(7.5)	12(6)	20(10)	22(11)	13(6.5)	100
Rural	Kalikapur Village		Rosulpur Village		Boshenter bag Village		
	32(16)		30(15)		38(19)		100

2.2: Study design.

Selection of Urban Sample:

To have a representative sample of the population of Dhaka city, care was taken to cover respondents from all socio-economic status. Out of 22 thanas of the Metropolitan Dhaka city, 6 thanas were selected randomly following the sample random sampling procedure. Then from each thana one sample area was purposely selected. 25 households from these areas were initially selected to cover 100 respondents from all the 6 thanas.

Selection of Rural sample:

Similar procedure were followed in selecting the sample from rural areas. 3 villages of Noakhali district were selected taking into consideration distance, time and convenience of the research workers. A total of 40 households from each villages were initially selected. Then 100 respondents from the 3 villages were drawn for the present study.

Selection of the Respondents:

The criteria used for the selection of the respondents were:

i) Respondents willing to participate.
ii) Only one respondent from each house was selected.
iii) Permanent resident of the house to ensure the return of the questionnaire, if left with the respondent to be collected later.
iv) 18 years of age and above.
v) Sick or person with physical or mental handicap like bedridden, short of hearing poor eye sight, mentally retarded etc. were excluded.

Number and percentages of certain demographic factors of urban and rural sample are presented in table 2 through table 8.

Table 2: Number and percentage of urban and rural sample according to family type.

Family type	Urban	Rural	Total
Single	67(33.5)	53(26.5)	120 (60)
Joint	33(16.5)	47(23.5)	80(40)
Total	100	100	200

Table 3: Number and percentage of urban and rural sample according to religion.

Religion	Urban	Rural	Total
Muslim	91(45.5)	85(42.5)	176(88)
Non Muslim	9(4.5)	15(7.5)	24(12)
Total	100	100	200

Table 4: Number and percentage of urban and rural sample according to marital status.

Marital status	Urban	Rural	Total
Unmarried	25(12.5)	24(12)	49(24.5)
Married	72(36)	67(33.5)	139(69.5)
Separated	0(0)	1 (.5)	1 (.5)
Widow	3(1.5)	8(4)	11(5.5)
Total	100	100	200

Table 5: Number and percentage of urban and rural sample according to occupation.

Occupation	Urban	Rural	Total
Student	44(22)	24(12)	68(34)
House wife	29(14.5)	65(32.5)	94(47)
Service	27(13.5)	11(5.5)	38(19)
Total	100	100	200

Table 6: Number and percentage of urban and rural sample according to Monthly income.

Income (monthly in Taka)	Urban	Rural	Total
Up to 1,000	2(1)	5(2.5)	7(3.5)
1,001-2,000	1(.5)	8(4)	9(4.5)
2,001-5,000	25(12.5)	36(18)	61(30.5)
5001-10,000	24(12)	29(14.5)	53(26.5)
10,001-20,000	29(14.5)	19(9.5)	48(24)
20,001-above	19(9.5)	3(1.5)	22(11)
Total	100	100	200

Table 7: Number and percentage of urban and rural sample according to education.

Education	Urban	Rural	Total
No education	0(0)	4(2)	4(2)
Class 1 to V	7(3.5)	34(17)	41(20.5)
Class VI to X	9(4.5)	32(16)	41(20.5)
S.S.C	7(3.5)	10(5)	17(8.5)
H.S.C	22(11)	5(2.5)	27(13.5)
Graduate	13(6.5)	9(4.5)	22(11)
Master & above	42(21)	6(3)	48(24)
Total	100	100	200

Table 8: Number and percentage of urban and rural sample according to age.

Age in years	Urban	Rural	Total
18-24	39(19.5)	45(22.5)	84(42)
25-39	43(21.5)	34(17)	77(38.5)
40-60	18(9)	21(10.5)	39(19.5)
Total	100	100	200

Age of the respondents ranged from 18 to 60 years, income ranged between taka 1000 to 44,000 and the range of education was from no education to Masters. Majority of the respondents were Muslim (176) and 24 respondents were Hindu. Respondents were engaged in different professions such as student, service, business, doctors, house wife, engineer.

2.3: Instrument used:

The instrument used for the present study were the following:

i) Life Stress Questionnaire.
ii) Coping Scale.
iii) Mental Health Questionnaire.
iv) Bio-data Form.

2.4: Life Stress Questionnaire:

The original version of the " How stressful is your life scale?"(Cohen, 1999) was translated into Bangla (Fahim,2001) was used to measure life stress of women in the present study in urban and rural areas. The correlation coefficient of the Bangla version of the life stress questionnaire with the English version was found to be .90 which was significant at .01 level. Test -Retest reliabilities over a period of 2 weeks was .94 which was significant at .01 level. This means that the reliability of the scale was satisfactory.

Scoring:

The scoring was easy and simply. For item number 1,2,3,7,9 and 10 respondents got 'O' for Never; '1' for 'Almost Never'; '2' for 'Sometimes'; '3' for 'Fairly Often'; '4' for 'Very Often'. And for item number 4,5,6 and 8 respondents got '4' for 'Never'; '3' for 'Almost Never'; '2' for 'Sometimes'; '1' for ' Fairly Often'; '0' for 'Very Often' responses. The sum was the total score was the life stress score of the respondents

2.5 Coping Scale:

The translated and adapted version of the Coping Scale (Huque,2004) originally developed by Folkman and Lazarus (1980) was used to measure coping behavior of the respondents.

The translation reliability of the coping scale was reported to be highly significant ($r=.86$; $p<.01$), and the test –retest reliability of the Bangla version of each of the subscales were also reported to be significant.

Scoring:

The coping scale is a 22 item self report measure of coping strategies . The measure is a 4-point likert type scale ranging from 1(I usually don't do this at all), 2 (I usually do this sometimes), 3 (I usually do this most of the time), and 4 (I usually do this always). The items in the scale contribute to one of the following 11 sub-scales. Problems solving (Items, 1, 12,16), Cognitive restructuring (2,4), Confrontive coping (3,13,17), Express Emotion (5), Social support (6,18,21,22), Problem avoidance (7), Wishful thinking (8), Social withdrawal (9,10,19), self criticism (11), Religion (14,20) and Acceptance (15).

Although coping scale is designed to be self- administered, it can also be administered orally by an interviewer who writes down the respondents answers. It requires about 10 to 15 minutes to complete.

2.6:Mental Health Questionnaire:

The Bangla version of General Health Questionnaire (GHQ –12), adapted by Sorcar and Rahman (1989), was used to measure mental health of the respondents. GHQ—12 originally developed by Goldberg (1972), was designed to detect minor psychiatric disorders in community and primary health care settings (Piccinelli et.al., 1993). The GHQ items was derived from 60 items in the original version. Reliability measured showed that the GHQ -

12 had a high degree of internal consistency with alpha values ranging from 0.82 to 0.90 (Gurije, 1991). Banks et.al., (1980) used it to measure mental health in occupational studies and found it to be a useful measure of mental health in employment and occupational problems. The development studies (Goldberg, 1972) showed high internal consistency (0.65), test-retest reliability (0.73) over a period of a 6 months and validity in terms of a good linear relationship with clinical check- up records as the criteria (r=0.70)

Validity Coefficient of the GHQ-12 had been found to be comparable to those of GHQ-20, GHQ-30 and GHQ-60 items version (sensitivity :M=74%; specificity M=82%; misclassification rate – 18%) (Chan and Chan, 1983; Piccnelli, et. al.,1993).

2.7: Bio-data Sheet.

A bio-data sheet containing some personal information was attached with the questionnaire and is given in (Appendix-1). It included information regarding age, religion, education, marital status, place of residence (urban or rural) monthly income, occupation, family type (Single or Joint), number of siblings , number of children if married, with whom living and member of family or others living with her.

2.8: Procedure.

The data for the present study was collected through questionnaires from the respondents of urban and rural areas. All the questionnaires are designed to be self administered. At the beginning each respondent was briefly explained about the purpose of the present study and was requested to co-operate with the research work. The respondents were first asked to fill-up the bio-data form which contained some personal information regarding age, marital status, monthly income, education etc. Before completing the questionnaires respondents were asked to read the instructions carefully printed on the top of the questionnaires. The life stress questionnaire was completed followed by the ways of coping scale and mental health questionnaire (GHQ) respectively. Thus it took some time to complete all the questionnaires.

However urban participants took relatively less time to complete than the rural participants. It should be mentioned that few respondents did not complete the questionnaires in front of the researcher. So the researcher had to leave the questionnaires for a day or two and then collected them later at their convenience. For respondents with low educational back ground, the items were presented verbally in simple language and their responses were noted down. Before collecting the questionnaire the researcher ensured that the respondents answered all the questions in the questionnaire. Participants were also assured that all information given by them would be kept confidential and would be used only for research purpose. After that the respondents were thanked by the researcher.

2.9:Scoring and Coding of Responses.

Upon completion of the data collection from selected areas, the researcher scored all the responses and made the necessary coding for data analysis.

Data Analysis:

Data analysis were done using SPSS for windows 10.0. The following statistical analysis were performed.

i) Descriptive statistics: Descriptive statistics for each variable was calculated (Mean and Standard Deviation).

ii) One Way ANOVA: a) One Way ANOVA was computed to see if life stress, coping strategies and mental health varied as a function of residential status.

b) If life stress, and coping strategies varied as a function of different age levels.

c) If life stress and mental health varied as a function of occupation, marital status and family type.

iii) Coefficient of correlation: Correlation of coefficient was computed to see the relationship between mental health and some selected variables namely,

adaptive coping strategies, non adaptive coping strategies, income, education, age and life stress.

RESULT

Chapter-III

Result

The main purpose of the present study was to investigate life stress and coping response in relation to mental health of women in urban and rural setting. The objectives of the present study were:

1. To examine whether life stress, coping strategies and mental health of women varies with residential status.

2. To investigate whether life stress and mental health varies with occupational, marital status and family type of the respondents.

3. To examine whether there was any significant age difference in life stress, coping strategies of the respondents.

4. To see whether there was any relationship between mental health of the respondents with adaptive coping strategies, nonadaptive coping strategies, income, education, age and life stress.

Life stress, coping strategies adopted and mental health assessed in the study where analyzed using appropriate statistical techniques.
Results of these analysis are presented in three sections.

Section I describes life Stress and effects of residential status, occupation, age, marital status and family type on life stress.

Section II describes coping strategies and coping strategies as a function of residential status and different age levels.

Section III describes mental health and effects of residential status, marital status, family type and occupation.

Section IV describes mental health and the effects of some socio demographic variables as correlates of mental health.

3.1:Stress: Residential Status, Occupation, Age, Marital Status and Family Type.

The Bangla version of "How stressful is your life?" scale(Fahim,2001) developed by Cohen (1999) was used in the present study. After collecting the data, mean and SD was calculated. One Way ANOVA was performed to see if there was any significant difference in life stress between urban and rural respondents. One way ANOVA was also performed to see whether life stress of the respondents varied with residential status, occupation, different age level, marital status and family type of the respondents . The results of these analysis are presented in table 9 through table 18.

Table 9: Mean and SD of life stress scores according to residential status of the respondents .

Type of Residence	N	Mean	SD
Urban	100	18.30	5.95
Rural	100	20.32	5.68
Total	200	19.31	5.89

Highest life stress mean score was obtained by rural respondents ($\bar{X}$=20.32) and lowest life stress mean score was obtained by urban respondents ($\bar{X}$=18.30).

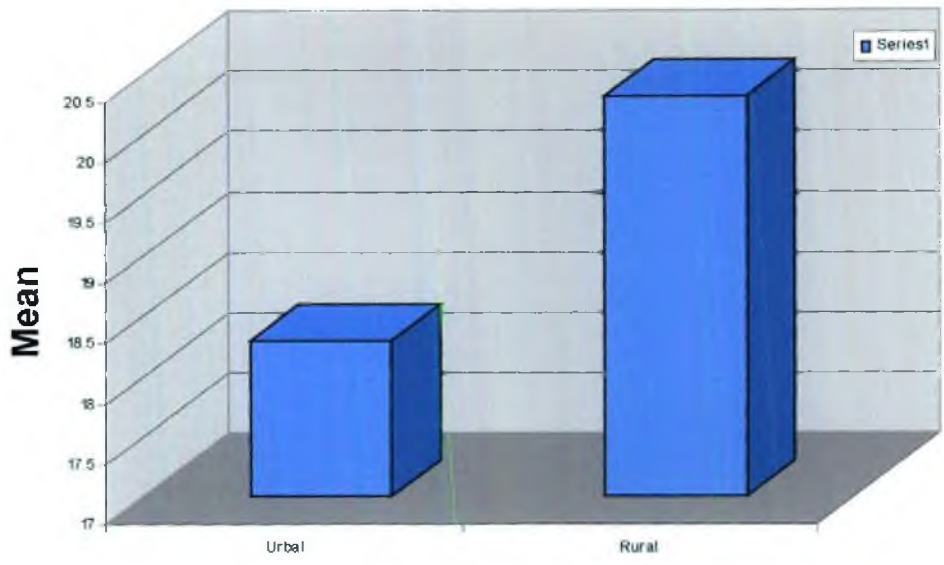

FIGURE 1: Mean of Life stress by Residential Status.

Table 10: Life stress scores by residential status of the respondents with F-value.

Source of variance	Sum of square	df	mean Square	F
Between groups	204.020	1	204.020	6.030
Within groups	6698.760	198	33.832	
Total	6902.780	199		

$P < .05$

Obtained result indicate that residential status had significant effect on respondents life stress ($F=6.030$; $df=1,198$; $P<.05$).

Table 11: Mean and SD of life stress scores according to occupation of the respondents.

Type of occupation	N	Mean	SD
Student	68	20.09	4.32
House wife	94	19.96	6.35
Service	38	16.32	6.31
Total	200	19.31	5.89

Highest life stress mean score was obtained by students ($\bar{X}$ = 20.09) and lowest life stress mean score was obtained by service holders ($\bar{X}$ = 16.32).

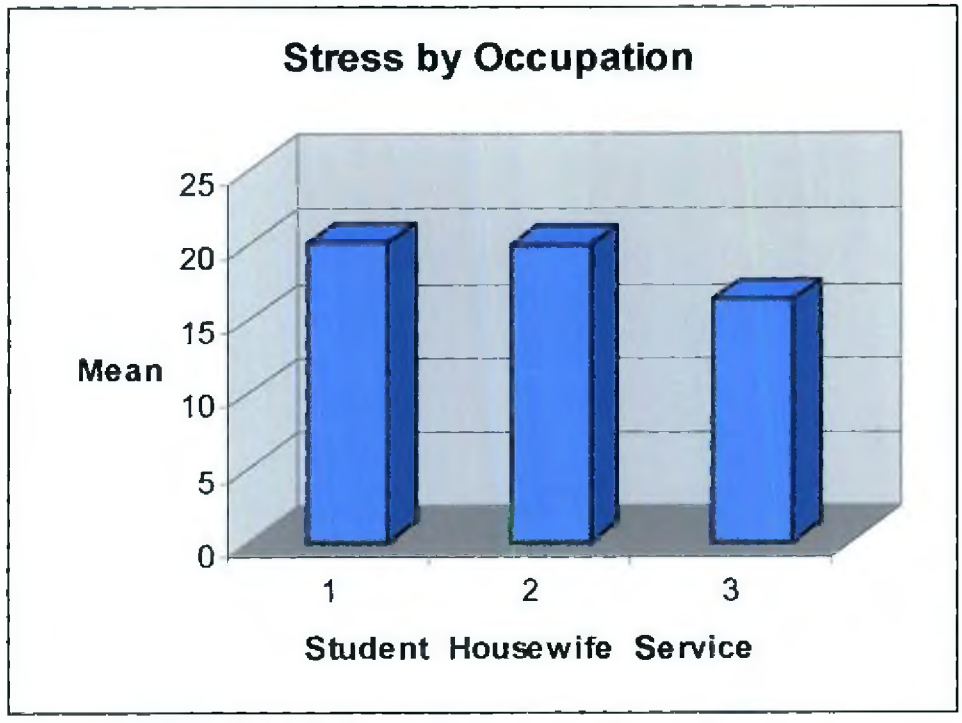

FIGURE 2: Mean of Life stress by Occupation

Table 12: Life stress scores by occupation of the respondents with F-value.

Source of variance	Sum of square	df	mean Square	F
Between groups	421.269	2	210.635	6.402
Within groups	6481.511	197	32.901	
Total	6902.780	199		

$P < .01$

Table 12 shows that life stress varied according to occupation of the respondents ($F = 6.402$, $df = 2, 197$; $P < .01$).

Table 13: Mean and SD of life stress scores according to different age level of the respondents.

Age group of respondents	N	Mean	SD
18 to 24	84	19.77	4.98
25 to 39	77	18.60	6.65
40 and above	39	19.72	6.11

Highest life stress mean score was obtained by 18 to 24 ($\bar{X} = 19.77$) age group and lowest life stress mean score was obtained by 25 to 39 ($\bar{X} = 18.60$) age group.

Table 14: Life stress scores by different age groups of the respondents with F-value.

Source of variance	Sum of square	df	Mean Square	F
Between groups	63.661	2	31.830	.917
within groups	6839.119	197	34.716	
Total	6902.780	199		

Table 14 shows life stress did not vary with different age levels of the respondents.

Table 15: Mean and SD of life stress scores by marital status of the respondents.

Type of Marital status	N	Mean	SD
Unmarried	64	20.25	4.40
Married	124	18.97	6.48
Widow	11	17.45	6.31
Separated	1	22.00	.
Total	200	19.31	5.89

Highest life stress mean score obtained by separated respondents($\bar{X}$=22.00) and lowest stress mean score was obtained by widow respondents($\bar{X}$=17.45).

Table 16: Life stress scores by marital status of the respondents with F-value.

Source of variance	Sum of square	df	mean Square	F
Between groups	116.182	3	38.727	1.118
Within groups	6786.598	196	34.626	
Total	6902.780	199		

Obtained result indicate that marital status of the respondents had no significant effect on their life stress.

Table 17: Mean and SD of life stress scores by family type of the respondents .

Type of Residence	N	Mean	SD
Single	100	19.20	5.57
Joint	100	19.48	6.37
Total	200	19.31	5.89

Highest life stress mean scores was obtained by joint family respondents ($\bar{X}$=19.48) and lowest life stress mean scores was obtained by single family respondents($\bar{X}$=19.20).

Table 18: Life stress scores by family type of the respondents with F-value.

Source of variance	Sum of square	df	mean Square	F
Between groups	3.630	1	3.630	.104
Within groups	6899.150	198	34.844	
Total	6902.780	199		

Table 18 shows that type of family had no significant effect on respondent's life stress.

3.2: Coping strategies: Residential Status and Age.

Table 19 shows the Mean and SD of each coping strategies for both urban and rural respondents and table 20 shows the Mean and SD for each coping strategies by residential status of respondents with F-value. One way ANOVA was performed to see if there was any significant difference between urban and rural respondents in adopting each coping strategy. Further to see whether each coping strategy varied with age, One Way ANOVA was also performed.

Table 19: Mean and SD of each coping strategy of the respondents.

Type	N	Mean	SD
Problem Solving	200	8.06	1.69
Cognitive Restructuring	200	5.83	1.46
Confrontive Coping	200	3.84	.99
Express Emotion	200	2.57	1.07
Social Support	200	10.58	3.06
Problem Avoidance	200	1.98	1.02
Wishful Thinking	200	1.51	.92
Social withdrawal	200	5.58	1.92
Self Criticism	200	2.05	.91
Religion	200	7.65	.84
Acceptance	200	2.50	1.07

Highest mean Score was obtained for social support ($\bar{X}$ = 10.58) followed by problem solving ($\bar{X}$ = 8.06) and Religion ($\bar{X}$ = 7.85). The lowest mean score was obtained for wishful Thinking ($\bar{X}$ = 1.51)

Table 20: Mean and SD each coping strategy according to residential status of the respondents with F –value.

Coping strategy	Type of Residence	N	Mean	SD	F
Problem Solving	Urban	100	8.13	1.76	.294
	Rural	100	8.00	1.63	
Cognitive Restructuring	Urban	100	5.82	1.44	.009
	Rural	100	5.84	1.48	
Confrontive Coping	Urban	100	3.91	1.09	1.146
	Rural	100	3.76	.88	
Express Emotion	Urban	100	2.55	1.15	.070
	Rural	100	2.59	.99	
Social Support	Urban	100	10.35	3.17	1.131
	Rural	100	10.81	2.95	
Problem Avoidance	Urban	100	1.98	1.01	.005
	Rural	100	1.99	1.04	
Wishful Thinking	Urban	100	1.79	1.11	20.920**
	Rural	100	1.22	.56	
Social Withdrawal	Urban	100	5.89	2.16	5.319*
	Rural	100	5.27	1.61	
Self Control	Urban	100	2.06	1.01	.006
	Rural	100	2.05	.80	
Religion	Urban	100	7.56	.94	2.326
	Rural	100	7.74	.72	
Acceptance	Urban	100	2.67	1.14	5.150*
	Rural	100	2.33	.95	

**P < .01;* P < .05

The above table (20) shows that there was a significant urban rural difference in wishful thinking coping strategy (F=20.920;df=1,198;P<.01); social withdrawal (F=5.319;df=1,198;P<.05); and acceptance (F=5.150;df=1,198; P < .05). No significant urban rural difference was found for the other coping strategies.

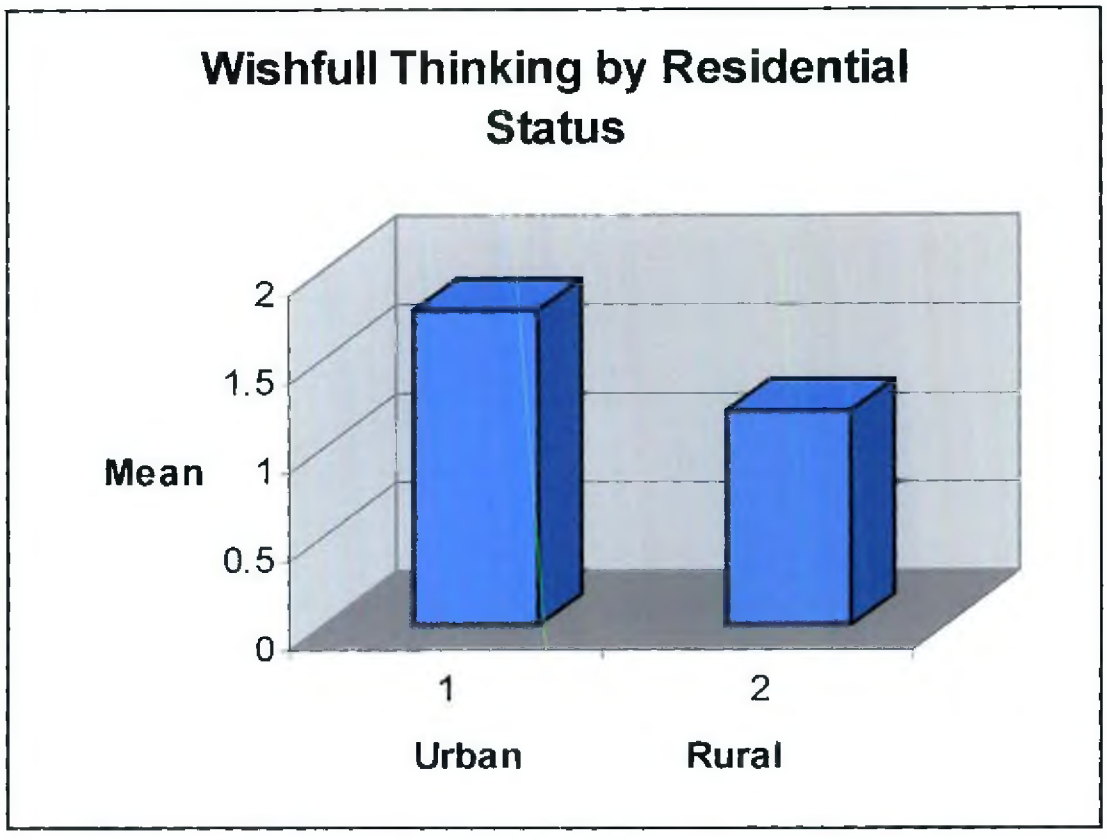

FIGURE 3: Mean of Wishful Thinking by Residential Status.

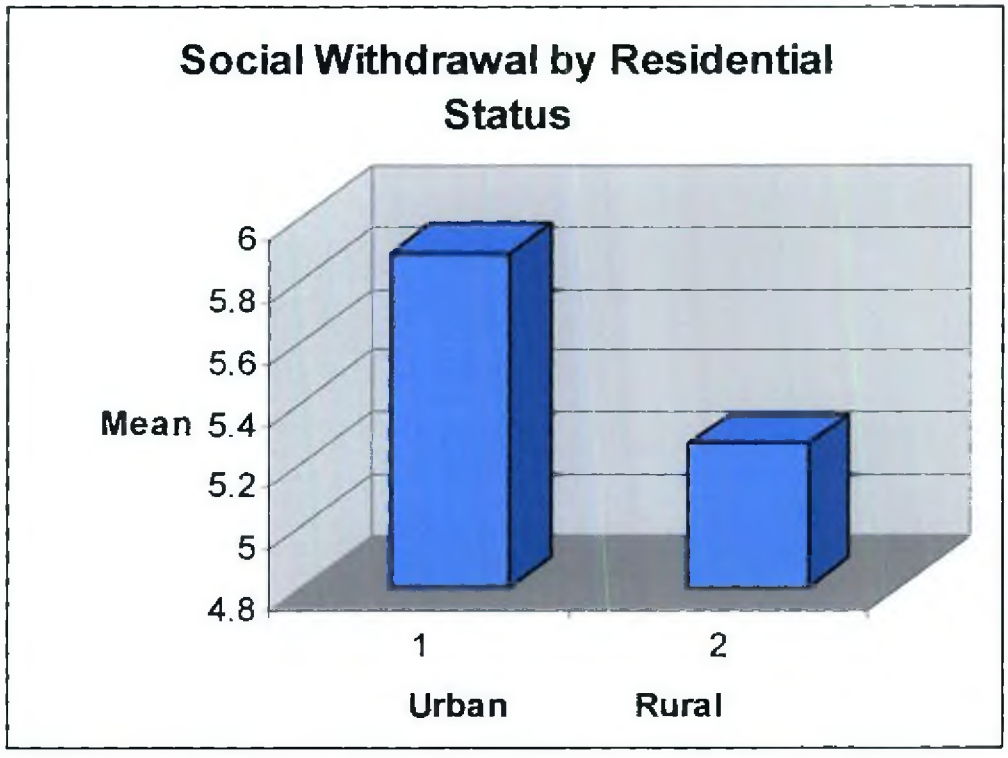

FIGURE 4: Mean of Social withdrawal by Residential Status.

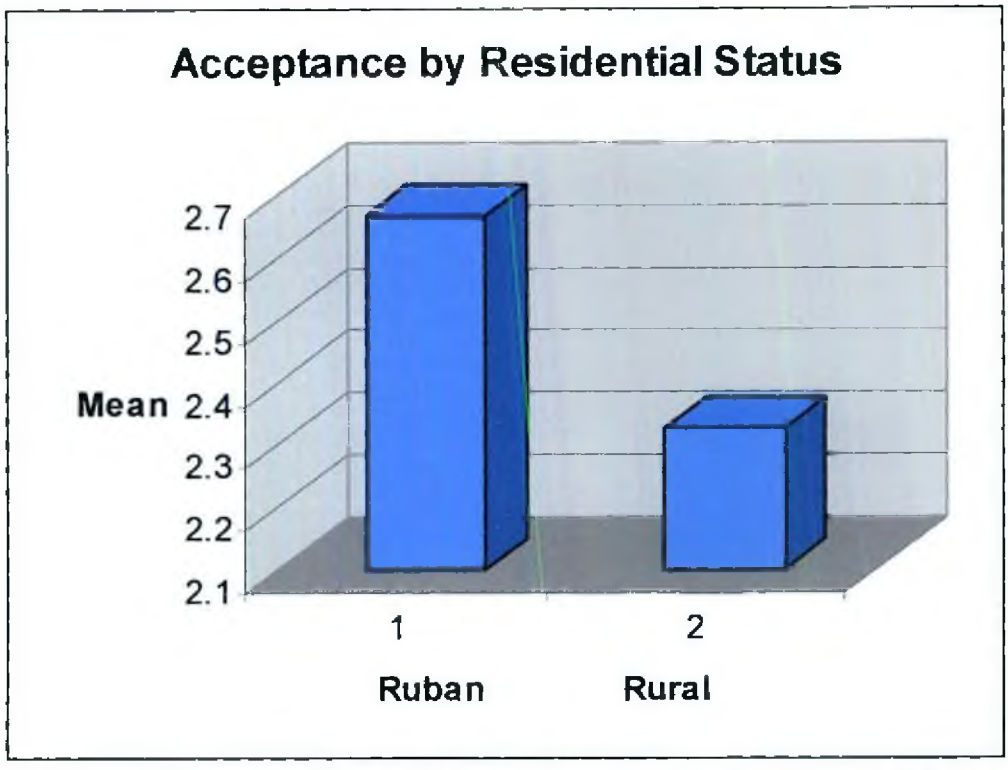

FIGURE 5: Mean of Acceptance by Residential Status.

Data were further analyzed to see if different coping strategies varied as a function of different age levels. For the purpose of analysis age of the respondents were divided into 3 categories: 18 to 24; 25 to 39; 40 and above. Table 21 shows the mean and SD of each coping strategy according to different age level of the respondents with F-value.

Table21: Mean and SD of each coping strategy according to different age levels of the respondents with F-value.

Coping strategy	Age Level	N	Mean	SD	F
Problem Solving	18-24	84	8.27	1.62	1.151
	25-39	77	7.95	1.74	
	40-above	39	7.85	1.74	
Cognitive Restructuring	18-24	84	5.88	1.52	.813
	25-39	77	5.91	1.47	
	40-above	39	5.83	1.27	

Coping strategy	Age Level	N	Mean	SD	F
Confrontive Coping	18-24	84	3.80	.99	.236
	25-39	77	3.90	1.03	
	40-above	39	3.79	.92	
Express Emotion	18-24	84	2.49	1.11	1.395
	25-39	77	2.73	1.03	
	40-above	39	2.44	1.02	
Social Support	18-24	84	10.56	3.20	.542
	25-39	77	10.81	2.86	
	40-above	39	10.18	3.18	
Coping strategy	Age Level	N	Mean	SD	F
Problem Avoidance	18-24	84	1.93	.99	.290
	25-39	77	2.00	1.05	
	40-above	39	2.08	1.06	
Wishful Thinking	18-24	84	1.46	.80	1.202
	25-39	77	1.62	1.08	
	40-above	39	1.36	.84	
Social Withdrawal	18-24	84	6.01	1.86	4.629*
	25-39	77	5.43	1.90	
	40-above	39	4.95	1.92	
Self Control	18-24	84	1.94	.90	1.197
	25-39	77	2.16	.95	
	40-above	39	2.10	.85	
Religion	18-24	84	7.70	.65	1.323
	25-39	77	7.53	1.02	
	40-above	39	7.77	.78	
Acceptance	18-24	84	2.44	1.06	1.865
	25-39	77	2.42	1.06	
	40-above	39	2.79	1.10	

*P<.05

Obtained results indicate significant difference in only social withdrawal coping strategy between the respondents of different age levels (F = 4.629;

df = 2, 197; P ~ .05) Highest mean score for social withdrawal coping strategy was obtained by age group (18-24) whereas lowest score was obtained by the age group (40 and above).

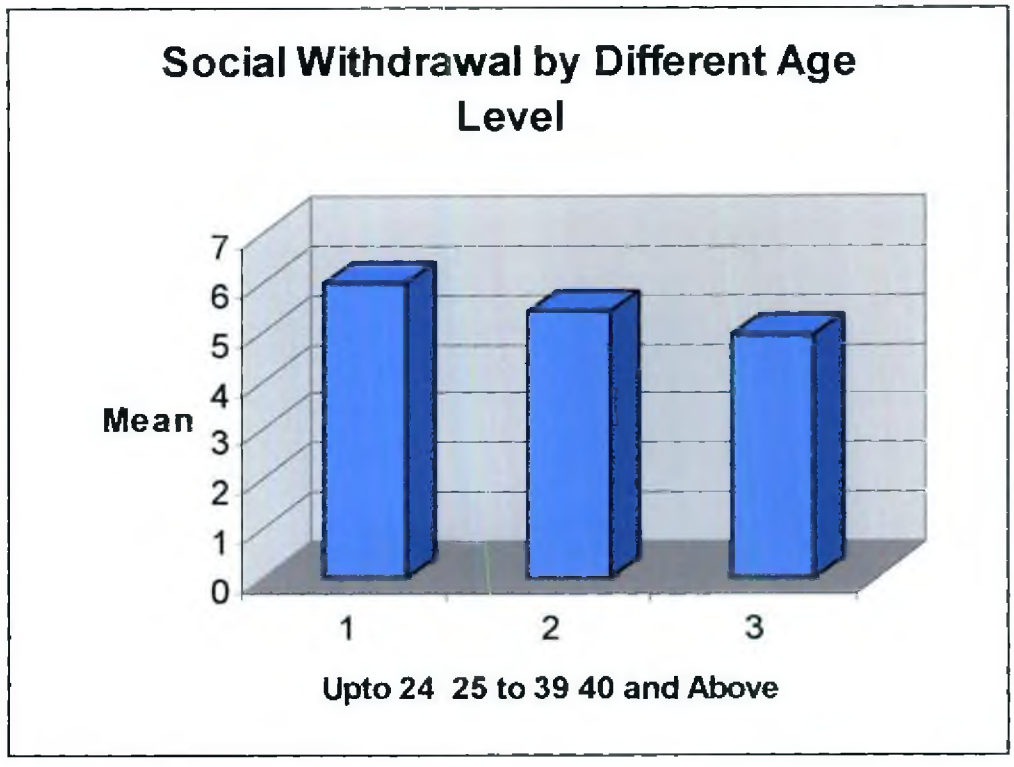

FIGURE 6: Mean of Social Withdrawal by Different Age Level.

3.3: Mental Health : Residential Status, Marital status, Family type and occupation.

To investigate the effect of residential status on mental health, the obtained data was analyzed by One Way ANOVA. Mean and SD of mental health scores with F-value are presented in table 22 and table 23.

Table22: Mean and SD of mental health scores according to residential status of the respondents.

Type of Residence	N	Mean	SD
Urban	100	36.49	5.55
Rural	100	34.95	7.10
Total	200	35.72	6.40

Highest mean score was obtained by urban respondents($\bar{X}$=36.49) and lowest mean score was obtained by rural respondents($\bar{X}$=34.95).Therefore, it can be said that urban respondents had poorer mental health than rural respondents.

Table23: Summary of Analysis of Variance of mental health score according to residential status of the respondents.

Source of variance	Sum of square	df	mean Square	F
Between groups	118.580	1	118.580	2.922
Within groups	8035.740	198	40.585	
Total	8154.320	199		

Obtained results indicates no significant difference in mental health between urban and rural respondents.

The study also attempted to see whether marital status, family type and occupation of the respondents had any effect on mental health of the respondents. One Way ANOVA was computed and the results are presented in table 24 to table 29.

Table24: Mean and SD of mental health scores according to marital status of the respondents.

Type of Marital status	N	Mean	SD
Unmarried	64	34.67	6.43
Married	124	36.06	6.55
Widow	11	38.00	3.58
Separated	1	36.00	.
Total	200	35.72	6.40

Highest mean score was obtained by widow ($\bar{X}$=38.00) and lowest mean score was obtained by unmarried ($\bar{X}$=34.67). Therefore, it can be said that widow respondents had poorer mental health than the other groups.

Table25: Summary of Analysis of Variance of mental health score according to marital status of the respondents.

Source of variance	Sum of square	df	mean Square	F
Between groups	141.606	3	47.202	1.155
Within groups	8012.714	196	40.881	
Total	8154.320	199		

Table 25 shows that marital status of the respondents had no significant effect on their mental health.

Table 26: Mean and SD of mental health scores according to family type of the respondents.

Type of Family	N	Mean	SD
Single	120	36.70	5.80
Joint	80	34.25	6.99
Total	200	35.72	6.40

Respondents who lives in joint family had better mental health ($\bar{X}$=34.25) than those living in single family ($\bar{X}$=36.70).

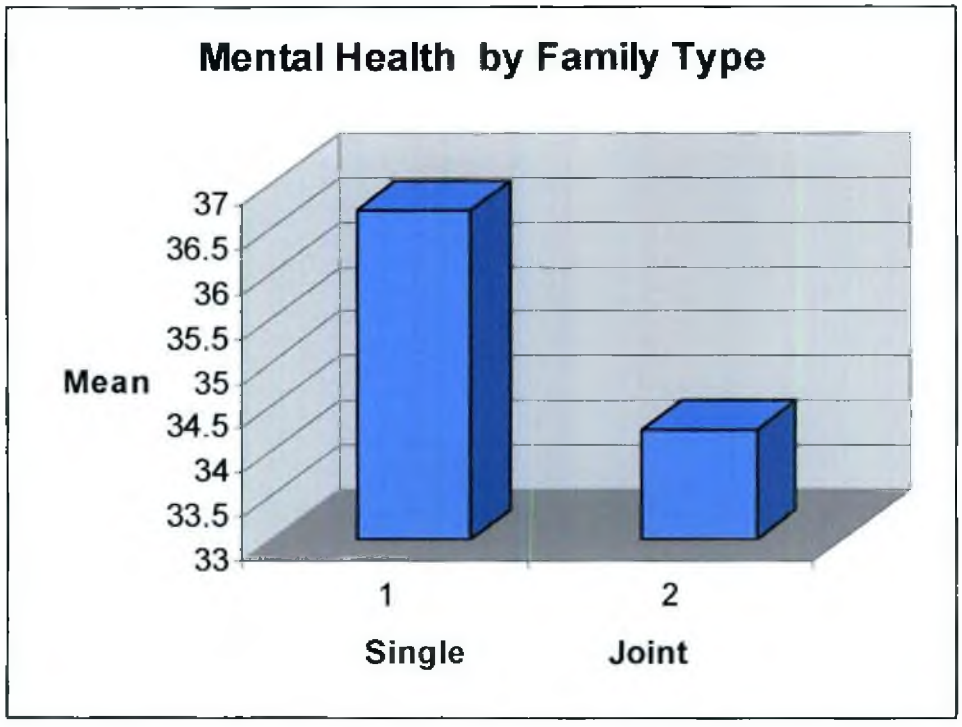

FIGURE 7: Mean of Mental Health by Family Type.

Table 27: Summary of Analysis of Variance of mental health score according to family type of the respondents.

Source of variance	Sum of square	df	mean Square	F
Between groups	288.120	1	288.120	7.252
Within groups	7866.200	198	39.728	
Total	8154.320	199		

P<.05

Obtained result indicate that family type had significant effect on respondents mental health. Respondents living in joint family had better mental health than those living in single family.

Table 28: Mean and SD of mental health scores according to occupation of the respondents.

Type of occupation	N	Mean	SD
Student	68	35.01	6.39
House wife	94	35.84	6.80
Service	38	36.68	5.31
Total	200	35.72	6.40

Highest mean score was obtained by service holders($\bar{X}$=36.68) and lowest mean score was obtained by students($\bar{X}$=35.01) which means students had better mental health than the other groups.

Table 29: Summary of Analysis of Variance of mental health score according to occupation of the respondents.

Source of variance	Sum of square	df	mean Square	F
Between groups	70.518	2	35.259	.859
Within groups	8083.802	197	41.035	
Total	8154.320	199		

The above table shows that mental health of the respondents did not vary as a function of occupation.

3.4: Correlates of Mental Health.

To investigate the relationship between several variables in the study correlation of coefficient was computed for some selected variables, namely mental health, adaptive coping strategies, nonadaptive coping strategies, income, education, age and stress. Table 30 report correlation matrix between the dependent and each independent variables as well as inter-correlation among independents variables.

Table 30: Correlation matrix among mental health and independent variables.

Variables	Mental health	Adaptive	Non adaptive	Income	Education	Age	Life stress
Mental Health		.148*	-.012	.120	-.028	.139*	-.526**
Adaptive			.279**	.194**	.073	-.058	-.062
Non adaptive				.080	.213**	-.104	-.092
Income					.403**	.057	-.149*
Education						-.367**	-.219**
Age							-.012
Life stress							

*Correlation is significant at the .05 level (2-tailed).

**Correlation is significant at the .01 level (2-tailed).

In the top row of the correlation matrix of table 30, simple correlation of each independent variables with dependent variable mental health is presented.

The results indicated significant positive correlation between mental health with adaptive coping strategies(r=.148,P<.05) and age(r=.139,P<.05) was found. Significant positive correlation (r=.194, P<.01) was obtained between the use of adaptive coping strategies with income of the respondents, between income and education of the respondents(r=.403, P<.01) High significant negative correlation between mental health and life stress was found (r=-.526,P<.01). Significant negative correlation was also found between income and life stress(r=.149, P<.05), education and life stress(r=.219, P<.01). No significant relationship was observed between mental health with nonadaptive coping strategies, income and education and also between other variables.

DISCUSSION

Chapter-IV

Discussion

The main purpose of the present study was to investigate life stress and coping response in relation to mental health of women in urban and rural setting. The objectives of the present study were:

1. To examine whether life stress, coping strategies and mental health of women varies with residential status.

2. To investigate whether life stress and mental health varies with occupational, marital status and family type of the respondents.

3. To examine whether there was any significant age difference in life stress, coping strategies of the respondents.

4. To see whether there was any relationship between mental health of the respondents with adaptive coping strategies, nonadaptive coping strategies, income, education, age and life stress.

The results of the study are presented in the previous chapter. This chapter discusses on the findings of the study. The discussion of the findings are categorized in the following sections.

4.1: Life Stress:

Life Stress: Residential status, occupation, age, marital status, and family type.

In this section, stress is treated as dependent variable. While residential status, occupation, age, marital status, and family type are treated as independent variables. All information regarding these variables were obtained from respondents during data collection phase.

a) Residential Status and Stress:

The result presented in table 10 showed that residential status had significant effect on respondents life stress. It was evident from the result of the study that the rural women's life stress was higher than urban women. Some possible explanation could be given for the higher score of stress among rural women.

As mentioned earlier rural living compared to urban is more stressful because of the floods, cyclones, social boundaries, traditional family life etc. A wide variety of other conditions produce stress among rural women. Some of these are limited resources, such as lack of adequate housing, health care children's schooling recreation and social activities.

More rural women were found to live in joint family. So it is quite possible for them to experience more family problems with more members living together. In our country, especially in rural areas they have to think about their family members first. Evidence also show women experience stress and strain from role conflict in balancing multiple responsibilities (Nelson et. al., 1990). The daily workload is particularly heavy for women in rural setting. Though more and more women are entering the work force and taking new roles, cooking, washing, cleaning, taking care of the family members are still their responsibilities. Rural women have less freedom than urban women.

Educated urban women with their experience can cope with their life stress better. Illiterate or less educated rural women experience a lot of problems to cope with stress. Some time family members do not allow the rural women to do job, so financially they have to depend on their husband. Rural women also suffer from many health problems. They are treated with less care, feed less nutrient food and rarely taken to the hospital when sick. These feelings create a constant stress on them. So they feel powerless and no control over their lives.

b) Occupation and Stress:

From table 11 it appears that life stress had significant effect on respondents of different occupations. The mean score for students on life stress was found to be higher than housewives and service holders.

A student life is very much important and crucial. This is the time to gather information, do hard work which is very much important for their life

success. Education can influence a person in different way. Education open the door for employment, earning, career and social advancement. Students must know the importance of education all the time. Students can make good results if they study at the right time. In this way students can built their future.

Our country is a developing country. In our country people do not give much importance on women's education. Sometime women work very hard to continue for their study. Though situations are changing day by day in our country but it is still grave in rural areas of Bangladesh. Sometimes family also put lots of pressure on them to do well in exam, to excel in all spheres of life, so it is quite obvious that to meet the challenges they feel stressed to cope with their problems.

In our country communication system is also not too good. Students especially girls have to face lot of troubles if their institute is far away from their house. Sometimes they might miss their classes. Environmental stress like traffic jam, noise, flood also create stress for the students. Students are too young to face all these problems. These might be some of the factors why a student's life is more stressful than the other groups.

C) Age and Stress:

The present findings failed to show any significant difference in life stress among the different age groups of the respondents.

People feel stressed at any age of their life. At any age each and every day especially women face new problems. Being students, they feel stress to do better results, when they grow up they get married. Making adjustments with the in-laws is quite difficult in our country, especially in the rural areas, Some traditional cultural expectations are still prevalent in the society. Some of them maintain both family and occupational life. Psychological and physiological problems are also common.

At old age women depend on their sons or other member in the family. Because of their dependency on others, they feel stressed most of the time. They have to take lots of responsibility in their whole life.

D) Marital Status and Stress:

The study results found no significant effect of marital status on life stress of the respondents .Women maintain different type of life style at different stage of their life. Before marriage parents always try to event control on their life. They also do their study and take some family responsibility. Parents put restrictions on their movement (Rozario,2002). After marriage women take more family responsibilities than other family members. Most of the time they stay at home and do most of the household work. Beside these family responsibilities they also take care their husbands, children, in laws. In our country widow and separated women have to struggle hard to maintain their life and also suffer a great deal of hardship (Amato, 1994).

Family Type and Stress:

Type of family had no significant effect on the respondent's life stress. Though no predictions were made in the present study it would have been, to see whether respondents living in joint family with their parents, aunts, uncles and grandparents would face more problems than those living in single family system. Science the results failed to show any significant difference, it is expected that the respondents whether living in joint or single family makes no difference. It might be possible that all members have shared their responsibilities and have cared for the well-being in one another.

4.2:COPING STRATEGIES:

Coping Strategies: Residential status and age :

One way ANOVA was used to see the effect of residential status and different age levels of respondents on coping strategies. The result of each of the coping strategy are discussed separately.

The study finding table 19 shows that in general social support coping strategy was adopted most by the respondents of the study. The next strategy used was religion and social withdrawal coping strategy. Wishful thinking coping strategy was adopted least by the respondents of the present study.

A) Wishful Thinking:

Significant residential status difference in the use of wishful thinking was found in the present study. Urban respondents used more wishful thinking

coping strategy than rural respondents. In one study Frydenbery and Lewis(1993) found women tend to use more wishful thinking than men.

It is interesting to find that urban women being more educated, more knowledgeable, have shown a stronger interest in thinking wishfully than rural women. It might be that since urban living is more stressful demands and requires continuous adjustments in different areas of life, sometimes they depend on wishful thinking coping strategy to get mental satisfaction and as a way of coping with these stresses.

No significant difference was found between respondents of different age groups in seeking wishful thinking coping strategy.

B) Social Withdrawal:

The present study result showed significant residential status difference in the use of social withdrawal coping strategy. Urban respondents adopted more than rural respondents. As mentioned earlier, due to the demanding, challenging life situations, urban women try to detach themselves from the situation as a way of coping with stress. Urban women try to cope with stress by watching T.V. listening radio, going to cinema, talking others over phone, pray a lot. Now a days television with different satellite channel provide excellent source of entertainment for urban women which in tern helps them to reduce their stress.

Significant difference in the use of social withdrawal coping strategy was found between respondents of different age levels. Up to 24 years age group adopted more social withdrawal than other two age groups. This finding suggest that at this age, respondents experiences stress in various way. They have to study hard to built their future, take responsibility of her family, start

a new life with their in-laws etc. These young age group might find the social withdrawal method as a source of reducing stress.

C) Acceptance:

Significant residential status difference in the use of acceptance coping strategy was found in the present study. Urban respondents used more acceptance coping strategy than rural respondents. Several factors may contribute to this difference such as family structure, expectation, experiences, personal growth etc. The present study was conducted in Dhaka city with women engaged in different professions. Meeting the demands of different life situations, focusing challenges sometimes might compel urban women to accept the situation in order to avoid further problems.

No significant difference was found between respondents of different levels in seeking acceptance coping strategy.

D) Problem Solving, Cognitive Restructuring, Confrontive Coping, Express Emotion, Social withdrawal, Problem Avoidance, Self Criticism, Religion:

The present study failed to show any significant difference in the use of problem solving coping strategy, cognitive restructuring coping strategy, confrontive coping strategy, express emotion coping strategy, social withdrawal coping strategy, problem avoidance coping strategy, self criticism coping strategy, and religion coping strategy between urban, rural respondents and respondents of different age levels.

Possible explanation for such results is that in our country urban and rural women hold almost the same position and similar type of life style. Women are taught to be submissive, dependent and nurturant from their childhood. Family teaches how women can control their temper, aggressive behavior, their expectation etc. Our cultural norm and expectation is that, women should take care others and also fulfill the need of others. Women have experienced strong feelings that accompany both very pleasant and very negative experiences. This feeling are represents as emotions. Personality type also play an important role in expressing emotion. They suffer from different type of deprivation. Women are worst affected by socio-cultural attitudes and values needs social support very much. Sometime women tend to put blame on themselves. Most of the time they attempting to modulate their own feeling or action in relation to the problems. They accept the situation and try to solve it. They try to put good face on a bad situations. Such as making comparisons with individuals who are less off, or seeing something good growing out of the problem. Sometime they feel so stress that they can't control their aggression, or thinking action to escape or avoid it. Religion is an important aspect of people's live around the world. Women in our country try to create a positive meaning from the situation in terms of personal growth. When women are asked about their situation, their common response is that, "it is Gods wish". In one study (Ahmed,1995) in which women of low SES were found to value, "being religious" more than either "becoming rich" or "attaining power".

4.3: MENTAL HEALTH:

Mental Health: Residential status, marital status, family type and occupation.

In order to see the effect of residential status marital status, family type and occupation on mental health, marital status, family type and occupation One Way ANOVA was computed.

A)Residential Status and Mental Heath:

No significant difference in mental health was found between urban and rural women. Though urban living is more stressful than rural living in terms of living cost, competition, housing etc, it was interesting to find that these women did not have poorer mental health than rural women. On the other hand, rural women being less educated, deprived of all facilities of urban living did not show more signs of lower life satisfaction than urban women.

B) Marital Status and Mental Health:

Table 25 showed that marital status of the respondents did not have any effect on women's mental health.This contradicts with the findings of Amato(1994) who studied the impact of divorce on mental health of men and women in India and United States. The results revealed that Indian women's economic dependence on men, cultural beliefs etc, make them suffer more hardship than men. They also concluded that mental health of Indian women who are divorced and separated had poor mental health than US women.

C) Family Type and Mental Health:

The study found significant difference in mental health between respondents living in single and joint families. Respondents living in joint families had better mental health score than those living in single families.

Most of the people in our country live in a joint families. Several factors might help explain such findings. Living with parents, uncles, aunts, in-laws etc, might sometimes be more enjoying and pleasurable than living alone. All the members share family responsibilities like caring and looking after others, sharing financial matters, helping each other in times of crisis and giving social support. Studies have found an association between social support and

mental health (Leavy.1983). Social support, the knowledge that we are part of a mutual network of caring, interested others enables us to lower our levels of stress and to cope better with the stress we do undergo(Uchino, Uno and Holt-Lunstad,1999;McCabe et.al.2000). So it is quite reasonable to believe that women lives in joint families getting support from significant others can bring solution to many difficult problems in life and hence enhance their well-being.

D) Occupation and Mental Health:

The present study found no significant effect of occupation on mental health. Women, whether they are students, housewives, working etc have a great deal of responsibilities like studying, household activities, taking care of family members etc, so it seems fair to conclude from the present research that mental health of these women would not differ.

4.4: CORRELATES OF MENTAL HEALTH:

In this section, some selected variables, namely adaptive coping strategies, nonadaptive coping strategies, income, education, age, life stress were correlated with mental health. This helped to see how each of these variables (independent) was related with the dependent variable(mental health) and also intercorrelatoin among the various variables. In the top of the row of the correlation matrix of table 30, simple correlation of each independent variable with dependent variable mental health is presented. Intercorrelation among the several variables under study also discussed.

1) Coping Strategies and Mental Health:

The present study found significant positive correlation between adaptive coping strategies and mental health (r=.148; P<.05).It is evident that mentally healthy people use adaptive coping strategies to deal with life stress. Mentally healthy people with their adaptive coping skills have control over the stressful events in their lives. Their strong personality permits them to challenge tasks and ultimately contributes to their sense of well-being. Numerous empirical studies which examined the relationship between coping strategies and mental health have reported that, in general, optimism has been associated with the use of more adaptive, engaged coping activities, such as problem solving, cognitive restructuring etc, whereas pessimism has been associated with the use of more maladaptive, disengaged coping activities such as problem avoidance, social withdrawal (Chang,1995; Long and sangster,1993; Scheier and Carver,1985).

2) Income and Mental Health:

The study failed to show any significant relationship between income and mental health. Contradictory findings have been reported in previous research. Diener(2000), Oishi(2000), Easterlin(1974) found wealthier persons were happier than poorer persons. Higher SES is associated with more positive mood and cognition (Barefoot et. al., 1991;House et.al.,1994;Ross and Wu, 1995).

3) Education and Mental Health:

The study failed to show any significant relationship between education and mental health. Contradictory findings have been reported in previous research. Mahmuda (1998) found respondents having high education had better mental health than respondents with low education. A person with a

high education, independent life, vocation and good income is likely to perceive his wishes fulfilled to a large extent and thus it causes to have a more positive outlook toward everyday life activity (Nagpal and Sell,1985). Huque (2004) also found positive correlation between education and psychological well- being.

4) Age and Mental Health:

Significant positive correlation was also found between age and mental health($r=.139; P<.05$). Younger age group respondents had significantly better mental health than the older groups. This leads support to Wilson's study (1967). One criterion of positive psychological that emerged from his well-being study was "being young". Young people are mentally stronger, worry less, and have the capacity to handle problems more efficiently and realistically than older people. Compbell et. al.(1976) concluded from their study Americans younger than 35 years were the happiest while those above 75 years were the least happy groups.

5) Life Stress and Mental Health:

Recent studies suggest that there is a strong link between stress and the oneset of psychological symptoms (Blair, 1983; Johnson and Roberts, 1995). The present study found significant negative relationship between perceived life stress and mental health($r=-.526, P<.01$).Individual who perceived high stress showed poorer mental health. It is evident from previous studies that levels of perceived stress are correlated with dissatisfaction (Cohen and Willamson, 1988). A good number of researches have consistently reported the impact of life stress on our physical and psychological health. Among the symptoms that develop from prolonged stress are anxiety, depression, irritability, fatigue, loss of appetite, headache etc. In one study, Daniel (1995) reported

that those respondents who displayed more signs of marital maladjustments showed more psychiatric symptoms and lower levels of life satisfaction.

The correlation matrix(Table-30) showed the intercorrelation among the several variables under study, The results are discussed below:

1) Highly significant positive correlation was found between adaptive coping strategies and nonadaptive coping strategies($r=.279, P<.01$).It means that those who uses adaptive coping strategies, also know very well when and which situation they can use nonadaptive coping strategies to solve their problems.

Highly significant positive correlation was also found between adaptive coping strategies and income($r=.194, P<.01$).Those people who uses adaptive coping strategies are very active and hard working. They can do different type of work in a easy and simple way. That is why they succeed in life and earn more. No significant relationship was found between adaptive coping strategies with education, age and life stress.

2) Highly significant positive correlation was found between nonadaptive coping strategies and education ($r=.213, P<.01$). It appears that those who use nonadaptive coping strategies have high education. No significant relationship was found between nonadaptive coping strategies with income, age and life stress.

3) Highly significant positive correlation was found between income and education($r=.403, P<.01$). It is obvious that highly educated person do better jobs, earn more and are successful in life. Significant negative correlation was found between income and life stress($r=-.149, P<.05$). It can be said that those who earn less, feel more stressed in their life. With the small amount of

money they cannot fulfill their needs. No significant relationship was found between income and age.

4) Highly significant negative correlation was found between education and age($r=-.367, P<.01$). It might be that older respondents in the present study were less educated than younger respondents. Highly significant negative correlation was also found between education and life stress($r=-.219, P<.01$). This means highly educated person experienced less stress in their life. As mentioned earlier, higher education means self confidence, better job, high social status. Education also helps individuals to cope with difficult problems confidently and realistically.

5) No significant relationship was found between age and life stress.

SUMMARY & CONCLUSION

CHAPTER V

SUMMARY AND CONCLUSION

The present study attempted to asses life stress, coping strategies and mental health of the urban and rural women. 200 women were selected randomly as the sample of the study. Of the total respondents, 100 women were from urban setting (6 thanas from Dhaka city) 100 women were from rural setting (3 villages of Noakhali district).Life stress was measured by the Bangla version of "How stressful is your life?" Cohen(1999) scale translated by Fahim(2001). The Bangla version of the coping scale (Huque, 2004) originally developed by Folkman and Lazarus(1980) and the Bangla version of the mental health scale(Sorker and Rahman, 1989) originally developed by Goldberg(1972) was used for the present study.

Mean, SD, One Way ANOVA and correlation of coefficient was used for analyzing the data.

One Way ANOVA was used to see if life stress, coping strategies and mental health of women varies with residential status. The results showed significant difference in life stress as a function of residential status of the respondents. Significant residential status difference in the use of wishful thinking, social withdrawal and acceptance were found in the present study. Urban respondents used more wishful thinking ($\bar{X}$=1.79), social withdrawal ($\bar{X}$=5.89), acceptance ($\bar{X}$=7.56) than the rural respondents ($\bar{X}$=1.22,$\bar{X}$=5.27,$\bar{X}$=2.33). No significant difference was found between mental health of urban and rural women.

One Way ANOVA was also used to see if there was any significant age difference in life stress and coping strategies of the respondents. No significant difference was found between the different age groups and life stress. Significant difference in the use of social withdrawal was found between respondents of 3 different age groups.

F-test was also used to investigate whether life stress and mental health varies with occupation, marital status, and family type. Significant difference was found in life stress with occupation. The result showed that students had the highest mean score ($\bar{X}$=20.09) than house wives ($\bar{X}$=19.96) and service holders ($\bar{X}$=16.32). Results showed no significant difference in life stress with marital status, and family type. Significant difference was found in mental health with family type. Respondents living in joint families had better mental health ($\bar{X}$=34.25) than those living in single families ($\bar{X}$=36.70). Results also showed that there was no significant difference in mental health with marital status and occupation of the respondents.

Correlation of coefficient was also used to see the relationship among different variable under study.

Findings of the present study have revealed some interesting similarities and differences between urban and rural women of Bangladesh in using coping skills, their life stress and mental. The findings also indicated the significance of using adaptive coping strategies for the promotion of better mental health. Numerous studies have linked stress with different forms of psychopathology (Elken and Rosch,1990; Karaselc et.al.1988; Humell and Colligen,1987; Salvendy and Smith, 1981). The study points to the need for teaching women more adaptive coping methods for dealing effectively with their problems in life. Stress management and other wellness programs can be developed like

good dietary practices, social skills training, physical exercise and other relations techniques.

Limitation of the present study:

In addition to above discussion, it is important to point out several potential limitation of the present study.

1) The sample was not representative of the whole population of Bangladesh. Urban sample was drawn only from Dhaka city and rural sample was drawn from 3 villages of Noakhali districts.

2) The study did not take full account of the whole spectrum of variables that might affect an individual's mental health, such as personality characteristics, perceived social support etc.

Recommendation: Bangladesh context:

1) The study points to some important aspects, such as education, occupation, and other facilities for women.

2) In future studies women issues can particularly be high lighted so that we can have better understanding of urban and rural women sources of stress and their coping strategies.

3) For management of stress, mere knowledge of awareness is not enough. Vigorous training programs are necessary to develop skills to meet the stresses before it becomes a problem.

4) A broad based and well controlled nationwide survey on mental health need to be conducted to confirm the findings.

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APPENDIX

APPENDIX-A
Bio-data
ব্যক্তিগত তথ্য

১. নাম ঃ ----------

২. বয়স ঃ ---------- বছর

৩. ধর্ম ঃ ----------

৪. শিক্ষাগত যোগ্যতা ঃ (শেষ ধাপ উল্লেখ করুন)----------

৫. বৈবাহিক অবস্থা ঃ (যথা স্থানে টিক----- দিন)
---------- অবিবাহিত
---------- বিবাহিত
---------- বিধবা
---------- তালাকপ্রাপ্ত
---------- বিচ্ছিন্ন
---------- পরিত্যক্তা
---------- পুনঃ বিবাহিত

৬. বাসস্থান ঃ গ্রাম/শহরের নাম ----------
জেলার নাম ----------

৭. বর্তমান মাসিক আয় ঃ ব্যক্তিগত আয় ----------টাকা
পারিবারিক ----------টাকা

৮. পেশা ঃ পেশার ধরন ও পদবি উল্লেখ করুন-
----- ছাত্রী
----- গৃহিনী/কর্মজীবি
----- অবসর প্রাপ্ত
----- অবসরের পর পুনঃ নিয়োজিত

৯. পরিবারের ধরন ঃ একক / যৌথ

১০. ভাই-বোনের সংখ্যা ঃ ---------- জন

১১. সন্তানের সংখ্যা ঃ (বিবাহিত হলে)-----ছেলে, -----মেয়ে

১২. থাকার ব্যবস্থা ঃ আপনি কার সংসাওে আছেন?
(যথা স্থানে টিক----- দিন)
------ পিতা-মাতার সংসাওে
------ নিজের সংসাওে
------ ভাই-বোনের সংসাওে
------ শ্বশুর-শ্বাশুড়ীর সংসাওে
------ একা
------ ছেলে / মেয়ের সংসাওে
------ অন্য কারো সংসারে

১৩. আপনার পরিবাওে আপনি ছাড়া আর কে বর্তমানে একসাথে আছেন?
(যথাস্থানে টিক দিন) ------ স্বামী ------ অবিবাহিত ছেলে/মেয়ে
------ বিবাহিত ছেলে/মেয়ে ------- নাতি/নাতনী ------ অন্যান্য
(সংখ্যা উল্লেখ করুন)

APPENDIX –B

Bangla version of the Life Stress Questionnaire

আপনার জীবন কতটা চাপমূলক ?

নির্দেশনা ঃ

নিম্নে জীবনের চাপমূলক অবস্থা সংক্রান্ত ১০টি প্রশ্ন রয়েছে। প্রতিটি প্রশ্নের জন্য পাচটি করে উত্তর রয়েছে। প্রতিটি প্রশ্নে যে উত্তরটি গত একমাসে আপনার জীবনের চাপমূলক অবস্থাকে সবচেয়ে ভালো বর্ননা করে তার পাশে টিক(√)দিন।

	কখনই না	প্রায়ই না	কখনও কখনও	প্রায়ই	সবসময়
০১. অপ্রত্যাশিতভাবে কোন কিছু ঘটার জন্য আপনি কতবার বিচলিত হয়েছেন?					
০২. কতবার আপনার মনে হয়েছে যে, জীবনের গুরুত্বপূর্ন বিষয়গুলোর উপর আপনি নিয়ন্ত্রন রাখতে পারছেন না?					
০৩. আপনি কতবার বিচলিত ও 'চাপবোধ' অনুভব করেছেন?					
০৪. ব্যক্তিগত সমস্যা মোকাবেলা করার ক্ষমতা সম্পর্কে আপনার কতবার নিজেকে আত্মবিশ্বাসী মনে হয়েছে?					
০৫. কতবার আপনার মনে হয়েছে যে, যেভাবে চেয়েছেন সেভাবে সবকিছু আপনার ইচ্ছামত ঘটছে?					
০৬. আপনি কতবার আপনার জীবনের বিরক্তিবোধ নিয়ন্ত্রন করতে সক্ষম হয়েছেন?					
০৭. আপনি কতবার দেখেছেন, যেসব কাজ আপনার করার দরকার ছিল, সেগুলির সাথে আপনি মোকাবেলা করতে পারছেন না?					
০৮. কতবার আপনার মনে হয়েছে যে, সবকিছু আপনার নিয়ন্ত্রনে আছে?					
০৯. কোন কিছু আপনার নিয়ন্ত্রনের বাইরে যাওয়ার কারনে কতবার আপনি রাগান্বিত হয়েছেন?					
১০. কতবার আপনার মনে হয়েছে, এতবেশী সমস্যা জমেছে যে আপনি তা অতিক্রম করতে পারছেন না?					

APPENDIX –C

Bangla version of Coping Scale

অভিযোজন প্রশ্নমালা

জীবনের কঠিন বা চাপমূলক পরিস্থিতির সাথে খাপ খাইয়ে নেয়ার জন্য মানুষ বিভিন্ন উপায় অবলম্বন করে। এই প্রশ্নমালায় আমরা জানতে চাই আপনি এই ধরনের চাপের সম্মুখে কি করেন? অথবা তখন আপনার অনুভূতি কেমন হয়? এখানে সঠিক কিংবা ভুল উত্তর নাই। তাই যে উত্তরটি আপনার জন্য প্রযোজ্য সেটি বেছে নিন। অন্যরা এই পরিস্থিতিতে কি করে তা চিন্তা করবেন না। আপনি নিজে সাধারণতঃ কি করেন তা নীচের চারটি উত্তরের মধ্য থেকে একটিতে টিক (√) চিহ্ন দিন।

		আমি সাধারণত: এটা করিনা	আমি সাধারণত: এটা মাঝে মাঝে করি	আমি সাধারণত: এটা বেশীরভাগ সময় করি	আমি সাধারনত: এটা সব সময় করি
০১	আমি এই পরিস্থিতিতে সমস্যার সমাধান করতে চেষ্টা করি				
০২	নিজেকে বোঝাতে চেষ্টা করি যে, পরিস্থিতি যতটা খারাপ ভাবছি সবকিছু ঠিক ততটা খারাপ নয়				
০৩	এমন পরিস্থিতিতে আমি গালিগালাজ/বিরক্তি প্রকাশ করি				
০৪	যা ঘটছে তার মধ্যে আমি ভাল কিছু খুজে বের করতে চেষ্টা করি				
০৫	আমি আমার আবেগ/ অনুভূতিগুলি প্রকাশ করি				
০৬	আমার কেমন লাগে তা অন্যদের সাথে আলোচনা করি				
০৭	আমি সমস্যা সম্বন্ধে চিন্তা বা কিছু করা পরিহার করি				
০৮	আমি আশা করি অলৌকিক কিছু ঘটবে				
০৯	মানুষকে এড়িয়ে চলি				
১০	বেশী করে গান অথবা রেডিও শুনি				
১১	আমি নিজেকে দোষী মনে করি				
১২	এই পরিস্থিতিতে কি করা যায় সে রকম একটা কৌশল বের করতে চেষ্টা করি				
১৩	অন্যদেরসাথে মারামারি করি				
১৪	আমি তখন আল্লাহর উপর বিশ্বাস রাখি				
১৫	আমি সবকিছু মেনে নেই অথবা এই সমস্যা নিয়ে বেঁচে থাকার চিন্তা করি				
১৬	অতিরিক্ত কিছু কাজ করে সমস্যা এড়িয়ে যাই				
১৭	অন্যের জিনিস পত্রের ক্ষতি করি				
১৮	এই পরিস্থিতিতে কি করতে হবে তা এমন একজনের কাছ থেকে উপদেশ নেই				
১৯	যাতে করে কম চিন্তা করতে হয় তাই সিনেমা দেখতে যাই অথবা টিভি দেখি				
২০	আমি আল্লাহর সাহায্য প্রার্থনা করি				
২১	যে এমন পরিস্থিতিতে আমাকে সাহায্য করবে এমন কারও সাথে কথা বলি				
২২	অন্যেরা এমন পরিস্থিতিতে কি করছে তা জিজ্ঞাসা করি				

APPENDIX –D

Bangla version of Mental Health Questionnaire

নীচে মানসিক অবস্থা সংক্রান্ত ১২টি উক্তি রয়েছে। প্রতিটি উক্তির জন্য চারটি করে উত্তর ওয়েছে। প্রতিটি উক্তিতে যে, উত্তরটি গত তিন মাসে আপনার মানসিক অবস্থানে সবচেয়ে ভালো বর্ননা করে তার পাশে টিক (√) চিহ্ন দিন।

	সব সময়	মাঝে মাঝে	কদাচিৎ	একেবারে না
০১. আপনার দৈনন্দিন কাজকর্মে মনোযোগ দিতে পারছেন কি?	------	-------	------	------
০২. দুশ্চিন্তার কারনে আপনার ঘুমের ব্যাঘাত ঘটছে কি?	------	-------	------	------
০৩. কোন কাজে গুরুত্বপূর্ন ভূমিকা কওেছেন বলে মনে হয় বা হয়েছে কি?	------	-------	------	------
০৪. কোন বিষয়ে সিদ্ধান্ত দেওয়ার ক্ষমতা রাখেন বলে মনে হয়?	------	-------	------	------
০৫. আপনি কি ক্রমাগত মানসিক চাপের মধ্যে আছেন?	------	-------	------	------
০৬. আপনার অসুবিধাগুলি আপনি কাটিয়ে উঠতে পারবেন না বলে মনে হয়?	------	-------	------	------
০৭. আপনার দৈনন্দিন সাধারন কাজগুলি উপভোগ করতে পারছেন কি?	------	-------	------	------
০৮. আপনার সমস্যাগুলি আপনি নিজেই মোকাবেলা করতে পারছেন কি?	------	-------	------	------
০৯. নিজেকে কি আপনার অসুখী বা বিষন্ন বলে মনে হয়?	------	-------	------	------
১০. নিজের উপর থেকে আস্থা হারিয়ে ফেলেছেন বলে মনে হয়?	------	-------	------	------
১১. নিজেকে একজন অপদার্থ ব্যক্তি বলে মনে হয় ?	------	-------	------	------
১২. সবকিছু বিবেচনা করে নিজেকে সুখী বলে মনে করেন কি?	------	-------	------	------