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Religiosity and its Relation with Subjective Well-being among Working Women

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Abstract:

The present study ascertained the relationship between religiosity and subjective well-being among working women of Kashmir. The sample of the study consisted of 150 working women from different areas of Kashmir. They were working in different departments (education, health, social welfare and banking). The tools used for data collection were self made general information schedule, religiosity questionnaire (self made) and subjective well being scale developed by Sell and Nagpal. The results were analyzed by computing mean, SD and coefficient of correlation by using SPSS. The results of the study show that there exists a positive yet significant correlation between religiosity and well-being (r=.61), negative and significant correlation between religiosity and ill-being (r=-.28) and positive and significant correlation between religiosity and overall subjective well-being (r=.48).

Keywords : *Religiosity, working women and subjective well-being.*

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Introduction:

Some consider well-being to be a quality of life, as defined by Emerson (1985:282), representing the satisfaction of the individual's goals and needs through actualization of abilities and lifestyle. This concept nonetheless remains as of yet ambiguous, lacking a universally acceptable definition and often facing competing interpretations. Well-being for McGillivray merely describes the state of life of peoples (McGillivray 2007, p. 3). Precise definition of the concept of well-being remains nonetheless difficult and may even be challenging to measure. Generally speaking, however, measures of well-being may be either objective or subjective. The objective category measures well-being by means of observable indicators including economic, social, and environmental statistics. As such well-being is assessed indirectly by means of cardinal measures. Subjective measures of well-being, however, capture people's feelings or real experiences in a direct way, therefore assessing well-being through ordinal measures (McGillivray and Matthew 2006; Van Hoorn 2007). It can be assumed, however, that subjective well-being describes a subjective state which is moderately independent of objective conditions. This is reflected as early as the 1970s, where Campbell (1974) proposed looking beyond the material conditions of life that have traditionally been accepted as a criteria of well-being; into the subjective world of feelings and emotions where the quality of life is ultimately determined. Campbell et al. (1976) believe that in spite of the fact that people live in objective environments, they nonetheless tend to perceive the world subjectively. As such the concept of well-being is multidimensional, inclusive of various dimensions of mental and physical health, supporting social relationships, and the ability to cope with stressful situations (McDowell 2010). Subjective well-being describes the overall

evaluation of one's quality of life (Diener 2009). Subjective wellbeing is defined as a person's judgement or evaluation of his / her life either in terms of life satisfaction (cognitive evaluations) or affect (emotional reactions) which is further divided into pleasant affect (positive feeling) and unpleasant affect (negative feeling). Negative perceptions or expectations of subjective wellbeing are associated with the less adaptive and coping efforts eroding feelings of mastery and hope in the individuals. The level and type of subjective wellbeing varies from individual to individual. There is no denying the fact that besides performing a dual role i.e. procreation and housekeeping, working women have to perform an additional role which may add to their stress thereby affecting their subjective well-being. Based on currently pertaining literature, most employees attempt to use different strategies to cope with life problems and events such as stressors, anxiety, and work-family conflict. It appears, however, that these methods are often applied exclusively. Furthermore, a significant number of researchers exhibit interest in the study of methods dealing with work-family issues in a variety of environments and contexts, while exploring their relationship with a number of variables. Lazarus and Folkman (1988), for instance, found social support, transition from subject, self-control, and plans for problem solving as coping strategies used to deal with pressing and urgent conditions. In addition, earlier studies indicate that religiosity or religious coping strategies play a vital role in reducing and buffering the effect of job stressors in person, and achieving individual well-being. To further reinforce these notions, Kasberger's (2002) study reflects that religious coping strategies reduce the amount of stress. For Safaria et al. (2010), religious coping strategies also act as a moderator variable in modifying the impact of stressors on job stress.

From the literature it appears that religion has some connection with well-being. Keeping the previous researches in mind, the investigator became motivated to examine whether the religiosity plays any role in the subjective well-being of working women of Kashmir valley.

Objective:

The main purpose of the study is to examine the role of religiosity in the subjective well-being of working women.

Method:

Sample:

A sample of 150 female employees working in different sectors (education, health, banking, social welfare, defense, etc.) was selected randomly. The age range of the respondents was between 30 and 55 years and all of them were married Muslim women having their own family.

Tools:

1. **General information schedule**

   The schedule includes the items related to the demographic characteristics prepared by the researchers.

2. **Religiosity questionnaire**

   A self made religiosity questionnaire consisting of 15 items was used to collect the data on religiosity level of the respondents. Each item has 5 response options ranging from 'Strongly agree' (5) to 'Strongly disagree' (1). The higher the score, the greater is the level of religiosity. The split half reliability for the questionnaire was found to be .86 and the test-retest reliability was found to be .74. The questionnaire was also found to possess the content validity as measured by the views expressed by experts.

3. **Subjective Well-Being Scale**

   The subjective wellbeing of the respondents was measured by Subjective Wellbeing

Scale developed by Sell and Nagpal (1992). This scale consists of 40 items, 19 items illicit positive effects which come under the dimensions of wellbeing (general wellbeing positive affect, expectation achievement congruence, confidence in coping, transcendence, family group support and social support) and 21 items elicit negative effects about the individual life concerns which belong to the dimensions of ill being (primary group concern, inadequate mental mastery, perceived ill health, deficiency in social contacts and general wellbeing negative affect). Each statement has 3 alternative answers i.e. 'Very good', 'Quite good' and 'Not so good' excluding the items 14, 27 and 29 having an extra option 'Not applicable' with the scoring of 3, 2 and 1 for positive and reverse scoring for negative items.

Procedure of data collection:

The data was collected individually from the participants at their respective places. The rapport was established by explaining the importance and relevance of the study. Before proceeding with the data collection, consent from the participants was sought. They were assured that the information provided by them would be kept confidential and would be used for academic purpose only. First of all data was collected on the general information schedule for recording the personal and demographic information of the participants and thereafter were requested to complete the religiosity questionnaire. Finally, the subjective wellbeing scale was administered on the same participants. After completion of the task the participants were thanked for their cooperation and support.

Data analysis:

The data was analyzed by computing mean, SD and coefficient of correlation using SPSS.

Results:

The results of the study are presented in the following tables: -

Table1: Correlation between religiosity and well-being, ill-being and overall well-being

Variable	Mean	S.D.	1	2	3	4
1.Religiosity	51.29	5.58	1			
2. Well-being	49.03	3.18	.671	1		
3. Ill-being	50.30	5.21	-.28	-.10	1	
4. Overall well-being	99.33	4.29	.48	.359	.17	1

The above table shows that there is a positive significant correlation between religiosity and well-being (.671), negative yet significant correlation between religiosity and ill-being (-.28), positive yet significant correlation between religiosity and overall wellbeing (.48). The table also shows that there is a negative correlation between well-being and ill-being (-.10) and positive but significant correlation between well-being and overall subjective well-being.

Table2: Correlation between religiosity and dimensions of subjective well-being.

Variable	Mean	SD	1	2	3	4	5	6	7	8	9	10	11	12
1. Religiosity	51.29	13.63	1											
2. General wellbeing positive effect (GWB-PA)	9.00	2.65	.53	1										
3. Expectation achievement congruence (EAC)	9.00	3.14	.34	.26	1									
4. Confidence in coping (CC)	9.00	3.36	.37	.21	.00	1								
5. Transcendence (Trans)	8.00	4.24	.29	.22	.05	.02	1							
6. Family group support (FGS)	7.00	3.18	.27	.18	.09	.06	.14	1						
7. Social support (SS)	7.00	2.31	.31	.19	.08	.07	.03	.16	1					
8. Primary group concern (PGC)	10.00	2.45	.09	.07	.05	.03	.01	.02	.05	1				
9. Inadequate mental mastery (IMM)	12.00	5.09	.07	.01	.06	.08	.08	.06	-.01	.04	1			
10. Perceived ill health (PIH)	9.00	2.48	-.31	.11	.00	.09	.06	.09	.00	.01	.05	1		
11. Deficiency in social contact (DSC)	10.00	2.13	.00	-.12	.01	-.06	.09	.00	-.13	.08	.06	.19	1	
12. General wellbeing negative affect (GWB-NA)	9.00	1.96	-.21	-.11	-.07	-.13	.04	-.15	-.40	.07	.02	.21	.05	1

From the above table it is clear that there is a positive yet significant correlation between religiosity and GWB-PA (r=.53), EAC (r=.34), CC (r=.37). Trans (r=.29), FGS (r=.27), SS (r=.31). There is negative and significant correlations between religiosity and PIH (r=-.31) and GWB-NA (r=-.19). There is insignificant correlations between religiosity and PGC (r=.09), IMM (r=.0.7) and no correlation between religiosity and DSC (r=.00). GWB-PA is positively correlated with EAC (r=.26), CC (r=.21), Trans (r=.22), FGS (r=.18) and SS (r=.19) and insignificantly correlated with PGC (r=.07), IMM (r=.01), PIH (r=.11), DSC (r=-.12) and GWB-NA (r=-.11). There is also a significant yet negative correlation between SS and GWB-NA (r=-.40). There is also positive yet significant correlations between PIH and DSC (r=.19), and PIH and GWB-NA (r=.21). Moreover, rest of the correlations between different dimensions are insignificant.

Discussion:

The present study examined the relationship between religiosity and subjective well-being among working women of Kashmir. From the results analyzed in the above section it was found that religiosity is positively yet significantly related with the overall subjective well-being. Also it was found that religiosity is positively and significantly related with the well-being and negatively yet significantly related with ill-being (Ref. Table1). It means as the religiosity increases (i.e. as the people have more religious belief, faith and do religious practices), their well-being and overall subjective well-being increases while increase in the religiosity decreases the ill-being. So for as the overall well-being is concerned, religiosity is the best option. These results are inline with the previous studies carried out abroad. Noor (2008) found that like other religions, Islam is associated with well-being because it provides guidance on how to live ours' life, offers comfort and support during good and bad times, and gives meaning and identity to individuals. Tiliouine & Belgoumidi (2009) have shown that religiosity predicts meaning and life satisfaction in Muslim students in Algeria. Moreover, Abdel Khalek (2010) found that religiosity among Muslim Kuwaiti adolescents was related to better health and well-being and less anxiety.

Regarding the relationship of religiosity with various dimensions of subjective well-being, it was found that religiosity is positively and significantly correlated with General well-being positive Affect, Expectation achievement congruence, Confidence in coping, Transcendence, Family group support and social support (Ref. Table2). As the religiosity increases in a person, his General well-being positive Affect, Expectation achievement congruence, Confidence in coping, Transcendence, Family group support and social support also increases. These results converge with the results of the previous studies. Taha (2006) reported that the proper practice of worship in Islam is seen as an effective tool for coping with life stresses. It was also found that religiosity is negatively related with Perceived ill health and General well-being negative affect (Ref. Table2). Hence, increase in religiosity decreases the feelings of ill health and negativity in life. These results are supported by Kandaswamy (2007) who reported that stress can be reduced through the use of a number of Islamic coping strategies such as supplication to God (Dua), patience (Sabr), religious devotion, remembrance of God (Zikr), remembrance of death, trust is God (Tawakul) and reflective recitation of Holy Quran (Tilawat).

Conclusion:

Religiosity has a positive effect on the subjective well-being of working / stressed women.

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