Original Article

The Role of Religious Coping Strategies in Predicting Depression among a Sample of Women with Fertility Problems in Shiraz

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Abstract

Background: One of the most common mental health problems among women with infertility problems is depression. Research has shown that religious beliefs and practices can help people to cope with difficult situations. The purpose of this study was to explore the role of different religious coping strategies in predicting depression in a group of infertile women in Shiraz.

Methods: A total of 72 women with fertility problems were recruited from several private infertility clinics in Shiraz using convenience sampling. The participants completed the research questionnaires including Beck Depression Inventory and Religious Coping Scale. The Religious Coping Scale consists of five dimensions including practice, active, passive, benevolent reappraisal and negative religious coping. Descriptive statistics (frequency percentage, mean and standard deviation), Pearson's correlation and simultaneous multiple regression analysis were used for data analysis using SPSS version 16. A p-value less than 0.05 was considered statistically significant.

Results: The present study showed that about 30% of women with fertility problems experienced the symptoms of depression. The findings also indicated that the most commonly used religious coping strategy was practice religious coping, while the least commonly used religious coping strategies were passive and negative religious coping. The findings also showed that active religious coping, practice religious coping and benevolent reappraisal coping predicted depression reduction.

Conclusion: This study highlights the effect of religious coping on depression reduction of women with fertility problems. In other words, women who used religious coping strategies were less likely to experience depression symptoms.

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Introduction

It is estimated that about 22 percent of Iranian couples have primary infertility problems (1). Infertility is the inability of a couple to achieve conception after a year or more of regular unprotected intercourse (2). Many studies have documented that couples with infertility problems experience mental health problems such as distress, anxiety and depression. One of the most common mental health problems among women with infertility problems is depression (3, 4). Research has found that 21% of couples with fertility problems experienced clinical depression (5). Studies on the prevalence of depression among Iranian couples with infertility have reported various statistics from 5 to 50 percent (6-8). Previous research has found that several factors including the age, education, social support and the pressure of husband's family for pregnancy influence infertile couples' mental health. Within traditional societies such as Iran, women are expected to give birth and families blame them if they cannot give birth so, they are more

under the mental pressure compared with men (9). Religious coping refers to the use of religious beliefs or practices to cope with stressful life situations (10). Research has shown that religious beliefs and practices can help people to cope with difficult situations such as physical illnesses (11), stress and depression (12-14). Individuals who use religious coping appear to handle their conditions more effectively than those who do not (15). Religion is often involved in the reconstruction of traumatic events and provides a framework for understanding the most senseless accident, the most unbearable pain, or the most unjust outcome (16). If one relies on a higher power, one feels less pressure to control circumstances and to worry about results (17). This way of appraising a stressful life situation may relieve anxiety and counteract feelings of hopelessness and despair, even in the most desperate circumstance (18). Studies have indicated that people with higher level of religiosity use religious beliefs and practice strategies more frequently than other ways of coping. Many studies have reported a positive relation between use of religious coping and physical/mental health (19). For example, research has examined the reactions of victims of chronic illnesses, and found that the most common explanation for the event was to view it as part of God's plan (10). Furthermore, Pargament also found that in several health-related situations, causal attributions to God were greater than to any other sources (20). The surveys have shown that religion and spirituality are significant for the majority of Iranian people (21). A relatively large proportion of Iranian couples with infertility experience psychological distress (22, 23). The majority of studies in Iran on the relation between religiosity and mental health have reported the positive impact of religious beliefs and practice on mental health. Research conducted in Iran so far has used a general measure of religiosity to assess religious coping. It is important to explore the types of religious beliefs that women use for coping with such stressful situations as infertility. The present study tried to use a multi-dimension scale to assess different ways of religious coping. The various forms of religious coping have had different implications for adjustment to major life events. More specifically, the purpose of this study was to explore the role of different religious coping strategies in predicting depression in a group of women with fertility problems in Shiraz.

Methods

This study was a correlational one in which the components of religious coping (practice religious, active religious coping, passive religious coping, benevolent reappraisal and negative religious coping) were considered as independent variables and depression was considered as dependent variable. A total of 72 women with fertility problems seeking treatment were recruited for this study from several private infertility clinics in Shiraz using convenience sampling. All participants gave consent to participate in this study and they were assured of anonymity and confidentiality. The research proposal was approved by the Research Committee of the University of Shiraz. The criteria for entering into the study included the inability to achieve conception despite unprotected sexual intercourse of at least 1 year confirmed by a gynecologist and the ability to understand the questionnaires. Descriptive statistics (frequency percentage, mean and standard deviation), Pearson's correlation and simultaneous multiple regression analysis were used for data analysis using SPSS version 16. A $p<0.05$ was considered statistically significant.

Beck Depression Inventory: The Beck Depression Inventory (BDI-II) is the most commonly used screening instrument for measuring depression in the general population. The BDI-II (24) is a 21-item self-report instrument designed to measure severity of depression. Each item is rated on a 4-point scale ranging from 0 (never) to 3 (often). The ratings are summed, yielding a total score that can range between 0-63 (0-9 minimal depression, 10-18 mild depression, 19-29 moderate depression, 30-63 severe depression). The reported Cronbach's alpha is .92 (25). Studies carried out in Iran have used this scale and reported a good reliability and validity for that. This research has reported a Cronbach's alpha coefficient of 0.85 for this scale (26).

Religious Coping Scale: Religious coping scale is used to assess religious beliefs and practice strategies within Islamic context (27). This scale has been developed for use within Islamic context. The content of items is based on Islamic religious beliefs. This scale consists of 21 items and five dimensions including practice religious coping (6 items –*e.g.*, I sought help with prayer), benevolent reappraisal religious coping (6 items –*e.g.*, I saw my situation as God's will), active religious coping (3 items –*e.g.*, I turned the situation over to

God after doing all that I could), passive religious coping (3 items –*e.g.*, I didn't do much, just expected God to solve my problems for me) and negative religious coping (4 items –*e.g.*, I was disappointed with God's grace and mercy). The participants answered the items on a 5 Likert scale ranging from 0 (not at all) to four (a great deal). Higher score on this measure indicates frequent use of religious beliefs and a lower score indicates infrequent use of religious coping. This scale has been utilized in Iran and has been found to have a good reliability and validity. The internal consistency of the scale using Cronbach's alpha has been reported 0.89 for practice, 0.79 for negative, 0.82 for benevolent, 0.72 for passive and 0.78 for active religious coping. The concurrent validity of this scale has also been confirmed (27).

Results

The average age of the participants was 31.60 years (SD=5.35). The education level for the sample was: below high school (24%), high school (49.3%), undergraduate (22.6%), and postgraduate (3%). The majority of the participants were housewives (84%). The average duration of the treatment was 4.17 years (SD=0.97). Furthermore, the average time from diagnosis to treatment was 3.41 years (SD=0.85). Thirty percent of the participants scored above the cutoff point on the BDI scale and met the criteria for clinical depression. Fifty six individuals fell on minimal depression range; sixteen persons fell on mild depression range; six individuals fell on moderate depression range, and no one had severe depression. With regards to religious coping, positive patterns of religious coping were used more frequently than the negative patterns by women with infertility problems. The most commonly used religious coping strategies were practice religious coping (Mean=3.05, SD=0.73) and active religious coping (Mean=2.87, SD=0.88), while the least commonly used strategies were passive religious coping (Mean=1.52, SD=1.04) and negative religious coping (Mean=1.88, SD=0.49). The descriptive data are displayed in table 1. Furthermore, simultaneous multiple regression was used to assess the prediction of depression based on religious coping dimensions. Preliminary analyses were conducted to ensure no violation of the assumption of normally, multicollinearity, and homoscedasticity. The regression analysis showed that active religious coping (ß=-0.33, p<0.01), practice religious coping (ß=-0.32, p<0.01) and benevolent reappraisal religious coping (ß=-0.34, p<0.01) negatively predicted depression. The strongest predictor of depression reduction was benevolent reappraisal religious coping strategy. All the independent variables (benevolent reappraisal, active, practice, negative and passive religious coping) explained 32 percent of the total variance of depression. Furthermore, women using religious practices for coping with their stressful conditions were less likely to experience the symptoms of depression and those with benevolent beliefs were less likely to suffer from depression. The results

Table 1. Demographics characteristics for sample (n=72)

Variable		
Age (year) (M±SD)	31.60±5.35	
Education	**N**	**%**
Below high school	14	19.4
High school	37	51.3
Undergraduate	18	25
Postgraduate	3	4.1
Employment status	**N**	**%**
Housewife	60	84
Employed	12	16

Table 2. Means and standard deviations of religious coping scales

Variable	Mean	SD
Benevolent religious coping	1.97	0.66
Passive religious coping	1.52	1.02
Active religious coping	2.87	0.88
Practice religious coping	3.05	0.73
Negative religious coping	1.88	0.43

Table 3. Predicting depression based on different dimensions of religious coping

Model	Unstandardized coefficients		Standardized coefficients	t	P	Collinearity coefficients	
	B	Std.	Beta			Tolerance	VF
Benevolent religious coping	-0.60	0.20	-0.34	-2.99	0.001	0.64	1.56
Passive religious coping	0.30	0.21	0.16	1.26	0.14	0.85	1.17
Active religious coping	-0.74	0.23	-0.33	-3.19	0.002	0.69	1.44
Practice religious coping	-0.43	0.13	-0.32	-3.24	0.002	0.74	1.34
Negative religious coping	-0.01	0.20	-0.07	-0.06	0.95	0.78	1.37

Dependent variable: Depression

of multiple regression are presented in table 2.

Discussion

The present study showed that about 30% of women with infertility problems met criteria for depression. These women used practice religious coping more frequently than the other types of religious coping strategies. They also used negative and passive religious coping strategies less frequently than positive religious coping methods. These results are in agreement with literature that suggests the use of religious coping can help people under stress to manage their distress (28). These results support Pargamen's conceptualization of religious coping that indicates religion as an important philosophical orientation influencing the understanding of the world, and making reality and sufferings understandable and bearable (29). This study also demonstrated that benevolent reappraisal, practice and active religious coping strategies predicted the lower rates of depression. These findings are in agreement with literature showing the different types of religious coping in relation with increased or decreased depression (30, 31). With regard to the impact of benevolent reappraisal, the participants might redefine their stressful situation as an opportunity for spiritual growth and see their infertility as God's will or as God's trail (15, 20). The findings of this study on benevolent reappraisal support previous research indicating that religion facilitates the perception of positive aspects of stressful situations (32). To the extent that religious people believe that their lives are controlled by a higher power or that negative life events happen for a reason or that life events are opportunities for spiritual growth, they may experience life events as less threatening and less stressful (33). As a result, these positive appraisals may help to protect some religious individuals from depressive symptoms by helping them to perceive negative events as less stressful. This study revealed that women who actively tried to overcome their problems and then turned their situation to God were less likely to experience depression. It was found that active religious coping helped infertile women to adjust with their situation. Indeed, by using active coping, people take the required action and leave the results to God. The findings that active religious coping were associated with decreased depression is similar to that of Koenig's study on religious coping and depression (34). It is argued that religious practices such as praying can help couples to cope with their stressful conditions. Difficult situations such as infertility may encourage individuals to use religious coping strategies to adapt to their conditions. These results support the notion that there is a unique relation between positive religious coping methods and depression reduction (30). Furthermore, people who feel the most desperate may be more likely to turn to religion; that is, high levels of depression may precede increased use of religious coping (12, 35). This study suggests that individuals who use religious coping are able to view infertility as an opportunity for positive growth and that this has a positive effect on psychological well-being (27). The present study has several limitations. First, this study only surveyed women with fertility problems. Future studies should include men with infertility as well. Second, this study used cross-sectional design, so future research should use a longitudinal design. Finally, this study investigated only women who were seeking treatment, whereas, a number of couples may not seek treatment, and a more general population should be included in the next studies. The present study provides more support for the impact of religious coping strategies on mental health and also offers significant directions for future studies. It can help health system to include religiosity and spirituality into intervention programs to promote the mental health of couples with fertility problems.

Conclusion

The present study highlights the importance of religious beliefs and practice to protect women with infertility against depression. This finding showed that the greater use of religious coping was associated with lower levels of depression; thus, they can help professionals to consider religious coping for treatment interventions.

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Conflict of Interest

The authors have no any conflict of interest.

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