ORIGINAL ARTICLE

PSYCHOSOCIAL WELL BEING OF URBAN AND RURAL INFERTILE WOMEN

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ABSTRACT

OBJECTIVE
To investigate difference between psychosocial well being through Psychological Wellbeing, Self-Esteem, Marital Satisfaction and Social Support in urban and rural infertile women.

STUDY AND DESIGN
Cross sectional research design

PLACE OF DURATION OF STUDY
This study was conducted at Hameed Latif Hospital, Australian Concept Infertility Center, Medical Center and Jinnah Hospital Lahore in the months of March to April, 2013.

SUBJECTS AND METHOD
A purposive sample of 60 infertile women from rural and urban Punjab with age range of 17-35 years, (mean age= 25.92,SD=3.29) belonging to different socioeconomic status were taken from Hameed Latif Hospital, Australian Concept Infertility Center, Medical Center and Jinnah Hospital Lahore. A demographic information sheet and Urdu translation of Psychological Wellbeing, Self Esteem, Social Support and Marital Satisfaction scales were used.

RESULTS
Independent sample t- test showed that rural women scored significantly low on psychological wellbeing, marital satisfaction, social support and self esteem. Moreover, difference in examined variables across socioeconomic classes was explored through ANOVA which showed that low social economic status was related to low psychological wellbeing, marital satisfaction and self-esteem in infertile women.

CONCLUSION
It was concluded that urban infertile women had better Psychosocial well being than the rural infertile women. Therefore providing support and developing a deeper understanding of the infertility experiences of women can improve their well being. Another conclusion was that the socioeconomic status affects rural infertile women more than the urban infertile women for this purpose a better social structure needs to be developed.

KEY WORDS
Infertility, Psychosocial well being, Urban/rural infertile women.

INTRODUCTION

Infertility is a social issue as well as being a health problem. In clinical setting infertility is defined as failure to ascertain pregnancy within a year after marriage[1]. According to existing studies around 8-10% of couples have some kind of infertility problem and approximately 70-80 million couples worldwide are currently infertile[2,3]. Some other worldwide estimates recommend that approximately 72.4 million couples face infertility problems[2]. It was found that though Pakistan is mainly a populated country the population growth frequency is 2 %. The infertility rate is high i.e. 21.9%. P[rim]ary infertility rate is 3.5% whereas secondary infertility rate is18.4%[2].

Women experiencing infertility also face many problems and dilemmas. An infertile woman becomes a central issue and topic of discussion within her family after some years of her marriage. There are several causes of infertility. The most common condition in case of a quarter of infertile women is due to problems in ovulation[4]. Stress is another agent that causes infertility. Research evidence shows that women with high level of stress stop ovulating which makes them unable to become conceived or be pregnant[5].

Age of female is also an important factor in explaining infertility[6] and so is her weight[7]. Another likely cause maybe of Endometriosis[8]. Other possible factors include smoking, environmental toxicants, sexually transmitted diseases, uterine factors and problems with fallopian tubes[9,10]. Fibroid[11] and exposure to radiation have also been observed as causes[12].

Many psychosocial factors have been linked with infertility in previous researches such as, stress, anxiety, low self-esteem, social support, threat, marital and sexual distress, depression, guilt, anxiety, frustration and emotional and psychological distress[13]. Usually when a couple is diagnosed with infertility they, especially women express emotions such as guilt, deep sadness, loneliness and fear of being anxious and insecure[14]. It is noticed that women experiencing infertility are at greater risk of experiencing psychological problems than men[15].

The factors previous researches found related to infertility are the core ingredients in psychosocial well being. No research is available upon the comparison of these factors between rural and urban infertile women. current study was designed to investigate psychosocial well being through Psychological Wellbeing, Self-

Esteem, Marital Satisfaction and Social Support in urban and rural infertile women.

SUBJECTS AND METHODS

Participants

Sixty infertile women, 30 from rural and 30 from urban areas from within and outside of Lahore were included. All the participants were accessed in public and private hospitals of Lahore. The age range of the participants was 17-35 years. Only those women were included in the sample that were diagnosed with primary infertility, who did not conceive within two years of marriage and who were undergoing infertility treatment. Secondary infertile women and those not undergoing any infertility treatment were not included in the study.

Instruments Four scales were employed for gauging the respondents' psychosocial well being through psychological well being, self esteem, social support and marital satisfaction along with the demographic sheet to gather information regarding the participants' age, area of residence, years of marriage and socio economic status.

The Ryff scale of Psychological Wellbeing[16] is a 54 item scale used to measure person's Self-Acceptance, Purpose in Life, Autonomy, Personal Growth, Environmental Mastery and Positive Relationships.

Self-Esteem scale[17] is a one dimensional, 10 item scale used to measure self-worth of an individual. The internal consistency of the self-esteem scale ranges from .77 - .88 and test retest reliability ranges from.82-.85.[17] Multidimensional scale of Perceived Social Support (MPSS)[18] was designed by Zimet, Dahlem, Zimet and Farley in 1998. This scale consists of 12 items. It is used to measure how a person perceives their social support system from their family and friends. MPSS demonstrated good test-retest and internal reliability. The range of coefficient alpha for MPSS and its subscale ranges from .85 - .91 and the test retest reliability was found to be .72 – 85[18]. Enrich Marital Satisfaction Scale[19] comprises of 12 categories which are timeout activities, economic executive, sexual association, problems in behavior, religious orientation, parenthood and offspring, interaction, friends and family, idealistic distortion, marital contentment, managing economic issues and equalitarian roles. The alpha coefficient of this scale is .92 and the test retest reliability of the scale is found to be.92. The internal reliability shown by Cronbach's alpha is .86.[19]

Instruments

Internalized Stigma of Mental illness Scale (ISMI)[18]

The ISMI is a 29-items 4-point Likert self-report scale. It is comprised of five sub scales: alienation, stereotype endorsement, discrimination experience, social withdrawal ad stigma resistance. Higher total scores indicate higher levels of internalized stigma. It has high internal consistency (alpha=0.90) and test-retest reliability (r=0.92). For present sample Cronbach alpha is .93 and .87, .81, .85, .88, and .52 for the alienation, SE, SW, DE and SR subscales respectively.

A demographic sheet consisted of information related to age, gender, education, occupation, marital status, family structure, total monthly income of the family, type of mental illness, duration of mental illness, duration of psychological or psychiatric treatment of the problem, and history of mental illness in the family was also administered.

Procedure

Marital Satisfaction Scale and Self-Esteem scale were translated for this study. Permission was obtained from the concerned department of the sampled hospitals. The under treatment respondents were approached, after informed consent was taken, they were given brief instructions and were requested to fill out the demographic sheet and the scales. The purpose of the research was explained to them along with the assurance of maintaining confidentiality. The respondents were thanked for their participation after completion of instruments. Scoring was carried out according to the given procedure for each scale.

RESULTS

Results showed that 5% of the respondents lied in the age range of 16-20, 47% of the respondents lied in the age range of 21-25, 39 % were in the category of 26-30 and 9% were in the age ranges of 31-35. A significant segment 75% had been married for 1-5 years, 24% had been married for 6-10 years, and .only one woman had been married for 16-20. 24% of the respondents belonged to upper class whereas 43 % women lie in middle class category and 33% women lie in the lower class category.

Table 1
Descriptive of Demographic Variables

C	F	%
Age		
16-20	2	3.33
21-25	29	48.3
26-30	24	40
31-35	5	8.33
Year of marriage		
1-5	45	75
6-10	14	23.3
11-15	0	0
16-20	1	1.6
Socio economic status		
1(upper class)	20	33.3
2(middle class)	20	33.3
3(lower class)	20	33.3

Table 2
Group differences between Wellbeing, MS, SE and SS

	Urban women		Rural women			
Measures	*M*	*SD*	*M*	*SD*	*t*	*P*
Wellbeing	222.20	27.63	189.47	20.87	5.17	.000
Marital Satisfaction	57.63	5.23	48.09	10.49	4.45	.000
Self Esteem	19.83	3.14	14.07	3.38	6.84	.000
Social Support	1.26	.21	.93	.188	6.22	.000

df=58, p< .001

Independent sample t test showed that there was a significant difference between the Well Being, Marital Satisfaction, Self Esteem and Social Support of urban and rural infertile women. The psychological WellBeing of infertile urban women (M=222.20, SD= 27.63) was significantly better, t=5.17, p < .001, than rural women (M=189.47, SD=20.87). It also revealed that the differences in the scores of Marital Satisfaction of urban infertile women ((M=57.63, SD=5.23) and rural infertile women (M=48.09, SD=10.49) were significant t=4.45, p < .001. Moreover, differences in the scores of Self-Esteem between urban women (M=19.83, SD=3.14) and rural women (M=14.07, SD=3.38) were also significant t=6.84, p < .001. The differences on the level of Social Support among urban women (M=1.26, SD=.21) were found higher than the rural women (M=.93, SD=.188), t=6.22, p < .001.

Table 3
Multiple comparisons among Wellbeing, Social Support, Self-Esteem and Marital Satisfaction

Measures	*Upper class*		*Middle class*		*Lower class*		
	M	**SD**	**M**	**SD**	**M**	**SD**	***Tukey Post hoc***
Well Being	222.4	24.3	200.6	31.2	192.6	23.3	3<2<1
Social Support	1.32	.167	1.01	.266	.96	.171	3<2<1
Self Esteem	19.80	2.80	16.70	4.49	14.3	3.85	3<2<1
Marital Satisfaction	57.31	6.17	51.23	12.08	50.03	8.08	3<2<1

df=58, p< .001

Tukey Post Hoc Multiple comparisons among wellbeing across socio economic status showed that the wellbeing scores of upper class (M=224.35, SD=24.29) are significantly higher than lower class (192.60, SD=23.26) however the middle class (M=200.55, SD=31.15) and lower class (192.60, SD=23.26) are not significantly different. The post hoc comparison using Turkey HSD revealed that social support scores of upper class (M=1.32, SD=.167) and middle class (M=1.01, SD= .266) are significantly higher than lower class (M=.96, SD=.171); however scores of upper and middle class do not vary. The post hoc comparison using Turkey HSD showed that self-esteem scores of upper class (M=19.80, SD=2.82) are significantly higher than lower class (M=14.3, SD=3.85). The post hoc comparison using Turkey HSD revealed that Marital Satisfaction scores of upper class (M=57.31, SD=6.17) and middle class (M=51.23, SD= 12.08) are significantly higher than lower class (M=50.03, SD=8.08).

DISCUSSION

This research has yielded substantial evidence to suggest that significant differences between rural and urban infertile women exist in psychosocial well being in terms of Psychological WellBeing, Self Esteem, Marital Satisfaction and Social Support. Previous studies have produced similar results[20]. Rural and urban socio-cultural context have a significant role in determining the experience of infertility. The very fact that one belongs to areas where there is a general lack of facilities and technology required for the treatment of infertility might be adding to the dissatisfaction, stress, agony, and frustration. This in turn might cause low sense of well being[21]. According to researchers[22] the occurrence of unusual stressors is more in rural women than urban women. They are more vulnerable and exposed to multiple risks of infertility, inferior housing, less able to respond effectively to the risks. In prior researches[23], it was seen that rural women face poor quality of support because support network is not very satisfying and lacks positive outcomes. Studies have also endorsed that either support system is lacking or it is present in a negative way creating isolation and exclusion especially where close net communities are present. Although rural women receive social support from friends and family and it may be valuable but professionals can provide it in a much better way. Lack of health care professionals in rural area creates hindrances in social support for women. The women of rural area are exposed to lack of resources, limited access to treatment and conventional civilizing belief systems[24]. Repercussions of infertility are also seen on married life where infertility is the fault of women or there is a denial of male infertility, all these factors combine to affect the wellbeing of infertile women[25].

CONCLUSION AND RECOMMENDATIONS

Significant differences were found between the Psychological Well being, Marital Satisfaction, Social Support and Self Esteem of rural and urban women which high light the effects of infertility on rural women. There is a need to create awareness, especially in young women, about women's reproductive health issues including infertility. This can be started at as early as at school level to safeguard health and well being of girls and women. Proper awareness and knowledge of such issues might help to reduce stigmas attached to infertility. This in turn can help in minimizing the consequences which women have to face, especially the blame that only women are the cause of infertility. A social structure should be implemented to protect rural infertile women in the shape of holding support programs and campaigns.

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