Introduction

All individuals come across varying degree of stress in their day-to-day life. However, stress lasting for longer duration can potentially give rise to mental health disorders. Mental health disorders are now established to be one of the prime causes of morbidity even in the developing countries. In patriarchal societies like India, little is known about the coping mechanisms used by homemakers to deal with stress in their lives. Aim: To identify usual coping mechanisms used by the homemakers residing in Kumaon region, India, to deal with stress in their day-to-day lives.

Settings and Design: This is a population-based, cross sectional study done in the urban field practice area of a teaching tertiary care health facility in the Kumaon region of Uttarakhand, India. Materials and Methods: A total of 324 ever-married, apparently healthy homemakers age 18–59 years residing in the area for at least 6 months were interviewed. Systematic random sampling along with population proportionate to size method was used to recruit study participants. Pretested, semi-structured questionnaire was used to elicit information on coping mechanisms used by the study participants. Standardized questionnaires were used to determine possible depressive or anxiety disorders.

Statistical Analysis: Data were entered in Microsoft Excel Sheet followed by analysis in SPSS and Epi Info. Chi-square test, Chi-square for trend, and Fisher’s exact test were used. Results: Multiple ways including praying, watching TV, taking care of children, and talking to family and friends were identified as the usual coping mechanism used by study participants. Coping mechanism varied with the mental health status and other sociodemographic characteristics of the study participants.

Conclusion: Coping strategy was predominantly “emotion-based” in the study population. Understanding of usual coping mechanism used by women may help counselors and clinicians in fine-tuning their therapeutic approach as per needs and preferences of such women.

Keywords: Ever-married women, mental health, praying, stress
fact, studies on Indian women have shown that paid work is less distressing to women compared with the high amounts of unpaid household work done by homemakers and that the working women have higher psychological well-being when compared with homemaker women.\[9\] Even many of the necessary sanitation behaviors of women, like during menstruation, are restricted due to societal reasons and act as stressor for them.\[9\] Indeed, women in India suffer from both depressive and anxiety disorders more frequently than their male counterparts, which may be one of the reflections of these societal pressures and restrictions.\[9\] Women face considerable stress in their day-to-day life, and many of them cope with it within their own houses/neighborhood without any formal help from outside. Coping is usually defined as the cognitive or behavioral efforts put in by an individual to deal with a situation appraised to exceed resources at the individual’s disposal.\[10\] However, there is little if any information in literature about the usual ways of coping with stress by married Indian women who do not work formally, that is, are homemakers. We thus carried out this study to identify the usual ways of coping by ever-married, homemaker women residing in urban area in the Kumaon region of Uttarakhand state in India with their day-to-day stresses and also the determinants for use of such coping mechanisms. We also aimed to identify the differences in coping mechanisms used by study participants if they possibly had depression, anxiety, or both.

**Materials and Methods**

This study is a population-based, cross-sectional study, done in the urban field practice area of the Community Medicine Department of a Government Medical College in Haldwani. Sample size calculations were based on estimated prevalence of depression in the study population (24.9%) with precision of 5% and a nonresponse rate of 15%.\[11\] Sample size thus obtained was 320 participants. Systematic random sampling was used along with population proportionate to size method to recruit study participants in the study: Every seventh house was included in the study and eligible study participant was sought; if that house did not have eligible participant, we moved to the next house until eligible participant was available. In this way, we included a total of 324 ever-married, apparently healthy homemakers age 18–59 years residing in the area for at least 6 months as study participants. Women who were suffering from chronic medical conditions or were pregnant or had delivered in the past 3 months from the date of data collection were excluded.

Data collected from study participants included socioeconomic data and usual household method used to cope with adverse situations (stresses) in their day-to-day life along with other information for the study. To screen and identify participants with possible depression or anxiety disorder, standardized tools available in the public domain were used. *Patient Health Questionnaire 9 (PHQ 9)*, based on Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition Text Revision (DSM-IV-TR) criteria, was used for possible depressive disorder. It has a sensitivity and specificity of 88% for major depressive disorder when cutoff of score 10 or above is used (as used in this study).\[12\] For possible anxiety disorder, *Generalized Anxiety Disorder - 7 (GAD 7) questionnaire* was used, which has a sensitivity of 89% and specificity of 82% for generalized anxiety disorder when cutoff of score 10 or above is used (as used in this study).\[13\] The questionnaires were administered by trained data collector. The study was conducted between June 2016 and May 2017. Data were entered in Microsoft Excel Worksheet, and analysis was done in SPSS version 17.0. Frequencies and percentages are reported where required. Chi-square test or Fisher’s exact test were applied where appropriate for testing significance and P values reported. “Chi-square for trend” test was done using Epi Info 7.2 software where appropriate.

The study was approved by the institutional ethics committee. All persons with clinically significant depressive or anxiety symptoms were given general advice at the end of the interview and were referred to the psychiatry department of the medical college for taking formal professional help.

**Results**

The prevalence of possible depression in our study was 18.8%, whereas that of GAD was 13.6%. Both anxiety and depression were present in 11.7% of study participants. This is presented in detail in Table 1. The determinants and associated factors for these have been published elsewhere and can be referred to for details.\[8\] None of the women was seeking medical care for their symptoms as most of them considered them as normal part of lives and felt that they did not require medical treatment as they were not serious.

Table 1: Distribution of study participants by possibly having depressive and anxiety disorder (n=324)

| Participant’s mental health status | Number | Percentage |
|-----------------------------------|--------|------------|
| Possible depression               | 61     | 18.8       |
| Possible GAD                      | 44     | 13.6       |
| Possibly both depression and anxiety | 38   | 11.7       |
| Neither possible depression nor anxiety | 257 | 79.3       |

GAD: Generalized anxiety disorder

Answer to the questions regarding usual coping mechanisms used by the study participants were given by 286 women (response rate = 88.3%), the distribution of which is presented in Table 2. Watching television (TV), getting busy with the work, and praying were the most frequently reported methods of coping by the study participants. Activities involving children (including scolding them) and talking or discussing their situation with friends and neighbors also formed an important coping mechanism for study participants. Participants also reported self-induced activities which help them deal with the situation at hand (it included walking, getting a message, drinking water, self-appraisal of the situation, and devising a plan) which have been labeled by us as self-help activities. Husbands formed relatively less important role in coping of participants with any of the mental health issues in our study. Sleeping was more common in participants with
possible mental health issues. Therefore, there was preference for remaining alone with such participants. Hobbies such as reading, listening to music, singing, and cooking were also reported by participants as their coping mechanism. However, indulgence in these activities was reported in less participants with possible anxiety disorder. Other activities or mechanisms reported were self-medication and doing nothing (waiting for time to pass), and one participant also tried self-harm [Table 2].

Table 3 presents data on analysis of coping mechanisms with regard to the mental health status of the participants. Praying was significantly more frequently used as coping mechanism if the participant was having possible anxiety disorder. Similar was the case for praying with other possible mental health disorders, but the results were not statistically significant. Watching TV as coping mechanism decreased significantly in participants if they had any of the mental health condition we studied. In our study, work, involvement with children, discussing life situation with friends and neighbors, self-help activities, and getting involved in hobby were consistent across possible mental health conditions, and no statistically significant difference across groups were identified. Preference for being alone as coping mechanisms increased in participants with any of the possible mental health condition. Although it was not statistically significant, it was approaching significance. Interaction with husband formed much less frequent coping mechanism for these women if they had depression and comorbid depression and anxiety.

Coping mechanisms also varied with various sociodemographic variables of the study participants [Table 4]. Praying was significantly more common in women who were married for longer duration (Chi-square for trend *P* value = 0.005), whereas those women who were married at later age more frequently watched TV to cope (Chi-square for trend *P* value = 0.045). Also, women who were still married at the time of the study were significantly more likely to watch TV as coping mechanism compared with others. Significantly more women indulged in work to cope with their stresses if they were non-Hindu. Younger women reported significantly more that their children acted as their mechanism of dealing with stress and the trend continued with decreasing age of study participants (Chi-square for trend *P* value <0.001). Participants who were non-Hindu reported children as coping mechanism significantly more frequently. Those having more living children also felt that children were helpful in coping with stress and the trend was significant with an increase in the number of living children of the participants (Chi-square for trend *P* value = 0.013). Friends and neighbors were significantly more common mechanism of coping in women if they had more children, and a significant trend was detected in our study (Chi-square for trend *P* value = 0.002). More women preferred to remain alone if they were married for longer duration (Chi-square for trend *P* value = 0.005) and were older (Chi-square for trend *P* value = 0.004). Hobby pursuing was more commonly used as coping mechanism in middle-aged women with both youngest and oldest group not reporting pursuing or indulging in hobby for stress relief. Women with lesser living children and those getting married at later age were significantly more often indulging in hobby activity to relieve their stress (Chi-square for trend for living children *P* value = 0.007; Chi-square for trend for age at marriage *P* value <0.001).

### Table 2: Distribution of coping mechanism used by the study participants by possible mental health disorders*

| Coping mechanism | All (n=286) | Depression (n=61) | GAD (n=44) | Depression and GAD (n=38) |
|------------------|-------------|------------------|------------|---------------------------|
| Watching TV      | 85 (29.7)   | 9 (14.8)         | 5 (11.4)   | 5 (13.2)                  |
| Getting busy in work | 61 (21.3) | 17 (27.9)        | 9 (20.5)   | 9 (23.7)                  |
| Praying          | 60 (21.0)   | 17 (27.9)        | 15 (34.1)  | 11 (28.9)                 |
| Children         | 49 (17.1)   | 10 (16.4)        | 10 (22.7)  | 9 (23.7)                  |
| Family           | 46 (16.1)   | 9 (14.8)         | 4 (9.1)    | 4 (10.5)                  |
| Self-help activities | 39 (13.6) | 5 (8.2)          | 4 (9.1)    | 2 (5.3)                   |
| Husband          | 26 (9.1)    | 1 (1.6)          | 1 (2.3)    | 0 (0)                     |
| Sleep            | 29 (10.1)   | 9 (14.8)         | 6 (13.6)   | 6 (15.8)                  |
| Prefer being alone | 25 (8.7)   | 9 (14.8)         | 7 (15.9)   | 7 (18.4)                  |
| Family           | 9 (3.1)     | 2 (3.3)          | 2 (4.5)    | 2 (5.3)                   |
| Hobby            | 27 (9.4)    | 5 (8.2)          | 2 (4.5)    | 1 (2.6)                   |
| Other            | 16 (5.6)    | 2 (3.3)          | 2 (4.5)    | 2 (5.3)                   |

GAD: Generalized anxiety disorder, *Multiple responses possible

### Table 3: Differences in coping mechanism used by the study participants by possible mental health disorder (n=286)

| Coping mechanism | Depression | GAD | Depression and GAD |
|------------------|------------|-----|--------------------|
| Praying          | 43 (17) 0.136 | 45 (15) 0.020 | 49 (11) 0.195 |
| Watching TV      | 76 (9) 0.004 | 80 (5) 0.004 | 80 (5) 0.016 |
| Work             | 44 (17) 0.160 | 52 (9) 0.878 | 52 (9) 0.703 |
| Children         | 39 (10) 0.863 | 39 (10) 0.284 | 40 (9) 0.250 |
| Self-help        | 34 (5) 0.163 | 35 (4) 0.340 | 37 (2) 0.106 |
| Sleep            | 20 (9) 0.178 | 23 (6) 0.404 | 23 (6) 0.215 |
| Prefer being alone | 16 (9) 0.061 | 18 (7) 0.067 | 18 (7) 0.023 |
| Family           | 7 (2) 0.947 | 7 (2) 0.563 | 7 (2) 0.422 |
| Husband          | 25 (1) 0.022 | 25 (1) 0.087 | 26 (0) 0.036 |
| Friends and neighbors | 37 (9) 0.813 | 42 (4) 0.188 | 42 (4) 0.344 |
| Hobby            | 22 (5) 0.784 | 25 (2) 0.254 | 26 (1) 0.137 |

GAD: Generalized anxiety disorder; *Chi-square or exact test where appropriate
Table 4: Association of different coping mechanisms used by the study participants with various sociodemographic variables (n=286)

|                | Age                   | Age difference with husband | Religion | Living children | Age at marriage | Marital status | Family type | p*          |
|----------------|------------------------|-----------------------------|----------|-----------------|----------------|----------------|-------------|-------------|
| Praying        | 0.110                  | 0.830                       | 0.380    | 0.713           | 0.138          | 0.038          | 0.455       | 0.993       |
| TV             | 0.459                  | 0.871                       | 0.379    | 0.174           | 0.037          | 0.225          | 0.045       | 0.936       |
| Work           | 0.444                  | 0.125                       | 0.001    | 0.107           | 0.669          | 0.222          | 0.244       | 0.122       |
| Children       | 0.004                  | 0.769                       | 0.020    | 0.005           | 0.092          | 0.063          | 0.087       | 0.781       |
| Friends and neighbors | 0.755                  | 0.271                       | 0.156    | 0.007           | 0.420          | 0.199          | 0.641       | 0.209       |
| Self-help      | 0.236                  | 0.235                       | 0.092    | 0.462           | 0.486          | 0.224          | 0.419       | 0.677       |
| Sleep          | 0.532                  | 0.456                       | 0.615    | 0.014           | 0.015          | 0.566          | 0.647       | 0.456       |
| Prefer being alone | 0.021                  | 0.358                       | 0.068    | 0.868           | 0.241          | 0.045          | 0.518       | 0.467       |
| Family         | 0.281                  | 0.371                       | 0.166    | 0.889           | 0.228          | 0.776          | 0.473       | 0.738       |
| Hobby          | 0.009                  | 0.281                       | 0.059    | 0.019           | <0.001         | 0.051          | 0.737       | 0.530       |
| Husband        | 0.505                  | 0.423                       | 0.766    | 0.096           | 0.147          | 0.788          | 0.208       | 0.958       |

*Chi-square or exact test where appropriate

Discussion

In our study, a majority of the participants (more than 88%) reported one or more usual coping mechanism used by them to deal with stress in their life. The usual methods of coping used by the women in our study – either alone or in combination – were watching TV, praying, indulging in work or hobby or self-help activities, getting some alone time, and discussion or engagement with children, friends, and neighbors, husband, and parental family members. Most of these coping mechanisms indicate “emotion-based approach” of the study participants to deal with stressful situations rather than “problem-based approach” which is considered to be more adaptive response to stress.[19,20] Similar finding, that is, emotion-based coping as predominant method of coping, was reported from a community-based study in Iran.[19] Low self-esteem has been reported to be associated with emotion-focused coping style in women.[19] Our findings may at least be partially related to low self-esteem in study participants because of a variety of reasons – not engaged in paid employment, restrictive societal norms, limited decision-making freedom, and so on – though we did not collect data on participants’ self-esteem directly. However, on the positive side, emotion-based coping style is associated with better adherence to self-care activities in at least some chronic conditions.[19] A fifth of all study participants (20.7%) in our study possibly had either depression or anxiety disorder or both, requiring professional help from a mental healthcare provider. Clearly, the usual coping mechanisms used by the women in the study were not sufficient to deal with all situations and circumstances causing stress in day-to-day life.

Religiosity is potentially a positive coping mechanism in a variety of mental health disorders and also in preventing them.[20,21] In our study also, praying was more commonly practiced by women having any of the mental disorder we studied (significantly more with women having anxiety disorder). Praying helps in a few ways – first, usually while praying individual tends to focus and forget everything else including the stimuli-causing anxiety, thus relieving anxiety akin to a relaxing exercise; also, praying might give a sense of availability of an invisible support system[22] which will take care of the stressful situation, thereby possibly avoiding panic response from the participants. Praying also helps in emotion management through multiple mechanisms.[23] Women in our study prayed more often with increasing duration of their marriage. The finding may be explained as a general trend of increasing religiosity/spirituality in people as they age.[24] However, in our study, age by itself was not a factor with which praying increased.

TV watching has been reported as an coping mechanism to deal with stress in a number of studies with different age and occupational groups.[25-27] It was the single most common (29.7%) coping mechanism reported by the study participants in our study. However, watching TV was significantly less in women with either possible depressive or anxiety disorder. It might be because in usual circumstances TV might act as stress buster and provide some entertainment. However, in case of severe or continuous stress, it might initially become an unwanted distraction, and later on when women have developed mental health issues, they may become disinterested in it altogether. Women living with spouse at the time of study or who got married at later age more often watched TV as coping mechanism. TV might be perceived an enjoyable experience by women who thought that they were in control of their day-to-day life. This might be the case with women who got married at an older age and also with women living with spouse compared with those who were married early and those whose marriage broke down or whose spouse died.

Women also preferred to remain alone more if they possibly had both anxiety and depression. They also preferred to spend time alone when having either depression or anxiety disorder; however, the results on statistical analysis were not significant (though approaching it). It could be a either a cause or effect: women may first get isolated, with breakdown of communication channels with others contributing to development of mental health disorders in these women later on, or women might have
developed mental health disorder first as a result of which they themselves might avoid engagement with other people. Older women and women married for longer periods also preferred to spend time alone more often than others as coping mechanism to deal with stress. This might be more of an effect of children being older and busy, and less inclination of participants to share personal concerns/problems with others as they age. Also with age, people tend to understand themselves better and become more comfortable in their own space. Older participants are more likely to have physical morbidity limiting their mobility which could be another factor for this finding. This could also be an adaptive coping mechanism used by these women if they utilized this time (being alone) to build strategy to overcome the stressful situation.

Women in our study reported interaction/activities with husbands as means of coping with stressful situations less often when they had depression – either in isolation or associated with anxiety. This might be because of the effect of breakdown of communication with husband first, resulting later on in development of mental health disorders, or mental disorders might have developed first, followed by decreased marital relationship satisfaction and breakdown in communication with their partners later on. Poor perception of relations with spouse may contribute to development of mental health disorder through depleted psychological resources and unhealthy behavior in such individuals.

Women who believed in religions other than Hinduism more often indulged in work as coping mechanism. Despite our efforts and experience of working with the community, we could not identify reasons for such finding. Different cultural or religious beliefs might be one of the causes of such finding.

Younger women more often reported that children were their means of coping with stressful situations. With an increase in the number of living children, more women reported them as their coping mechanism in our study. This finding is corroborated by another study in south-Asian domestic workers who also used children as their coping mechanism. However, they differ from our study participants in terms of employment and migration to another country. Children might provide women with limited life opportunities, a sense of purpose and meaning to their life, which at least partially explains them being a coping mechanism for such women. Also as younger children are often more dependent on parents (especially on mother), taking care of them might be a useful and productive way to cope with stresses of the day-to-day life. However, as children grow and become less dependent and finally become independent, it is intuitive that they are less often available as they (and the participant) age. With more children, the younger one/s remain dependent for longer duration. More children may mean more engagement time with children helping in dealing with stress inadvertently. Women with more children might have more friends in the neighborhood due to children’s engagement and friendship with other children in the neighborhood and school (if school-going). That also explains women with more children reporting neighbors and friends as coping mechanism more often compared with women with lesser number of children or no children.

Women engaged in hobby activity if they were in their middle ages and had lesser number of children or no children. Younger women may be too busy with their newly married life and taking care of children to find time to engage in their hobby. Older women, on the other hand, might not have enough strength, visual acuity, or both to engage in their hobbies. Also, older women might have to worry about settlement of their children. They may have other health issues which could prevent them from engaging in their hobby activity. With lesser children, however, married women might get enough time after taking care of children to engage in their hobby activity. Women who got married at later age were also able to engage in their hobby activity to deal with stress. This might be because of feeling of better control of life situation and better understanding of different life situations with increasing age, facilitating meaningful engagement in hobby activity by these women.

**Strength and limitation of the study**

This is a population-based study with a relatively large sample size. The study instruments used are standardized tools available in public domain to ascertain potential mental health issues in the study participants. This is probably the only study researching the coping mechanisms of homemakers in India in community settings.

However, being a cross-sectional study, no cause–effect relationship can be inferred. As the responses were self-reported, there is potential to remember and report recently used coping mechanisms more often than those used in more consistent ways. The possibility of some unusual or culture/religion-specific ways of coping being not reported cannot be excluded.

**Relevance to family practice and primary care**

Human body is affected adversely by stress. Both physiological and psychological changes occur in response to chronic stress and may result in many common physical illnesses such as hypertension, diabetes mellitus, and obesity, when stress is sustained over a period of time. Sometimes stress is expressed in physical symptoms for which no underlying abnormality is found on examination and/or investigations. Family physicians being primary caregivers are most important healthcare providers who can be instrumental in the early identification and effective management of stress and its consequences. It is important for them to have a holistic approach toward their patients. They should look for and identify chronic stress in their patients and the usual coping mechanism used by them to deal with this stress. Our study identifies that emotion-focused coping strategies are more commonly used by the homemakers – physician should be alert to this finding in general and especially while treating homemakers with less defined, vague complaints. Family physicians should judge whether their patients are using an
effective coping strategy or they need to be taught new coping strategies. Successful coping mechanisms used by patients should be appreciated and reinforced, whereas those using less useful mechanism should be counseled and taught coping strategies which could be more appropriate and effective to deal with their life situation. Quick assessment of stress and effectiveness of coping strategies followed by remedial measures in primary care settings can potentially prevent or delay many diseases and visits to specialist by patients.

Conclusion

In this study, we report the usual household methods used by ever-married women age 18–59 years to deal with stress encountered in their day-to-day life. We also analyzed differences among coping mechanism by various socioeconomic and possible mental health issues. Age, age at the time of marriage, number of living children, marriage duration, and religion were major determinants identified for using different coping mechanisms by the study participants. Coping mechanisms also varied by the mental health status of the women included in the study. There is a need of more studies for more data in this field. Study evaluating household coping strategies in successfully preventing or aiding treatment of mental health illnesses may also be contemplated.

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Conflicts of interest
There are no conflicts of interest.

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