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Coping Styles, Aggression and Interpersonal Conflicts among Depressed and Non-Depressed People

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ABSTRACT

Background: The present study compared people with depressive symptoms and people without depressive symptoms with reference to their coping styles, level of aggression and interpersonal conflicts.

Methods: A purposive sample of 128 people (64 depressed and 64 normal controls) was selected from four different teaching hospitals of Lahore. Both the groups were matched on four demographic levels i.e. age, gender, education and monthly income. Symptom Checklist-R was used to screen out depressed and non-depressed people. The Brief COPE, the Aggression Questionnaire and the Bergen Social Relationship Scale were used to assess coping styles, aggression and interpersonal conflicts respectively. The Independent *t*-test was used to compare the groups. Binary logistic Regression was also carried out to predict the role of research variables in causing depression.

Results: The results showed that level of aggression and interpersonal conflict was significantly more in people with depressive symptoms as compared to control group. On the other hand control group was using more adaptive coping styles than people with depressive symptoms but no difference was found in the use of maladaptive coping styles.

Conclusion: The present findings revealed that coping styles, aggression and interpersonal conflicts play important role in depression. Therefore, these dimensions must be considered while dealing with the depressive patients. Implications for preventive work are also discussed in the light of previous researches.

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Introduction

Presently depression is the most prevalent mental disorder worldwide and is being predicted that by 2020 depression would be the second largest killer disease worldwide [1, 2]. In Pakistan, depression is much more common than other developing countries and is one of the most prevalent psychological diseases. According to one study prevalence rate was 44.4 percent in a survey conducted in a village of Pakistan [3] and according to another study, it was 53.4 percent in city of Lahore [4]. Psychosocial theories proposed that social adversities and stressors lead to depression. Psychoanalytical school of thought says that repressed anger in childhood leads to depression later in life and negative interpersonal behaviors can cause depression. Behavioral school believes that poor personal skills to cope with

the lack of reinforcement in the environment leads to depression. Cognitive school of thought proposes that negative schemas and thinking causes depression [5-7]. All the etiological factors indicate dysfunctionality in a depressed person.

In the previous studies coping styles were reported to be associated with depression; people with depression and people without depression showed marked difference in coping [8-10]. Higher levels of maladaptive coping and lower levels of adaptive coping were strongly associated with higher levels of depression [9, 11-13]. Use of adaptive coping plays important role in buffering the effects of social stressors. Hence, adaptive coping can play important role in saving people from depression [10, 14-16]. Furthermore, many researchers suggest that aggression can turn into depression [17] while other studies conclude that depression turns into aggression afterwards [18, 19]. Whether it is the cause or consequence, aggression is certainly interlinked with depression specifically in youth [20, 21].

Depressive patients tend to have conflicts that are more interpersonal and once depressed their interpersonal conflicts increase too [22-25]. Hence, it can be concluded that a depressive patient is trapped into a vicious cycle of interpersonal conflicts.

The present study was aimed to find out the coping styles, level of aggression and interpersonal conflicts among people with depressive symptoms as compared to control group. The increasing corruption, recession, unemployment and many other social adversities are leading to high rates of frustrations, lack of optimism, depression and suicidal ideation in Pakistani people, especially in youngsters [26-30]. The present researcher assumed that the three research variables would be highly featured in depressed patients of Pakistan, keeping in view the socio economic and socio political factors of Pakistan.

The study contained three main hypotheses. Firstly, the people with depressive symptoms would have lower level of adaptive coping and high level of maladaptive coping than control group. Secondly, the depressed people would have more aggression than non-depressed individuals would. Thirdly, the depressive patients would have more interpersonal conflicts than non-depressed individuals would.

Materials and Methods

Sample

The present study included 128 participants (64 depressed and 64 non-depressed). The sample size was determined by the G power analysis. The Power analysis for independent *t*-test was used; effect size according to Cohen's calculated effect size was medium. The power of the test was taken 80% with 95% confidence interval because it is a recommended level by number of authors. A purposive sampling technique was used to collect data from psychiatric and medicine units of four different teaching hospitals of Lahore. The participants reported the family income ranging from Rs. 2, 000 to Rs. 200, 000 (20.28 US dollar to 2027.80 US dollars) and age ranged between 18 to 35 years. The education level of participants varied from uneducated to master's degree. Informed written consent was taken from the participants after explaining them the purpose of research.

Exclusion Criteria

- Patients with psychotic depression were excluded from the study, as they were not able to respond to the questionnaires of the study.
- Patients with any other co morbid psychological disorders, other than depression were also excluded from the study because their responses could be affected by other disorder.
- Participants with some serious general medical condition were also not selected.

Inclusion Criteria

- Only patients with Major Depressive Disorder were included in the study.
- Depressed patients were screened on depression scale of Symptom Checklist-R (Rehman,

Dawood, Rehman, Mansoor, Ali, 2009) which is based on DSM –IV- TR criteria of Depression, patients were also diagnosed with depression priory by a psychiatrist or psychologist of the hospital [31].

- The control group participants were not having any psychiatric or serious physical illness.
- Participants were selected in the age bracket of 18 to 35 years.
- The participants can read or understand the Urdu.

Measures

The Brief Cope

The shorter version of Coping Inventory, the Brief COPE Scale [32] 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, comprised of 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 [33] 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 [33].

The Aggression Questionnaire

The Aggression Questionnaire [34] assesses the level of aggression and various types of aggression. The aggression questionnaire contains 4 scales: Physical Aggression, Verbal Aggression, Anger, and Hostility. It contained 29 items. Scoring is on 1 to 4 point Likert scale ranging from 1 for least, 2 for mild, 3 for average, and 4 for greatest. Item number 7 and 18 are reversed scored. Minimum score is 29 and maximum is 145. The alpha for the total score indicated considerable internal consistency with the score of .82 for original instrument.

The Urdu translated version of the measures was used in the present study. The Urdu translation of the measure was conducted at National Institute of Psychology, Islamabad [35]. Overall, alpha coefficient of the Aggression Questionnaire was reported to be .75 and for subscales: Physical Aggression .63, Verbal Aggression is .46, Anger Subscale is .43, and for Hostility, it is .64.

Symptom Checklist -Revised

Symptom Checklist- Revised [36] helps to screen out the patients with different disorders. It is an indigenously developed tool in Urdu language. It comprised of six scales, including depression, anxiety, obsessive compulsive, schizophrenia and level of frustration tolerance. The present research used the depression scale only. It has 25 items with the cutoff point of 37 at 2 SD. Validity studies has shown that depression scale has high correlation with the BDI with the correlation coefficient of .73. The reliability studies showed the

concurrent coefficient for Depression scale .88 for normal population and .96 for psychiatric population.

The Bergen Social Relationship Scale

The Bergen Social Relationship Scale [37] assesses the interpersonal relationship problems. It is a six item self-report measure. The responses were on four points scale describe me well (3) to do not describe me at all (0). The scores range from 0 to 18. A higher score indicates higher interpersonal conflicts. Cronbach's alpha for the BSRS was reported to be 0.76. The test-retest correlation was reported to be 0.75. The construct validity of the BSRS was ranged from 0.40 to 0.32, all statistically significant at $P < 0.001$.

The BSRS was back translated in Urdu for the present study. The internal consistency of the present tool was identified as good with a Chronbach's alpha of .85 with the present sample.

Procedure

The available tools were identified, and permission was taken from the National Institute for Psychology for the use of translated version of brief COPE and Aggression Questionnaire. Permissions for the Symptom Checklist and Bergen Social Relationship Scale were taken from the authors directly and BSRS was back translated into Urdu.

The study was started with a trial study with 30 participants. Informed written consent was taken from each participant after explaining them the purpose of the study and assuring the confidentiality. Each participant was provided with the written self-administered set of three questionnaires, the feedback form and the demographic form in Urdu.

Feedback showed no significant problem in understanding or in completion of questioners and fatigue factor. The set of questionnaires took 15 to 25 minutes to complete. All the questionnaires were completed on face-to-face individual bases to ensure the completion.

The main study was then carried out with 128 participants. The depressed patients were selected from psychiatric departments and normal controls with minor illness were selected from medicine departments of four different teaching hospitals of Lahore. The control group participants were, patients with minor illnesses e.g. fever, headaches, flue, muscular pains etc. Medical doctors were instructed to refer only those patients to the researcher who had only minor illnesses. Furthermore, the researcher also asked the patients about their illness and only those patients were selected who had been fulfilling the criteria of matching with depressed group. The participants were matched based on age, gender, education and monthly income. The questionnaires were administered individually in hospital settings. All the ethical requirements were taken into account. After the 2 months of data collection phase, data was organized on SPSS data sheet and statistical analysis was run. The Independent *t*-test was run to find out the difference in two groups for research variables at different levels.

Results

Comparing coping styles

The depressed group were using less adaptive coping on Religious Coping Scale (M= 5.50), Positive Coping Scale (M=14.53) and Problem Focused Coping Scale (M=16.11) as compared to normal controls respectively. The results of independent *t*-test showed that there was significant difference between the groups on all three adaptive coping styles which were religious coping positive coping and problem focused coping On the other hand depressed group was using maladaptive coping styles, which were Denial (M= 4.45) and Avoidant Coping (M= 22.67) similar to those of control group respectively. The results for independent *t* -test showed that there is no difference between the two groups in use of maladaptive coping styles, which were denial and avoidant [Table 1].

Table 1: *Results of Independent t-test* for Coping Styles, aggression and interpersonal conflicts between depressed and non-depressed individuals

Coping styles	Depressed people *M (SD)*	Non Depressed people *M (SD)*	*t*	*df*	*p*
Religious coping AD[a]	5.50 (2.30)	7.30 (1.09)	5.626	89.908	0.0**
Positive coping AD	14.53(5.38)	20.03(4.33)	6.362	120.466	0.0 **
Problem focused AD	16.11 (6.17)	21.66 (4.09)	5.992	109.398	0.0 **
Denial MA[b]	4.45 (2.26)	4.08 (1.76)	1.046	119.052	0.1
Avoidant MA	22.67 (4.93)	22.39 (3.79)	0 .361	126	0.4
Aggression	93.45(27.76)	70.33(15.54)	5.814	98.950	0.0 **
Interpersonal conflict	13.28 (5.03)	8.59(4.71)	5.436	126	0.0**

Note. X=mean; *SD*= Standard Deviation df= Degree freedom; t= Sample Value of t-test Statistic; P= Probability
AD[a] = Adaptive Coping Styles; MD[b] = Maladaptive Coping Styles/ $^{**}P < 0.01$, one- tailed.

Comparing the level of aggression

Secondly the depressed group had higher level of aggression (*M*= 90.45) as compared to the non-depressed group (*M*= 70.33). The results for independent test showed that the there is significant difference between the two groups [Table 1].

Comparing the level of interpersonal conflict

Thirdly the depressed group had higher level of interpersonal conflict (*M*= 13.28) as compared to the non-depressed group (*M*= 8.59). The results for independent test showed that the there is significant difference between the two groups [Table 1].

Regression Analysis

Binary logistic regression analysis was performed to investigate if coping styles; aggression and Interpersonal conflict can predict depression by Enter method, with coping styles, aggression and interpersonal conflict as Independent variables and illness as Dependent variable. The data of the sample of 128 patients with both depression and General Medical condition were analyzed by Binary logistic regression analysis. The results show that the model is significant as the significance of chi- square is *P*= 0.0. All the variables significantly predict the outcome that is depression [Table 2].

Table 2: Binary regression analysis predicting presence or absence of depression on the coping styles, aggression and interpersonal conflict

	B	SE	Odds Ratio/Exp(B)	*P*
Maladaptive Coping	-.12	.06	0.88	0.04
Aggression	-.04	.01	0.95	0.00
Interpersonal Conflict	-.13	.05	0.02	0.02

Note: R square=0.479(Cox & Snell), 0.639 (Nagelkerke). Model χ^2 (1) = 0.00 /$^{*}P < .05$. $^{**}P < .01$. $^{***}P < .001$

Discussion

The participants selected for the study aged ranged between 18 to 35 years. There were two reasons to select this age bracket. Firstly, the focus of the study was Pakistani youth, and secondly, according to WHO [1] depression is second major cause of deaths in the age range of 15 to 44 years.

The present results partially rejected the first hypothesis in which it was supposed that depressive group would be having more maladaptive coping styles. The previous literature stated that depressed individual use more of maladaptive skills as compared to non-de-

pressed and the maladaptive coping styles mediates with the psychosocial stressors and leads to depression [5-7, 10-13]. However, the results of the present study were contrary to all of the above findings. The non-depressive group was using maladaptive coping styles as much as the depressive group.

The present researches' finding can be explained in the light of present socio economic and socio political scenarios of Pakistan and its devastating effects on the psychological health of the people. The youth of Pakistan is facing many problems including corruption, unemployment, load shedding, terrorism, and uncertainty in every field of life, and these social adversities are causing frustrations and increasing rates of suicide in youth [29, 30]. Other studies have shown that unemployment, violence, stressful environment are increasing rates of depression in Pakistani youth [26, 27]. Hence, in the present researcher's view is that the normal Pakistani youth has started using maladaptive coping styles in same manner as the depressed group, making the demarcation difficult among the depressed and non-depressed groups. The present finding presents a pertinent question that whether in a third world country like Pakistan the youth is only using maladaptive coping styles like denial and avoidance as a way to deal with ever increasing daily life hassle, or many of them who are at a sub- clinical depression level and may very soon succumb to this pathology. It can also be assumed in the light of present results that possibly similar dynamics are playing their part in perpetuating depression among Pakistani non-depressed sample, thus, leading to the ever-increasing rates of depression in Pakistan. The present results also signify the fact that there are people who may have clinical problems but they are not approaching psychiatric units for their unhealthy coping styles. At the same time the results shows that there was significant difference among depressed and non-depressed group in the use of adaptive coping styles. Adaptive coping styles have buffering effect in lowering the life stress and in return less depression [9-11,15,16]. The results of the present study confirmed the previous findings that adaptive coping is predictor of absence of depression. In present researcher's opinion, the adaptive coping seems to be the main factor, which is saving the Pakistani youth from depression. Perhaps adaptive coping is buffering these individuals from succumbing to depression. The Interventions should focus on as how to eliminate the maladaptive behaviors and to introduce adaptive behaviors.

The second hypothesis of the study was confirmed that people with depressive symptoms would have more aggression as compared to the control group [Table 3]. The psychoanalytical school of thought believes that repressed anger against the strict parents and hostile environment leads to depression [5]. Anger not expressed is one of the most common resources that lead to depression [17]. On the other hand, studies showed that stressful environment along with depression causes aggression [18, 19]. The present results are similar to previous findings that people with depressive symptoms had more aggression as compared to control group. The results of the previous studies in Pakistan and west showed that the main causes of aggression and depression were social and environmental problems, for example financial problems, unhealthy peer interaction, job dissatisfaction, negative family environment and other stressful life events [26, 27, 29, 30]. Therefore the Pakistani population and specifically the youth is becoming a victim to depression and aggression as a result of many daily hassles, being the citizen of a third world country with loads of social, economic and security issues.

In the present researcher's opinion, the aggression, whether as cause or consequence of the depression, must be taken into account on priority basis while dealing with the depressive patient. Aggression also perhaps leads to more suicides when interjected in the form of depression [6, 7]. As the more and more number of Pakistani youngsters is committing sui-

cide when they do not find the way out for their problems and as a result, they get frustrated, angry and depressed. In such circumstances by teaching adaptive coping styles and adaptive ways to deal with their anger the depression can be decreased though not totally eradicated, from the society.

The third hypothesis of the study stated that interpersonal conflicts would be more in depressed group as compared to the non-depressed group. The finding confirmed the hypothesis. Coyne's Interpersonal Theory of depression says that depressed people's negative behaviors cause them to be rejected by their relations and this rejection and avoidance causes the symptoms of depression worsen [5]. Another study had shown that not only the interpersonal conflict causes the depression but also the depressed people had more interpersonal conflicts as compared to normal people [22]. Hence, the cause of depression was probably based on interpersonal conflict, a depressed person seems to be trapped into a vicious cycle of interpersonal conflicts and this worsens his or her symptoms of depression. So taking into account the present findings depressed people not only needed to be taught about adaptive coping styles, managing anger but also how to dealing with their interpersonal interactions. By doing so, the depressed patients not only feel better but would also be saved from other serious mental disorders.

Implications of the finding

The findings of the present research can have several implications, both theoretical and clinically. Theoretically, present research findings will be addition to the body of knowledge regarding the most threatening ailment of the century, worldwide and in Pakistan too [1]. The present research is also very important from the clinical point of view for the development of preventive intervention of depression. By teaching and counseling the youth of Pakistan about adaptive coping styles, assertiveness training, anger management, better communication styles, the youth can be saved from future threat of depression and many other psychological illnesses.

The results suggests that the normal population of the country is also dwelling into maladaptive coping styles in the same manner as depressed population, which can lead them towards depression and other psychological illnesses. In such circumstances, the psychologists need to emphasize on teaching the adaptive coping styles and replacing maladaptive coping styles by adaptive ones, in both clinical and non-clinical settings.

The results also suggest the use of aggression models and interpersonal therapy while treating the depressive patients. As the present research confirming the previous findings that depressive patients get trapped into the vicious cycle of interpersonal conflict, aggression and depression. However once they already have maladaptive coping they do not know how to break that cycle, and it worsens their symptoms. Hence, it is very important to focus on the coping styles, anger management and interpersonal conflict resolution of the depressed patients, for their better prognosis.

The present research also focused on the gender differences among the depressed patients in the use of three research variables. The results for gender differences are opening new doors for further research. As the previous researches and studies showed that females are gender that is more fragile innately and they perceive life events more negatively and hence get into depression. On the contrary, the present results do not show any differences among depressed male and females in use of maladaptive coping styles and having interpersonal conflicts. These results implicate that day by day increasing social adversities are affecting men negatively with the result their functionality has deteriorated so much so that maladaptive and adaptive coping become similar to that of women in Pakistan. Therefore, clinicians need to be more careful and precise in dealing with their patients, and they need to

take into account the new results and treatment options, regardless of the gender.

The results also gives another important finding that male depressive patients shows more aggression than female depressive patients. The recent studies have also shown that suicidal rates in men in Pakistan are higher than women are. The previous records have also shown that male depressed patients have different symptomology as compared to female depressed patients. So there could be possibility that male patients get their way to suicide before reaching to the clinics, or they are always hiding their depression under the cover of aggression, which is more acceptable way for males in Pakistan. Therefore, the clinicians, parents and teachers are suggested to treat, understand and educate the male proportion of the society cautiously keeping in view the gender sensitive model of depression, so that we can save them from committing suicides and guide them towards better treatment options.

The Binary Logistic Regression was also run as an additional analysis to check the maladaptive coping, aggression and interpersonal conflicts as the predictors of depression. The overall value of the model was significant (P= 0.00). According to the model maladaptive coping, aggression and interpersonal conflict are significantly predicting the depression. These results again confirm the previous findings and support the main findings.

Limitations and Recommendations

Despite all the efforts to overcome the hindrances in the way of present research process, there were number of limitations.

- One of the limitations of the present study was that the translated versions of tools were used in the study. Indigenized tools must be used in Pakistani Population.
- Another limitation was that data was collected only from Lahore and more specifically from government hospitals. Based on the present study the results cannot be generalized to the whole of Pakistani community. In future research the data must be collected from other cities and private hospitals.
- In present research the biological and genetic influences were not been evaluated and many other psychosocial determinants e.g. poverty, terrorism, also needed to be probed in further research in Pakistani context.
- Further research on depression must be conducted to identify the pathway of valid etiological factors, so that dynamics of depression in Pakistan can be explored in detail and solid preventive measures can be established.
- Present research was a cross sectional research, longitudinal research must be conducted to study the effects of all these variables in development of depression.
- The present research scrutinize the control group only for depressive symptoms, more detailed clinical inspection should be conducted for other mental illnesses for example anxiety, for clearer results in future projects.
- The present research explored the variables in quantitative manner; detailed qualitative study should be conducted to explore the psychosocial factors in Pakistani context.
- Short awareness campaigns must be run by the practitioners and psychology students in the light of these results to save the youth of Pakistan from depression and even to help themselves.
- Higher authorities in the field of psychology should compile and introduce some curriculum based on preventive steps and insight against the psychological illnesses into the normal youth at schools and college level to save them against psychological illness.

Conclusion

Despite all the above-mentioned concerns and limitations, the present research identified different important dynamics of depression in Pakistani society. The present research findings suggested new results in the use of coping styles, while aggression and interpersonal conflicts were found to be higher in depressed population. Evidences of gender-based asymmetry were also found in the level of aggression among depressed population. Therefore, different trends regarding the coping styles and interpersonal conflict were reported in Pakistani sample. The present study also seemed to provide links between the psychosocial adversities and depressed. Under developing countries like Pakistan, need to pay more attention towards the preventive and treatment steps. As eradication of social adversities and steps towards the developed country is not a single hand or short-term project, but one can always save him and people around from the devastating effects by learning the better way to cope with these issues.

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