BONDING TO GOD, COPING STYLES AND QUALITY OF LIFE AMONG INDIVIDUALS WITH INFERTILITY.

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DEDICATION

To my beloved Nana Abu,

who departed the world recently,

who never left my hand since he held it, even in eternal rest.

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ABSTRACT

The present study sought to examine the relationship between Boning to God, Coping styles and quality of life among infertile individuals. A sample of 189 participants consisting 57 males and 132 females. The main objective of this study was to determine bonding to God (connection to God, complaining attitude towards God, connection with God, Level of content) associated to quality of life. And to determine coping styles (Emotion Focused and Problem Focused) mediate the association between bonding to God and quality of life. It was hypothesized that there would be a significant relationship between quality of life, coping styles, and bonding to God among individuals with infertility. It was hypothesized that there would be a relationship of bonding to God and quality of life with mediating role of Coping Styles (Problem focused coping and Emotion focused coping) among individuals with infertility. There would be a significant difference on the variable of Bonding to God, coping styles and Quality of life between male and females with infertility and there would be a significant relationship between socio-demographic variables and Bonding to God, Coping styles, and Quality of life among individuals with infertility. For assessing the Bonding to God, Saleem (2004) Bonding to God Scale was utilized, for measuring Coping Styles, Zaman & Ali (2004) Coping Styles Scale was utilized, and for Quality of life, Boivin (2011) Fertility Quality of Life was utilized. Hence, the findings of this study indicated significant positive relationship between problem focused and quality of life besides negative significant relationship between emotion focused and quality of life among infertile individuals' emotion focused coping is more in females and problem solving coping is more in males. Furthermore, no significant gender differences were revealed for Bonding to God. There is a signification relationship between Bonding to God and Quality of life with mediating role of Emotion focused and Problem focused coping among infertile individuals. The outcomes of present study will provide help and benefit to infertility clinics. It will help the mental health professionals to create specific management plans for individuals with infertility, how to cope with infertility and connect to God.

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ABBREVIATIONS

BTG	Bonding to God
CTG	Connection to God
CAG	Complaining Attitude toward God
NTG	Nearness to God
LOC	Level of Content
CS	Coping Styles
PFS	Problem Focused Coping
EFS	Emotion Focused Coping
FertiQoL	Fertility Quality of Life
C FQoL	Core Fertility Quality of Life
E	Emotional
M/B	Mind/Body
R	Relational Core Fertility Quality of Life
S	Social Core Fertility Quality of Life

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CHAPTER 1

INTRODUCTION

1.1. Background

Infertility is a serious health issue that affects males and females of all ages and backgrounds in every region of the world. The WHO defines infertility as the inability to conceive following regular sexual activity for 12 months that does not involve birth control or other measures of prevention is the definition of infertility. Having an effect on families and communities everywhere, infertility affects millions of individuals of reproductive age every year.

Infertility affects anything from 48 million couples to 186 million people worldwide, according to estimates. Infertility might be a possible additional cause of a combination of factors. There are two categories of infertility, which are divided into two categories, primary infertility, and secondary infertility. Primary infertility is diagnosed if a female has never conceived after having sexual relations without contraception. The opposite of primary infertility is secondary infertility, which occurs when a female has already carried a child to term at least once. (WHO, 2018).

The world's biggest conference on the health and rights of females took place in Copenhagen in 2016, and one of the topics that were discussed there was the issue of infertility among women. The conference was attended by nearly 5,500 individuals, including ministers, lawmakers, business executives, non-governmental organization (NGO) representatives (NGOs), and activists.

The Director of Reproductive Health and Research from the World Health Organization (WHO) spoke at the conference and discussed the many consequences of infertility. Health Organization of the United Nations (WHO) and Women Deliver, together with the International Committee Monitoring Assisted Reproductive Technologies (ICMAT) and the International

Federation of Gynecology and Obstetrics (FIGO), have formed a partnership to increase global advocacy for infertility in developing countries. This objective will be accomplished via the partnership's continued efforts to promote education and research within the sector. With greater advocacy initiatives like this, maybe the rest of the world will come to realize the grave public health problem that is infertility in underdeveloped nations (Khadija et al., 2016).

10% of the world's population suffers fertility issues. Infertility in underdeveloped nations has social, psychological, and economic repercussions. All of the aforementioned works represent the culmination of in-depth interviews and focus groups conducted in regions with limited resources, such as those in Africa, Asia, and the Middle East. The following article intends to increase awareness of the implications of infertility in underdeveloped countries and to highlight infertility as a public health concern. Education programs customized to each society's religious beliefs and customs may assist overcome social shame, poor psychological effects, and loss of economic stability caused by infertility. Untreated sexually transmitted infections are a primary cause of infertility in poor areas. Infections cause 85% of female infertility in Africa, but only 33% internationally. Chlamydia and gonorrhea are common STDs. Infertility risk factors include negative cultural perceptions of women, economic difficulties, and lack of formal education. Finally, restricted contraception is a danger (Ombelet et al., 2008).

In Pakistan, 21.9 percent of the population is affected by infertility, which compares to a global total of 186 million people and 48 million couples who are coping with the problem of infertility (Sumera et al., 2011). According to the findings, around 22 people out of every 100 in Pakistan's population are likely to struggle with the issue of infertility at any one time. Regardless of the reason as result of the couple's inability to have children, the female partner is traditionally blamed in Asian society when reproductive issues arise in the relationship (Grey, 2017). On the other hand, Possible causes of infertility include a wide variety of difficulties in the reproductive

system of either the male or the female. Polycystic ovary syndrome, tubal occlusion (blocked fallopian tubes), uterine abnormalities (including endometriosis, septate uterus, and uterine fibroids), and disorders of the endocrine system are the reasons for female infertility. Other causes include blocked fallopian tubes (Samuel & Caleb, 2011).

Even though male infertility accounts for half of all instances, women in poor nations bear the brunt of the problem. When a woman has infertility, her husband may decide to divorce her or marry another woman, depending on local customs. Social stigmatization of infertile women is another kind of prejudice they face. They may be stigmatized as carriers of an infertility-causing "bad eye" in certain societies. Women who are unable to conceive often go uninvited to special occasions like weddings and other celebrations (Bhandari, 2020). Due to a lack of fundamental understanding of the factors that lead to infertility and the possible treatments that may be necessary, the rate of infertility is much greater in developing nations. It was found that infertility impacted 22 percent of people in Pakistan, with primary infertility affecting just 4 percent of those who were afflicted (Geneva, 2020; Sami & Saeed, 2012).

The Merck Foundation's "Merck More than a Mother" program is working to reduce the social isolation of infertile women in low-income regions by increasing their access to higher education. More than 109 fertility doctors and endocrinologists have been educated under the program since 2016. Music videos, songs, and fashion shows have also been produced by the charity to spread the idea that women should not be held responsible for infertility (Springer, 2014).

Research conducted on couples sees both spouses as a single entity. Both pair checks at once may speed up diagnosis and therapy. Gynecologists struggle with sperm analysis findings and infertile men. Urologists utilize the same approach for female investigations. If gynecologists and urologists worked together, they'd know the best diagnostic and treatment techniques for a

patient (Darwish, 2017). Azoospermia, aberrant sperm morphology, ejaculatory duct occlusion, and hormonal abnormalities may also cause male infertility (Skinner, 2018). Infertility risk factors include aging, diabetes, anorexia and bulimia, excessive alcohol usage, lead and pesticide exposure, and extreme exercise. Both male and female reproductive systems may cause infertility. Infertility must be diagnosed and treated for a woman to get pregnant (Pooja, 2021).

A polycystic ovarian syndrome is characterized by excessive ovarian androgen production. Androgens are male sex hormones found in lesser amounts in women. The polycystic ovarian syndrome is characterized by ovarian cysts. To put it another way, when a woman has tubal occlusion, no sperm can reach her egg and no fertilized egg can return to her uterus. The uterus is the target of treatment for a wide range of conditions. When tissue that looks like the uterine lining develops in the wrong place, it's called endometriosis. Septate uterus condition is a standard-shaped uterus with a layer of tissue making two cavities. Uterine fibroids are non-cancerous tumor that grows in the uterine wall (WHO, 2018). Endocrine dysfunction produces an imbalance in reproductive hormones (Samuel & Caleb, 2011).

Azoospermia is when men's testicles can't generate sperm. Ejaculate has no sperm. It may be obstructive, preventing sperm from ejaculating, or non-obstructive, reducing testicular sperm production. Abnormal sperm with abnormalities in the head or tail might cause infertility. Malformed heads, crooked tails, and multiple tails are examples of these abnormalities. Due to sperm abnormalities, sperm can't reach and enter an egg. Steroids alter sperm shape and function. Ejaculatory duct occlusion prevents semen from exiting one or both ejaculatory ducts. A malfunction in the endocrine system created an abnormal imbalance in testicular hormones (Skinner, 2018).

There have only been a few of research that looks at how cannabis affects male fertility. Cannabis usage, on the other hand, has been linked to a lowered libido, sexual dysfunction, and

shrinkage of the testicles, in addition to reduced levels of several hormones necessary for reproduction, including testosterone. The use of cannabis has also been associated with a decline in sperm count and concentration, morphological abnormalities, decreased motility and viability, and reductions in the capability of sperm to fertilize an egg (Harlow et al., 2019).

Being a mother is one of the most important aspects of being a woman, and for a woman living in a poor nation in Asia, the inability to have children may be a very distressing experience. In underdeveloped countries, the majority of patients have little or no access to medical treatment. The diagnosis and treatment of infertility are only offered at a few numbers of medical facilities. In addition, there is widespread ignorance regarding infertility among the general population, which contributes to the problem. As a consequence of this, a significant number of couples seek out alternative treatments and participate in religious rites to conceive, so squandering precious years of their lives (Moazzam, 2017).

According to the results of a health survey, primary infertility accounted for 63.38 percent of cases, while secondary infertility without a baby accounted for (24.93%) of cases, and secondary infertility with a kid accounted for 7.21 percent of cases (11.69%). Over half of infertile women (54.5%) had a poor quality of life, whereas (45.5%) reported a high one. Social and demographic aspects were not linked with infertility-related quality of life in either the main or secondary samples. However, for both primary and secondary infertility, there was a statistically significant correlation between the length of time spent trying to conceive and the quality of life during those years, and the reason for infertility and the quality of life during secondary infertility without a kid (Subhadra, 2020).

The degree to which cultural and family values are prioritized is a major factor in determining the occurrence of infertility (Alhassan et al., 2014). The majority of married couples in our society have the goal of starting a family because they are under the impression that having

children is essential to the success of any relationship. One definition of infertility is the incapacity to obtain a natural pregnancy following a period of at least a year of regular, unprotected sexual activity. This period of sexual activity must be without interruption (Gurunath et al., 2011).

Infertility is one of the most distressing situations that a couple will go through throughout their lifetime together. It is also a complicated problem that causes psychological danger and emotional strain. The unique ideas and feelings that are connected to infertility that the individual struggles to rid themselves of are what constitute infertility stress. Stress is defined as "a dynamic circumstance in which a person is presented with an opportunity, limitation, or demand connected to what he or she wishes and for which the result is regarded to be both unclear and crucial," according to specialists in the field of mental health (Awtani et al., 2017).

The medical treatment of infertile patients is prioritized by medical experts to attain a singleton pregnancy for every one of their patients. Patients who never seek out medical attention, who do not return for treatment following the diagnostic workup, or who stop receiving therapy are seldom ever seen. However, this is the result that occurs for the majority of patients, and the emotional component is the biggest reason, after financial concerns, why therapy is discontinued. To offer all of our patients with genuine access to treatment, we have to make it a greater priority to address the psychological concerns of those we treat (Camilla, 2016).

In spite of the fact that when a couple is told they have infertility, both spouses should be evaluated, according to the National Institute for Healthcare and Care Excellence and the Centers for Disease Control and Prevention, the results of a survey conducted by the National Survey of Family Growth indicate that male partners do not receive an evaluation in anywhere from 18 percent to 27 percent of cases. 2–5. In point of fact, only nine percent of males in the same age range have ever reported utilizing infertility services, in contrast to the seventeen percent of women in the same age range who have admitted to having done so (Oakley et al., 2020).

One of the most significant changes that happen to all sexes once they reach adulthood is becoming a parent. The strain of having a desire for a child not come true has been linked to a variety of mental consequences, including rage, melancholy, anxiety, marital discord, sexual dysfunction, and social isolation. In the context of their infertility, couples often suffer feelings of shame, loss, and a reduction in their sense of self-worth (Nachtigall, 1992). However, when infertility is linked to a male reason, men's emotions toward infertility roughly match the severity of women's responses. In general, women are usually the ones that bear the burden of infertility in a partnership and exhibit greater degrees of pain than their male partners (Nachtigall, 1992; Wright, 1991; Greil, 1988). Both men and women report feeling as if they have lost their identities and having severe sentiments of defectiveness and ineptitude as a result of their condition (Havard, 2020).

Male infertility has been linked to many negative psychological effects, including stress, despair, and anxiety. According to the findings of several studies, the prevalence of major depression ranges anywhere from 15 percent to 54 percent among infertile couples who seek infertility treatment. There has been an alarming rise in the occurrence of depression seen in fertile couples who do not seek treatment for infertility (Chen 2004; Domar 1992; Demyttenaere, 1998; Parikh, 2000). Infertile couples have been proven to have much greater rates of anxiety in comparison to the typical person, with anything between 8% and 28% of infertile couples experiencing clinically severe anxiety (Anderson 2003; Chen, 2004; Parikh 2000).

Miscarriage or stillbirth affects 25% of pregnancies. Most women heal emotionally after a miscarriage, but some grieve. Studies show many women experience PTSD (PTSD). Miscarriage studies focus on the early months. New research looked for PTSD, depression, and anxiety nine months following the loss. 338 of 737 women completed a 9-month online evaluation after 1, 3, and 9 months. After one month, more early pregnancy loss women fulfilled PTSD criteria,

although this dropped to 18% after nine. 17% of women experienced moderate to severe anxiety at nine months. 11% of women were depressed after one month, and 6% after nine. Nine months later, 1 in 5 women has PTSD and 1 in 4 has significant anxiety. This illness will reduce among women. Doctors and counselors seldom urge early miscarriages. Miscarriage or stillbirth can affect a woman's quality of life and capacity to perform, but there are as well long-term implications. Studies show stress and worry might impair a mother's fertility. If these symptoms recur, other hazards may exist (Farren et al., 2019).

Treatment-seeking behavior of infertile patients to the Center for Assisted Reproduction (CARe) was documented by Fatima et al. (2017). Infertility causes, as well as socioeconomic and cultural factors, differ by area. Their financial situation also influences patients' health-seeking behavior. Therefore, the reasons for infertility are social, cultural, medical psychological and their behaviors towards treatment also vary (Fatima et al., 2017). The Fertility Quality of Life (FertiQoL) questionnaire was used to evaluate the overall quality of life of women. The results indicated no statistically significant relationship between the kind of treatment and the willingness to engage in psychological intervention. Further, the Pearson correlation test results showed a strong negative association between the overall score of PTSD and quality of life, and a direct relationship between the total score of PTSD and stress (Azam, 2013; Dadkhahtehrani, 2018).

There are several therapies available for infertility, one of which is the use of drugs to either control or stimulate ovulation in the patient. Any damage to the reproductive organs and tissues is either surgically corrected or managed surgically. A fertility therapy known as assisted reproductive technology (ART) involves taking the egg and sperm from the body and placing them in a separate container. There are four distinct categories of art. In vitro fertilization, more often referred to as IVF, is a kind of assisted reproductive technology (ART) that involves the collection of eggs and their subsequent fertilization in a laboratory setting. After those eggs have been

fertilized, they are reintroduced into the uterus of the female. In a laboratory, the fertilization process takes happens. Similar to in vitro fertilization (IVF), zygote intrafallopian transfer (ZIFT) involves the transfer of fertilized eggs to the fallopian tube rather than the uterus. The lab is where the fertilization process takes place (Carriann et al., 2012).

The most common reason for using in vitro fertilization (IVF) is still infertility, which affects around ten percent of all married couples. Even without taking into account the growing number of indications for IVF that go beyond infertility, these straightforward numbers point to the possibility that in vitro fertilization (IVF) use may greatly increase in the next decades if obstacles to its utilization are reduced. The in vitro fertilization (IVF) rate is directly proportional to both the cost of the procedure and its availability (Chambers, 2013). In point of fact, an increasing number of nations and states in the United States are pursuing a variety of measures that are meant to reverse the trend of falling fertility rates. These policies vary from mandatory insurance coverage for fertility treatments to subsidies designed to make it easier to raise children, and they are all imposed by the government. The idea that having children is a fundamental human right is only beginning to acquire popularity, which will undoubtedly hasten the widespread adoption of laws along these lines (Kushir et al., 2022).

However, IVC employing INVOCELL as an alternate model for infertility therapy validates its applicability as a feasible alternative to conventional in vitro fertilization performed in an incubator. The method may be integrated into the existing structure of practice patterns and, when used correctly, produces blastocyst recovery and live satisfactory birth rates. It would be prudent to use INVOCELL in further therapeutic settings moving forward (Nolan et al., 2021). GIFT introduces sperm and eggs into a woman's fallopian tube. The female host fertilizes. Intracytoplasmic sperm injection (ICSI) injects a single sperm cell into a mature egg, which is subsequently cultivated. Fertilization without sperm (Tolu, 2008). Infertility affects a person's

quality of life. People also employ a range of coping mechanisms. Daily coping strategies might be the solution- or emotion-focused (Silvia et al., 2015). Troubles might affect a person's relationship with God. The problem may increase or weaken people's ties with God (Moltmann, 1974).

Hormones are also used to diagnose female infertility, a topic of many investigations. This study aimed to examine if hormonal imbalances (FSH, LH, and Prolactin) contribute to female infertility and, if so, how they relate to socio-demographic and clinical parameters. Most research participants had normal FSH, LH, and Prolactin levels. The study indicated that infertile women's FSH levels increased with age. According to women's studies, hormonal imbalance (low LH, high FSH, and low prolactin) might cause infertility. FSH rises with aging, but prolactin falls. It was advised that large-scale case-control studies be done to evaluate the association between infertility and hormone abnormalities in women who struggle to conceive (Helal & et.al, 2016).

Asian society discriminates against childless women. A new notion of reproductive health includes family planning, good motherhood, treatment for reproductive infections, and delivery help for infertile couples. This new idea of reproductive health is part of an effort to enhance women's health. Family history, age, obesity, irregular menstrual cycle, dysmenorrhea, hysteroscopy tubal obstructions, big uterus, and polycystic ovarian disease cause PCOS (PCOD). Lifestyle changes are increasing the incidence of PCOD, the leading cause of female infertility. PCOD is easy to cure and predicts infertility more accurately than other reasons. PCOD is often accompanied by thyroid dysfunction and hyperprolactinemia, which must be addressed for the best outcomes. Environmental and lifestyle factors can contribute to male and female infertility. Drug addiction, obesity, incorrect nutrition, and stress may cause infertility. Environmental pollutants may affect gametes. Infertility may be caused by traumas and incidents like those mentioned above. Age-related infertility is another factor (Rakesh et al., 2013).

Evidence of a healthy reproductive system is a monthly menstrual cycle. Obesity, stress, and smoking have all been linked to premature menopause and irregular periods in the past. However, there is still a lack of knowledge on how these preventable risk factors interact with one another. The effects of smoking, drinking, obesity, and self-reported high levels of stress on menstruation and menopause were analyzed using univariate and multivariate logistic regression methods. Analyses of the correlation between smoking and menopausal age were conducted using both logit and linear models. As confounders, we accounted for things like equivalent family income, marital status, and educational attainment. To further account for the influence of smoking, alcohol consumption, and excess body weight, modifiable risk factor scores were also generated. Cigarette smoking, obesity, and stress were all found to be strong predictors of menstrual cycle irregularity. Early menopause was also associated with a lifetime of smoking (Bae et al., 2018).

Abnormal sperm, varicocele, and Teratozoospermia may cause male infertility. Oligospermia is fewer than 20 million sperm per milliliter of ejaculate. According to Dr. Abhishek, infertility in males and a low sperm count are considerably more common than most couples realize. The attitude is so evolved that if a woman doesn't get pregnant, people tend to believe it's her infertility. Male factor infertility is more likely, says the research. Couples who have been trying to conceive for a year without success should have infertility testing. Normal sperm count and motility/morphology are 20 million or greater. If your sperm count is less than 20 million or you have difficulties with morphology, motility, or movement, homeopathic drugs may help enhance the quality and quantity of your sperm naturally (Abhishak, 2017).

When patients contemplate homeopathic infertility treatment, a homeopath first evaluates whether the condition is male or female. This article focuses on the woman's symptoms. Patient or

customer symptom description. Homeopaths cure women with mental and emotional suffering by restoring their health so they may heal themselves (Masiello et al., 2017).

Furthermore, Cleland and Wilson (1998) state that a woman's level of education has a significant influence on all aspects of reproduction. These aspects include fertility desires, the utilization of contraception, the age at which a woman marries for the first time, postpartum amenorrhea and abstinence, and child survival. Although there are other components of socioeconomic progress related to education that contribute to the observed discrepancies, the significance of women's education cannot be denied, as seen in other regions of the world. Women who have completed their educations are more likely to be motivated to exercise fertility control, and they have a fundamental grasp of how to do so (Dudley, 1998).

Assisted reproduction increases worry, unhappiness, and stress, even though many infertile couples already face severe psychological distress (Leiblum, 1987). Increasing numbers of research publications concentrate on the effects of failed IVF procedures on infertility therapy at different stages. Hynes and her colleagues studied patients before and after IVF. IVF patients were sadder, had poorer self-esteem, and were less confident than fertile women. Women with unsuccessful IVF cycles having more depression and less self-esteem than before therapy (Hynes, 1992). Based on comparisons between first-time IVF participants and women with several rounds, prolonged treatment may worsen depressive symptoms (Thiering, 1993).

The statistics, on the other hand, are still up for debate because other researchers have shown minor psychological disruption caused by the process of infertility therapy or IVF failure (Paulson, 1988; Boivin, 1996). The disparate outcomes have sparked a renewed focus on understanding what causes people to stop receiving infertility therapy. Given that this population is frequently excluded from studies or chooses not to participate in them, there has been a growing interest in these factors. A recent study reveals that a considerable proportion of treatment dropouts

are attributable to psychological causes, despite the fact that expense and the unwillingness of doctors to continue therapy have been listed as reasons for treatment discontinuation in the past (Hammarberg, 2001; Olivius, 2004).

There is some evidence that psychological issues might play a role in the outcome of infertility therapy. Numerous research has been conducted to investigate impact of stress and emotional state on assisted reproduction outcomes. The findings of the bulk of this research lend credence to the hypothesis that women undergoing therapy for infertility are less likely to get pregnant if they are experiencing emotional discomfort (Demytenaere, 1998; Smeenk, 2001; MGH, 2020).

1.2. Rationale

Infertile persons are the focus of this research, which analyses the link between the quality of life, coping techniques, and a sense of spiritual connection to God. There has been a disproportionately little amount of research conducted on infertile persons about the quality of life, coping mechanisms, and spiritual connections (Coley & Chase- Lansdale, 1998). The bulk of the study that has been done on the topic has been on the social factors that put adolescents at risk of becoming pregnant. Because of the strong correlation between pregnancy and dropping out of school, either before or after the birth of the child, psychological distress may accompany pregnancy (Ibid). It is more frequent for teenage mothers to exhibit symptoms of depression in comparison to their non-parenting counterparts and older mothers (Kalil & Kunz, 2000). The present research investigates the impact that infertility has on a person's quality of life, in addition their coping mechanisms and relationship with God. It examines the impact that coping strategies and spiritual connections have impact the standard of living of childless couples.

1.2.1. Theoretical Gap

In the psychology field, regarding the topic of religion, there is a diverse range of points of view. Positive thinkers believe that religion has immense power and has the potential to aid

individuals in overcoming the effects of traumatic experiences (Ghobary et al., 2013; Younas et al., 2017). Pathology, on the other hand, is tied to an unfavorable perception of God, whereas mental wellness is associated with a favorable perspective of God. There is evidence that links unfavorable views of God to many ailments; this finding, along with other research, is relevant to the field of mental health (Koenig et al., 2001; Pirutinsky et al., 2017; Weber & Pargament, 2014). To believe in God is seen as one of Islam's most fundamental principles. One way it helps Christians grow spiritually is by marking a significant transition point along the way. Muslims are encouraged to acquire this quality of dependence on God as part of their spiritual growth (Sabzvari & Faghfoory, 2008).

In addition, it helps Muslims cope with the pressures of daily life. As an example, Khan et al. (2018) identified four primary ways that Muslims might get closer to God: through visualizing God's names, reciting Quranic chapters, memorizing Quranic passages, and engaging in various rituals and customs. These spiritual practices help people cope with difficulties in life and strengthen their bonds with God. The greatest way to deal with dangerous circumstances in life is, indeed, to rely on God or to trust in God (Bonab & Koohsar, 2011; Mottaghi et al., 2011; Khan et al., 2018).

While there is some research on the topic, it is not extensive. In Pakistan, there is a dearth of studies examining the effects of religious affiliation on infertility. Staying faithful to God is crucial in overcoming infertility. The relationship between men and women with God is the focus of this research. This study will also compare the spirituality of men and women to see which group is closer to the divine.

1.2.2. Contextual Gap

Most of the previous study on infertility was conducted in Western and Iranian cultures. The demographic that is the focus of the majority of research on female infertility. Infertility, on the other hand, is a problem that affects men as well as women in many different ways. This

research will bridge the gender gap by incorporating both men and females in its participants (Safarinejad, 2008).

1.2.3. Methodological Gap

In the prior investigation, we used certain equipment that was not native to our region. Instruments designed in accordance with Pakistani cultural norms will be a part of this research. The test that has been designed by a Pakistani researcher at the Institute of Clinical Psychology and will be used to assess the different types of coping methods is as follows: (Zaman & Ali, 2014). Bonding to God is an additional tool that was created by a Pakistani scholar working at the National Institute of Psychology. These implements are designed in accordance with Pakistani cultural norms. The third instrument, which will be used to assess the quality of life, is an instrument that has been created specifically for the purpose of measuring the quality of life among infertile persons (Boivin, 2011).

1.2.4. Population Gap

In previous research, samples consisted of both single women and married couples. Participants in this research will comprise men and women of reproductive age who are unable to have children due to infertility (Peterson et al., 2003).

1.3. Problem Statement

The present study warrants scientific investigation for the following reasons: The rate of infertility is on the rise year after year as a direct result of changes in the living environment, the quickened pace of life, and the prolonged periods of time spent waiting to get married and have children. Infertility affects between 8 and 12 percent of couples throughout the globe, according to statistics provided by the World Health Organization (WHO) (Tong, 2021).

It may have adverse psychological effects and a worse quality of life and well-being (Zurlo, 2018). For example, studies have revealed that a bad mental state may lower IVF-ET pregnancy rates and negatively impact pregnancy outcomes (Cooper, 2007). In addition, women experiencing

infertility have a worse quality of life than other women of reproductive age (Drosdal, 2018). As a result, patients' quality of life declines, decreasing treatment adherence and, as a result, the pregnancy rate (Keramat, 2014).

Religiosity levels and infertility were studied; a study reported infertile women with high levels of religiosity and spirituality to have lower levels of psychological suffering. Religious and spiritual challenges impact infertile women's psychological health and responsiveness to infertility therapy (Alice & Domar, 2017). One potential reason is that women who have had several fertilization operations are emotionally fatigued and have much lower stress-coping methods than women who are just starting therapy. Another cause might be the three-month interval between two treatment cycles (Turner, 2013; Verhaak, 2007). However, there has not been much research done on the quality of life of infertile patients, as far as we can tell from the available literature.Therefore, this study aimed to look into the current state of infertile patients' fertility QoL and discuss the factors that affect their quality of life related to fertility, therefore providing a scientific basis for the development of efficient therapeutic interventional methodsand assisting infertile patients in improving their fertility QoL.

The present quantitative study will Investigate the connection between quality of life., coping styles, and bonding to God among infertile individuals. Also, to examine the effect of demographic variables on study variables. The data gathered in this study will help understand the relationship among study variables.

1.4. Research Question

Is an individual's perceived Bonding to God associated with their use of coping style, and are those coping style, in return related to Quality of life?

1.5. General Objectives

1. To determine bonding to God (connection to God, complaining attitude towards God, connection with God, level of content) associated to quality of life.

2. To determine coping styles (Emotion Focused and Problem Focused) mediate the association between bonding to God and quality of life.

1.6. Hypotheses of the Study

1. There would be a significant relationship between quality of life, coping styles, and bonding to God among infertile individuals.
2. There would be a relationship of bonding to God and quality of life with mediating role of Problem focused coping among individuals with infertility.
3. There would be a relationship of bonding to God and quality of life with mediating role of Emotion focused coping among individuals with infertility.
4. There would be a significant difference on the variable of Bonding to God, Coping styles and quality of life between male and females with infertility.
5. There would be a significant relationship between socio-demographic variables, quality of life, coping styles, and bonding to God among infertile individuals.

CHAPTER 2

LITERATURE REVIEW

Infertility is diagnosed when a couple has frequent, unprotected sexual encounters but is unable to conceive a child or carry a pregnancy to term. There is a one-in-four possibility that a couple may conceive naturally during the next year even if they have been trying to conceive for more than three years without success. These couples had been attempting to conceive for more than three years (NHS, 2020). Fertility quality of life is developed to measure the fertility issues that influence many aspects of life, everything from one's physical well-being to one's mental and emotional state to one's connections with others to one's career and aspirations for the future is all part of one's life. It also measures the environment and tolerability of fertility treatment (Jacky et al., 2011). Fertility quality of life is a tool designed to assess the impact of fertility challenges on various elements of life. It also assesses the health of the environment and the tolerability of reproductive treatments (Andrea, 2011).

However, infertile couples manage their emotional distress because of unmet needs by using coping styles; to cope with both internal and external sources of stress, one must engage in certain mental and behavioral processes. Essentially, it is a way of thinking that separates the conscious and deliberate mobilization of actions from 'defense mechanisms,' which are subconscious or unconscious adaptive responses aimed at reducing or tolerating stress (Folkman, 2004). When confronted with a stressful situation, people have a wide range of options on how to handle it, collectively known as coping strategies. These constants hold true regardless of time or environmental factors (Buwalda, 2017).

Furthermore, religion is also a factor have been studied with infertility in the past. The belief and worship of a dominating power, such as a personal god or another supernatural entity, is at the heart of most religions. This is a simplistic description, because not all religions revolve around a belief in a deity, but it does capture the essence of the term. Religion may provide solace and direction. It may provide us something to ground our moral convictions and actions in. As an added bonus, it may help people feel closer to one another and to their heritage. Some studies have even shown possible health effects. For instance, studies examining how religion affects people's health and longevity have historically met with methodological challenges. It has been hypothesised (by some) that frequent churchgoers have better health than their nonreligious counterparts (Andrew, 2007; Peate, 2012).

2.1. Infertility

Failure to conceive after trying for at least 12 months during routine, unprotected sexual activity is considered infertility, a disorder of the male or female reproductive system. (WHO, 2018). Families and communities everywhere feel the effects of infertility, which affects millions of individuals of reproductive age. Around the world, infertility affects anywhere from 48 million couples to 186 million people, according to estimates (Boivin,2007; Mascarenhas, 2012). Most cases of male infertility may be traced back to issues with the ejection of semen (WHO, 2018), Infertility is caused by a lack of sperm, defective sperm count, morphology, or motility. Infertility in women may have many different root causes, including issues with the ovaries, uterus, fallopian tubes, or the endocrine system. Primary and secondary infertility are both possible. When a person has never gotten pregnant, they are said to be suffering from primary infertility, whereas infertility that has already been overcome by at least one pregnancy is said to be suffering from secondary infertility. Infertility treatment and care includes monitoring for any issues and administering any necessary treatments. Access to reproductive health care is still not universally or fairly available,

especially in poor and middle-income nations. Contrary to popular belief, fertility services are not often a top priority in national universal health coverage benefit packages (Gore,2015; Segal, 2019).

According to Kalantari, and Molavi (2011), infertility is a major medical issue that affects a person's quality of life. The most important motivation for a person's desire for fertility is to have children, followed by a desire to experience paternity. If this need is not met, it may impact their quality of life (Kalantari, & Molavi, 2011; Mahmoud et al., 2017).

Past research by Schmidt et al. (2005) examined the relationship between infertility and stress affecting both members of the infertile couple, and it is negatively affecting different domains Personal (including health and happiness) Social (including friendships and family) Marital (e.g., marital satisfaction and sexual pleasure) (Schmidt et al., 2005).

N et al. (2005) studied infertility and its risk factors. Results revealed the levels of stress and anxiety in infertile women to see if they could be linked to risk factors. The study found that infertile women are more stressed than fertile women but that they can adjust to stressful situations without suffering substantial physical or psychological impairment (N et al., 2005).

Fido (2004) reported Infertility among Kuwaiti females was investigated, and it was discovered that literate females choose traditional medicine and traditional healers for reproductive treatment. Instead, they blame their infertility on dietary, marital, and psychosexual problems. But on the other hand, illiterate women rely on faith and traditional means. They dismiss intangible factors such as evil spirits, witchcraft, and God's punishment for Infertility (Fido, 2004).

Infertility is growing rapidly. Research revealed that the average age of the 236 women with primary infertility who were recruited from the Gynecology Obstetrics Clinic was 33.21 (range: 20 to 46) years, and the average time it took to conceive was 3.24 years. Quality of life connected to fertility was negatively correlated with infertility-related stress. Infertility affects both

males and females, according to a study. The psychosocial side of infertility severely affects couples' quality of life. According to reports, infertile women's quality of life is impacted more than infertile male. It is well recognized that infertility has a severe impact on family life and relationships, particularly among women, making them feel ill, worthless, and miserable (Tashan, 2013).

The study conducted by Monga (2004) on 18 couples seeking infertility treatment was asked to complete the questionnaires to assess their quality of life. 83% of participants Those who were married said their quality of life and ability to adapt to their spouse's new circumstances were both low. There was no variation in marital adjustment scores between male and female participants. However, the difference in score of quality of life was noted. Female participants reported lower quality of life as compared to male participants (Monga, 2004).

Hee (2019) conducted a cross-sectional study that analyzed infertility and resilience and quality of life among female participants; resilience and infertility revealed a negative correlation, and infertility and quality of life have a positive connection 53.6% of participants reported low quality of life and Infertility.

A past study by Jordan and Revenson (1999) states that infertility affects both males and females in different ways. However, meta-analysis (1966-1995) researches suggest significant gender differences; for example, families that make use of it Women are more likely than men to engage in strategies such as seeking social support, avoiding conflict, methodically approaching problems, and reevaluating their situation positively (Jordan et al., 1999).

2.2. Bonding with GOD

Religion is a set of organized beliefs, practices, and systems that most often relate to the belief and worship of a controlling force such as a personal god or another supernatural being. It can also provide a sense of community and connection to tradition. Some research even suggests

that it may affect health and quality of life. The impact of religion on health and life expectancy has always been a tricky area of research (Aldwin, 2014; Ayvaci, 2016).

Religiosity has a link with Infertility; Mabel and Kwaku (2017) proposed the link between psychological distress and positive and negative religious coping among Ghanaian women dealing with infertility. The findings revealed that the psychological discomfort in infertile females rises with age and the infertility period. Negative religious coping was also significant and linked with somatization, despair, and anxiety. The use of negative religious coping in infertility among women is particularly noteworthy, especially given that it was related to poor psychological. It's conceivable that participants questioned God's might or saw their position as a punishment from God. Infertile female mental health appears to be influenced by their religious beliefs (Mabel & Kwaku, 2017).

Religiosity levels and infertility were studied; a study reported infertile women with high levels of religiosity and spirituality to have lower levels of psychological suffering. Religious and spiritual challenges impact infertile women's psychological health and responsiveness to infertility therapy (Alice & Domar, 2017). Spirituality and religion seem to have a significant influence on the psychological well-being of infertile women. Infertile women with a higher level of spiritual well-being had reduced infertility suffering and depressive symptoms (Domar et al., 2001).

It is also important to identify that the quality of life of infertile couples has been shown to improve with increased use of Meaning-based coping methods and decreased use of active avoidant coping strategies, as well as shorter durations of infertility. Consequently, as well as focusing on medical therapies, it is important to provide infertile couples with psychological assistance and educational initiatives that teach them how to develop healthy coping mechanisms. (Yousefzade et al., 2017).

Meanwhile (Abdulaziz & Mahdiyar, 2016) looked at religious coping mechanisms in infertile women's despair. This research focuses on religious coping on depression decrease in infertile women. According to the findings, women who used religious coping techniques were less likely to experience depression symptoms (Abdulaziz & Mahdiyar, 2016).

2.3. Coping Styles

It attempts, both consciously and unconsciously, to deal with adversity and manage our stress that are referred to as coping. The human mind is equipped with a self-correcting process that brings it back to optimal functioning. Coping skills, often called coping strategies, are a collection of adaptive methods that people may use to actively protect themselves from experiencing burnout (Roth 1986; Walinga, 2008).

Silvia, Chiara, and Piccoli's (2015) study are valuable study that enhanced the knowledge of life satisfaction and ways of coping. The role of gender as a moderator in the relationship between coping styles and quality of life and the role of coping techniques. According to the findings, problem-focused coping techniques increase the quality of life, but emotion-focused coping strategies deteriorate it. Self-blame is more negative for men since it lowers their quality of life in the total four categories. Gender plays a role as a moderator: social and instrumental quality of life enhances relationship quality of life for females, but self-blame lowers relationship quality of life for males (Silvia et al., 2015).

According to Peterson et al. (2007), the coping techniques of couples living with infertility were explored. The suffering of couples increased when one member of the couple employed high levels of distance while the other member used low levels. Couples where the woman employed more self-controlling coping strategies than her partner reported more distress than those where both partners utilised the strategies equally (Peterson et al., 2007).

Infertile individuals use coping styles reported by Szigeti (2012), Infertility affects the quality of life of an individual. The infertility problem is considered challenging to adapt to as it is linked with severe loss experience. To deal with infertility, one use different coping styles to cope with a difficult situation. The term loss is explained as since the when a couple can't have children, they lose out on the thrill of parenthood and all the happiness that comes with having a kid. and social acceptance from society. Infertile individuals face failure to accomplish the future they have high hopes for but low expectations for and so feel they must rehabilitate and rebuild (Szigeti, 2012).

However, the role of coping was studied in infertile couples. Results showed a significant correlation between marital adjustment, beneficial religious coping mechanisms, and post-traumatic growth. Positive religious coping methods were associated with post-traumatic growth in a significant way. The association between marital adjustment and post-traumatic growth has been mediated by positive religious coping mechanisms (Ghafouri et al., 2016).

Furthermore, a study revealed that infertile couples' quality of life improves when they adopt meaning-based coping strategies rather than active avoidant coping strategies and have a shorter duration of infertility. As a result, providing psychiatric therapy and educational interventions for appropriate coping mechanisms and biological treatments for infertile couples is prioritized (Yousefzade et al., 2017).

2.4. Quality of Life

World Health Organization (WHO) put it another way, quality of life is how a person feels about his or her own situation of their place in life, value system and cultural expectations, aim, standards, and priorities. The main components of quality of life include an individual's well-being, level of sadness and happiness, satisfaction and discontent, and overall happiness (Shahla et al., 2010).

Quality of life has become progressively more familiar in most studies, as Katayoun (2019) revealed that age has influence on both physiological and psychological well-being. Females under the age of 35 were shown to have much improved physical and mental health than females in older age groups. The infertile female also had lower quality of life ratings fertility, but scored better on the social health subscale than women who were not pregnant (Katayou et al., 2019).

According to Roozialab (2021), there was no significant relationship between the type of treatment and the receipt of psychological assistance in a study. Furthermore, Pearson correlation results revealed a significant inverse relationship between total post-traumatic stress disorder score and quality of life, as well as a direct relationship between total post-traumatic stress disorder score and level of stress and PTSD was present in 41.3% of women who could not conceive. Because of the linkages between PTSD and quality of life and the stress of Infertility (Roozitalab, 2021).

Chi. (2016) conducted a study on the quality of life of infertile Korean women was researched, and the results revealed that infertile women's depression, anxiety, and stress scores were significantly higher than fertile women's despair, anxiety, and stress scores. The social ($r = -0.537$) and relationship ($r = -0.385$) subscales, on the other hand, revealed a stronger negative connection with depression (Chi, 2016).

According to Monga et al. (2004), the quality of life loss and infertility caused there is a rise in marital strife and erectile dysfunction. The experimental group consisted of couples seeking infertility therapy, while the control group consisted of couples seeking sterilization. According to the findings, infertile couples' females have a lower quality of life than their male counterparts. Poor marital adjustment and quality of life were also mentioned by women in infertile couples, which was in contrast to the control group (Monga et al., 2004).

However, a study was conducted on guys who sought treatment for infertility at a tertiary care hospital's reproductive medicine department. It looked into the prevalence of psychiatric

disease in infertile men and their quality of life factors. According to the findings, infertility produces psychological concerns in infertile males, which may affect their quality of life. In addition, a shared mental condition was linked with poorer quality of life scores (Jacob et al., 2021).

Furthermore, Carter et al. (2011) looked into the consequences of emotional, sexual, physical, and quality of life on infertile women waiting for oocyte donation. Infertility was discovered to harm sexual function, quality of life, and emotional well-being. Infertile women also have a high bodily quality of life but a terrible mental quality of life (Carter et al., 2011).

2.5. Supporting Theories

Bonding with God The capacity to form an emotional link to another person is what we mean when we talk about bonding. It is the capacity to connect with another person on a more profound level. Therefore, an individual’s emotional link with God, and the Divine spirit, is what is meant by the term "bonding to God." An emerging facet of religious belief is an emotional connection with God (Miner, 2009). Scientists have shown that attachment theory (Kirkpatrick & Shaver, 1992) may provide light on the dynamics between believers and their deity, and that those who have a strong sense of attachment to their loved ones also have a strong connection to God.

Both of these findings can be found in Kirkpatrick & Shaver's research. Attachment theory has contributed a significant quantity of empirical study to the field of psychology of religion (Granqvist, 2010), specifically with the idea of divine power. For example, earlier studies have shown a correlation between having a healthy bond with one's parents and having a positive view of God (Granqvist et al., 2012; Reinert & Edwards, 2009). On the other hand, a distant and domineering view of God is associated with an insecure interpersonal relationship with close loved ones. In addition to this, when compared against the idea of a loving God, it presents an antagonistic viewpoint (Granqvist et al., 2012; Reinert & Edwards, 2009).

According to Dickie et al. (2006), creating notions of God was the primary factor that affected a person's relationship with their closest loved ones. This is despite the fact that people's perceptions of God did have an effect on how they bonded with their cherished ones. It's also possible that a bad attitude toward God is the result of deeper, more personal, and more severe wounds and disappointments (Zarzycka, 2016). One possible reaction in the aftermath of unfortunate life experiences such as death, disease, accidents, disasters, or natural catastrophes is to blame God for the situation (Pargament et al., 1998). Concerning the topic of religion, several points of view may be found within the field of psychology (Ghobary et al., 2013; Younas et al., 2017).

Optimistic thinkers regard religion as getting ultimate power that may assist people in coping with awful conditions and better quality of life. They believe that this power can aid people. There is a positive correlation between one's mental health and a favorable impression of God, whereas there is a negative correlation between pathology and mental health. Negative views of God have been related to illnesses, which in turn lead to pervasive ideas about mental health (Khosravi et al., 2011; Koenig et al., 2001; Pirutinsky et al., 2017; Weber & Pargament, 2014).

Lazarus and Folkman established the transactional theory of emotion and coping, which is sometimes referred to as "the coping theory" (1984). Cognitive assessment and the ability to cope are said to have a moderating role in the emotional response that one has after experiencing a hazardous experience, as stated by Lazarus and Folkman (1987). One might consider the negative feelings (such as tension, anxiety, wrath, or shame) that a person may have been the temporary result of the terrible occurrence, after having experienced stress because of it. These feelings can be experienced by an individual after a stressful encounter. It is possible that, in the long run, the individual's physical health will be negatively affected depending on the strength of the emotional consequence.

According to the transactional theory of emotion and coping proposed by Folkman (1987), health may be negatively impacted when an individual focuses on their emotions rather than on developing health-promoting coping mechanisms. When a person relies primarily on avoidance to deal with stressful situations, they are engaging in a dysfunctional coping method. Maladaptive coping processes contribute to the worsening of a person's physical or mental health. It's possible that avoiding things will help you feel less emotional anguish. On the other hand, it may inhibit the individual from approaching the issue in a practical and appropriate manner. As a result, the dispute can continue to fester in the unconscious and not be addressed. In the long term, the accompanying emotional consequence (such as emotional distress) may be reflected as a psychological and physical symptom, seizures if it is channeled via the body (Caplan & Plioplys, 2010).

Compared to the healthy control group, the Convulsions of a psychogenic origin that are not epileptic (PNES) patients in this research reported using coping mechanisms that were more emotionally oriented (factors like hiding and distance from danger) in order to cope with the effects of stress.

These techniques included: When taking into consideration Lazarus and Folkman's (1984; 1987) One can assume that the PNES patients in our research utilised maladaptive emotion-focused coping techniques (such avoidance) based on the transactional theory of emotion and coping. Because they continued to be more stressed and had a worse time coping with life's challenges than the healthy control group. This is because the PNES patients in our study relied on emotion-focused coping strategies (such as avoidance). It has been determined that PNES is an "in the flesh 85 symptomatic expressions of psychological suffering" (Alsaadi & Marquez, 2005). According to what researchers have discovered, people with the mental issue often express their psychological anguish as shown by actual physical distress (Bewley et al., 2005).

Owczarek (2003) suggests that dysfunctional coping strategies are at the heart of many mental health problems. These mechanisms sheild the patient from suffering additional intensely negative effects that may manifest themselves if situations are left unresolved or when they are forced to confront situations that cannot be resolved. Accordingly, to the findings of previous studies, To the contrary, I argue that the deployment of ineffective, emotional-based coping mechanisms Particularly aversion coping mechanisms)) can have an effect on the individuals' somatic health and make them more susceptible to the emergence of psychogenic problems (Bakvis et al., 2011; Baslet, 2011; Frances et al., 1999; Lanceman et al., 1993; Zaroff et al., 2004).

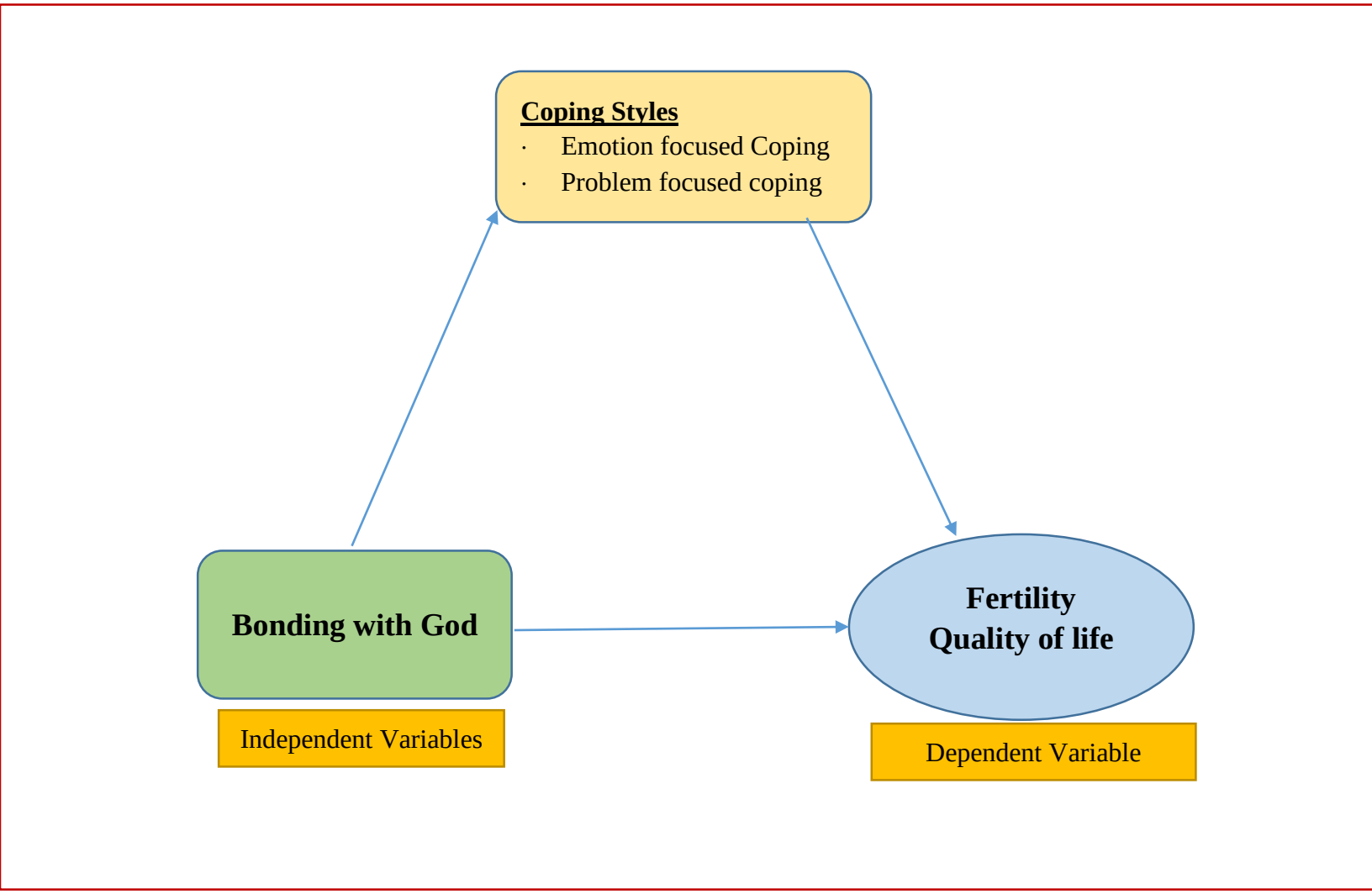
According to Lazarus and Folkman's (1984; 1987) transactional theory of emotion and coping, "the quality of life and what we normally understand by mental and physical health are linked up with the manner in which people evaluate and deal with the stresses of existence."

Maslow formulated the notion of needs in a very fundamental way. Maslow discusses a more abstract desire to actualize oneself, in addition food, libido, and companionship are three of life's most basic need. This concept has been ingrained in our society. "I need a drink of water," or "We all need the security that only a family be able to provide" is a common phrase. The notion is applied with significantly more rigor in scientific terms since the word's meaning is nebulous and vague. The idea of meeting a need is naturally attractive. Thus, we have included it in our spectrum as a transitional state between the deepest, profoundly existential features and the shallow external facts. Wants and the feeling of fulfillment we all experience, when our needs are satisfied, are likewise tied to needs and quality of life.

Happiness is found midway between the surface and the center of our life on the subjective end of the spectrum. Because requirements are tied to characteristics of human personality, they are different from well-being. However, it is a component of the idea of needs that we feel happy if our wants are met. Life potential, the extreme position that one's only goal in life should be to

actualize one's biological information, is not the same as basic human needs being met. Nevertheless, the need idea is already built into many languages, making its practical use a breeze. An updated perspective on is presented in the third paper in this series. (Maslow, 1954).

Figure 2.1. Conceptual Framework



CHAPTER 3

RESRACH METHODOLOGY

3.1. Research Epistemology

It is primary research. Data will be collected and analyzed on the variables of quality of life, coping styles and bonding to God from infertile individuals from twin cities, i.e. Islamabad and Rawalpindi.

3.2. Research Approach

Quantitative research by using survey method.

3.3. Research Strategy

This study was based on correlation research design by utilizing survey method. The study involves purposive sampling technique to collect data. Research population include infertile individuals. Data was collected from infertility clinical and gynecology departments of Islamabad and Rawalpindi. A permission letter, along with review board letter was presented to different hospitals and clinics of Islamabad and Rawalpindi for data collection. Appropriate instructions were given to the participants. No time limit is determined to complete the questionnaire; however, 15-20 minutes was given. Participants were thanked and appreciated after their voluntary participation.

3.4. Population and Sampling

Participants were infertile individuals. Both males(N=57) and females (N=132) were the part of the study. Both types of infertility i.e. primary infertility and secondary infertility was included. Data was collected from different infertility clinics of twin cities. Purposive sampling was used to collect data. Proposed sample for this study will be of 18-45 years of age for female and 19-45 years of age for males. Number of participants was 189 as calculated by G power.

3.4.1. Inclusion criteria

Potential participants were married individuals (love and arrange marriage) with the duration minimum of one year. Both types of infertility i.e. primary infertility and secondary infertility was included. Individuals should be living with their partner and do not using any intraceptic means to avoid conception. Muslim individuals were included. According to the Pakistani law, minimum age limit for female is 16 years and for male is 18 years (Iqbal, 2021). infertility clinics and gynecological departments. Therefore, proposed sample for this study will be of 18-45 years of age for female and 19-45 years of age for males.

3.4.2. Exclusion criteria

Individuals below 18 years were excluded. Couples who are not planning baby or delaying the pregnancy will be excluded. Menopause takes place usually between the ages of 45-55. Female above age the age of 45 will also be excluded. Males with Type I diabetes were excluded. Non-Muslim individuals will be excluded. Individuals who are divorced were excluded. Individuals who were divorced and remarried were also excluded.

3.5. Data Collection and Data Analysis

Data was collected from different infertility clinics of twin cities. SPSS version 23.0 was used. To analyze data and compute frequency, mean, percentage of demographic variables, descriptive statistics were used. Moreover, correlation, mediation and t test were used.

3.5.1. Operational Definition

3.5.1.1. Fertility Quality of Life

Fertility Quality of Life is the subjective evaluation/ perception of infertile individual that score on subscales emotional, mind body, relational, social, treatment tolerability and treatment environment.

3.5.1.2. Coping styles

The extent of using cognitive or behavioral psychological mechanisms by infertile individuals to deal with the stressors through problem- focused coping style or emotional- focused coping style.

3.5.1.3. Bonding with God

Bonding to the God is the subjective feeling of being emotionally and spiritually committed, attached and content with God.

3.5.2. Instruments

This section entails complete and multiple set of measures that will be used to collect data related to each variable.

3.5.2.1. Demographic Data sheet

Self-formulated demographic data sheet will be utilized to assess the participant's gender, birth order, age, religion, education level, occupation, timings of job, number of earning member, type of marriage, duration of marriage, family system, duration of infertility, family system, number of family members, treatment name, duration of treatment, number of sexual intercourse per week and weather female participant got pregnant previously.

3.5.2.2. Fertility Quality of Life (Boivin, 2011)

Fertility quality of life was developed by (Boivin, 2011). It consists of 36 items; responses were scored on 5 response categories. Score ranges from 0-4, with 5 response categories. Response categories include evaluation from very poor to very good, satisfaction from very dissatisfied from very satisfied, frequency from always to never, intensity from extreme amount to not at all and capacity from completely to not at all. There are 6 subscales and two extra items for overall evaluation of satisfaction and physical health. There are two main domain i.e. Core FeriQoL (24 items) which include emotional consist of item 4, 7,8,9,16,23, mind body consist of 1,2,3,12,18,25 relational consist of 6,11,15,19,20,21 and social subscales include 5,10,13,14,17,22 and Treatment FertiQoL which is optional (10 items) include treatment environment consist of 2,5,7,8,9,10 and treatment environment include item 1,3,4 and 6. The Cronbach alpha of emotional is .90, mind body is .84, relational is .80, social is .75, tolerability is .72 and environment is .84. Following

items will be reverse scored 4,11,15,21 14, and 2t, 5t. Treatment FertiQoL is optional. The age range for this instrument is 18 years and above.

3.5.2.3. Coping Styles Scales (Zaman & Ali, 2014)

Coping style scales was developed by Zaman and Ali (2014), which consist of 21 items. It consists of two subscales Problem Focused Coping (PFC) included 8 items (item 3, 4, 6, 10, 13, 15, 16, and 19) and Emotion Focused Coping (EFC) included 14 items (item 1, 2, 5, 7, 8, 9, 11, 12, 14, 17, 18, 20, 21 and 22). The Cronbach Alpha level of problem focused coping is .87 and emotion focused coping is .89. The age range for this instrument is 19 years and above.

3.5.2.4. Bonding to God (Saleem, 2004)

Bonding with God is developed by Saleem, (2004). It consists of 33 items and responses was scored on 5-point Likert scale. High scores indicate strong bonding and low score indicate weak bonding with God. It consists of four subscales. Connection to God include 7 items (item 28, 34,33, 30, 25, 26 and 27), Complaining attitude toward God includes 14 items (item 4, 15, 18, 7, 31, 9, 8, 5, 24, 13, 22, 12, 11 and 20), Nearness to God includes 8 items (item 1, 23, 19, 16, 17,2, 10 and 21) and Level of Content includes 4 items (item 6, 32, 14 and 29). Following items will be reverse scored 4, 5, 7, 8, 9, 11, 12, 13, 15, 18, 20, 22, 24 and 31). The Cronbach Alpha of connection to God is .91, complaining attitude toward God is .83, nearness to God is .87 and level of content is .82. The alpha reliability of whole scale is .80. This instrument is suitable for individuals with 17 and above age.

3.5.3. Research Ethics

This study will be conducted after the approval from departmental ethical board of Bahria University. Scales will be administered after the permission of authors and approval from different

hospitals and clinics. Informed consent will be signed by each participant. The data will be kept confidential and will be utilized for research purpose only.

CHAPTER 4

RESULTS

Table 1

Socio-demographic characteristics of sample (N=189)

		M	SD	*f*	%
Age		28.64	3.63		
Gender	Male			57	30.2
	Female			132	69.8
Qualification	Under Matric			8	4.20
	Matric			12	6.30
	Intermediate			13	6.90
	B.A/BSc/B.Ed.			32	16.90
	M.A/MSc/M.Ed.			44	23.30
	BS/BEE/LLB			44	23.30
	MS/M Phil			23	12.20
	MBBS/FCPS			9	4.80
	PhD			4	2.10
Type of Marriage	Love Marriage			67	35.40
	Arrange Marriage			122	64.60
Family System	Nuclear Family			99	52.40
	Joint Family			90	47.60
House	Own			105	55.60
	Rent			84	44.40
Treatment	Yes			116	61.40
	No			73	38.60
Name of Treatment	Medicines(Tablets)			54	28.60
	Injections			14	7.40
	Surgery			3	1.60
	IVF			17	9.00
	Herbal			8	4.20
	Spiritual			2	1.10
	Homeopathic			12	6.30
	IUI			7	3.70
	No treatment			72	38.10

Table 1 illustrates the descriptive statistics of the participants (N=189). The sample was consisted of 30.2% males and 69.8% females. Participants from under matric were 4.20%, matric 6.3%, intermediate 6.9%, B.A/BSc/B.Ed. 16.9%, M.A, MSc/M.Ed. 23.3%, BS 23%, MS 12.20%, MBBS/SCPS 4.80 and PhD. For type of marriage, 33.40% sample were from love marriage and 64.60% were from arrange marriage. Furthermore, 47.60% sample was from joint family system and 52.40% from nuclear family system. For house, 55.60% lived in their own home and 44.40% lived on rent. 69.80 % were seeking for treatment and 38.60 are not taking any treatment. 28.60% are taking medicines(tablets), 7.4% injection, 1.6% undergone a surgery, 9% IVF procedure, 3.7% IUI, 4.20% herbal treatment, 1.1% spiritual treatment, 6.30% homeopathic treatment.

Table 2

Psychometric properties of study variable (N=189)

Variables	M	SD	Range		*a*
			Min	Max	
Bonding to God	127.07	17.33	80.00	158.00	.88
Connection with God	29.30	4.28	15.00	35.00	.83
Complaining Attitude towards God	49.24	9.18	26.00	66.00	.81
Nearness to God	33.72	4.37	17.00	40.00	.77
Level of Content	11.75	3.51	4.00	20.00	.75
Emotion Focused	40.14	7.78	24.00	61.00	.64
Problem Focused	20.46	4.26	11.00	33.00	.64
Core FertiQoL	47.22	19.14	5.00	91.00	.95
Emotional	49.36	22.01	4.17	100.00	.89
Mind/Body	47.09	23.67	0.00	100.00	.91
Relational	60.14	25.17	0.00	100.00	.91
Social	41.77	22.62	0.00	95.33	.84
Treatment Environment	50.04	15.09	12.50	83.33	.81
Treatment Tolerability	48.45	25.17	0.00	100.00	.84

Illustrates the alpha reliability statistics (Table 2) for study variables. The composite of Bonding to God is .88 followed by reliability of subscale as .83 for connection to God, ,81 for complaining attitude toward God, .77 for nearness to God and .75 for level of content. The reliability of Problem Focused coping is .64 and emotion focused coping is .64. Core FertiQoL composite has shown reliability of .95 and followed by reliability of subscales as .89 for emotional, .91 for mind/body, .91 relational and .84 for social. Treatment environment is tolerability is .81 and .84 vice versa.

Table 3

Inter scale correlation of study variables (N=189).

	1	2	3	4	5	6	7	8	9	10	11	12
1. BTG	-	-	-	-	-	-	-	-	-	-	-	-
2. CTG	.87**	-	-	-	-	-	-	-	-	-	-	-
3. CAG	.88**	.62**	-	-	-	-	-	-	-	-	-	-
4. NTG	.85**	.78**	.60**	-	-	-	-	-	-	-	-	-
5. LOC	.67**	.64**	.39**	.54**	-	-	-	-	-	-	-	-
6. PF	.36**	.31**	.36**	.24**	.27**	-	-	-	-	-	-	-
7. EF	-.16**	-.007**	-.33**	-.002**	.09	-.12	-	-	-	-	-	-
8. CFQoL	.62**	.50**	.63**	.47**	.32**	.43**	-.33**	-	-	-	-	-
9. E	.57**	.45**	.61**	.40**	.27**	.37**	-.37**	.92**	-	-	-	-
10. M/B	.54**	.42**	.57**	.38**	.29**	.38**	-.35**	.90**	.85**	-	-	
11. R	.52**	.43**	.51**	.46**	.20**	.31**	-.19**	.75**	.55**	.50**	-	-
12. S	.50**	.43**	.47**	.35**	.35**	.43**	-.24**	.88**	.81**	.76**	.50**	

*p<0.05, **p<0.01

Table 3 illustrates the bivariate correlation between bonding to God, coping styles and quality of life among infertile individual. There is a significant positive relationship between Bonding to God and its subscale (Connection to God, Complaining attitude toward God, Nearness to God and Level of Content). Problem focused coping is significantly positively correlated with bonding to god and its subscales (Connection to God, Complaining attitude toward God, Nearness to God and Level of Content). Emotion focused coping is significantly negatively correlated with Bonding to God and its subscales (Connection to God, complaining attitude toward God, Nearness to God and Level of Content) and problem focused coping. Fertility Quality of life and its subscales (emotions, mind/body, relational and social) are significantly positively correlated with Bonding to God, its subscales (Connection to God, complaining attitude toward God, Nearness to God and Level of Content) and Problem focused coping. However, Fertility quality of life and subscales (emotions, mind/body, relational and social) are negatively correlated with Emotion focused coping.

Table 4

Mediation Analysis bonding to God and Quality of life through Emotion focused coping styles (N= 189)

Antecedent	Consequent					
	Emotion focused			Quality of Life		
	Coeff.	*SE*	*p*	*Coeff.*	*SE*	*p*
Bonding to God	-.14	3.60	.000	.59	.06	.000
Emotion focused				-.17	.17	.017
Covariates						
Gender				.13	2.8	.064
		R^2= .36			R^2= .447	
	$F(2, 186) = 51.94$, $p< .000$			$F(3,185) = 49.80$, $p<. 000$		

Note:Coeff= standardized regression coefficient

Mediation results indicated that Bonding to God was found to be negative significant predictor of emotional focused coping and positive predictor of Quality of life. Whereas emotion focused was found to be significant predictor of quality of life. So, mediation was found to be significant. Indirect effect (indirect effect= .026 bootSE = .014, BootLL =.002, Boot UL = .058) However the indirect effect of emotion focused was found to be positively significant between bonding to God, Emotion focused coping and Quality of life.

The Statistical Model of Mediation Analysis

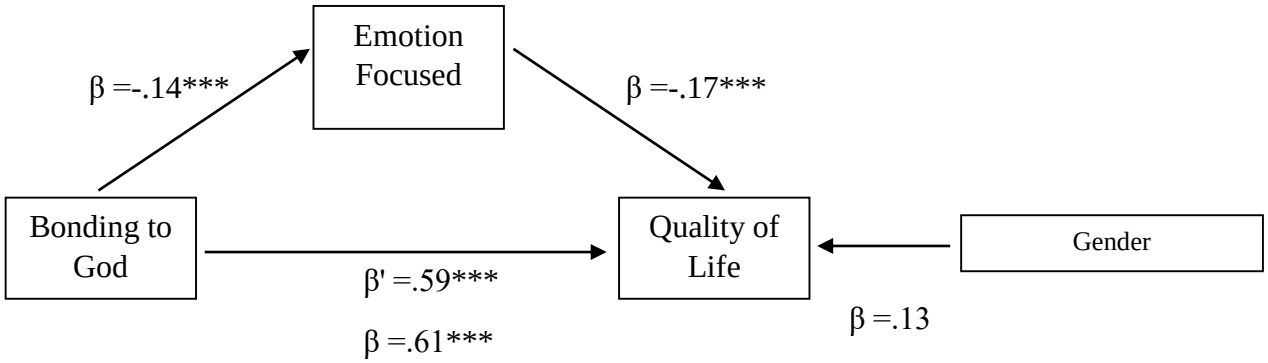


Table 5

Mediation Analysis between bonding to God and Quality of life through Problem focused coping styles (N= 189)

Antecedent	Consequent					
	Problem focused			Quality of Life		
	Coeff.	*SE*	*p*	*Coeff.*	*SE*	*p*
Bonding to God	.35	.02	.000	.54	0.06	.000
Problem focused				.20	0.27	.001
Covariates						
Gender	.35	.61	.000	.17	2.33	.002
		R^2= .185			R^2= .460	
		$F(2, 186) = 21.128$, $p < .000$			$F(3,185) = 52.609$, $p < .000$	

Note:Coeff= standardized regression coefficient

Mediation results indicated that Bonding to God was found to be Positive significant predictor of Problem Focused coping and Quality of life. Whereas Problem Focused Coping was found to be significant predictor of quality of life. So, mediation was found to be significant. Indirect effect (indirect effect= .076 bootSE = .030, BootLL=.021, Boot UL = .141) However the indirect effect of problem focused was found to be positively significant between bonding to God, and Quality of life

The Statistical Model of Mediation Analysis

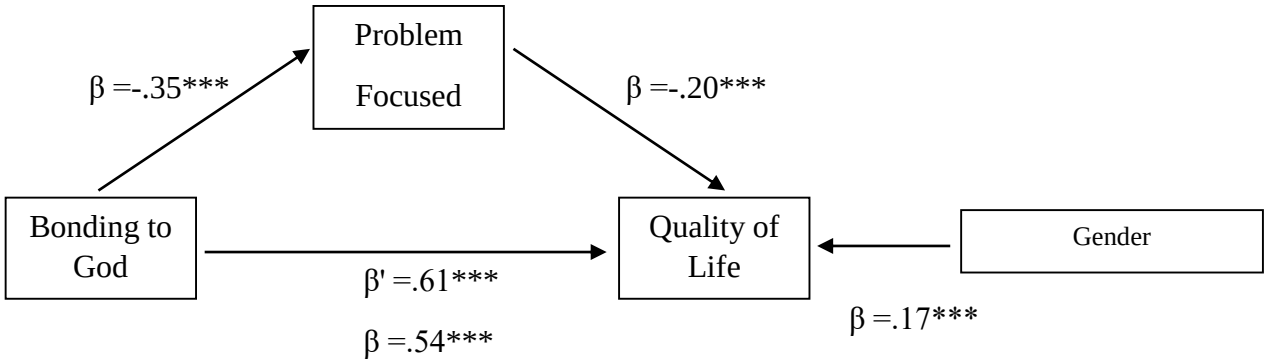


Table 6

t-test analysis between male and female individuals on study variables (N=189)

	Male (n=57)		Female (n=132)		t	p	95% CL		Cohen's d
	M	SD	M	SD			LL	UL	
Bonding to God	127.92	16.37	126.70	1.53	4.48	.66	-6.62	4.17	.10
Connection to God	28.79	4.17	29.56	4.33	1.14	.24	-.57	2.12	.18
Complaining	51.77	8.30	48.14	9.36	2.53	.01	6.46	-.80	.41
Attitudes toward God									
Nearness to God	32.87	4.33	34.08	4.35	1.74	1.20	-.16	2.56	.29
Level of Content	11.44	3.15	11.89	3.66	.80	.45	-.65	1.55	.13
Problem Focused	22.09	3.55	19.76	4.36	3.56	.00	3.62	-1.04	.59
Emotion Focused	33.26	6.11	43.11	6.47	9.77	.00	7.86	11.84	1.57
Core FertiQoL	54.21	15.08	44.20	19.99	3.40	.001	-15.83	-4.18	.57
Emotional	60.16	16.69	44.70	22.44	4.67	.00	-21.99	-8.94	.78
Mind/Body	58.19	18.16	42.30	24.21	4.44	.00	-22.95	-8.83	.70
Relational	60.75	22.75	59.88	26.22	.22	.83	-8.76	7.02	.04
Social	48.80	17.75	38.80	23.87	2.80	.006	-16.80	-2.91	.48

Table 6 indicates the results of independent sample t-test, which shows no significant difference on bonding to god and its subscales among males and females with infertility. Problem solving coping is more common in males than females and emotion focused coping is more common in females than males. There are significant differences on Core FertiQol, emotional, mind/body and social among males and females with infertility. However, there is no significant difference between males and females in FertiQoL relational.

Table 7

t-test analysis between types of marriage on study variables N=189)

	Love Marriage (n=67)		Arrange Marriage (n=122)		t	p	95% CL		Cohen's d
	M	SD	M	SD			LL	UL	
Bonding to God	127.22	15.44	126.99	18.19	.09	.93	-4.95	5.41	.02
Connection to God	29.42	3.56	29.28	4.65	.21	.83	-1.15	1.43	.03
Complaining	48.63	8.82	49.57	9.39	.68	.50	-3.71	1.81	.10
Attitudes toward God									
Nearness to God	33.93	4.06	33.60	4.54	.50	.62	0.99	1.64	.08
Level of Content	12.06	3.21	11.58	3.66	.90	.37	-.58	1.53	.14
Problem Focused	20.61	4.10	20.37	4.36	.36	.72	-1.06	1.52	.06
Emotion Focused	39.28	8.61	40.61	7.31	1.12	.26	-3.66	1.01	.17
Core FertiQoL	49.55	19.11	45.94	19.11	1.24	.22	-2.12	9.34	.18
Emotional	52.05	21.68	47.88	22.13	1.25	.21	-2.42	10.76	.19
Mind/Body	49.88	24.07	45.56	23.40	1.20	.23	-2.78	11.41	.18
Relational	60.95	24.47	59.70	25.63	.33	.75	-6.32	8.81	.05
Social	45.34	22.48	39.82	22.54	1.61	.11	-1.23	12.27	.25

Table 7 indicates the results of independent sample t-test, which shows no significant differences on bonding to God and its subscales, problem focused and emotion focused among individuals with infertility (love and arrange marriage). However, there are slight differences on Core FertiQol, emotional, mind/body and social among individuals with love marriage and arrange marriage. There is a significant difference on relational between individuals with love marriage and arrange marriage on FertiQoL relational.

Table 8

t-test analysis between types of family system on study variables (N=189)

	Joint Family (n=90)		Nuclear (n=99)		t	p	95% CL		Cohen's d
	M	SD	M	SD			LL	UL	
Bonding to God	127.79	17.17	126.42	17.34	.54	.59	-3.59	6.32	.08
Connection to God	29.55	4.30	29.13	4.29	.67	.51	-.82	1.66	.09
Complaining	49.38	9.33	49.11	9.09	.19	.84	-2.37	2.91	.03
Attitudes toward God									
Nearness to God	34.01	4.28	33.44	4.45	.89	.38	-.69	1.82	.13
Level of Content	11.73	3.39	11.77	3.63	.07	.95	-1.05	.98	.01
Problem Focused	19.84	4.25	21.02	4.21	1.9	.06	-2.39	.04	.28
Emotion Focused	40.33	7.81	39.97	7.82	.32	.75	-1.88	2.61	.05
Core FertiQoL	46.72	19.81	47.68	18.59	.34	.73	-6.47	4.56	.05
Emotional	47.96	21.75	50.63	22.27	.83	.41	-8.99	3.66	.12
Mind/Body	46.67	24.51	47.47	22.99	.23	.82	-7.63	6.01	.03
Relational	59.68	27.88	60.56	22.57	.24	.81	-8.14	6.36	.03
Social	41.99	21.66	41.58	23.56	.12	.90	-6.11	6.92	.02

Table 8 indicates the results of independent sample t-test, which shows no significant difference on bonding to god and its subscales among individuals with infertility living in joint family system and nuclear family system. No significant difference on problem focused coping and emotion focused coping among individuals with infertility living in joint family system and nuclear family system. There are no significant differences on Core FertiQol, mind/body, social and relational among individuals with infertility living in joint family system and nuclear family system. However, there is slight difference on Core Fertiqol (emotional) among joint family system and nuclear family system.

Table 9

t-test analysis between having own home and rent home on study variables N=189)

	Own home (n=105)		Rent home (n=84)		t	p	95% CL		Cohen's d
	M	SD	M	SD			LL	UL	
Bonding to God	130.92	13.96	122.26	19.64	3.54	.001	3.83	13.49	.51
Connection to God	30.36	3.59	28.04	4.73	3.86	.00	1.14	3.54	.55
Complaining	50.73	8.08	47.37	10.14	2.54	.01	.75	5.98	.37
Attitudes toward God									
Nearness to God	34.53	4.00	32.69	4.62	52.94	.004	.61	3.08	.43
Level of Content	12.26	3.39	11.12	3.57	2.34	.03	.14	2.14	.34
Problem Focused	20.62	4.25	20.26	4.28	.57	.57	-.88	1.59	.08
Emotion Focused	39.37	8.05	41.11	7.41	1.54	.13	-3.98	.51	.22
Core FertiQoL	50.54	17.37	43.07	20.50	2.71	.007	2.04	12.91	.39
Emotional	52.71	20.26	45.14	23.46	2.39	.018	1.32	13.89	.35
Mind/Body	50.16	22.97	43.25	24.10	2.01	.046	.12	13.68	.29
Relational	65.16	22.73	53.86	26.76	3.14	.002	4.19	18.39	.46
Social	44.24	21.21	38.69	24.04	1.69	.09	-.95	12.05	.24

Table 9 indicates the results of independent sample t-test, which shows that bonding to God is slightly higher in individuals with infertility living in their own home. No significant difference on problem focused and emotion focused among individuals with infertility living in their own home and rent home. However, slight differences on Core FertiQol, emotional, mind/body, social and relational among individual's infertility living in own home and rent home. Fertility quality of life is better in individuals with infertility living in their home.

CHAPTER 5

DISCUSSION

This study focused on the analysis of the association between infertile persons' perceived Bonding to God and coping styles, as well as with how those coping styles affected their Quality of life. Previous researches have been done to study the spiritual and religious aspects associated with infertility and some research on psychological impacts on one's life due to infertility. A lack of literature was noticed regarding the effects of religious affiliation on coping styles of infertile people and how these coping mechanisms impacts their quality of life. Therefore, this study will bridge the literature gap in this context.

More or less couples' spiritual crises may be triggered by infertility. People who go through this unintentional childlessness condition typically have conflicting desires and emotions. The meaning and purpose of life—two fundamental parts of spirituality—are frequently questioned in this context. Infertility has an impact on a couple's overall well-being. Adversity raises spiritual demands as well as unfulfilled parental instincts. Couples' capacity to cope with sorrow and childlessness can be improved by coping techniques that incorporate spirituality (Romeiro, Caldeira, Bardy, Hall, and Timmins, 2017).

Prior to testing the hypotheses, psychometric properties of all study variables were assessed (Table 2). The findings illustrate that Core and Treatment FertiQoL composites and subscales were highly reliable ranging from .81 to .95 which is comparable with the results of other studies (Aarts et al., 2011; Boivin et al., 2011). Bonding to God composite with its subscale also showed high

reliability range from .75 to .88 having consistency with the literature (Saleem, 2004). The reliability of Problem Focused coping and emotion focused coping was moderately significant (*a=.64).* This maintains that further analysis will be constructive for these study variables.

The participant's demographic characteristics showed that majority of the respondents were females (N=132) and males were only 57 which is due to the fact that in our society, infertility is frequently not publicly acknowledged, and because it is ingrained in male culture that infertility has nothing to do with men, men tend to avoid talking about it. Another fact related to this is that the number of infertile women increased by 14.962 percent over almost three decades, from 1366.85 per 100,000 in 1990 to 1571.35 per 100,000 in 2017 (Sun et al., 2019). Despite the fact that the issue is not her fault, women are frequently held responsible for the couple's infertility due to cultural norms (Ullah et al., 2021).

The study's hypotheses were confirmed by the findings and discussed in detail further. The first hypothesis stated that there would be significant association between socio-demographic variables and infertile individuals' quality of life, coping styles, and bonding to God. For this purpose, t –test analysis was performed for each demographic variable to assess its relationship with study variables. The results indicated that a gender difference exists in Core FertiQol, emotional, mind/body and social domain, while no significant difference between males and females in FertiQoL relational was seen. This is owing to Taylor's (2018) results that indicate how differently men and women experience the anguish of infertility and how they express their distress. While women reported feeling pressure from family and society, being socially maladjusted, going through excruciating diagnosis and treatment procedures, and experiencing stress connected to their monthly cycles, men reported feeling confused about the issue, having a

strong sense of masculinity, concealing their infertility, and displaying resistance to treatment (Naz & Batool, 2017).

Males are more likely than females to utilize problem-solving coping strategies, whereas females employ emotion-focused strategies more commonly. Males typically view infertility as a question mark on their manly ego, which causes negative social stress and fosters a culture of concealment and possessiveness. Male patients attempt to resolve their issues privately and without discussing them to others (Peronace et al., 2007). Infertile men and women, both appear to use problem-solving coping mechanisms whether they seek treatment or attempt to address the psychosocial problem's root cause. They take proactive measures to address their problem (Naz and Batool, 2017). Sami and Saeed (2012) conducted research on how adoption is utilized as a coping strategy for infertility in the industrialized nations. In their study, over half of the women with secondary infertility wanted to adopt a child but were unable to do so because of opposition from the in-laws.

On the bonding to God scale and its subscales, there are no appreciable differences between males and females. According to study results, religious people tend to be more adjusted, more content with their lives, and experience less distress, according to the patients' spouses and infertility specialists. Strong religious believers experienced medical crises with improved efficiency and showed greater problem-solving skills (Naz and Batool, 2017). The couples' lives were heavily influenced by religion and spirituality, which helped them deal with their infertility (Taylor, 2018). Literature showed that positive thinking, being proactive, accepting oneself, using coping mechanisms like emotions and religion, and being accepting of oneself are generally effective ways to deal with spiritual suffering. The process of adjusting to being childless, finding hope again, and feeling empowered by establishing a connection with a higher force were all

viewed as being much aided by prayer. Additionally, it was believed that prayer was a spiritual discipline that had a favorable impact on people's health and happiness (Romeiro, Caldeira, Brady, Timmins, & Hall, 2017).

Type of marriage was noticed to create difference in only the relational domain of quality of life while other domains of Core and Treatment Fertiqol, coping styles and bonding to God were not observed with any differences on the basis of marriage type. Quality of life is better in infertile individuals who are not seeking for treatment, while no significant difference exists on the basis of 'treatment seeking' and 'no treatment' in other variables. Type of home in which people live also showed a few to no differences in study variables. A marked disparity exists regarding evidence of type of marriages and type of homes having influence on infertile person's quality of life, coping, and spirituality. Infertility has been linked to higher psychological discomfort for couples where women are subjected to more social pressure than males. According to studies, women in these circumstances not only experience family member harassment but also numerous types of marital instability (Sami & Saeed, 2012). Qadir et al. (2015) conducted a study to ascertain the prevalence rates of psychological distress among Pakistani women pursuing therapy for primary infertility. Also examined were the connections between socio-demographic traits, marital adjustment, social support, and psychological suffering. The outcomes of the logistic regression revealed that psychological distress was substantially inversely correlated with adjustment in marriage and social support.

Quality of life is better in infertile individuals living in nuclear family system, with no significant difference on coping styles used and bonding to God among infertile individuals living in joint family system and nuclear family system. In Pakistan, where joint families are the norm, it is usual for extended family members to meddle in the private affairs of couples. Particular

pressures experienced by infertile men and women include family interference, stigmatization, blame and jeering from in-laws, forced medication by the family, an interrogation by relatives, and property concerns. This scenario was more upsetting for those who were part of a joint family system (Naz and Batool, 2017).

In this study, there was a negative correlation between emotion-focused coping and quality of life (Table 3). This is consistent with the outcomes of earlier studies, such as one whose results showed that avoidance coping is characterized by avoiding reminders of the issue and other people. It is a reliable indicator of psychological discomfort among women who are infertile. Avoidance coping is often connected with more distress and is therefore detrimental to quality of life. Reduced stress and better long-term health are benefits of adaptive coping. While unhealthy coping methods cause long-term poor health, they alleviate stress (Saif et al., 2021). A recent study found that in assessing the indicators of quality of life and psychological health in infertile couples, the length of infertility had a moderating effect. It was discovered that whereas problem-solving coping methods were only linked with greater quality of life and psychological health in male patients, high educational level (college) and social support coping strategies were only connected with these outcomes in female patients. Additionally, connected to a higher quality of life and psychological health were a positive outlook and avoiding negative people (Zurlo et al., 2018).

The results of current study demonstrated positive association between quality of life and bonding to God. The relationship between spiritual well-being and psychological outcomes is said to be strengthened through spiritual practices like prayer, Divinity, finding spiritual significance, and forgiving others. The research by Bradshaw and Kent (quoted in Counted et al., 2018) indicates that frequency of prayer is ineffective for enhancing psychological well-being in the absence of a relationship with God. There is strong evidence that religiousness and spirituality is linked to

improved QoL outcomes in the aspects of psychological and physical health, quality of social connection, and spiritual performance. Additional research further supports this association between a person's belief perspective and psychosomatic functioning as well as between spiritual actions and perspectives established via prayer and increases in QoL (Counted et al., 2018).

The study's fifth hypothesis was confirmed by the observation that problem focused coping and quality of life are positively correlated. A prior study found that for women who were infertile in primary nature, positive coping strategies were a major predictor of quality of life and psychological discomfort (González-Echevarra et al., 2019). Additionally, positive and problem-solving coping mechanisms can help to lessen mental health issues and can also improve the quality of life for infertile women, according to Park and Adler (2003). Young women with endometriosis who frequently utilize adaptive coping methods have higher QoL scores, according to the study's assessment of their coping mechanisms (González-Echevarrá et al., 2019).

Emotion focused coping was greater in females than in males, while problem focused coping was more prominent in males thus confirming the sixth hypothesis. According to Sami and Saeed (2012), infertility has been linked to higher psychological discomfort in couples where there are more societal expectations placed on the female partner than the male partner. Eventually, emotional coping is more likely employed by females, whilst males may be better able to compartmentalize their feelings and carry on with their professional lives without being distracted or hindered by anxiety (Fisher and Hammarberg, 2012). While women tried to interact with other children, males tended to stay busy at work, gather appropriate information, maintain silence in front of others, lie about their diagnosis, and pray, while women also lied about their monthly cycles and diagnoses. The researchers have shown how various coping mechanisms reduced the stress associated with infertility (Rapoport et al., 2009). In general, compared to women who

conceive naturally, women who experience infertility exhibit greater emotional suffering and a lower quality of life (Romeiro, Caldeira, Brady, Timmins, & Hall, 2017). Infertility is not typically acknowledged in public, and infertile women would have to rely on internal coping mechanisms, according to a study of infertile women in Northern Ghana. One of the main coping strategies used by infertile couples was to have faith in God and to hope for a miracle. Women claimed to deal by turning to their Christian faith (Donkor and Sandall, 2009), and striving for greater success in their line of work was another typical coping mechanism (Tabong and Adongo, 2013).

Seventh hypothesis was that there would be a gender difference in terms of bonding with God. Studies from the West show that women are typically more religious than men. Miller and Stark (2002) also proposed that variations in risk-taking behavior between men and women are the root of gender disparities in religiousness. These differences may develop very early, either as a result of genetic tendency or initial socialization. As a result, risk avoidance can be added to other "feminine qualities" that discourage taking risks. Other research has cautioned that such gender disparities in religiosity may not be prevalent. Researchers continued by asserting that social elements, not just biological or behavioral ones, are more important for understanding gender disparities in religiousness (Martoyo et al., 2019).

Lastly it was hypothesized that coping styles (problem focused and emotion focused) will act as a mediator between bonding to God and quality of life. The results (Table 9 and 10) reveal that emotion focused coping mediates the relationship between quality of life and bonding to God in a negative way, and problem focused coping act as a significant positive mediator between quality of life and bonding to God. A better quality of life perception by people who are infertile will lead to using problem-focused coping skills, which will maintain a close bond with God. Numerous studies have revealed that involuntary childlessness is a life event with serious mental

and physical implications that provokes existential concerns and anxiety about the life purpose (Oddens et al. 1999). It is well established that spirituality is becoming one of the growing themes in nursing literature, but the assessment approach to infertility is still underdeveloped (Roudsari et al., 2007). A new sense of purpose and meaning in life is often sought by many couples who are struggling with infertility by using coping mechanisms to deal with the side effects of treatment and the forced childlessness. Individuals and couples need to be assessed and supported in their spiritual coping. Strong evidence suggests that women who do not view infertility as a disability rate their life satisfaction higher than women who are fertile (McQuillan et al. 2007). The importance that how much people value their life objectives and the meaning of life is believed to be associated with satisfaction (Park, 2016).

5.1. Conclusion

The present study was designed to explore the relationship between bonding to God, Coping Styles and Quality of life among infertile individuals. This chapter has provided comprehensive explanation of findings analyzed through descriptive statistics, independent sample t-test and mediation related to current study. However, a sample of 189 infertile individuals participated in this research, where 57 participants were males and 132 were females.

Findings of this study revealed that there was a significant relationship between quality of life, coping styles and bonding to God. There was a negative relationship between emotion focused coping and quality of life and positive relationship between problem focused coping and quality of life.

Moreover, results from the independent samples t-test has also revealed that male quality of life is better than female. Problem Focused coping is higher in males and Emotion focused

coping is higher in females. However, there was no significant difference was found on study variable Bonding to God among infertile male and females.

Findings from mediation analysis revealed significant relationship between Bonding to God and Quality of life with mediating role of Emotion focused coping among infertile individuals. It also revealed that there is a significant relationship between Bonding to God and Quality of life with mediating role of Problem focused coping among infertile individuals.

5.2. Implications

This research can help to identify issues faced by infertile individuals. Taboos related to infertility can be dealt and educated. Awareness to be made about male infertility and how to accept this fact. This research will help mental health professionals to create certain management plans how to cope with infertility and connect to God. It will be providing help and benefit to infertility clinics.

5.3. Limitations

The data sample was obtained from Infertility clinic and gynecological department of Islamabad, which doesn't correspond to heterogeneous sample. Hence, the exploration of phenomenon has been restricted to particular groups rather than entire Pakistani society. This study was conducted on Muslim individuals which can't be generalized on individuals of other religions. This study has also incorporated a small sample size which makes it difficult to generalize over larger population. Thus, a larger sample size could have generated a broader and more generalizable picture. Due to cultural taboo and cultural limitations, collection of data was made difficult as many clinics and patients refused to share their personal information. This research

cannot be generalized over the whole population as the collected data contained more female responses and fewer male responses due to cultural biases.

Lastly, as described in methodology section, data has been collected using self-report measures, which might have resulted in response bias generally known as social desirability. As respondents had shown reluctance while fulfilling the response on Fertility quality of life, which might have resulted in biased and dishonest responses.

5.4. Recommendations

This research has demonstrated association of perceived bonding to God and coping strategies with mediating effect of coping styles on quality of life. The limitations confronted in this study must be taken into account so that future researches can be conducted with better design. This study being quantitative in nature has an advantage of generalization to a larger population although; yet in future qualitative study could be utilized in order to get detailed analysis of infertile people's perception about their bonding to God and quality of life and to seek why and how they use coping styles.

Future studies could be managed to design interventions regarding education of the families and society about how to behave effectively with the infertile people and provision of information of the influence of familial and societal behavior on infertile individual's mental and physical wellbeing as well as how much they suffer from the misbehavior presented by closed ones. Moreover, study including all ethnic and religious groups could also be designed so that comparable findings can be achieved giving a better understanding of the effects of different cultural values on the perception of people living with infertility and their families. Additionally, counseling the families and psycho-education in this regard is direly needed to improve the living conditions of people with infertility.

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Zurlo, M. C., Della Volta, M. F. C., & Vallone, F. (2018). Predictors of quality of life and psychological health in infertile couples: the moderating role of duration of infertility. *Quality of Life Research*, *27*(4), 945–954. http://www.jstor.org/stable/44856420

Annexures-A

Download FertiQoL

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1. You must use FertiQoL as it is without making any changes to the items, order of items, instructions or response scales. **PLEASE DO NOT DO YOUR OWN TRANSLATION**. We have a translation procedure in place. If you detect an error or a problem, or want a translation into another language or to give us some feedback then email us at **fertiqol@cardiff.ac.uk**.

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Boivin, J, Takefman, J, Braverman, A. (2011). Development and preliminary validation of the fertility quality of life (FertiQoL) tool. *Human Reproduction, 26*(8), 2084–2091. DOI: 10.1093/humrep/der171 [Download the free PDF]

Boivin, Takefman & Braverman. (2011) The Fertility Quality of Life (FertiQoL) tool: development and general psychometric properties. *Fertility and Sterility, 96*, 409-15. DOI: http://dx.doi.org/10.1016/j.fertnstert.2011.02.046 [Download the free PDF]

3. Please do not distribute FertiQoL to other researchers or clinicians for their use. Please ask them to visit this website.

4. If you are doing research then at the end of your project we would be grateful if you could send us the sample size for your project, and means and standard deviations for each FertiQoL subscale for our monitoring purposes via email at **fertiqol@cardiff.ac.uk**.

Gmail

Qubsha Munir <qubshamunir@gmail.com>

request for scale

Noshi Irum <noshirum@yahoo.com> Tue, Nov 16, 2021 at 12:36 PM
Reply-To: Noshi Irum <noshirum@yahoo.com>
To: "noshi.irum@bahria.edu.pk" <noshi.irum@bahria.edu.pk>, Qubsha Munir <qubshamunir@gmail.com>

Ws. Qubsha,
You have my consent to use this scale. This scale is in the Urdu language to use it and ***update me about your study results and reliability of my scale in your data.*** Following are the details of my scale it's called Coping Styles Scale (CSS) and this is the description of scale and reference;

Scale scoring

Problem Focused Coping (PFC) included (8 items);

item 3, item 4, item 6, item 10, item 13, item 15, item 16, item 19

Emotion Focused Coping (EFC) included (14 items);

item 1, item 2, item 5, item 7, item 8, item 9, item 11, item 12, item 14, item 17, item 18, item 20, item 21, item 22.

Alpha level of **problem focused coping i.e. (.87)** and **emotion focused coping i.e. (.89)**

Reference

Zamaan, N. I., & Ali, U. (2015). VALIDITY ASSESSMENT OF COPING STYLES SCALE (CSS). *Pakistan Journal of Psychology*, *46*(1).

Zaman, N. I., & Ali, U. (2014). Predictive role of problem focused coping in the psychological wellbeing of university students. *Journal of Pakistan Psychiatric Society*, *11(2), 23-25*

Best of luck n the scale is also attached.

Best Regards,

Dr. Noshi Iram Zaman

Sr. Assitant Professor
Professional Psychology
Bahria University, Islamabad Campus

STUDENT COPY

PERMISSION FORM
(For Research Only)

Applicant's Name Rubsha Munir Supervisor's Name Dr. Nosh Iram

Applicant's Email qubshamunir@gmail.com

Institution/ Department Bahria University Islamabad Campus

Topic of Research Quality of life, coping styles & Bonding to God among infertile ~~female~~ individuals

M.Sc. / M.Phil / M.S / Ph.D / Diploma M.S

Test Required: (scale title, year, author) Bonding to God, 2004, Kiran Saleem

Undertaking

- This is hereby specified that the above mentioned information is correct.
- I applied for the above mentioned scale after consultation with my supervisor.
- I also understand that I have to follow the copy rights requirements of the National Institute of Psychology.
- This test / scale is the intellectual property of the National Institute of Psychology. No part of this test / scale may be reproduced or photocopied or disseminate or to republish without written permission from the National Institute of Psychology.
- I am also under obligation to share my data and research findings with the TRC of National Institute of Psychology.

N. Iram 19/11/2021.
Research Supervisor

Qubsha
Student

Permission granted for the above mentioned research only

You are not allowed to share this scale /test with other students.

22/11/21
Incharge TRC (Signature)
Test Resource Centre,
National Institute of Psychology, Quaid-i-Azam University

Annexures-B

Bahria University
Discovering Knowledge

April 14, 2022

The Director
Islamabad Medical Complex
H-11/4
Islamabad

We may allow her as she has assured us to maintain privacy /secrecy of our patients institution/pt
15/Apr/22

Dir IMC 15/4/22
DD(Gyn) 15/4/22 HOD TRS
HOD Gynae/Obs.

REQUEST FOR DATA COLLECTION

It is stated that **Ms. Qubsha Munir** Enrollment No. 01-275202-016 is a student of MS Clinical Psychology Bahria University Islamabad Campus conducting research on "**Quality of life coping styles and bonding to God among infertile individuals**" under supervision of Dr. Noshi Iram Zaman. It is requested that kindly allow her to collect the data from your esteemed institution.

Regards,

Dr. Rizwana Amin
Head of Department
Professional Psychology
Bahria University
Islamabad

Recommended.

DR. RIAZ HUSSAIN SIDDIQUI
M.B.B.S, F.C.P.S, D.O.T (UK)
Dy. Dir, Surgery
NESCOM Hospital Islamabad

14/04/2022.

Dr. Noshi Iram Zaman
Senior Assistant Professor
Professional Psychology
Bahria University
Islamabad

Dr. Noshi Iram Zaman
Senior Assistant Professor
Professional Psychology
Bahria University
Islamabad

Bahria University
Discovering Knowledge

April 11, 2022

TO WHOM IT MAY CONCERN

REQUEST FOR DATA COLLECTION

It is stated that **Ms. Qubsha Munir** Enrollment No. 01-275202-016 is a student of MS Clinical Psychology Bahria University Islamabad Campus conducting research on "**Quality of life coping styles and bonding to God among infertile individuals**" under supervision of Dr. Noshi Iram Zaman. It is requested that kindly allow her to collect the data from your esteemed institution.

Regards,
Dr. Rizwana Amin 11/04/2022
Head of Department
Professional Psychology
Bahria University, Islamabad

Allowed
THE RAPID CURE

Dr. Rizwana Amin
Head of Department
Professional Psychology
Bahria University
Islamabad

Annexures-C

اجازت نامہ

میں قبضہ منیر شعبہ نفسیات بحریہ یونیورسٹی مسٹر زان کلینکل سائیکالوجی کی طالبہ ہوں۔ ڈگری کے حصول کے لیے میں Issueless Individual پر تحقیق کر رہی ہوں تا کہ انہیں درپیش مسائل کو بہتر طور پر سمجھا جا سکے۔ اس تحقیق میں شمولیت کے لیے آپکو یہ کتابچہ پڑھتے ہوئے اپنے ذاتی تجربے کی بنا پر اس کو مکمل کرنا ہوگا۔ یہاں آپکو یہ یقین دلایا جاتا ہے کہ آپکی دی گئی ذاتی معلومات خفیہ رکی جائے گی اور صرف تحقیقی مقاصد کے لیے ہی استعمال کی جائے گی۔ یہ تحقیق کسی طور سے آپ کی شناخت کو واضع نہیں کرے گی اور اس تحقیق سے آپ کو کسی قسم کا نقصان کا احتمال نہیں ہوگا آپ کو پورا اختیار ہے کہ آپ اس تحقیق میں شمولیت سے کسی بھی وقت انکار کر سکتے ہیں۔ اگر آپ اس تحقیق میں حصہ لینے کے لیے رضامند ہیں تو نیچے دی گئی جگہ پر دستخط کریں۔

آپکی شمولیت اور تعاون کا بہت شکریہ۔

اگر آپ اس تحقیق کے نتائج کے بارے میں جاننا چاہتے ہیں تو مندرجہ ذیل دے گئے E-mail پر رابطہ کرے۔

دستخط: ---------- تاریخ: ----------

Annexures-D

ذاتی کوائف نامہ

جنس: مرد/عورت

پیدائش میں آپکا نمبر:

عمر:

مذہب

تعلیم: شریک حیات کی تعلیم:

پیشہ: شریک حیات کا پیشہ:

شہر میں/شہر کے باہر/ملک کے باہر

ملازمت/بزنس کے اوقات:

کمانے والے افراد

گھر کا سربراہ :

شادی کی قسم: پسند کی شادی/ارینج میرج:

شادی کی مدت:

خاندانی نظام: مشترکہ/انفرادی

رہائش کی جگہ: ذاتی گھر/کرایہ کا گھر

گھر میں رہنے والوں کی تعداد:

کیا آپکو شوگر کا مرض ہے؟ ہاں/نہیں

مرض کی مدت:

کیا آپ بچوں کے حصول کے لیے کوئی علاج کروا رہے ہیں: ہاں/نہیں

اگر ہاں تو علاج کا نام تحریر کریں----------

علاج کی مدت

کیا آپ کو کبھی حمل ٹھرا ہے/یا آپ کے شریک حیات کو(مرد حضرات کے لیے)

Annexures-E

FertiQol International

[illegible] (2008)

[illegible]

[illegible]

بہت اچھی	اچھی	نہ اچھی نہ خراب	خراب	بہت خراب	[illegible]	
☐	☐	☐	☐	☐	[illegible]	اے
بہت مطمئن	مطمئن	نہ مطمئن نہ غیر مطمئن	غیر مطمئن	بہت غیر مطمئن	[illegible]	
☐	☐	☐	☐	☐	[illegible]	بی
بالکل نہیں	تھوڑا سا	درمیانی حد تک	کافی حد تک	مکمل طور پر	[illegible]	
☐	☐	☐	☐	☐	[illegible]	سوال 1
☐	☐	☐	☐	☐	[illegible]	سوال 2
☐	☐	☐	☐	☐	[illegible]	سوال 3
☐	☐	☐	☐	☐	[illegible]	سوال 4
بہت مطمئن	مطمئن	نہ مطمئن نہ غیر مطمئن	غیر مطمئن	بہت غیر مطمئن	[illegible]	
☐	☐	☐	☐	☐	[illegible]	سوال 5
☐	☐	☐	☐	☐	[illegible]	سوال 6*
کبھی نہیں	کبھی کبھار	کبھی کبھی	اکثر	ہمیشہ	[illegible]	
☐	☐	☐	☐	☐	[illegible]	سوال 7
☐	☐	☐	☐	☐	[illegible]	سوال 8
☐	☐	☐	☐	☐	[illegible]	سوال 9
☐	☐	☐	☐	☐	[illegible]	سوال 10
☐	☐	☐	☐	☐	[illegible]	سوال 11*
☐	☐	☐	☐	☐	[illegible]	سوال 12
☐	☐	☐	☐	☐	[illegible]	سوال 13
☐	☐	☐	☐	☐	[illegible]	سوال 14
بالکل نہیں	تھوڑی حد تک	درمیانی حد تک	بہت زیادہ	انتہائی زیادہ	[illegible]	
☐	☐	☐	☐	☐	[illegible]	سوال 15*
☐	☐	☐	☐	☐	[illegible]	سوال 16
☐	☐	☐	☐	☐	[illegible]	سوال 17
☐	☐	☐	☐	☐	[illegible]	سوال 18
☐	☐	☐	☐	☐	[illegible]	سوال 19*
☐	☐	☐	☐	☐	[illegible]	سوال 20*
☐	☐	☐	☐	☐	[illegible]	سوال 21*
☐	☐	☐	☐	☐	[illegible]	سوال 22
☐	☐	☐	☐	☐	[illegible]	سوال 23
☐	☐	☐	☐	☐	[illegible]	سوال 24

FertiQol International

(افزاری علاج کا مالیول (FertiQol) نیشنل مالیول)

کیا آپ نے زرخیزی (حمل قرار) کے لیے علاج شروع کیا ہے (اس میں کسی بھی قسم کی طبی مخلصانہ یا علاج شامل ہے)؟ اگر جواب ہاں میں ہے تو براہ کرم مہربانی کر سوال کے لیے اس جواب کا نشان لگائیں (صرف ایک کے لیے نشان لگائیں) کہ آپ کی سوچ اور احساس کی کیفیت کیا ہے۔ اپنے خاندان اپنے مخلصانہ تعلقات اور احساسات کے متعلق زیر۔ یہ سوالات آپ کی ذاتی زندگی کے متعلق ہو سکتے ہیں۔ لیکن وہ آپ کی زندگی کے تمام پہلوؤں کا کسی نہ کسی طرح احاطہ کرنے کے لیے ضروری ہیں۔

		بہت	اکثر	کبھی کبھار	کبھی نہیں
T1	کیا بانجھ پن (اولاد نہ ہونے) کا مسئلہ آپ کے لیے کوئی تکلیف دہ بات ہے؟	□	□	□	□
T2	کیا آپ کو (اولاد نہ ہونے) کی وجہ سے اپنے آپ پر شرم آتی ہے؟	□	□	□	□
	درج ذیل کے لیے اس جواب پر نشان لگائیں جو آپ کے متعلق زیادہ مناسب ہو۔ احساسات کے قریب تر ہو	**بہت**	**اکثر**	**کبھی کبھار**	**کبھی نہیں**
T3	آپ کے بانجھ پن (اولاد نہ ہونے) کے علاج (طریقہ) کے طریقہ سے آپ کا رشتہ (تعلق) کیسا متاثر ہوا ہے؟	□	□	□	□
T4	کیا آپ اپنی زندگی میں (اولاد نہ ہونے) کے علاج کے لیے کسی سے مدد لینے کے متعلق پریشان ہیں؟	□	□	□	□
T5	کیا آپ محسوس کرتے ہیں کہ آپ اس صورتحال سے نمٹنے میں زرخیزی کا علاج کرنے والے عملہ کی مدد کر رہے ہیں؟	□	□	□	□
T6	کیا آپ (اولاد نہ ہونے) کے علاج کے اخراجات کے متعلق پریشان ہیں؟	□	□	□	□
	درج ذیل کے لیے اس جواب پر نشان لگائیں جو آپ کے متعلق زیادہ مناسب ہو۔ احساسات کے قریب تر ہو	**بہت غیر مطمئن**	**غیر مطمئن**	**نہ مطمئن نہ غیر مطمئن**	**مطمئن**	**بہت مطمئن**
T7	کیا آپ اپنی جنسی زندگی سے لطف کے لیے (علاج) شروع کرنے کے بعد سے مطمئن ہیں؟	□	□	□	□	□
T8	آپ ضروری ادویات یا آپ کو طبی علاج حاصل ہوا ہے اس کے بعد کے بارے میں کیا کہیں گے؟	□	□	□	□	□
T9	آپ کو فراہمی ضروری ادویات یا طبی علاج کے متعلق جو معلومات حاصل ہوئی ہیں اس کے بعد کے بارے میں کیا کہیں گے؟	□	□	□	□	□
T10	کیا زرخیزی کے طبی عملے کے ساتھ آپ کا جو معاملہ ہوا یا اس سے آپ مطمئن ہیں؟	□	□	□	□	□

Annexures-F

مشکلات/مسائل سے نبرد آزما ہونے کا پیمانہ

یقہ

ہدایت: نیچے دیے گئے سوالات روزمرہ زندگی کے مسائل سے نمٹنے کے مختلف طریقے کار سے متعلق ہیں۔
آپ اپنی روزمرہ زندگی کے مسائل سے نمٹنے کے لیے جو طریقے کار کرتے ہیں برائے مہربانی اس کی نشاندہی کرتے ہوئے اس کا ایسے پانچ پر ریٹ کریں۔

۱۔ بالکل نہیں	۲۔ کبھی کبھار	۳۔ کسی حد تک	۴۔ اکثر اوقات	۵۔ ہمیشہ

نمبر شمار	بیانات	بالکل نہیں	کبھی کبھار	کسی حد تک	اکثر اوقات	ہمیشہ
۱	صرف خدا پر چھوڑ دیتا/دیتی ہوں۔	۱	۲	۳	۴	۵
۲	انہیں نظر انداز کرتا/کرتی ہوں۔	۱	۲	۳	۴	۵
۳	دوسروں سے مشورہ کرتا/کرتی ہوں۔	۱	۲	۳	۴	۵
۴	سوچ سمجھ کر لائحہ عمل اختیار کرتا/کرتی ہوں۔	۱	۲	۳	۴	۵
۵	قریبی لوگوں سے اپنے مسائل بیان کر کے خود کو سکون کرتا/کرتی ہوں۔	۱	۲	۳	۴	۵
۶	انہیں ترتیب وار حل کرتی ہوں۔	۱	۲	۳	۴	۵
۷	انہیں وقت پر چھوڑ دیتا/دیتی ہوں۔	۱	۲	۳	۴	۵
۸	انکے مثبت پہلوؤں کو مدنظر رکھتا/رکھتی ہوں۔	۱	۲	۳	۴	۵
۹	چڑچڑے پن کا شکار ہوتے ہوئے دوسروں سے الجھ پڑتا/پڑتی ہوں۔	۱	۲	۳	۴	۵
۱۰	قریبی لوگوں کے حل کے لیے رجوع کرتا/کرتی ہوں۔	۱	۲	۳	۴	۵
۱۱	خود کو یہ باور کراتا ہوں کہ ہر وقت گزر جانے کے لیے پریشان ہونے سے فائدہ نہیں۔	۱	۲	۳	۴	۵
۱۲	دوستوں کے ساتھ گھومنے جاتا ہوں/جاتی ہوں۔	۱	۲	۳	۴	۵
۱۳	ہر ممکن کوشش کرتا/کرتی ہوں۔	۱	۲	۳	۴	۵
۱۴	منشیات/سکون آور ادویات کا استعمال کرتا/کرتی ہوں۔	۱	۲	۳	۴	۵
۱۵	مسائل کی نوعیت کو سمجھتے ہوئے انہیں حل کرتا/کرتی ہوں۔	۱	۲	۳	۴	۵
۱۶	اپنی قوت ارادی کو بروئے کار لاتا/لاتی ہوں۔	۱	۲	۳	۴	۵
۱۷	خود کو دوسروں کاموں میں مصروف کر لیتا/لیتی ہوں۔ جیسے ٹی وی دیکھنا میوزک سننا سو جانا یا خریداری کرنا۔	۱	۲	۳	۴	۵
۱۸	خود کو اہل نہیں سمجھتا/سمجھتی ہوں۔	۱	۲	۳	۴	۵
۱۹	قریبی لوگوں سے حل کے لیے مدد لیتا/لیتی ہوں۔	۱	۲	۳	۴	۵
۲۰	صبر و تحمل کا مظاہرہ کرتا/کرتی ہوں۔	۱	۲	۳	۴	۵
۲۱	خود پر تنقید کرتا/کرتی ہوں۔	۱	۲	۳	۴	۵
۲۲	دوسروں سے جذباتی کو سہارا لیتا/لیتی ہوں۔	۱	۲	۳	۴	۵

Annexures-G

The Final Bonding to God Scale (BTGs)

یہ سوالنامہ انسان کے خدا سے تعلق کے بارے میں جانے کے لیے تشکیل دیا گیا ہے۔ ہر سوال کے پانچ جوابات ہیں۔ان میں سے جو بھی آپکو موزوں لگے اس پر تیغ (✓) کا نشان لگائیں۔ برائے مہربانی سوال کا جواب دیں۔

نمبر شمار	بیانات	مکمل پور پر حق	کسی حد تک متفق	معلوم نہیں	کسی حد تک غیر متفق	مکمل طور پر غیر متفق
۱	میں نے زندگی کے ہر قدم پر اللہ کو اپنے قریب محسوس کیا ہے۔					
۲	میں اللہ کے زیادہ قریب ہونا چاہتا/چاہتی ہوں۔					
۳	میں بعض اوقات اللہ کو بھول جاتا/جاتی ہوں۔					
۴	میں صرف ضرورت کے وقت ہی اللہ کو یاد کرتا/کرتی ہوں۔					
۵	مجھے محسوس ہوتا ہے کہ اللہ مجھ پر زیادہ مہربان نہیں ہے۔					
۶	میرا زیادہ تر وقت اللہ کی یاد میں گزرتا ہے۔					
۷	مجھے محسوس ہوتا ہے کہ اللہ مجھ سے کسی بات پر ناراض ہے۔					
۸	مجھے محسوس ہوتا ہے کہ اللہ مشکل میں میری مدد نہیں کرتا۔					
۹	میرا اللہ سے تعلق زیادہ مضبوط نہیں ہے۔					
۱۰	اللہ نے ہمیشہ میری کوتاہیاں اور غلطیوں کو معاف کیا ہے۔					
۱۱	اللہ سے رابطہ کرنے پہ بعض اوقات مجھ مایوسی کا سامنا ہوتا ہے۔					
۱۲	مجھ اللہ پر زیادہ یقین ہے۔					
۱۳	اللہ نے میرے ساتھ کچھ اچھا نہیں کیا۔					
۱۴	میرا زیادہ تر وقت اللہ کی عبادت میں گزرتا ہے۔					
۱۵	میرا اللہ سے دعا مانگنے کو دل نہیں چاہتا۔					
۱۶	اللہ نے مجھے ہر وہ چیز دی جس کی مجھے کبھی بھی ضرورت پیش آئی۔					
۱۷	اللہ میرا سب سے بڑا ہمراز ہے۔					
۱۸	میں اللہ کو نہیں مانتا/مانتی۔					
۱۹	میری یہ کوشش ہوتی ہے کہ اللہ مجھ سے خوش رہیں۔					
۲۰	مجھ اللہ سے کچھ شکایات ہیں۔					
۲۱	مجھے ہمیشہ اللہ کی ضرورت رہتی ہے۔					
۲۲	مجھے محسوس ہوتا ہے کہ اللہ مجھ سے زیادہ دوسروں پر مہربان ہیں۔					

۲۳	اللہ میرا سب سے قریبی دوست ہے۔					
۲۴	اگر اللہ میری بات نہ سنے تو مجھ غصہ آجاتا ہے۔					
۲۵	اللہ میری زندگی کی اولین ترجیح ہے۔					
۲۶	اللہ کی موجودگی کے احساس سے میں خود کو محفوظ محسوس کرتا/کرتی ہوں۔					
۲۷	میں جب بھی پریشان ہوں تو صرف اللہ سے مدد مانگتا/مانگتی ہوں۔					
۲۸	اللہ کی عبادت کرنے سے مجھے خوشی ہوتی ہے۔					
۲۹	میرا ہر کام اللہ کی مرضی کے مطابق ہوتا ہے۔					
۳۰	مجھے اللہ سے محبت ہے۔					
۳۱	اللہ نے میرے ساتھ بہت زیادتی کی ہے۔					
۳۲	میں ہر کام صرف اللہ کے لیے کرتا/کرتی ہوں۔					
۳۳	اللہ نے ہمیشہ میری رہنمائی کی ہے۔					
۳۴	اللہ نے میری تمام پریشانیوں اور تکلیفوں کو دور کیا ہے					

Annexures-H

ORIGINALITY REPORT

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