



History:

Received: Jan 1, 2022

Revised/Accepted: March 10, 2022

Published: March 28, 2022

Collection year: 2022

Status: Published

Identifiers and Pagination:

Year: 2022

Volume: 7

First Page: 1

Last Page: 10

Publisher ID:

10.21065/2520-5986.7.1

doi:<https://dx.doi.org/10.21065/25205986.7.1>

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Citation:

Ayesha Mubeen et al. Quality of life and
coping strategies in depressive and non-
depressive individuals' Hum & Soc Sci, 2022
vol 7, p 1- 10

Funding:

The authors received no direct funding for this
research.

Competing Interests:

The authors declare no competing interests

Additional information is available at the end of
the article.

Original Research Article

**QUALITY OF LIFE AND COPING STRATEGIES IN
DEPRESSIVE AND NON-DEPRESSIVE INDIVIDUALS**

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ABSTRACT

The present study was compared depressive and non-depressive individual with reference to their coping strategies and quality of life. A purposive sampling technique was used to collect data. A total of 200 (N=200) individuals were taken, 100 with diagnosed depressed patients from psychiatric unit of Multan and 100 taken from general population. Both groups were matched on four demographic variables like age, education, gender, and profession. The Brief Cope Scale and WHOQOL-BREF were used for data collection, to assess 14 coping strategies and quality of life. The independent t-test was used to see the difference between depressive and non-depressive individual and ANOVA was used to compare the groups on the bases of their age differences. Findings of the research show that depressed individual had different score on quality of life and coping strategies scale. Non-depressive individual used less maladaptive coping strategies as compare to depressive individual.

Key words: Depression, Quality of life, Coping strategies

Author contributions: The author have materially participated in the research and in article writing.1. Conception, Study design, data collection& processing, critical review.2 & 4 Conception & study design, data collection & processing.3-4 Data Analysis and/or interpretation.3 Drafting of manuscript.4 Drafting of manuscript, critical review.

ACKNOWLEDGEMENT: We would like to acknowledge the extensive support of Madam Sarwat Sultan Department of Psychology, National College of Business Administration and Economics, Multan Campus, Multan, Pakistan.

INTRODUCTION

Depressive disorders are leading causes of incapacity worldwide (Hays et al., 1995; Wells et al., 1996; Murray et al., 1996; Kessler et al, 2003). When some symptoms of depression do not match with diagnostic criteria then these symptoms or subthreshold depression have also some links with disorder (Hays et al., 1995; Wells et al., 1996; Sherburne et al, 1994). Some efforts like quality improvement programs show significance progress in treatment of depression in primary care settings (follow up periods of 12-28 months) (Baker et al, 2000; King et al, 2002; Katon et al, 1995; Simon et al, 2001; Hunkeler et al, 2000 Rost et al, 2001; Von et al, 1998). Mostly, these programs of quality improvement are interested in depressive disorders instead of sub threshold depression (Katon et al, 1995; Katon& Robinson 1996; Hunkeler et al, 2000; Rost et al, 2001; Von et al, 1998; katon et al, 2002; Rost et al, 2002; Liu et al, 2003). Some studies suggest that the treatment effectiveness for sub threshold depression is not beneficial because the proper treatment is not designed for this group but some studies had different view that this is useful for sicker patients (Miranda et al, 1994; Barrett et al, 2001; Williams et al, 2000; Wells et al, 2000) . Patients with sub threshold depression have a high natural retrieval rate (Katon et al, 1995), but these patients may have some other threats like short-lived, long-lasting symptoms of depression and they may have episodes of depressive disorders (Wells et al, 1992; Judd et al, 2002; Judd et al, 1998). Though, response to treatment or to programs of quality improvement in the long-term follow-up data is limited.

Quality of life is a life style that people adopt according to their social and cultural values that is linked with their interests, life goals and desired values (Barbot, 2001). The term quality of life also explains the patient-reported outcome, that how an individual adopts his/ her health condition and what ways of treatment he/she adopts. The understanding of health condition is a significance aspect for the individual and also for researcher in clinical treatment. The researchers measured the QOL to associate different groups of people on the basis of their performance. Sometimes it would be different, researcher study the individual for many years to measure his/ her health condition in clinical settings. Most researchers agreed that it is used to study in clinical settings but others not (Acquadroet al, 2003; Szendeet al, 2005).

The trend to measuring quality of life with reference to chronic problems is greater than before. It is very important to understand the life problems related to material and spiritual aspects that a person faces in many situations and able to cope with these situations. Quality of life is always associated with health conditions that include physical health, mental health, psychological health and environment, so that study the whole life span is important (Mangueira, 2009).

The term coping is usually described as determined exertions to deal with or vitiate the negative impact of stress (Burish& Bradley, 1983). Coping helps the person to deal with strategies not stressful events that decrease the effects of bad feelings and other emotional suffering and also help to deal with depression, the condition which has long term disturbed the mental functioning (Skinner, Edge, Altman & Sherwood, 2003). One such transitional variable might be coping strategies in which people use their all mental and physical abilities without regard to their efficiency or value (Lazarus & Folkman, 1984).

To understand and analyze the coping strategies process, four factor model of coping is used. that include problem-focused coping (planning, active coping,), emotion-focused coping (humor, positive reframing, religion, acceptance), avoidant coping (denial, substance use behavioral disengagement,), and also social coping (instrumental support, emotional support, and venting) ,Nahlen Bose et al., 2015.

Lazarus (1999) stated that coping is a powerful intermediary between stressful encounter and the resulted emotional response and that clarifying the way it operates is fundamental to understanding the individuals' struggle to adapt to life stressors. These confirmations are consistent with our argumentation regarding the importance of coping as a possible intermediate variable in debating the adaptive-maladaptive perfectionism dilemma and emphasize the utility that research on perfectionists'

coping strategies might have, mainly because of the various results that have revealed an important relation between perfectionism and stress (e.g., D'Souza et al., 2011; Hewitt & Flett, 1993). The use of active coping strategies lead to a positive and healthy life as compare the use of avoiding coping strategies. Positive life events also liked positive life style (Paykkel and Cooper, 1992; Sherbourne et al 1995 and Swindle et al, 1989).

MATERIALS AND METHODS

The present study included 200 participants (100 diagnosed depressed patients and 100 non-depressed individuals). Convenient sampling technique was used to collect data from psychiatric unit and from general population of Multan. The education level of participants varied from matric to Post-graduation Scholars. Degree. Age range between 20 to 60 and participants belongs to different professions. Informed written consent was taken from the participants after explaining them the purpose of research.

The Brief Cope

The shorter version of Coping Inventory, the Brief COPE Scale was developed to measure both adaptive and maladaptive coping skills. The Brief COPE was developed based on concepts of coping from Lazarus and Folkman in 1984. The scale was designed to yield fourteen subscales, comprising two items each. The reliability value ranged from .45 to .92 for the original instrument. The Urdu translated version of the scale was used. The Urdu translation was conducted at National Institute of Psychology, Islamabad The scale contained total of 28 items and five subscales. The subscales were Avoidant Coping (10 items), Religious Coping (2 items), Denial (2 items), Positive Coping (7 items) and Problem Focused Coping (7 items). These subscales encompass the fourteen more subscales, which were identical to original tool. Scoring of the scale was on a four point Likert scale scoring: I have not been using it at all (1) – I have been doing this a lot (4). The Avoidant Coping scores range from 10-40. The religious Coping score range from 4-8. The Denial Coping scores range from 4-8. The Positive Coping scores range from 7 to 28. The Problem Focused Coping scores range from 7-28. The higher scores on each subscale indicated higher use of that coping strategy. In another study the reliability values of the Urdu version for different subscales was as follows: Avoidant Coping .63, Religious Coping .65, Denial Coping .65, Positive Coping .59 and Problem Focused Coping .70.

World Health Organization Quality of Life BREF (WHOQOL-BREF)

The QOL was measured with WHOQOL-BREF, an abbreviated version of the WHOQoL-100 quality of life assessment (WHOQOL Group, 1998). QOL scale consists of 26 items and 4 domains which include physical health (7 items), psychological health (6 items), social relationships (3 items) and environment (8 items). It also includes a facet on overall quality of life (2 items). This questionnaire is considered a valid and reliable measure in different populations, including patient samples for assessing their QOL profile (WHOQOL Group, 1998; Skevington et al, 2004). Transformed score range is 4-20. The high score is indicates good quality of life of the individual (WHOQOL, 1995). For this Urdu version of QOL scale, was used, translated by Khan, et al., 2003.

RESULT

Table No 1: Differences in mean, standard deviation and t values for the score of dependent variables in depressive and non-depressive individuals

Variables	Group	M	SD	T	P	Cohens'd
Overall QOL	Depressed	1.7750	.71906	-23.222	.000	3.284
	Non-depressed	4.0700	.67801			
Physical Health	Depressed	2.3257	.64564	-12.877	.011	1.820
	Non-depressed	3.4014	.53014			
Psychological Health	Depressed	2.4117	.57122	-17.263	.000	2.441
	Non-depressed	3.7950	.56201			
Social Relation	Depressed	1.9733	.54160	-25.741	.000	3.640
	Non-depressed	4.1133	.63071			
Environment	Depressed	1.7350	.40564	-26.204	.000	3.705
	Non-depressed	3.8075	.67896			
Self-Distractio	Depressed	1.5700	.559667	-12.867	.004	1.819
	Non-depressed	2.7500	.72648			
Active Coping	Depressed	1.6550	.45889	-23.240	.000	3.286
	Non-depressed	3.3950	.59159			
Denail	Depressed	2.0800	.79047	1.273	.204	0.180
	Non-depressed	1.9300	.87334			
Substance Abuse	Depressed	2.9000	.94281	15.491	.000	2.190
	Non-depressed	1.2150	.54242			
Emotional Support	Depressed	1.4850	.5480	-9.384	.000	1.299
	Non-depressed	2.4550	.90200			
Behavioral Disengagement	Depressed	2.2200	.76976	3.914	.000	0.553
	Non-depressed	1.7700	.85405			
Venting	Depressed	1.7250	.61699	-9.772	.000	1.382
	Non-depressed	2.6600	.73126			
Instrumental support	Depressed	1.4100	.39171	-13.020	.000	1.841
	Non-depressed	2.7000	.91010			
Positive reframing	Depressed	1.4050	.44207	-18.519	.000	1.803
	Non-depressed	3.1200	.81377			
Self-blame	Depressed	2.4850	1.02852	2.739	.001	0.387
	Non-depressed	2.1350	.75830			

Planning	Depressed	1.6200	.48783	-18.809	.000	2.659
	Non-depressed	3.2550	.71948			
Humor	Depressed	1.6200	.56461	-5.270	.000	0.745
	Non-depressed	2.0850	.67814			
Acceptance	Depressed	1.5000	.54123	-14.218	.000	2.0107
	Non-depressed	2.8500	.78012			
Religion	Depressed	1.7000	.51247	-18.288	.002	2.5864
	Non-depressed	3.20509	.64391			

Note: N=200, *p<0.05

Table.2 ANOVA summary of Quality of life

Scales	SS	Df	Mean Square	F	P
Overall IQOL	24.296	2	12.148	7.128	.001**
	335.752	197	1.704		
	360.049	199			
Physical Health	2.628	2	1.313	2.081	.128
	124.325	197	.631		
	126.951	199			
Psychological Health	7.257	2	3.628	4.703	.010*
	151.997	197	.772		
	159.253	199			
Social Relation	22.160	2	11.080	7.930	.000**
	275.242	197	1.397		
	297.402	199			
Environment	8.295	2	4.147	3.044	.050*
	268.396	197	1.362		
	276.691	199			

Note. *p<0.05, **p<.01, p>.05

Table.3 ANOVA summary of coping strategies

Scales	SS	Df	Mean Square	F	P
Self-Distraction	2.957	2	1.478	1.942	.146
	149.923	197	.761		
	152.880	199			
Active Coping	8.127	2	4.063	4.028	.019*
	198.748	197	1.009		
	206.875	199			

Denial	739	2	.369	.528	.590
	137.756	197	.699		
	138.495	199			
Substance Abuse	8.752	2	4.376	3.444	.034*
	250.336	197	1.271		
	259.089	199			
Emotional Support	2.299	2	1.150	1.505	.265
	150.521	197	.706		
	152.820	199			
Behavioral Disengagement	1.889	2	.945	1.338	.265
	139.106	197	.706		
	140.995	199			
Venting	1.435	2	.717	1.063	.347
	132.904	197	.675		
	134.339	199			
Instrumental Support	3.839	2	1.919	2.142	.120
	179.556	197	.896		
	180.395	199			
Positive Reframing	6.773	2	3.386	2.962	.054*
	225.196	197	1.143		
	231.969	199			
Self-Blame	.539	2	.269	.317	.729
	167.241	197	.849		
	167.780	199			
Planning	8.127	2	4.064	3.996	.020*
	200.341	197	1.017		
	208.469	199			
Humor	1.010	2	.505	1.145	.320
	86.889	197	.441		
	87.899	199			
Acceptance	13.382	2	6.691	7.893	.001**
	166.993	197	.848		
	180.375	199			
Religion	11.918	2	5.959	6.972	.001**
	168.381	197	.855		
	180.299	199			

Note. *p<0.05, **p<.01, p>.05

DISCUSSION

It is vital to underscore at this point disabilities in quality of life and social working might be as extraordinary as those connected with other chronic medical conditions (Hirschfeld et al., 2000). It doesn't appear to be, be that as it may, that the diminishment of center symptoms of depression fundamentally deciphers into enhanced quality of life. For example, alleviation of symptoms in

dysthymic patients, social and occupational working regularly enhance (e.g., social working, for example, work, associations with family and life partner, and also sexual conformity). The past researches expressed that depressive people utilized a greater amount of maladaptive coping strategies than non-depressive people and the maladaptive coping strategies intercedes to the psychological stressors and prompts depression (Nemade, 2000). Results of the present study were also showed the same findings. Maladaptive coping strategies like self-blame and substance abuse more used by depressive individual as compare to non-depressive individuals. But self-distraction, a maladaptive coping strategy, frequently used by non-depressive individuals. Adaptive coping styles have shielding effect in dropping the life stress and in return less depression (Horwits,2010)

CONCLUSION

These findings suggest that maladaptive coping strategies are associated with higher levels of depressive symptoms and quality of life decrements in patients with depression. Non-depressive individual mostly used adaptive coping strategies that helped them to enhance their quality of life. In Pakistan patients especially psychiatric has to face lots of problems because of limited awareness of treatment facilities. Therefore, individuals with mental illness are at a high danger of unemployment, disconnection and deferred treatment-looking for, which regularly causes a genuine general wellbeing weight

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