INFLUENCE OF FAMILY AND SPIRITUAL SUPPORTS ON COPING WITH INFERTILITY AMONG COUPLES IN IBADAN OYO STATE NIGERIA

OJEDOKUN, I. M. Ph. D
Department of Social Work,
Faculty of Education,
University Ibadan, Ibadan, Nigeria
+2348064386174 or +2348053384012
mobolajiojedokun@yahoo.com

ABSTRACT

The study examines the influence of family and spiritual supports on coping with infertility among couples in Ibadan, Oyo state Nigeria. The study adopts a descriptive survey research. One Hundred and Seventy-five (175) couples were purposively selected. A self-structured and validated questionnaire with a reliability co-efficient value of 0.85 through the use of Cronbach alpha method was used for data collection. Four (4) trained research assistants helped in data collection. Analysis was done using Pearson Product Moment Correlation (PPMC). Hypotheses were tested at 0.05 level of significance. The findings revealed that family support greatly influence coping ability of couples attending family health clinic ($r=0.846$, $df=173$, $p<0.05$). It further revealed that, family support significantly influences emotional status of couples attending family health clinic ($r=0.763$, $df=173$, $p<0.05$). Finally, there is a significant influence of spiritual support on coping ability of couples attending family health clinic ($r=0.840$, $df=173$, $p<0.05$). The study concludes that there is a relationship between family and spiritual support and coping ability among couples experiencing infertility. It was recommended that family members should support couples experiencing infertility both psychologically, socially and spiritually to reduce depression, discrimination and stigmatization. The social workers and other health stake holders should create awareness about coping with infertility among couples. Government should subsidise treatment to restore hope among couples experiencing infertility.

Key Words: Couples, Infertility, Coping ability, Psychosocial support, Family support, Spirituality

INTRODUCTION

The desire to have children is powerful and widespread, but for a sizeable minority it is not easily fulfilled. Challenges to fertility arise from genetic abnormalities, infections or environmental agents, delayed childbearing, behavior, and certain diseases. Awareness of the potential risks may lead some people to adopting corrective behaviors and maintain fertility. Many people find themselves coping with infertility because most people have the strong desire to conceive a child at some point during their lifetime. Understanding what defines normal fertility is crucial to helping a person or couple to know when it is time to seek help. Omberlet (2012) documents that most couples (approximately 85%) would become pregnant within one year of trying, with the greatest likelihood of conception occurring during the earlier months and an additional 7% of couples will conceive in the second year. As a result, infertility is defined as the inability to conceive within 12 months. According to Dyer, Abraham, Hoffman and Spy (2004), the true meaning of marriage in the African culture is fulfilled only when the couple conceives and bears children.

Donkor and Sandall (2009) found that Africans sees children as a source of power and pride; and children act as insurance for their parents in old age. The most important aspect of bearing children is an assurance of family continuity. Donkor et al further found that women seeking infertility treatment cope by keeping their infertility problem to themselves. This is because they don't want to be stigmatized while others cope through faith. According to Tamparo and Lewis (2011), female fertility normally peaks at age 24 and diminishes after 30, with pregnancy occurring rarely after age 50 years. A female is most fertile within 24 hours of ovulation. American society for reproductive medicine (2006) sees infertility as the result of a disease (an interruption, cessation, or disorder of body functions, systems, or organs) of the male or female reproductive tract which prevents the conception of a child or the ability to carry a pregnancy to

delivery. Primary infertility is the inability to conceive a first child. Secondary infertility is the inability to conceive after one live birth.

McLachlan (2007) found that low sperm production process in the testes is a common cause of infertility and about two thirds of infertile men have sperm production problems. Low number of sperm produced by the male partner may also be weak and may not be able to swim early to meet with the female gamete called ovum. In the same vein, a number of other factors can disrupt the production of sperm including undescended testis, infections such as mumps, heat, sperm antibodies, torsion, drugs or radiation damage. Blockages (obstructions) in the tubes leading sperm away from the testes to the penis can cause a complete lack of sperm in the ejaculated semen. This is assumed to be the second most common cause of male infertility and it may affect about three in every twenty infertile men. Further, Kamel (2010) found that sperm antibodies can develop in some men and about one in every sixteen infertile men was said to have sperm antibodies and this may cause male infertility. Major causes of infertility among women include: ovarian dysfunction, tubal disease, endometriosis, and uterine or cervical factors.

Daniluk (2001) earlier found that, the experience of infertility is not only a medical one, but it is also an emotional experience. Those experiencing infertility encounter a variety of feelings. These feelings vary widely from stress, reactions to diagnosis and medical treatments to the experience created by the physician and medical environment. Gender is sometimes linked with couple infertility. According to Geelhoed (2002), the underlying cause of infertility may be a male factor (40%), a female factor (40%) or a combination (20%) of problems. In Nigeria, Makanjuola (2010) found that about 15% of married couples aged 19 to 45years have various forms of infertility problems. Of these, 23.6% had primary infertility, 28.3% had secondary infertility while the remaining 48.1% had other gynaecological disorders. National Collaboration Centre for Women and Children Health (2012) estimated that 60 to 80 million couples worldwide currently suffer from infertility. Makanjuola (2010) further found that, up to 65% of gynaecological consultations are for infertility. It is a growing problem across all cultures and societies almost all over the world and it affects an estimated 10-15% of couples of reproductive age.

Hassani (2010) found that infertility in Africa is commonly associated with negative psycho-social consequences. It is a crisis that leads to a psychological imbalance especially when a possible and quick solution is not within reach. Also, Derka (2010) found that the feeling of a loss of something have negative influence on a couples' mental and social wellbeing. In support of the above, Ashkani,Akbari and Heydari (2006) found that depression is a reaction which appears as a consequence of sorrow. Domar, Moragianni, Ryley and Urato (2012) found that there is evidence that the majority of infertile women will report depressive symptoms at some point during their treatment especially following unsuccessful treatment cycles. World Health Organization (WHO) evaluation of Demographic and Health Surveys (DHS) data (2013) estimated that more than 186 million ever-married women of reproductive age in developing countries were maintaining a "child wish", translating into one in every four couples.

World Health Organisation WHO (2013) postulated that infertility could be prevented through control of weight because women who are underweight or overweight ovulate (release an egg) less regularly, or sometimes not at all, compared to women of a healthy weight. Patients who are significantly overweight are strongly urged to lose weight, because being overweight is not only a risk factor for infertility, it also reduces the likelihood that treatment will be successful. WHO further recommends that diet must be checked or monitored to reflect nutritious, balanced diet of at least five portions of fruit and vegetables a day. Stress can often affect fertility because it may lead to having sex less frequently. For the best chance of becoming pregnant, couple

needs to have sex every two to three days. Regular exercise may also be helpful. Illegal drugs such as marijuana or cocaine can affect fertility, and can seriously damage the development of the baby in-utero if pregnancy occurs. WHO warns that expectant couples should avoid using drugs not prescribed if they are trying to get pregnant. Both man and woman must embark on routine health checks and tests to rule out any sexually transmitted infections (STIs). Infections such as chlamydia may not have symptoms, but can cause infertility if left untreated. In the same vein, Domar et al (2012) also found that medications used to treat infertility can cause a range of psychological side effects. The estrogen drug clomiphene, commonly prescribed to boost ovulation, can cause disrupted sleep, anxiety, irritability and mood swings. According to Domar et al (2012), some other drugs can lead to mania, depression and disrupted thought processes. Both clinicians and patients may find it difficult to pinpoint whether the side effects are psychological or caused by medications, but it is essential to identify the cause in order to determine how to proceed.

Hardee, Gay and Blanc (2012) found that women older than 35 years also may benefit from ovarian reserve testing of follicle-stimulating hormone and estradiol levels on day 3 of the menstrual cycle. Infertility attributed to ovulatory dysfunction often can be treated with oral ovulation-inducing agents in a primary care setting. Hardee et al (2012) further found that women with poor ovarian reserve have more success with oocyte donation. In certain cases, tubal disease may be treatable by surgical repair or by in-vitro fertilization. Infertility attributed to endometriosis according to Donkor and Sandall (2009) may be amenable to surgery, induction of ovulation with intrauterine insemination, or in-vitro fertilization. In this same vein, Donkor et al (2009) further found that unexplained infertility may be managed with ovulation induction, intrauterine insemination or both. There is an assurance that the overall likelihood of successful pregnancy with treatment is nearly 50 percent. Gibson et al (2000) found that a careful history and physical examination of each partner can suggest a single or multifactorial etiology and can direct further investigation.

Peterson (2006) and Slade (2007) see psychosocial support as the perception that one has an available confidant or experiences provided by partners, family and friends. Having social support from these sources can reduce the impact of a large number of life stressors. Schmidt (2009) affirmed that there are relatively few studies examining the impact of family social support on a woman's level of infertility, stress and psychological adjustment. In furtherance to this, Slade (2007) found that support from social networks can also benefit a woman's adjustment when dealing with the stress of infertility. For example, family support has been associated with lower levels of depression and anxiety and reductions in infertility stress. In addition to social support, coping strategies are used to deal with infertility-related stress. Coping strategies refer to cognitive or behavioural efforts to manage a stressful event that is perceived to exceed an individual's personal resources.

Schmidt (2009) further found that, active and problem-focused coping strategies involve actions intended to resolve the stressor, and are typically more effective in dealing with a stressor than passive and emotion-focused strategies. In the same vein, Verhaak (2005) found that, since infertility is a low-control stressor, women can do little or nothing to actively change the nature of the situation. As a result, passive coping styles and emotion-focused strategies, which include efforts to focus on diversional therapy to relieve anxiety can also be adaptive. It is important to say here that family support can promote adaptive coping styles. Mahajan (2009) found that it is essential that studies include social support as a variable to further disentangle the complex relationship between coping and infertility-related stress. In the light of the above, the family plays a significant role by supporting the infertile couples. Being near, close and encouraging

them through counselling and selective treatments will help the infertile couple to cheer up. Regular visits, financial support and genuine advice on choice of clinical treatment will also build up the confidence of the infertile couples.

In the same trend, Klock (2008) also found that partners may become more anxious to conceive, ironically increasing sexual dysfunction and social isolation. Marital discord often develops in infertile couples, especially when they are under pressure to make medical decisions. Hassani (2010) found that couples experience stigma, sense of loss, and diminished self-esteem in the setting of their infertility. In general, Chetty (2013) found that in infertile couples, women show higher levels of distress than their male partners. It should be noted that, both men and women experience a sense of loss of identity and have pronounced feeling of defectiveness and incompetence. Emotional stress and marital difficulties are greater in couples where the infertility lies with the man. Therefore, the psychological impact of infertility can be devastating to the infertile person and to their partner. It is also believed that infertility has an effect on a couple's mental health. Zuraida (2010) found that different psychological factors have been shown to affect the reproductive ability of both partners. Changes in immune function associated with stress and depression may also adversely affect reproductive function.

Spirituality and religion are important sources of solace for most individuals experiencing infertility. A high level of spiritual well-being is significantly linked with less infertility distress and fewer depressive symptoms, suggesting a relationship between spirituality and the psychological well-being of women undergoing infertility treatment. According to Aysel and Gul (2015), physicians may be well-advised to inquire about and support patients' religious beliefs to help promote their physical and psychological well-being. In the African context, religious people tend to have a greater sense of well-being, greater life satisfaction, lower levels of depression and anxiety, and a decreased risk of suicide. Strong religious beliefs may help or interfere with coping and healing. On the one hand, some may find comfort by believing that infertility is part of a divine plan, while others may interpret infertility as punishment from a higher power for past sins and indiscretions. It is heart-warming to also note that some infertile women who display strong religious or spiritual beliefs may achieve relaxation through prayer. Others may experience heightened levels of distress from feeling that their prayers for a child have gone unanswered, or from agonizing over whether to pursue a treatment that may be specifically banned by their religion. Being religious may benefit the infertility patient by providing a feeling of community and reducing social isolation. Spirituality appears to play an important role in the psychological health of infertile women. Health care professionals may be well-advised to inquiry about and support their patients' religious beliefs to promote the physical and psychological well-being of infertile women.

Sequel to the aforesaid, Alice, Alan, Jeffery, Amora, Dalia, Babara and Debika (2012) found that high level of religiosity and spirituality correlated with low levels of psychological distress. They suggested that clinicians should be prepared to discuss religious issues with their patients as those issues may play an important role in the psychological health of infertile women and in their response to infertility treatment. It should therefore be noted that a high level of spiritual well-being is significantly linked with less infertility distress and fewer depressive symptoms. This is suggestive of a relationship between spirituality and the psychological well-being of women undergoing infertility treatment. Marie (2008) found that patients with strong religious faith overcome medical crisis with better outcomes than those who do not hold strong spiritual beliefs or maintain religious practice. Infertile and religious people are said to have greater sense of well-being, greater life satisfaction and low levels of depression, anxiety and a decreased risk of suicide.

Crisis theory, family theory and labelling theory are applicable to this study. Crisis theory advocates that the emotions that accompany a traumatic crisis like infertility can be described in different ways. The description has existential base being grounded on the emotional experience of being a human being. Dustink (2016) said everybody has a basic need of a kind of existential structure and everybody seeks a position for being human in a place and function in the world. Infertility among couples is a situation that demands maximum adjustment (coping). If the affected couple can learn new and appropriate reactions and coping mechanisms, the crisis will lead to development of an individual.

Family theory established that members of the family system are expected to respond to each other in a certain way according to their role which is determined by relationship agreements. Mellisa (2017) theorised that maintaining the same pattern of behaviours within a system may lead to balance in the family system but also to dysfunction. Labelling theory holds that deviance is not inherent to an act, but instead, focuses on the tendency of majorities to negatively label minorities or those seen as deviant from the standard cultural norms. Ashley (2017) theorised that stigma is placed on the wife (most times) in most African cultures when the infertility crisis arises. This may be a wrong concept because the man (husband) may have reproductive problems and other issues. Human behaviour is the result of meanings created by social interaction of conversation, both real and imaginary. Labelling causes stress, anxiety, depression and emotional disturbances for the couple.

Statement of problem

In Africa parlance, waiting couples pass through a lot of psychological trauma both from the family and the general society. Infertile couples suffer unending consultations with spiritualists. To this end, the female is said to be a witch who purposely decline to have children. Parenthood is one of the major transitions in adult life for both men and women. The stress of the non-fulfilment of a wish for a child has been associated with emotional sequel such as anger, depression, anxiety, marital problems and feelings of worthlessness. In the same trend, partners' anxiety to conceive tends to increase sexual dysfunction and social isolation. Some family members especially in Africa frowns at infertility. Their responses to issues tend to create more stress, anxiety, depression and associated family problems such as taking another wife for their male children. Marital discord often develops in infertile couples, especially when they are under pressure to make medical decisions. People nowadays stigmatise the infertile couple and tag them as barren. Infertility has been a major cause of family dysfunction, separation and or divorce; all of which are social problems. Despite increasing calls that have been made to include family and spiritual supports as variables in infertility studies, there are relatively few studies examining the impact of these variables on a woman's levels of infertility stress and psychological adjustment. Hence, this study tries to bridge the gap and to find out the relationship between family and spiritual supports on coping with infertility among couples in Ibadan, Oyo State Nigeria.

Objectives of the study

1. To find out the influence of family support on coping ability among infertile couples
2. To find out how family support influences the emotional status of infertile couples

3. To find out the influence of spiritual support on copping ability among infertile couples

Hypotheses

1. There is no significant relationship between family support and coping ability among married couples experiencing infertility.
2. There is no significant relationship between family support and emotional stability of married couples experiencing infertility.
3. There is no significant relationship between spiritual support and coping with infertility among married couples experiencing infertility.

METHODOLOGY

Descriptive survey research design was used for this study. It was considered appropriate because it shows the relationship between the variables considered in this research (family and spiritual support; emotional stability and coping ability). One hundred and seventy-five (175) couples experiencing infertility and are attending Government Maternity Hospital, Adeoyo, Ibadan, Oyo State served as respondents. A convenient sampling technique was adopted. A self-constructed and validated questionnaire with a reliability coefficient of 0.85 tagged influence of family and spiritual support on coping ability among infertile couples (IFSSCAIC) was used for data collection. The instrument was in two sections (A and B). Section A featured the respondents' demographic characteristics, while section B highlighted categorical statements that measured the levels of family and spiritual support received by couples experiencing infertility. The items were drawn from infertility stress scale. The instrument was personally administered with the help of four (4) trained research assistants. The completed questionnaire was analysed using the descriptive statistics of frequency count, simple percentages and Pearson Product Moment Correlation (PPMC). Hypotheses were tested at 0.05 alpha level.

RESULTS

Based on the result, 18.3% of the respondents were males, while 81.7% of the respondents were female. The implication is that, more than half of the respondents were females. The results also showed that 50.9% were between 23 - 25 years while 49.1% of the respondents were between 36 - 46 years. The result further revealed that, 82.3% of the respondents were Christians while 17.7% were Muslims by faith. 31.4% of the couples were civil servant, 36% were traders, and 32.6% were unemployed.

Hypothesis One: There is no significant influence of family support on coping ability of married couples with infertility.

Table 1: Pearson Product Moment correlation showing the influence of family support on coping ability of married couples with infertility

Variables	Mean	Standard Deviation	N	R	P	Decision
Family support	11.4286	2.5785	175	0.846	0.05	Sig.
Coping ability	11.2171	3.0679				

r=0.846 N= 175 df=173 p< 0.05

The result presented in the table above revealed that, family support significantly influence coping ability of married couples attending family health clinic (r= 0.846, df =173, p<0.05). The null hypothesis is rejected in favour of the alternative hypothesis.

Hypothesis Two: There is no significant influence of family support on emotional status of married couples with infertility.

Table 2: Pearson Product Moment correlation showing the influence of family support on emotional stability of married couples with infertility

Variables	Mean	Standard Deviation	N	R	P	Decision
Family support	11.4286	2.5785	175	0.763	0.05	Sig.
Emotional stability	10.5600	2.3697				

r=0.763 N= 175 df =173 p< 0.05

The result in table 2 showed that, family support significantly influence emotional stability of married couples attending family health clinic(r=0.763, df=173, p<0.05). Since, the (r value) of the result is not up to one, the null hypothesis is rejected in favour of the alternative.

Hypothesis Three: There is no significant influence of spiritual support on coping ability of married couples with infertility

Table 3: Pearson Product Moment correlation showing the influence of spiritual support and coping ability of married couples with infertility

Variables	Mean	Standard Deviation	N	R	P	Decision
Spiritual support	9.6800	1.3306	175	0.840	0.05	Sig.
Coping ability	11.2171	3.0670				

r=0.840 N= 175 df =173 p< 0.05

The result in table 3 showed that, spiritual support significantly influenced coping ability of married couples attending family health clinic (r=0.840, df=173, p<0.05). The null hypothesis is therefore rejected in favour of the alternative.

DISCUSSION OF FINDINGS

The result revealed family support significantly influenced coping ability of married couples with infertility. The result is line with Hassani (2010) who found that infertility in Africa is commonly associated with negative psychological consequences. Infertility is seen as crisis in social work and it is assumed to lead to a psychological imbalance especially when a possible and quick solution is invisible. The result is also in line with Derka (2010) who associated family support with the relief of feeling of a loss of something even though previously non-existent. The said feeling is thought to have negative influence on couples' mental and social well-being could be reduced if the family members show concern and support. In the same vein, the result supports Ashkani, Akbari and Heydari (2006) that infertile couples may experience relief from depression with the support of the family members. It is needful to say that coping strategies refer to cognitive or behavioural efforts to manage a stressful event that is perceived to exceed an individual's personal resources. Social support is fundamental to one's physical and psychological well-being. Having social support from family sources can reduce the impact of a large number of life stressors, including infertility. In this trend, Domar, Moragianni, Ryley and Uranto (2012) found that infertile couples without adequate family support may report depressive symptoms at some point during their treatment especially following unsuccessful treatment cycles. In the same vein, Mankanjuola (2010) also found that stress, depression and anxiety are common consequences of infertility. To this end, the family is the immediate source of hope and succor to the infertile couple. They are expected to stand by the couple for them to be able to cope with infertility even in the seemingly difficult period being experienced.

The study further showed that, family support significantly influenced emotional status of married couples experiencing infertility. The result corroborates the findings of Kamel (2010) that parenthood is one of the major transitions in adult life for both men and women. In order to fulfil this role, the infertile couple needs the family support at all times till they bear children. Premised on the above, there is the need to say here that, the non-fulfillment of a wish for a child has been associated with emotional sequel such as anger, depression, anxiety, marital problems and feelings of worthlessness. Partners may become more anxious to conceive, ironically increasing sexual dysfunction and social isolation. This seems to be a crucial period that the support of the family members would be highly appreciated. Similarly, Hassani (2010) found that couples experience stigma, sense of loss, and diminished self-esteem in because of their infertility. The infertile couple therefore needs the support of their family members to overcome their emotional problems. In the same vein, Chetty (2013) found that infertile women show higher levels of distress than their male partners. The psychological impact of infertility can be devastating to the infertile person and to the partner. The emotional trauma created by infertility is better imagined than experienced. This could be doused if the family members are there for them at all times.

Finally, the result revealed that spiritual support significantly influence coping with infertility. The study corroborates the findings of Jenings (2010) that religious people tend to have a greater sense of well-being, greater life satisfaction, lower levels of depression and anxiety, and a decreased risk of suicide. Society, especially religious society, has traditionally valued woman for her life-giving role. Therefore, it is not surprising that living with unrealized hopes for a child can negatively affect a woman's psychological wellbeing. Furthermore, strong religious beliefs may help or interfere with coping and healing. The result is also in line with the findings of Marie (2008) that spirituality appears to play an important role in the psychological health of infertile women. Some infertile women who display strong religious or spiritual beliefs may achieve relaxation through prayer. Similarly, couples may experience heightened levels of distress from feeling that their prayers for a child have gone unanswered, or from agonizing over whether to pursue a treatment that may be specifically banned by their religion. Being religious may benefit the infertile patient by providing a feeling of community and reducing social isolation. According to Aysel and Gul (2015), physicians may be well-advised to inquire about and support patients' religious beliefs to help promote their physical, emotional and psychological well-being.

Health care professionals may be well-advised to inquiry about and support their patients' religious beliefs to promote the physical and psychological well-being of infertile women. Alice, Alan, Jeffery, Amora, Dalia, Barbara, and Debika (20014) found that high level of religiosity and spirituality correlated with low levels of psychological distress. They advised that clinicians should be prepared to discuss religious and spiritual issues with their patients as those issues may play an important role in the psychological health of infertile women and in their response to infertility treatment. A high level of spiritual well-being is significantly linked with less infertility distress and fewer depressive symptoms. This is suggestive of a relationship between spirituality and the psychological well-being of women undergoing infertility treatment. Spirituality and religion are important sources of solace for most individuals. It is believed that, couples with strong religious faith sustain medical crisis with better outcomes than those who do not hold strong spiritual beliefs or maintain religious practice. Hence, family support has greater influence on coping with infertility. Similarly, family support can influence emotional well-being and spiritual support can restore hope to the couples.

Implications of the study for Social Workers

1. Social worker have significant roles to play concerning infertility and the couples involved. There is the need to incorporate biological, psychological and social factors in the management of infertility.
2. The Social worker develops a modality to “buffer” the effects of infertility on couples by seeing them as a unit, searching for adaptive strengths, improving sharing and communication. These efforts can strengthen the couple’s ability to cope and be resilient for the future.
3. Social worker focuses on normalizing, validating, and educating the infertile woman. She can also teach clients mindfulness meditation to help them manage unavoidable overwhelming situations.
4. Social worker acts as a bridge builder; needs to recognize that infertile women who make the decision to stop treatment or not to adopt a child often continue to identify their infertility as the primary component of their live.
5. Social workers can help infertile women work through the trauma and shame of infertility so that it doesn’t affect their bodies and minds by assisting them through in-depth explanation on their situation. This involves: identifying all the losses, social identity and helping clients articulate what the losses mean to them. This is fundamental in helping to integrate the loss into client’s life story.
6. The social worker also can introduce themes of acceptance and choice. Hope can still be instilled by reassuring that it is possible to live a good and rewarding life without children. If all efforts failed, the social worker can suggest child adoption.

Conclusion

Premised on the findings, it could be deduced that, infertility is a growing social problem because the population affected has increased dramatically in recent decades. The result of this finding is a pointer to certain fundamental issues in reproductive life. Infertility brings along with it some emotional problems that the couple may not be able to explain. It is expedient therefore that the family should be there for them. The couple usually feel incomplete whenever they see the children of their mates. The psychological trauma experienced could precipitate other clinical conditions such as hypertension and insomnia. Those affected by infertility needs general clinical attention as well as psychological support from families and friends to enhance coping ability. It is therefore concluded that infertility is a painful experience on the affected couples who needs the reassurance and support of the entire family to be able to cope fully. It could also be concluded that spirituality and religion are important sources of solace for most individuals experiencing infertility. A high level of spiritual well-being is significantly linked with less infertility distress and fewer depressive symptoms, suggesting a relationship between spirituality and the psychological well-being of people undergoing infertility treatment. Religious people are said to have a greater sense of well-being, greater life satisfaction, low levels of anxiety and decreased risk of suicide. When occasion such as infertility arises, it takes courage and intense family and spiritual support including the society at large to assist the couples to be able to cope with and possibly overcome the problem of infertility. The study finally concludes that there is a relationship between family and spiritual support and coping ability among married infertile couples

Recommendations

1. The family members should assist the infertile couple with the much needed social and psychological supports.

2. Society and family members should not stigmatize couples. Women must not be seen or referred to as barren but must be supported physically, emotionally and spiritually.
3. The social workers have significant roles to play. They should help through individual counseling, group and family psychotherapy. These functions will also encourage the infertile couple that they still have hope of bearing children.
4. The government should provide a highly subsidised expectant family health services to encourage and to instill hope in the lives of the infertile couples.

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