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Anxiety among Working and Non-Working Women

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KEYWORDS

Working and non-working women;
WHO

A B S T R A C T

According to the World Health Organization, Health Fitness is a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity. The aim of the study is to investigate anxiety among working and non – working women. Thirty working women and thirty non-working women were selected for the study through purposive sampling. Student t test is used to test the hypothesis. Both working and nonworking women shown normal level of anxiety and there is no significant difference in anxiety among working and non-working women.

Introduction

Anxiety is one of the most common psychiatric disorders whether it is the fear of an upcoming public speaking situation, or experiencing discomfort before going into a doctor's office, most people have felt anxiety in their lives. The symptoms of anxiety are well-known and include increased heart rate and shallow breathing, sweating, cold hands, trembling, butterflies in stomach and host of other symptoms.

The role of work has changed throughout the world due to economic conditions and social demands. Originally, work was a matter of necessity and survival. Throughout the years, the role of "work" has evolved and the composition of the workforce has changed. Today, work still is a necessity but it should be a source of personal satisfaction

as well. Traditionally the salient role of women was viewed as wife and mother and their identity in the society was viewed in terms of their relationships with their husbands and children. Certain roles in the family like cooking, cleaning, housekeeping, laundry, baby-sitting, etc. are considered as women's job only. This worsens the situation of working women who are overworked at office due to increased standards and expectations at their respective offices. After having a hectic day at office still women comes back home and does the cooking, cleaning, teaching children, looking after old parents, etc. Traditional gender roles and an unequal division of domestic labour still prevail in our country leaving women, particularly the mothers of young children, with higher levels of anxiety and stress (Chowhan *et al.*, 2016).

Both economical and psychological research provides convincing evidence that unemployment adversely affects a person's wellbeing. While the impact of unemployment on wellbeing has been well documented, these simultaneous effects of low and high anxiety levels on life satisfaction have been less explored (Muller *et al.*, in press; Waters and Moore, 2002). Compare to employed individuals and those in low paid jobs, the unemployed are more likely to suffer: anxiety, depression, hostility, paranoia, loss of confidence, reduction in self-esteem, poorer cognitive performance, loss of motivation, learned helplessness, lower happiness, suicidal ideation, lower levels of coping, psychosomatic problems, and behavioral problems (Creed *et al.*, 1999; Flatau *et al.*, 2000; Goldsmith *et al.*, 1997; Layard, 2005; Morrell *et al.*, 1998; Murphy and Athanasou, 1999; Shamir, 1986; Theodossiou, 1997).

Lack of balance between work and non-work activities are related to reduce psychological and physical well-being (Sparks *et al.*, 1999; Frone *et al.*, 1997; Thomas and Ganster, 1995; Martens *et al.*, 1999; Felstead *et al.*, 2002).

Without anxiety, our response to stressful situations - an icy road at night, an impending exam, a big dinner party we must attend - might be inadequate and lead to disastrous consequences. Anxiety is our body's way of telling us we feel vulnerable and unprepared. But it also spurs us on to make sure we are extra vigilant and ensure that we are equipped to accomplish our tasks and goals successfully.

However, anxiety that is free-floating, intense and inappropriately directed can be extremely disabling. When anxiety is no longer helpful or adaptive and begins to

cause significant distress, it may cross the realm into an anxiety disorder. Frequently occurring for the first time in childhood or adolescence, anxiety disorders can appear in a variety of forms and affect behavior, often in dramatic and difficult-to-explain ways.

Prolonged anxiety can lead to hypersensitivity and chronic worrying, which influences many areas of function (Kennerley, 1995).

Human beings have a natural response to danger or threat and these manifests as anxiety. This is known as the 'fight or flight' response. Physiologically, a hormone adrenaline is produced which brings about an array of physical symptoms and the feeling of anxiety. This response prepares us to 'fight or flee' in the presence of danger or threat. However, an anxiety disorder may be present if the anxiety is excessive, no danger is present or the danger is not matching the actual danger.

Anxiety Disorders are common. They are as prevalent as Depression. It is estimated that 1 in 9 people in Ireland will experience an anxiety disorder in their lifetime. 1 in 10 people consult their general practitioner with symptoms of anxiety, most not knowing they are anxiety symptoms. Anxiety disorders can happen at any age. Many have an onset in childhood or adolescence or even in adulthood.

Anxiety disorders may happen due to genetic predisposition or experiences in life early experiences or recent experiences. A maintenance cycle develops involving physical symptoms, thoughts, behaviors and emotions which continues the experience of anxiety on (Baron, 1997).

Although a person may describe anxiety that is felt in a general way, most anxiety

problems fit into a specific anxiety disorder. The main Anxiety disorders are:

Phobias: an irrational fear of an object, situation or place that leads to avoidance. The four main classifications of phobias are: Specific phobia, Agoraphobia, Social phobia and Blood injury phobia.

Panic Disorder: this involves intense anxiety associated with a misinterpretation of physical symptoms where a person thinks they will collapse and die or 'go mad'.

Generalized Anxiety disorder: involves a central component of 'worry' which feels out of control for the person.

They will worry about many different areas of their life and will also have worries about the worry.

Obsessive Compulsive disorder: involves cycles where obsessive thoughts cause anxiety and then rituals/ compulsions occur to reduce that anxiety. There are 4 main subtypes of OCD: contamination, harm to others, sexual obsessions and symmetry obsessions.

Body Dimorphic disorder: involves extreme distress due to imagined or real physical abnormalities that leads to behavioral change.

Health anxiety: involves excessive anxiety about health which involves thoughts about having an illness and dying which leads to behavioral changes.

Post-Traumatic stress disorder: involves intense fear and anxiety which relates to the experience of trauma or traumas. There are specific symptoms present such as distressing thoughts of the trauma, avoidance, nightmares and flashbacks.

Habit disorders: are presentations of behaviors which are repeated Example: Nail biting, hair pulling, skin picking.

Sexual difficulties: involves difficulties in sexual relationships. For men, these difficulties involve erectile dysfunction, premature ejaculation or low libido. For women the difficulties are vaginismus, anorgasmia or low libido.

The exact cause of anxiety disorders is unknown, but anxiety disorders like other forms of mental illness are not the result of personal weakness, a character flaw, or poor upbringing. As scientists continue their research on mental illness, it is becoming clear that many of these disorders are caused by a combination of factors, including changes in the brain and environmental stress.

Anxiety can be experienced with long, drawn out daily symptoms that reduce quality of life, known as chronic anxiety, or it can be experienced in short spurts with sporadic, stressful panic attacks, known as acute anxiety. Symptoms of anxiety can range in number, intensity, and frequency, depending on the person. While almost everyone has experienced anxiety at some point in their lives, most do not develop long-term problems with anxiety.

The behavioral effects of anxiety may include withdrawal from situations which have provoked anxiety in the past. Other effects may include changes in sleeping patterns, changes in habits, increase or decrease in food intake, and increased motor tension.

The emotional effects of anxiety may include "feelings of apprehension or dread, trouble concentrating, feeling tense or jumpy, anticipating the worst, irritability,

restlessness, watching for signs of danger, and, feeling like your mind's gone blank as well as nightmares bad dreams, obsessions about sensations, déjà vu, a trapped in your mind feeling, and feeling like everything is scary.

The cognitive effects of anxiety may include thoughts about suspected dangers, such as fear of dying. People may fear that chest pains are a deadly heart attack or that the shooting pains in the head are the result of a tumor or aneurysm. People feel an intense fear when they think of dying, or they may think of it more often than normal, or can't get it out of their mind.

Literature review

The prevalence of depression and pain comorbidity by Matthew J. Bair *et al.*, (2015). The prevalence of pain in depressed cohorts and depression in pain cohorts are higher than when these conditions are individually examined. The presence of pain negatively affects the recognition and treatment of depression. When pain is moderate to severe, impairs function, and/or is refractory to treatment, it is associated with more depressive symptoms and worse depression outcomes (example: lower quality of life, decreased work function, and increased health care utilization). Similarly, depression in patients with pain is associated with more pain complaints and greater impairment. Depression and pain share biological pathways and neurotransmitters, which has implications for the treatment of both concurrently. A model that incorporates assessment and treatment of depression and pain simultaneously is necessary for improved outcomes.

Individually, depression and pain symptoms are highly prevalent conditions encountered by primary care physicians and specialists.

Epidemiologic studies indicate that the lifetime prevalence of pain symptoms (example: joint pain, back pain, headache, chest pain, arm or leg pain, and abdominal pain) ranges from 24% to 37% and that physical symptoms such as pain are the leading reason that patients seek medical care. Major depression is also common, with prevalence in primary care patients of 5% to 10%. This underestimates the true impact of depression, since many more people have depressive symptoms but do not fully meet the major depressive disorder diagnostic criteria of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition for duration or number of symptoms. Depression has become the fourth leading cause of disability worldwide and is projected to become even more burdensome in the future.

Working status and anxiety levels of urban educated women in Calcutta by Mujumdar (2011). The primary objective of the present study was to assess the impact of out-of-home employment on anxiety levels of mothers. A study group of working mother's resident in Calcutta (India) was compared with a socioeconomically similar group of non-working mothers with respect to their anxiety level, measured by the Anxiety Scale Questionnaire, in terms of the total anxiety score and its various personality components. The possible relationships between anxiety score and age of these mothers as well as their children were studied. Non-working mothers showed higher anxiety levels than their working counterparts with respect to the total anxiety score as well as its components, although the differences were statistically non-significant. The anxiety scores of non-working mothers showed increasing values with increasing age of children. This trend was absent among the working mothers. The age of

these mothers was not related to their anxiety level.

Another research relevant to the same study was on anxiety among women in family by Bhattacharjee (2011). He studied on family adjustment of married working and non-working women. A specially developed adjustment inventory, a health-status questionnaire, a neuroticism scale, and an incomplete sentences blank to 76 married working and 70 married nonworking women. No significant differences in adjustment or neuroticism were found between the working and nonworking so, nor were any differences found on the incomplete sentences measure of psychological conflicts. It is concluded that a woman's adjustment, whether employed or not, is a function of her own personality traits, expectations, and perceptions combined with those of her spouse and family members. Canlon (1986) examined the sexual dysfunction and disorder patterns of 218 married working and nonworking women were compared in a retrospective analysis of couples presenting for sexual and marital therapy at the Masters & Johnson Institute. Results indicated that women who were pursuing careers of an ongoing, developmental nature were twice as likely to present with a primary complaint of inhibited sexual desire than women's who were employed in jobs that emphasized the immediate organization of activities) or women's who were unemployed outside of the home. "Career" women were also significant⁴ more likely to present with veganism's than the other two groups of subjects. "Job" and "Unemployed" women were more likely to complain of concerns related to orgasmic return than "career" subjects. The results were interpreted in terms of psychological and interpersonal stressors characteristic of married couples when wives pursue careers) and in terms of the impact of traditional values regarding

sexuality when wives are not involved in careers. Hashmi, Khurshid and Hassan (2007) conducted a study to determine the marital adjustment, stress and depression among working and non-working married women. Sample of the study consisted of 150 working and non-working married women. Their education was at least gradation and above. They belong to middle and high socio-economic status. Results indicated highly significant relationship between marital adjustment, depression and stress. The findings of the results also show that working married women must face more problems in their married life as compared to non-working married women. The results further show that highly educated working and non-working married women can perform well in their married life and they are free from depression as compared to educated working and non-working married women's.

Another research relevant to the study was conducted by Rani (2011), who studied the job role and performance of 140 married and educated working women (70% were graduates or postgraduates). Ages ranged from 20-55 yrs.; two-thirds of them were teachers. Interviews provided data regarding work atmosphere, working hours, length of service, performance on job, commitment to job, attitudes of the husband, employer, colleagues and members of the family and the so use of leisure time. Most of the participants had joined their jobs less than 10 years back, indicating recent sharp increases in the employment of women. Most felt that they carried out their jobs satisfactorily and were interested in but not too strongly committed to their work. Very few husbands had prejudices against working women, and most employers had positive reactions. The attitude of colleagues was generally helpful, and family members were generally supportive.

An overview of Indian research in anxiety disorders by Trivedi and Gupta (2010) shows that anxiety predates the evolution of man. Its ubiquity in humans, and its presence in a range of anxiety disorders, makes it an important clinical focus. Developments in nosology, epidemiology and psychobiology have led to significant advancement in our understanding of the anxiety disorders in recent years. Advances in pharmacotherapy and psychotherapy of these disorders have brought realistic hope for relief of symptoms and improvement in functioning to patients. Neurotic disorders are basically related to stress, reaction to stress (usually maladaptive) and individual proneness to anxiety.

Interestingly, both stress and coping have a close association with socio-cultural factors. Culture can affect symptom presentation, explanation of the illness and help-seeking. Importance given to the symptoms and meaning assigned by the physician according to their cultural background also differs across culture. In this way culture can affect epidemiology, phenomenology as well as treatment outcome of psychiatric illness especially anxiety disorders. In this review, an attempt has been made to discuss such differences, as well as to reflect the important areas in which Indian studies are lacking.

The word anxiety is derived from the Latin “anxieties” (to choke, throttle, trouble, and upset) and encompasses behavioral, affective and cognitive responses to the perception of danger. Anxiety is a normal human emotion. In moderation, anxiety stimulates an anticipatory and adaptive response to challenging or stressful events. In excess, anxiety destabilizes the individual and dysfunctional state results. Anxiety is considered excessive or pathological when it arises in the absence of challenge or stress, when it is out of proportion to the challenge

or stress in duration or severity, when it results in significant distress, and when it results in psychological, social, occupational, biological, and other impairment.

Materials and Methods

Aim

To study the level of Anxiety among working and non-working women.

Objectives

To understand the difference in level of anxiety among working and non-working women

Hypotheses

H1. There is significant difference in the level of anxiety among working and non-working women.

Period of study

The study was conducted from January 2016 to April 2016.

Plan

The present study was planned in such a way that the selected variables were compared with respect to the selected sample. It was further planned to obtain a sample of 60 subjects. The researcher procured appropriate tools as per the variable of the study. The obtained results were assessed according to the norms of the respective tests and with relevant techniques.

Variables of the study

The study involves both dependent and independent variable:

Dependent variable: Anxiety

Independent variable: Working and Non-working women

Tools for the study

General information schedule

Taylor Manifest Anxiety scale (1953)

General Information Schedule: This is a scale that includes personal details of the subject. It elicits responses for names, educational level etc. of the sample.

Taylor Manifest Anxiety Scale (1953): This scale is used to measure the levels of Anxiety among working and Non-working women

Sampling design

The present study involves of total 60 women from working and non-working women. Convenient sampling method was used. As this project is based on anxiety among working and non-working women, the researcher selected working women of various institution in Mysore, and non-working women through friends and acquaintances. Among the participants 29 (48.33%) were aged between 30 to 39 and

the 23 (38.33) were aged between 20 and 29. Among the working women population 4 (13.13%) of them were working in Bank sector, 17 (56.6%) of them were teachers and 7 (23.33%) were sales women.

The questionnaire administered was the general information schedule and Taylor’s Manifest Anxiety Scale. The following instructions were given to them. Look at the questionnaire given to you and fill in the general information schedule and subjects were instructed to fill the manifest anxiety.

This research is done to assess your anxiety level. There is no time limit but work as quickly as possible. After the instructions were given, the subjects could take the test after confirming that they have understood the instructions properly.

Results and Discussion

The above table shows that the mean of level of anxiety among working women is 19.97 and non-working women are 20.20. There is no much difference in their mean. It is seen that the t value is not significant. Hence the null hypothesis is rejected. It is found that there is no significant difference in anxiety among working and non-working women.

Table.1 Anxiety among working and nonworking women

Subject	N	Mean	SD	t value
Working women	30	19.97	1.32	0.17 ^{ns}
Non-working women	30	20.20	1.46	

ns - not significant

The present study was conducted within the aim of assessing the level of anxiety among working and non-working women in Mysore city. The results reflect that there is a comparable level of anxiety prevalent among working and non-working women.

The status of being employed or unemployed does not go to define or impact an individual’s anxiety. However, the nature of job as well doesn’t go to influence the level of anxiety. It is also essential to understand anxiety in the background of

several other factors such as personality, attitude towards life, responsibilities, experiences, ability to cope with stressful situations etc. these factors might be impacting an individual's level of anxiety and their physical health.

Therefore, extensive research in the same area will help the researcher to reach to better conclusions.

Limitation of the present study

The present study has certain limitations that need to be considered while considering the study and its result interpretation:

The respondents belong to different socio-economic status.

The age factors were not kept constant or equal throughout the sample.

The study was limited to only working and non-working women within Mysore city

The study is a minor project work on a sample of only 60 subjects.

The present study is not applicable for men as the total sample did not include men

The present Study included only three occupations i.e. Bank Employees, Teachers and Sales Women professionals. Therefore, these finding cannot be applicable for any other occupation nor can they be widely generalized.

Only Indian participants were taken for the research hence it is not universally applicable to other countries.

References

Caroline S. (2007). "A comparative analysis of the use of work-life balance

practices in Europe", *Women in Management Review*, 22(4), 289-304.

Cattell, R. B. (1973). *Personality and mood by questionnaire*. San Francisco: Jossey-Bass.

Chowhan, S., Jha, S., & Malviya, V. (2016). Anxiety in Working Women in Delhi: A Survey. Unpublished Article.

Cilli, A. S., Kaya, N., Bodur, S., Ozkan, I., Kueur, R. (2011). "A comparative analysis of the psychological symptoms observed in the working women and housewives." Retrieved from <http://www.aile.selcuk.edu.tr/text/article1.pdf>.

Diener, E., & Diener, M. (1995). Cross-cultural correlates of life satisfaction and self-esteem. *Journal of Personality and Social Psychology*, 68, 653-663.

Diener, E. and Fujita, F. (2005). Hedonism revisited: Life satisfaction is more than the sum of pleasant days. Manuscript under revision.

Diener, E. (1984). Subjective well-being. *Psychological Bulletin*, 95, 542-575.

Diener, E. (2000). Subjective well-being: The science of happiness and a proposal for a national index. *American Psychologist*, 55, 34-35.

Diener, E. (2000). Subjective well-being: The science of happiness and a proposal for a national index. *American Psychologist*, 55, 34-43.

Diener, E., and Diener, M., (1995). Cross-cultural correlates of life satisfaction and self-esteem. *Journal of Personality and Social Psychology*, 68, 653-663

Hughes, J., Bozionelos, N., (2007). "Work-life balance as source of job dissatisfaction and withdrawal attitudes", *Personnel Review*, 36 (1), 145-154.

Koyuncu M., Burke R., Fiksenbaum L. (2006). "Work experience and satisfaction of male and female professors in Turkey: signs of progress?" *Equal Opportunity International*, 25 (1), 38-47.

Lee, Y., Kleiner B. (2005). "How to use humour for stress management",

Management Research News. 28(11/12), 179-186.

Miller K., Clark D. (2008). "Knife before Wife": an exploratory study of gender and the UK medical profession", *Journal of Health Organisation and Management*, 22(3), 238 253

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