SSRG International Journal of Humanities and Social Science
ISSN: 2394 – 2703 /doi:10.14445/23942703/IJHSS-V8I1P109

Volume 8 Issue 1, 61-68, Jan-Feb, 2021
2021 Seventh Sense Research Group®

Problem Solving Orientation, Religious Coping and Depressive Symptomatology among Military Personnel Participated in Boko Haram Fight in Nigeria

Mahmood Danasabe[1], Auwal Yahaya[2], Mohammed Ibrahim Bello[3]

[#]*Psychology Department, Federal University Gashua Yobe State, Nigeria*
[*]*Nursing Department, State College of Nursing, Bauchi State, Nigeria*
[#] *Midwifery Dept. Abubakar Tafawa Balewa University Teaching Hospital, Bauchi. Nigeria*

Abstract *- Military personnel are human beings facing numerous problems but very resilient because of their training. Depression is one of the grievous consequences of the problem. Individual's orientation to the problem can be constructive or destructive in terms of problem-solving. Religious coping has been implicated in problem-solving ability. This study examines the role of problem-solving orientation and religious coping in relation to depression among the military involves in fighting against Boko Haram in Nigeria. 120 soldiers were randomly sampled from the Shadawanka barrack and the school of armor that willingly participated in the study. Multiple regression and descriptive statistics were employed via SPSS version 21 for the study analysis. The result shows a significant inverse relationship between positive problem-solving orientation (PPSO), positive religious coping (PRC), and depression, while a positive relationship exists between negative problem-solving orientation (NPSO), negative religious coping (NRC), and depression. Meaning that positive religious coping serves to buffer the effects of depression and improves positive problem-solving orientation. This study is implicated for the policymakers in the ministry of defense, health, and all security agencies.*

Keywords — *Depression, Negative Problem-Solving Orientation, Positive Problem-Solving Orientation, Negative Religious Coping, and Positive Religious Coping*

I. INTRODUCTION

Military work is a rigorous profession with rigorous tasks highly adhered to command, obedience, and compliance to order regardless of problems encountered in discharging duties. "Obey before complain" is a phrase people attached to military personnel. Physiologically and psychologically, military personnel are human beings facing numerous problems but very resilient because of their training. Problem is an unpleasant or unwanted instance that is inevitable in human life. A problem is any present or anticipated life circumstance or task which needs to be responded to for adaptation where the immediate solution was not readily available (D'Zurilla, 1971). Problems or difficult situations may originate in the environment such as the war field, superiority and inferiority complex, high societal expectation with high task or demand, or from within the person that can be intrapersonal or personal. Problem-solving is an act or attempts to overcome a problem depending on the situation and individual differences. Problem-solving aims at changing a situation of difficulties to a better, less emotional distress arises due to conflicts (D'Zurilla & Nezu, 2010).

Problem-solving orientation, on the other hand, is how an individual sees and perceives a problem constructively or destructively in approaching a solution to a problem. Destructive problem-solving orientation is a transition to unresolved problems leading to many psychological problems, such as fear, depression, substance abuse, military combat stress reaction, anxiety, suicide, etc. Such problems, especially depression, weaken an individual problem-solving ability (Rees et al., 2015). Once problems are perceived as negative, they can threaten an individual life and become hopeless. This may be a reason why some of our militaries are committing suicides and homicide, as reported by one of the Nigeria daily papers (Sunday Punch03/08/2020).

Religious coping is away an individual is mobilizing his faith to adjust and solve his problem, especially when the problem is metaphysical and beyond his control. A religious approach to the problem can be positive or negative depending on the person's orientation to such a problem situation.

People with positive problem-solving orientation tend to have positive religious coping, while negative problem-solving orientation is associated with negative religious coping (Abu Raiya, 2010; Carter & Rashidi, 2010). Putting into consideration the observation made by one of the

Nigerian media on military suicides and homicide at the battleground as cited in Sunday Punch newspaper, "worried by the disturbing rate of soldiers killing themselves and their colleagues. The defense headquarters has, therefore, commenced the deployment of psychologists to the battleground in the bid to reduce the suicides and murders among the troop fighting against Boko Haram" (Sunday Punch03/08/2020). It has become imperative on the need of such detrimental report by this newspaper to be investigated. The majority of the Nigerian army have a religious faith that is believed to have control directly or indirectly over their problem-solving. However, no empirical study so far conducted on the role of the religious coping and problem-solving orientation of such military personnel in determining depressive symptomatology that may have advanced effects like suicide or homicide. This forms the basis of examining these concept's relationship among the military. Hence, this study examines the role of religious coping and problem-solving orientation or approach in problem-solving, like depression among the military personnel that participated in the Boko Haram fight.

II. LITERATURE REVIEW

A. Depression

Beck (1972) proposed and defined depression from the cognitive viewpoint. Beck believed that negative automatic thoughts due to irrational beliefs are the causes of depression. These thoughts include beliefs about the self, the world, and the future and lead to automatic negative thought patterns. The same source asserts that depression is linked with self-defeating beliefs; the highest fillings are pessimism, indecision, suicidal wishes, and week inhibition. Depression is detrimental to life if not properly managed. It may have a distressing and fatal consequence, such as killing oneself and others (Wu *et al*., 2012; Gauthier *et al.*, 2010; Hayakawa *et al*., 2012; Tan & Yadav, 2013; Lobato *et al*., 2010; Cheadle *et al.*, 2014; Mann *et al*., 2008). The devastating effects of depression on the well-being of military personnel may be attributed to poor or weakness in their problem-solving orientation. This is because the deficit in problem-solving ability worsened depression and other psychological problems (Cuijpers *et al*., 2012; Gellis & Bruce, 2010). Depression deteriorates an individual's problem-solving, and when depression sets in, the individual is not able to concentrate and solve his own and others' problems (D'Zurilla & Nezu, 2010). Military personnel who have a deficiency in problem-solving orientation are more vulnerable to developing affective mood-related problems because they lack the constructive ingredients required to direct instance conflicts efficiently and effectively (Yen et al., 2011).

B. Problem-solving orientation

Problem-solving orientation (PSO) entails an individual's mental and emotional responses that are stimulating in a difficult situation. It also refers to an individual response to a problem in a way that includes emotional reaction, his general beliefs about the problem, his evaluations of the problem, and his perception of the ability to improve or resolve a problem. Theoretically, soldiers who have a deficiency in problem-solving abilities are more vulnerable to developing depression because they lack the constructive orientation and skills needed to direct initial frustration and family separation effectively, which may result in life stress, depression, and suicidal tendency (Rubin, Allen, & Yu, 2015). Response to a conflict in problem orientation can be positively constructive or negatively destructive. The former is defined as a positive problem-solving orientation **(PPSO),** while the latter is a negative problem-solving orientation **(NPSO)**.

a) Positive problem-solving orientation (PPSO)

This is an optimistic and encouraging adaptive response to problem-solving. It entails an individual's appraisal of a problem as a challenge, not a threat. The individual sees and perceives problems with a constructive view of solving them through positive attempts (Rubin et al., 2015). There are confidence and hope without fear that a problem, in this case, is not irreparable. People with this kind of problem orientation are not afraid of the problem and always see the problem, not as a weakness but a strength. Hence any military personnel with this type of problem-solving orientation is less likely to develop depression late alone thinking of suicide or attempting to kill his colleagues. Many studies have reported fewer depressive symptoms with high positive problem-solving orientation and more depression with less problem-solving orientation (Nasiri et al., 2015; Ranjbar et al., 2013)

b) Negative problem-solving orientation (NPSO)

People, in this case, see and perceive the problem as a threat, worrisome, and with a destructive view of solving it. They are hopeless and afraid of problems as well as becoming miserable at the sight of problems. Negative problem-solving orientation is the maladaptive approach or reaction to problem-solving. Persons under this category of problem-solving see the difficult situation as a threat, not a challenge, doubt their capability and success in controlling conflicts. They can simply become depressed, frustrated, and upsetting

in the face of distress with the inability to endure and withstand disappointment. Hence, the military with this type of problem orientation is more likely to develop depression and commit suicide with less hardship. Negative problem-solving orientation increases depressive symptoms across studies (Yen et al., 2011; Rees et al., 2015).

C. RELIGIOUS COPING

The use of religious teachings (beliefs and practices) to adjust or cope with problems is termed religious coping (Koenig, & AlShohaib, 2014). Religious beliefs and practices lay a crucial role in helping people to handle problems like physiological diseases, destructive anxiety, depression, and stress. Religious coping in the context of this study include:

a) Positive religious coping

Positive religious coping is effective in reducing depression (Abu Raiya, 2010; Carter & Rashidi, 2003). Positive religious coping is a way or strategy in putting faith in divine power and a safe relationship with God, greater meaning in life, and a sense of spiritual links with others. A higher level of religiousness is positively related to positive religious coping and higher hope in life (Sabry & Vohra, 2013; Ball, 2013). Positive religious coping among immigrant Muslims population staying in the U.S.A that escape from the Kosovo war was found positively significant in coping with their stressors and depression (Ai et al., 2003).

Religious beliefs and practices have been utilized as a coping mechanism against depression and anxiety to the sample of University students in Pakistan. Higher levels of religious motivation negatively related to lower levels of depression (Khan & Watson, 2006; Abu Raiya et al., 2008; Carter & Rashidi, 2010). For example, religious people performed different methods to adjust or cope with life problems. These include believing in destiny, considering that problem is a test from God to deepen faiths, putting trust, and believing that only God can solve the problem and no problem exists in the world without a solution. Other ways of religious coping involve religious practices like a recitation of Holy Books, supplications, prayers, and give charity and love to relatives and one another (Hamdan, 2008; Carte & Pargament, 2008; Abu Raiya, 2005).

b) Negative religious coping

While positive religious coping has been found to be a source of relief, support, and care, it is also argued as a source of worry when it becomes negative as religious struggles. Negative religious coping (NRC) or negative religious struggles can be referred to as an expression of conflict, questioning, and doubting about the issues of beliefs, God, and anything to do with the matters of religion (Pargament, 2007; McConnell et al., 2006). Three types of religious struggle exist, which includes divine, intrapsychic, and interpersonal (Abu Raiya Pargament, 2010). Divine struggles refer to tension in the individual's relationship with the divine. This tension might be manifested in questions about the benevolence and power of God, feelings of divine abandonment, and anger toward God. Intrapsychic religious struggles are characterized by questions and doubts about religious beliefs and issues, such as the belief in the afterlife and conflicts between religious teachings and human impulses and appetites. Interpersonal religious struggles include religiously-related conflicts with family, friends, and institutions.

D. Religion and depression

Numerous studies implicated religion as a protector to depression (Ai, Huang, Bjorck & Appel, 2013; Cheadle *et al.*, 2014; Mann *et al.*, 2008; Walpole, McMillan, House, Coltrell & Mir, 2013; Regus, 2012).), but very few found religion as a risk to depression (Hamdan & Tamin, 2010; Hamdan, 2008). Pierce (2012) has indicated that some life problems and purpose of living related to negative thoughts expressed from the religious beliefs cannot be sufficiently overcome without putting into consideration some region beliefs. For this reason, any soldier who has a destructive orientation to a problem due to dysfunctional or irrational beliefs may have religious struggling that may equally be threatening his life to depression or suicidal tendencies (Propst *et al.*, 1992; Sabry & Vohra, 2013; Ball, 2013). Religious coping refers to the use of religious beliefs or practices to cope with stressful life situations

Studies have shown that religious beliefs are rapidly growing worldwide with a higher rate of emotional problems like anxiety and depression among those believers as well as having little or non-effective mechanism like positive problem orientation towards solving such problem. Additionally, very few empirical studies were carried out in order to test the effectiveness of religious coping among military personnel, especially in this part of the world (Nigeria). Studies on religious coping combined with an individual's problem-solving orientation among military professionals are lacking. This study examined the relationship between religious copings: positive religious coping (PRC), negative Islamic religious coping (NRC), problem-solving orientation: positive problem-solving orientation (PPSO), negative problem-solving orientation (NPSO), and depression among military personnel that participated in Boko Haram fight.

The main objective of this study is to examine the role of problem-solving orientation and religious coping in depression and also to further find out whether individual differences in the use of religious coping strategies would decrease or increase the symptoms of depression.

hypothesis

- It is hypothesized that positive religious coping serves to buffer the effects of depression and improves positive problem-solving orientation.
- Negative religious coping aggravates the symptoms of depression and increases negative problem-solving orientation

III. METHODOLOGY

This is a cross-sectional correlation study that examined the relationship between five variables. These variables are Religious coping with two dimensions (PRC & NRC), Problem-solving orientation with also two dimensions (PPSO & NPSO) as independent variables, and depression (DP) with one dimension as the dependent variable. The participants of this research are any soldiers that participated in the Boko Haram fight, and most of them were obtained from the school of armor and shadawanka barrack in Bauchi after getting approval from the authority. The barrack consists of many departments that run military operations and training.

A. Samples and Procedure

The participants were obtained through simple random sampling. About 181 soldiers who participated in the fight were contacted screened for depression, but only 142 met the diagnostic criteria for depression using CES-D depression and symptoms compared with the diagnostic and statistical manual for mental disorders (DSM IV) (APA, 2013). All the 181 screened met the criteria for this study. The questionnaires were collectively distributed to this number (181) in their various offices and houses as well as in some of their recreational places with the assistance of some friends that were also colleagues to the participants. These questionnaires were followed-up by the researcher, and clarifications were made to some that have one problem or another in filling the questionnaires. 120 (66.3%) questionnaires were returned and useful and provide valid responses for this study. 12 (6.6%) were not returned, and 10 (5.5%) were rejected due to damaged. The distribution and collection of the questionnaires lasted for 21 days (2^{nd} - 22^{nd} June 2020)**.**

B. Instruments

a) Center for Epidemiological Depression Scale (CES-D)

The depressive symptoms were measured by the Center for Epidemiological Depression Scale (CES-D; Radolf, 1977) was employed in measuring depression in this study. The scale has 20 items ranked on the 4-Linkert scale from 0(R = Rarely), 1(S=Sometimes), 2(M=moderately number of time), and 3(MT = most of the times). An example of the items is "I was bothered by the things that usually don't bother, "I felt fearfull. The CES-D scale has high internal consistency, test-retest reliability of 90% among the patient population and 85% in the general population (Radolf, 1977). The Cronbach 's Alpha coefficient in this study is 73%. Scores range from 0 to 60, with high scores indicating greater depressive symptoms. The optimal cut-off scores varied between 16 and 24. In this study, a cut-off score from 16-23 indicates mild depression, 24-35 moderate depression, and from 36 and above severe depression.

b) Social Problem-Solving Inventory-Revised Form

The dimensions of the problem-solving orientation that is the positive problem orientation (PPSO) and negative problem orientation (NPSO), were measured by the Social Problem-Solving Inventory-Revised, Short Form (SPSI-RF) developed D'Zurilla, Nezu, and Maydeu-Olivares, (2002). The scale of the two dimensions consists of 10 items with 5 items per dimension. Each item is rated on a Likert scale ranging from 0 (not at all true of me) to 4 (extremely true of me). The sum of the scores on the items for each component constitutes that scale's total score. This research used only positive problem-solving orientation (PPSO) and negative problem-solving orientation (NPSO). SPSI.RF has been used widely in researches across different populations with good reliability. Example, internal consistency of alpha Cronbach's reliabilities for PPSO: $\alpha = .76$ and NPSO $\alpha = .91$ (Vasilevskaia, 2010), PPSO: $\alpha = .76$ and NPSO: $\alpha = .80$ (Emam, 2013). In this study, the Cronbach's alpha reliability for the two dimensions is PPO, $\alpha = .808$, and NPO, $\alpha = .849$.

c) Psychological Measure of Islamic Religiousness.

The two dimensions of Religious coping, that is, Positive religious copping (PRC) and negative religious coping (NRC), were measured by the psychological measure of Islamic religiousness (PMIR) developed by Abu Raiya (2008). The scale has 7 items for positive religious coping and 6 items for negative religious coping. The 7 items in Positive religious copping (PRC) ranked on a 4-Linkert scale from 1(I do not do this at all), 2 (I do this a little), 3 (I do this medium amount), and 4 (I do this a lot). An example of the items is when I face a problem, I look for a stronger connection with God" or I seek God's care. Higher scores reflect more of the construct, indicating higher positive religious coping. The Cronbach's alpha coefficient of the construct in this research is 76%. The 6 items of negative religious coping (NRC) ranked on a 5-Linkert scale from 0 (never), 1 (rarely), 2 (sometimes), 3 (often), and 4 (very often). An example of the items is "when I face a problem, I find myself doubting the existence of God. Similarly, higher scores reflect more of the construct, indicating higher negative religious coping. The Cronbach's alpha coefficient of the construct in this study is 85%.

Table 3.1 Study Scales, Constructs and their Reliability results

Scales	Constructs	Cronbach Alpha reliability
DP	Depression (PPD)	.89
SPSI-R-SF	Positive problem orientation (PPO)	.80
SPSI-R-SF	Negative problem orientation (NPO)	.84
PMIR	Positive Religious coping (PRC) and Negative Religious coping (NRC)_	.70

C. Analysis

Descriptive statistics and regression analysis via SPSS were used for this study analysis. Descriptive was used for the analysis of means, and regression was used for sorting out the relationship between the constructs.

IV. RESULTS AND DISCUSSION

This research examined the presence of depression and the role of problem-solving orientation (PPSO & NPSO) and Religious copings (PRC & NRC) as predictors to depression among army participants in the Boko Haram fight. The study also finds out whether individual differences in the use of religious coping strategies would decrease or increase the symptoms of depression. We expected negative religious coping to worsen the symptoms of depression over time and positive religious coping with cushioning the symptoms of depression.

Out of 181soildiers screened for depression, 120 (66.3%) scored 16 and above from the scale. This indicated that 120 were depressed using cut-off scores of 16 and above of the Center for Epidemiologic Studies Depression Scale (CES-D). These 120 respondents were further used for descriptive and regression analyses. Therefore, based on this study outcomes, depression was present among soldiers who participated in the Boko Haram fight in Borno, Yobe, and Yola. 62 (51.7%) of the participants scored 16-20, indicating mild depression, 42(35%) scored 20-24 cut off point indicating moderate depression, and 16 (13.3%) have severe depression with 26 and above cut off point as can be seen in Table 4.1 below. It is not astonishing that the Present of Depression among the Soldiers is linked with the Higher Level of NPSO as compared to the level of PPSO as found in the Study.

Table 4.1 Screening outcome for DP at the different cut off scores

CEDS Scores	Depressed	%
≥ 16	62	51.7
≥ 24	42	35
≥ 16	16	13.3

Table 4.2 shows that the negative problem-solving orientation (NPSO) mean score for the soldiers was higher (2.32) as compared to the positive problem-solving orientation (PPSO) mean score of (2.06). This could be the reason for their depression. However, the positive religious coping (PRC) mean score for the participants was higher (2.38) compared to the negative religious coping (NRC) mean score (1.61). This result indicated that soldiers who participated in the war considered and relied on religious coping in problem-solving but weak in how they see or oriented to the problems at hands. The same table indicates that the mean score for depression (1.82) is lower compared to the mean score of the Negative problem-solving orientation (2.32). This shows that the soldiers participated in the fight saw their problems as a threat, not a challenge, which may be the reason why they resort to religious coping more but poor in the application and utilization of religious coping mechanism. This may be highly contributed to the depressive symptoms in this study. This is in line with the findings of Rees et al. (2015) and Shittu et al. (2014) that reported self-harm and suicidal tendency due to depression**.**

Table 4.2 Constructs and their statistical mean and standard deviation

Constructs	Mean	Std. Deviation	N
DP	1.82	.512	120
PRC	2.38	.755	120
NRC	1.61	.699	120
PPSO	2.06	.744	120
NPSO	2.32	.905	120

Table 4.3 shows that there exists a significant negative relationship between positive religious coping (PRC) and depression, but an insignificant negative relationship between positive problem orientation (PPSO) and depression (DP), while a significant positive relationship exists between negative religious coping (NRC) and depression (DP), but insignificant positive relationship between negative problem-solving orientation (NPSO) and depression (DP).

Table 4.3: Multiple Regression

Constructs	Unstandardized coefficient B	Standardized coefficient Beta	T-Value	Sig.
DP				
PRC	-.294	-.432	-5.688	.000
NRC	.277	.378	.4.965	.000
PPSO	-.053	-.077	-1.166	.264
NPSO	.22	.38	.583	.561
R	**R^2**	**Adj. R^2**	**R^2 Change**	**F-Change**
.717	.514	.497	.514	30.356

Dependent Variable DP: df1 = 4. df2 = 155. Durbin Watson

The correlation coefficient between depression and positive religious coping is 0.000. The obtained correlation of coefficient is significant at the **0.05** level of significance. So, as the level of positive religious coping increases, the level of depression decreases among depressed soldiers. A high level of positive religious coping (PRC) is related with a low level of depression (DP) (Yen et al., 2011). The correlation coefficient between negative problem orientation (NPSO) and depression in this study is positively insignificant at 0.561. The obtained correlation of coefficient is insignificant at the 0.05 level of significance. Therefore, as the level of NPSO increases, so as depression increases among depressed soldiers. A high level of NPSO is related with a high level of depression as well. Soldiers with a high level of depression have low positive religious coping and low positive problem-solving orientation toward problem-solving, as shown by the present study.

More also, a significant positive relationship between negative religious coping and depression was obtained. The correlation coefficient between negative religious coping (NRC) and depression is 0.000. The obtained correlation of coefficient is significant at the 0.05 level of significance. This study indicates that soldiers with a high level of negative religious coping were more likely to suffer from depression. As the level of negative religious coping increases, so as the depression increases also. This means that and going by this research findings, the soldiers with a high level of negative religious coping have a higher level of depression and negative problem-solving orientation. These results were supported and in line with previous studies (Rees et al., 2015; Carpenter et al., 2011; Jackson & Dritschel, 2016; Visser et al., 2015; Yen et al., 2011).

The findings of this study show that the Nigerian army fighting Boko Haram are depressed due to low and poor problem-solving orientation and poor religious coping, meaning that their hope for success is low and viewed their problems as a threat, not a challenge. That is why they resort to religious coping, though their surrender to religious coping is insignificant due to their bad orientation to problem-solving resulted in depression. That may be what constituted their suicidal thought and homicide, as reported by Sunday (Punch03/08/2020).

The findings of this study are in line with those studies that indicated the use of religious coping among people with depression to manage their depressive symptoms (Jackson, & Dritschel, 2016; Visser et al., 2015; Yen et al., 2011; Ano & Vasconcelles, 2005; Pargament, Smith, Koenig & Perez, 1998). It is expected that negative religious coping worsens the symptoms of depression, and positive religious coping buffers the symptoms of depression. The assumption that negative religious coping increases depressive symptoms is supported by the result of this study. The result of the study indicates a significant positive relationship between negative religious coping and depression. Participants' levels of negative religious coping during the field period of study were positively and significantly directly related to depressive symptoms. This tallied with the second hypothesis of this study, which means that increased negative religious coping increases the symptoms of depression, while a decrease in negative religious coping decreases the symptoms of depressive symptomatology.

These results support the notion that there is a direct inverse relationship between positive religious coping and depression reduction (Carpenter, Laney & Mezulis, 2011). With regard to the impact of fear, battle, war stress, and depression, the results of this study might redefine the soldier's stressful orientation and situation as an opportunity for mystical growth and see their war situation as God's will, destiny, or trial from God. Difficult circumstances like physical combat on a battlefield or gorilla war as being experienced by the Nigerian army may predispose them to mental problems like depression. Such a situation needs courage and resilience through positive orientation and religious coping strategies toward problem-solving religious coping strategies for adaptation to any depressive conditions. Soldiers who are seriously worried may experience a high level of depression, and they are more likely to turn to precede the use of religious coping.

Participants with positive religious coping see problems as a challenge and have a less negative problem-solving orientation with less symptoms of depression, as indicated by the outcomes of the study. Soldiers with these dimensions, as can be seeing in the result of this study, are less likely to self-harm, homicide, or commit suicide (Rees & Langdon, 2015). While the suicidal tendencies and homicide reported by (Sunday Punch03/08/2020) among the army in fighting insurgency in the northern, eastern part of Nigeria may be attributed to the less positive problem-solving orientation and higher negative problem-solving orientation with the high negative religious coping that pushed the army into depression and depression weaken an individuals' problem-solving ability. An individual with these problems are more likely to commit suicide and homicide (Nasiri, Kordi & Gharavi, 2015; Rees & Langdon, 2015; Ranjbar, Bayani & Bayani, 2013)

Putting into consideration the long time stay in Sambisa forest facing with gorilla war and loneliness from their beloved as reported by some soldiers made them lose hope in the fight. The sudden disappearance or death of their colleagues and friends subjected them to pessimism and helplessness. Some complaints of the future of their families as many of their colleagues have gone living their families in anguish and shattered. The only alternative for adjustment by the army is divinely resorting to God for wonderful intervention. The soldiers that were not utilizing religious coping or perceive religion as irrational or negative tend to

be highly vulnerable to a mental problem, especially depression, as supported by literature (Capenter et al., 2011). The result of this study confirmed this assertion as it can be seeing that soldiers with negative religious coping are showing more symptoms of depression and negative problem-solving orientation. Outcomes of this research were supported by Carpenter, Laney, and Mezulis (2011) which said that the Youth reporting high use of negative religious coping strategies reported more depressive symptoms when faced with stress than youth with less utilization of negative religious coping strategies.

V. SUMMARY AND CONCLUSIONS

A. Summary

This study suggests that soldiers who use religious coping are able to view war stress as an opportunity for positive growth and that this has a positive effect on psychological well-being. Individuals' faith and religious belief simplify the insight of positive sides of stressful conditions to the point that religious adherents believe that their existents are controlled by a divine and destiny. They also believed that undesirable life events happen for a reason and test for opportunities for spiritual growth opportunities. This makes them perceive life events experienced as a challenge and less stressful which at last protect them from depressive symptoms. The outcomes of the present study revealed that soldiers who actively tried to overcome their problems and then turned their situation to God were less likely to experience depression. It was found that positive religious coping and positive problem-solving orientation helped soldiers to adjust to their problems. People that are utilizing religious coping are certainly taking action and leave what is beyond their ability to their faith.

B. Conclusion

Outcomes of this research support the idea that religion is a vital rational orientation influencing the universal understanding and making the reality of life for accepting and adjustment with miseries. This study also established positive evaluation and perception of religious belief and practiced with active religious faith predicted the lower rates of depression.

REFERENCES

[1] Abu Raiya, H., & Pargament, K. I., Religiously integrated psychotherapy with Muslim clients: From research to practice. Professional Psychology: Research and Practice, 41(2)(2010) 181.

[2] Abu Raiya, H., Pargament, K. I., Mahoney, A., & Stein, C., A psychological measure of Islamic religiousness: Development and evidence for reliability and validity. The International Journal for the Psychology of Religion, 18(4)(2008) 291-315.

[3] Ai, A. L., Huang, B., Bjorck, J., & Appel, H. B., Religious attendance and major depression among Asian Americans from a national database: The mediation of social support. Psychology of Religion and Spirituality, 5(2)(2013) 78.

[4] American Psychiatric Association., Diagnostic and Statistical Manual of Mental Disorders (Fifth ed.). Arlington, VA: American Psychiatric Publishing. (2013) 74–85.

[5] Ano GG, Vasconcelles EB. Religious coping and psychological adjustment to stress a meta-analysis. J Clin Psychol. 61(4)(2005) 461-80.

[6] Ball, S., Addressing depression in Muslim communities., (2013).

[7] Carpenter TP, Laney T, Mezulis A. Religious coping, stress, and depressive symptoms among adolescents: A prospective study. Psychology Religious Spiritual. 4(1)(2012) 19-30.

[8] Carter, D., & Rashidi, A., A theoretical model of psychotherapy: Eastern Asian-Islamic women with mental illness. Health care for women international, 24(5)(2003) 399-413.

[9] Cheadle, A. C., Schetter, C. D., Lanzi, R. G., Vance, M. R., Sahadeo, L. S., Shalowitz, M. U., & Sankofa, N., Spiritual and religious resources in African American women protection from depressive symptoms after childbirth. Clinical Psychological Science, 3(2)(2015) 283-291.

[10] Cuijpers, P., Driessen, E., Hollon, S. D., van Oppen, P., Barth, J., & Andersson, G., The efficacy of non-directive supportive therapy for adult depression: a meta-analysis. Clinical Psychology Review, 32(4)(2012) 280-291.

[11] D'Zurilla, T. J., & Nezu, A. M., Problem-solving therapy. Handbook of cognitive-behavioral therapies, 3(2010) 197-225.

[12] D'Zurilla, T. J., Nezu, A. M., & Maydeu-Olivares, A. (2002). Manual for the social problem-solving inventory-revised. North Tonawanda, Multi-Health Systems.

[13] Emam, M. M., Problem-solving orientation and attributional style as predictors of depressive symptoms in Egyptian adolescents with visual impairment. British Journal of Visual Impairment, 31(2)(2013) 150-163.

[14] Gauthier, L., Guay, F., Senécal, C., & Pierce, T., Women's depressive symptoms during the transition to motherhood the role of competence, relatedness, and autonomy. Journal of Health Psychology, 15(8)(2010) 1145-1156.

[15] Gellis, Z. D., & Bruce, M. L., Problem-solving therapy for subthreshold depression in-home healthcare patients with cardiovascular disease. The American Journal of Geriatric Psychiatry, 18(6)(2010) 464-474.

[16] Hamdan, A., Cognitive restructuring: An Islamic perspective. Journal of Muslim Mental Health, 3(1)(2008) 99-116.

[17] Hamdan, A., & Tamim, H., Psychosocial risk and protective factors for postpartum depression in the United Arab Emirates. Archives of women's mental health, 14(2)(2011) 125-133.

[18] Hayakawa, N., Koide, T., Okada, T., Murase, S., Aleksic, B., Furumura, K., & Ohoka, H., The postpartum depressive state in relation to perceived rearing: a prospective cohort study. PloS one, 7(11)(2012) e50220.

[19] Jackson, S. L., & Dritschel, B., Modeling the impact of social problem-solving deficits on depressive vulnerability in the broader autism phenotype. Research in Autism Spectrum Disorders, 21(2016) 128-138.

[20] Koenig, H. G., & Al Shohaib, S., Health and well-being in Islamic societies: Background, research, and applications. Springer., (2014).

[21] Lobato, G., Moraes, C. L., Dias, A. S., & Reichenheim, M. E., Alcohol misuse among partners: a potential effect modifier in the relationship between physical intimate partner violence and postpartum depression., (2012).

[22] Mann, J. R., McKeown, R. E., Bacon, J., Vesselinov, R., & Bush, F., Do antenatal religious and spiritual factors impact the risk of postpartum depressive symptoms? Journal of Women's Health, 17(5)(2008) 745-755

[23] Nasiri, S., Kordi, M., & Gharavi, M. M., A comparative study of the effects of problem-solving skills training and relaxation on the score of self-esteem in women with postpartum depression. Iranian journal of nursing and midwifery research, 20(1)(2015) 105.

[24] Pargament, K. I., Smith, B. W., Koenig, H. G., & Perez, L., Patterns of positive and negative religious coping with major life stressors. Journal for the Scientific Study of Religion, 37(1998) 710–724. doi:10.2307/1388152

[25] Pierce, D., Problem-solving therapy: Use and effectiveness in general practice. Australian family physician, 41(9)(2012) 676.

[26] Propst, L. R., Ostrom, R., Watkins, P., Dean, T., & Mashburn, D., Comparative efficacy of religious and nonreligious cognitive-

behavioral therapy for the treatment of clinical depression in religious individuals. Journal of consulting and clinical psychology, 60(1)(1992) 94.

[27] Radloff, L. S., & Rae D S., Susceptibility and precipitating factors in depression: Sex differences and similarities. Journal of Abnormal Psychology **88**(2)(1979) 174-181.

[28] Ranjbar, M., Bayani, A. A., & Bayani, A., Social problem-solving ability predicts mental health among undergraduate students. International journal of preventive medicine, 4(11)(2013).

[29] Regus, P. J., Postpartum Depression: Standardizing Motherhood? ProQuest LLC. UMI. USA., (2012).

[30] Rees, J., & Langdon, P. E., The relationship between problem-solving ability and self-harm amongst people with mild intellectual disabilities. Journal of Applied Research in Intellectual Disabilities., (2015).

[31] Rubin, Allen, and Miao Yu. Within-Group Effect-Size Benchmarks for Problem-Solving Therapy for Depression in Adults. Research on Social Work Practice (2015).

[32] Sabry, W. M., & Vohra, A., Role of Islam in the management of psychiatric disorders. Indian journal of psychiatry, 55(6)(2013) 205.

[33] Shittu, R. O., Alabi, M. K., Odeigah, L. O., Sanni, M. A., Issa, B. A., Olanrewaju, A. T., & Aderibigbe, S. A., Suicidal Ideation among Depressed People Living with HIV/AIDS in Nigeria, West Africa. Open Journal of Medical Psychology, (2014).

[34] Tan, K. L., & Yadav, H., Depression among the urban poor in Peninsular Malaysia: A community-based cross-sectional study. Journal of health psychology, (2012) 1359105311433908.

[35] Thomas P. Carpenter, Tyler Laney, and Amy Mezulis., Religious Coping, Stress, and Depressive Symptoms Among Adolescents: A Prospective Study: Psychology of Religion and Spirituality May, 16 Advance online publication. doi: 10.1037/a0023155 (2011).

[36] Vasilevskaia, T., Social problem solving as a moderator in the relationship between pregnancy-specific stressors and depressive symptoms (Ph.D. Thesis), Drexel University., (2010).

[37] Visser, M. M, Heijenbrok-Kal, M. H., Spijker, A., Oostra, K. M., Busschbach, J. J., & Ribbers, G. M., Coping, Problem Solving, Depression, and Health-Related Quality of Life in Patients Receiving Outpatient Stroke Rehabilitation. Archives of Physical Medicine and Rehabilitation., (2015).

[38] Walpole, S. C., McMillan, D., House, A., Cottrell, D., & Mir, G., Interventions for treating depression in Muslim patients: a systematic review. Journal of affective disorders, 145(1)(2013) 11-20.

[39] Wu, Q., Chen, H. L., & Xu, X. J., Violence as a risk factor for postpartum depression in mothers: a meta-analysis. Archives of women's mental health, 15(2)(2012) 107-114.

[40] Yen, Y. C., Rebok, G. W., Gallo, J. J., Jones, R. N., & Tennstedt, S. L., Depressive symptoms impair everyday problem-solving ability through (2011).

[41] S. M. Metevand V. P. Veiko, Laser Assisted Microtechnology, 2nd ed., R. M. Osgood, Jr., Ed. Berlin, Germany: Springer-Verlag. 5(3) (1998) 300-320.

[42] J. Breckling, Ed., The Analysis of Directional Time Series: Applications to Wind Speed and Direction, ser. Lecture Notes in Statistics. Berlin, Germany: Springer. 61(1)(1989) 200-220.

[43] S. Zhang, C. Zhu, J. K. O. Sin, and P. K. T. Mok, A novel ultrathin elevated channel low-temperature poly-Si TFT, IEEE Electron Device Lett. 20(4)(1999) 569–571.

[44] M.Wegmuller,J.P.vonder Weid,P.Oberson and N.Gisin, High-resolution fiber distributed measurements with coherent OFDR, in Proc. ECOC'00, paper 11(3)(2000) 109-125.

[45] R. E. Sorace, V. S. Reinhardt, andS. A. Vaughn, ‐High-speed digital-to-RFconverter, U.S.Patent5668842, 20(2)(1997) 300-325.

[46] FLEX Chip Signal Processor(MC68175/D), Motorola, 15(3)(1996) 250-275.

[47] PDCA12-70 data sheet, OptoSpeedSA, Mezzovico, Switzerland.

[48] A. Karnik, Performance of TCP congestion control with rate feedback: TCP/ABR and rate-adaptive TCP/IP, M. Eng. thesis, Indian Institute of Science, Bangalore, India. 7(6)(1999) 450-465.

[49] J. Padhye, V. Firoiu, and D. Towsley, A stochastic model of TCP Reno congestion avoidance and control, Univ. of Massachusetts, Amherst, MA, CMPSCI Tech. Rep. 8(4)(1999) 99-120.

[50] Wireless LAN Medium Access Control (MAC) and Physical Layer (PHY) Specification, IEEE Std. 12(11)(1997) 260-280.