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Influence of age and locality on coping strategies among Iranian women

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ABSTRACT

The present study is an attempt to assess the influence of age and locality on coping strategies among Iranian women in Esfahan Province. A total of 880 Iranian women randomly selected from Esfahan province for the present study. They were administered coping checklist , which measured coping strategies in healthy cognitive, social support, spiritual related, physical activity related, problem solving, unhealthy coping, and high risk coping. The results were analyzed through One-way ANOVA. Results revealed that in unhealthy coping habits, respondents below 20 years, 21-35 years and 51-65 years found to use more of unhealthy coping habits compared to other age groups. Further, significant differences between women from rural and urban areas in physical activity related, problem solving, and unhealthy cognitive strategies. Social work measures to improve the conditions of women in general have been discussed.

Introduction

Issues of women's independence, employment and participation have been the most important considerations through all historical periods, whether at the time of primitive agricultural innovations by women that started the matriarchal period or at the time of patriarchal period. In view of the fact that jobs are different and are dependent on people's talents, capacities, mental and bodily differences, some jobs are suitable for men and others are suitable for women. But these differences should not make one group inferior to the other.

In most countries, of course, there are such limitations for women and although the number of employed women in those countries has been increased since two decades ago. This increase in the number has not been in synchronization with a just distribution of jobs and incomes between men and women. A study on the skills, development, education and evaluation of men and women's activities in Brazil show that male employee's goals are to achieve higher occupational hierarchy and advancing from one situation to a better one. But women, steadily, remain in the low levels of occupational hierarchy. Because man, as opposed to women, gain experience and learn. By skill, education and development, men have a great future ahead of them (Humphrey, 1987, p. 163).

In the last two decades, issues concerning women have received global attention. It was Boserup (1989) who opened up for the first time a discussion on development and its impact being different on women. She cautioned about the misallocation of resources that often result form non-recognition of roles that women play as key workers in the national economy. In all societies, the development models designed were working within the framework of the dominant patriarchal notions. Hence, the notion that development automatically improves all sections proved wrong. Equally fallacious was the view that development programmes leaves the same impact on men and women.

Coping strategies refer to the specific efforts, both behavioral and psychological, that people employ to master, tolerate, reduce, or minimize stressful events. Two general coping strategies have been distinguished: problem-solving strategies are efforts to do something active to alleviate stressful circumstances, whereas emotion-focused coping strategies involve efforts to regulate the emotional consequences of stressful or potentially stressful events. Research indicates that people use both types of strategies to combat most stressful events (Folkman & Lazarus, 1980). The predominance of one type of strategy over another is determined, in part, by personal style (e.g., some people cope more actively than others) and also by the type of stressful event; for example, people typically employ problem-focused coping to deal with potential controllable problems such as work-related problems and family-related problems, whereas stressors perceived as less controllable, such as certain kinds of physical health problems, prompt more emotion-focused coping.

An additional distinction that is often made in the coping literature is between active and avoidant coping strategies. Active coping strategies are either behavioral or psychological responses designed to change the nature of the stressor itself or how one thinks about it, whereas avoidant coping strategies lead people into activities (such as alcohol use) or mental states (such as withdrawal) that keep them from directly addressing stressful events. Generally speaking, active coping strategies, whether behavioral or emotional, are thought to be better ways to deal with stressful events, and avoidant coping strategies appear to be a psychological risk factor or marker for adverse responses to stressful life events (Holahan & Moos, 1987). Broad distinctions, such as problem-solving versus emotion-focused, or active versus avoidant, have only limited utility for understanding coping, and so research on coping and its measurement has evolved to address a variety of more specific coping strategies, noted below in the measurement section.

The present study is aimed to identify the coping strategies employed by Iranian women, as there is lot of change in the political, economical and other spheres and woman being highly vulnerable due to globalization. There is an urgent need to study coping strategies employed by women as the researcher did not find any supporting study on coping strategies employed by

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Iranian women. Further, the researcher intended to study the influence of age and locality on coping strategies as they would definitely influence coping strategies.

Method

Sample

The sample population is drawn from the entire parts of Esfahan province, that's why, clustering sampling is adopted. To achieve the goal the researcher considered the latest census of year 2006 with regarded the Esfahan province on the basis of three classifications as low, medium and high density of population. Then two provinces from each division and one city and village from each province were selected at random. Due to the statistics 2006 on the city settlement ratio, 76.3 percent of the samples are selected from city dwellers, 23.8% from villages. Table 1 presents the distribution of the sample by age groups.

Tools employed

Coping Checklist (CCL) Rao, *et al* (1990):

Rao *et al* (1986) developed the coping checklist within the transactional perspective for use with an urban Indian population. The transactional model used referred to the individual's 'cognitive and behavioral efforts to manage the internal and external demands of the person – environment transaction that is appraised as taxing or exceeding the person's resources' (Folkman and Lazarus, 1986). Coping behaviors selected for this tool were required to serve one of the following three function- To change a stressful situation, to control the meaning of the situation and to control emotional distress in relation to stresses. Therefore, problem-focused, emotion-focused and appraisal- focused coping behaviors were included in this instrument.

The CCL was comprised of 70 items and the responses were scored in a binary fashion – Yes/No indicative of the presence or absence of a particular coping behavior. The total number of positively-responded to items were summed up to represent the size of the coping repertoire. This procedure assessed the individual's coping patterns or resources in terms of the tendency for use in certain stressful situations (Rao, *et al*1986). The tool was kept open-ended, allowing the individual to report additional coping behaviors. Items that were not relevant to this population were deteleted from the original tool and three commonly rated responses to stress were included. The final version of the adapted tool consisted of 56 items.

Procedure

The data collection on coping strategies was done in a single setting. The required data was collected through administering the tools. The interview was held during the leisure time of the respondents in a free and congenial atmosphere. The researcher informed every respondent the objective of the study and established a rapport with the respondent to collect the required and relevant data. Further, an attempt was made to collect the required secondary data through discussion with the respondents. They were given clear instructions and were asked to give true responses in the sheet provided. Whenever they had doubt in understanding the question, the researcher made them clear by their local language. Once the data were collected, they were verified for completeness and scores were assigned and a master chart was prepared. Later the master chart was fed to the computer, and with the help of SPSS for Windows, One-way ANOVA and 't' tests were employed to see the influence of age and locality respectively on coping strategies.

Results

One-Way ANOVA was employed to find out significant differences between respondents in different age groups as well as in different professions on coping strategies. Age and professions were considered as independent variables, and coping strategies were considered as dependent variables. Whenever, F value was found to be significant, further, Duncan's Multiple Range Test was applied to see which of the means differ significantly from others. Table 2 presents the Mean coping scores of Iranian females in different age groups and results of One-way ANOVA

Influence of age on coping strategies

When age-wise analysis was done for various coping strategies, it was found that only in one component-unhealthy coping habit, significant difference was observed. In rest of the coping strategies-healthy cognitive, social support, spiritual related, physical activity related, problem solving and high risk copings respondents in different age groups had similar scores.

Only in one component of coping strategies, respondents in different age groups differed significantly. In the case of unhealthy coping habits (F=2.39; P=.049), where the mean scores on unhealthy coping habits of the respondents in the age groups of below 20 years, 21-35 years, 36-50 years, 51-65 years and above 65 years were 18.06, 17.72, 17.59, 17.78, and 17.51 respectively. From the mean values it is evident that respondents below 20 years, 21-35 years and 51-65 years found to use more of unhealthy coping habits compared to other age groups.

Influence of locality on coping strategies

Table 3 presents the Mean coping scores of Iranian females in living in Urban and Rural areas. As far as the influence of locality is considered, it was observed that only in 3 components of coping strategies, respondents from urban and rural areas differed significantly, when subjected to Independent samples 't' test. The 't' values obtained for differences between rural and urban area respondents for physical activity related coping, problem solving and unhealthy cognitive coping were 3.226, 1.998, and 2.46 respectively which are all found to be significant either at .05 and .01 level. Further mean values clearly indicated that in physical activity related coping and problem solving, urban sample scored significantly higher than rural sample, whereas in unhealthy cognitive coping, respondents from rural area had higher scores than respondents from urban area. However, no significant differences were observed in coping strategies-healthy cognitive, social support, spiritual related and high risk coping.

Discussion

Main findings of the present study are:

- In unhealthy coping habits, respondents below 20 years, 21-35 years and 51-65 years found to use more of unhealthy coping habits compared to other age groups.
- Significant differences between women from rural and urban areas in physical activity related, problem solving, and unhealthy cognitive strategies

From the above major findings it is clear that women at very young age as well as at very late age use more unhealthy coping habits. The reasons could be women at young age may not be much psychologically mature enough to deal with stress effectively, which may lead to usage of more unhealthy coping habits. Women at very late age also used more of unhealthy coping strategies, being old and may not have much patience, they may resort to usage of unhealthy coping habits.

Further, urban respondents used more of physical activity related coping and problem solving and rural sample used more of unhealthy cognitive coping. Again, since no studies available, one can just reason out like urban females may have higher levels of exposures through media and other sources and rural women may be more traditional, and lack of much awareness they may use more of unhealthy cognitive coping strategies.

A study by (Taleghani, *et al*, 2006) on coping strategies revealed that these strategies associated with adaptation to breast cancer, and despite the number of women with newly diagnosed breast cancer increasing each year, there is no information on how Iranian women cope with breast cancer when compared with women of other cultures. The main themes emerging from this qualitative study included coping using a religious approach (acceptance of disease as God's will; spiritual fighting), thinking about the disease (positive thinking: positive suggestion, hope, intentional forgetfulness; negative thinking: hopelessness, fear, impaired body image), accepting the fact of the disease (active acceptance; passive acceptance), social and cultural factors and finally finding support from significant others.

Understanding how Iranian women cope with distress is important to social workers and psychologists involved in the process of counseling and guidance. The majority of strategies used by Iranian women were positive, and religious faith played a major role in this. The findings of the study can be used to design a approach to improve successful coping in Iranian women suffering from wide variety of distress.

Here are 5 simple techniques to help manage stressors and cope more effectively. One has to try the suggestions immediately when a person becomes aware of feeling tense, overwhelmed or anxious. These tips will hopefully normalize the stressful experience and give some quick and easy options when feeling overwhelmed.

1. Deep Breathing
2. Go for a Short but Brisk Walk
3. Decrease Caffeine and Sugar in your Diet
4. Go to Bed Earlier
5. Sing or Play

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Table 1: Distribution of the sample by age groups

Age groups (in years)	Frequency	Percent
Below 20	48	5.5
21-35	287	32.6
36-50	372	42.3
51-65	73	8.3
Above65	100	11.4
Total	880	100.0

Table 2 Mean coping scores of Iranian females in different age groups and results of One-way ANOVA

Coping startegies	Age groups	Mean	S.D	F value	P value
HEALTHY COGNTITVE COPING	Below 20	52.63	10.80	1.221	.300
	21-35	52.40	10.57		
	36-50	53.42	12.82		
	51-65	50.16	13.95		
	Above 65	52.03	13.27		
SOCIAL SUPPORT COPING	Below 20	16.19	3.72	.941	.439
	21-35	16.34	3.71		
	36-50	16.74	3.30		
	51-65	16.62	3.28		
	Above 65	16.91	3.04		
SPIRITUAL RELATED COPING	Below 20	19.56	4.66	1.429	.222
	21-35	18.21	5.75		
	36-50	18.39	5.76		
	51-65	18.38	5.42		
	Above 65	19.49	5.48		
PHYSICAL ACTIVITY RELATED COPING	Below 20	18.75	5.23	1.105	.353
	21-35	19.91	5.06		
	36-50	19.40	4.87		
	51-65	19.38	4.49		
	Above 65	18.99	4.54		
PROBLEM SOLVING COPING	Below 20	18.25	5.14	1.436	.220
	21-35	18.20	3.96		
	36-50	17.53	4.00		
	51-65	18.38	4.03		
	Above 65	17.91	4.62		
UNHEALTHY COPING HABITS	Below 20	18.06	0.98	2.390	.049
	21-35	17.72	1.22		
	36-50	17.59	1.25		
	51-65	17.78	0.99		
	Above 65	17.51	1.27		
HIGH RISK COPING	Below 20	11.54	6.42	.439	.781
	21-35	11.52	6.35		
	36-50	11.33	6.21		
	51-65	11.25	5.72		
	Above 65	12.24	6.92		

Table 3 Mean coping scores of Iranian females residing in urban and rural areas and results of Independent samples't' tests

Coping strategies	Locality	Mean	S.D	't' value	P value
Healthy cognitive	Rural	53.15	12.45	0.723	.470
	Urban	52.45	12.11		
Social support	Rural	16.56	3.13	0.144	.885
	Urban	16.60	3.53		
Spiritual related	Rural	18.80	5.41	0.837	.403
	Urban	18.43	5.72		
Physical activity related	Rural	18.54	4.54	3.226	.001
	Urban	19.78	4.96		
Problem solving	Rural	18.40	4.61	1.998	.046
	Urban	17.75	3.97		
Unhealthy cognitive	Rural	17.85	1.15	2.460	.014
	Urban	17.61	1.23		
High risk coping	Rural	11.95	6.34	1.172	.242
	Urban	11.36	6.29		