

Coping styles, resilience and emotional intelligence in clinical and nonclinical groups

Abolghasem Yaghoobi^a, Serwa Mohammadzadeh^b, Semko Mohammadzadeh^c

^aAssociate professor of psychology, Bu Ali Sina University, hamedan, Iran.

^bPh.D student of general psychology, Bu Ali Sina University, hamedan, Iran.

^cMaster of Clinical psychology, tamin ejtemaei organization, Iran.

Abstract

The aim of the current study was to compare a clinical and nonclinical group across three psychological factors: coping styles, resilience and emotional intelligence. Participants (N =60) completed the Mississippi post-traumatic stress disorder scale, Connor and Davidson resilience scale, Moos and Billings coping styles scale and Schulte emotional intelligence scale. Results showed there are significant differences in all three psychological factors between 2 groups. Clinical group used emotional coping styles but nonclinical group more used behavioral and cognitive coping styles. Nonclinical group had higher emotional intelligence and psychological resilience scores. The results suggest that these psychological factors can be good protectors against prevention and treatment after exposure.

Keywords: Coping styles, resilience, emotional intelligence

Introduction:

Injury is part of everybody's life. Flood, earthquake, war, torture, accident, rape, etc., are The inevitable events of human life. Unpleasant and damaging events occur frequently. Some times traumatic events overload individual's ability to cope in his or her usual fashion and leads to psychological crisis. Psychological crisis cannot reliably be predicted based on the events that precede them. An event that accelerate a psychological crisis for one person is not necessarily going to accelerate a crisis for another person (National Collaborating Centre for Mental Health, 2005). Nonetheless, some events such as physical attack, torture, rape, automobile accidents, intense personal losses, and natural catastrophes (earthquake, fire and flood) commonly accelerate psychological crisis reactions. When an individual can't

adjust with stressor may meet post-traumatic stress disorder criteria. (American Psychiatric Association, 2013). The diagnosis may be given when a group of symptoms, such as disturbing recurring flashbacks, avoidance or numbing of memories of the event, and hyper arousal, continue for more than a month after the occurrence of a traumatic event (American Psychiatric Association, 2013). Children are less likely to experience PTSD after trauma than adults, especially if they are less than ten years of age. War veterans are commonly at risk for PTSD (Zoladz, 2013). While most people eventually adjust to the after effects of such events, some people find their symptoms getting worse with time. These worsening symptoms are the product of PTSD.

Theoretical models of traumatic stress syndromes and the literature on PTSD have established that there is a wide range of outcomes in how persons cope with traumatic experiences (Bonnano, 2004). In recent decades psychologists and researchers focused on Pre-traumatic psychological factors that play protector role or may be a risk factor for disease. These factors lightly explain why events in one person accelerate psychological crisis but in another person do not.

Coping styles is one of the pre traumatic psychological factors that play an important role in individual perception of traumatic events. Clinical research on coping has attracted a great deal of attention because of its potential benefits to the health and well-being of individuals. Broadly defined, it is the efforts used by individuals to deal with the demands and stresses of life (Herbert, Silver, Ellard, 1991; Wong, 2002).

Resilient individuals have a repertoire of coping skills that help them to adapt to the specific situation. These coping skills allow them to effectively manage stressful situations, thereby transforming the situations into less stressful ones or enabling the individuals to come to terms with aspects of life that are uncontrollable. Furthermore, resilient individuals view change as challenging but inevitable and manageable. This outlook on life makes them less likely to perceive situations as stressful (Aroina & Norris, 2000; Grossman, Cook, Kepkep, & Koenen, 1999; Turner, 2001; Valentine & Feinauer, 1993).

Another psychological factor that is associated with resiliency and effective coping styles is emotional intelligence. The study of emotional intelligence (EI) is relatively new, (Mayer, Salovey 1993) Professionals have approached this subject from different perspectives. These include some significant findings from mental health research (Fernandez-Berrocal, Alcaide, Extremera & Pizarro, 2006; Lomas, Stough, Hansen, Downey, 2012; Mikolajczak, Petrides, Hurry, 2009).

Theoretical basis of research:

Coping styles

useful and adaptive coping styles can moderate PTSD reactions among those experiencing a traumatic event, since training patients in the use of effective coping styles is part of treatment for PTSD (Foa, Davidson, & Frances, 1999). Most coping responses are considered to broadly encompass problem- or emotion-focused coping (Carver & Scheier, 1994; Folkman & Lazarus, 1985). Problem-focused coping is generally viewed as an adaptive mode of coping that involves actively planning or engaging in a specific behavior to overcome the problem causing distress (Folkman & Lazarus, 1985). Emotion focused coping involves attempts to regulate one's emotions, and can be considered active or avoidant (Holahan & Moos, 1987). Active emotional coping, such as venting one's emotional distress or cognitively reframing a stressor's impact, is typically viewed as an adaptive emotion-regulation strategy (Folkman & Lazarus, 1985). Avoidant emotional coping is viewed as maladaptive, for example, using denial or self-distraction to avoid the source of distress (without engaging in problem-focused behavior) (Holahan & Moos, 1987). Although avoidant coping may help individuals manage their day-to-day activities soon after a crisis,

reliance on this coping style over time can lead to mental health problems (Holahan & Moos, 1987); similarly, problem-focused coping in the absence of active emotional coping may be problematic. Little is known about the relationship between specific coping responses and traumatic events, or between coping and PTSD. However, studies have found that emotion-focused coping, especially an avoidant strategy, is generally related to worse overall mental health outcomes (Coyne & Racioppo, 2000).

Psychological resilience

Psychological resilience is defined as an individual's ability to properly adapt to stress and adversity.(APA,2014) Individuals show resilience when they can face difficult experiences and rise above them with ease. Resilience is not a rare ability; in reality, it is found in the average individual and it can be learned and developed by virtually anyone. Resilience is more a process, rather than a trait(Rutter,2008) There is a common misconception that people who are resilient experience no negative emotions or thoughts and display optimism in all situations. Contrary to this misconception, the reality remains that resiliency is demonstrated within individuals who can effectively and relatively easily navigate their way around crises and utilize effective methods of coping(klohn,1996) In other words, people who demonstrate resilience are people with positive emotionality; they are keen to effectively balance negative emotions with positive ones(APA,2014). Resiliency implies strength, flexibility, a capacity for mastery, and resumption of normal functioning after excessive stress that challenges individual coping skills Resilient characteristics (self-esteem, hope, and spirituality) have a significant negative relationship with usage of maladaptive coping strategies (Lazarus&Folkman, 1984; Richardson, 2002).

Emotional intelligence

Another factor that can lead to difference in response to injury is Emotional Intelligence, because emotion is an important component of PTSD. EI can have important role in difference of severity of symptoms. EI is an ability to understand others. Emotion and affect to achieve an emotion that could be effective in help to others (Mayer & Salovey, 1993). EI has been found useful in psychological intervention strategies at school(Petrides, Frederickson, Furnham,2004) and low EI has been linked to behavioral problems such as bullying (Lomas, Stough, Hansen, Downey,2012)EI has also been found to negatively and significantly correlate with depression and maladaptive coping styles among adolescents (Mikolajczak, Petrides, Hurry.2009)In light of correlation between some psychological problems and EI, and the utility of EI in psychological intervention, an examination of PTSD symptoms and their relationship to EI seems appropriate. The impact of war on children's mental health is devastating. Many have suffered from various form of mental disorders and most of them are diagnosed with PTSD. A majority of adolescents exposed to violence during the Gulf War subsequently suffered PTSD and often depression and anxiety(Al-Turkait, Ohaeri,2008).A research results show relationships between emotional intelligence and the severity of PTSD among the refugee children(Ghazali,2014).An individuals with PTSD tend to have lower emotional intelligence((Fernandez Berrocal, Alcaide, Extremera &pizarro,2006).

Research Background

Stewarts (1999) results showed grief is often accompanied with avoidant coping reactions and avoidant coping is one of the best predictors of PTSD.

Many researches showed significant positive relationship between psychological resilience and adaptive coping strategies. For example a research finding showed resilient women utilize adaptive/healthy coping

strategies when faced with adversity and abuse (Grossman, et. al., 1999; Higgins, 1994; Valentine & Feinauer, 1993).

A research finding showed there is relationship between EI and PTSD severity ((Fernandez Berrocal, Alcaide, Extremera & Pizarro, 2006).

Another research showed significant negative relationship between EI and behavioral problems (Lomas, Stough, Hansen, Downey, 2012).

Ciarrochib et al (2001) low EI has relationship with maladaptive coping, higher psychopathology and more severity of PTSD symptoms

Research methodology

The population, sample and sampling

The population of this research is all people referring to Sanandaj Quds hospital who have received PTSD diagnosis. Sampling done with the convenient sampling method (available). 60 (30 PTSD patient and 30 normal cases) participants who agreed to participate in this study and it is a sufficient number for correlational research on a clinical population (Gay, 1996).

Research tools

In this study we used 4 questionnaire:

1-Mississippi Posttraumatic stress disorder scale: Is a self-report scale for assessing the severity of symptoms of posttraumatic stress disorder. The scale has 35 items in five categories: the re -experience and numbness, hyper arousal, withdrawal, self-harm. Some of these symptoms are closely related to DSM criteria for post-traumatic stress disorder. The test of internal consistency coefficient is 0.97, Cronbach's alpha, reliability is 0.66 and 0.73 (Keane, Caddell, Taylor, 1988)

2- Moos and Billings coping styles scale: it measures coping strategies each Subject responses to the scale by choose one of the options never "0", sometimes "1", often "2" and always "3". The range of subjects score will vary between 0 and 57. This scale measures, three cognitive coping style (6 items), behavior (6 items) and avoidance (7 items). The correlation coefficient of this questionnaire with the Lazarus and Folkman questionnaire (1984) is 69/0 (Lazarus & folkman, 1984).

3 Schutte -Emotional Intelligence Scale. The Emotional Intelligence Scale, by Schutte et al (1998) measures emotional intelligence based on Salovey and Meyer model (1990). The scale consists of 33 questions. Five options for a range of scores for each question (strongly disagree) to score five (strongly agree), is intended. In Besharats research (1384) Cronbach's alpha of this scale has been reported 89/0. (Jonker and Volsoo,)

4- Connor and Davidson Resilience scale: The scale includes 25 items and measures the strength to cope with pressure and threats that answered by subjects. A five-point Likert-type (no, low, medium, high and very high) to zero (never) to four (very high) is grading. Resilience minimum score on this scale is zero and a maximum score is 100. Subjects High score in this scale, reflects more resiliency (Connor and Davidson, 2004)

The Analysis of Data

We have used Descriptive statistics (Mean and standard deviation) and inferential statistics such correlation, multivariate regression analysis in entry method.

Research Findings

Mean and standard deviation of variables presented in table1 and The correlation between variables and symptoms severity of posttraumatic stress disorder presented in table2

Table 1: Mean and standard deviation of Coping Styles, resiliency and emotional intelligence and symptom severity in clinical and nonclinical group.

nonclinical		PTSD		variable
S.D	mean	S.D	mean	
1/8	7/96	2/88	15/96	Avoidant coping style
1/7	13	1/5	4/5	Behavioral coping style
1/81	13/5	1/42	4/63	Cognitive coping style
6.75	63/4	2/37	614/6	resilience
6/95	120/3	8/63	75/23	EI
9/4	62/3	13/28	131/4	Symptoms' severity

Table 2: The correlation between variables and symptoms severity of posttraumatic stress disorder

Avoidant coping	Cognitive coping	Behavioral coping	resilience	Emotional intelligence	Symtoms severity	variable
1	0/21	0/21	0/09	0/18	0/93**	Avoidant coping
0/21	1	-0/05	-0/024	0/008	-0/27**	Cognitive coping
0/21	-0/05	1	0/034	0/12	-/03**	Behavioral coping
0/09	-0/024	0/034	1	0/21	0/46**	resilience
0/18	0/008	0/12	0/21	1	0/41**	EI

As seen in Table 2 there is a positive significant relationship ($93/0 = r$), between clinical symptoms PTSD severity and avoidant coping style. And negative correlation ($r = -0/27$) between cognitive coping style and clinical symptoms PTSD severity. There is negative relationship ($r = -0/30$) between behavioral coping styles and symptoms of PTSD severity clinically significant. There is negative relationship ($r = -0/46$), between resiliency and clinical symptoms of PTSD severity. There is negative relationship ($r = -0/41$), Between EI and clinical symptom of PTSD severity

Table 3: Summary Results of multivariate regression analysis, the method of entry

Sig	t	standard	crude		model
		Beta	B	SE	
0/001	7/335	-	84/736	11/552	(constnt)
0/001	13/984	0/954	4/397	0/314	* avoidant
0/073	0/654	-0/045	-0/420	0/642	cognitive
0/082	0/775	-0/056	-9/491	0/634	behavioral
0/031	7/584	0/586	-1/298	0/393	resilience
0/045	5/158	0/406	-1/254	0/252	EI

As Table 3 shows the crude and standardized regression coefficients were converted to “t” number and their significant has been Specified and offers Standardized beta coefficients to assess the contribution of each variable in the model size. Large scores indicate that the one unit change in in predictor variable has an enormous impact on Criterion variable .table3 indicates that if all variables simultaneously are controlled and enter the Equation, Only avoidant coping style ($p < 0/001$), resilience ($p < 0/003$), and EI ($p < 0/04$) significantly are related to the severity of symptoms

Conclusion:

this study found that resiliency, Emotional Intelligence, cognitive and behavioral coping style were significantly negatively correlated with PTSD severity, and avoidant coping style was significantly positively correlated with PTSD severity.

This finding Coordinates to Suarez (2013) that indicates psychological resilience contribute the variance of avoidance symptoms in PTSD. Also Burnett and Helm (2013) showed relationship between PTSD severity and resilience.

Results indicated significant positive relationship between resilient characteristics and adaptive coping strategies, which supports past findings that resilient women utilize adaptive/healthy coping strategies when faced with adversity and abuse (Grossman, et. al., 1999; Higgins, 1994; Valentine & Feinauer, 1993). This explains the current data on use of restraint coping as an adaptive coping strategy.

Psychological resilience were found to have a significant negative relationship with usage of maladaptive coping strategy,

Other finding of this research was negative correlation between EI and PTSD severity

This finding is consistent with Ghazali's finding (2014) that found an inverse relationship between PTSD severity and emotional intelligence in refugee children.

Our finding suggests that as the ability to understand and to use emotion decreases, symptoms of PTSD increase, that consistent with older research on emotional intelligence and other mental illness (Mikolajczak, Petrides AND Hurry, 2009). Individuals with severe PTSD symptoms appear to lack the abilities to understand and to use emotions. Individuals with severe PTSD symptoms cannot use emotions to express their feelings, resulting in trauma that is suppressed. These persons may lack the ability to understand emotions and their meaning and may fail to separate one feeling from another. There are two implications of this finding. First, successful treatment for PTSD need to enhance emotional intelligence; for example, training in identifying, using, and managing emotion. As noted by Goleman(1995), patients can increase their emotional intelligence. It is possible that increasing emotional intelligence among patients may lead to a reduction in PTSD symptoms, a promising subject for Future research.

The findings showed negative relationship between cognitive and behavioral coping styles and PTSD severity

Coping may be a mediating variable between traumatic events and PTSD, as studies have demonstrated that people who experience a traumatic event have a greater risk of developing PTSD (Stewart, 1999)

Trauma theorists and practitioners have at times assumed that virtually all individuals exposed to violent or life-threatening events could benefit from these active coping and professional intervention.

Last finding was positive relationship between avoidant emotional coping style and PTSD severity. This finding consistent with Schnider, Elahi and Gray (2007) that sound avoidant emotional coping is a significant predictor of PTSD severity. Stewart (1999) also found that avoidant coping style is one of the best predictors of PTSD (Stewart, 1999). This latest finding is also consistent with the broader literature demonstrating a reliable relationship between emotion-focused (avoidant) coping and psychopathology (Coyne & Racioppo, 2000). We suggest that the positive correlations between avoidant coping style and PTSD severity indicate a strong association between avoidant coping and these forms of emotional distress. Likely users of avoidant coping strategies more employ a negative emotion to process and avoidant coping, could merely tap the constructs of PTSD (Coyne & Racioppo, 2000).

Although for centuries practitioners have linked violent or life-threatening events with psychological and physiological dysfunction

Practical suggestions:

The research finding showed cognitive and behavioral coping style were significantly negatively correlated with PTSD severity and avoidant coping style was significantly positively correlated with PTSD severity. Psycho education focused on coping styles for PTSD patients can be useful

Psychological resiliency was other variable related to adaptive coping styles and PTSD severity. We can help patients and their families recognize their resilience references .as said sooner resilience can be

learned and developed by virtually anyone. As psychologists we can develop programs that elevate psychological resilience.

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