Association between the Religious Coping of Infertile People with their Own Quality of Life and Their Spouses': A Correlation Study in Iranian Infertile Couples

Abstract

**Background:** Infertile couples have a lower quality of life (QoL) than that of the general population. Religious coping strategies (RCOPE) could affect QoL in distressing situations. The present study aimed to assess the association between the RCOPE of infertile people with their own QoL and that of their spouses'. **Materials and Methods:** This cross-sectional study was conducted among 200 infertile couples referring to Infertility Center of Qom, Iran in 2015. The data was collected using three questionnaires including Brief RCOPE scale, Short Form Health Survey, and a demographic questionnaire. p value of ≤0.05 was considered as significant level. **Results:** Multivariate analysis showed relationship between women’s RCOPE-N with their own QoL (β = −1.31, p < 0.001). Further, in husbands, RCOPE-P showed significant positive relationship with their own QoL (β = 0.80, p = 0.002), and their RCOPE-N had significant negative relationship with it (β = −0.61, p = 0.02). Surprisingly, women’s RCOPE-P showed negative relationship with husbands’ QoL (β = −0.62, p = 0.04); whereas their RCOPE-N had no significant relationship with their husbands’ QoL. In addition, neither RCOPE-P nor RCOPE-N of husbands had a significant relationship with their wives’ QoL. **Conclusions:** In summary, we could not find an obvious and significant relationship between RCOPE of each spouse with QoL of the other spouse in infertile couples. Hence, further investigations with more participants of various religions are recommended.

**Keywords:** Infertility, Iran, quality of life, religious coping

Introduction

Infertility is defined as the failure of a couple to become pregnant after 12 months of sexual intercourse without using any contraception. In Iran, 16–18% of 20–27-year-old married women experience primary infertility. The majority of infertile couples report profound suffering such as conflict, communication difficulties, disagreement over medical treatment, absence of empathy, and differential investment in the infertility treatment procedure that lead to depression, social isolation, sense of incompetency, embarrassment, shame, and finally divorce. Several studies have verified significant adverse effects of infertility on quality of life (QoL) among infertile couples. QoL is a subjective concept including four subscales – physical symptoms, psychological symptoms, outlook on life, and meaningful existence. Although factors such as age, occupation, education, personality, and other individual characteristics are effective on QoL, values and beliefs are also significant in interpreting and coping with adverse events. Belief in a divine being or eternal life may make individuals more resilient when faced with worldly trials, disappointments, and major life changes. Religious coping refers to how a patient makes the habit of his/her system of religious beliefs and practices to understand and cope with stress. RCOPE-P is characterized by a constructive reliance on faith to promote healthy adaptation (e.g., through “seeking God’s love and care”). RCOPE-N is characterized by tension, question, and conflict about spiritual issues within oneself, with the divine, and with other people associated with psychological distress, worse QoL, and increased mortality in patients with a wide range of chronic medical conditions. Considering that infertility requires long-term treatment or is even incurable in some cases, strengthening of

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Religious beliefs can be considered as an effective factor to improve the QoL for infertile couples. Several studies have investigated the effect of RCOPE on QoL in infertile men and women, however, no study has investigated the association of RCOPE of one spouse with the QoL of her/his spouse. The present study aimed to assess the association between the RCOPE of infertile couples with own QoL and of his/her spouse.

Materials and Methods

This cross-sectional study was conducted among infertile couples referring to the Infertility Center of Qom, Iran in 2015. Two hundred couples with known infertility (at least 1 year after diagnosis and in the process of treatment) were selected by convenience sampling. To calculate the sample size, \( \alpha = 0.05 \) and \( \beta = 0.8 \) were considered. Further, correlation coefficient = 0.2 between RCOPE and QoL was applied based on a similar research by Taheri et al. Couples were not included in the study if one or both spouses had a history of psychological disorders or any acute/chronic diseases. Exclusion criteria was incomplete questionnaire. Participants completed three questionnaires – Brief RCOPE scale, Short Form Health Survey (SF-36), and demographic questionnaire. The researcher patiently answered any questions the participants had regarding the study. Both spouses separately completed the questionnaires without helping and counseling each other. The demographic questionnaire included age of both spouses, educational level of both spouses, economic status of family, having children, history of abortion, previous infertility treatment, cause of infertility, duration of marriage, and duration of infertility. To measure the QoL, Short Form Health Survey (SF-36) was used. This self-administered questionnaire is a general QoL instrument that measures eight health-related concepts including physical functioning (PF, 10 items), role limitations due to physical problems (RP, 4 items), bodily pain (BP, 2 items), general health perceptions (GH, 5 items), vitality (VT, 4 items), social functioning (SF, 2 items), role limitations due to emotional problems (RE, 3 items), and perceived mental health (MH, 5 items). Furthermore, a single item that provides an indication of perceived change in general health status over a 12-month period (health transition) is also included in SF-36. The validity and reliability of the Persian version of this scale has been reported by Montazeri et al. in Iran. In the present study, the reliability of SF-36 was determined by Cronbach’s alpha as 0.88. Brief RCOPE, designed by Pargament et al., consists of 14 items in two subscales (positive and negative). Seven items measure positive religious coping (RCOPE-P) and the other seven items measure negative religious coping (RCOPE-N). Responses to each statement were rated on a 4-point Likert scale from 0 “Not at all” to 3 “A great deal,” so that each participant received one score for RCOPE-P and one score for RCOPE-N. A higher score on each subscale shows a greater use of that RCOPE. To use this questionnaire in Farsi, it was translated into Farsi by forward-backward translation method. The internal consistency was assessed by Cronbach’s alpha coefficient which was calculated as 0.9. Paired \( t \)-test was applied to compare the scores of wives and husbands in QoL and its subscales as well as RCOPE. To analyze the association between QoL and demographic characteristics as well as RCOPE in the spouses, we applied analysis of variance (ANOVA), independent \( t \)-test, and Pearson’s correlation coefficient. In this manner, association between two variables was assessed by univariate analysis. Considering that the QoL of the wives and husbands had significant relationship with each other (\( p < 0.0001, r = 0.4 \)), multivariate regression was used to simultaneously determine the factors associated with wives’ and husbands’ QoL. In this manner, wives’ and husbands’ QoLs were entered into the model as dependent variables and RCOPE and demographic variables as independent variables. To interpret the coefficients of qualitative variables (categorical variables), one of the categories was considered as reference category and others were compared with it. Data were analyzed using SPSS 21, IBM, Armonk, NY, United States of America. \( p \) value of \( \leq 0.05 \) was considered as significant level.

Ethical considerations

The study protocol was approved by the Ethics Review Committee of Qom University of Medical Sciences. All questionnaires were anonymous and participation was voluntary. All participants also signed a consent form.

Results

The mean (SD) age of wives and husbands was 28.82 (5.13) and 32.61 (5.32) years, respectively. The mean (SD) of marriage duration and infertility duration was 7.31 (4.76) and 4.93 (3.95) years, respectively. Regarding the view of the couples, most had a good economic status (83.50%) and did not have any children (83.50%), and reported that the cause of their infertility was unknown (33%) [Table 1]. Total score of the QoL and all its subscales were significantly lower among wives in comparison with their husbands (\( p < 0.05 \)) except perceived mental health. Among the subscales of the QoL, the lowest was “role limitations due to emotional problems” in wives and “vitality” in their husbands; whereas, the highest subscale was “physical functioning” in both spouses [Table 2]. Regarding RCOPE, the mean of RCOPE-P was significantly higher in wives (\( p = 0.01 \)); however, the wives and their husbands were not significantly different in RCOPE-N [Table 2]. The results of univariate analysis showed that wives’ QoL was not correlated with RCOPE-P and RCOPE-N of the husbands and demographic variables. However, in wives, both RCOPE-P and RCOPE-N were correlated with their own QoL, as RCOPE-P was positively (\( r = 0.15, p = 0.02 \)) and RCOPE-N was negatively correlated with...
Multivariate analysis indicated that wives’ age had a significantly negative relationship with husbands’ QoL ($\beta = -0.52, p = 0.04$), as the lower was the wives’ age the higher was the husbands’ QoL. Having a history of previous infertility treatment had a negative relationship with only wives’ QoL, indicating that wives with a previous history of infertility treatment had lower QoL rather than ones without it ($\beta = -4.43, p = 0.04$). In cases where infertility was due to husbands, wives’ QoL was higher than the cases with unknown factor ($\beta = 6.13, p = 0.03$). Educational level of the wives did not have any relationship with husbands’ QoL as well as their own; however, educational level of the husbands had a significant relationship with both wives’ and husbands’ QoL, respectively ($\beta = -5.93, p = 0.04$ and $\beta = -6.04, p = 0.02$), indicating that the husbands with higher educational level had higher QoL both for themselves and their wives [Table 4].

Regarding the main objectives of the study, the results showed that, in wives, RCOPE-N had significant negative relationship with their own QoL ($\beta = -1.31, p < 0.001$); whereas, RCOPE-N had no significant relationship. Moreover, in husbands, RCOPE-P showed significant positive relationship with their own QoL ($\beta = 0.80, p = 0.002$) and their RCOPE-N had significant negative relationship with it ($\beta = 0.53, p = 0.02$). Surprisingly, wives’ RCOPE-P showed negative relationship with husbands’ QoL ($\beta = -0.62, p = 0.04$); whereas, their RCOPE-N had no significant relationship with their husbands’ QoL ($\beta = -0.21, p = 0.30$). Furthermore, neither RCOPE-P ($\beta = 0.14, p = 0.60$) nor RCOPE-N ($\beta = 0.31, p = 0.20$) of husbands had a significant relationship with their wives’ QoL.

**Discussion**

The results of our study showed that scores of all subscales of QoL SF-36 were significantly lower in wives in comparison with their husbands. In a study by Keramati et al., wives’ QoL was lower in comparison with their husbands in all subscales of both general QoL (SF-36) and infertility-related QoL questionnaires. Moreover, the findings of three studies by Dillu and Rashidi and Ragni are consistent with our findings. Rashidi et al. reported markedly lower SF-36 scores in females compared to males and concluded that female gender was a significant predictor of poorer health-related QoL. The probable cause is that infertile wives experience more stress than their husbands maybe due to cultural factors and more involvement in diagnostic and treatment interventions;
Moreover, women are often more sensitive to childlessness. Some studies have demonstrated that the effect of infertility and its treatment was stronger in women than men, indicating that having children was more important to women than men.\[^{24,25}\] Another explanation is that women are blamed more frequently for couple’s infertility or sometimes they take the blame themselves; thus, the stigma relating to such blaming causes more distress and deteriorations in QoL among female partners.\[^{26,27}\]

In the present study, univariate analyses showed that, out of all demographic variables of wives and husbands, only husbands’ educational level was associated with their own QoL. This finding supports the study of Rashidi et al. who found that low educational level was a significant predictor of poor health-related QoL in infertile couples.\[^{21}\] However, multivariate analysis indicated that, in addition to husbands’ educational level, the cause of infertility was associated with their wives’ QoL, as when the cause of infertility was male factor, the wives’ QoL was better. Psychologists believe that if the cause of infertility is the female, they will encounter critical emotional problems such as worry and fear of their spouses’ attitude towards the problem and disruption of the family.\[^{28}\] The result of a study by Charandabi et al. is consistent with our finding. They found that low mental component of QoL was associated with unexplained cause of infertility in infertile women.\[^{29}\] Both studies showed that, when the cause of infertility was the husband, wives’ QoL was higher and when it was the wife or was uncertain, wives’ QoL was lower. It seems that, when the cause of infertility

### Table 3: Association of RCOPE and demographic variables with QOL using univariate analysis

| Variables                                      | Wives’ QoL | Husband’s QoL |
|------------------------------------------------|------------|--------------|
| Variables                                      | Pearson correlation (r) | p            | Pearson correlation (r) | p            |
| Wives’ RCOPE-P                                 | 0.15       | 0.02         | -0.12              | 0.09         |
| Wives’ RCOPE-N                                 | 0.31       | <0.001       | -0.13              | 0.04         |
| Husbands’ RCOPE-P                              | 0.13       | 0.14         | 0.12               | 0.07         |
| Husbands’ RCOPE-N                              | -0.02      | 0.70         | -0.23              | 0.002        |
| Duration of marriage (year)                     | 0.06       | 0.31         | -0.03              | 0.63         |
| Duration of infertility (year)                  | 0.04       | 0.54         | -0.03              | 0.56         |
| Wives’ age                                      | 0.04       | 0.50         | -0.06              | 0.30         |
| Husband’s age                                   | 0.12       | 0.10         | -0.03              | 0.60         |

| Mean (SD) | F/t | p  | Mean (SD) | F/t | p  |
|-----------|-----|----|-----------|-----|----|
| Educational level of wives                      |     |    |           |     |    |
| Secondary school or lower                       | 66.31 (15.92) | 0.16 | 0.81 | 70.12 (16.11) | 1.56 | 0.22 |
| High school                                     | 67.33 (18.21) |     |      | 74.64 (15.93) |     |      |
| University education                            | 65.34 (18.81) |     |      | 74.75 (15.36) |     |      |
| Educational level of husbands                   |     |    |           |     |    |
| Secondary school or lower                       | 66.12 (15.72) | 1.39 | 0.25 | 67.3 (16.41)  | 7.06 | 0.001 |
| High school                                     | 64.21 (19.94) |     |      | 73.12 (15.33) |     |      |
| University education                            | 69.12 (16.93) |     |      | 78.14 (14.41) |     |      |
| Economic status of family                       |     |    |           |     |    |
| Good                                             | 66.03 (19.42) | 0.02 | 0.97  | 69.25 (16.22) | 1.70 | 0.18  |
| Average                                          | 66.51 (17.12) |     |      | 74.76 (15.33) |     |      |
| Weak                                             | 67.06 (21.02) |     |      | 73.08 (17.24) |     |      |
| Having children                                  |     |    |           |     |    |
| Yes                                              | 69.42 (17.83) | -1.03 | 0.30 | 73.1 (15.80)  | -0.92 | 0.35  |
| No                                               | 65.94 (17.81) |     |      | 75.9 (15.50)  |     |      |
| History of abortion                              |     |    |           |     |    |
| Yes                                              | 65.14 (19.65) | 0.51 | 0.60  | 73.04 (16.07) | 0.23 | 0.82  |
| No                                               | 66.82 (17.45) |     |      | 73.71 (15.73) |     |      |
| History of infertility treatment                 |     |    |           |     |    |
| Yes                                              | 64.93 (19.11) | 1.42 | 0.15  | 72.42 (15.95) | 1.27 | 0.21  |
| No                                               | 68.65 (15.91) |     |      | 75.32 (15.53) |     |      |
| Cause of infertility                             |     |    |           |     |    |
| Female factor                                    | 65.56 (17.63) | 0.97 | 0.40  | 0.46  | 0.90 | 0.44  |
| Male factor                                      | 69.78 (16.73) |     |      | 74.16 (16.57) |     |      |
| Both female and male factors                     | 67.16 (17.22) |     |      | 69.92 (16.97) |     |      |
| Unexplained                                      | 64.24 (19.17) |     |      | 74.42 (15.11) |     |      |

F: fisher statistics, t: t statistics, p: p-value
is the male, annoyance and harassment of husband and his relatives decrease and negative feelings such as abandonment, insufficiency, stigmatization, and sin reduce in female spouses which can raise her QoL. Meanwhile, when the cause of infertility is unexplained, female spouses are usually blamed or sometimes they take the blame themselves leading to a lower QoL. Rashidi et al. reported that in univariate analysis health-related QoL was better in infertile couples with male factor or both male and female infertility factor; however, in multivariate analysis the cause of infertility was not a significant predictor of poor health-related QoL. In addition, multivariate analysis indicated that the history of treatment was associated with wives’ QoL. Treatment interventions could harm infertile women both physically and psychologically resulting from hospitalization, fear of procedures, feeling of pain, and treatment frustration. In contrast, based on a logistic regression analysis, Rashidi et al. reported that previous treatment for infertility was not a significant predictor of poor health-related QoL in infertile couples. This contradiction in results is probably caused by different analysis methods. We found no association between age and their own QoL in wives and husbands; however, in a study by Rashidi et al., lower age was a significant predictor for poor mental component of health-related QoL in infertile couples receiving in-vitro fertilization or ICSI (Intra Cervical Sperm Injection) treatment. This contradiction may be due to different sample sizes. In our study, wives’ age was negatively associated with husbands’ QoL, as the older the wives were, the lower the husbands’ QoL was. It seems that a younger infertile woman is hopeful to become pregnant and have a baby but when she becomes older her disappointment and depression and anxiety could affect her husband’s QoL. In the present study, economic status of family was not associated with infertile wives’ QoL; however, Charandabi et al. in another study indicated that low mental component of QoL was associated with low income in infertile women. In this case, different ways for categorization of economic status of family can explain the different results of two studies.

The results showed that the mean of RCOPE-P was significantly higher in wives. This finding supports the finding of another study on cancerous patients in which women applied RCOPE-P more than men. Regarding the main objective of the present study, multivariate analysis demonstrated that in husbands RCOPE-P and RCOPE-N had positive and negative associations, respectively, with their own QoL. These findings are consistent with several studies conducted to assess the association of RCOPE with QoL in various patients. For example, Vallurupalli showed that QoL was associated with RCOPE-P positively in cancerous patients. On the other hand, RCOPE-P improved their QoL. In a similar study, Tarakeshwar et al. found similar results in hemodialysis patients. However, multivariate analysis demonstrated that in wives RCOPE-P had no significant positive association with their QoL. This finding is in contrast to the abovementioned studies. This contradiction could be because of various conditions (hemodialysis versus infertility), different religions, and cultural situation. Surprisingly, we found that wives’ RCOPE-N had no

### Table 4: Association of RCOPE and demographic variables with QOL using multivariate analysis

| Variables | Wives’ QoL | Husbands’ QoL |
|-----------|-----------|--------------|
|           | β        | SE (β) | p     | β        | SE (β) | p     |
| Wives’ RCOPE-P | 0.51 | 0.32 | 0.10 | −0.62 | 0.31 | 0.04 |
| Wives’ RCOPE-N | −1.31 | 0.31 | <0.001 | −0.21 | 0.25 | 0.30 |
| Husbands’ RCOPE-P | 0.14 | 0.24 | 0.60 | 0.80 | 0.20 | 0.002 |
| Husbands’ RCOPE-N | 0.31 | 0.30 | 0.20 | −0.61 | 0.21 | 0.02 |
| Wives’ age | −0.45 | 0.31 | 0.21 | −0.52 | 0.24 | 0.04 |
| Husbands’ age | 0.31 | 0.23 | 0.15 | 0.24 | 0.25 | 0.36 |

Degree of free (df) for all parameters=1

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In a similar study, Tarakeshwar et al. demonstrated that RCOPE-P had a positive association and RCOPE-N had a negative association with QoL in cancerous patients. Moreover, Ramirez et al. found similar results in hemodialysis patients. However, multivariate analysis demonstrated that in wives RCOPE-P had no significant positive association with their QoL. This finding is in contrast to the abovementioned studies. This contradiction could be because of various conditions (hemodialysis versus infertility), different religions, and cultural situation. Surprisingly, we found that wives’ RCOPE-N had no

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association with husbands’ QoL; however, their RCOPE-P had negative association with their husbands’ QoL. An explanation is that infertile women seeking miraculous cure usually involve in religious activities hopefully. It can be resulted in reminding the problem consistently and rising anxiety in their husbands. Moreover, we found that neither RCOPE-N nor RCOPE-P of husbands was associated with their wives’ QoL. To rationalize this finding, we could say that most men usually do not express and exhibit their feelings and attitudes and keep it to themselves; so, their RCOPE does not affect their wives. One possible limitation is that all participants were Muslim and our findings cannot be generalized. Further studies are required among infertile couples belonging to other religions. Another limitation is convenient sampling employed for selecting participants.

**Conclusion**

We found that husbands’ RCOPE (either positive or negative) was associated directly with their own QoL rather than their wives’ QoL. In addition, wives’ RCOPE-P was associated with their husbands’ QoL negatively; however, their RCOPE-N was not associated with their husbands’ QoL. In summary, we could not find an obvious and significant relationship between RCOPE of each spouse with QoL of the other spouse in infertile couples. Therefore, further investigations with more participants of various religions are recommended.

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**Conflicts of interest**

Nothing to declare.

**References**

1. Kazemijalish H, Behboudi-Gandevani S, Hosseinpanah F, Khalili D, Azizi F. The prevalence and causes of primary infertility in Iran: A population-based study. Glob J Health Sci 2015;7:226-32.
2. Mohammad K, Ardalan A. An overview of the epidemiology of primary infertility in Iran. J Reprod Infertil 2009;10:213-6.
3. Onat G, Beji NK. Effects of infertility on gender differences in marital relationship and quality of life: A case-control study of Turkish couples. Eur J Obstet Gynecol Reprod Biol 2012;165:243-8.
4. Fekkes M, Buitendijk S, Verrips G, Braat D, Brewaes A, Dolling J, et al. Health-related quality of life in relation to gender and age in couples planning IVF treatment. Hum Reprod 2003;18:1536-43.
5. Khayata G, Rizk D, Hasan M, Ghazal-Aswad S, Asaad M. Factors influencing the quality of life of infertile women in United Arab Emirates. Int J Gynecol Obstet 2003;80:183-8.
6. Monga M, Alexandrescu B, Katz SE, Stein M, Ganiats T. Impact of infertility on quality of life, marital adjustment, and sexual function. Urology 2004;63:126-30.
7. Taebi M, Gandomani S, Nilforoushian P, Gholami Dehaghi A. Association between infertility factors and non-physical partner abuse in infertile couples. Iran J Nurs Midwifery Res 2016;21:368-37.
8. Cohen SR, Mount BM, Strobel MG, Bui F. The McGill Quality of Life Questionnaire: A measure of quality of life appropriate for people with advanced disease: A preliminary study of validity and acceptability. J Palliat Med 1995;9:207-19.
9. Dafei M, Noorbala A, Faghihzadeh S, Dehghani A. A study on the relation of coping strategies with personal characteristics and mental health in infertile couples referred to Yazd Infertility Center. Hakim Res J 1999;1:197-205.
10. Poursardar F, Sangari A, Abbaspour Z, Alboukuri S. The effect of happiness on mental health and life satisfaction. J Kermanshah Univ Med Sci 2012;16:139-47.
11. Ellison CG, Boardman JD, Williams DR, Jackson JS. Religious involvement, stress, and mental health: Findings from the 1995 Detroit Area Study: Soc Forces 2001;80:215-49.
12. Rosmarin DH, Bigda-Peyton JS, Öngur D, Pargament KI, Björngvesson T. Religious coping among psychotic patients: Relevance to suicidality and treatment outcomes. Psychiatry Res 2013;210:182-7.
13. Ramirez SP, Macêdo DS, Sales PMG, Figueiredo SM, Daher EF, Araújo SM, et al. The relationship between religious coping, psychological distress and quality of life in hemodialysis patients. J Psychosom Res 2012;72:129-35.
14. Trankle TM. Psychological well-being, religious-coping and religiosity in college students. Encyclopedia of Quality of Life and Well-Being Research 2006;53-6.
15. Closs SJ, Edwards J, Swift C, Briggs M. Religious identity and the experience and expression of chronic pain: A review. J Relig Disabil Health 2013;17:91-124.
16. Peric V, Borzanovic M, Stolic R, Jovanovic A, Sotvic S, Djikic D, et al. Quality of life in patients related to gender differences before and after coronary artery bypass surgery. Interact Cardiovasc Thorac Surg 2010;10:232-8.
17. Taheri-kharameh Z, SaeidY, Ebadi A. Relationship between religious coping styles and quality of life in patients with coronary artery disease. J Cardiovasc Nurs 2013;22:24-32.
18. Montazeri A, Goshtasebi A, Vahdaninia M, Gandeck B. The short form health survey (SF-36): Translation and validation study of the Iranian version. Qual Life Res 2005;14:875-82.
19. Pargament KI, Koening HG, Perez LM. The many methods of religious coping: Development and initial validation of the RCOPE. J Clin Psychol 2000;56:519-43.
20. Keramat A, Masoomi SZ, Mousavi SA, Poorolajal J, Shobeiri F, Hazerihi SM. Quality of life and its related factors in infertile couples. J Res Health Sci 2013;14:57-64.
21. Rashidi B, Montazeri A, Ramezanizadeh F, Shariat M, Abedinia N, Ashrafi M. Health-related quality of life in infertile couples receiving IVF or ICSI treatment. BMC Health Serv Res 2008;8:1.
22. Dillu R, Sheoran P, Sarin J. An exploratory study to assess the quality of life of infertile couples at selected infertility clinics in Haryana. IOSR J Nurs Health Sci 2013;2:45-51.
23. Ragni G, Mosconi P, Baldini MP, Somigliana E, Vegetti W, Caliari I, et al. Health-related quality of life and need for IVF in 1000 Italian infertile couples. Hum Reprod 2005;20:1266-91.
24. van Balen F, Trimbos-Kemper T. Factors influencing the well-being of long-term infertile couples. J Psychosom Obstet Iranian Journal of Nursing and Midwifery Research | Volume 23 | Issue 3 | May-June 2018
Gynaecol 1994;15:157-64.
25. Oddens BJ, den Tonkelaar I, Nieuwenhuyse H. Psychosocial experiences in women facing fertility problems-a comparative survey. Hum Reprod 1999;14:255-61.
26. Donkor ES, Sandall J. The impact of perceived stigma and mediating social factors on infertility-related stress among women seeking infertility treatment in Southern Ghana. Soc Sci Med 2007;65:1683-94.
27. Peronace LA, Boivin J, Schmidt L. Patterns of suffering and social interactions in infertile men: 12 months after unsuccessful treatment. J Psychosom Obstet Gynaecol 2007;28:105-14.
28. Kohan SH, Ghasemi Z, Beigi M. Exploring infertile women’s experiences about sexual life: A qualitative study. Iran J Nurs Midwifery Res 2015;20:34.
29. Charandabi SM, Kamalifard M, Sedaghiani MM, Montazeri A, Mohammadian ED. Health-Related quality of life and its predictive factors among infertile women. J Caring Sci 2012;1:159.
30. Tarakeshwar N, Vanderwerker LC, Paulk E, Pearce MJ, Kasl SV, Prigerson HG. Religious coping is associated with the quality of life of patients with advanced cancer. J Palliat Med 2006;9:646-57.
31. Vallurupalli MM, Lauderdale MK, Balboni MJ, Phelps AC, Block SD, Ng AK, et al. The role of spirituality and religious coping in the quality of life of patients with advanced cancer receiving palliative radiation therapy. J Support Oncol 2012;10:81.