Self-Acceptance in Women

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It is not unusual to open the daily newspaper to see headlines "Female stars relegated to the underclass" referring to the "…discrimination that resulted in Australia's women Olympic basketball players flying to London in economy class, while the men travelled in business class" (The Age, July, 20, 2012, p. 1). Then two pages further on, "Most women say 'I do' to husband's name". Reporting on a recent study by sociologist, it was stated that the vast majority of women take their husband's name at marriage with 90 % of children also having their father's, not their mother's, surname (The Age, July, 20, 2012, p. 5). Then a week later, "Women's work never done and pay still lousy". Reporting information from the Bureau of Statistics, the headline pointed out that "Men are better paid, but women are better educated. Men dominate the top executive jobs, at least in business, while women do most of the unpaid work at home" (The Age, July, 28, 2012, p. 5). One cannot but wonder what this differential treatment of men and women in our society can have on women's self-image and their self-acceptance. History and the research literature in fact paint a complex picture of gender self-image and self-acceptance.

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Development of Gender Self-Image and Self-Acceptance

Wolfe and Naimark (1991) presented a model outlining the way attitudes about gender roles, many of which are very subtle, became part of a woman's automatic repertoire of cognitions and, thus, influenced her self-acceptance and behaviour, frequently in a detrimental and often debilitating manner. In their model, the process of gender-role stereotyping starts with the messages the young infant, toddler, child, and adolescent girl receives from her social context (Step 1). These messages begin at a very early age and have an influence even before the child develops language (Wolfe & Naimark). Parents, siblings, teachers, members of the social milieu, and the media transmit these messages (Fodor, 1990). The messages tended to be taken for granted and are rarely questioned. The way boys and girls are handled and dressed, toys and activities provided, and behaviour tolerated differ for the two genders.

Wolfe and Naimark (1991) suggested that these messages were internalised by women by the time they reached adulthood and developed into a belief system (Step 2). In terms of rational emotive behaviour therapy (REBT) theory (Ellis, 1962), these beliefs can be irrational or dysfunctional as they are frequently in the form of absolutistic demands regarding how the woman should behave, talk, feel, look, and think in order to be accepted, valued, and appreciated (Wolfe & Naimark). Since the beliefs were internalised, they influenced the women's self-perception and self-acceptance.

These internalised demanding beliefs often create feelings and behaviours that are dysfunctional for women (Step 3). Thoughts associated with poor self-acceptance, anxiety about behaviour that deviated from the gender norms, and depression over lack of control were cited as frequently present in women seeking therapy. Women also presented with self-defeating behaviours including procrastination, lack of assertiveness, and failure to follow through with self-generated goals (Wolfe & Naimark, 1991).

In Wolfe and Naimark's (1991) model society's reaction to women completed the cycle (Step 4) with institutions and programmes reinforcing the presence of sex-role stereotypes. They asserted that both institutions and individuals reacted negatively to woman's deviations from the sex-role norms. The burning of St Joan of Arc for taking up arms and the placement of Zelda Fitzgerald, Scott Fitzgerald's wife, in a psychiatric hospital because she, too, liked to write have been claimed to be extreme examples of the treatment of women who deviated from gender stereotypes (Chesler, 1972).

In this context self-acceptance by women, or lack of it, was therefore considered to be a mirroring of the way they were treated by those around them and society in general.

What Is Self-Acceptance?

Defining self-acceptance is complex, particularly given the different understanding of what the concept "self-acceptance" means and, hence, how it might be measured.

Cognitive Behaviour Theory and Self-Acceptance

To cognitive behaviour therapists, self-acceptance, while related to self-esteem, is not the same; self-acceptance being based on a philosophical concept regarding how an individual sees himself or herself. Self-esteem is seen as how an individual values himself or herself based on characteristics, behaviours, and achievements as well as approval from others. It is basically how the individual rates himself or herself. The problem with such rating is that we feel good and rate ourselves positively if we have desirable characteristics, behaviours, achievements, and approval from others but feel down and rate ourselves poorly if these features are lacking. Self-esteem is therefore conditional.

Self-acceptance, on the other hand, is unconditional with all ratings of the self, either positive or negative, considered to be erroneous. While it has been suggested that people both biologically and socially tend to rate themselves and their characteristics, behaviours, thoughts, feelings, and achievements, it has been suggested that they can learn to omit self-rating and rate only their performances (Ellis, 1992/1994). It has furthermore been suggested that "…people will undo much of their self disturbance if they rate and evaluate their thoughts, feelings and actions in regard to their goals and purposes and if they refuse to measure their global 'selves' or 'beings'" (Ellis, 1995, p. 213).

This view of self-acceptance is based on a humanist and existential position that people create their own world with an emphasis on full and unconditional acceptance of self and others. People can choose not to prove themselves but to be themselves and enjoy themselves. Emotionally healthy people are glad to be alive and accept themselves just because they are alive and can enjoy themselves. They do not measure their worth based on achievements or what others think of them (Ellis & Whiteley, 1979). In essence self-acceptance is a philosophical decision to accept the self unconditionally and not play the rating game.

Following the writing of Ellis, others (Walen, DiGiuseppe, & Wessler, 1980) have pointed out that there is no scientific way to prove conclusively that one human being has more or less worth than another. It therefore follows that all people are of equal worth. However, the notion of worth also leaves it open for the opposite to apply that of worthlessness. In eliminating the notion of worth, Ellis proposed the concept of unconditional self-acceptance. Self-acceptance is, therefore, not based on an assumption of worth related to a behaviour, characteristic, achievement or support, or approval from others. Rather it is a choice to accept oneself. Instead of rating oneself as a bad (or good) person, it is seen to be more helpful to accept oneself as a person who does some bad things (Ellis, 1994).

What then is the self? A simple way to see this is to regard the self as the experiential being at the core of a person; that which sees, hears, dreams, thinks, feels, and becomes sexually excited (Franklin, 1993). Rather than there being one "I" or self it has been suggested by Franklin that the self is composed of many "i"s. There is the i that watches a sunset, the i that plays tennis, the i that works as a gardener, and the i that cares for children. The whole self is then not put down if one i is faulty.

Existential philosophy is not the only basis for self-acceptance. Other common philosophies also espouse this notion. In the Christian New Testament, Jesus was asked "What was the most important commandment?" He responded, "Thou shalt love the Lord thy God with all thy heart, and with all thy soul, and with all thy mind. This is the first and great commandment. And the second *is* like unto it. Thou shalt love thy neighbor as thyself. On these two commandments hang all the law and the prophets" [Matt22:37–40]. This gives a clear message of the need for self-love or self-acceptance.

In Buddhist writing self-acceptance is also espoused. "Self-acceptance is the ability to rejoice in one's own good qualities and be at peace with and tolerant towards one's faults". In Buddhist psychology the terms attapiya (Dhp.157), attakāra (S.I,75), and attakāma (A.II,21) mean "self-appreciation", "self-respect", and "self-love" and are always used by the Buddha in a positive sense. In the practice of loving-kindness meditation, the first step is to develop love towards oneself. It is considered that we can hardly love, respect, and care about others unless we have such feelings towards ourselves. As the Buddha says: "One who truly loves himself will never harm another" (S.I,75) (Dhammika, 2006). No doubt there are other philosophies that espouse similar messages.

Cognitive behaviour therapists other than Ellis also were aware of the concept of self-acceptance. Beck (1991), as a result of his empirical research was aware of the lack of self-acceptance in his depressed patients who tended to negatively reproach themselves, suffer self-blame and self-castigation.

In Ellis's Rational Emotive Behaviour therapy (Ellis, 1962; 1994), Ellis considered that absolute shoulds, musts, and oughts were the primary source of disturbance, for example, "I must do all I can for my family". He also referred to three evaluative cognitive processes in the form of awfulising, for example, "It is awful if I don't do all I can for my family", low frustration tolerance, for example, "I can't stand it if I don't do all I can for my family" and globalising, for example, "I'm no good if I don't do all I can for my family". This last process of globalising reflects a global, negative evaluation of self based on one feature, characteristic or behaviour which Ellis would say reflects lack of self-acceptance.

That self-esteem and self-acceptance differ is supported by research. In a study to examine the relationship between the two concepts and their effect on psychological health different patterns were evident for self-esteem and self-acceptance. "Self-esteem was more closely associated with affect, with higher levels of self-esteem being indicative of lower levels of depression. Self-acceptance appeared to be more closely associated with general psychological well-being and to be more helpful when undertaking clinical work for general psychological problems" (Macinnes, 2006, p. 483).

Within the cognitive behaviour therapy school, a number of scales have been developed to measure beliefs that reflect core unhelpful beliefs relating to demands for affiliation, achievement, and comfort as well as the processes of demands, awfulising, low frustration tolerance, and global rating of self and others. Some of the scales actually focussed on the negative aspect of negative self-rating or lack of self-acceptance such as the Attitude and Belief Inventory (Burgess, 1986). However,

the General Attitude and Belief Scale (DiGiuseppe, Leaf, Robin, & Exner, 1988) included items that reflected self-worth or self-acceptance and lack of self-acceptance. This scale was further developed by Bernard (1990) to include negative evaluation of others and a sorter version, the SGABS, was further developed (Lindner, Kirkby, Wertheim, & Birch, 1999). The Unconditional Self-Acceptance Questionnaire was also developed (Chamberlain & Haaga, 2001).

The author also developed a scale, the Women's Belief Scale, specifically to measure the gender beliefs of women focussing on the demands a woman places on herself, along with awfulising, low frustration tolerance, and negative self-rating or lack of self-acceptance if these demands are not met (O'Kelly, 2011).

Self-Acceptance and Well-Being

Another approach to the conceptualisation and understanding of self-acceptance comes from the research on well-being. In fact, a recent literature search revealed more articles in this area than any other area of research with regard to the term self-acceptance.

In contrast to the mental health literature that typically focusses on the negative end of psychological functioning, Ryff (1989a, 1989b, 1989c) focussed on psychological features that account for positive functioning and well-being; the presence of wellness rather than the absence of illness. Ryff (1989a, 1989b, 1989c) was critical of the lack of theory guiding research in this area of well-being. As a result, she reviewed the literature in this area, teasing out the major features associated with well-being. Based on the multiple frameworks of positive functioning, such as those suggested by Erickson, Neugarten, Maslow, Allport, and Rogers, she developed a multidimensional model of well-being. The six dimensions were positive evaluation of one's self and one's past life (Self-Acceptance), a sense of continued growth and development as a person (Personal Growth), the belief that one's life is purposeful and meaningful (Purpose in Life), the possession of quality relations with others (Positive Relations with Others), the capacity to manage one's life and surrounding world (Environmental mastery), and a sense of self-determination (Autonomy). Self-acceptance was therefore seen by Ryff (1989a, 1989b, 1995) as a major contributing factor to well-being.

Having explored the theory of well-being, including the dimension of self-acceptance, she constructed a scale that has come to be known as the Psychological Well-Being Scale (PWS) (Ryff, 1989b). Knowledge of the development of this scale helps to understand more fully her conceptualisation of the term self-acceptance. Scale definitions for each dimension were developed reflecting bipolar high and low scores. Self-acceptance was defined in the following ways:

> *High scorer*: Possesses a positive attitude toward the self; acknowledges and accepts multiple aspects of self, including good and bad qualities; feels positive about past life.
>
> *Low scorer*: Feels dissatisfied with self; is disappointed with what has occurred in past life; is troubled about certain personal qualities; wishes to be different to what he or she is. (Ryff, 1989b, p. 1072)

Three item writers were instructed to write self-descriptive items that were consistent with the definitions. Thirty-two items, half positive and half negative, were finally used for the scale. Shorter versions of the scale have also been developed with as few as three items in the Self-Acceptance Scale (Carr, 2002). Examples of the items in the Self-Acceptance Scale are (1) I like most parts of my personality, (2) When I look at the story of my life, I am pleased with how things have turned out so far, and (3) In many ways I feel disappointed about my achievements in life (reverse coded) (Carr).

While this approach to self-acceptance reflects cognitive statements about self, they are evaluative. In this sense they differ from the approach of the cognitive behaviour therapist such as Ellis who was critical of any form of evaluations and ratings of self and stressed the need for unconditional self-acceptance. Ryff's conceptualisation was based on psychological theory while that of Ellis was based on philosophical foundations shared with others.

What the Research Tells Us About Self-Acceptance in Women

It was considered productive in this chapter to explore self-acceptance issues that relate to significant issues that women in general have to deal with rather than self-acceptance issue for women with mental health issues. In this regard the topics explored below include self-acceptance and the difference between men and women, self-acceptance in multirole women, and self-acceptance and violence towards women.

Gender Differences

From the time of her early work on well-being, Ryff and her colleagues explored gender differences (Ryff, 1989b; Ryff & Keys, 1995; Ryff & Singer, 1996). The results regarding overall differences between men and women on the PWS dimension of self-acceptance are of interest and have been consistent. In her early study of well-being in 321 men and women across the life span, divided among young, middle-aged, and older adults, a number of gender differences were evident in the six dimensions of well-being. These differences occurred on the measure of positive relations with other, on which women scored higher than men. The difference between men and women on the measure of personal growth approached significance, again with women scoring higher. That was it. There was no difference between men and women on the self-acceptance measure for any of the age groups (Ryff, 1989b). In a study relating parents' well-being and that of their adult children, again no significant difference was found between self-acceptance of the mothers and the fathers although women did score higher on personal growth and positive relations with others (Ryff, Lee, Essex, & Smutte, 1994). Similar results were again obtained in a later, larger study with a sample size of 1,108, which was

also divided into the three age groups. The only scale that showed significant gender differences was the Positive Relations Scale. There were no differences with regard to self-acceptance nor did self-acceptance differ across the age groups (Ryff & Keys, 1995). These results support the belief that women are more focussed on interpersonal relationships while men are tied to individualism and autonomy as was suggested a number of years earlier (Gilligan, 1982).

It is particularly interesting to note that in a number of the studies reported by Ryff and her colleagues (Ryff, 1989b; Ryff et al., 1994; Ryff & Keys, 1995) there was a consistent pattern of negative associations between well-being and several measures of depression. These were accompanied by consistent positive associations between the measures of well-being and positive affect, happiness and satisfaction. Of the measures of well-being the strongest relationships were present for self-acceptance and environmental mastery.

These results tend to create a dilemma. It has been well documented that women, from early adolescents and throughout adulthood, are twice as likely to experience depression, as do men. This is the case across different cultures and ethnic groups. It is true whether it is subclinical symptomatology or diagnosed depression. Lifetime prevalence of depression of 21.3 % has been cited for women in contrast to a prevalence of 12.7 % for men (Nolen-Hoeksema, 2001). What then do we make of the fact that women in Ryff's studies did not show differences between men and on self-acceptance yet self-acceptance was one of the two scales of the well-being scale that was most highly negatively related to depression. A possible reason for this lack of gender differences is that the samples in Ryff's studies may have been selective. Individuals suffering from depression may have opted not to take part in the "well-being study". The participants in the studies might therefore not have truly represented the range of well-being. The studies may be focussing on individuals, both men and women, who are more at the positive end of the mental health spectrum. Measurement issue may also impact on this lack of gender difference. For all subscales of the PWS information tends to concentrate in the midrange. Score precision therefore diminishes at the high and low levels of well-being and therefore the high and low levels of self-acceptance (Abbott, Ploubidis, Hubbert, Kuh, & Croudace, 2010).

The heritability of self-acceptance in men and women has also been studied. Self-acceptance, as measured on the PWS (Ryff, 1989b), is considered one of the most important aspects of psychological functioning that accounts for the heritability of resilience. In a major twin study, from the National Survey of Mid-Life Development in the United States (MIDUS), men and women did not differ with regard to self-acceptance. In men, however, environmental mastery, involving the ability to maintain a sense of empowerment and competency, along with a positive view of oneself in the face of psychosocial stressors, both contributed to psychological resilience. When there were statistical controls for self-acceptance, the heritability for men was only reduced by 33 %. In women, however, the one significant psychological resource of self-acceptance contributed most to heritability. Controlling for this one factor in women reduced the heritability by 70 % (Boardman, Blalock, & Button, 2008). It seems from this study that when it comes to heritability of resilience in women one factor, that of self-acceptance, is significant whereas

men are not solely dependent on this one factor but derive additional benefit from environmental mastery. This is a possible reason why the incidence of depression is lower in men.

To date there has been no study reported exploring gender difference on the various measures of beliefs, in particular self-worth or self-acceptance beliefs, within the CBT framework. It seems that this is an area where further research is warranted to get a fuller understanding of gender difference and self-acceptance.

Self-Acceptance and Multiple Roles

It has been suggested that the differential environmental factors, such as women's social roles and the high incidence of violence and sexual abuse in women, might also contribute to the higher incidence of poorer emotional well-being in women in comparison with men (Nolen-Hoeksema, 2001) although more research in this area is warranted.

The lives of women have changed considerably throughout the twentieth century. Prior to World War II, the majority of women were involved in full time, unpaid, domestic duties: cooking, washing, cleaning, and nurturing their husbands, children, and the elderly. External pressure associated with World War II led to many women entering the paid workforce, initially through necessity, to replace men who were serving in active combat in the armed forces. Following the war women's participation in the paid workforce continued to increase. Women's representation in positions of leadership and in professions also increased (Chesney & Hill, 1988).

Although women took on paid work outside the home, they continued to do most of the domestic work, working longer hours in combined workforce employment and household tasks than did their male partners (Bittman, 1991; Cowan, 1983; McBride, 1990; Rexroat & Shehan, 1987). This was the case regardless of income, education, social background, employment, or age. This increased workload for multirole women was presumed to have a deleterious effect on their health and well-being (Bittman, 1991).

While it may not be the ideal for women to carry a double load, to date there is in fact little empirical evidence supporting the contention that a double workload has a negative effect on women's physical or emotional health. A number of cross sectional and longitudinal studies have reported an association between employment and good physical health (Haynes, Eaker, & Feinleib, 1984; Verbrugge, 1982, 1983, 1986; Waldron & Herold, 1986; Waldron & Jacobs, 1988, 1989; Woods & Hulka, 1979). The nature of the association between paid employment and women's emotional health is not as clear as for physical health. No studies, however, have found women in paid employment to be more distressed than women who were not in paid employment (Warr & Parry, 1982).

In modern society gender roles are not clearly defined with the result that both men and women juggle multiple roles, for example homemaker, worker, partner, parent, career for an aged parent, and voluntary worker. It appears that a greater

number of roles enhances well-being in both men and women. In fact increased role involvement that is the more roles a person had, was among other measures, associated with more positive self-regard. In this context, however, the self-acceptance of women was lower than that of men (Ahrens & Ryff, 2006). This result is in contrast to other studies of well-being and self-acceptance in women suggesting that self-acceptance in women may be influenced by context.

Women with young children adapt to work and family demands in different ways. Some stop work altogether for some time, others reduce their work hours, and others may move into work that complements the maternal role. Making these adjustments impacts on a woman's career. They have access to less on-the-job training, less work experience, and fewer promotions with resulting reduced income, erosion of earnings, prestige, and mobility in the labour market (Carr, 2002). These work-family trade-offs impact on how a woman evaluates herself. Again using data from the MIDUS study focussing on the PWS (Ryff, 1989b), it was shown that these factors impacted on self-acceptance differentially for men and women. Income was positively related to men's but not women's self-acceptance; however, a college degree had a greater impact on self-acceptance for women than it did for men. Furthermore, for women, the impact of work-family trade-offs varied depending upon the cultural norms of the cohort or peer group. For all age groups women who changed jobs or reduced their work hours did not differ in self-acceptance from those who remained full time in the workforce. However for those women born between 1931 and 1944 stopping work to raise children was a large positive predictor of self-acceptance. In contrast women born between 1960 and 1970 who stopped work to care for their children reported significantly lower self-acceptance (Carr, 2002). It is well known that the feminist revolution has led to a change in gender-role behaviour and attitudes from the late 60s and thus the two groups of women mentioned above are likely to have had very different expectations with regard to gender-role behaviour. It appears that adhering to cultural norms or specific sub-cultural norms for gender-role behaviour enhances a woman's self-acceptance (Carr, 2002). When the impact of unpaid work, such as childcare, housework, voluntary work, and caring for elderly or ill relatives, was explored in a more recent study, similar results were obtained. Unpaid work was negatively associated with self-acceptance (Lindfors, Berntsson, & Lundberg, 2006). We cannot, however, assume that in current times being out of the workforce causes a woman to have low self-acceptance. It could be that women with low self-acceptance opt to stay out of paid employment while those with high self-acceptance opt to work in paid employment. The impact of cultural norms for gender-role behaviour is again relevant.

Restriction in the number of roles may also be a factor in women who opt not to work in paid employment as a commitment to multiple roles has shown to be related to life satisfaction and self-acceptance. Managerial women in particular who are committed to a variety of roles have a very strong sense of self-worth (Ruderman, Ohlott, Panzer, & King, 2002).

Self-acceptance and self-efficacy, being the belief a woman has in her ability, are also related in women in paid employment. Women with higher self-acceptance

have higher self-efficacy. This is the case across a range of work sectors and is particularly so for the health and industrial sector (Srimathi, Kumar, & Kiran, 2011).

The demands multirole women placed on themselves and then how they evaluated themselves were also explored in a large research project exploring stress and well-being in multirole women conducted by the author (O'Kelly, 1999). All the women working at a large teaching hospital were asked to take part in the study. Of the 2,562 questionnaires sent out 974 (44 %) were returned completed. Of the 974 women 422 were living with a male partner, had children living at home, and had a household to maintain in addition to their paid employment. The main measure taken was the Women's Belief Scale (O'Kelly, 2011). This scale was developed for the purpose of this study and was created to explore gender-role beliefs. It was based on REBT theory with subscales of demands, awfulising, low frustration tolerance, and negative self-rating. It is this last subscale that is of particular relevance to this chapter as it is indicative of lack of self-acceptance.

The multirole women who rated themselves negatively also had high score on the global severity index of the brief Symptom Inventory, a measure of emotional distress. They also reported that they felt stressed overall with life in general. They experienced more negative affect and less positive affect and reported less satisfaction with life as a parent, worker, and with life in general. The relationship between self-acceptance or negative self-rating and well-being however differed with occupational status and education. Professional and managerial women were less inclined to rate themselves negatively in comparison to blue-collar workers such as kitchen hands and cleaners. In addition those with a higher level of education also had lower scores on negative self-rating in comparison to those with lower levels of education. It is not surprising then that those with a lower level of education, having left school before the end of their secondary schooling, rated themselves lower than those with a postgraduate degree.

It is of interest that the relationship between stress and well-being and self-acceptance as measured by negative self-rating varied for different occupational groups and levels of education. For blue-collar and clerical workers there were no relationships between negative self-rating and their Global Severity Ratings, their positive and negative affect and life satisfaction measures. So it seems that the higher level of stress in these women is not related to their view of themselves. The managerial and professional women as well as the nurses were however more stressed, as measured by the Global Severity Rating, if they rated themselves negatively. For the managerial and professional women higher score on negative self-rating were also related to lower positive affect and higher negative affect as well as lower quality of life and life satisfaction measures. If the nurses had high negative self-rating, they also had low positive affect and low measures of life satisfaction. Likewise it was only for those with higher levels of education that there were relationships between negative self-rating and the Global Severity Index, with those with a tendency to rate themselves negatively being more stressed.

This research again suggests that context is important in exploring the relationship between self-acceptance and well-being in women. The blue-collar and clerical women are basically continuing to work in roles that are traditionally female roles.

There is therefore not a conflict between the demands placed on them in the workforce and their gender-role beliefs. Hence their self-acceptance is not challenged. For the more highly educated managerial and professional women and to a lesser extent the nurses, the demands of the workplace may require them to take on roles that are traditional male work roles and have demands on their time that detract from their role as wife, mother, and homemaker. Such pressures may challenge their self-acceptance as a woman leading to greater stress.

Abuse of Women and Relationship with Self-Acceptance

Gender-based violence towards woman has been noted by the General Assembly of the United Nations as a worldwide issue. It is a major contributor to poor physical and emotional health of women (United Nations, 1993). Such violence not only includes physical and sexual abuse but also psychological, social, and economic abuse. The World Health Organisation (2005) study reported that across a number of countries more than a quarter of women reported that they had been physically or sexually assisted since the age of 15 years with the incidence being as high as 50 % in some countries. In the study the extent of physical or sexual violence or both by an intimate partner over a lifetime varied from 15 % in urban Japan to 70 % in provincial Ethiopia. The statistics indicate the great extent to which violence is a part of a partnered woman's life in many countries. There were variations, with more highly educated women reporting a lower level of violence, and a higher incidence of violence in rural areas rather than urban sites. While intimate partner violence was the most common, non-partner perpetrators were most often the woman's father or other male or female family members. Controlling behaviour by males was strongly related to the physical and sexual violence as well as other forms of controlling behaviour such as controlling access to health care, wanting to know where she is at all time and being angry if she has contact with another man. In the WHO study it was assumed that power and control are the motivators underlying men's violence towards women and that they use a range of strategies to assert that power and control. For many women home was not a restful sanctuary.

In addition to intimate partner violence high incidence of childhood sexual abuse of women was reported. Across different countries incidence ranged from 1 to 21 %. Strangers and male family members posed the greatest risk. Many women reported that their first sexual experience was by force, often before the age of 15 years. It is possible that both the figures regarding childhood sexual abuse and the life time experience of abuse actually are under reported as a percentage of women regard the abuse as normal or justified. The status of women in society was seen by the WHO as a key factor in the prevalence of violence towards them.

In the WHO study the consequence of violence towards women was of concern as violence has a major impact on the women's physical, mental, sexual, and reproductive health. With regard to their mental health, women who had experienced violence were more likely to contemplate and attempt suicide. The experience of

past violence was also related to the report of mental distress in later life. Of particular concern was that violent, controlling men often kept women from sources of help. Women also were reluctant to seek help as a result of fear of retaliation from their abusive partner and stigmatising reactions from other. Also the women's own beliefs were highlighted, namely, feelings of shame and self-blame. One cannot but assume that such treatment would have an impact on a woman's self-acceptance. There is, however, little research exploring the relationship between violence towards women and self-acceptance.

A study of Jordanian women has explored the relationship between violence against women and self-acceptance. In a large sample with 915 women, it was evident that women who had been educated at school were less likely to be abused by their partner, with higher reports of abuse in women who had not received school education. Of more significance was the relationship between abuse and self-acceptance. Both environmental mastery and self-acceptance, as measured on the PWS, were significantly negatively correlated with all forms of marital abuse; physical, psychological, social, and economic. Of the two PWB measures, self-acceptance had the higher, negative correlations with psychological, physical, and economic abuse. The authors assumed from this data that women with a high level of self-acceptance are less likely to be victims of marital abuse (Hamden-Mansour, Arabiat, Sato, Obaid, & Imoto, 2011). It is, however, also likely that women who have positive attitudes towards themselves do not tolerate abuse or manage situations in a manner that do not lead to abuse, possibly due to an accompanying sense of environmental mastery. Such a sense of mastery gives them competence in managing their environment, controlling a complex array of external activities, and making effective use of opportunities. However, in such a correlational study it is hard to know the direction of causality. It is also likely to be the case that women who are respected and not abused by their partners have a higher level of self-acceptance than women who are abused. All we can say is that a negative relationship exists between abuse and self-acceptance. Working with men to develop different perceptions and attitudes towards women and more effective communication strategies would undoubtedly enhance the well-being of women in addition to programmes to educate women and develop their sense of self-worth.

A number of studies have also explored issues associated with self-acceptance in women who were sexually abused as children. A study of factors contributing to resilience in women who had been sexually abused as children but who had subsequently gone on to college indicated both risk and protective factors. In this study three subscales of the PWB were used as indicators of resilience; positive relations with others, environmental mastery, and self-acceptance. It was surprising that there was a positive relationship between severity of abuse and both self-acceptance and environmental mastery. The women who had experienced several different abusive incidents, and yet got to college later in life, in fact were more accepting of themselves and felt more competent in managing their lives than others. Women would no doubt have to have self-acceptance to survive such experiences to the extent that they could achieve academically. Family conflict was, however, negatively related to self-acceptance. In those homes where the trauma occurred in the context of negativity and where

depreciation and disapproval was common, the child would understandably mirror a negative view of self (McClure, Chavaz, Agars, Peacock, & Matosian, 2008).

On a more positive note development of self-acceptance and even passionate self-acceptance (Payne, 2010) was seen as a key factor in healing the impact of childhood sexual abuse in adult survivors. Several studies used qualitative methods, consistent with the feminist approach and philosophy to explore women's experience of therapy. The women spoke about their feeling of self at the start of therapy, being characterised by self-loathing and shame and seeing themselves as victims. As a result of the therapy process, they were able to not only see themselves as survivors but also progress to regard the abuse as just an experience and not defining who they are. In contrast they learnt to be self-accepting and appreciate themselves with all the different facets of their lives: women, mothers, lovers, friends, teachers, dancers, artists to name a few roles (Phillips & Daniluk, 2004). Disengaging and externalising the trauma or abuse experience enabled the women to see it as an experience in their life and not self-defining. They saw the responsibility for the abuse shifting from the abused to the abuser and hence shifting the blame and with it shifting their negative attributional patterns (Saha, Chung, & Thorne, 2011). Problem-focussed coping strategies were considered to enhance favourable mental health outcomes being characterised by social support, psychological interventions, cognitive reappraisal of the abuse, and self-acceptance (Phanichrat & Townshend, 2010).

What Is the Self That Women Need to Accept?

Taking gender into account creates a complex picture when one explores the importance of self-acceptance in women. What is the self that is actually being referred to or what self needs to be accepted? Gender self-confidence, gender self-definition, and gender self-acceptance are all terms used in the literature (Hoffman, 2006). Gender self-confidence refers to the strength of a woman's belief that she meets her own personal standard of femininity. Whereas gender self-definition takes into account how strongly her femininity contributes to her identity and gender self-acceptance refers to the degree of comfort a woman has as a member of her gender (Hoffman, Borders, & Hattie, 2000). The picture is even more complicated given that, on the one hand, a woman may simply adopt and define her femininity by internalising external and societally based roles and values regarding womanhood, while others may develop their own perception of what it means to be a woman with their own values, beliefs, and abilities (Ossana, Helms, & Leonard, 1992). This later concept has been referred to by earlier writers and researchers as gender schema. Bem (1981a) used the term gender "schema", a schema being "…a cognitive structure, a network of associations that organises and guides an individual's perception" (p. 355). Her gender schema theory proposed that children internalised society's sex typing and linked preferences, attitudes, behaviours, and personal attributes to their own sex and ultimately to themselves. This supposedly developed "…an internalized

motivational factor that prompts the individual to regulate his or her behaviour so that it conforms to the culture's definition of maleness and femaleness" (p. 355). This is a similar view to that of Wolfe and Naimark (1991) mentioned previously.

It has been suggested that a person's gender schema, with a corresponding set of demands and expectations on behaviour, influences his or her well-being. Historically it was assumed that development of gender-typed behaviours and characteristics congruent with those considered appropriate and even dictated by society for each gender was essential for good mental health (Broverman, Broverman, Clarkson, Rosenkrantz, & Vogel, 1970). Women therefore needed to develop a feminine gender identity with self-acceptance being associated with acceptance of traditional feminine traits. It is evident from examples mentioned earlier, namely, Joan of Arch and Zelda Fitzgerald, that woman have been treated badly if they did not accept their traditional feminine role.

While it was traditionally believed that congruence between physical sex and gender schema was advantageous for the individual, in more recent decades research has proved this not to be the case for women. Androgynous individuals, having both masculine and feminine qualities, are often psychologically and physically healthier and less stressed than others (Bem, 1975; Shaw, 1982; Thornton, Leo, & Alberg, 1991). That this applies more to women rather than men suggests that it is the taking on of masculine characteristics that gives an advantage rather than the incorporation of feminine characteristics (Roos & Cohen, 1987). There are suggestions that psychologically feminine women have learnt to be more helpless than others, particularly androgynous women (Baucom & Danker-Brown, 1979, 1984). In a broader sense, it is possible that women who are androgynous have a more diverse repertoire of behaviours that are acceptable to them and are therefore more flexible in responding to a range of demands. This leads to them having a greater range of coping skills (Patterson & McCubbin, 1984). For a woman to be psychologically robust she needs to incorporate traditional masculine qualities into her sense of self. Masculine qualities of achievement and competency orientation as well as self-assertion, leadership, individualism, and dominance are valued more by society than feminine traits. The presence of these traits has also been shown to be positively related to self-acceptance in women. In contrast the feminine traits of nurturance involving self-sacrifice, compassion, understanding, and support of others are not related to self-acceptance (Long & Goldfarb, 2002).

In modern society conflicts can arise for women if their culture and context places expectations on them that differ from their self-defined expectations associated with their role as a woman. Conflicts could occur between their self-acceptance as a worker, which may require the adoption of traditionally masculine characteristics, and their self-acceptance as a woman particularly if in their gender definition they value traditional nurturing roles of wife and mother. That managerial and professional women as well as nurses, more so than clerical and blue-collar women, were more distressed and had poor self-acceptance if traditional gender-role demands were not meet (O'Kelly, 1999) can be explained by this conflict; the assumption being made that the workplace demands were not consistent with their gender-role expectations. A similar conflict was evident in Israeli Jewish women

living in a culture with strong historical and religious traditions with regard to gender role. Professional women juggling the workplace demands, with a view of self as the worker, and the personal demands, with a view of self as nurturer, also had poor self-acceptance in comparison to women from cultures that were more flexibly regarding gender role (Long & Goldfarb, 2002).

Culture and context therefore creates a complex picture with regard to self-acceptance for women. Lewin (1984) argues that women should develop their femininity and gender confidence based on personal and idiosyncratic views of themselves rather than stereotypical, societally dictated views. The transcendence of gender roles, characterised by the ability to perceive and express qualities as human rather than masculine or feminine (Rebecca, Hefner, & Oleshansky, 1976), would appear to free women from unhelpful gender-role conflicts and enhance their self-acceptance.

Conclusion

Self-acceptance in women undoubtedly has an impact on the lives of women. Historically it was considered to be in the best interest for a woman to develop a view of herself that internalised societal expectations for feminine behaviour and characteristics. Research, however, has shown that this is not a healthy view for women to take of themselves as the traditional passive behaviour of women predisposes them to poor mental health. On the contrary, to enhance their well-being, women need to develop a sense of self that accepts the inclusion of traditional masculine qualities.

While self-acceptance is not a panacea for women, self-acceptance has been shown to enhance resilience and hardiness in modern women. The research referred to in this chapter clearly shows that women with high self-acceptance manage better with juggling the complex multiple roles that many women now deal with as they pursue careers like their fathers yet bear and nurture children like their mothers. They are also better able to manage the abuse that is directed their way in male-dominated societies. It has been suggested that women benefit the most if they transcend gender self-acceptance and focus on self-acceptance as an individual.

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