IJNRD.ORG

ISSN : 2456-4184

INTERNATIONAL JOURNAL OF NOVEL RESEARCH AND DEVELOPMENT (IJNRD) | IJNRD.ORG

An International Open Access, Peer-reviewed, Refereed Journal

A COMPARATIVE STUDY TO ASSESS THE LEVEL OF STRESS AMONG WORKING AND NON-WORKING WOMEN OF PREMENSTRUAL SYNDROME UNDER THE AGE GROUP OF 25-35 YEARS AT SRINIVASA RAO THOTA IN GUNTUR , ANDHRA PRADESH.

BY

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MASTER OF SCIENCE

IN

MENTAL HEALTH NURSING

KSR COLLEGE OF NURSING, GUNTUR

Dr. NTR UNIVERSITY OF HEALTH SCIENCES

VIJAYAWADA,A.P.

2018

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DISSERTATION SUBMITTED TO
Dr. NTR UNIVERSITY OF HEALTH SCIENCE,VIJAYAWADA
IN PARTIAL FULFILLMENT OF THE REQUIREMENT
FOR THE DEGREE OF MASTER OF SCIENCE

UNDER THE GUIDANCE OF
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ABSTRACT

BACKGROUND OF STUDY:

Premenstrual syndrome is a collection of emotional symptoms, with or without physical symptoms related to a women's menstrual cycle

The aim of the study is to assess the level of stress among working and non-working women of premenstrual syndrome under the age group of 25-35 years at srinivasarao Thota in Guntur, A.P.

Index terms - comparative study,premenstrual syndrome,stress levels,working and nonworking women

OBJECTIVES OF THE STUDY:

1.   To assess the level of stress among working and non-working women under the age group of 25-35 years.

2.   To Compare the level of stress experienced by non-working women with working women

3.   To Associate the differences of stress levels among working and non-working women in selected demographic variables

METHOD:

This was a descriptive comparative study, total 60 women from which 30 working and 30 non-working women who are attaining the menstrual period were selected through simple random technique. Data collected by structured questionnaire data was collected under 2 sections (socio-demographic data, knowledge questions regarding premenstrual syndrome stress. The reliability of the tool was established   .

Data was analyzed by using descriptive and inferential statistics in terms of frequency, percentage, mean, standard deviation, chi square values.

RESULTS:

Out of 60, 30 non working women of premenstrual syndrome among 30 nonworking women, 22(73.33%) were having mild stress & 08 (26.67%) were having moderate stress. Among 30 working women of premenstrual syndrome. Among 30 working women, 14(46.66%) were having severe stress, 11 (36.67%) were having moderate stress and 5(16.67%) were having mild stress. Comparison of stress level of both working and nonworking women. The mean knowledge value of non working women is 13.60 with standard deviation of 3.552. The mean percentage is 45.33%. The mean knowledge value of working women is 17.06 with standard deviation of 4.6542. The mean percentage is 56.86%. The unpaired t' value is 3.1839.Hence there is a significant difference in knowledge levels between working and nonworking women.

INTERPRETATION or CONCLUSION:

There is no significant association between stress levels and demographic variables of age, religion, income, marital status, occupation and source of information. There is a significant association between stress levels and demographic variables of education and working hours per day.

ACKNOWLEDGEMENT

An individual can achieve the aim only when he or she is being assisted and supported by others. In the course of this research I have been fortunate enough to receive continuous assistance and support from various sources which helped me on to the successful completion of this venture.

I take this opportunity to express my gratitude to the people who have helped, encouraged, guided and pushed me on to this accomplishment.

It is a joy for me to express my heartfelt gratitude to the management of Kavuri Subba Rao College of nursing, Guntur who gave us a golden opportunity to conduct a research project, as partial fulfillment towards masters of nursing program.

I express my sincere, wholehearted gratitude to the good administrator, empathetic and dynamic Director Mr.VijayChand, Kavurisubbarao college of Nursing, Guntur, I have been extremely fortunate to have them as our directors who has been an opportunity to start my education.

I express our sincere, wholehearted gratitude to the good administrator, empathetic and dynamic principal, Dr.Venkamma M.sc (N).,Ph.D.,professor, for her altruism and human approach that saw us through these days of experiencing our teaching troubles.

I express my heart full gratitude to Mrs.KrishnaPriya, M.Sc(N) Associate Professor of Mental Health Nursing, Kavuri Subbarao college of nursing, Guntur for her expert guidance, valuable and thought provoking suggestions & constructive criticism.

I extend my deep sense of gratitude to all the experts of different departments who have validated the questionnaire,for their judgements,constructive criticism and enlightening suggestions.

The statistical guidance always remains at the peak when it comes to quantum with the help extended by K.RAJARAO, statistician,Guntur, whose statistical assistance helped to complete the data.

I express my sincere thanks to Librarian Kavuri Subbarao College of nursing for her support and cooperation in collecting information for the study.

I express my gratitude to all the women who participated for exerting their cooperation without whom this study would have been impossible.

My heart full thanks to my parents and my friends for their moral support, inspiration and for upholding us in the prayers constantly.

Once again my heart full thanks & warm appreciation to all those who have directly or indirectly contributed towards the growth of this project with heartfelt and everlasting gratitude.

Ms. D.POORNIMA
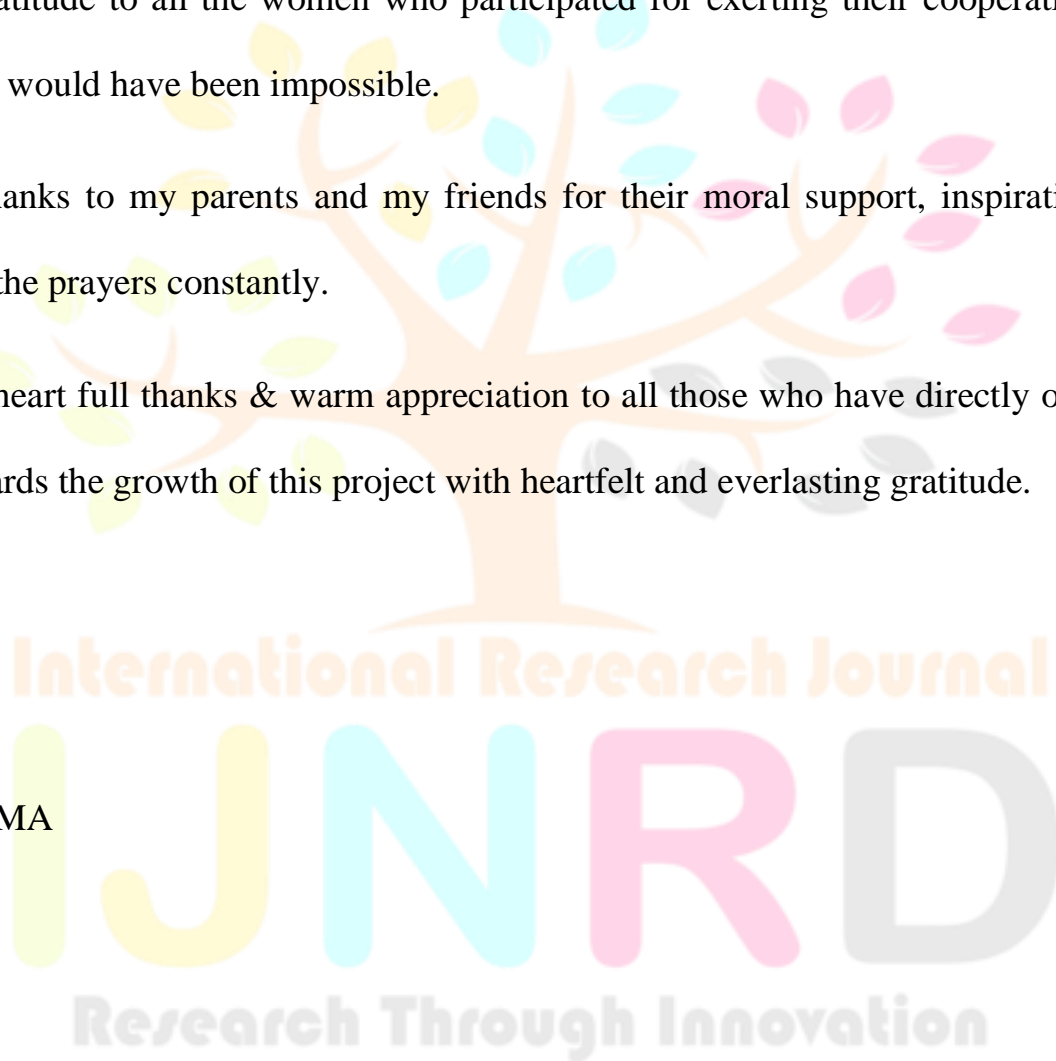
CHAPTER - I

INTRODUCTION

CHAPTER-I

INTRODUCTION

Stress is simply a fact of nature, forces from the inside or outside world affecting the individual. The individual responds to stress in ways that affect the individual as well as their environment. Because of the overabundance of stress in our modern lives, people usually think of stress as a negative experience, but from a biological point of view, stress can be a neutral, negative, or positive experience.

The word "stress" is defined by "Oxford dictionary of psychology" as "Psychological and physical strain or tension generated by physical, emotional, social, economic or occupational circumstances, events or experiences that are difficult to manage or endure.

The menstrual cycle is the regular natural change that occurs in the female reproductive system that makes pregnancy possible. The cycle is required for the production of ovocytes, and for the preparation of the uterus for pregnancy up to 80% of women report having some symptoms during the one to two weeks prior to menstruation

Menstruation stops occurring after menopause which usually occurs between 45 and 55 years of age. Bleeding usually lasts around 2 to 7 days. The word "menstruation" is etymologically related to "moon". The terms "menstruation" and "menses" are derived from the Latin *mensis* (month), which in turn relates to the Greek *mene* (moon)In a number of countries, mainly in Asia, legislation or corporate practice has introduced formal menstrual leave to provide women with either paid or unpaid leave of absence from their employment while they are menstruating .

For centuries, and still at present, the social history of premenstrual syndrome (PMS) and phenomena is entangled with the social history of gender relations. [1]In early 1980s PMS became a household term. Popular press articles told women how to "beat the Blues", "overcome the menstrual uglies" and negotiate interpersonal relations during those times of month. Clinicians and researchers met at international conferences to discuss definition, etiology and possible treatment of a syndrome estimated by some to affect 80% of women. Feminist and legal scholars debated the validity of the term and its use as a defense for criminal behavior. Premenstrual Tension (PMT), as PMS was first termed, has been in medical discourse since Frank (1931) associated it with hormonal imbalances. [2]

The premenstrual syndrome (PMS) was first described in 1931 by Frank and Horney, who speculated on the possible pathological origins of the condition and on some forms of treatment [3]

The World Health Organization's (WHO) International Classification of Disease, 10th edition includes premenstrual tension syndrome in its section of gynecologic disorders, as a disorder of the female genital organs

Premenstrual syndrome (PMS), also called premenstrual tension (PMT) is a collection of emotional symptoms, with or without physical symptoms, related to a woman's menstrual cycle.PMS symptoms are usually not very severe, and most women cope well with them. But some women have such severe PMS that they are unable to go about their everyday lives during that time. If that is the case, various treatment options are available.

Premenstrual syndrome is a set of physical and psychological symptoms that start about 7 to 10 days before a woman gets her monthly period (menstruation). Many women experience breast tenderness and abdominal pain. Other symptoms include headaches, back pain and joint or muscle ache. They may also have water retention (bloating) and sleeping problems or digestive problems... The cause of PMS is unknown. Some symptoms may be worsened by a high-salt diet, alcohol, or caffeine. The underlying mechanism is believed to involve changes in hormone levels. Reducing salt, caffeine, and stress along with increasing exercise is typically all that is recommended in those with mild symptoms. Calcium and vitamin D supplementation may be useful in some. Anti-inflammatory drugs such as naproxen may help with physical symptoms. In those with more significant symptoms birth control pills or the diuretic spironolactone may be useful.

For the women who took part in the study for more than one cycle, symptoms corresponded with changes in their stress level. For example, women who felt stressed in the weeks preceding one cycle but didn't feel stressed during the other cycle, tended to have more pronounced premenstrual symptoms after the cycle in which they reported stress. Women with high stress preceding both cycles were 25 times more likely to report moderate to severe symptoms than were women with low stress preceding both cycles.

The researchers couldn't rule out that anticipation of pain and other symptoms might add to a woman's stress level and result in more severe symptoms. However, they sought to compensate for this possibility by administering the questionnaires on stress early, during the symptom-free parts of the women's cycles, when they were less likely to be anticipating severe symptoms.

A number of medications are used to treat the symptoms of premenstrual syndrome, said study author Mary Hediger, PhD, also of the Division of Epidemiology, Statistics and Prevention research. These include diuretics, pain killers, oral contraceptive pills, drugs that suppress ovarian function, and antidepressants

Women are socialized to be the caretakers of others. More women than men have both a career outside the home and continue to try to juggle traditional responsibilities after hours. Over 70% of married women with children under the age of 18 are employed outside the home. A new study has found that a significant number of working women are taking sick days because of PMS. A third of us take four or more sick days a year because of severe discomfort.

Even worse, we're anxious about calling in sick. Nearly half (46 per cent) are too scared to reveal the reason they need a day off. While a quarter (24 per cent) think period symptoms just won't be taken seriously by their employer.

And really – would they? How many of us would feel totally fine calling up our male bosses and telling them we can't come to work because our breasts are too tender and our insides feel like they're being pounded?

Precisely.

This is something that goes across all professions, too. Only last week, former Wimbledon champion Petra Kvitova spoke about how 'difficult' it is to play big tournaments at the time of the month. And Britain's Heather Watson has attributed her Australian Open loss earlier this year to PMS symptoms (when you're playing in a grand slam, the option of a sick day isn't really there).

In the Women's section, we often write about periods being taboo. But to be faced with hard evidence that they're harming women's career prospects is deeply concerning. This isn't just a debate about whether we should, or shouldn't hide our tampax when walking past colleagues on the way to the ladies.

This is a watershed moment for all employers. Because if period pain is causing female staff stress – as well as cramping – our health, happiness and jobs could be seriously at risk.

I have previously written that women don't need menstrual leave. Last year, Harley Street professor of obstetrics and gynecology, GedisGrudzinskas, said that paid days-off during our periods would boost women's motivation and productivity. "Some women feel really gritty when menstruating. Coming into work is a struggle and they feel lousy. When you feel like that, it's harder to take pride in your work or perform as well. This is about employers being sensible and aware," he said.

He suggested that three days a month would cover it – in addition to an employee's illness entitlement. Well, I stick by my argument – periods are not a sickness. They are a natural process. We can't force half the population to hide away at home like hermits, quietly shedding their womb lining in confinement.

Compulsory menstrual leave is not the answer. Yes, many women suffer horribly with physical and emotional symptoms – but we need support, not to be put in solitary.But, there's clearly a need for greater understanding by employers.

Sociologists describe women as struggling to achieve the "male standard" at work, while trying to maintain the perfect wife and mother standards at home. Women are also less likely to be in as powerful positions as men to change their environment. Women find it harder to say no to others' requests and often feel guilty if they can't please everyone. They often spend less time nurturing their own emotional and physical needs, as that might be perceived as selfish. In addition, relationship alterations or the loss of loved ones can produce empty nests or other separation syndromes. As women progress through life's stages, hormonal balance associated with premenstrual, post-partum and menopausal changes can affect chemical vulnerability to stress and depression together which consequently results in severe headache and irritability. Women may also have irregular monthly cycles, high blood pressure, stomach ulcers, etc., due to stress.

Even though you may not be planning an adventure around the world, stress and anxiety can still take a toll on you – and your period. Although some stress can be good and even help us challenge ourselves, too much can negatively impact health. The body is sensitive to any unexpected disruptions. Excessive worrying can put the digestive system into overdrive, causing stress

symptoms like diarrhea, frequent urination, and abdominal pain; the pulmonary system may respond with rapid breathing. The female reproductive system can be affected, too.

In fact, for some women, stress may play a role in causing irregular or missed periods. As stress levels rise, there's a chance that your menstrual period will temporarily stop, a condition known as secondary amenorrhea.

Not much is known about the relationship between stress and periods. However, stress certainly plays a role in suppressing the functioning of the hypothalamus, which controls the pituitary gland — the body's master gland — which, in turn, controls the thyroid and adrenal glands and the ovaries; they all work together to manage hormones. Ovarian dysfunction may lead to problems with estrogens production, ovulation, or other reproductive processes. Estrogens are important hormones that help build the uterine lining and prepare the body for pregnancy. If the ovaries aren't working properly, side effects may involve the menstrual cycle, including missed periods or irregular periods.

Most women of reproductive age may feel more physiological and/or emotional discomfort in the week before the menses. These symptoms can vary between individuals and have the potential to affect work, personal life, and place additional stress on a relationship. In all, 30%–40% of women of reproductive age suffer from the more severe premenstrual syndrome (PMS) and 3%–8% suffer from premenstrual dysphoric disorder (PMDD), which is the more serious variant of PMS. The symptoms of PMS cover emotion, physiology, and behavioral fields and can be related to the menstrual cycle. These symptoms typically occur in the premenstrual or luteal phase of the

menstrual cycle and tend to vanish in or near the end of the cycle. The exact etiology of PMS is unknown, but it may be related to hormone variations. Some theories state that PMS is not caused by abnormal concentration of gonadal steroids but more likely by variations in levels of the sex hormones. The differences between women with and without PMS may also be explained by increased sensitivity to variations in levels of sex hormones. Moreover, some studies showed that the onset and course of PMS are related to stress.

The variations in hormone levels across the menstrual cycle cause an increase in negative emotions in women and can influence mood regulation and sensitivity to stress. Specifically, women have stronger responses to stressors before the menstruation or in the luteal phase, which may increase the risk for negative emotions or moods, suggesting stress may strengthen PMS symptoms. Lustyk et al made a distinction between a "high symptom" group and a "low symptom" group in women with PMS (N=114) on the severity of PMS symptoms. Their results showed that, compared with the low symptom group, the high symptom group reported more stressful experiences. Previous studies have also found that stressful experiences of women with PMDD before the menses were mainly related to a higher stress sensitivity.

PMS affects the daily lives of women and can deteriorate their quality of life and social skills . The severity of PMS symptoms is associated with its duration in how it impairs the daily lives of women. The physical symptoms of PMS, such as irritability and muscle, joint, back, and abdominal pain, are more prevalent than the mental symptoms. These symptoms are cyclic; however, their severity and extent can vary. PMS also negatively affects a woman's sleep quality. Several scales are used to determine the level of severity as well as the diagnosis of PMS. The development of the

Premenstrual Syndrome Scale (PMSS) was based on DSM-III and DSM-IV-R, and is a reliable scale for measuring the severity of premenstrual symptoms.

Work-related quality of life can be described as the physical and mental perceptions of an employee about their working conditions and factors associated with the workplace. These conditions and factors include: working hours, salary, physical conditions, career possibilities, and interpersonal relationship . A woman's quality of life is strongly affected by both her social life and her working life. However, quality of life measurements at work are difficult when using generic quality of life scales. The Work-Related Quality of Life Scale (WRQoL) was developed by Van Laar et al for measuring work-related quality of life. The WRQoL scale can be used as a key performance indicator for workers with high levels of education.

Various biosocial and psychological causes have been proposed as the cause of the syndrome, including abnormal serotonin function, presence of progesterone, altered endorphin modulation of gonadotropins secretion, exercise habits, smoking, use of alcohol, altered trans capillary fluid balance, and a diet rich in beef or caffeine containing beverages. Adiposity may also be related to PMS through a variety of hormonal, neural, and behavioral mechanisms, and several studies have found women with PMS or menstrual symptoms more likely to be overweight and obese than women without PMS.PMS is not real life threatening but it can seriously alter the quality of life of many women and affect their productivity and mental health. The number of women seeking treatment for premenstrual symptoms is on the rise.

Therefore, in this study, the frequency and severity of PMS among female adolescents and young adults in El-Minia University, Egypt, is studied. They are already under a lot of academic-related stress, and therefore there is a need to explore the PMS problem and the added stress that could

impact them which may jeopardize their quality of life and negatively affect activities of daily living. The potential association between the manifestations of PMS as dependent variables and diet, BMI, and demographic and behavioral factors as independent variables was determined to use the information in tailoring counseling sessions regarding lifestyle modification to improve PMS.

A healthy lifestyle is the first step to managing PMS. For many women, lifestyle approaches are often enough to control symptoms. The following is an example of a lifestyle modification advice.(i)Drink plenty of fluids (water or juice, not soft drinks, alcohol or other beverages with caffeine) to help reduce bloating, fluid retention, and other symptoms.(ii)Eat frequent small meals, leave no more than 3 hours between snacks, and avoid overeating.(iii)Eat balanced diet with extra whole grains, vegetables, and fruit and less or no salt and sugar.(iv)A health care provider may recommend nutritional supplements as vitamin B6, calcium, and magnesium.(v)Get regular aerobic exercise throughout the month to help reduce the severity of PMS symptoms

NEED FOR THE STUDY

The fact that women's participation in India's workforce is miserable, possibly fails to shock anyone anymore. From India's own census data and government surveys to studies conducted by various agencies, it has been firmly established that there's a very long way to go before as many women start working in India, as men. Findings of the National Sample Survey (68th Round) results indicated that in 2011-2012, 24.8 of every 100 women worked in rural areas. The corresponding number when it came to men was 54.3. Women's participation was drastically less in urban areas. To every 54.6 employed men, there were just 14.7 working women. The NSSO collected information from over 100,000 households between July 2009 A study aimed at investigating the two cyclic traits of seasonal affective disorder and premenstrual syndrome (PMS) with respect to

bipolar I and II disorders as well as evaluating the association between them among 61 female patients with bipolar I or II disorders and 122 healthy women. The prevalence of moderate to severe PMS as indicated on the PSST was also significantly higher in bipolar II disorder patients (51.6%) as compared to controls (19.7%). A significant association between seasonality and PMS was observed in both patient and control groups.The results suggested that female patients with bipolar disorder experience seasonal and premenstrual changes in mood and behavior regardless of their mood episodes, and traits of seasonality and PMS are associated with each other.[19]

A study was carried out to assess the impact of premenstrual symptomatology on functioning and treatment-seeking behavior for a community-based sample of women. Out of 1045 menstruating women (aged 18-49) completed a telephone questionnaire that measured, at a point in time, premenstrual symptoms, impact on functioning, and treatment-seeking behavior. Irritability/anger,fatigue, and physical swelling/bloating, or weight gain were among the most commonly reported symptoms (approximately 80%). Among working women, over 50% reported at least somewhat affected occupational functioning. Treatment with selective serotonin reuptake inhibitors (SSRIs), which have demonstrated efficacy in this population, occurred with surprisingly low frequency. The functional impairment of premenstrual symptomatology (home, social, and occupational) and treatment-seeking behavior is consistent. This suggests significant unmet medical need in this more severely affected population. Improved clinical identification of these women and increasing awareness of the efficacy of SSRIs in treating premenstrual symptomatology may be of benefit.

According to the 1,081-page report, as of 2010, India had an estimated 112 million female workers. "Health is a positive state of well-being, people are in a state of emotional, physical and social well-

being, fulfills their responsibilities, functions effectively in daily life and are satisfied with their interpersonal relationships and themselves." According to WHO.

The pre- menstrual period is one of the crucial periods in adolescent girls, the reported prevalence of about 20-40 % shows that a significant group of women may be affected by premenstrual syndrome. Reports of premenstrual syndrome among adolescents in western countries indicate a prevalence ranging from 14 to 30 percent. The incidence and prevalence of stress levels of the premenstrual syndrome are worldwide 91%, India 47.8%, Andhra Pradesh 60%-73%.The symptoms like mood depression feeling of hopelessness lethargy and excessive fatigability may create serious negative consequences for the adolescents, their families and their social relationship including low self-esteem, low tolerance to stress and feeling of inadequacy. The consequences necessitate the adolescents learning to control their premenstrual symptoms.

A study revealed the following symptoms:

● marked depressive mood, feeling of hopelessness or self depreciation thoughts 77.7%

● difficulty of concentration 65.8%

● marked change in appetite ,over eating or specific food craving 82.8 %

● affective lability ,with sadness tearful and increased sensitivity to rejection 65.8%

● hypersomnia or insomnia 59.7%

● lethargy, excessive fatigability 91.6%

● breast tenderness ,swelling headache ,joint muscular pain and a sensation of bloating and weight gain 81.9%

- the most severe symptoms were fatigue and irritability 73.9%

Up to 80% of women report having some symptoms prior to menstruation.These symptoms qualify as PMS in 20 to 30% of pre-menopausal women. Premenstrual dysphoric disorder (PMDD) is a more severe form of PMS that has greater psychological symptoms. PMDD affects three to eight percent of pre-menopausal women. Antidepressant medication of the selective serotonin reuptake inhibitors class may be used in addition to usual measures for in PMDD.

Women who reported feeling stressed two weeks before the beginning of menstruation were two to four times more likely to report moderate to severe symptoms than were women who did not feel stressed. We were interested in identifying factors that might predict who might be most at risk for having more severe symptoms," said Audra Gollenberg, Ph.D., a postdoctoral fellow in NICHD's Division of Epidemiology, Statistics and Prevention Research. "It may be possible to lessen or prevent the severity of these symptoms with techniques that help women to cope more effectively with stress, such as biofeedback, exercise, or relaxation techniques."

The current analysis was part of the NICHD's BioCycle Study, directed by Enrique Schisterman, Ph.D., also an author of the current article. The BioCycle Study seeks to examine ovarian functioning during the course of the menstrual cycle in healthy women. The researchers administered questionnaires to 259 women ages 18-44 who did not have any long-term health conditions, and who were not using oral contraceptives or taking any other hormonal formulations.

Each woman was provided with an at-home fertility monitor to follow the phases of her monthly cycle. The women completed questionnaires about their stress levels for each of the four weeks of their cycle. Items on the survey included:

●   How often have you felt unable to control the important things in your life?

●   How often have you felt nervous or stressed recently?

●   How often have you been able to control interruptions in your life?

Women ranked their responses according to a scale, ranging from never to fairly often. In addition to the weekly questionnaires about stress, the women also responded to questionnaires about their symptoms, in the week coinciding with ovulation, and the following week, during menstruation. Most of the women (250) took part in the study for two menstrual cycles. The remaining nine women participated for only one cycle. Women whose responses indicated they felt stressed were more likely to report moderate or severe levels of psychological symptoms, such as depression or sadness, crying spells, anger, irritability, and anxiety associated with menstruation. Similarly, women who felt stressed were also more likely to report moderate or severe levels of physical symptoms such as body aches, abdominal bloating, lower back pain, fatigue, abdominal cramping, headache, and cravings for sweet or salty foods. Overall, women reporting high stress levels were two to four times more likely to report moderate to severe psychological and physical symptoms during menstruation than were women who did not report high stress levels.

premenstrual syndrome, which can occur 7 -14 days before the onset of menstruation and subsides with the commencement of menstrual flow, affects girls during her reproductive age and is associated with physical, psychological and behavioral changes.

Investigator personally feels that there will be a problem stress levels of premenstrual syndrome among working and non-working women under the age group of 25-35 years help in terms of increasing adolescent girls knowledge, regarding premenstrual and menstrual symptoms, and

decreasing the incidence and severity of premenstrual and menstrual symptoms, gaining knowledge has been regarded as an important goal towards an improving individuals health status.A lack of knowledge can contribute to a variety of responses including anxiety and self-care deficit. The STP will increase knowledge and help in coping with such problems and reducing the symptoms of premenstrual syndrome.

PROBLEM STATEMENT:

"A Comparative study to assess the level of stress among working and nonworking women of premenstrual syndrome under the age group of 25-35 years at SrinivasaRaoThota in Guntur,AndhraPradesh"

OBJECTIVES:

1.   To Assess the level of stress among working and non-working women under the age group of 25-35 years.

2.   To Compare the level of stress experienced by non-working women with working women

3.   To Associate the differences of stress levels among working and non-working women in selected demographic variables

OPERATIONAL DEFINITIONS:

COMPARISON: A comparison of stress level among working and non-working women of pre-menstrual syndrome

ASSESS: To evaluate or estimate the stress level of pre-menstrual syndrome among working and non-working women

STRESS: Psychological and physical strain or tension generated by Physical, emotional, social, economic or occupational circumstances, events or experiences that are difficult to manage or endure.

WORKING WOMEN: A woman who is regularly employed

NON-WORKING WOMEN: A woman who is not employed for a salary, fees or wages or not engaged in or directed towards work

PREMENSTRUAL SYNDROME: Physical and emotional symptoms that occur in the one to two weeks before a woman's period

ASSUMPTIONS:

1. Working women may have more stress than non-working women.
2. The working women may manage the stress by work diversion
3. The non-working women may take rest and can be no more victims of stress.

LIMITATIONS:

1. The study is limited to the working and non-working women under the age group of 25-35 years.

2. It is limited to the women who are attaining the menstrual periods.

3. It is limited to women who are able to read and write Telugu.

4. It is limited to the women who are available at the time of data collection.

5. It is limited to women who are residing at Srinivas Rao Thota in Guntur.

DELIMITATIONS:

1.   Study is delimited to the women who are below 25 and above 35

2.   It is delimited to the women who are not attaining the menstrual period.

3.   It is delimited to the women who are not able to read and write Telugu.

4.   It is delimited to the women who are not available at the time of data collection.

5.   It is delimited to the women who are not residing at Srinivasa rao Thota in Guntur

CONCEPTUAL FRAMEWORK

The self-care deficit nursing theory by Orem (2001) was utilized as the theoretical framework for this research. The self-care deficit theory offers a meaningful perspective in the management of stress and how it can influence health outcomes including those related to the working and nonworking women. An individual who is capable of maintaining his or her own life, health, and wellbeing is defined as a self-care agent (Orem, 2001). According to Orem, adults are capable of self-care while infants, children, the elderly, and individuals in poor health may not be capable of self-care. Self-care is a human, learned behavior that has deliberate action. The self-care agency is

the attained capability to meet the requirements for self-care. Orem states that a self-care deficit exists when an individual is unable to meet his or her own self-care demands, requiring assistance from other resources in order to maintain a state of wellbeing.

The nursing system of care, or nursing agency, can be utilized at the time of a self-care deficit. Nursing interventions assist the self-care agent experiencing a self-care deficit to cope with the deficit, empowering this individual to maintain or improve his or her health state and thus return to a self-care agent. Orem states that wellbeing involves contentment, pleasure, and happiness and may include spiritual experiences that are important to the individual to maintain or improve the state of health (Orem, 2001).

The following is a necessary set of actions to meet the universal self-care requisites required by all individuals as described by Orem (2001): the maintenance of sufficient intake of air, water, and food; regulation of elimination processes; maintenance of activity and rest balance; maintenance of solitude and social interaction balance; prevention of hazards to life, functioning, and well-being; promotion of normalcy. This study identified specific areas of action where nursing interventions could be incorporated to assist the working and nonworking women to meet her self-care requisites. For this particular study, the self-care agent is identified as the working and nonworking women (Figure 1). The self-care agency is the ability to perform the needed daily activities. The working and nonworking woman may experience changes in her lifestyle related to the stress associated with the working hours of premenstrual syndrome. Stress alters an individual's state of wellbeing in that it alters levels of contentment, pleasure and happiness. An actual or potential self-care deficit exists when a woman needs assistance to reduce stress associated with a premenstrual syndrome and to participate in health promoting behaviors. The bold arrow seen on Figure 1 demonstrates that nursing can assist in alleviating the self-care deficit of the working and nonworking woman by

implementing interventions aimed at reducing stress, such as health promoting self-care behaviors. The fundamental goal of all interventions related to the working and nonworking woman is maintaining and/or improving the outcome of her health and pregnancy. As nursing intervenes to assist the self-care agent to reduce or diminish the self-care deficit, this empowers the woman to regain the ability to care for herself.

The hyphenated line on Figure 1 displays the fact that nurses can use preventative methods with self-care agents in the future to preclude a self-care deficit from occurring.
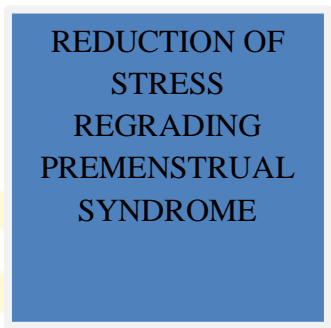
This research study is beneficial to future prevention of self-care deficits as the women in the study identify areas where nursing assistance is needed.
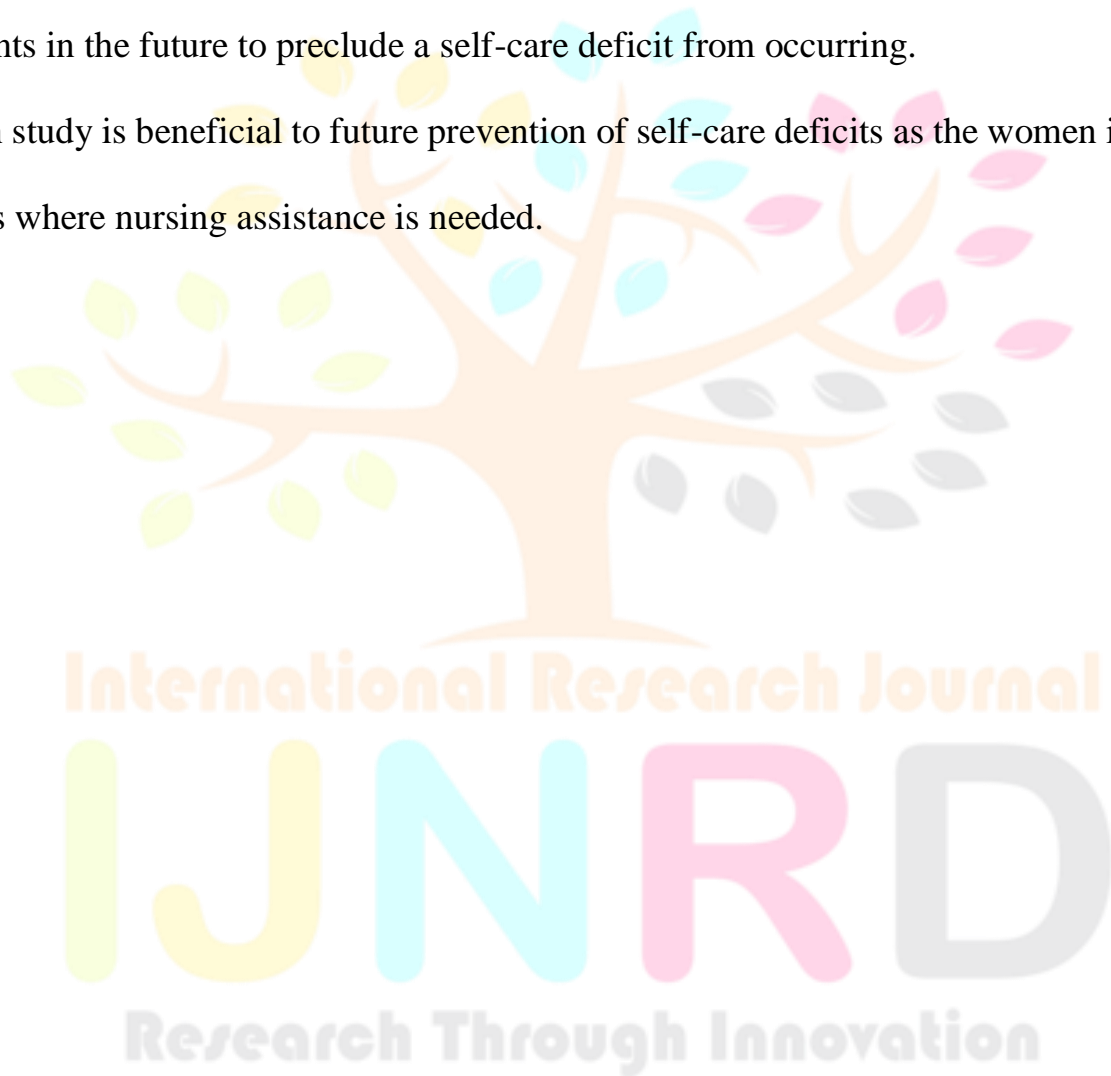
SELF CARE AGENT
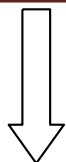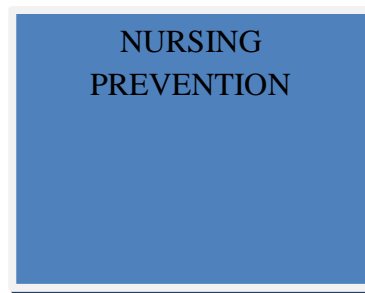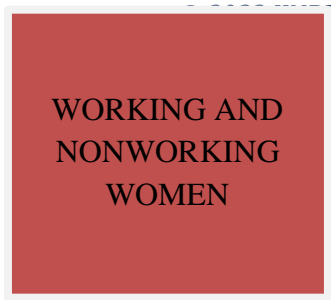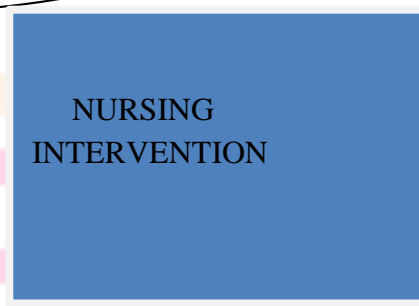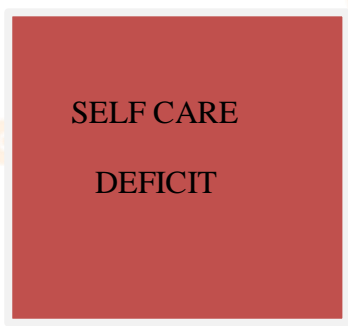
The Relationship between Self-care Agent and Self-care for the working and nonworking women: **Conceptual Model**

CHAPTER – II

REVIEW OF LITERATURE

CHAPTER-II

REVIEW OF LITERATURE

Review of Literature is a vital aspect of scientific research; it involves symptomatic identification of research problems. The role of the literature is to formulate and clarify the research problem, provide information on previous works, make available conceptual text , facilitate accumulation of scientific knowledge and lead to suggestions for methodology to be followed in the new research study concerned.

This chapter presents a review of literature related to the present study. Scientific research cannot add to human knowledge if it is conducted in isolation from other scientific efforts.

The review of literature means a systematic and critical review of the most important published scholarly literature on a particular topic (Carol Johnson 1992). Review literature is an important aspect of any research project from the beginning to the end. It gives great insight into the problem, helps in selecting methodology and developing tools and analyzing data.

Review of literature collected under following

Buddhabunyakan and et.al(2017): a prospective study conducted among menstruating high school students in KhonKaen, Thailand, from September to December, 2015. Participants were asked to prospectively complete an anonymous questionnaire, which included information about demographic data, menstrual patterns, and symptoms to be recorded on a daily calendar of premenstrual experiences according to the diagnostic criteria proposed by the American College of Obstetricians and Gynecologists. All of the data were prospectively recorded for 90 consecutive days. Result of the 399 participants, 289 (72.4%) completed the self-report questionnaire. Eighty-six participants (29.8%; 95% CI, 24.5%–35.4%) reported having PMS. The most common somatic and affective symptoms among participants with PMS were breast tenderness (74.4%) and angry outbursts (97.7%). There were significant differences between the PMS and non-PMS groups, and PMS was associated with various problems related to educational activities, including lack of concentration and motivation, poor individual work performance, poor collaborative work performance, and low scores. However, there were no significant differences regarding interpersonal relationships between the PMS and non-PMS groups.

CamyBhagat ,Parashurama(2016): A descriptive study was conducted among women to assess the premenstrual syndrome and coping behavior among them. A total of 248 women were selected for collection of data. The questionnaire consisted of two parts. Part one is assessment of

premenstrual syndrome and part two is for a checklist on coping behavior. The most common (79.43%) out of 248 having lower abdominal pain, (66.12%) having backache, (52.01%) having low efficiency of work performance. Majority of them were using healthy coping strategies. (89.11%) do not blame themselves for this problem, (75.40%) accept it as nothing can be done, (98.11%) take hot or cold drinks.

Mengying etal.(2016):the current study was to test whether women with premenstrual syndrome (PMS) had difficulties in emotion regulation. In Study 1, we investigated the relationship between the habitual use of emotion-regulation strategies and the severity of PMS ($n = 230$). The results showed that the severity of PMS was negatively associated with the habitual use of reappraisal, but positively associated with the habitual use of suppression.

In **Jan. - Feb. 2016** a survey study conducted in India among 50 young and 50 middle aged women of S.B.K.S Medical Institute and Research Centre to find the prevalence of premenstrual syndrome with an emphasis on its management. It was found that 42% faced PMS regularly, while 58% occasionally. Of the 100 participants 68% suffered with backache, 64% leg cramps, 62% fatigue, and breast tenderness and anger whereas 58% suffered with anxiety and generalized body ache. Of all the sufferers only 34% had received the treatment for PMS. Irrespective of the age PMS is a common problem faced by womens . Another study conducted to assess the problems related to menstrual problems in adolescent girls in New Delhi, revealed that drowsiness (92%), irritability (90%), low noise tolerance (68%), anxiety (68%), and decreased libido (85%). The most prevalent somatic symptoms are abdominal distension, seborrhea, headache, and vomiting, cardiac arrhythmias, vascular lesion.

In **2013-2014** The present study aimed to determine the prevalence of premenstrual syndrome in university students of Sis tan and Baluchestan University (Iran) in the academic year 2013-2014. Two hundred and one female university students living in dormitories were randomly selected. The subjects completed two questionnaires of Demographic Information and Symptom Assessment based on the criteria of ACOG and DSM-IV. Results: According to the mentioned criteria, "36.3%" of subjects suffered from Premenstrual Dysphoric Disorder (PMDD) and "85.6%" of subjects indicated the symptoms of PMS. The severity of PMS in 14(%7) subjects was high. Of 86 and 72 subjects "42.8%" and "35.8%" were moderate respectively, it was mild. Among university students, the most common mood symptom (emotional) and somatic symptom (physical) were fatigue and lethargy and abdominal pain ("72.6%" and "62.7%", respectively)

A very recent study by **Brahmabhatt et al (2013)** revealed the prevalence of premenstrual symptoms among young girls and middle-aged women to be 100% but the severity and number of symptoms varied. Young girls had a higher frequency of acne(54%),food cravings(38%)and pains, whereas mood swings were more common in middle aged women(48%).

In **2010 Patil and WasnikWadke** studied health problems amongst adolescent girls in rural areas of Maharashtra, India and found that the majority of the girls had one or the other problems related to their menstrual problems. Dysmenorrhea (44.2 %) was the commonest problem stated by adolescent girls and more than 50% of the study subjects had one or the other symptoms of PMS.

In **2010 Sharma, Malhotarc, Taneja and Saha** studied the type and frequency of problems related to menstruation among adolescent girls in New Delhi, India. The results revealed that dysmenorrhea (67.2) was the commonest problem and 63.1% had one or other symptoms of PMS. Daily routine of 60% of girls was affected due to prolonged bed rest, missed social activities /commitments,

disturbed sleep and decreased appetite. Seventeen percent had to miss a class and 25% had to abstain from work. Mothers and friends were the most common source of information on the issue.

In **2010 Choi et.al.,** Population based online survey regarding PMS was conducted among 1000 Korean women aged 15-49 years. The result revealed that prevalence of PMS/ PMDD by the WHO International classification of diseases (ICD-10), ACOG, and DSM IV was 98.6, 32.1 and 2.8% respectively and the proportion of women with 29 impaired activities of daily life were significantly associated with the severity of PMS and also mentioned most of the women (91.5%) had no knowledge regarding terminology pertaining to PMS

In **2010** Karthiga, Abhijit Borate, ShibSekharDatta, SubaJoice, Sherin Billy Abraham and Anil Purty conducted a study on menstrual problems and pattern of consultation among adolescent school girls in Pondicherry, India. Results revealed that 193 (52.02%) girls had experienced dysmenorrhea and 150 (40.43%) 27 reported passing of clots in menstrual flow. 272 (73.32%) girls stated that they had some or other kind of menstrual problem since menarche. Eleven (2.96%) girls had menses for the first time (just prior to survey) and were unable to comment on duration of menstrual cycle and regularity. Two-third (66.39%) girls had menses for the duration from 1-5 days while rest reported beyond 5 days. Three-fourth (75.83%) of the study subjects had a regular menstrual cycle. Out of 272 adolescent girls who had faced menstrual problems, 73 (26.84%) had sought consultation. Majority 43 (58.09%) girls had consulted doctors and 3 (4.12%) girls had consulted health worker while 25 (34.25%) girls had discussed their problem with their mother and concluded that there is an urgent need for strong health educational activities among the adolescent girls, their parents and teachers for effective management of menstrual problems among all adolescent girls.

In **KSA (2009)**, in the area of Al Ahsa, cross sectional study was done about the phenomenology of PMS in female medical students. The research was conducted over a six month period. 288 questionnaires were distributed, 271 were filled, of the 250 students approached PMS was diagnosed in 89 (35.6%) using the ACOG criteria. PMS had a significant trend for older age, rural residence, unstable family income, and earlier age of menarche, more regular cycles and positive family history of PMS [19].

In November-December 2008, a study to assess the prevalence of premenstrual symptoms, Premenstrual syndrome and Premenstrual Dysphoric Disorder in a sample of Spanish women of fertile age, was approached as representative of the general Spanish population. 2108 women participated, they were personally interviewed at home and completed the PSST (premenstrual symptoms screening tool). 73.7% complained of some of the premenstrual symptoms during the last 12 premenstrual cycles. 91.0% of women (1415) presented isolated premenstrual symptoms and (8.9%) of them presented a moderate/ severe premenstrual syndrome. Only 1.1% fulfilled criteria for a diagnosis of PMDD [17].

In 2008 A descriptive study was conducted among nursing students, NINE, PGIMER, Chandigarh during the month of February 2008 to assess the premenstrual syndrome and coping behavior among them. A total 248 students from all classes were selected for collection of data. The questionnaire consisted of two parts. Part one is assessment of premenstrual syndrome and part two is for a checklist on coping behavior. The most common (79.43%) out of 248 students had lower abdominal pain.(66.12%) having backache, (52.01%) having low efficiency of work performance. Majority of students were using healthy coping strategies. (89.11%) do not blame themselves for this problem, (75.40%) accept it as nothing can be done 181 (98.11%) take hot or cold drinks.

In **2007-2008-USA** an American study was conducted in Chicago ,1246 women aged 13-55 years using a random sampling procedure were studied, they completed daily symptoms questionnaires and screened for psychiatric disorders by trained interviewers. Result in final analysis. 1.3% met criteria for DSM-IV diagnosis [14]. A comparison of prevalence of PMDD and co-morbidities among adolescents in the United States and Nigeria-a research approached in 537 patients attending outpatient clinics (cross-sectional survey), in 3 sites, the mean age (13-21) years. The overall prevalence of PMDD was 4.1% (Maiduguri, Nigerian 6.5%, Lagos N 3.1% and 2.9% in Akron, USA [15]

In **2006 Houston, Abraham, Huang and Angelo** stated that PMS was the most prevalent reported menstrual disorder (84.3%) followed by dysmenorrhea (65%). Only 2% of teens reported receiving information about menstruation from their health care provider. Negative expectations regarding menstruation were associated with higher rates of school absenteeism and missed activities.

In **2006 Lee, Chen, Lee and Kaur** carried out cross sectional descriptive study among 2,411 secondary school adolescent females in Negeri Sembilan, Malaysia. The study found that the majority (74.6%) experienced PMS and 69.4% had dysmenorrhea . Only 11.1 percent of school girls seeked medical consultation for menstrual disorders.

In 2005, in Iran, a cross-sectional study was carried out among female students, aged 18-27 years to assess the frequency of premenstrual symptoms and prevalence of Premenstrual syndrome among Iranian women. 300 students were asked to complete a questionnaire assessing PMS, which was derived from DSM-IV diagnostic criteria for PMDD. The result was: 98.2% reported at least one

mild to severe premenstrual symptom. 16% met the criteria of DSM-IV for PMS. Most common symptoms were feeling of sadness or tearfulness (70.3%), anxiety (70%), backache (69%), sleep problems (66%), depressed mood (72.4%) [21]. There was a significant difference for severity of symptoms with younger women compared to older women.

In 2004 a research study was also studied in India, to determine the prevalence of premenstrual symptoms in premenopausal age. Women attending Health Care programmer (HCP) for women around 40 years of age were included in the study. Last 200 women who attended form April 2002 to October 2004 were included for analysis, out of these 107 qualified for final analysis.

In **2003** this was a cross-sectional population-based study, involving 1,395 women aged 15 to 49 years old in a medium-sized municipality in Southern Brazil, carried out in 2003. Questionnaires were applied to measure the prevalence of premenstrual syndrome by means of a score based on five premenstrual symptoms that interfered with family life or led to absence from work or school. Associations with socioeconomic, demographic and behavioral variables were investigated. Self-reported syndrome was investigated with regard to its sensitivity and specificity, taking the score as the gold standard. The statistical analyses performed were Pearson c^2, Mantel-Haenszel and Poisson regression, with Kappa coefficients to verify the concordance of the responses. The obtained prevalence was 25.2% (95% CI: 22.5-27.9) and the self-reported prevalence was 60.3% (95% CI: 57.4-63.3). The principal premenstrual symptoms found were: irritability, abdominal discomfort, nervousness, headache, fatigue and breast pain; all of these showed prevalence of over 50%. Higher risk was presented by women of higher socioeconomic level, better schooling level, aged under 30 years and with white skin color. Psychotropic drug users and women who were not using any

hormonal contraceptive presented higher prevalence of the syndrome. The sensitivity of the test was 94%, specificity 51% and accuracy 62%.

In 2002 a research project was conducted in Ethiopia, Jimma University . It was aimed to assess prevalence of PMS and its effect on academic and social performances of students in Jimma University. A cross sectional study was conducted among 242 randomly selected female students. A structured and pretested self-administered questionnaire was employed for data collection. The criteria proposed by the DSM-IV were used to diagnose PMS. The age of participants ranged from 17 to 38 years. Results: Almost all (99.6%) had at least one premenstrual symptom in many of the menstrual cycles in the last 12 months. The prevalence of PMS or PMDD was 27% (according to DSM-IV criteria). About 14% of the study participants frequently missed classes and 15% missed examinations or scored a lower grade at least once because of PMS. The study revealed a high prevalence and negative impact of PMS on students

In **2000** a multicentric study (12 centers) involving 466 women with moderate to severe PMS diagnoses were randomized into a placebo group and another group receiving 1200 mg/day of calcium carbonate. After the third cycle, in the calcium-users group, there was a 48% reduction of symptom intensity compared to the initial symptoms severity and to placebo group (p <0.01). Due to this study sample size, its methodology and the positive impact on treatment, these findings generate good evidence for inclusion of calcium as additional PMS treatment.

In **1998**, a study about prevalence, incidence and stability of premenstrual dysphoric disorder in the community was carried out in Germany, 1251 women aged (14-42) were studied by clinical interview using DSM-IV algorithms. Results were as: 5.8% met DSM-IV criteria for PMDD, lifetime incidence was 7.4% [16].

In **January 1990-February 1996,** the modal current study dealing with premenstrual syndrome or tension has a within-subjects design and includes 20 to 80 non pathological subjects. Conclusions based on prospective self-reports are that negative psychological and somatic ratings increase premenstrual or menstrual and that changes are more pronounced (and scores higher) for groups who are identified with symptoms.

CHAPTER – III

RESEARCH METHODOLOGY

CHAPTER-III

RESEARCH METHODOLOGY

The methodology of research indicates the general pattern of organizing procedures for gathering valid and reliable data for an investigation.

This chapter is concerned with the methodology adopted to determine the stress level of pre-menstrual syndrome among working and non-working women of age group 25-35 years at Srinivasa Rao Thota in Guntur .It consists of brief description of research approach, research design, variables, setting of the study population, sample size, sampling technique and data collection tool and data analysis.

RESEARCH APPROACH

The research approach was based on following objectives of the study

1.   To assess the level of stress among working and non-working women under the age group of 25-35 years.

2.   To Compare the level of stress experienced by non-working women with working women

3.   To Associate the differences of stress levels among working and non-working women in selected demographic variables

Quantitative research approach was elected and this study was designed to assess the stress level of premenstrual syndrome among working and non-working women of age group 25-35 years at Srinivasa Rao Thota in Guntur.

RESEARCH DESIGN

A research design is concerned with an overall framework for conduction of the study

According to B.T.Basavanthappa, the research design is the plan, structure and strategy of investigation of answering the research question which is the overall plan (or) blueprint which the researchers select to carry out their study.

The research design for this present study is descriptive research design

VARIABLES UNDER STUDY

The independent variable was a self-instructional module and the dependent variable was stress related to premenstrual syndrome among working and non-working women of 25-35 years age group at Srinivasa rao Thota in Guntur.

SETTING OF THE STUDY

It is the physical location and conditions in which the data collection takes place in a study.

The setting for the present study is at Srinivasarao Thota in Guntur.The rationale for the selection of the study was availability of subjects, feasibility and familiarity of the investigators with the setting.

POPULATION FOR THE STUDY

According to Pilot and Hungler, population refers to the entire aggregation of cases that need a designated set of criteria. The population for this study is working and non-working women of age group 25-35 years at Srinivasarao Thota in Guntur.

SAMPLE AND SAMPLE SIZE

Sampling refers to the process of selecting a portion of the population to represent the entire population. Sample consists of 60 from which 30 working and 30 non-working women who are attaining the menstrual period.

SAMPLE TECHNIQUE

Non-probability convenient sampling technique was used for the study

SAMPLING CRITERIA

Inclusive criteria:

● Both working and non-working women who are under the age group of 25-35

● The women who are residing at Srinivasa rao Thota in Guntur

● The women who are willing to participate and give consent at Srinvas rao Thota in Guntur.

Exclusive criteria:

● The women who are not attaining menstrual period.

● Both women who are not available at the time of data collection.

DEVELOPMENT AND DESCRIPTION OF TOOL

The most important aspect of any investigation is the collection of appropriate information which will provide the necessary data to answer the questions raised in the study.

Based on the objectives and conceptual framework of the study,the following instrument was developed in order to generate the data.

Structured stress measurement questionnaires to evaluate the stress level of premenstrual syndrome among working and non-working women of age group 25-35 years at srinivasarao thota in Guntur.

The tool developed for the study was structured stress scale

DEVELOPMENT OF STRUCTURED STRESS SCALE

Various steps adopted for the preparation of structured stress scale and selection of items include.

● Review of literature and non-literature

● Opinion of expert

● Professional experience in the field

● Blueprint for the knowledge

Major steps in the development of the structured knowledge questionnaire were:

● The preparation of blue print

● Items construction

● Establishing validity

● Final preparation of tool

TOOL: Structured stress scale

DESCRIPTION OF STRUCTURED STRESS SCALE

A Structured stress scale consisting of two sections

Section:1   Demographic variables

Section:2   Stress measuring scale 1-30 items with score of 30

SCORING KEY

Scoring score was prepared for section 2,for each correct answer a score of ONE mark and wrong answer ZERO mark was given.Thus a total of 30 marks were allotted. To interpret the level of knowledge, the scores were distributed as follows,

Level of stress as per range of scores:

S. No.	Level of Stress	Percentage
1.	Mild stress	1-50%
2.	Moderate stress	51-75%
3.	Severe	>75%

DEVELOPMENT OF INFORMATION BOOKLET

Information booklet for working and non-working women of age group 25-35 years to enhance the knowledge of premenstrual syndrome stress based on the findings

1. Preparation of content outline

2. Preparation of rough self-instructional module

3. Content validity of self-instructional module

4. Preparation of final draft of self-instructional module

PREPARATION OF SELF-INSTRUCTIONAL MODULE

The self-instructional module was prepared on the basis of review of literature. Some of the important factors while preparing self-instructional were, simplicity of language content covering all the aspects of knowledge on premenstrual syndrome stress.

DESCRIPTION OF SELF-INSTRUCTIONAL MODULE:

The content areas of self-instructional module on premenstrual syndrome stress

➢ Introduction

➢ Meaning

➢ Definition

➢ Causes

➢ Signs and symptoms

➢ Management

Self-Instructional module for working and non-working women of age group 25-35 years on stress related to premenstrual syndrome were prepared in the form of instruction booklet with images for easy understanding

CONTENT VALIDITY OF THE TOOL

The self-instructional module on the stress related to premenstrual syndrome in the form of were submitted to six experts for validation. The 100% agreement on the content approximately and practicability of the self-instructional for few additions and modifications

RELIABILITY

Reliability is the degree of consistency that the instrument of procedure demonstrates, whatever it is measuring it does so consistently.

The reliability of the tool was a major criteria for assessing its quality and adequacy. A pretest was done to establish the reliability and to determine the language clarity and using split half method with assessed feasibility of the tool reliability of tool for stress questionnaire was found to be 0.94 and stress score found to be

ETHICAL CONSIDERATIONS

Ethical considerations refer to a system of moral values that is concerned with the degree to which research procedure adheres to professional legal and social obligations to study participants.

The study was conducted after getting ethical clearance from the community. Final permission was obtained from community health officer, mental health nursing experts of KSR College of nursing.

Informed consent was taken from respondents. The study procedure was explained to respondents.

PILOT STUDY

Pilot study was conducted to find the feasibility of study. 10 women were selected from KalyaniNagar Guntur. The investigator personally administered the structured stress questionnaire and elicited the data from the subjects. The investigator was satisfied with the feasibility of the tools. The data was analyzed using descriptive and inferential statistics. The findings of the study revealed that it was feasible and practicable to conduct the study(r=0.94)

Therefore the plan of data collection was finalized as investigators did not face any problem during pilot study.

PROCEDURE FOR DATA COLLECTION

The working and non-working women of age group 25-35 years were selected using probability sampling technique as per the sampling criteria.

Study was explained the purpose of the study and was assured about the confidentiality of their responses. A structured stress tool was administered to each woman by the investigator to elect the data.

PLAN FOR DATA ANALYSIS

The data obtained was analyzed using both descriptive and inferential statistics in terms of frequency distribution, percentage, mean, standard deviation and chi square value & X^2

DESCRIPTIVE STATISTICS INCLUDE:

● Frequency distribution and percentage of stress level among working and non-working women of age group 25-35 years

● Mean, Standard deviation of stress levels

INFERENTIAL STATISTICS

't' test for the comparison of working and non-working women stress levels.

Chi square(X^2) to associate the stress scores with selected demographic variables

Research Approach → Research Design → Independent Variable → Dependent Variable → Demographic Variables

Quantiatative approach

Descriptive Comparison

Self Instructional Module on pre-menstrual syndrome stress

Stress level among working and non-working women of age group 25-35 years

Age,Religion,Education,Income,Occupation,Working hours

RESEARCH METHODOLOGY

Working and non-working women

Simple random sampling

Discussion of study results

Discussion

Data analysis ← Intervention ← Data collection method ← Setting

Inferential statistics,chi-square test,mean,median standard deviation

Instruction booklet

Structured stress scale

Srinivasraothota Guntur

CHAPTER – IV

DATAANALYSISANDINTERPRE TATION

CHAPTER-IV

DATA ANALYSIS AND INTERPRETATION

This charter deals with statistical analysis and interpretation of the findings. The data was collected from 30 working and 30 nonworking women. The collected data was tabulated and analyzed by using descriptive and inferential statistical methods. The findings were summarized in the following sections.

Section-I

It deals with demographic variables of working women.

Section -II

It deals with demographic variables of non working women.

Section – III

It deals with assessment of the level of stress of both working and nonworking women.
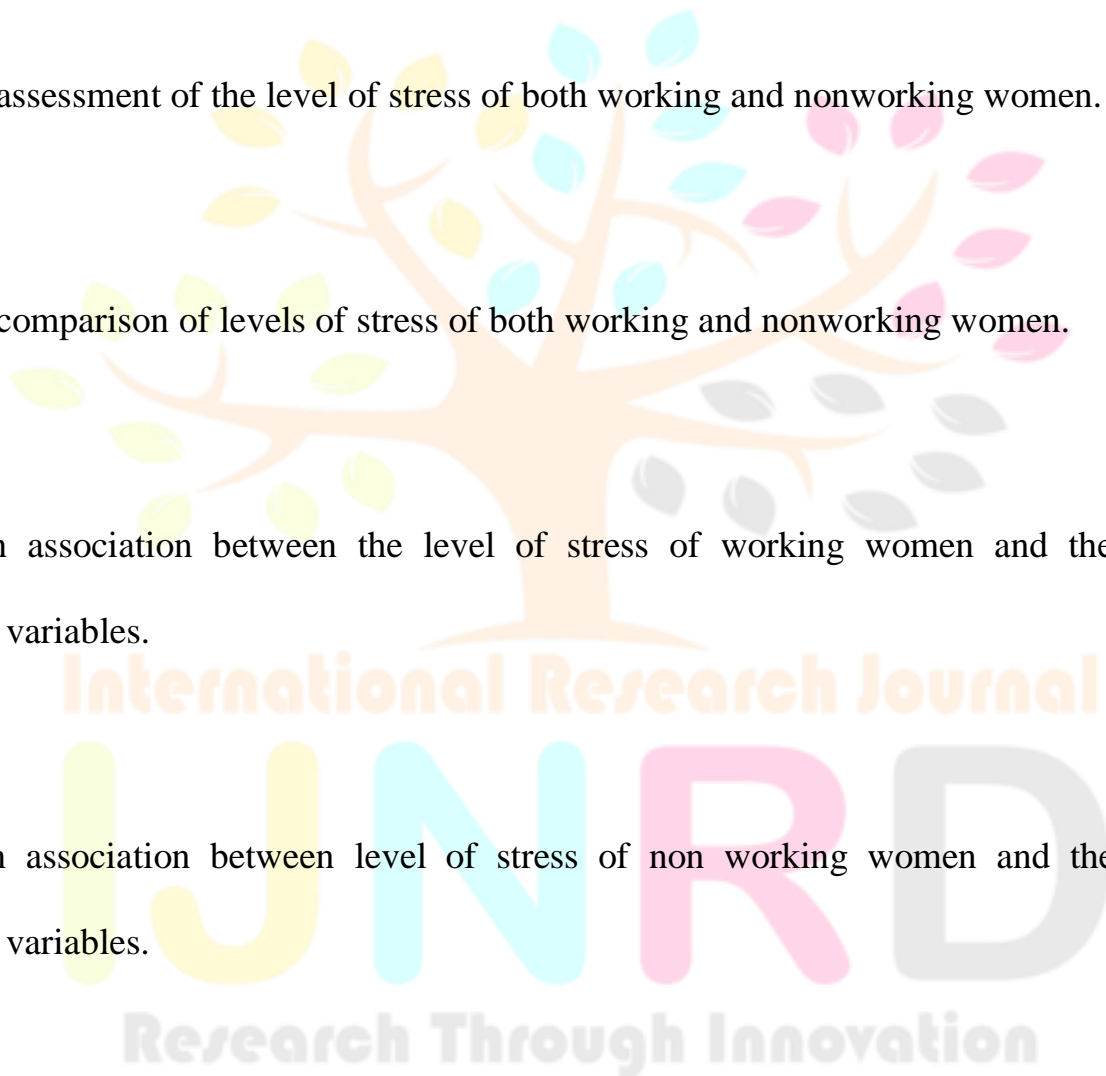
Section –IV

It deals with comparison of levels of stress of both working and nonworking women.

Section –V

It deals with association between the level of stress of working women and their selected demographic variables.

Section – VI

It deals with association between level of stress of non working women and their selected demographic variables.

SECTION-I

TABLE – I

FREQUENCY AND PERCENTAGE DISTRIBUTION OF DEMOGRAPHIC VARIABLES OF WORKING WOMEN

(N= 30)

S.No.	Demographic Variables	Frequency (f)	Percentage (%)
1.	**Age in years** a)25-28 years b)29-32 years c)33-35 years	 8 10 12	 26.67% 33.33% 40.00%
2.	**Educational qualification** a)primary education b) secondary education c) degree and above	 11 10 9	 36.67% 33.33% 30.00
3.	**Religion** a)Hindu b)Christian c)Muslim d)Others	 13 10 7 -	 43.33% 33.33% 23.34% -
4.	**Occupation** a) private employee	 10	 33.33%

|			
	b)house wife	5	16.67%
	c)business	4	13.33%
	d) government employee	7	23.34%
	e)coolie	4	13.33%
5.	**Income**		
	a)5000-9000	12	40.00%
	b)10000-14000	3	10.00%
	c)15000-19000	5	16.67%
	d)19000-23000	6	20.00%
	e)>24000	4	13.33%
6.	**Working hours**		
	a)8 hours/day	9	30.00%
	b)12 hours	15	50.00%
	c)>12 hours	6	20.00%
7.	**Marital status**		
	a)married	9	30.00%
	b)unmarried	11	36.67%
	c)divorce	8	26.67%
	d) widow	2	6.66%
8.	**Source of information**		
	a)Health personnel	9	30.00%
	b)Mass media	12	40.00%
	c)Family members & friends	5	16.67%
	e)Relatives & Neighbors	4	13.33%

FIGURE-1

PERCENTAGE DISTRIBUTION OF WORKING WOMEN ACCORDING TO AGE
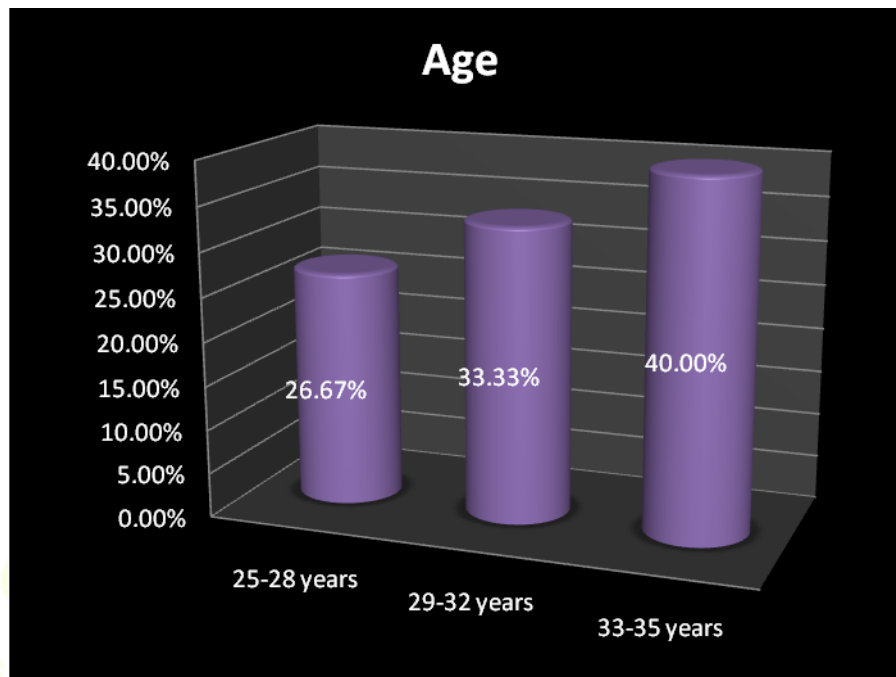
The above figure shows that age of working women reveals that 25-28 years were 26.67%, 29-32 years were 33.33%, and 33-35 years were 40%.

FIGURE-2

PERCENTAGE DISTRIBUTION OF WORKING WOMEN ACCORDING TO EDUCATION
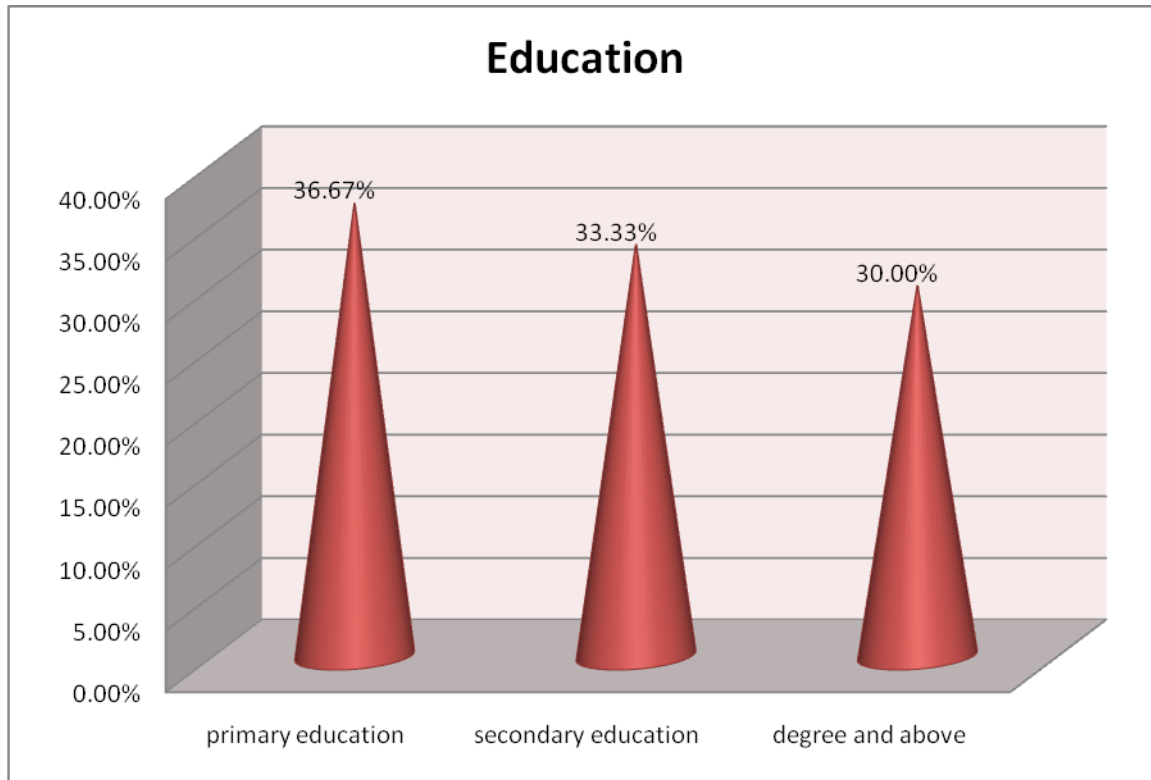
The above figure shows that education of women shows that primary education was 36.67%, secondary education was 33.33%, and degree and above were 30%.

FIGURE-3

PERCENTAGE DISTRIBUTION OF WORKING WOMEN ACCORDING TO RELIGION
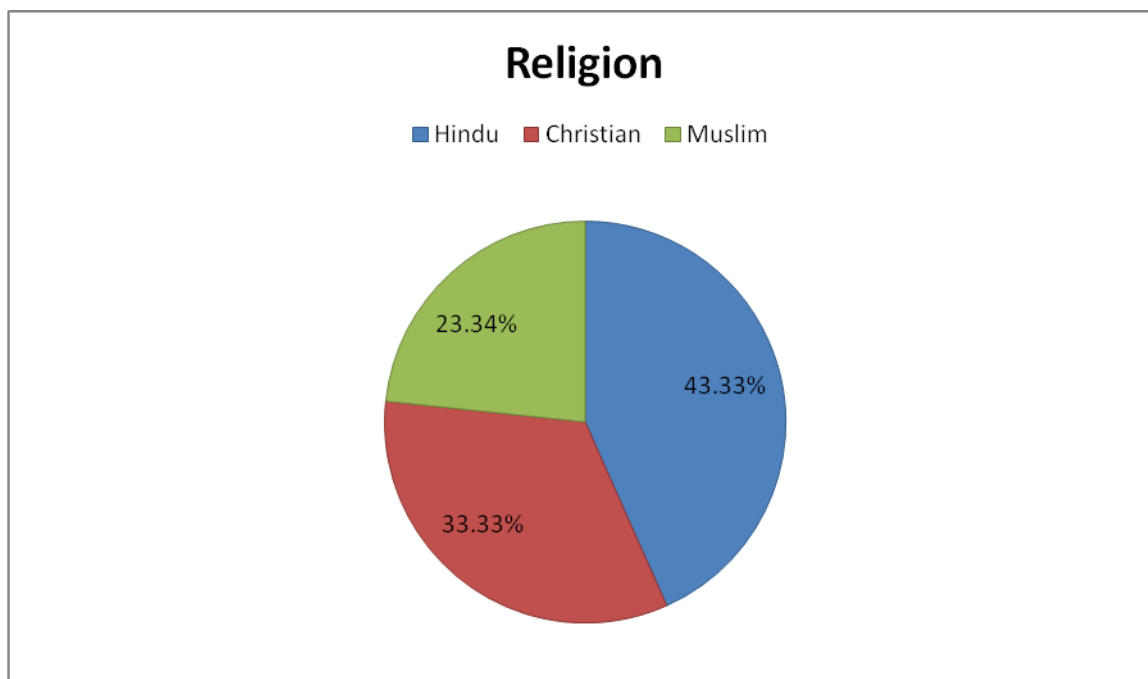
The above figure shows that the religion of women shows that hindu were 43.33%, Christian were 33.33%, and muslims were 23.34%.
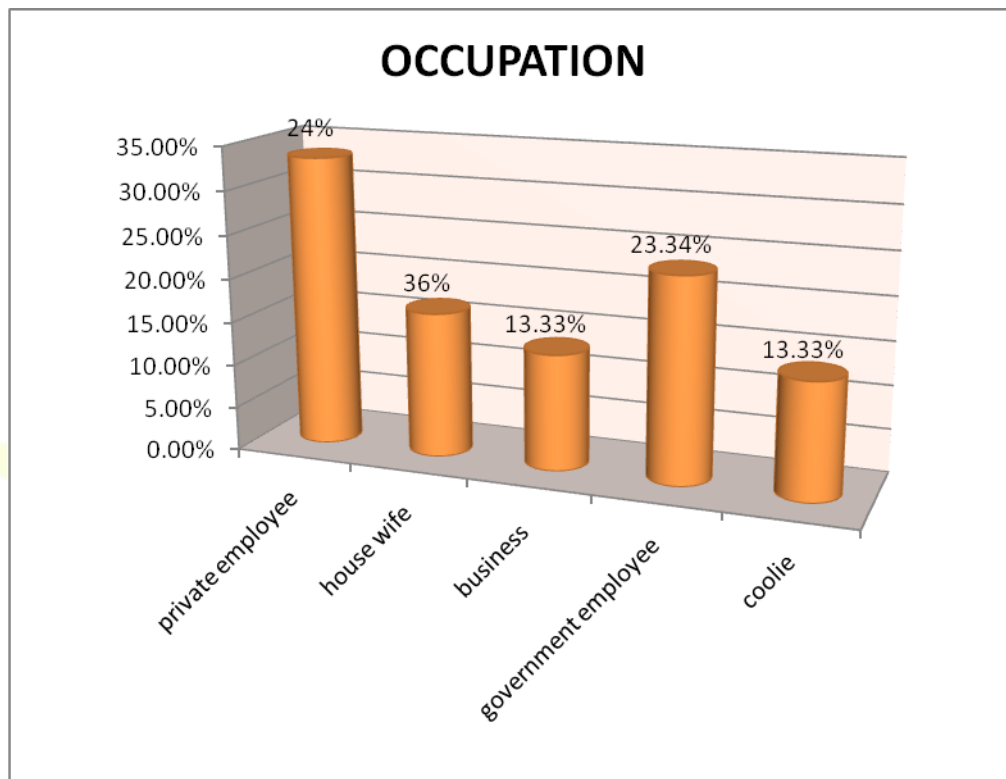
FIGURE-4

PERCENTAGE DISTRIBUTION OF WORKING WOMEN ACCORDING TO OCCUPATION

The above figure shows that the occupation of women shows that private employees were 24%, house wives were 36%, business were 13.33%, government employees were 23.34% and coolies were 13.33%.

FIGURE-5

PERCENTAGE DISTRIBUTION OF WORKING WOMEN ACCORDING TO INCOME
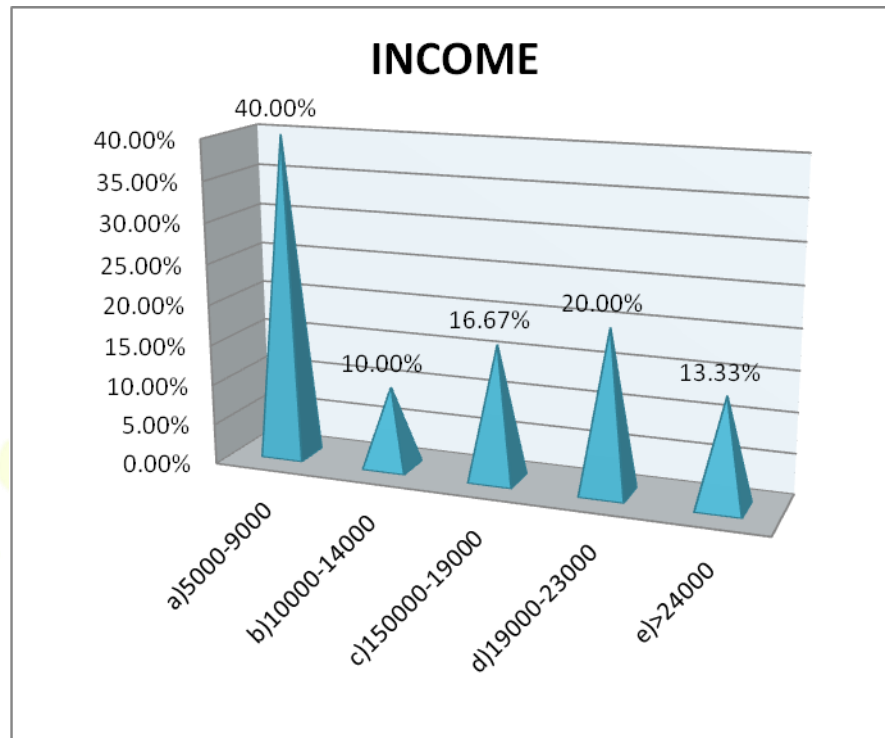
The above figure shows that the income of women shows that 5000-9000 were 40%, 10,001-14,000 were 10%, 150,000-19,000 were 16.67%, 19,000-23,000 were 20% and >24,000 were 13.33%.

FIGURE-6

PERCENTAGE DISTRIBUTION OF WORKING WOMEN ACCORDING TO WORKING HOURS PER DAY
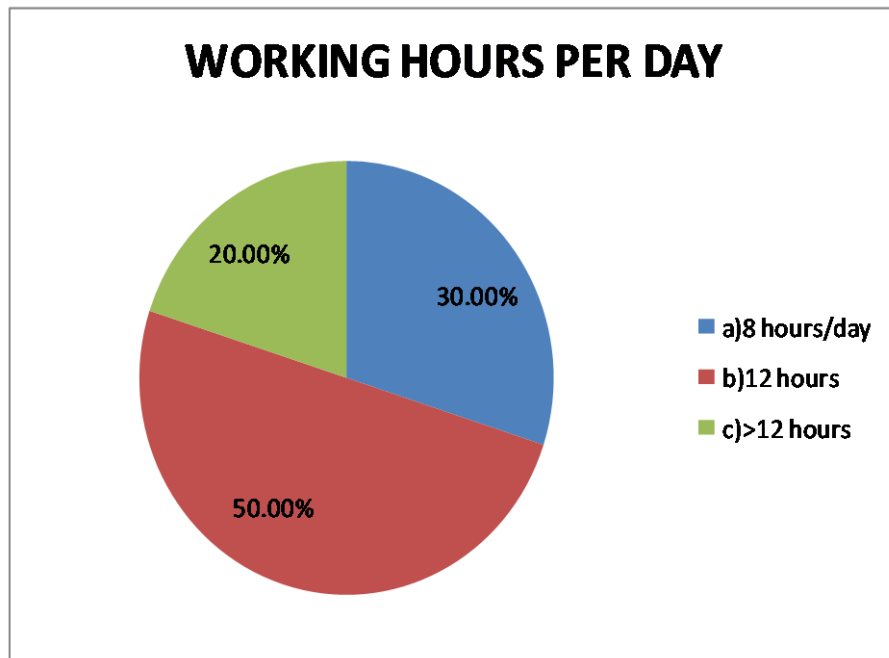
The above figure shows that working hours per day of women shows that 8 hours/day are 30%, 12 hours are 50%, and >12 hours are 20%

FIGURE-7

PERCENTAGE DISTRIBUTION OF WORKING WOMEN ACCORDING TO MARITAL STATUS
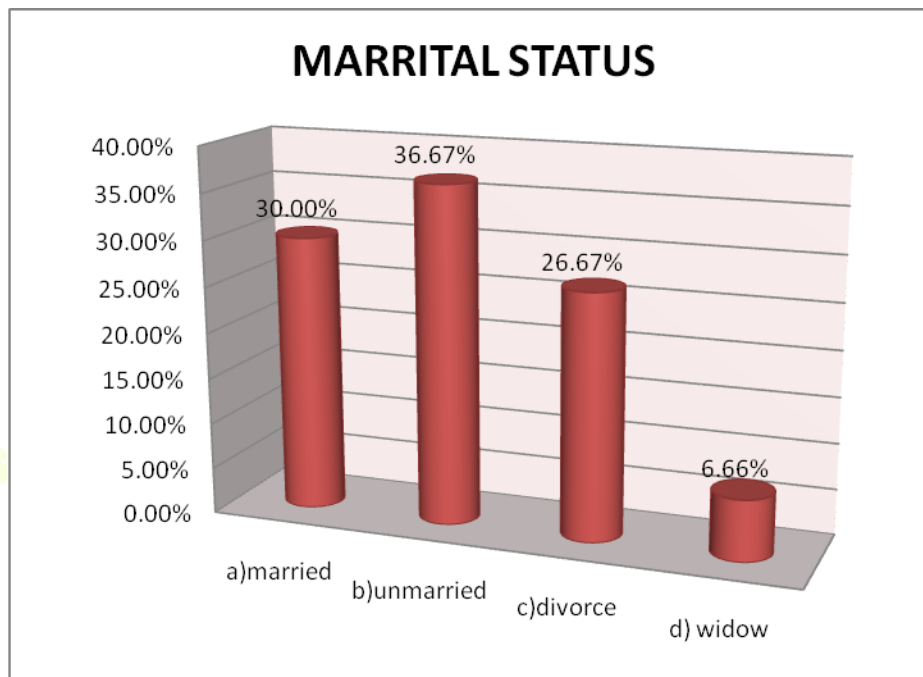
The above figure shows that marital status of women shows that married were 30%, unmarried were 36.67%, divorce were 26.67% and widow were 6.66%.

FIGURE-8

PERCENTAGE DISTRIBUTION OF WORKING WOMEN ACCORDING TO SOURCE OF INFORMATION
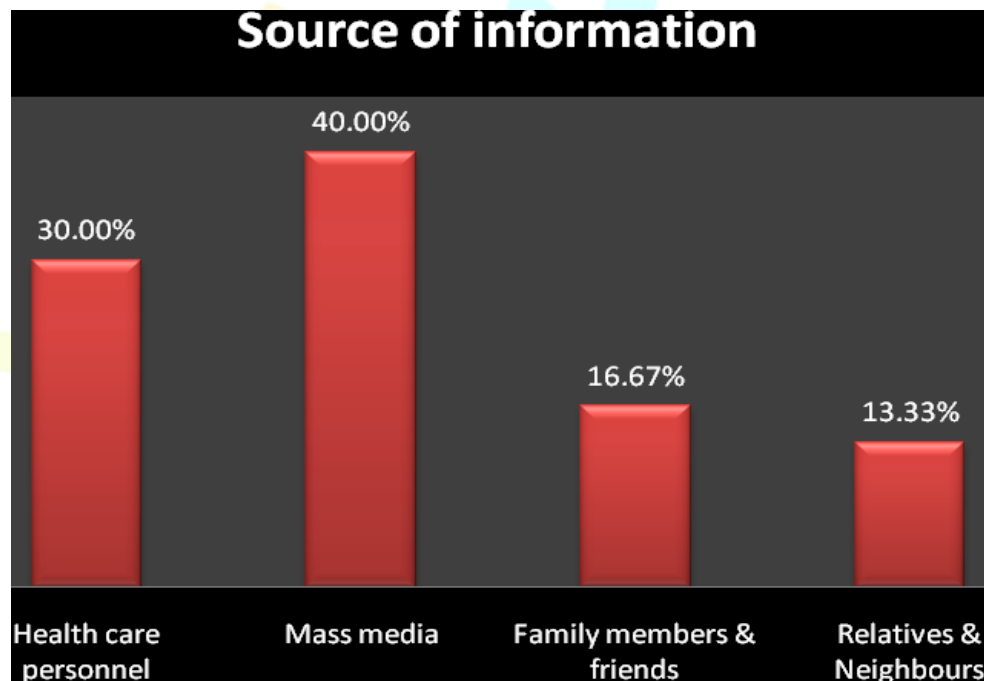
The above figure shows that the source of information of women shows that health care personnel were 30%, mass media were 40%, family & friends were 16.67% and relatives and neighbors were 13.33%.

SECTION-II

TABLE – 2

FREQUENCY AND PERCENTAGE DISTRIBUTION OF DEMOGRAPHIC VARIABLES

OF NON WORKING WOMEN

(N_2= 30)

S.No.	Demographic Variables	Frequency (f)	Percentage (%)
1.	**Age in years**		
	a)25-28 years	10	33.33%
	b)29-32 years	11	36.67%
	c)33-35 years	9	30.00%
2.	**Educational qualification**		
	a)primary education	10	33.33%
	b) secondary education	8	26.67%
	c) degree and above	12	40.00%
3.	**Religion**		
	a)Hindu	12	40.00%
	b)Christian	10	33.33%
	c)Muslim	8	26.67%
	d)Others	-	-
4.	**Occupation**		
	a)coolie	5	16.67%

	b)business	7	23.33%
	c) self-employee	8	26.67%
	d)house wife	10	33.33%
5.	**Income**		
	a)5000-9000	2	6.67%
	b)10000-14000	7	23.33%
	c)150000-19000	5	16.67%
	d)19000-23000	9	30.00%
	e)>24000	7	23.33%
6.	**Working hours**		
	a)8 hours/day	14	46.67%
	b)12 hours	10	33.33%
	c)>12 hours	6	20.00%
7.	**Marital status**		
	a)married	4	13.33%
	b)unmarried	8	26.67%
	c)divorce	10	33.33%
	d) widow	8	26.67%
8.	**Source of information**		
	a)Health personnel	8	26.67%
	b)Mass media	9	30.00%
	c)Family members & friends	7	23.33%

e)Relatives & Neighbors	6	20.00%

FIGURE-9

PERCENTAGE DISTRIBUTION OF NON WORKING WOMEN ACCORDING TO AGE
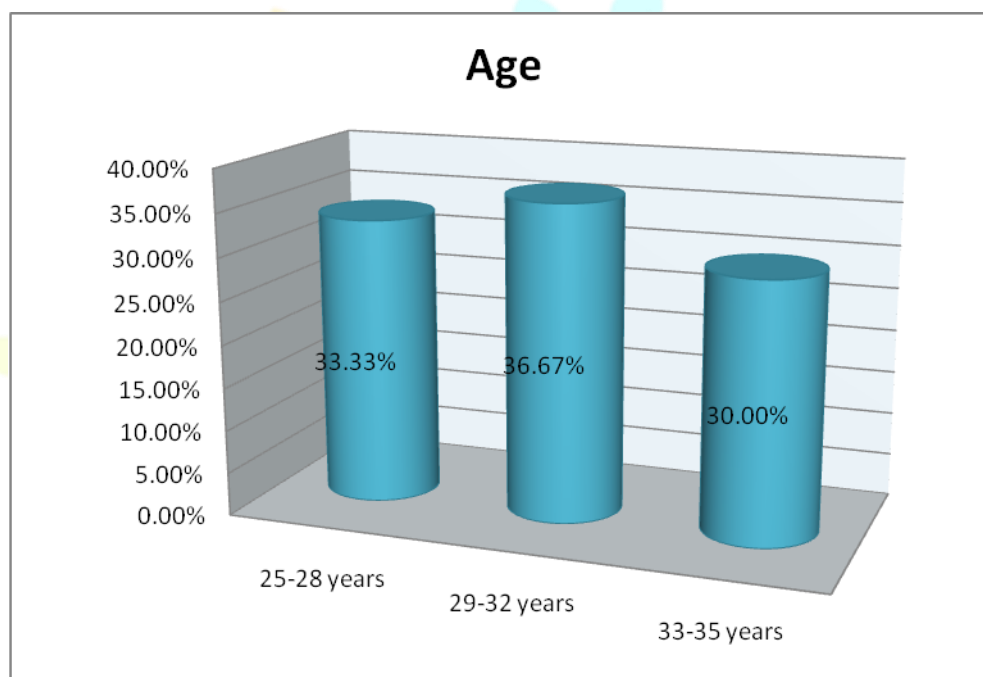
The above figure shows that the age of nonworking women reveals that 25-28 years were 33.33%, 29-32 years were 36.67%, and 33-35 years were 30%.

FIGURE-10

PERCENTAGE DISTRIBUTION OF NON WORKING WOMEN ACCORDING TO EDUCATION
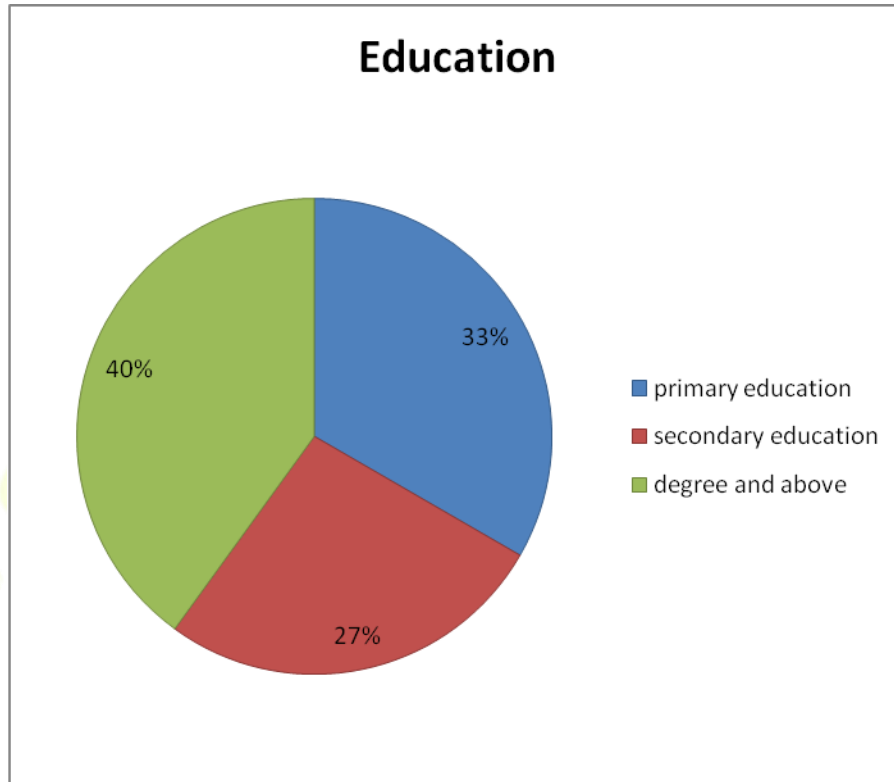
The above figure shows that education of women shows that primary education were 33%, secondary education was 27%, and degree and above were 40%.

FIGURE-11

PERCENTAGE DISTRIBUTION OF NON WORKING WOMEN ACCORDING TO RELIGION
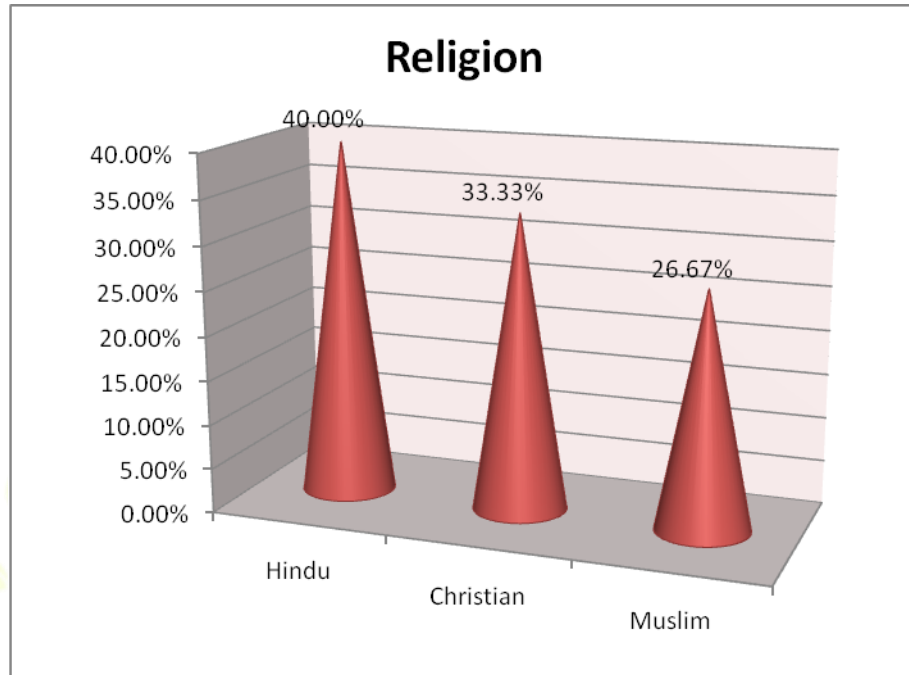
The above figure shows that the religion of women shows that hindu were 40%, Christian were 33.33%, and muslims were 26.676%.

FIGURE-12

PERCENTAGE DISTRIBUTION OF NON WORKING WOMEN ACCORDING TO OCCUPATION
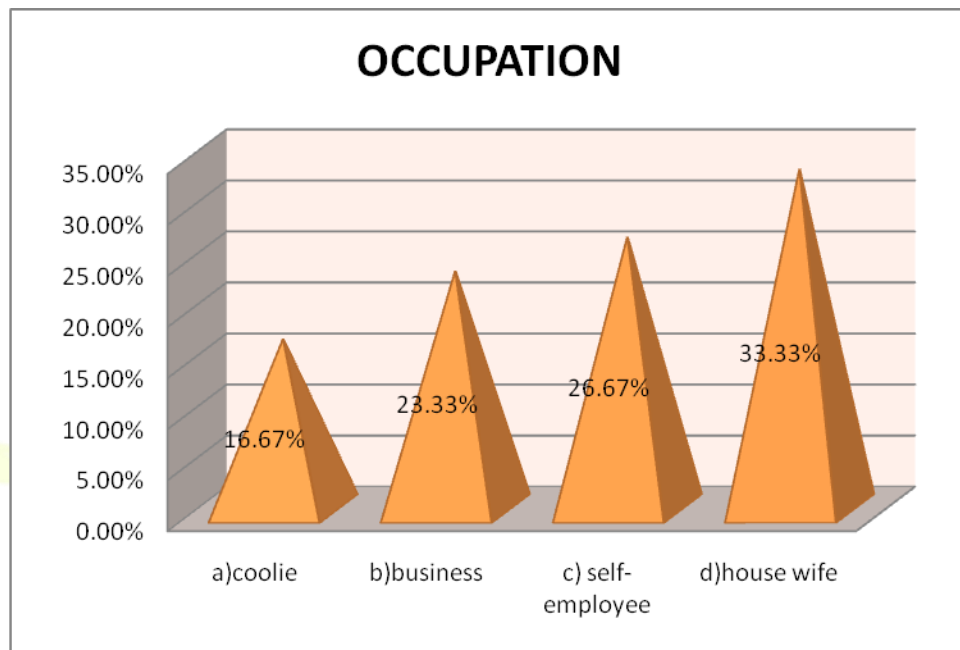
The above figure shows that occupations of nonwomen were 16.67%, business were 23.33%, self-employed were 26.67%, and house wives were 33.33%.

FIGURE-13

PERCENTAGE DISTRIBUTION OF NON WORKING WOMEN ACCORDING TO INCOME
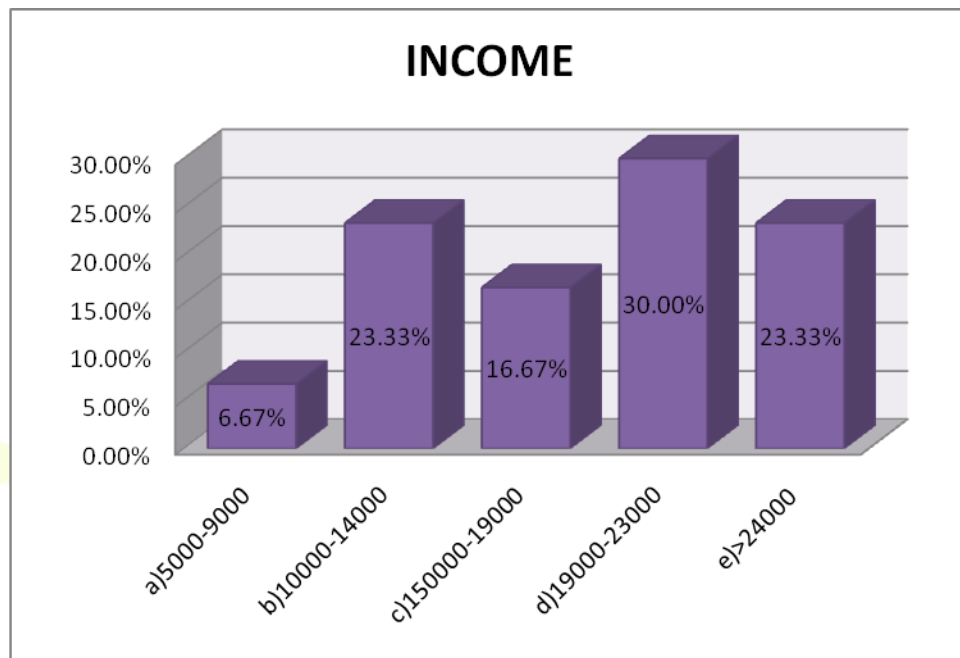
The above figure shows that the income of women shows that 5000-9000 were 6.67%, 10,001-14,000 were 23.33%, 150,000-19,000 were 16.67%, 19,000-23,000 were 30% and >24,000 were 23.33%.

FIGURE-14

PERCENTAGE DISTRIBUTION OF NON WORKING WOMEN ACCORDING TO WORKING HOURS
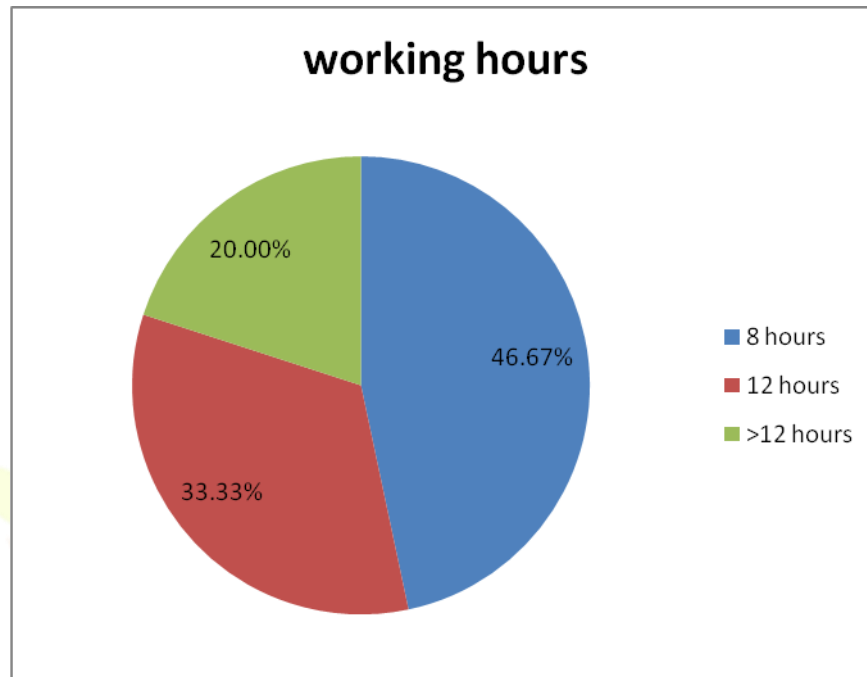
The above figure shows that working hours per day of women shows that 8 hours/day were 46.67%, 12 hours were 33.33%, and >12 hours were 20%.

FIGURE-15

PERCENTAGE DISTRIBUTION OF NON WORKING WOMEN ACCORDING TO MARITAL STATUS
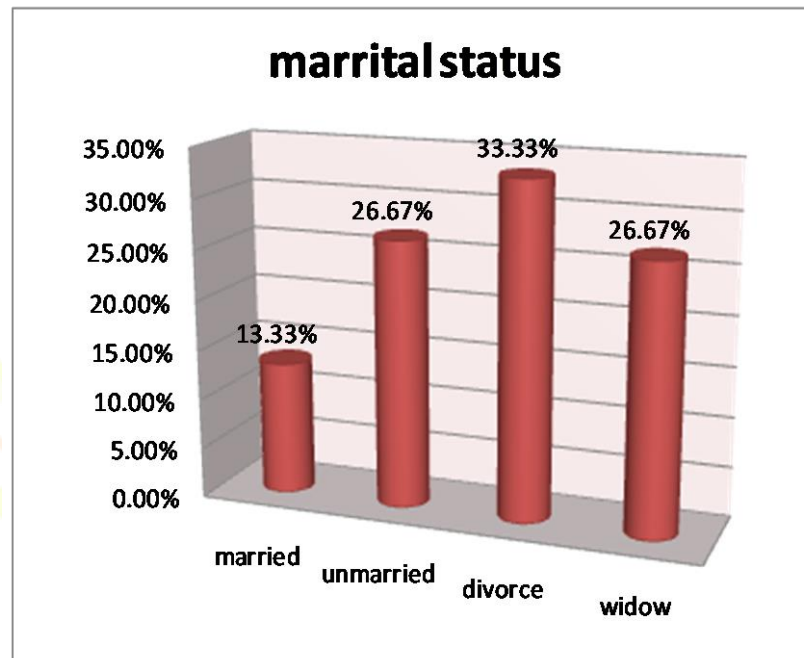
The above figure shows that marital status of women shows that married were 13.33%, unmarried were 26.67%, divorce were 33.33% and widow were 26.67%.

FIGURE-16

PERCENTAGE DISTRIBUTION OF NON WORKING WOMEN ACCORDING TO SOURCE OF INFORMATION
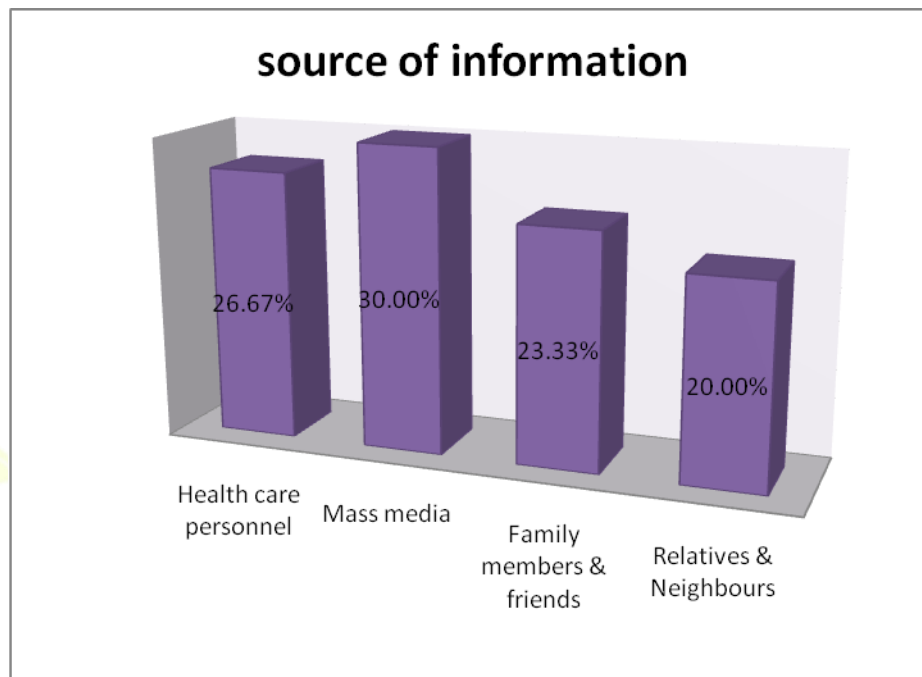
The above figure shows that the source of information of women shows that health care personnel were 26.67%, mass media were 30%, family & friends were 23.33% and relatives and neighbors wer

SECTION –III

TABLE –3

FREQUENCY AND PERCENTAGE DISTRIBUTION OF LEVEL OF STRESS OF NON WORKING WOMEN OF PREMENSTRUAL SYNDROME

$(N_1=30)$

S. No.	Level of Stress	Frequency (f)	Percentage (%)
1.	Mild stress (1-50%)	22	73.33%
2.	Moderate stress (51-<75%)	08	26.67%
3.	Severe (>75%)	-	-

The above table shows the level of stress of non working women of premenstrual syndrome Among 30 nonworking women, 22(73.33%) were having mild stress & 08 (26.67%) were having moderate stress.

FIGURE-17

PERCENTAGE DISTRIBUTION OF STRESS LEVELS IN NON WORKING WOMEN
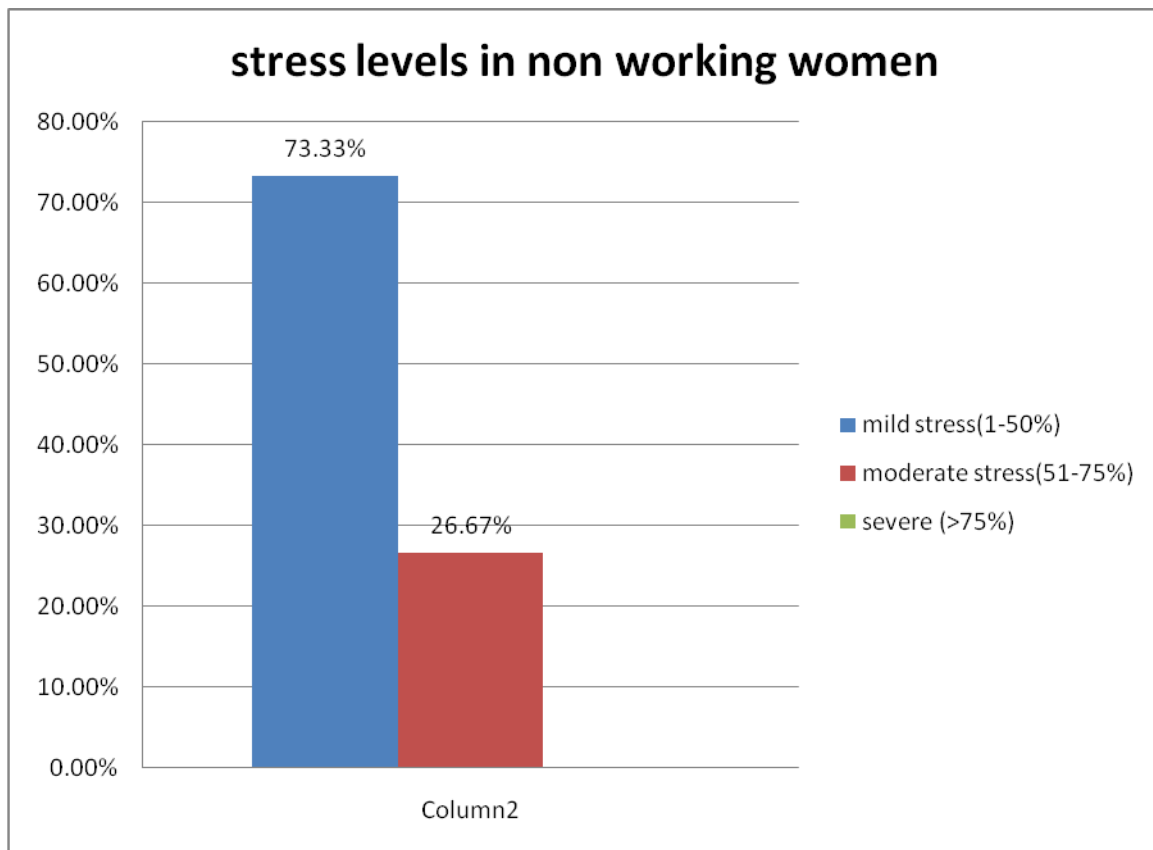
The above figure shows that level of stress of non working women of premenstrual syndrome Among 30 nonworking women, 22(73.33%) were having mild stress & 08 (26.67%) were having moderate stress.

TABLE –4

FREQUENCY AND PERCENTAGE DISTRIBUTION OF LEVEL OF STRESS OF WORKING WOMEN OF PREMENSTRUAL SYNDROME

(N_2=30)

S. No.	Level of stress	Frequency (f)	Percentage (%)
1.	Severe stress (1-50%)	14	46.66%
2.	Moderate stress (51-<75%)	11	36.67%
3.	Mild stress (>75%)	5	16.67%

The above table shows the level of stress of working women of premenstrual syndrome. Among 30 working women, 14(46.66%) were having severe stress,11 (36.67%) were having moderate stress and 5(16.67%) were having mild stress.

FIGURE-18

PERCENTAGE DISTRIBUTION OF STRESS LEVELS IN WORKING WOMEN
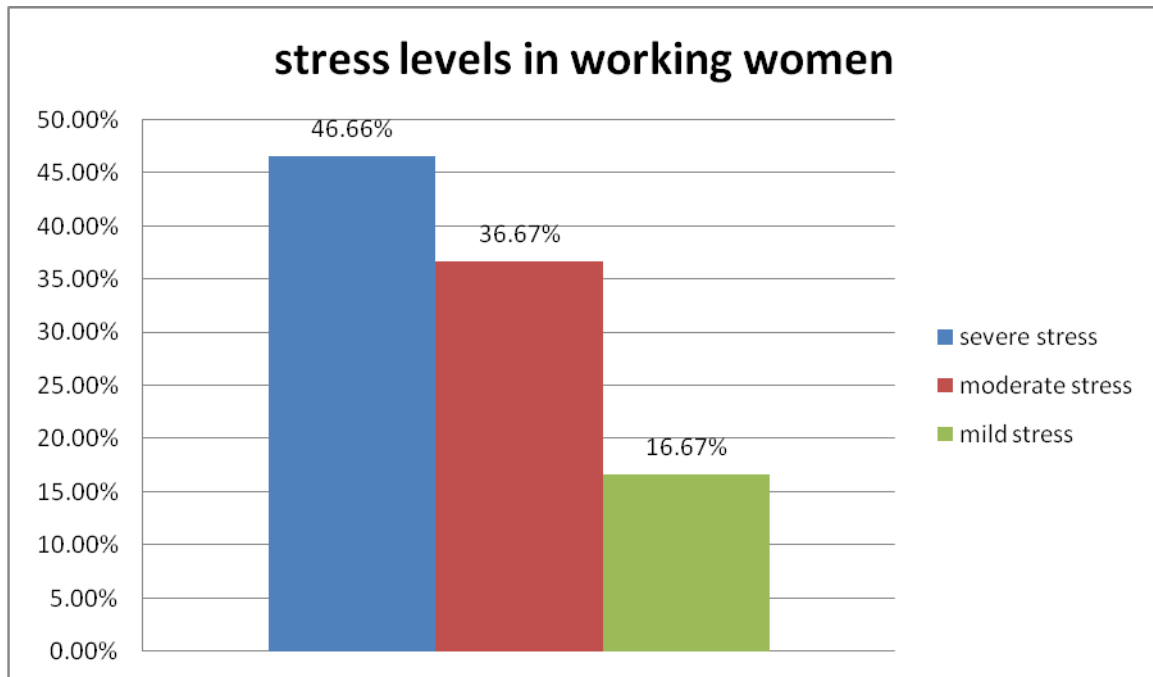
The above figure shows the level of stress of working women with premenstrual syndrome. Among 30 working women, 14(46.66%) were having severe stress, 11 (36.67%) were having moderate stress and 5(16.67%) were having mild stress.

SECTION -IV

TABLE -5

COMPARISON OF LEVELS OF STRESS OF PREMENSTRUAL SYNDROME BETWEEN WORKING AND NON WORKING WOMEN.

$(N_1 = 30)$ $(N_2 = 30)$

S.No	Group	Mean	Mean percentage	Standard deviation	Unpaired 't' value
1	Nonworking women	13.60	45.33%	3.5552	T=3.1839 Table value at df
2	Working women	17.06	56.86%	4.6542	=58 at 0.05 level 2.0000

The above table shows a comparison of the level of stress of both working and nonworking women. The mean knowledge value of non working women is 13.60 with standard deviation of 3.552. The mean percentage is 45.33%. The mean knowledge value of working women is 17.06 with standard deviation of 4.6542. The mean percentage is 56.86%. The un paired 't' value is 3.1839. Table value at df=58 at 0.05 level is 2.000. The calculated value is more than the table value. Hence there is a significant difference in knowledge levels between working and nonworking women.

SECTION –V

TABLE -6

ASSOCIATION BETWEEN STRESS LEVELS OF NON WORKING WOMEN AND THEIR SELECTED DEMOGRAPHIC VARIABLES

N=30

S.No	Demographic Variables	Level of stress			df	Chi square		Inference
		Mild stress	Moderate stress	Severe stress		Tab value	Cal – value	
1.	**Age in years** a)25-28 years b)29-32 years c)33-35 years	6 7 9	2 3 3	- - -	02	P= 5.991	$X^2=$ 0.0864 P>0.05	NS
2.	**Educational qualification** a)primary education b) secondary education c) degree and above	10 9 3	1 1 6	- - -	02	P= 5.991	$X^2=$ 10.518 P<0.05	*S
3.	**Religion** a)Hindu b)Christian c)Muslim	9 8 5	4 2 2	- - -	02	P= 5.991	$X^2=$ 0.3522 P>0.05	NS

#	Item							
	d)Others	-	-	-				
4.	**Occupation**						X^2 =	
	a)coolie	8	2	-			5.7099	NS
	b)business	4	1	-				
	c) self-employee	3	1	-	04	P= 9.488	P>0.05	
	d)house wife	6	1	-				
		1	3	-				
5.	**Income**						X^2 =	
	a)5000-9000	11	1	-			7.2019	NS
	b)10000-14000	2	1	-	04	P= 9.488		
	c)150000-19000	4	1	-			P>0.05	
	d)19000-23000	4	2	-				
	e)>24000	1	3	-				
6.	**Working hours**						X^2=	
	a)8 hours/day	8	1	-			6.3634	*S
	b)12 hours	12	3	-	02	P = 5.991		
	c)>12 hours	2	4	-			P<0.05	
7.	**Marital status**						X^2 =	
	a)married	7	2	-			0.6656	NS
	b)unmarried	8	3	-	03	P= 7.815		
	c)divorce	6	2	-			P>0.05	

S. No								
	d) widow	1	1	-				
8.	**Source of information**						$X^2 =$	NS
	a)Health personnel	7	2	-			0.5692	
	b)Mass media	9	3	-	02	P= 7.815	P>0.05	
	c)Family members & friends	3	2	-				
	e)Relatives & Neighbors	3	1	-				

NS=Non significant   S- Significant

SECTION –VI

TABLE -7

ASSOCIATION BETWEEN STRESS LEVELS OF WORKING WOMEN AND THEIR SELECTED DEMOGRAPHIC VARIABLES

N=30

S. N o	Demographic Variables	Level of stress			df	Chi square		Infere nce
		Inadequa te	Moderat e	Adequat e		Tab value	Cal – value	
1.	**Age in years**						$X^2=$	
	a)25-28 years	8	1	1				

	b)29-32 years	4	6	1	04	P= 9.488	8.9785	NS
	c)33-35 years	2	4	3			P>0.05	
2	**Educational qualification** a)primary education b) secondary education c) degree and above	9 4 1	1 3 7	- 1 4	04	P= 9.488	X^2= 13.5165 P<0.05	*S
3	**Religion** a)Hindu b)Christian c)Muslim d)Others	6 5 3 -	4 3 4 -	2 2 1 -	04	P= 9.488	X^2= 0.8935 P>0.05	NS
4	**Occupation** a) private employee b)house wife c)business d) government employee e)coolie	- 5 2 1 -	- - 4 5 5	- - 1 2 5	06	P= 12.592	X^2 = 18.5914 P<0.05	*S
5	**Income** a)5000-9000	2	-	-				

	b)10000-14000	5	2	-	08	P=	X^2 =	NS
	c)150000-19000	1	3	1		15.307	9.9266	
	d)19000-23000	4	4	1			P>0.05	
	e)>24000	2	2	3				
6	**Working hours**							
	a)8 hours/day	2	9	3			X^2=	*S
	b)12 hours	6	2	2	04	P =	14.3193	
	c)>12 hours	6	-	-		9.488	P<0.05	
7	**Marital status**							
	a)married	1	2	1			X^2 =	
	b)unmarried	4	3	1	06	P=	1.1911	NS
	c)divorce	5	3	2		12.592	P>0.05	
	d) widow	4	3	1				
8	**Source of information**	3	4	1			X^2 =	NS
	a)Health personnel	5	2	2	06	P=	0.5692	
	b)Mass media	4	2	1		12.5912	P>0.05	
	c)Family members & friends	2	3	1				
	e)Relatives & Neighbors							

NS=Non significant   S- Significance

FINDINGS OF THE STUDY

SECTION-I

Findings related demographic variables of working women.

➤ Age of working women reveals that 25-28 years were 26.67%, 29-32 years were 33.33%, and 33-35 years were 40%.

➤ Education of women shows that primary education was 36.67%, secondary education was 33.33%, and degrees and above were 30%.

➤ Religion of women shows that hindu were 43.33%, Christian were 33.33%, and muslims were 23.34%.

➤ Occupation of women shows that private employees were 24%, house wives were 36%, business were 13.33%, government employees were 23.34% and coolies were 13.33%.

➤ Income of women shows that 5000-9000 were 40%, 10,001-14,000 were 10%, 150,000-19,000 were 16.67%, 19,000-23,000 were 20% and >24,000 were 13.33%.

➤ Working hours per day of women shows that 8 hours/day were 30%, 12 hours were 50%, and >12 hours were 20%.

➤ Marital status of women shows that married were 30%, unmarried were 36.67%, divorce were 26.67% and widow were 6.66%.

➢ Source of information on women shows that health care personnel were 30%, mass media were 40%, family & friends were 16.67% and relatives and neighbors were 13.33%.

SECTION –II:

Findings related to demographic variables of non working women.

➢ Age of nonworking women reveals that 25-28 years were 33.33%, 29-32 years were 36.67%, and 33-35 years were 30%.

➢ Education of women shows that primary education was 33%, secondary education was 27%, and degrees and above were 40%.

➢ Religion of women shows that hindu were 40%, Christian were 33.33%, and muslims were 26.676%.

➢ Occupation of nonwomen shows that coolies were 16.67%, business were 23.33%, self employees were 26.67%, and house wives were 33.33%.

➢ Income of women shows that 5000-9000 were 6.67%, 10,001-14,000 were 23.33%, 150,000-19,000 were 16.67%, 19,000-23,000 were 30% and >24,000 were 23.33%.

➢ Working hours per day of women shows that 8 hours/day were 46.67%, 12 hours were 33.33%, and >12 hours were 20%.

➢ Marital status of women shows that married were 13.33%, unmarried were 26.67%, divorce were 33.33% and widow were 26.67%.

➢ Source of information on women shows that health care personnel were 26.67%, mass media were 30%, family & friends were 23.33% and relatives and neighbors were 20%.

SECTION –III:

Findings related to the level of stress of both working and nonworking women.

Among 30 non working women of premenstrual syndrome Among 30 nonworking women, 22(73.33%) were having mild stress & 08 (26.67%) were having moderate stress.

Among 30 working women of premenstrual syndrome. Among 30 working women, 14(46.66%) were having severe stress, 11 (36.67%) were having moderate stress and 5(16.67%) were having mild stress.

SECTION – IV:-

Findings related to comparison of stress levels between working and non working women.

comparison of level of stress of both working and nonworking women. The mean knowledge value of non working women is 13.60 with standard deviation of 3.552. The mean percentage is 45.33%. The mean knowledge value of working women is 17.06 with standard deviation of 4.6542. The mean percentage is 56.86%. The un paired 't' value is 3.1839. Table value at df=58 at 0.05 level is 2.000. The calculated value is more than the table value. Hence there is a significant difference in knowledge levels between working and nonworking women.

SECTION – V:-

Findings related to association between stress levels of non working women and their selected demographic variable.

There is no significant association between stress levels and demographic variables of age, religion, income, marital status, occupation and source of information

There is a significant association between stress levels and demographic variables of education and working hours per day. Hence H_2 is partially accepted.

SECTION – VI:-

Findings related to association between stress levels of working women and their selected demographic variables.

There is no significant association between knowledge levels and demographic variables of age, religion, income, marital status and source of information.

There is a significant association between stress levels and demographic variables of education, occupation and working hours per day. Hence H_3 is also partially accepted.

CHAPTER – V

DISCUSSION, SUMMARY

&

CONCLUSION OF THE STUDY

CHAPTER-V

DISCUSSION

The discussion of the study is based on obtained data from the statistical analysis.The following deals with

the discussion based on the findings of the data analyzed in accordance with the objectives of the study

To assess the stress level related to premenstrual syndrome among working and non-working women Among 30 non working women of premenstrual syndrome Among 30 nonworking women, 22(73.33%) were having mild stress & 08 (26.67%) were having moderate stress.

Among 30 working women of premenstrual syndrome. Among 30 working women, 14(46.66%) were having severe stress, 11 (36.67%) were having moderate stress and 5(16.67%) were having mild stress.

To determine the association between stress levels of non working women and their selected demographic variable.

There is no significant association between stress levels and demographic variables of age, religion, income, marital status, occupation and source of information

There is a significant association between stress levels and demographic variables of education and working hours per day. Hence H_2 is partially accepted.

To determine the association between stress levels of working women and their selected demographic variables.

There is no significant association between knowledge levels and demographic variables of age, religion, income, marital status and source of information.

There is a significant association between stress levels and demographic variables of education, occupation and working hours per day. Hence H_3 is also partially accepted.

CHAPTER-VI

SUMMARY,CONCLUSION, IMPLICATIONS &RECOMMENDATIONS

CHAPTER-VI

SUMMARY,CONCLUSION,IMPLICATIONS or RECOMMENDATIONS

This chapter deals with the summary of the study & conclusions drawn. It clarifies limitations of the study, its implications & recommendations for area like nursing education, nursing administration, nursing practices & nurse research

SUMMARY

The purpose of the study was to focus on working and non-working women of the age group 25-35 years. The main purpose was to assess the stress level related to premenstrual syndrome among working and non-working women of age group 25-35 years. The ultimate aim is to compare the stress level among working and non-working women.

In this view "A Comparative study to assess the level of stress among working and non-working women of premenstrual syndrome under the age group of 25-35 years at SrinivasaRaoThota in Guntur, Andhra Pradesh"

Objectives of the study

1.   To assess the level of stress among working and non-working women under the age group of 25-35 years.

2.   To Compare the level of stress experienced by non-working women with working women

3.   To Associate the differences of stress levels among working and non-working women in selected demographic variables

ASSUMPTIONS:

1.   Working women may have more stress than non-working women.

2.   The working women may manage the stress by work diversion

3.   The non-working women may take rest and can be no more victims of stress.

Related literature was reviewed for the purpose of finding the feasibility of the study. The conceptual framework used in this study was based on the conceptual framework.

Simple random sampling technique was used to select the subjects. The study included a sample of 60 (30 working and 30 non-working women).

A structured questionnaire was prepared and used for data collection,which consists of sectional demographic variables &section II with structured stress questionnaire

Experts established content validity & self-instructional modules. The self-instructional module on stress related to pre-menstrual syndrome among working and non-working women of age group 25-35 years was organized and it was implemented in English.

The Pilot Study was conducted and the purpose of the pilot study was

To find out the feasibility of conducting pilot study.

To determine the time duration of the interview.

To administer and evaluate the effectiveness of a self-instructional module.

To determine the method of statistical analysis.

Ten working and non-working women were selected at kalyani nagar by simple random sampling technique, which are excluded from the actual study.

The final study was conducted by using structured knowledge questionnaire & self-instructional module on premenstrual syndrome stress

The data was collected, grouped, tabulated & interpreted to the objectives of the study, descriptive and inferential statistics were used for data analysis.

Major findings of the study

Findings related to sample characteristics

➢ Age of working women reveals that 25-28 years were 26.67%, 29-32 years were 33.33%, and 33-35 years were 40%.

➢ Education of women shows that primary education was 36.67%, secondary education was 33.33%, and degrees and above were 30%.

➢ Religion of women shows that hindu were 43.33%, Christian were 33.33%, and muslims were 23.34%.

➢ Occupation of women shows that private employees were 24%, house wives were 36%, business were 13.33%, government employees were 23.34% and coolies were 13.33%.

➢ Income of women shows that 5000-9000 were 40%, 10,001-14,000 were 10%, 150,000-19,000 were 16.67%, 19,000-23,000 were 20% and >24,000 were 13.33%.

➢ Working hours per day of women shows that 8 hours/day were 30%, 12 hours were 50%, and >12 hours were 20%.

➢ Marital status of women shows that married were 30%, unmarried were 36.67%, divorce were 26.67% and widow were 6.66%.

➢ Source of information on women shows that health care personnel were 30%, mass media were 40%, family & friends were 16.67% and relatives and neighbors were 13.33%.

Implications

The investigator recommended the following implications drawn from the study which are vital concerns for nursing practice,nursing education,nursing administration and nursing research.

Nursing practice

Nursing personnel have the main role in preventing and controlling pre-menstrual syndrome stress among working and non-working women of age group 25-35 years.

Nursing Education

Nursing education should provide a thorough and detailed knowledge to working and non-working women regarding premenstrual syndrome stress.They can act as a change agent in changing values,tradition and practice by awareness on premenstrual syndrome stress.

Nursing Administration

Nursing Administration is the backbone of the management in planning, organizing and implementing a different health awareness programme in the clinical area.

So, here the study shows the importance of planning, organizing and implementing the health policies & strategies in the area of administration.

Nursing Research

The research is an important exercise in training out nurse researchers about knowledge issues on stress related to premenstrual syndrome regarding definition, risk factors, types and clinical features and its prevention.

The study is limited to working and non-working women of age group 25-35 years

➢ Who are living in srinivasarao thota

➢ Who are willing to participate the test

RECOMMENDATIONS

The following are some recommendations that are suggested on the basis of findings of present study.

➢ The study can be done with a large number of samples to validate & generalize the findings.

➢ The study can be conducted by using a self-instructional module to enhance awareness of students.

➢ A follow up study can be done to evaluate the effectiveness of self-instructional modules on premenstrual syndrome stress.

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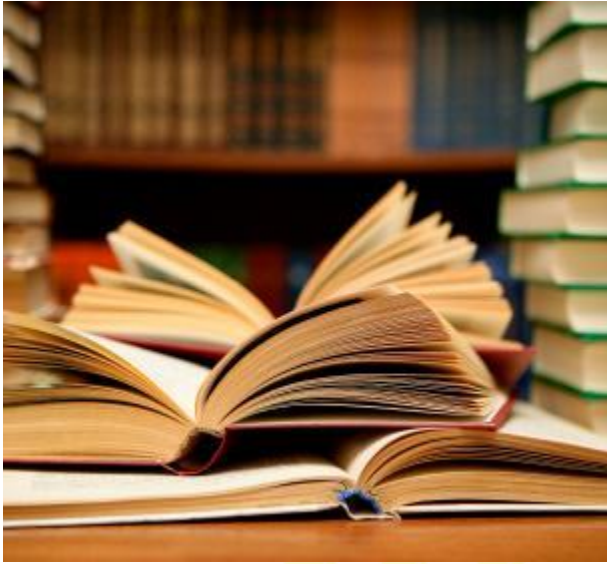
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APPENDICES

APPENDIX-A

CONTENT VALIDITY CERTIFICATE

I hereby certify that I have validated the questionnaire of Ms. D. Poornima, II year M.Sc Nursing, KavuriSubbaRao College of Nursing, Guntur, who is undertaking dissertation work on is "A comparative study to assess the level of stress among working and non-working women of premenstrual syndrome under the age group of 25-35 years in SrinivasaRaoThota, Guntur, Andhra Pradesh" as the partial fulfillment of M.Sc Nursing Programme.

Signature of Expert

Name and Designation

Date :
Place :
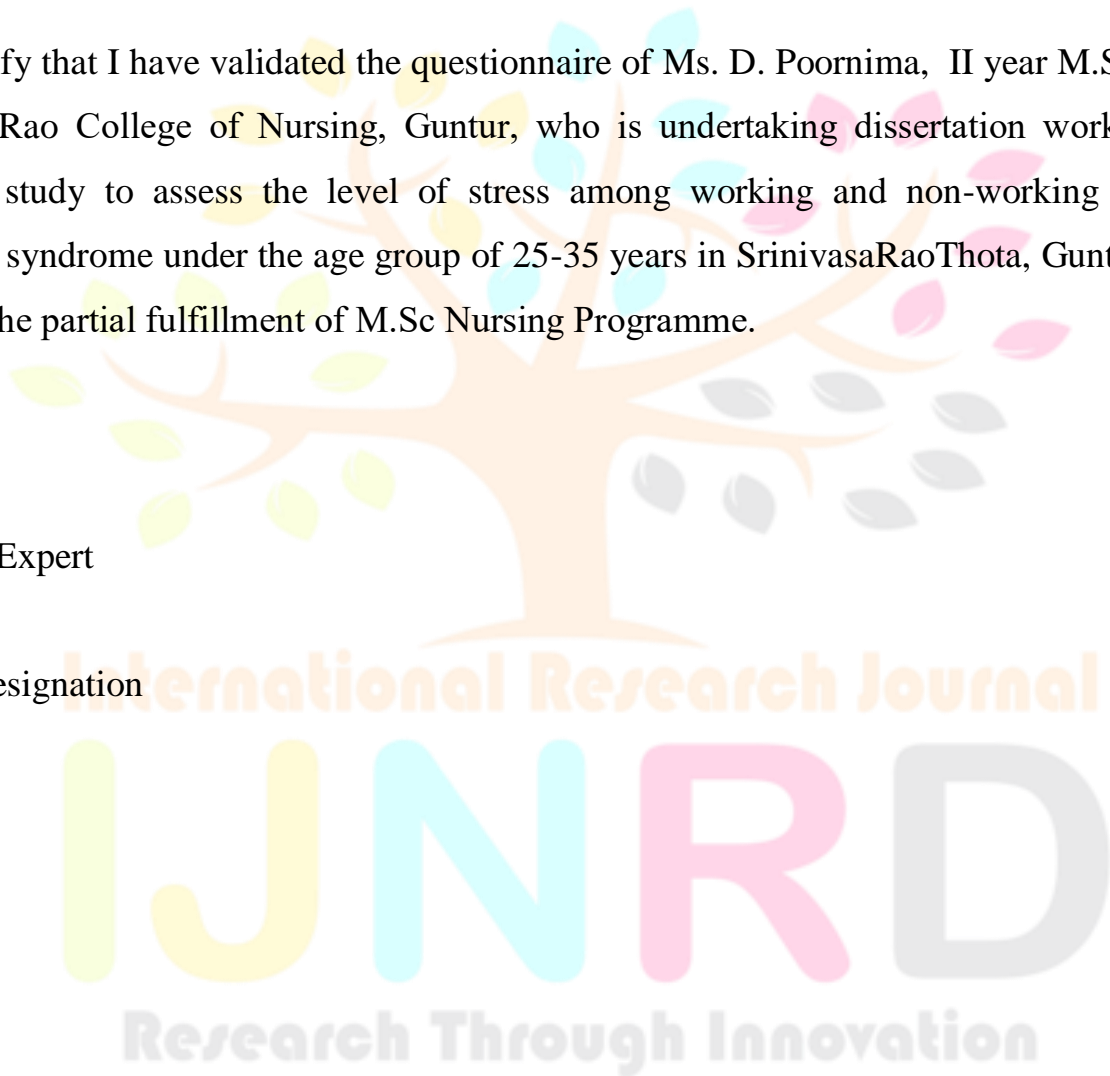
APPENDIX-B

LETTER SEEKING EXPERT OPINION FOR THE CONTENT VALIDITY OF THE TOOL

From

D.Poornima

MSC(N),II year,

KavuriSubbaRao College Of Nursing,

Guntur.

To,

Through Proper Channel

Respected Sir/Madam,

Sub:- Requesting expert opinion and suggestions on content validity of research questionnaire-request-regarding.

I,D.Poornima,a post graduate nursing student from the KavuriSubbaRao College of Nursing Guntur,have undertaken the dissertation work the partial fulfillment of Msc Nursing program.The topic selected for the study is **".A COMPARATIVE STUDY TO ASSESS THE LEVEL OF STRESS AMONG WORKING AND NON-WORKING WOMEN OF PREMENSTRUAL SYNDROME UNDER THE AGE GROUP OF 25-35 YEARS AT SRINIVASA RAO THOTA IN GUNTUR , ANDHRA PRADESH."** Department of Mental Health Nursing,KavuriSubbaRao College of Nursing,Guntur.

Here I am enclosing the problem statement,objectives and data collection tool.I am seeking your valuable suggestions and modifications on data collection tools.

Thanking you Sir/Madam,

Date   Yours faithfully

Place:Guntur   (D.Poornima)

Signature of the Principal

APPENDIX-C

LETTER OF PERMISSION TO CONDUCT PILOT STUDY

Date:

Place:

To

The Medical Officer,

Srinivas Rao Thota,

Guntur.

Respected Sir/Madam

Sub: **Seeking permission to conduct Pilot Study for Project**

This is to introduce Mrs.D.Poornima,M.Sc.Nursing II year student of Mental Health Nursing of Kavuri Subba Rao College of Nursing,Guntur is conducting a research project in partial fulfillment of M.Sc Nursing programme and her topic is "A comparative study to assess the level of stress among working and non-working women of premenstrual syndrome under the age group of 25-35 years in SrinivasaRaoThota, Guntur, Andhra Pradesh".

Hence I request you to kindly accord permission to conduct Pilot study at your organization.

Thanking you

Principal

APPENDIX-D

LETTER OF PERMISSION TO CONDUCT THE STUDY

Date:

Place:

From

The Principal,

Kavuri Subba Rao College of Nursing,

Guntur.

To

The Medical Officer,

Srinivas Rao Thota,

Guntur.

Respected Sir/Madam

Sub: **Seeking permission to conduct the Study for Project**

This is to introduce Mrs.D.Poornima,M.Sc.Nursing II year student of Mental Health Nursing of Kavuri Subba Rao College of Nursing,Guntur is conducting a research project in partial fulfillment of M.Sc Nursing programme and her topic is "A comparative study to assess the level of stress among working and non-working women of premenstrual syndrome under the age group of 25-35 years in SrinivasaRaoThota, Guntur, Andhra Pradesh".

Hence I request you to kindly accord permission to conduct Pilot study at your organization.

Thanking you

Principal

APPENDIX-E

LIST OF EXPERTS

1.   Dr.P.Lokeshwara Reddy   Associate Professor of Psychiatry,

Guntur Medical College,Guntur.

2.   Dr.K.Sree Lakshmi   Assistant Professor of Psychiatry,

Guntur Medical College,Guntur.

3.   Mrs.M.Yasoda   Obstetrics Gynaecology,HOD

K.S.R College of Nursing,Guntur.

4. Mrs.S.Vamsi Ujwala   Asst.Professor,

Govt.Nursing College

5. Mrs.CH.Aruna   Asst.Professor,of MHN

Govt.Nursing College

STRUCTURED STRESS QUESTIONNAIRE

DEMOGRAPHIC DATA

Instructions:

❖ Please answer all the questions

❖ You need not write your name

❖ Please be free and frank in answering the questions

❖ You are free to use pen or pencil for answering

❖ Please write the correct answer in the bracket given against each question

SECTION-A

1.   Age   [   ]

a)   25-28 years

b)   29-32 years

c)   33-35 years

2.   Religion   [   ]

a)   Hindu

b)   Muslim

c)   Christian

d)   Others (specify)………………

3.   Education   [   ]

a)   Illiterate

b)   Below 10th class

c)   10th class

d)   Inter/Degree and above

4.   Occupation   [   ]

a)   Employee

b)   Un-Employee

c)   Cooli

d)   Business

e)   Housewife

5.   Working hours   [   ]

a)   More than 8 hours

b)   More than 12 hours

6.   Income   [   ]

a)   5000-9000

b)   1000-14000

c)   15000-19000

d)   Above 20000

7.   Marital status   [   ]

a)   Married

b) Unmarried

c) Widow

d) Divorcee/Separated

8.Source of information   [   ]

a)Health personnel

b)Mass media

c)Family members & friends

d)Relatives &Neighbours

SECTION –B

PREMENSTRUAL SYNDROME STRESS SCALE   <u>Please</u>

<u>choose the correct answer :</u>

1.   Do you suffer from Mood swings before a period?   □Yes

□No

2.   Do you feel Restless before your period?   □Yes

□No

3.   Do you get Irritated often before your period?   □Yes

□No

4.   Do you Angry easily before your period?   □Yes

□No

5.   Do you feel upset about little things before your period?   □Yes   □No

6.   Do you suffer from Backache before your period?   □Yes   □No

7.   Do you have Muscle pain   before your period?   □Yes

□No

8.   Do you have Breast pain before your period?   □Yes

□No

9.   Do you have sleeplessness before your period?   □Yes   □No

10.   Do you have difficulty making decisions before your period?   □Yes

□No

11. Do you have a lack of interest in sex before your period? □Yes □No

12. Do you have Confusion & forgetfulness before your period? □Yes □No

13. Do you get extremely tense before your period? □Yes □No

14. Do you feel so sad often before your period? □Yes □No

15. Do you feel Depressed unknowingly before your period? □Yes

□No

16. Do you have interest in daily activities before your period? □Yes □No

17. Do you have a throbbing Headache before your period? □Yes □No

18. Do you gain Weight before your period? □Yes □No

19. Do you crave food before your period? □Yes □No

20. Do you have Bloating before your period? □Yes

□No

21. Do you have Dizziness before your period? □Yes

□NO

22. Do you feel nausea/vomiting before your period? □Yes □No

23. Do you observe Acne on your face before your period? □Yes

□No

24. Do you have Diarrhea before your period? □Yes □No

25. Do you have Constipation before your period? □Yes □No

26. Do you have intense menstrual cramps before your period? □Yes □No

27. Do you get easily tired before your period?

□Yes □No

28.   Do you suffer from the heaviness of extremities before your period?   □Yes

□No

29.   Do you feel pain radiating down the thighs before your period?   □Yes

□No

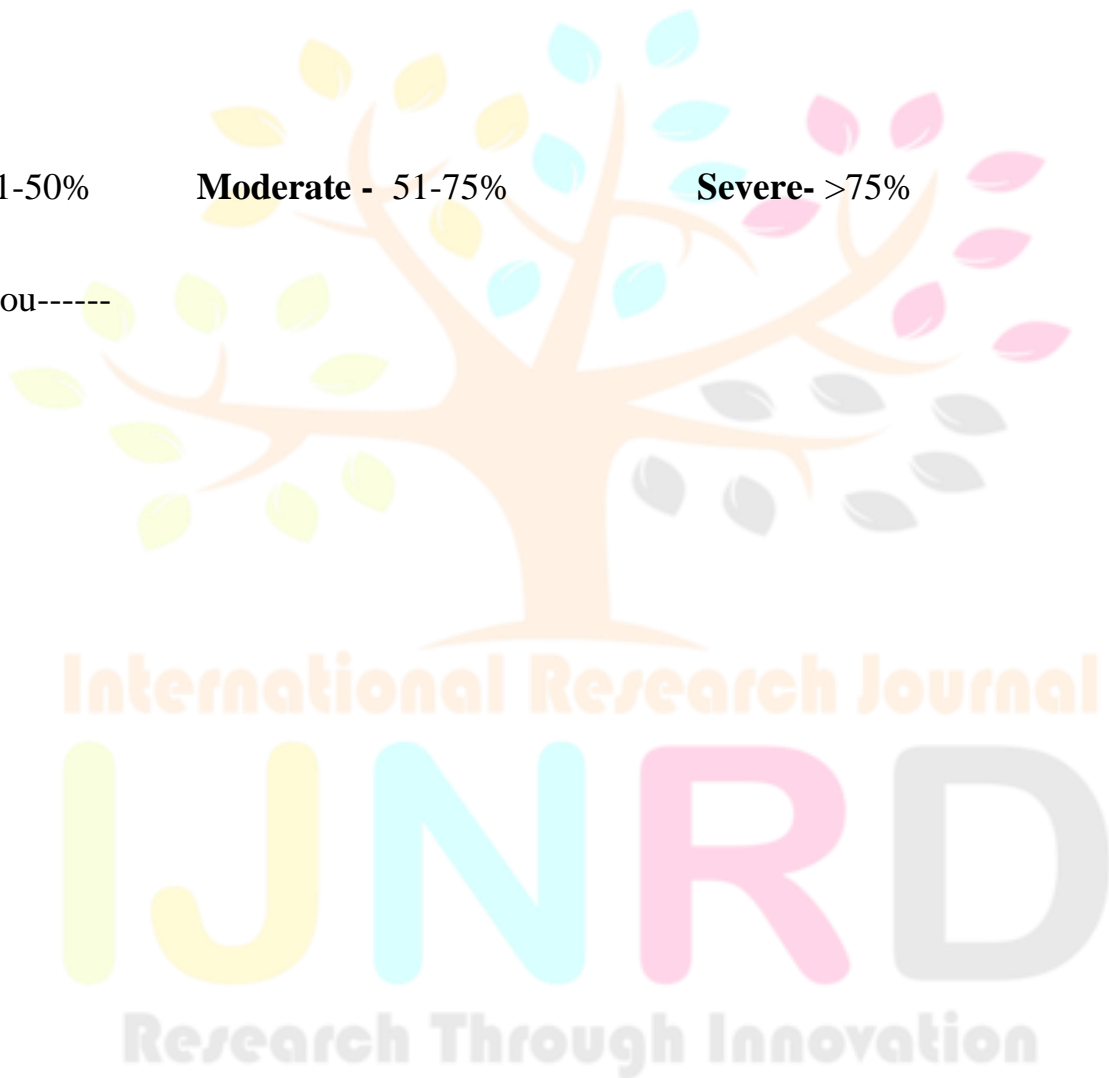30.   Do you feel fatigued from doing a little work before your period?   □Yes

□No

Key: **Mild-** 1-50%   **Moderate -** 51-75%   **Severe-** >75%

------Thank you------

SELF INSTRUCTIONAL MODULE

PREMENSTRUAL SYNDROME -HOW TO EASE PMS AND STRESS CAUSED BY IT

Do you ever start crying about something and then the next day you got your period?

Then you have to know what causes you to cry and stressed before your period

Let's know about PMS and stress caused by it

Stress can be one of the more debilitating symptoms of PMS.It can just strike you down at random and make an ordinary day suddenly overwhelming.

Premenstrual syndrome makes you more prone to feeling stressed,then every task you face the week before your period becomes a hard chore and suddenly,you can't seem to cope as well as you usually do.

What is PMS?

Premenstrual syndrome (PMS) is the name given to the physical,psychological and behavioral symptoms that can occur in the two weeks before a women's monthly period.

What causes PMS?

➢   -Hormone changes(estrogen progesterone rise & fall)

➢   -Chemical changes in brain

➢   -Decreased serotonin levels affects Mood

➢   -Life style

➢   -Weight(obesity)

➢   -Lack of exercise

➢   -Stress

➢   -Diet(too much salty food)

➢   -Alcohol

➢   -Caffeinated drinks

➢   -low levels of vitamins minerals

➢   -Smoking

What are the Signs and symptoms of PMS?

Physical symptoms

❖   Bloating

❖   Pain & discomfort in the abdomen

❖   Headache

❖   Back ache

❖   Breast pain

❖   Muscle & joint pain
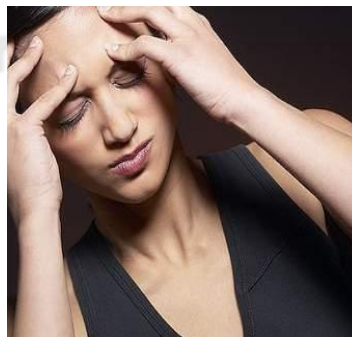
- ❖ Trouble sleeping
- ❖ Nausea
- ❖ Weight gain

Psychological and behavioral symptoms

- ❖ Mood swings
- ❖ Feeling upset or emotional
- ❖ Feeling irritable or angry easily
- ❖ Crying
- ❖ Anxiety
- ❖ Difficulty concentrating
- ❖ Confusion Forgetfulness
- ❖ Clumsiness
- ❖ Restlessness
- ❖ Tiredness
- ❖ Decreased self-esteem
- ❖ Loss of interest in sex
- ❖ Lack of hunger
- ❖ Food cravings

How can PMS be treated?

- ✓ Pain killers
- ✓ Oral contraceptive pills
- ✓ Estrogen patches and implants
- ✓ Antidepressants
- ✓ Gonadotropin releasing hormones

What are the measures to be taken to control PMS?

Diet:

- ✓ Eat smaller and frequent meals to reduce bloating

✓   Eat salt restricted or limited foods to reduce bloating and fluid retention

✓   Drinking more water decreases headaches and tiredness

✓   Eat complex carbohydrates which can be found in fruits, vegetables and whole grains

✓   Eat calcium rich foods such as milk and cheese,ragi malt,jaggery.

✓   Eat foods rich in B-complex vitamins which keep your body and brain healthy

✓   Avoid caffeine and alcohol which affects your mood and energy levels

Exercise:

✓   Improves your overall health

✓   Releases happy hormone serotonin lifts your mood and makes you more able to face challenges

Relax:

✓   Yoga and pilates can help you sleep better and reduce your stress levels

Smoking:

✓   Quit if you smoke to reduce PMS symptoms

Complementary treatments:

✓   Supplements of calcium, Vit-D and magnesium may reduce some symptoms of PMS

Tracking of symptoms:

✓   Keep track of your symptoms with every menstruation in the dairy

Look for something positive in each day,even if some days you have to look a little harder

------THANK U-----