ISSN: 0975-833X

Available online at http://www.journalcra.com

International Journal of Current Research
Vol. 8, Issue, 04, pp.30107-30114, April, 2016

INTERNATIONAL JOURNAL OF CURRENT RESEARCH

RESEARCH ARTICLE

THE PERVASIVE ROLE OF RELIGION/SPIRITUALITY IN PAKISTANI WOMEN'S SELF-MANAGEMENT OF RECURRENT DEPRESSION: A QUALITATIVE STUDY

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ARTICLE INFO

Article History:
Received 17th January, 2016
Received in revised form
26th February, 2016
Accepted 25th March, 2016
Published online 26th April, 2016

Key words:

Self-management strategies,
Major Depressive Disorders,
Pakistani Women,
Religion,
Spirituality and Culture,
Qualitative Method.

ABSTRACT

Background and objectives: Major Depressive Disorder (MDD) is a recurrent, chronic, and debilitating mental illness which demands daily management using self-management strategies (SMS). Much of the literature on self-management is derived from research focused on Western culture. Less is known about how people self-manage their MDD in other cultures. Hence, a qualitative study was designed to understand how women in Pakistan self-manage their recurrent MDD. The aim of this paper is to describe a set of findings pertinent to the role of religion/spirituality in Pakistani women's experiences with recurrent depression and their use of religious/spiritual SMS that were extracted from results of a larger study.

Population: A purposive sample of 10 Pakistani women living in Karachi, Pakistan and seeking treatment for MDD from the psychiatric outpatient clinic at a private tertiary care hospital in Karachi were included in the study.

Methods: A qualitative, descriptive study was conducted using the data from a total of 27 interviews. ATLAS.ti was used to organize, manage, and qualitatively and thematically code and analyze the transcribed interview data.

Results: Three major themes emerged from the data. The first theme was the experience of depression. The women's experience of depression was integrated with their individual religion/spirituality. They all shared a polarized perspective, i.e. depression as positive as well as painful. The second theme was strategy selection. Women unanimously reported that faith in God, family and social network structure, and broader cultural practices influenced their selection of religious/spiritual focused strategies. The third theme was religious/spiritual SMS. Women identified (a) having faith in God, and (b) ways of connecting with God as their religious/spiritual focused strategies. Having faith in God was not only viewed as an influencing factor but also as a strategy. Women shared four ways through which they connected with God (i) performing prayers, (ii) reciting the holy Qur'an, (iii) talking to God, and (iv) performing a Pilgrimage.

Interpretation and Conclusions: Religion and spirituality are the critical lenses through which Pakistani women understand their illness and make decisions about how to manage their MDD. Since self-management occurs within a socio-cultural context, it is imperative for nurses to understand not only the religious and spiritual perspectives but also socio-cultural perspectives to facilitate and support women's efforts to self-manage their MDD.

Citation: Nadia Ali Muhammad Ali Charania and Bonnie M. Hagerty, 2016. "The pervasive role of religion/spirituality in Pakistani women's self-management of recurrent depression: a qualitative study", *International Journal of Current Research*, 8, (04), 30107-30114.

INTRODUCTION

MDD is a recurrent and chronic illness (Burcusa & Iacono, 2007; Chambers *et al*., 2015; Greden, 2001), and treating one episode of depression may not address the challenge of living a life with this incapacitating illness. As with other chronic illnesses, living with MDD requires managing the symptoms on a day to day basis, detecting episodes early, and preventing future episodes. Self-management (SM) is a framework that supports an individual's activities designed to monitor and manage his/her illness over time. Much of the literature on SM is derived from research focused on Western culture. Less is known about how people self-manage their MDD in other cultures. Hence, a qualitative study was designed to understand how women in Pakistan, a South Asian country, self-manage their recurrent MDD. There is no nation-wide epidemiological research that demonstrates the prevalence of depression among Pakistani women. Nonetheless, studies conducted in various regions of the country indicated that prevalence of depression among Pakistani women may be high (Ayub *et al*., 2009; Dodani S, & Zuberi, 2000; Mumford, Nazir, Jilani, & Baig, 1996; Zainab, Fatmi, & Kazi, 2012). Moreover, a study conducted comparing the prevalence of depression in Pakistani women and men revealed a more than double prevalence of depression in women compared to men (Ali *et al*., 2002). Considering how little is known about Pakistani women's mental health in general and how they manage their MDD in particular, it is timely to better understand how these women live their day-to-day lives with recurrent MDD including their use of specific strategies and their effectiveness.

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Religion/spirituality is central in the lives of Pakistanis. However, the role of religion/spirituality in how Pakistani women deal with recurrent depression is not yet empirically explicated. Rafique (2010) interviewed Pakistani women living in the UK about their experiences of depression and coping. Her findings demonstrated that the women used a variety of coping strategies such as talking to someone, being strong for the children, keeping busy, religious coping, positive self-talk, comparing themselves to others less fortunate, and using antidepressants. Though this study provided some information on coping activities Pakistani women used for their depression, they were not queried from a perspective of self-management framework and the women interviewed did not reside in Pakistan. Hence, there is a knowledge gap regarding Pakistani women's use of SMS for MDD and the role of religion/spirituality.

Aim

The aim of this paper is to describe a set of findings pertinent to the role of religion/spirituality in Pakistani women's experiences with recurrent depression and their use of religious/spiritual SMS that were extracted from results of a larger study.

MATERIALS AND METHODS

A qualitative, descriptive study was conducted to understand the strategies Pakistani women use to self-manage their recurrent MDD including: (i) Pakistani women's experience of depression, (ii) factors that influence SMS, and (iii) SMS and their perceived effectiveness. Prior to conducting the larger study, IRB approvals were sought from both a public Midwestern university, USA, and a private university which had a tertiary care hospital, in Karachi, Pakistan. Using purposive sampling, 10 Pakistani women who met the pre-specified inclusion and exclusion criteria were recruited from the outpatient psychiatric clinics of the hospital in Karachi. Women who met the following inclusion criteria were included in the study: (a) born in Pakistan; (b) 18 years of age or older; (c) diagnosed with two or more episodes of major depression; (d) follow-up patient in the outpatient psychiatric clinic; (e) aware that she had depression; (f) spoke Urdu and/or English; (g) gave permission to access medical files to validate diagnosis and history of two or more depressive episodes; to validate the absence of bipolar disorder or current substance abuse; and (h) was willing to participate in the study. The exclusion criteria were: (a) a diagnosis of bipolar disorder, (b) currently abusing a substance, and c) currently admitted to the in-patient psychiatric unit. Two approaches were used to recruit participants. First, a flyer in two languages, English and Urdu (Pakistan's national language), describing the study was posted in the outpatient psychiatric clinic of the private university hospital to recruit self-referred participants. Second, the patients were referred to the primary researcher directly by psychiatrists to the primary researcher. Data were collected through semi-structured interviews using an interview guide. Some participants wanted to elaborate on the questions and as a result, returned for a second or third interview to complete the questions on the interview guide. A total of 27 interviews were conducted from the sample.

The primary investigator, fluent in English and Urdu, translated all the interviews into English and then back translated three randomly selected interviews. To avoid biased interpretations, two independent bilingual Pakistani colleagues currently residing abroad translated one interview each. In addition, throughout the data analysis, interpretations of the data were discussed and cross checked with the co-investigator who has expertise in self-management of recurrent MDD. Content analysis was used to analyze data aimed at describing Pakistani women's experience of depression, factors influencing strategies, and SMS for their recurrent depression. Content analysis is a qualitative analysis procedure for methodically making sense of the transcriptions of open-ended interviews using three basic techniques: (a) deciding on the unit of analysis, (b) borrowing or developing a set of categories, and (c) developing the rationale and illustrations to guide the coding of data into categories (Wilson, 1989). Once all the text data were organized into categories and sub-categories, a descriptive summary for each category was written. ATLAS.ti, a qualitative data analysis and research software, was used to organize, manage, and qualitatively and thematically code and analyze a large body of textual data such as the transcribed interview data in this study.

RESULTS

The sample consisted of ten Pakistani Muslim women who had experienced at least two episodes of major depression and considered themselves to be recovering. These women did not have a clear idea about when they had their first experience of depression. They considered their symptoms to be the result of stress. Early on, they focused on dealing with the physical manifestations of depression and the current stressors in their lives. Over time they accepted that they were suffering from depression based on physicians' diagnoses and from family members and/or friends who had some knowledge of mental illness. At the time of the interviews, the women were living in Karachi, Pakistan and seeking treatment for MDD from the psychiatric outpatient clinic at a private tertiary care hospital in Karachi. They were between 30 and 55 years old, with a mean age of 40.4. Nine were married and one was single. Of those married, two had four children, four had two children, one had one child, and two did not have any children. Six were living in an extended family situation either with their own parents or with in-laws. Two had a graduate education, four had an undergraduate education, three had a middle to high school education, and one had no formal education. Based on household income, three women were from the upper middle socioeconomic class, four were from the lower middle socioeconomic class, and three were from the lower socioeconomic class. Women were from varied ethnic groups. Half of them described their identity as Urdu speaking; three as Punjabi; one as Gujrati; and one as Memon. Only two were employed. One was self-employed at home, and the other had an office position. Two had been admitted to a hospital once for treatment of depression.

The rest sought treatment from outpatient psychiatric clinics. Three major themes emerged from the qualitative analysis: a) the experience of depression, b) strategy selection, and c) religious/spiritual SMS.

The experience of depression

The experience of depression was integrated with each woman's religion/spirituality. During the recovery phase of recurrent major depression, all of the women viewed their experience of depression through the lens of religion/spirituality citing both positive and negative perspectives. The first positive insight was framed as "depression, a gift from God". For example, one woman stated, "And I do feel like it is very God sent and God's very precious gift." Viewing depression as a gift from God instilled the belief that anyone could have depression even those who are fortunate and well off. They described empathy for others who struggled with depression and how their own experience of depression demystified their views about the stigma of having mental illness. The second positive insight was framed as "renewed faith in God and Islam". Women described this as becoming more regular in performing religious rites and rituals such as praying and reciting the Qur'an. All of the women shared their experience of depression as painful. They viewed depression as the worst of all illnesses primarily because of its insidious and hidden course and presentation. They compared depression with other physical illnesses such as a cold or cancer that people could see and sympathize with. According to one:

"…if there is a fever or God forbid there is a cold then everyone can see it but this illness is such which I am feeling it but no one can see it. How can somebody think that I have this problem, someone may think I am acting or faking it". That is why this illness is a very serious/dangerous illness. Another one shared "... that people with cancer probably could be treated and can be seen as cured but this is something nobody can see it, nobody can understand it, unless you experience it yourself you don't even know its whereabouts." Women with such attitudes expressed strong conviction that in order to avoid recurrences they must make every effort to continue using strategies to deal with their depression regardless of whether or not they actually felt depressed".

Strategy selection

The second theme of strategy selection was influenced by women's faith in God, family and social network structure, and broader cultural practices. They unanimously agreed that faith in God was the strongest influence on their selection of religious/spiritual strategies. The women viewed that God had the power to solve all of their problems, God was the only solution to all the problems in their lives, and God was the source of courage and strength. For example, one woman shared "I felt so much weakness that I couldn't even able to get up…. When I took medication for my symptoms, God helped me in getting up; otherwise I couldn't even get up…." The family and social network structure also influenced women's selection of religious/spiritual focused strategies. These were not always the nuclear family members but people in their extended social network such as their mothers, brothers, mother-in-laws, friends, neighbors, and/or office colleagues who encouraged them to seek help from religious/spiritual healers. For example, a woman described how her friend learned aboutsomeone's experience with a religious/spiritual healer, "Like a friend said that there is a spiritual healer; someone shared personal experience that the treatment helped actually."Broader cultural practices also shaped women's strategy selection. For example, seeking help from religious/spiritual healers is reinforced in Pakistani culture. Seven women approached religious/spiritual healers primarily based on requests from family members or other people in their extended social network. Four of these women did not want to pursue these healers, viewing them as people only interested in making money or duping women out of money. Hence, such women questioned the idea of going to these individuals. They reiterated that they could consider seeking help from religious/spiritual healers if their treatments had involved using strategies that were cathartic or educational; or that diverted their attention to religious practices such as reciting holy Qur'anic verses. As one described, "So prayers and medication treatment should go hand in hand, both should be done, there are so many verses in God's Quran that if you read them your heart will be at peace…." The fifth participant shared that the use of an amulet which was given by a religious/spiritual healer at her place of worship would be acceptable. Of these five women who worked with religious/spiritual healers, two had opposite views related to integrating psychiatric and religious/spiritual approaches to manage their depression. One supported integrating strategies suggested by a religious/spiritual healer with using medication; whereas, the other did not consider such integration to be part of her treatment plan.

Religious/spiritual SMS

The third theme of religious/spiritual strategies included: (a) having faith in God, and (b) ways of connecting with God. All women shared how they incorporated religious/spiritual strategies to either manage and/or prevent depression. Moreover, women shared their valuable perspectives about the frequency and effectiveness of using religious/spiritual SMS.

Faith in God

Faith in God was viewed as a (i) source of healing, contentment and ease, (ii) source of help, and (iii) sense of hope. With respect to a source of healing, contentment and ease, religion/spirituality guided women to be happy with God's will. For example, one stated, "Everything is on him, if he gives then he takes it away. Illness, happiness everything is from him. I just have to try." Hence, their struggles with depression and the consequences of implementing strategies to relieve depression were considered to be the will of God. Consequently there was a sense of relief from the stress associated with whether strategies would be helpful or not. The perspective that God only gives as much struggle as one could handle and would never give more than one can tolerate created a sense of contentment and ease. Women noted that it was because of God's blessings that the condition was tolerable. Faith in God as a source of help encompassed the idea that God had the power to solve all problems; therefore, God was the one who helped now and in the future. Hence, there was considerable reliance on faith in God. For example, one woman shared, "…in this world God is almighty and one has to have a faith in him, if you have the faith in God then you

would be able to use all these strategies." Faith in God created a sense of hope, "I am going to get better." This perspective was of particular relevance when women viewed depression as hopeless. Having a sense of hope gave them courage to speak to God, "…I can do it". Moreover, such a perspective prevented them from getting involved in self-harm activities such as suicide. For example, one woman shared that harming herself made her feel fearful of God that "…God will punish me, why are you doing it I gave you a life why you are burning it."

Connection to God

Women shared various ways through which they connected with God including (i) performing prayers, (ii) reciting the holy Qur'an, (iii) talking to God, and (iv) performing a Pilgrimage. Use of the following ways restored or sustained divine connection.

Connecting to God through prayers

Women shared four key aspects related to connecting to God through prayers including (i) performing prayers as a therapy, (ii) performing prayers that may or may not be continued during depression, (iii) performing prayers at certain times as a greater struggle compared to other times, and (iv) more prayers than the obligatory prayers were performed. Eight women viewed the process of praying as a therapy, promoting self-care and bringing a sense of peace. The process of prayers cleansing the body prior to performing themto the actual act of praying was perceived as a way to ensure self-care. Islamic prayers include posturing, similar to yoga, that the women considered daily exercise. With regards to a sense of peace and happiness, a woman shared, "Saying prayers bring peace." Another said, "Mental, meaning my heart is very satisfied. Meaning heart feels better, and meaning the symptom of loneliness reduces." Contrary to its perceived benefits, at times, women exerted great effort to continue performing all five prayers regularly during the acute phase of depression. However, once in the recovery phase, the routine of praying resumed. Nine women struggled to pray regularly during an acute phase of depression due to a lack of interest and ability to fully concentrate, physical discomfort, immobility, fatigue, and medication side effects. For example, according to one, "Sometimes during depression I don't feel like saying prayers at all. Okay if not today I will say it tomorrow." Another said, "For me there is fatigue, I keep lying down, don't feel like doing…." With respect to the effect of medications, one woman reported "…morning prayer, yes… I don't wake up and don't set the alarm, because ….I had taken medicine."

For some women praying at certain times such as morning and evening was a struggle compared to other times of the day. For example, one woman clearly communicated her struggle of perform morning prayers:Performing early morning prayers was difficult due to sleepless nights and the effects of medication which kept me sleeping in the morning…. But you know again during that time I would say that I don't want to miss my early morning prayer. Similarly, evening prayers were difficult for some due to worsening depression at night. Performing all five prayers during depression was a struggle. One shared that she could only pray after her depression improved. However, even during the recovery period, women did not do their prayers regularly. "Sometimes I say five times, sometimes the evening one is left out…, I don't do the evening one with great regularity." Four women found comfort performing more than the five obligatory prayers. For example, according to one, "Saying my prayers had made a difference. My concentration has improved from before, before I could hardly concentrate." Examples of additional prayers included performing Nafils (non-obligatory prayers), and Istaikhara (when one intends to do something important one makes special prayers to receive the goodness of Allah).

Connecting to God through reciting the Holy Qur'an

Nine women described that they used the holy Quran in their daily lives (reciting or listening to the holy Qur'an and reciting Qur'anic verses as tasbih (repetitive utterances of Qur'anic verses frequently to glorify God). For some it was easy, for others it was not and they varied in their duration of recitation. The women made every effort to use the holy Qur'an regardless of whether or not they were depressed. The motivation behind reciting or listening to the holy Qur'an was to remain busy and keep their mind occupied, be spiritually enlightened, redefine illness from a positive perspective, seek help from God to manage life's struggles, re-experience happiness and peace, and heal. Women recited Qur'anic words or verses whenever they remembered to do so, usually after each prayer, before the afternoon nap, and before bedtime. They recited for example, Durood Sharif (specific phrases in praise of Prophet Muhammad PBUM), the first and third Kalmas (words which talk about the fundamentals of Islam), Yaseen Sharif (reading a Qur'anic chapter for blessings), asthaghfar (verse on forgiveness) and La Hawla Wala Quwata Illah Billah (an invocation, a treasure of paradise).

Connecting to God through talking

Six women connected to God through talking, usually at night, to tell God what they desired. This differed from praying in that talking to God (Dua) was not a scripted prayer. Women asked for help in the form of Dua with the conviction that God would listen to them if not immediately then later. Talking to God included topics such as seeking happiness and peace, seeking health and being free from struggles or suffering, punishing those who instigated sufferings, and complaining to God for causing an illness, which they later regretted. Talking to God helped them manage specific symptoms of depression such as loneliness, stress, frustration, lack of sleep and/or loss of interest. For example, for loss of interest, one woman shared, "I do dua (talking to God) that I g*et al*l my interests back."

Connecting to God through performing Pilgrimage

Umrah and Hajj are pilgrimages to Mecca. One of three women performed pilgrimages to both Umrah and Hajj, while the other two performed Hajj only. This was not an on-going strategy since Muslims were only expected, if they could

afford it, to perform a Hajj at least once in a life time. Umrah on the other hand could be performed more than once if financial and travel related concerns could be addressed. Women perceived that performing a pilgrimage empowered them to change their attitudes, outlooks, and priorities in life. God was viewed as the center of existence and the only priority in life. For example, one woman shared that since her pilgrimage she learnt to be happy in God's will. She further described that before performing a pilgrimage she used to get annoyed by people who used to inquire about her not having kids during her five years of marriage. But after pilgrimage, her responses were like, "I started to say God will give.… If he gives then thanks to God and if he doesn't then that is God's decision and will…."

Frequency of using religious/spiritual SMS

There was no format or pattern regarding the frequency to which these women used their religious/spiritual SMS. This depended upon their ability to use their religious/spiritual strategies, such as prayer, at different times of the day. Hence, the women with depression often used similar strategies, but the manner in which they incorporated them in their daily life was individualized.

Effectiveness of religious/spiritual SMS

Women described their perceived effectiveness of specific religious/spiritual SMS in terms of whether they were helpful or not in managing or preventing depression. The perceived effectiveness of the strategies changed over time. For example, women who sought out religious/spiritual healers eventually found them ineffective. Not all religious/spiritual SMS were viewed as equally helpful in managing and/or preventing depression. Faith in God and the performing pilgrimages were viewed as helpful in both managing and preventing depression. Connecting to God through prayers and reciting the holy Qur'an were viewed primarily effective in managing depression. For example, one woman shared her views regarding the managing depression through praying as "Meaning the depression, the thoughts which come won't come, and then my mind would be able to concentrate on religious education and faith." Another woman shared her views about the effectiveness of reciting the Qur'an as "…. Because for me it's a prophet book and it can heal anything and everything."

DISCUSSION

The discussion section highlights unique research findings from each of the three themes. Future implications regarding research, practice, and education are discussed, and finally, the strengths and limitations of the study are identified.

The experience of depression

A unique perspective that emerged from the interviews was depression as a positive as well as negative experience. Viewing depression as a gift from God and a source of reviving faith in God and Islam created an opportunity to learn and grow from their adversity. The perspective of depression as a gift from God is consistent with Muslims views of illness as a positive rather than a negative event because it assists in purifying the body (Rassool, 2000). Nesse (2000) presented the idea that one possible function of depression was to communicate a need for help. This supports the idea that depression motivates women to connect more with their faith, reach out to God, and to continue their use of religious practices. In addition, an understanding that depression could occur in anyone, even in the most fortunate generated deeper level of empathy and understanding. Having these two positive perspectives promoted women's feelings of closeness to God, help-seeking from doctors and use of medications. The women's attitude of continuing to strive for sustaining health and preventing recurrence of illness is consistent with their religious perspective in which maintaining health is viewed as Muslim's spiritual responsibility (Mardiyono, Songwathana, & Petpichetchian, 2011). Lovering (2012) endorsed this idea that in Islam though God pre-determines illness and cure, an individual must try to prevent illness and pursue treatment. Hence, the women's attitude of continuing to use strategies could be a reflection of their religious/spiritual ideals.

Strategy selection

Faith in God was perceived as having the power to heal. In one study with depressed Pakistani women, faith in God was reported to be a factor which assisted women to recover from depression and/or anxiety by decreasing their tension (Naeem, Ali, Iqbal, Mubeen, & Gul, 2004). It is important to understand patients' personal perspectives of healing and sources of healing in general. For Muslim patients, understanding their religious/spiritual beliefs pertaining to illness, healing, and health become critical considerations because for them their religion of Islam offers the basis for such beliefs (Rassool, 2014) and strategies selection. Pakistani women's decisions regarding the selection of strategies were affected by their immediate and extended family and broader socio-cultural contexts which call for health care providers to integrate such contexts. Understanding patients' religious/spiritual perspectives within a broad socio-cultural context would not only assist in providing holistic care but would also assist in successful development and implementation of a self-management plan for people to live a life with recurrent depression.

Religious/spiritual SMS

The religious/spiritual strategies included having faith in God and ways of connecting with God. Religious/spiritual strategies have been studied within the context of a variety of serious and chronic medical illnesses (Koenig, George, & Titus, 2004; Thuné-Boyle, Stygall, Keshtgar, Davidson, & Newman, 2011). For example, Koenig, Pearce, Nelson, and Daher's (2015) found that people with depression and other chronic medical illnesses who have higher baseline religiosity independent of the treatment groups (religiously integrated cognitive behavioral therapy or standard cognitive behavioral therapy) showed increase in optimism over time regardless of the treatment. The role of religious/spiritual strategies is increasingly recognized for its healing role in mental illnesses as well. This study's finding related to religious/spiritual

strategies is one such example. The findings underscored the extensive, valuable, and pervasive contribution of religious/spiritual strategies for managing and preventing recurrent depression, although performing religious/spiritual strategies was not without a struggle during acute depressive phases. The findings of this study lend support the point regarding the importance of using people's religious/spiritual perspectives in the care of mental illness to accelerate remission (Koenig, 2012; Rosmarin, Pargament, Pirutinsky, & Mahoney, 2010). In this study, women's use of religious/spiritual strategies helped them in two ways. The first and most direct way was having faith in God. Faith in God helped women as it made them recognize God's power to solve their problems and created a sense of hope. The literature reported hope as a vital element in recovering from mental illness (Noh, Choe, & Yang, 2008). The notion of faith in God as a source of hope and healing supported what Gadit (2007) described, "The concept of God and faith in 'His' powers can help an individual in times of mental upheaval" (p. 522). The findings of this study suggest the importance of incorporating a global spiritual component in nursing and medical education curricula. The findings also alluded that it was the influence of faith in God that promoted women's belief in their own abilities and directed them to select religious/spiritually driven strategies such as performing prayers, reciting the holy Quran, talking to God, and performing a pilgrimage. All these religious/spiritual strategies were women's ways of connecting with God, although they were not without struggle. Compared to other reported ways of connecting to God, only a few women shared that performing a pilgrimage was a way to manage and prevent depression. This could possibly be due to the financial implications associated with it. All the women in this study reported that praying was a way to connect with God. Prayers having a therapeutic effect support Thoresen, Alex, and Harris's (2002) conclusion from their review of the empirical evidence. McCaffrey, Eisenberg, Legedza, Davis, and Phillips (2004) conducted a national survey in the United States in 1998 and reported that of those who participated in the survey 35% used prayers for health related concerns, 75% used it for wellness, and 22% used it for a specific medical condition. Of all those who used prayers for specific medication conditions, 69% reported prayers to be very helpful. Yet most of the survey participants did not discuss prayers with their doctors. This overall discussion of findings related to religious/spiritual SMS clearly indicates that health care professionals should take the initiative to explore religious/spiritual SMS and their effectiveness in dealing with recurrent depression. In this study, the variations of the frequency of use of strategies clearly indicate the need for health care providers to consider assessing each patient's frequency of using strategies. No other studies reported on the frequency of use of SMS in Pakistani women with depression. However, studies conducted with patients self-managing other conditions such as dyspnea (Christenbery, 2005; Nield, 2000) provided mixed results. Some studies demonstrated variations in the frequency of use of strategies among participants (Nield, 2000) while others did not (Christenbery, 2005). It was beyond the scope of the current study to identify specific factors involved in the variation of frequency of use of a variety of strategies. However, it would be worth exploring in future studies to develop a better understanding about the frequency of use of SMS. The literature, however, indicated several factors involving the variation in the frequency of use of SMS such as perceived effectiveness (Hammond, 1998), perceived burden associated with performing strategies (Weijman *et al*., 2005) better and formally educated about the strategies (Christenbery, 2005), and length of use and trying out multiple strategies (Keysor *et al*., 2003).

The findings related to perceived effectiveness should alert health care providers that they must assess women's this over time as their perceived effectiveness about the use of a particular strategy was not constant. Lastly, future studies should consider exploring a range or continuum of the effectiveness of strategies (Eller *et al*., 2005).

Future implications

This paper provides valuable insights about the role of religion/spirituality in understanding the experience of depression and its management among Pakistani women. It will be important to study religious/spiritual SMS across a variety of populations and genders to test its comparative effectiveness. Further systematic exploration is needed to develop evidence-based clinical practices in mental health care delivery that incorporate religious/spiritual SMS. Such research would inform both health care providers and patients about the relative benefits of using religious/spiritual SMS on an ongoing basis during and after a depressive episode. The findings of this study form the basis for future cross-cultural research regarding religious/spiritual SMS. Findings also have the potential to help mental health care professionals, particularly nurses, expand the way the mental health care of women with depression could be delivered in Pakistan and beyond. It is important to involve, collaborate, and partner with patients to develop a feasible plan of holistic care from which they can effectively execute their daily lives. Health care providers partnering with patients to promote their self-management of depression is a shift from Pakistan's traditional health care delivery system of quickly fixing problems through professional treatment where the provider is on the giving end and patient is at the receiving end. Nursing and medical education and practice requires a conceptual shift focusing on partnering with patients and encompassing religious/spiritual perspectives of patients in their management of chronic mental illnesses. This shift requires that nurses to be taught about such concepts theoretically and be provided opportunities to practice them.

Strengths and limitations

In this study, the credibility (validity) of the findings was derived from the data collection process, by collecting rich data and soliciting feedback with an expert in self-management strategies throughout the data analysis. Coding by two independent reviewers was compared with the investigator's to ensure the reliability of the findings. In addition, throughout the analysis, an effort was made to ensure logic, clarity, and the appropriateness of themes to reach the most plausible interpretations in relation to the study context. Special attention was paid to the reliability of the coding process such

as ensuring that the emergent categories were separate, independent, and mutually exclusive.It is important to report that the data collection and analysis methodologies used to address the research questions were appropriate. Data collected through repetitive semi-structured interviews using an interview guide and using open-ended questions allowed the investigator to react to each individual woman's differences and assisted in obtaining detailed, complex, and interrelated descriptions of women that were deemed relevant and appropriate to the aims of the study. Throughout the interviews, women used religion and spirituality interchangeably. Since the purpose of the study was not to validate the difference between religion and spirituality, the investigator respected women's approach to describing their experiences and ways in which they manage their depression. Moreover, there has been a debate in the literature on the definitions of religion and spirituality (Hill*et al*., 2000) noting that they overlap with respect to experiences, beliefs and values (Mattis, 2002). One limitation was that themes were not validated with women. The sample size was from a recognized private mental health care setting, it is unclear if the findings are transferable and applicable to similar contexts. Women were selected from one of the most recognized mental health care services settings in the private sector, in an urban settlement, known for providing quality mental health care services in Pakistan. The bilingual investigator was involved in transcribing all the interviews in Urdu and translating them into English. Yet there was only one randomly selected interview translated into English by an expert in both Urdu and English. However, the investigator listened to each of the interviews several times and cross checked the English translations with the actual Urdu transcripts as well as back translated three interviews.

Conclusion

Religion and spirituality are the critical lenses through which Islamic women understand their illness and make decisions about how to manage their depression. Pakistan and many South Asian and Middle Eastern countries are homogenous with respect to religion. In Western culture, there is more heterogeneity in religious beliefs and spiritual practices. Since self-management occurs within a cultural context, the norms of the culture influence the options that women have for illness self-management. Although these concepts are relevant in Western culture, it is critical for nurses, in order to provide culturally sensitive care, to understand the unique religious, spiritual, and cultural perspectives that influence how women understand and manage their depression.

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