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Personality Traits, Coping Strategies and Social Support in patients with Depression and Anxiety

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Abstract

Present study was aimed to investigate the relationship of personality traits, coping strategies and social support in patients with depression and anxiety disorders. It was hypothesized that (a) there would likely to be a significant relationship between Personality Traits, Coping Strategies and Social Support in patients with depressive illness and anxiety disorders, (b) personality traits would likely to predict coping strategies in patients with depressive illness and anxiety disorders and (c) there would likely to be a gender difference with respect to personality traits, coping strategies and social support in patients with depressive illness and anxiety disorder. The total sample of 140 including 100 with depressive illness (men = 29 and women = 71) and 40 with anxiety disorder (men = 16 and women = 24) were recruited through purposive sampling technique. Self-designed demographic questionnaire, Depression, Anxiety and Obsessive compulsive Scale of Symptom Checklist-Revised (Rahman & Dawood, 2002) were used for screening. Eysenck Personality Questionnaire (Amjad & Kausar, 2001), Coping Strategies Questionnaire (Kausar & Munir, 2004) and Multidimensional Scale of Perceived Social Support (*Zimet, Dahlem, Zimet & Farley, 1988)* were administered respectively. Results revealed significant inverse relationship of personality traits with active practical coping strategies and active distractive coping strategies and social support in patients with depressive illness and anxiety disorders. Likewise, extraversion was the significant predictor of active distractive coping strategy in patients with depressive illness whereas neuroticism was found to be the significant predictor of active distractive coping strategy in patients with anxiety disorders.

Key words: Extraversion, Neuroticism, Coping Strategies, Social Support, Depression, Anxiety Disorders.

Introduction

The personality dimensions have an important effect on anxiety disorders (Anthony & Stein, 2009). There is a concept that personality and coping are both related to the mental health pathology. Some personality traits are more related to the task oriented coping while some personality traits are related to the emotional coping strategies (Uehara, Sakado, Sakado, Sato, & Someya, 1999). Cross sectional studies on the coping and depression suggest that people with depression perceives less social support. Social support proceeds and influences coping, more social support leads to approach coping strategies and would have better functioning whereas less social support would lead to more pathology and depression (Ell, 1996).

Bucu, Guerrero, Pascual and Mateo (1997) described personality as an aggregate of all the individual's traits and characteristics. Personality is determined by a number of traits. Goldman (2000) defines the personality traits as "enduring patterns of perceiving, relating to, and thinking about the environment and oneself and are exhibited in a wide range of social and personal contexts". Personality has certain negative traits like neuroticism, extraversion and psychoticism and recent prospective studies have stressed neuroticism as a premorbid risk factor for depression (Maier, Lichtermann, Minges & Heun, 1992).

Brannon and Feist (2010) defines coping as it is not something that completely eliminates the one's problem in fact it's a strategy that tells how to live with the problem and find better solutions in order to deal with the severity of the problem by staying emotionally and mentally stable. Coping strategies and social support are related to the severity of depressed and anxious patients. Depressed patients mostly use emotion-focused coping strategies.

Freire (2007) showed show that all disorder groups had significantly higher neuroticism means when compared to the control group. Ell's (1996) results indicated that family support is a primary source of patient support and that the impact of illness on families is substantial, underscoring their need for support.

The aim of the present study was to investigate the relationship of personality traits, coping strategies and social support in patients with depressive illness and anxiety disorders. It is the common understanding that man is a social animal and at sometimes in their lives they need some kind of social support. The present study helped the future researchers to know about the level of social support and run some campaign and developed techniques for the improvement of patients with depressive illness and anxiety.

Hypothesis

(a)There will be a relationship in personality traits, coping strategies and social support of patients with depressive illness and anxiety disorders, (b) Personality traits will likely to predict coping strategies in patients with depressive illness and anxiety disorders and (c) There will be gender difference with respect to personality traits, coping strategies and social support among patients with depressive illness and anxiety disorder.

Method

Sample/Sampling strategy

A sample of 140 (age range; 18-65) patients including 100 with depression (29 men & 71 women) and 40 with anxiety (16 men & 24 women) were recruited from the Sir Ganga Ram Hospital (depression =25 and anxiety = 9), Mayo Hospital (depression = 29 and anxiety=9), Jinnah Hospital (depression = 9 and anxiety = 5), Services Hospital (depression = 4 and anxiety = 6), General Hospital (depression = 10 and anxiety = 6), Punjab Institute of Mental Health (depression = 22 and anxiety = 5) and Centre for Clinical Psychology (depression = 1) Lahore, Pakistan through purposive sampling strategy.

Table 1

Demographic Characteristics of the sample

Variables	Men		Women	
	f	%	f	%
Depressive Illness	29	29	71	71
Anxiety	16	40	24	60

Note. N = 100. F: Frequency; %: Percentage

Measures

1. ***Symptom Check List-Revised (SCL-R;*** *Rahman & Dawood, 2002).* Depression scale (24 items), anxiety scale (29 items) and OCD scale (15 items) of Symptom Checklist-Revised were used to screen out the symptoms of depression, anxiety and OCD. The test retest reliability of depression scale for clinical population was 0.96, for anxiety subscale was 0.95, for obsessive compulsive disorder subscale was 0.74. The validity for depression, anxiety, obsessive compulsive disorder, was 0.73, 0.74 and 0.31 respectively.
2. ***Eysenck Personality Questionnaire (EPQ;*** *Amjad & Kausar, 2001).* Urdu translated and adapted version of EPQ (Amjad & Kausar, 2001) was used. It measures extraversion, neuroticism, psychoticism, and lie behavior. It has 90 items and out of 90, extroversion has 21, neuroticism has 23 items, psychoticism has 25 items and lie scale has 21items which is an index of dependability of subject's response. The test-retest reliabilities for above mentioned four scales were 0.89, 0.57, 0.99 and 0.84 respectively. The chronbach alpha of Eysenck personality questionnaire for the present study was found to be .79.

3. ***Coping Strategies Questionnaire (CSQ;*** *Kausar & Munir, 2004).* CSQ measures four dimensions. Active practical coping consists of 16 items, active distractive coping consists of 9 items, avoidance coping consists of 24 items and religious focused coping consists of 13 items. The reliability of active practical coping and active distractive coping is found 0.79, while reliability of avoidance coping is found 0.74 and reliability of religious focused coping is 0.73. In the present study, the Cronbach alpha for this questionnaire was found to be .86.
4. ***The Multidimensional Scale of Perceived Social Support (MSPSS;*** *Zimet, Dahlem, Zimet & Farley,1988).* The scale consists of 12 items. It measures three dimensions of social support; Family, Friends and Significant others. MSPSS has a whole scale reliability is 0.86 and internal reliability of the subscales is ranged from 0.86 to 0.90. Urdu version (Jabeen, 2010) of the MSPSS was used. The Cronbach alpha for this scale in the present study was found to be .88.
5. ***Demographic Questionnaire.*** Self-designed demographic questionnaire was used which elicit details of the participants like age, gender, education, occupation, nature of residence, family system, duration of illness and history of psychiatric illness in the family.

Procedure

Permission from the respective authors for using their Questionnaires was followed by the second step of the study which was to take permission from the administration of the Government Hospitals of Lahore in order to collect sample from that hospitals. 20 participants were selected for the pilot study to check the level of difficulty while administrating questionnaires of the study. After that, main study was done by informing the aim and objectives of the study to the respective participants. Written consent was taken and were assured about the confidentiality of their information and results. They were also provided an opportunity to refer them to any clinical psychologists in case of any distress they were experienced during administration. This was a verbal administration and only those participants were selected who willingly participated in the study. About 15 patients with depression and 23 patients with anxiety were not included in the study as they were not fulfilling the DSM-IV-TR criteria for depressive illness and anxiety disorder. After providing with all the essential information, the researcher screened the patient with the help of Depression Scale of Symptom Checklist-R, Anxiety Scale of Symptom Checklist-Revised and Obsessive Compulsive Scale of Symptom Check List Revised, in about 10 minutes. After collecting personal information on the demographic questionnaire. Eysenck Personality Questionnaire, Coping Strategies Questionnaire, Multidimensional Scale of Perceived Social Support were administerd one after another.

Results

Pearson Product Moment correlational analysis was employed and the results are generated in the table given below

Table 2

Pearson's Product Moment Correlation for Scores on EPQ, CSQ and MSPSS

	Variables	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*	*11*	*12*	*M*	*SD*
1	P	-	-.14	.197	-.46**	-.10	-.16	.062	-.17	-.22*	-.08	-.28**	-.25*	6.27	2.00
2	E	-.09	-	-.25**	.00	.51**	.53**	-.02	.32**	.24*	.43**	.18	.36**	6.08	4.72
3	N	.23	-.43**	-	-.33**	-.23*	-.31**	.14	-.27**	-.10	-.12	-.00	-.09	16.60	2.52
4	L	-.21	-.01	-.04	-	.00	.01	-.16	.07	.09	-.08	.19*	.09	13.26	4.15
5	APC	-.19	.36*	-.51**	.10	-	.71*	.21*	.69**	.39**	.35**	.23*	.41**	148.72	28.07
6	ADC	-.19	.42**	-.62**	-.18	.64**	-	.03	.57**	.34**	.44**	.19	.41**	133.72	27.17
7	AC	.28	-.39*	.52**	.16	-.26	-.39*	-	.22*	.01	-.14	-.04	-.07	172.25	17.68
8	RC	.09	.26	-.13	.078	.31	-.36*	.08	-	.40**	.31**	.67	.32**	167.69	29.38
9	F SS	-.21	.34*	-.36*	-.08	.24	.49**	-.53**	.23	-	.30**	.59**	.80**	4.59	1.80
10	FR SS	-.89	.02	-.20	-.17	.25	.29	-.42**	-.04	.26	-	.29**	.67**	3.12	1.89
11	S SS	-.24	.23	-.43**	.133	.32**	.37*	-.36*	.03	.53**	.39*	-	.83**	3.96	2.16
12	T SS	-.22	.23	-.42**	-.06	.35*	.49**	-.56**	.08	.73**	.76**	.82**	-	3.89	1.51
M		6.20	8.5	15.54	12.90	171.80	150.92	161.67	171.73	5.15	3.79	4.06	4.33		
SD		1.89	5.05	2.73	3.82	24.36	26.92	18.06	25.68	1.54	2.00	1.73	1.35		

Note. N = 140. Correlation for patients with depressive illness are presented above the diagonal, and correlations for patients with anxiety disorders are presented below the diagonal; EPQ: Eysenck personality questionnaire; CSQ: Coping strategies questionnaire; MSPSS: Multidimensional scale for perceived social support; lP: Psychoticism; E: Extraversion; N: Neuroticism; L: Lie; APC: Active practical coping; ADC: Active distractive coping; AC: Avoidance coping; RC: Religious coping; F SS: Family scale of social support; FR SS: Friends scale of social support; S SS: Significant others scale of social support, T SS: Total scale of social support *< *p*.05. **< *p* .01.

Results showed significant inverse relationship between psychoticism trait of personality and social support (family social support, significant others social support and overall social support) which means that lower will be the social support, higher the trait of psychoticism. The trait of extraversion has a significant positive relationship with coping strategies (active practical coping, active distractive coping and religious coping) and social support (family social support, significant others social support and overall social support). There was a significant inverse relationship between trait of neuroticism and coping strategies (active practical coping, active distractive coping and religious coping). Moreover, coping strategies (active practical coping, active distractive coping and religious coping) and social support has significant positive relationship.

Highly significant inverse relationship was found among neuroticism, coping strategies (active practical coping and active distractive coping) and social support (family social support, significant others

social support and total social support). It was also found that neuroticism has positive relationship with avoidance coping strategies. Active practical coping and active distractive coping strategies have positive relationship with social support.

Table 3

Regression analysis for Predictors of Coping Strategies among Patients with Depressive Illness

Coping Strategies				
Variables	B	99% Cl	R^2	ΔR^2
Active Practical Coping			.27	.27
Psychoticism	-.01	-3.45 - 3.11		
Extraversion	.48	1.47 - 4.29		
Neuroticism	-.10	-3.79 – 1.53		
Active Distractive Coping			.32	.32
Psychoticism	-.06	-3.94 – 2.20		
Extraversion	.47*	1.42 – 4.06		
Neuroticism	-.18	-4.44 - .53		
Avoidance Coping			.02	.02
Psychoticism	.03	-2.07 – 2.73		
Extraversion	.01	-.97 – 1.09		
Neuroticism	.13	-. 98 – 2.91		
Religious Coping			.15	.15
Psychoticism	-.10	-5.20 – 2.22		
Extraversion	.25	.00 – 3.19		
Neuroticism	-.19	-5.22 - .79		

Note. * = $p < .05$ (two tailed).

Using the enter method, a significant model emerged: F (3, 96) = 15.247 = p< .01. The model explained 30% of the variance (Adjusted R^2 = .302). Extraversion trait of personality was the significant predictor of active distractive coping strategies among patients with depressive illness.

Table 4

Regression analysis for Predictors of Coping Strategies among Patients with Anxiety Disorders

Coping Strategies

Variables	B	99% Cl	R^2	ΔR^2
Active Practical Coping			.28	.28
Psychoticism	-.07	-6.03 – 4.06		
Extraversion	.75	-1.22 – 2.87		
Neuroticism	-.41	-7.59 - .16		
Active Distractive Coping			.42	.42
Psychoticism	-.04	-5.71 – 4.35		
Extraversion	.18	-1.06 – 3.01		
Neuroticism	-.53**	-9.12 - -1.39		
Avoidance Coping			.33	.33
Psychoticism	.17	-1.99 – 5.25		
Extraversion	-.21	-2.23 - .70		
Neuroticism	.38	-.23 – 5.32		
Religious Coping			.08	.08
Psychoticism	.13	-4.29 – 7.79		
Extraversion	.24	-1.19 – 3.71		
Neuroticism	-.05	-5.14 – 4.13		

Note: $\Delta R^2 = .289$; $R^2 = .289$APC; $\Delta R^2 = .422$; $R^2 = .422$ADC; $\Delta R^2 = .334$; $R^2 = .334$AC; $\Delta R^2 = .084$; $R^2 = .084$RC; β = standardized coefficient beta; Cl = confidence interval; ** = $p < .01$ (two tailed).

Using the enter method, a significant model emerged: F (3, 36) = 8.752 = p< .01. The model explained 37% of the variance (Adjusted $R^2 = .374$). Neuroticism trait of personality was the significant predictor of active distractive coping strategies among patients with anxiety disorders.

Table 5

Gender Differences in Social Support, Coping Strategies and Personality Traits (psychoticism, extraversion and neuroticism) in patients of depressive illness

Variables	Gender	M	SD	t (2-tailed)	P
Social Support	Male	3.879	1.4390	-.048	.503
	Female	3.896	1.5556		
Active Practical Coping	Male	149.03	31.826	.071	.341
	Female	148.59	26.641		

Active Distractive Coping	Male	144.25	29.862	2.544	.445
	Female	129.42	24.958		
Avoidance Coping	Male	168.10	19.983	-1.509	.430
	Female	173.94	16.502		
Religious Coping	Male	165.38	35.296	-.500	.115
	Female	168.63	26.826		
Psychoticism	Male	6.18	1.958	-.295	.743
	Female	6.31	2.031		
Extraversion	Male	6.73	3.453	.886	.085
	Female	5.81	1.966		
Neuroticism	Male	15.77	4.119	-1.709	.046
	Female	16.94	4.141		

Note: M = Mean; SD = Standard Deviation; t (2-tailed) = t-test value; P= Significance level.

Results showed that no significant gender differences were found with reference to personality traits, coping strategies and social support among patients with depressive illness.

Table 6

Gender Differences in Social Support, Coping Strategies and Personality Traits (psychoticism, extraversion and neuroticism) in patients of anxiety disorders

Variables	Gender	M	SD	t (2-tailed)	P
Social Support	Male	4.703	1.1718	1.406	.192
	Female	4.094	1.4441		
Active Practical Coping	Male	169.53	24.540	-.475	.787
	Female	173.31	24.658		
Active Distractive Coping	Male	156.94	29.010	1.290	.367
	Female	145.83	25.074		
Avoidance Coping	Male	157.94	16.740	-1.076	.690
	Female	164.15	18.825		
Religious Coping	Male	160.82	30.161	-2.313	.144
	Female	179.01	19.676		
Psychoticism	Male	1.774	1.774	-.813	.574

	Female	1.988	1.988		
Extraversion	Male	8.10	3.965	-.482	.090
	Female	8.89	5.704		
Neuroticism	Male	15	2.704	-1.026	.550
	Female	15.91	2.756		

Note: M = Mean; SD = Standard Deviation; t (2-tailed) = t-test value; P = Significance value

Results revealed no significant gender differences were found with reference to personality traits, coping strategies and social support among patients with anxiety disorders.

Discussion

In the present study, correlation analysis reveals that personality trait of neuroticism had a significant inverse relationship with coping strategies and social support whereas extraversion found positive relationship with the coping strategies and social support among depressive patients. The findings are consistent with Conner-Smith and Flashsbart (2007) findings as neuroticism predicted problematic strategies like wishful thinking, withdrawal, and emotion-focused coping. Significant positive relationship was also found between coping strategies and social support. These findings were also well relates with the study of Ell (1996) on social networks, social support and coping with serious illness that family support is a primary source of patient support and that the impact of illness on families is substantial and it underscored their need for support. The results of the present study were also correlated to the results of the Fondacaro and Moos (1987) study who investigated social support and coping as they said that in the family context, increases in support were related to increases in problem solving coping among women and to a decline in emotional discharge coping among men.

Results revealed that neuroticism had significant inverse relationship with coping strategies and social support and extraversion had direct relationship with coping strategies and social support. These findings are consistent with the Clark, David, and Susan (1994) study on temperament, personality, and the mood and anxiety disorders that neuroticism appears to be a vulnerability factor for the development of anxiety.

Findings are consistent with the Vollrath, Torgerson and Alnaes (1995) that neurotic traits were negative predictors of problem focused coping and positive predictors of emotional focused coping among psychiatric patients. These findings are also consistent with another Vollrath, Torgerson and Alnaes (1998) findings as he concluded in his study that neuroticism lead to the disengagement coping and it lacks problem solving strategies. t-test reveals no significant gender difference among patients with depressive illness and anxiety disorders. These findings of the study are consistent with the Aranda, Castaaneda and Sobel (2001) findings as it was concluded in his study that no gender differences were found in patients of depressive illness.

Limitations and Suggestions: First limitation of the present study was that sample was collected from government hospitals and no private clinics were visited, so sample is not representative. In the present study, no gender difference was found with reference to personality traits, coping strategies and social support among patients with depressive illness and anxiety disorders so it is suggested that future researchers can probe and investigate this area.

Future Implications: The results of the present study can create awareness among people about the dimensions of personality, coping strategies they mostly used and the social support they received from the society. As it was concluded in the study that active distractive coping was more evident among sample population so efforts can be made in order to develop some interventions for teaching healthy coping strategies in patients. Moreover, the society can also be helped with the findings of the study in a way by arranging workshops and seminars on the social support for the people in order to develop awareness among them. It can also be done by holding campaigns on the role of social support among patients with depressive illness and anxiety disorders.

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