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Neuroticism, Perfectionism and Coping Strategies among Patients with Depression and Anxiety Disorders

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The present study aimed to explore the relationship between neuroticism, perfectionism and coping strategies among patients with depression and anxiety. To attain these objectives *N*=110 participants (Depression *n*=60, Anxiety *n*=50) were approached from psychiatric wards of hospitals in Lahore. Neuroticism Scale of Eysenck Personality Questionnaire (EPQ), Almost Perfect Scale (APS) and Brief COPE were administered to assess study variables. The findings of the study revealed that neuroticism is positively linked with maladaptive perfectionism and with religious/denial and avoidant coping strategies, whereas maladaptive perfectionism has positive a relationship with avoidant coping. Moreover, perfectionism was found as the predictor of anxiety whereas maladaptive perfectionism was the predictor of depression. Depressed patients scored higher on religious and denial coping strategy and ranked higher on maladaptive perfectionism. On contrary, anxiety patients scored significantly higher on avoidant coping strategies. This study highlighted that maladaptive perfectionism as one of the leading factors in the development of anxiety and depression. Therefore, by providing proper therapeutic interventions for changing beliefs related to maladaptive perfectionistic approach, the future risk of the development of tendencies of anxiety and depression can be minimized to some extent.

Key words: Neuroticism, Perfectionism, Coping Strategies, Depression, Anxiety

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The World Health Organization (WHO) has anticipated that Depression would be the second most leading cause of disability by year 2020. In developing countries 10–44% individuals suffer from depression and anxiety disorders (Gadit & Mugford, 2007). A study carried out in rural Punjab estimated that 66% of women and 25% of men are suffering from anxiety and depressive disorders (Mumford et. al, 1997). In Pakistan psychological problems are increasing day by day (Dodani & Zuberi, 2000; Luni et. al, 2009; Mirza & Jenkins, 2004; Prasla, 2012; Saeed, Gater, Hussain, & Mubbashar, 2000). The prevalence of anxiety and depression among students in Lahore was measured by Rab, Mamdou and Nasir (2008), the results of the study revealed that 43.7% of students reported symptoms of anxiety and 19.5% showed depressive symptoms. According to Mirza and Jenkins (2004) the prevalence of anxiety and depressive disorders in Pakistan is 34% and one of the major reasons is, social problems.

The increase in frustration due to minimal resources and less opportunities, demand for high standards, disappointment, insecurity, and economic problems has increased the rate of anxiety and depression in Pakistan (Kasi et. al, 2012). Such individuals find the environment distressing, hostile and negative. They usually perceive the negative side of the events and are more prone to react negatively or in an unhealthy manner. (Eysenck & Eysenck, 1985). They tend to set unrealistic goals and high standards to catch up with the trends of the society ignoring their own potentials. This ultimately leads toward negative affects when they are unable to achieve those ideals and are unable to cope with the situation (Antony & Swison, 1998).

Eysenck (1967) described neuroticism as the temperament of an individual to experience negative affect. It can be viewed as a basic personality trait to experience negative emotions like anger, guilt, hostility and depression. When a person faces a traumatic

event in life he is susceptible to depression because of his innate tendency to focus on the negative sides of an event. The more the person has neurotic tendencies, the more he might have chances of experiencing depression and anxiety under stress (Jylha & Isometsa, 2006).

Another reason for increasing depression and anxiety is competence and demand for high standards. In this era of competition, everyone wants to see himself standing on the horizon of success (Slaney & Ashby, 1996). People with such a perfectionistic approach tend to set highly unrealistic and not easily approachable goals for themselves and exert themselves continuously in striving for or achieving those objectives. They evaluate themselves on the basis of the output of their efforts and achievements (Antony & Swison, 2008; 2009; Kuwamura et. al, 2001). Such individuals are unable to cope with failure which leads towards dysfunctional behaviors (Ellis & Harper, 1975; Schlenker & Leary, 1982). According to Hollender (1978) perfectionism is demanding high quality of performance from oneself and others. Individuals with a perfectionist approach set extremely high standards while performing a task and if they are unable to attain that standard they criticize themselves continuously (Frost & Marten, 1990).

Although perfectionism is irrational and maladaptive at one side, it has some positive sides as well. Setting high but achievable standards enhances the self-efficacy and self-satisfaction and could be considered healthy or adaptive perfectionism. Such individuals give their selves margin for mistakes and are less concerned for petty things; instead they try to seek the positive side, considering it as an opportunity (Schuler, 2000). It is the desire to excel in the particular field by setting rational goals. Adaptive perfectionism is positively correlated with indicators of good adjustment (Stoeber, Harris & Moon, 2007). While maladaptive perfectionism is unhealthy, neurotic and negative. Such individuals set unrealistic and overly generalized goals. In case of any mistake and failure they usually critically evaluate themselves. They evaluate their true worth in terms of their achievements and success (Enns & Cox, 2005). Such unhealthy perfectionism yields stress which can be

emotional, mental, and physical in nature (Schuler, 2000). They eventually avoid the situations in which they have to meet high standards and goals (Antony & Swison, 1998; Stober, Harris & Moon, 2007).

When a person faces a stressful situation which seems to be out of control, he/she tries to deal with it effectively so that the stress can be reduced (Folkman & Lazarus, 1998). This process has two components, i.e. coping and appraisal. In appraising any stressful situation, some action is required that one takes to react to any particular situation to *cope* with the situation. It is the personal choice of the individual what sort of coping he has to use; either reducing the stress or tolerating it or on the other hand effectively solving the problem by mastering it.

Problem-focused coping is adaptive coping with an action oriented approach. It helps to deal with the stress. It is active coping as the individual involved in it, seeks appropriate information, and analyzes different resources and solutions to solve the problem. People who are engaged in problem-focused coping are less stressed out, less anxious and less depressed in comparison to those who are involved in other patterns of coping (Lazarus & Folkman, 1984). Sherbourne, Hays and Wells (1995) found that when depressed individuals focus on solving the problem and strive towards finding the solution, they show improvement.

The other type of coping is *emotion-focused coping*. It has both aspects, that is adaptive and maladaptive. It merely focuses on emotions and their ventilation, avoiding/denying the actual problem. The person is detached from the real problem both behaviorally and mentally resulting in the maladaptive form of coping (Livneh & Martz, 2007). Seeking social support and acceptance are the adaptive categories of emotion-focused coping. Wijndaele et al. (2007) concluded that individuals having social support usually experience lesser symptoms of depression and anxiety. Religious coping (increased involvement in religious

activities) is also included in emotion focused coping (Carver, Scheier & Weintraub, 1989). Avoidant coping is purely a maladaptive form of coping and also leads to stress more than other types of coping strategies. Clinically depressed patients are involved in avoidant coping patterns (Billing & Moos, 1984).

One of the factors that impacts coping, as well as individual's reaction to stress, is neuroticism (Bogler, 1990). Neuroticism may be linked to anxiety and self-condemnation due to poor self-esteem that is seen as an underlying characteristic in perfectionists (Hill, Karen, & Verne, 1997). There is no medium level in case of perfectionism as there are always extremes i.e. best or worst. High discrepancy, the difference of ideal and actual performance may lead to poor coping (Antony & Swison, 1998). Park, Heppner and Paul (2009) reported that maladaptive coping plays a vital role in perfectionism and distress. A significant relation exists between evaluative concerns of perfectionism, maladaptive coping, self-esteem and distress (Slaney & Ashby, 1996). Maladaptive perfectionism is linked to neuroticism, anxiety and maladaptive attachment styles (Hill, Karen, & Verne, 1997; Ulu & Tezer, 2010). Larijani and Besharat (2010) stated that adaptive perfectionism was related to problem solving coping whereas maladaptive perfectionism was related to emotion-focused coping.

The present study intends to explore the relationship between *neuroticism, perfectionism* and *coping strategies* among patients of depression and anxiety; exploring neuroticism, perfectionism and coping strategies as the leading causes of depression and anxiety. This study will be helpful in finding the predictors of depression and anxiety which are the prevalent disorders in Pakistan. Thus, by understanding role of neuroticism, maladaptive perfectionism, and maladaptive coping in anxiety and depression would provide an insight of mental health professionals and will enhance the options regarding treatment of these disorders. Moreover, it would be helpful in making the patients realize that their own negative appraisals of the events and

unrealistic goals are causing problems for them. The perfectionist approach is problematic which engage them in maladaptive patterns while facing the stress. The results obtained can be used by mental health professional for counseling and for raising awareness for the positive side of perfectionism, reducing maladaptive coping patterns and strategies and being more positive towards goals, achievements and life.

Thus the study tested the following hypotheses:

1. Neuroticism, perfectionism and coping strategies are correlated with depression and anxiety.
2. The patients of Depression and Anxiety will differ on the scores of neuroticism, perfectionism and coping strategies.
3. There will be gender differences in neuroticism, perfectionism and coping strategies.

Method

Sample.

For current study *N*=110 participants 29% Men (*n=32*; Depression *n* = 19; Anxiety *n* = 13) and 71% women (*n=78* Depression *n* = 41; Anxiety *n*=37) with ages *M*=32.5 and *M*=30.8 respectively, participated in the study. Those scoring above the cut-off point on the Symptom Checklist-R were included in the study. For current study those participants were approached, who were the patients diagnosed with depression and depressive symptoms (*n*=60), and those participants who were diagnosed with anxiety disorders *(n*=50), from psychiatric wards of government and private hospitals in Lahore. Individuals diagnosed with any other psychological disorder and those who could not understand and comprehend the Urdu language were excluded from the study.

Measures

The following self-reported measures were used in the present study:

Demographic Questionnaire. This was devised to assess various personal characteristics which included age, sex, education level, socioeconomic, family status, marital and health status (including physical as well as psychological health) etc. of the participants.

Neuroticism Subscale of Eysenck Personality Questionnaire (EPQ). This scale was developed by Eysenck and Eysenck in 1975. This scale measures the genetic predisposition towards becoming neurotic. It has 23 items. All the items included in this scale have predetermined "yes" score. The sum of all the correct answers indicates the total score of neuroticism in individual. The tests-retest reliability of this scale is 0.82 over a period of one month. The consistency coefficient of EPQ ranged from 0.72-0.84. It was translated by Kausar & Amjad (2000) in Urdu language. The Cronbach's alpha reliability was found to be 0.80 in the present study for neuroticism subscale. The translated version of the EPQ was used in the current study.

Almost Perfect Scale-R (APS-R). This scale was developed by Slaney and Ashby in 1996. It measures multidimensional construct of Perfectionism. There are a total of 23 items in the scale. Response are to be made on 7-point Likert scale ranging from 1(strongly disagree) to 7(strongly agree). It is comprised of three subscales. *Standard* (7-items) measures the criteria set by a person for his achievement and performance. This subscale determines whether the individual is perfectionist or non-perfectionists. Individuals scoring high on this scale are perfectionists. *Order* (4-items) measures individual's tendency towards orderliness and organization. *Discrepancy* (12-items) is the measure of perceived differences in the ideals one set for performance and actual performance. It distinguishes between adaptive and maladaptive form of perfectionism. The individual scoring higher on this scale has maladaptive perfectionistic traits.

The t-test correlation between the subscale was found to be .72-.87 (Slaney & Ashby, 1996). It was translated in Urdu by Sitwat in 2010. The translated version was used in the present study to assess perfectionism among the participants. The Cronbach's alpha reliability of APS for the present study was found to be 0.82.

Brief COPE. This was developed by Carver (1997). There are total 28 items in the questionnaire. The responses were to be made on a 4-point Likert scale: 1(haven't doing this at all) - 4 (I've been doing this a lot). Hastings et. al (2005) reported four subscales for Brief COPE based on factor structure. Overall, these subscales can be combined to distinguish between adaptive and maladaptive coping strategies. Problem- focused and positive coping are included in adaptive coping strategies whereas religious, denial, and avoidant coping strategies were maladaptive. The items are summed together to get a total score on each category. High scores on each category indicate more use of that type of coping strategies (Javaid, 2011). The test-retest reliability of this scale ranged from 0.25-1.00. Translation of the tool in Urdu was done by Akhtar in 2005. This translated version was used in the present study. The Cronbach's alpha reliability for Brief COPE in the present study was found to be 0.82.

Symptom-Checklist R (1999). This test was validated by Rehman and Dawood in 2000. In the present study three subscales of this checklist were used for screening the patients of depression, anxiety and OCD. The responses were to be made on 4-point Likert scale based on how frequently one experiences the symptom: 0 (never) - 3 (a lot).

Procedure

Initially permission was taken from the respective heads of the psychiatric wards. Only patients diagnosed with Anxiety Disorders or Depressive Disorders were approached. The participants were screened initially by administering the anxiety and depression subscale of Symptom Checklist - R. The set of

questionnaires were administered orally following all ethical considerations. Informed consent was taken from the participants using the consent form which contained information regarding the purpose of the study assuring complete confidentiality. Debriefing procedures were conducted with those individuals who were provoked with certain questions for example, ideas of suicide and low self-worth were triggered in some depressed patients. Moreover, they were referred to Center of Clinical Psychology or to another institute that could provide them with the necessary psychotherapy.

Results

Pearson Moment Correlation, Descriptive, Regression and Mean Differences Analyses were conducted in the current study.

Table 1

Descriptive statistics and inter-correlation among study variables (N=110)

Measures	1	2	3	4	5	6	7	*M*	*SD*
1. Neu	-	0.12	0.54**	0.51**	0.36**	-0.10	-.24	15.31	03.56
2. Stds	0.32	-	0.16	0.01	0.08	0.17	.14	40.18	06.99
3. Disc	0.44**	-0.00	-	0.37**	0.33**	0.15	-.24	60.17	15.30
4. Av-Cp	0.41**	-0.19	0.45**	-	0.36**	0-.02	-.06	26.14	04.56
5. R/D-Cp	0.09	0.10	-0.04	0.52	-	0.16	.07	12.46	02.40
6. Ps-Cp	0.78	0.02	-0.03	0.02	0.17	-	.60**	18.13	04.17
7. PF-Cp	0.01	-0.02	-0.08	0.09	0.10	0.38**	-	20.72	04.03
M	15.31	40.18	60.17	26.14	12.46	18.13	20.72		
SD	03.56	06.99	15.30	04.56	02.40	04.17	04.03		

Note: Neuro=Neuroticism, Stds=Standards, Disc=Discrepancy, Av-Cp= Avoidant Coping, R/D-Cop=Religious/Denial Coping, Ps-Cop= Positive Coping, P-F Cop=Problem Focused Coping *p<0.05, **p<.001

Inter-correlation for depressive patients (*n*=60) are presented above the diagonal, and inter-correlation for Anxiety patients (*n*=50) below the diagonal. Mean and Standard deviation of Depression participants presented in the vertical column. Means and Standards deviations of Anxiety patients are given horizontally. Means and standard deviations of the study variables are shown in Table 1 with significant correlations among variables. The predicted correlations were in desired direction Neuroticism had a significant positive relationship with discrepancy (*r*=.54, p<.01), avoidant coping (*r*=.51, p<.01) and religious / denial coping (*r*=.36, p<.01) among depressive patients. Moreover, discrepancy was positively correlated with avoidant coping (*r*=.36, p<.01) and religious/denial coping (*r*=.33, p<.01) for depressed patients. In case of anxiety patient's neuroticism had significant positive relationship with discrepancy (r=.44, p<.01) and avoidant coping (r=.41, p<.01) among anxious patients. Moreover, discrepancy had positive correlation with avoidant coping (r=.45, p<.01) for patients with anxiety.

Table 2

Regression Analysis predicting Depression from Neuroticism, Perfectionism and Coping strategies (n=60)

Predictors	β	SEB	B	95% CL	
				LL	*UL*
Neuroticism	0.37	0.34	0.18	-0.31	1.06
Standards	0.10	0.13	0.10	-0.15	0.35
Discrepancy	0.18	0.08	0.39*	0.02	0.33
Positive Coping	-0.07	0.24	-0.05	-0.49	0.42
Problem Focused	0.16	0.27	0.11	-01.0	0.40
Active Avoidant	-0.03	0.23	-0.02	-0.56	0.41
Religious/denial	-0.31	0.36	-0.12	-0.37	0.70

Note: B=Unstandardized Coefficient, SEB=Unstandardized Error Coefficient, β=Standardized Coefficient, Δ*r*=.11, r^2=.22

Multiple linear regression analysis (Table 2) reveals that *discrepancy* subscale of APS was the significant positive predictor of Depression (β=.39, p<.05) reflecting that patients with maladaptive perfectionism scored higher on depression. The model accounts for 11% of variance in it (r^2 = .11, p <0.05).

Table 3

Regression Analysis predicting Anxiety from Neuroticism, Perfectionism and Coping strategies (n=50)

Predictors	B	SEB	β	95% CI	
				LL	*UL*
Neuroticism	0.07	0.65	0.02	-1.24	1.38
Standards	01.1	0.29	.48***	0.44	1.63
Discrepancy	-0.11	0.15	-0.12	-0.42	0.19
Positive Coping	0.51	0.63	0.12	-0.24	1.80
Problem Focused	-0.56	0.62	-0.14	-2.90	0.70
Active Avoidant	0. 78	0.51	0.24	-0.76	1.79
Religious/denial	-1.10	0.89	-0.17	-1.82	0.69

Note. B= Unstandardized Coefficient, SEB= Unstandardized Error of Coefficient, β= Standardized Coefficient. Δr = 0.14 r^2 = 0.26

Subscale of *standard* from APS was the positive predictor of Anxiety (β=.48 p=.001) reflecting that patients scoring higher on standard scale are perfectionists and scored higher on anxiety. The model accounts for 14% of variance in it (r^2 = .14, p=.001).

Table 4

Mean, standard deviation and t-values for patients with depression and anxiety and for men and women on study variables (N=110)

Variable	Diagnosis	*M*	*SD*	*t(209)*	*Gender*	*M*	*SD*	*t(108)*
Neuroticism	Depression	15.99	3.06	2.15	Men	15.03	2.39	-.53*
	Anxiety	14.50	3.97		Women	15.43	3.96	
Perfectionism								
Standards	Depression	60.35	6.40	.303	Men	58.44	16.10	-.73
	Anxiety	59.96	7.96		Women	60.88	15.01	
Discrepancy	Depression	40.37	13.46	.13*	Men	41.66	6.16	1.52
	Anxiety	39.96	17.39		Women	39.58	7.25	
Coping Strategies								
Problem Focused	Depression	20.73	4.09	.043	Men	21.72	3.39	1.84
	Anxiety	20.70	4.00		Women	20.31	4.21	
Positive Coping	Depression	18.48	4.42	.993	Men	19.31	3.75	1.93
	Anxiety	17.70	3.84		Women	17.64	4.26	
Religious/	Depression	12.63	2.47	.778	Men	11.75	2.41	-1.97
Denial	Anxiety	12.26	2.53		Women	12.76	2.48	
Active/	Depression	26.27	4.10	.320	Men	25.66	4.66	-.69
Avoidant	Anxiety	25.98	5.09		Women	26.33	4.54	

Note: *=p<.05

An independent sample t-test was conducted to find out gender differences and differences in responses of patients with depression and anxiety. Table reveals significant differences on discrepancy subscale of APS (t =.13, p<.05) where patients with depression (M=40.37, SD=13.46) scored higher as compared to patients with anxiety (M=39.96, SD=17.39). While significant differences appeared for Neuroticism (t = 0.53, p<0.05) Mean difference suggests that that women (M = 15.43, SD= 3.96) are more neurotic than men (M = 15.03, SD= 2.39).

Discussion

In general, the findings of the study supported the hypothesis that there is a significant link between neuroticism, perfectionism and coping strategies among patients with depression and anxiety. This hypothesis was fully supported as those patients with depression or anxiety who scored higher on neuroticism also scored higher on the discrepancy scale of perfectionism (perception of the self by a person when he fails to achieve high standards), and religious/denial and avoidant coping strategies (maladaptive coping strategies involving denial/ avoidance of the situation). Thus, neuroticism showed significant positive correlation with maladaptive perfectionism and maladaptive coping among depression and anxiety patients (as cited in Eysenck & Eysenck, 1975; Hewitt, Flett & Blankstein,1991; Hill, Karen, & Verne, 1997, 1997; Gunthert, Cohen & Armeli, 1999 and Jylha & Isometsa, 2006).

Thus, it can be concluded that those people who set unrealistic goals and have high standards are usually emotionally labile and end up with depression after failure since they are prone to negative thinking. This discrepancy is distressing for such individuals and they deal with these stressors by avoiding or simply denying the situation.

The next finding of the present study is that that individuals scoring higher on the maladaptive dimension of perfectionism would have been engaged in maladaptive form of coping (avoidant, denial/religious). This could also be supported through a series of researches (Dunkley & Blankstein, 2000; Larijani &Besharat, 2010; Rice, Steven & Pence, 2006). Ram (2005) concluded that maladaptive perfectionism was highly associated with negative effect, depression, anxiety, stress, neuroticism and dysfunctional coping strategies at the time of stress.

Regression Analysis was conducted to find the contribution of neuroticism, perfectionism and coping strategies in predicting depression and anxiety. Discrepancy subscale of Almost Perfect Scale was found the predictor of depression. This means that patients showing maladaptive perfectionism were prone to depression as supported by previous findings (Biase, 1998; Rice, Ashby & Slaney, 1998; Russell &Young, 2006; Shafran, Cooper & Fairburn, 2002). On the other side, standard subscale of Almost Perfect Scale was found significant in predicting Anxiety. This means that "demand for perfection" was one of the reasons behind anxiety disorders (Grzegorek, Slaney, Franze, & Rice, 2004; Kawamura, Hunt & Frost, & DiBartolo, 2001; Methikalam, 2008). A number of researches support the findings that maladaptive perfectionists usually experience more symptoms of anxiety and depression (Rice, Ashby, & Slaney, 1998; Rice & Slaney, 2002; Suddarth & Slaney, 2001).

The Independent sample t-test revealed there was a significant difference in the level of maladaptive perfectionism among patients with depression and anxiety as patients with depression scored higher on discrepancy (Clara, 2007); Maladaptive Perfectionism in depressive patients is higher than anxious patients since perfectionists tend to set critical roles and standards for themselves and are not willing to change their cognitions. They are not flexible in their behaviors and are not ready to change. When they try to attain some goal with these overly critical patterns and fail, they experience disappointment which eventually leads to low self-worth and ultimately causing depression (Ram, 2005; Tan & Carfagnini, 2008). Kawamura et. al, (2001) concluded that maladaptive perfectionism was an indicator of depression but there is also another separate aspect of perfectionism related to anxiety.

According to the results of t-test, significant difference was depicted in neuroticism across two genders. Women scored higher on neuroticism as compared to men. This suggests that females are more prone to negative appraisals of the stressors and are more emotional than males (Bushra & Aslam, 2010).

Conclusion

Based on obtained results, it can be concluded that there is a significant positive correlation between neuroticism, maladaptive perfectionism (discrepancy) and maladaptive coping strategies (avoidant, religious/denial). Perfectionism is the predictor of anxiety whereas maladaptive perfectionism leads to depression. The results also revealed that maladaptive perfectionism is higher in patients with depression as compared to patients with anxiety. Similarly, women have been found to be more neurotic than males. The findings of the current research in the Pakistani cultural context are consistent with previous findings of the literature.

Limitations and Suggestions

There are few limitations that need to be addressed while discussing the current study. The sample size was small due to some technical problems in the process of data collection. The sample size could be increased to represent the target population more accurately.

There was unequal representation of both genders in the sample with the ration of 1:2 (male and female respectively). This reduced the representativeness of one gender. Thus, results obtained must be cautiously generalized. The sample should be distributed proportionally across gender to enhance representativeness and generalization of the results.

The data was collected through self-report measures solely. This might have affected the results as self-reported measures provide only one-sided picture of the phenomenon. In this way, the possible reasons, major triggering causes of the phenomenon and above all individual differences are usually ignored in this way. Cross section research design and convenient sampling can be used to reduce the generalization of the findings. In the Pakistani culture the domains of neuroticism, perfectionism and coping were least explored in the clinical sample.

Perfectionism is seen as the leading cause of anxiety while maladaptive perfectionism leads to depression so there is a need to explore this variable qualitatively as well as quantitatively. This will help in understanding the causal relationship between perfectionism, depression and anxiety.

Psychological interventions can be planned to enhance the awareness and psychological well-being. As the study reveals that, if an individual has rational and achievable standards, being a perfectionist is not a problem in itself i.e. adaptive perfectionism. This could help in enhancing performance instead of being overly critical and evaluating oneself likewise. Moreover, adaptive coping strategies helps to deal with stressful events and can play a part in reducing future risk for developing psychopathologies. Adaptive coping styles include problem solving coping and directly facing the problem to get to the solution.

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