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Annals of Biological Research, 2015, 6 (6):39-47  
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## Religious coping and adjustment among pregnant women

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### ABSTRACT

From thousands of years women have make use of prayer and other spiritual practices for their own and others health concerns (National Center for Complementary and Alternative Medicine, 2005). Studies documented that relationship between religious involvement and health risk behaviors in childbearing women concluded that such involvement was significantly correlated with less risk health behaviors (Page, Ellison, & Lee, 2009). The present study wants to explore the relationship between religious coping and adjustment among pregnant women. Present study represents a sample of forty-seven participants including pregnant women coming obstetric clinic for their prenatal checkup. For the measurement of religious coping tools like R-COPE by (Pargament, 2000), was used and Adjustment was measured with the help of depression CES-D Scale by Radloff, 1977 and Hopkins Anxiety Checklist by Parloff, 1954. It was a cross-sectional study design in which descriptive statistics like correlation t-test and ANOVA techniques were used to analyze the data. Positive religious coping shows a significant negative relationship between age ( $r = -.79, p < .01$ ) and gestation period ( $r = -.49, p < .01$ ). Negative coping was found significantly and negatively correlated with age ( $r = -.56, p < .01$ ) and gestation period ( $r = -.44, p < .01$ ). Anxiety was found significant and negatively related with age ( $r = -.68, p < .01$ ) and gestation period ( $r = -.40, p < .01$ ). Depression was significantly and negatively related to age ( $r = -.84, p < .01$ ) and gestation period ( $r = -.55, p < .01$ ). Mean scores show that positive coping was higher among participants with <30 years of age ( $M = 50.60, SD = 6.36$ ) and same as negative coping with <30 years of age ( $M = 11.92, SD = 3.34$ ). Participants with short experience of pregnancy (i.e., <3 months) shows more positive coping ( $M = 49.22, SD = 7.30$ ) and negative coping ( $M = 11.78, SD = 3.49$ ) respectively. The overall findings suggest the role that understands the relationship of religious coping with adjustment among pregnant women.

**Keywords:** Religious coping, Age, Gestation age, and Adjustment

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### INTRODUCTION

There seems to be a general agreement that religiosity broadly defined in different health areas typically predicts good health.[1]Its use has been studied in risk pregnancies as a frequent coping strategy that seems to have a positive effect on health outcomes[2][3].Religious coping is a broad variety of spiritually and religiously based cognitive, behavioral, and interpersonal responses to stressors.[4]Women have used prayer and other spiritual practices for their own and others' health concerns for thousands of years.[5] Previous empirical research has shown that religious coping is used in response to threat and loss.[6]Religious coping has been associated with the health and mental health related outcomes of a wide variety of critical life situations[7][8][9]. However studies documented the relationship between religious involvement and health risk behaviors in childbearing women concluding that

such involvement was significantly correlated with less risk health behaviors.[10] Religion seems to be an important coping strategy for those with life threatening illnesses [11][12] The use of religious coping is associated with a higher level of mental and physical well being.[13][14] Religious coping have been used in the psychological research literature to describe a breadth of approaches to religious practice that influence mental health outcomes. For example, Muslims have been found to adopt an interpersonal and collective coping style. The effects of Islam and traditional practices on Turkish women's reproductive health have been described, with God seen as the "ultimate healer". [15] Strong religious beliefs are central to culturally based perceptions of wellbeing. [16][17] Whereas those from Christian backgrounds utilise a more individualistic approach. [18]The Spirit of the Lord helped me a lot to give birth to each baby. It is important to the Tongan lady that the first thing they do after they give birth is to give thanks to the Lord". [19] During pregnancy it was a good time to say a prayer and give thanks to the Lord. Tongan women believe that, during pregnancy, it is also good time to have spiritual experiences so that the baby will be created with a good body". In his study he indicated that religious coping is commonly used by many groups in times of stress, particularly the most disenfranchised in society. [20][21][22] A Ghanaian woman explained that "this junction of life and death" is dangerous for both mother and child.[23] Authors who conducted reviews of research regarding spirituality during pregnancy concluded powerful spiritual relationships exist between child-bearing women and their unborn children[24][25]. Fewer studies analysed distinctively the impact of positive and negative religious coping. Positive religious coping is based on a secure relationship with a benevolent God in contrast with negative religious coping reflecting a distant punishing God.[26] It appears that only positive religious coping is constructive and useful to the individual, being associated with better mental and emotional health and personal growth through adversity.[27][28] On the other hand, negative religious coping, feeling punished, sinful and abandoned, is associated with psychological distress and increased physical vulnerability. [29][30][31]Religious coping is also correlated with a number of positive outcomes, including better physical health [32] decreased levels of depression [33][34] increased mental health status [35] and stress related growth noted that religious coping has also been associated with better health and mental health outcomes in a wide variety of life situations including illness, victimization, war, and the death of a loved one.

Adjustment has been explained in terms of anxiety and depression.

#### **Anxiety:**

Pregnancy and the transition to parenthood involve major psychological and social changes in future parents. These changes have been linked to an increase in anxiety rates and depression symptoms. [36]The prevalence of anxiety disorders in pregnancy varies according to studies and evaluation moments. In a study [37] 54% of the women had antenatal anxiety during at least one trimester. Anxiety estimated in the 2nd pregnancy trimester was found to be lower in most of the studies from 6.6% to about 15% [38][39] Anxiety levels seem to be higher in the 1st and 3rd trimesters, when compared with the 2nd pregnancy trimester. In fact a non linear pattern for anxiety has been pointed out in women, with the 1st and 3rd pregnancy trimesters being identified as high risk periods.[40] Researchers, psychiatrists and related disciplines have been concerned about women experiencing anxiety and depression during pregnancy. They mostly focus on diagnosable mental disorders, primarily anxiety, and depressive disorders.[41][42] These periods are considered to be a high risk time both for preexisting and new psychiatric illness. These psychiatric illnesses occurring during the period not only affect maternal health but causes adverse action on fetal development as well.[43]It was found in studies that a significant portion of women experience prenatal anxiety both in general and about their pregnancy.[44][45] Anxiety during pregnancy have manifestations like: feeling anxious, concerned, afraid, or panicky about the pregnancy.[46] In a study using 10- item scale reflecting anxiety about the baby's growth was used during pregnancy, it was found that loss of the baby and harm during delivery as well as a few reverse-coded items concerning confidence in having a normal childbirth.[47]Empirical evidence across studies of diverse populations regarding the adverse effects of pregnancy anxiety on gestational age at birth.[48]Multidimensional modeling techniques revealed that state anxiety, pregnancy anxiety, and perceived stress all predicted the length of gestation. But pregnancy anxiety (as early as 18 weeks into pregnancy) was the only significant predictor when all three indicators were tested together with medical and demographic risks controlled [47] Women with high pregnancy anxiety were at 1.5 time's greater risk of preterm birth (PTB) controlling for socio-demographic covariates, medical and obstetric risks, and specific worries over a high-risk condition in pregnancy.[49]Women who are most anxious about pregnancy seem to be more insecurely attached of certain cultural backgrounds, more likely to have a history of infertility or to be carrying unplanned pregnancies, and have fewer psychosocial resources.[50] Screening for pregnancy anxiety, state anxiety, depressive symptoms, and stress in pregnancy stands to provide potentially important clinical benefits not only for mothers but their children as well [51] [52] because, then easy for us to aware about future planning.

**Depression:**

Pregnancy does not protect women against the development of depression. [53][54] It seems to be higher during pregnancy than in the postpartum period.[55] Study done by Evans et al., [56] found 13.5% of the women were depressed at 32 weeks of pregnancy and 9.1% at 8 weeks postpartum. An extensive amount of women who had a postnatal depression were already depressed during pregnancy.[57][58][59] Depression rates seem to decrease throughout pregnancy.[60] A depression prevalence of 15.5% was found at early and mid pregnancy 11.1% in the 3rd pregnancy trimester and 8.7% in the postpartum period.[61] Attention must be paid to these levels of influence in any attempts to screen and treat depression, anxiety, pregnancy anxiety among women because it has its own consequence which affects her either directly or indirectly. Depression occurs as frequently during pregnancy as in the postpartum.[62] It has been shown that women prefer psychosocial treatments for depression during the perinatal period.[63] More than a dozen studies on depressed mood or symptoms of trauma found significant effects on gestational age.[64] Changes in relationship adjustment and changes in depressive symptoms co-vary within individuals at times when an individual's relationship adjustment is lower than usual, that individual's depressive symptoms tend to be higher. [65][66][67] Relationship adjustment was found to be associated with depressive symptoms during pregnancy.[68] Marital adjustments continue to be significantly associated with depressive symptoms.[69] Researchers have found differences in risk factors associated with first onset versus recurrences of depression.[70] Recent study reporting that women with both depression and anxiety disorders were at highest risk of low birth weight (LBW) as compared to those with only depressive or anxious symptoms or none. [71] A recent review found relatively large effects of maternal depressive symptoms on infant birth weight across several studies with the largest effects for low-income or low social status women and women of color [72]. Evidence for effects of maternal stress, depression, and anxiety in pregnancy has adverse neuro developmental outcomes for the child.[73] Couple therapy has been shown to be effective in reducing depression and improving relationship adjustment in depressed individuals in the general population[74] as well as among pregnant women.

**MATERIALS AND METHODS****Aims and objectives**

The present study wants to explore the relationship between religious coping and adjustment among pregnant women.

**Sample**

Present research represents a sample of forty-seven participants including pregnant women coming to obstetric clinics for their prenatal checkup. The age of these participants ranged from 20 to 38 years. Majority of the participants had 3-6, 6-9 and some participants had less than 3 months of gestation period.

**Tools Used**

**Demographic Questionnaire:** The information about demographic history of the participants has been collected with the help of questions related to their Age, Gestation Period and Education Qualification. Additional information about their family background includes: area of residence, family type, family occupation and income has also been mentioned.

**Religious Coping:** Religious coping activities and individual spiritual resources is a modified version of select subscales of the RCOPE [75] was administered. This instrument assesses positive and negative religious coping methods. Each item is rated on a four-point Likert scale. In terms of criterion validity, higher scores on the positive religious coping subscale were associated with greater life satisfaction, spiritual growth, and stress-related growth as well as lower levels of depression, anxiety, distress, hopelessness, and Internal consistency estimates for the positive religious coping subscale have been relatively strong ( $\alpha > .80$ ) and the internal consistency estimates for the negative religious coping subscale have been relatively lower ( $\alpha > .70$ ). Internal consistency reliability (Cronbach's alpha) for the measure of positive religious coping is 0.75 and the internal consistency estimates for the negative religious coping subscale is 0.78.

**Depression:** Depression was examined by using a shortened version of the Center for Epidemiological Studies – Depression (CES-D).[76] It is a 10-item and 4-point Likert scale that asks about a variety of depression related symptoms in the mother's report of his perception of mother's depressive symptoms. The scale asks to describe how often he/she has experienced those symptoms over the past week. In the present sample the internal consistency reliability (Cronbach's alpha) of this measure was 0.83.

**Anxiety:** The Hopkins Anxiety Checklist was used to assess anxiety. [77] Ten items were rated on a 4-point Likert scale with higher scores indicating higher anxiety. Pregnant women rates how true each of the symptoms is for her. In the present sample the internal consistency reliability (Cronbach's alpha) of this measure was 0.89.

**Procedure:**

Present research was conducted according to prevailing ethical principles and received approval from Women's Hospital Bhopal. Participants were identified by the investigator and physicians through these appointment books, logs, and schedules. Necessary information was given about the nature and purpose of the study. The participants were invited to participate by the investigator and signed an informed consent before collecting the data. The participants were instructed that there were no right or wrong answers. The questionnaires took approximately 20 to 30 minutes to complete. After the completion of all the three assessments participants were thanked for their participation and cooperation.

## RESULTS AND DISCUSSION

**Table-1 Demographic History and Personal Characters of the Participants**

Characteristics	N	Percentage (%)
<b>Age</b> (Mean = 26.53, SD = 4.99)		
30 years	25	54
30 years and above	22	46
<b>Gestation period</b>		
Less than 3 months	10	21.3
3 – 6 months	12	25.5
6 – 9 months	25	53.2
<b>Area of residence</b>		
Rural	36	77
Urban	11	23
<b>Family Type</b>		
Nuclear	22	46
Joint	25	54
<b>Educational Qualification</b>		
Illiterate	19	40.4
Elementary Schooling	9	19.1
Matriculation	5	10.6
Higher Secondary part-II	5	10.6
Graduate	4	8.5
Post Graduate	5	10.6
<b>Occupation</b>		
House Wife	38	81
Job	9	19
<b>Monthly Income</b>		
Less than 10000 Rs	15	31.9
10001-25000	25	53.2
25001-50000	7	14.9
<b>No. of children</b>		
Less than 2	30	64
Greater than 2	17	34

Majority of the participants belong to rural areas (77%). Only 11 (23.00%) participants were residents of urban areas. The percentages of participants belonging to nuclear and joint families were 46.00 and 54.00 respectively. Majority (40.40%) of the participants of the present study were illiterates.

**Table-2 Coefficient of Correlation of Scores of Religious coping, Anxiety and Depression with Age and Gestation period**

Variables	Mean	SD	Age	Gestation Period
Positive coping	43.74	9.34	-.79**	-.49**
Negative coping	9.49	4.65	-.56**	-.44**
Anxiety	16.00	6.11	-.68**	-.40**
Depression	15.15	5.29	-.84**	-.55**

\* $P < .05$ , \*\* $P < .01$ 

In table-2 Pearson's coefficient of correlation was used to examine the relationship between scores on Religious coping, Anxiety, Depression, Age and Gestation period. Results shows significant negative relationship between positive coping and age of the pregnant women ( $r = -.79, p < .01$ ) and gestation period ( $r = -.49, p < .01$ ). Negative coping was found significantly and negatively correlated with age ( $r = -.56, p < .01$ ), and gestation period ( $r = -.44, p < .01$ ). Participants less than 30 years of age shows higher positive coping in comparison to more than 30 years of age. Same as participants with short experience of pregnancy reported more positive coping in comparison to participants with long experience of pregnancy.

Anxiety was significantly and negative related to age of the pregnant women ( $r = -.68, p < .01$ ), and gestation period ( $r = -.40, p < .01$ ). Participants less than 30 years of age show greater anxiety in comparison to more than 30 years of age. Same as participants with short experience of pregnancy reported more anxiety in comparison to participants with long experience of pregnancy.

Depression was significantly and negative related to age ( $r = -.84, p < .01$ ), and gestation period ( $r = -.55, p < .01$ ). Participants less than 30 years of age show greater depression in comparison to more than 30 years of age. Same as participants with short experience of pregnancy reported more depression in comparison to participants with long experience of pregnancy.

**Table-3 Mean, Standard Deviations and t-test of religious coping and age of pregnant women**

Religious Coping	Age	Mean	S D	t-value
Positive coping	<30yrs	50.60	6.36	74.95**
	30yrs & above	35.95	5.04	
Negative Coping	<30yrs	11.92	3.34	20.87**
	30yrs & above	6.72	4.43	

\* $P < .05$ , \*\* $P < .01$ 

In table-3 Mean scores and *SDs* of two groups of participants with varying age for the measures of religious coping along with t-test showed significant difference between mean positive coping scores of two groups of participants  $t = 74.95, p < .01$ . Mean scores show that positive coping was higher among participants with <30 years of age ( $M = 50.60, SD = 6.36$ ) as compared to the participants with 30 years and above ( $M = 35.95, SD = 5.04$ ).

Negative coping results revealed significant differences between mean scores of two groups of participants  $t = 20.87, p < .01$ . Mean scores clearly revealed that participants with <30 years of age ( $M = 11.92, SD = 3.34$ ) shows more negative coping as compared to the participants with 30 years and above ( $M = 6.72, SD = 4.43$ ).

**Table-4 Mean, Standard Deviations and One-way analysis of Variance of religious coping and Gestation Age of Pregnant Women**

Religious Coping	Gestation Age	Mean	S D	F (2, 44)
Positive coping	<3 months	49.22	7.30	7.06**
	3-6 months	42.73	9.98	
	6-9 months	38.89	8.19	
Negative Coping	<3 months	11.78	3.49	5.23**
	3-6 months	9.55	5.22	
	6-9 months	7.17	4.37	

\* $P < .05$ , \*\* $P < .01$ 

In table-4 Mean scores of three groups of participants along with the analysis of variance revealed significant differences between mean religious coping scores of three groups of participants for positive coping  $F (2, 44) = 7.06, p < .01$ , and negative coping  $F (2, 44) = 5.23, p < .01$ .

Mean score indicate that participants with short experience of pregnancy (i.e., <3 months) shows more positive coping ( $M = 49.22, SD = 7.30$ ) as compared to the participants with 3 – 6 months ( $M = 42.73, SD = 9.98$ ) and 6 – 9 months ( $M = 38.89, SD = 8.19$ ).

However negative coping participants with less than 3 months of pregnancy reported greater used of negative coping ( $M = 11.78, SD = 3.49$ ) as compared to the participants with 3 – 6 months ( $M = 9.55, SD = 5.22$ ) and 6 – 9 months ( $M = 7.17, SD = 4.37$ ).

## DISCUSSION

The purpose of the present study was to find out the relationship of religious coping with adjustment among pregnant women. Majority of the participants belongs to rural areas (77%) and (23.00%) participants were residents of urban areas. The percentages of participants belonging to nuclear and joint families were 46.00 and 54.00 respectively. Majority (40.40%) of the participants of the present study were illiterates. The findings obtained by the present study can be discussed as under:

In table-2 Pearson's coefficient of correlation was used to examine the relationship between scores on Religious coping, Anxiety, Depression, Age and Gestation period. Results shows significant negative relationship between positive coping and age of the pregnant women ( $r = -.79, p < .01$ ) and gestation period ( $r = -.49, p < .01$ ). Negative religious coping was found significantly and negatively correlated with age ( $r = -.56, p < .01$ ) and gestation period ( $r = -.44, p < .01$ ). Participants less than 30 years of age shows higher positive religious coping in comparison to more than 30 years of age. Positive religious coping may offers a response to situations in which personal control over the situation is limited. Woman dealing with the difficulty of a pregnancy which requires bed-rest might look to God for solace because the medical requirements are far beyond her own control. Religious coping may be beneficial in situations of extreme stress because the limits of human capabilities are buttressed by spiritual and religious resources that go beyond secular supports.

Same as participants with short experience of pregnancy reported more positive coping in comparison to participants with long experience of pregnancy. The observed findings was inconsistent with the study done by Lobel and colleagues (2002) studied a medically high risk sample of 167 women attending their health care appointments for their mid-pregnancy exam. Religious coping was assessed with a two item measure of prayer that asked to what degree the participants had prayed that the birth would go well and prayed that the baby would be healthy. It was found that women who prayed more frequently for the health of the baby reported small but significant amounts of greater distress. Hamilton and Lobel (2008) also found that coping strategies were correlated with greater self report of distress. People who use religion as part of their coping framework are likely to use religious coping efforts to deal with stress. Unfortunately these studies are limited in some important respects. Researchers have overlooked the place of religion and coping with pregnancy among females participants.

Anxiety was significantly and negative related to age of the pregnant women ( $r = -.68, p < .01$ ), and gestation period ( $r = -.40, p < .01$ ). Participants less than 30 years of age show greater anxiety in comparison to more than 30 years of age. The obtained result was supported by the study done by Conde, Pacheco, and Costa, 2009 on Anxiety and depression during pregnancy in women and men. Same as participants with short experience of pregnancy reported more anxiety in comparison to participants with long experience of pregnancy. The present findings was supported by the study done by Teixeira, Figueiredo, Conde, Pacheco, and Costa (2009) were he observed that the prevalence of depression in early and mid pregnancy was 15.5% , 11.1% in 3<sup>rd</sup> trimester and 8.7% in post partum. Thus the above finding clearly revealed that depression during early pregnancy was high among women.

Depression was significantly and negative related to age ( $r = -.84, p < .01$ ), and gestation period ( $r = -.55, p < .01$ ). Participants less than 30 years of age show greater depression in comparison to more than 30 years of age. Same as participants with short experience of pregnancy reported more depression in comparison to participants with long experience of pregnancy. The present findings were consisted with the findings of study done by (Start, Dubertret and Foll, 2011) were he observed that the level of depression was high among pregnant women with lower age group. But it was also found that depression was more common among young women (Lee, Lam, Lau, Chong, Chui and Fong, 2007). The present study was further supported by a Cross-sectional observational survey done by Ajinkya, Jadhav and Srivastava (2013) at the outpatient department (OPD) of obstetrics of a tertiary care hospital in Navi-Mumbai were Prevalence of depression during pregnancy was found to be 9.18% based upon BDI, and it

was significantly associated with several obstetric risk factors like gravidity ( $P= 0.0092$ ) unplanned pregnancy ( $P= 0.001$ ), history of abortions ( $P= 0.0001$ ), and a history of obstetric complications, both present ( $P= 0.0001$ ) and past ( $P= 0.0001$ ).

In table-3 Mean scores and *SDs* of two groups of participants with varying age for the measures of religious coping along with t-test showed significant difference between mean positive coping scores of two groups of participants  $t = 74.95, p < .01$ . Mean scores show that positive coping was higher among participants with <30 years of age ( $M = 50.60, SD = 6.36$ ) as compared to the participants with 30 years and above ( $M = 35.95, SD = 5.04$ ). The same finding has been observed from Correlational analysis and was discussed above.

Negative coping results revealed significant differences between mean scores of two groups of participants  $t = 20.87, p < .01$ . Mean scores clearly revealed that participants with <30 years of age ( $M = 11.92, SD = 3.34$ ) shows more negative coping as compared to the participants with 30 years and above ( $M = 6.72, SD = 4.43$ ). The study was supported by the findings highlighted by Lucero, 2010. In his study on religious coping with the stressors of a first time pregnancy as a predictor of adjustment among husbands and wives negative religious coping were it was revealed that strategies during pregnancy report higher levels of negative outcomes in terms of depressive and anxious symptoms, ambivalence in marriage, labor fears, and likelihood for divorce.

In table-4 (gestation age ) Mean scores of three groups of participants along with the analysis of variance revealed significant differences between mean religious coping scores of three groups of participants for positive coping  $F (2, 44) = 7.06, p < .01$ , and negative coping  $F (2, 44) = 5.23, p < .01$ . Mean score indicate that participants with short experience of pregnancy (i.e., <3 months) shows more positive coping ( $M = 49.22, SD = 7.30$ ) as compared to the participants with 3 – 6 months ( $M = 42.73, SD = 9.98$ ) and 6 – 9 months ( $M = 38.89, SD = 8.19$ ). The consistent finding was observed by Lucero, 2010 on religious coping with the stressors of a first time pregnancy as a predictor of adjustment among husbands and wives were positive religious coping was associated with lower pregnancy satisfaction ( $\beta = -.24, p < .05$ ).

However negative coping participants with less than 3 months of pregnancy reported greater used of negative coping ( $M = 11.78, SD = 3.49$ ) as compared to the participants with 3 – 6 months ( $M = 9.55, SD = 5.22$ ) and 6 – 9 months ( $M = 7.17, SD = 4.37$ ). The consistent findings was observed by Lucero, 2010 on religious coping with the stressors of a first time pregnancy as a predictor of adjustment among husbands and wives were negative religious coping was associated with higher levels of depression ( $\beta = .19, p < .01$ ), anxiety ( $\beta = .19, p < .01$ ), and ambivalence in marriage ( $\beta = .27, p < .01$ ).

## CONCLUSION

From the above discussion this was concluded that the age of the participants ranged from 20 to 38 years ( $Mean = 26.53, SD = 4.99$ ). The majority of the participants (53.20%) had 6 to 9 months gestation period while 25.50% had 3 to 6 months gestation period and 21.30% participants had less than 3 months gestation period. Overall the results seem to be consistent with and extend previous findings regarding the use of religious coping (Pargament, 1997). This study supports the application of religious coping among women experiencing pregnancy. Religious coping seems to contribute to a better understanding of the stressful transition that pregnant women experience. Positive forms of religious coping have generally positive outcomes while negative forms of religious coping have generally negative outcomes. This seems appropriate to encourage psychologists and other health professionals to explore the religious coping resources of their clients and patients. Once use of religious coping has been assessed among pregnant women would make sense to encourage its more positive forms.

### Limitations of the Study

The sample size was small and study only used a cross-sectional data from pregnant women. Second, these analyses relied only on self-report data which may be biased by the respondents, social desirability or conscious awareness of themselves. Third, there are a variety of statistical weaknesses with analyzing the data. Finally, the results of this study underscore the need for more empirical investigations of psychotherapies and interventions. This study contributes to an understanding the relationship of religious coping and adjustment among women experiencing pregnancy.

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