The Prevalence of Anxiety Disorders and its Relationship with Marital Satisfaction

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ABSTRACT

The aim of the present study was to study the pattern and prevalence of marital satisfaction in females with anxiety disorders, who are either treatment naïve or on treatment. The study was conducted on 150 married female patients aged 18-40 years fulfilling the diagnosis of anxiety disorders as per DSM 5 criteria at the Lady Hardinge Medical College and Smt. S.K. Hospital, in New Delhi were recruited for this study. The Dyadic Adjustment Scale (DAS-32) was used to assess the relationship quality of intact (married or cohabiting) couples. Hamilton Anxiety rating Scale was used to assess the severity of anxiety symptoms. Demographics of the sample were studied which provided insights into the prevalence of anxiety disorders. No significant correlation were found in marital satisfaction and anxiety disorder scale score.

Key words: Marital Satisfaction, anxiety disorder, married females, Dyadic Adjustment scale, Hamilton Anxiety rating Scale.

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Introduction

Anxiety Disorders

Anxiety is one of most frequently encountered psychiatric disorder. Excessive fear of social or performance circumstances in which one may be judged by others characterises social anxiety disorder. Women have a slightly greater lifetime prevalence (approximately 5%-15%) than men (around 4%-11%) (Kessler, 1994). All individuals are prone to have experienced anxiety at some point of their lives, but people suffering from anxiety disorders experience fear and worry that is high in intensity and frequency. Other symptoms related to anxiety disorders can be physical tension and other behavioural and cognitive symptoms. Anxiety disorders interfere with daily activities and can impair a person's family, social and school or working life. Anxiety disorders are the most common form of mental disorders.

Previous literature suggests that marriage decreases the prevalence of depression and anxiety. It helps to excel the mental well-being of a person. Research generally depicts that the mental well-being of single individuals was reported to be significantly more than that of their previously married counterparts, but much lower than that of married people (Gove and Shin, 1989; Kurdek, 1991). An epidemiologic survey reported that unsatisfactory marriage poses the risk for depression (Weissman, 1987). Similar to any other psychological disorder, Anxiety disorders can easily become the cause or be the consequence of marital conflicts (Schless et al. 1977; Rao & Nambi 2009).

Anxiety has been seen to be both the cause and consequence of marital dissatisfaction. High association were noted in experiences of marital instability and high anxiety (Postler, 2019). Anxiety disorders are linked to disturbing marital outcomes which may lead to high stress and tension that anxiety puts in a marriage relationship (Bradbury & Karney, 2004). A number of studies indicate Individuals with anxiety disorders tend to experience increased stress in their marriages, making these relationships more vulnerable to separation compared to those where neither partner has an anxiety disorder. Additionally, those with anxiety

disorders often report a lower quality of connection in their relationships compared to individuals without such disorders (Yoon & Zinbarg 2007; Scott et al. 2010).

Marital Satisfaction

Marriage is an important interpersonal relations, since most individuals marry at least once during their lifetime (Berscheid & Regan, 2005). Marriage is more of a social institution and not merely a close personal relationship which affects people's life (Ponzetti & Mutch, 2006). So it is important for a person to have marital satisfaction. Marital satisfaction is often defined "as the attitude an individual has toward his or her marital relationship" (e.g., Fincham and Beach 2010). It is a measure of the quality of relationship of a couple, depicting the subjective evaluation of their relationship's quality. (Janati Jahromi Mehrdad & Leila, 2010 ; Rosen-Grandon et. al, 2004).

Marital satisfaction is experienced by a couple when their marriage is consistent with what they had expected from the marital relationship (Rosen-Grandon et. al, 2004). But when these expectations are not fulfilled then marital dissatisfaction and conflicts arise between couples and the way in which couples choose to manage those conflicts is associated with individuals' perceptions of satisfaction within the relationship.

Methodology

Using convenience sampling, female patients of anxiety disorders who came to department of psychiatry of LHMC, within the time frame of study, and met the inclusion and exclusion criteria, who provided informed consent were included as study participants. A total sample of 150 married females in age group of 18- 40 years having diagnosed with anxiety disorders were taken for this study based on inclusion and exclusion criteria. The primary motive was to assess the level of marital satisfaction in both treated as well as untreated patients of Anxiety Disorders.

The demographic details of the patients were noted down at the start of the study using semi-structured proforma and Modified Kuppuswamy scale was used for socio-economic strata. Patients who were willing to offer written informed permission were contacted, and the research procedure was described with the use of a patient information.

Tools:

Participants were assessed on Hamilton anxiety rating scale for severity of anxiety. Marital satisfaction and other similar dyads were assessed using Dyadic adjustment scale (DAS).

Hamilton Anxiety rating Scale: This scale is widely used clinical tool designed to assess the severity of anxiety symptoms. HAM-A consists of 14 items, each aimed at assessing different aspect of anxiety as experienced by the individual. This test has been important in diagnosis and monitoring of anxiety disorders, covering both psychological and somatic symptoms.

The Dyadic Adjustment Scale (DAS-32) is a 32-item measure designed to assess the relationship quality of intact (married or cohabiting) couples. This original version of the measure includes items and subscales aimed at assessing relationship satisfaction, intimacy, affective expression and the degree to which the couple agrees on matters of importance to the relationship.

Statistics

- Proportion of Participants having score >101 score of Dyadic Adjustment Scale across two study groups*.
- Anxiety Disorders, treatment naive; Anxiety Disorders on treatment.
- Correlation of marital satisfaction with severity of anxiety as assessed by Correlation of DAS scores with HAM-A scores.

Results

DEMOGRAPHIC

In the present sample, 48.67% of females were between 31-40 years, while remaining 51.33% were between 18-30 years.

Parameter assessed	*Anxiety disorder (n=150)*
Mean age (years)	30.59 ± 5.84
Median age (years)	30
Minimum age (years)	18
Maximum age (years)	40
Females between 18-30 years	77 (51.33%)
Females between 31-40 years	73 (48.67%)

In the present sample, 54.67% participants had *e*ducation of up to 10th standard, while remaining 45.33% had education of >10th standard. 53.33% participants were not working, 46.67% were working for <8 hours, none were working for >8 hours. Also, 98% of participants were having husband as head of the family, while 2% had others as family head. In this sample, 74% of participants were living nuclear family, 18% lived in extended family while 8% lived in joint family. 71.33% of participants were living in urban area, while 28.67% lived in rural area. Based on Kuppuswamy Classification 60.67% females in anxiety group belonged to upper lower class, while 30.67% belonged to lower class. 80% females were Hindus, 18.67% were Muslims, 2 females were Sikh while none were Christians.

CHARACTERISTIC OF ANXIETY IN STUDY POPULATION

55.33% cases had panic type of anxiety disorders, 34% had generalized anxiety disorder (GAD), while 10.67% had phobias.

Distribution of study groups according to types of anxiety disorders

Type of Anxiety Disorder	*Number of patients (%)*
Panic	83 (55.33%)
GAD	51 (34%)
Phobias	16 (10.67%)
Total	150 (100%)

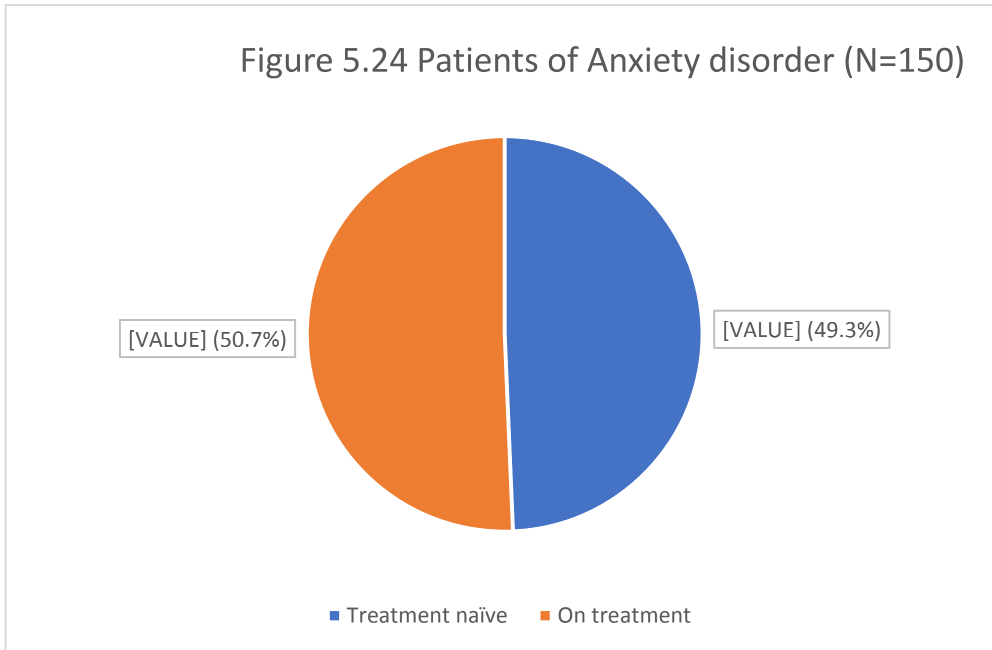
By HAM-A score, 40% cases had mild anxiety, 20% had mild to moderate anxiety, while remaining 40% had moderate to severe anxiety.

Distribution of study groups according to severity of anxiety by HAM-A score

Severity of Anxiety (HAM-A)	*Number of patients (%)*
Mild	60 (40%)
Mild to Moderate	30 (20%)
Moderate to Severe	60 (40%)
Total	150 (100%)

Proportion of patients of Anxiety Disorder On treatment vs. Treatment naïve

Patients of Anxiety disorder (N=150)	Number (n)	Percentage
Treatment naïve	74	49.3333333
On treatment	76	50.6666667



DYADIC ADJUSTMENT IN STUDY POPULATION

DAS score in study groups

The mean DAS score was noted to be 158.03 ± 48.05 in the anxiety score. The number of females who were diagnosed with distress based on total DAS score of ≤101 were 18 in number contributing to a total of 12% while the other 132 (88%) females were found to be not distressed whose DAS score was >101.

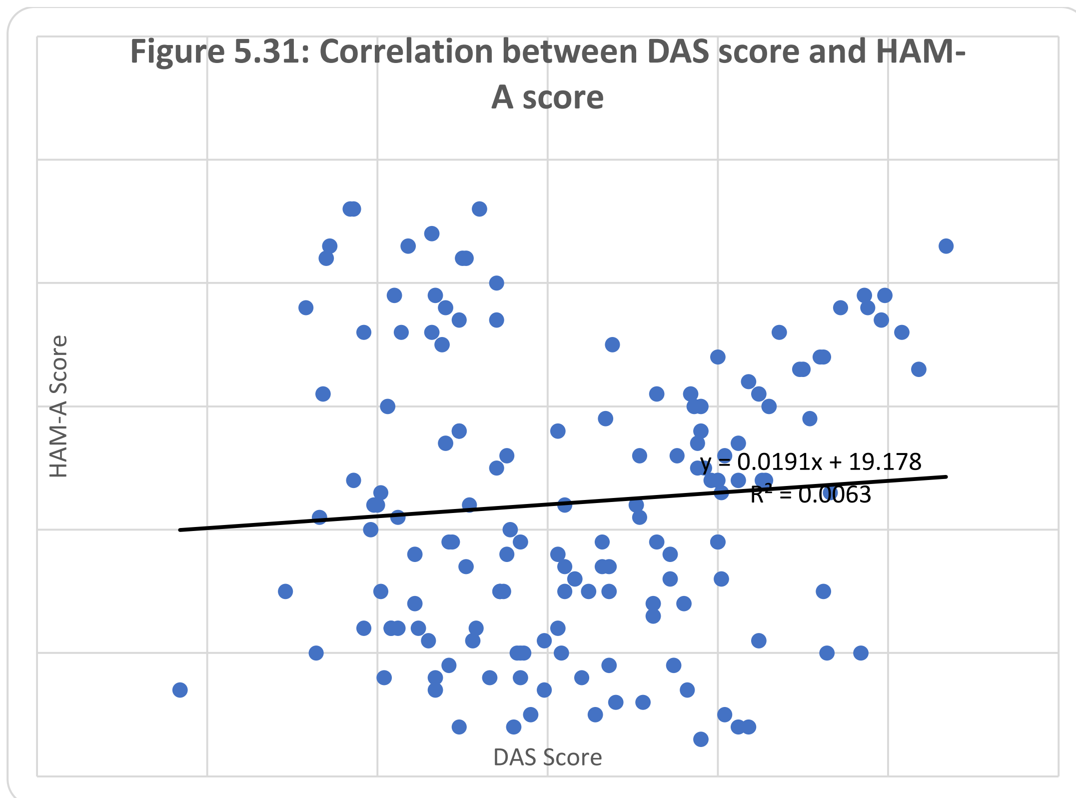
On comparing the Total DAS score between treatment naïve and on treatment groups with unpaired T-test:

Scores (N=150)	Treatment naïve (n=74)	On treatment (n=76)	p-value (Unpaired T-test)
DAS total score	161.4 ± 50.18	154.75 ± 45.3	0.19

The t value is 0.84, p = 0.19. The 74 participants who were treatment naïve (M = 161.4, SD = 50.18) compared to the 76 participants in the "on treatment" (M = 154.75, SD = 45.3) demonstrated no significant improvement in the DAS score with the t value is 0.84, p = 0.19.

Correlation

The correlation of DAS score and HAM-A score was noted to be not significant (p>0.05) and indicated very weak non-significant positive correlation. (Figure 23)



Correlation coefficient (r) = 0.26 (CI: 0.19 – 0.32, p-=0.19) by Pearson's correlation coefficient indicating weak non-significant positive correlation.

Discussion

Sex-related anxiety can make psychologically engaging in sexual activity harder since the woman is too busy with her sex-related worries to fully attend to sexually attractive cues (Barlow, 1986). High levels of anxiety may also be related with non-sexual cognitive distractions (such as worry, obsessions, and hypervigilance to physiological sensations) that might interfere with sexual responsiveness in the absence of specific sexual issues. Non-sexual cognitive distractions lower both physiological and subjective arousal to erotic stimuli in women who do not have sexual problems, according to laboratory studies (Adams et al., 1985).

A detailed analysis of the data reported the demographics of the sample. In the anxiety group, 54.67% of participants had education up to the 10th grad. There are multiple associations between depression and education status, according to the literature research. Unsurprisingly, those with lower levels of education experience higher rates of depression and anxiety than those with higher education levels (Bauldry, 2015; Bjelland et al., 2008). Our study also revealed that 53.33% of participants in the anxiety group were without employment at the time of the study. This demonstrates the significant impact of unemployment on mood disorders.

98% of those with anxiety disorders had a husband who served as the family's head. The individual who has substantial control over the other family members and is in charge of the family's financial affairs is referred to as the head of the family (Nazoktabar et al., 2008). The percentage of people with anxiety disorders who lived in nuclear families was 74%. It's crucial to view someone's mental health holistically. The influence of family, neighbourhood, and cultural factors on mental health is crucial. The family system supports people in all facets of their lives, enabling them to have contented and productive lives.

A significant portion of the participants, i.e. 71.33% of anxiety disorder subjects resided in urban areas. A higher proportion of participants with anxiety disorder (91.34%) belonged to

lower socio-economic status according to Kuppuswamy classification details. Several other studies also highlight a similar trend where low socioeconomic status is consistently associated with a higher prevalence of mood disorders including MDD and anxiety (Freeman et al., 2016). Poor individuals believe that they are comparatively disadvantaged and socioeconomically underprivileged in comparison to others. This may lead to anger, guilt, inferiority, and stress, all of which can have a negative influence on health and trigger symptoms of depression. Also, 5 females had thyroid disorders, 2 females each had hypertension and diabetes mellitus respectively, while 1 female each had asthma and PCOD respectively.

40% cases had mild anxiety, 20% had mild to moderate anxiety, while remaining 40% had moderate to severe anxiety which shows the high prevalence of anxiety disorders.

18 females were diagnosed as being distressed based on total DAS score of ≤101 contributing to a total of 12% while the other 132 (88%) females were found to be not distressed whose DAS score was >101. No significant improvement in scores were noted between the groups who were treatment naïve or on treatment.

The correlation study also indicated very weak non-significant positive correlation which was not significant between anxiety disorders and marital satisfaction.

Conclusion:

The study of demographics on the sample revealed that level of education, employment status, head of the family, area of residence, socio-economic status, etc. play a major role in the prevalence of anxiety disorders. It also highlighted the level of anxiety experienced by the study group under the categories of mild, moderate and severe. It can also be concluded that subjects on treatment and who were treatments naïve had almost similar results in term of marital satisfaction.

Limitations and Implications:

The present study highlights the prevalence of anxiety disorders on females only, no males were taken into consideration. Therefore, this study guides us to assess the level of anxiety disorders and quality of marital relationship in males also.

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