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Coping Strategies in relation to Mental Health

(Across-cultural study on Indian and Iranian students)

Abstract

The aim of the present study was to investigate the relationship of coping strategies with mental health in Iranian and Indian students. The sample of this study is comprised of 800 university students, 400

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students from Iran (University of Sistan and Baluchestan), and 400 students from India (Aligarh Muslim University). Coping Inventory for Stressful Situations (CISS) by Endler and Parker (1990) and General Health Questionairre-28 (GHQ) by Goldberg and Hillier (1979) were administered on the subjects. Correlation and step-wise multiple regression are used to evaluate the research hypotheses. Significantly negative correlation was found between problem focused coping strategies and mental health (GHQ-total), significantly positive correlation was found between emotion focused coping strategies and mental health with 99% confidence but avoidance-focused coping strategies was not significantly correlated with mental health among students. Step-wise multiple regression analyses revealed that emotion-focused coping strategies was first, and problem-focused coping strategies was second important predictor of mental health, but avoidance–focused coping strategies was not a predictor of mental health.

Keywords: Coping Strategies, Mental Health

Introduction

Over the last few decades, there has been a substantial amount of research in the area of coping strategies and its relation to mental health. Mental health was defined as an individuals state of well-being, when he or she realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully and is able to contribute to his or her community (World Health Organization, 2003a). According to the experts of this organization health is a status of wellbeing of body, mind, and society not only for the lack of disease (Boldero & Fallon, 1995:193). Mental health may be conceptualized in negative or positive terms. A negative conceptualization of mental health is based on the understanding that the absence of symptoms indicates good mental health. A positive mental health concept focuses on the presence of health-promoting factors, such as meaningful work and good relationships. One of the most famous researchers of the concept of positive health is Antonovsky, who defines positive health as a sense of coherence (Heikkinen, 2000:171), where the main focus is on the dynamic interaction between health-promoting factors and

stressors in human life, and how to move people to the healthy end of the health continuum. A sense of coherence is proposed to be a significant variable in effecting this movement (Antonovsky, 1985: 273). Mental health refers to a persons position, at any point in their life cycle, on "... a continuum that ranges from excruciating emotional pain and total psychological malfunctioning at one extreme to a full, vibrant sense of psychological well-being at the other" (Antonovsky, 1985:285).

Antonovsky describes the movement on the continuum towards better mental health as shifting:"...from the use of unconscious psychological defense mechanisms toward the use of conscious coping mechanisms; from the rigidity of defensive structures to the capacity for constant and creative inner readjustment and growth; from a waste of emotional energy toward its productive use; from emotional suffering toward joy; from narcissism toward giving of oneself; and from exploitation of others to reciprocal interaction" (Antonovsky, 1985:286).

Hyun and Jenny (2006:274) examined of graduate student mental health. The results showed that almost half of graduate student respondents reported having had an emotional or stress related problem over the past year, and over half reported knowing a colleague who had had an emotional or stress-related problem over the past year. Abdulghani (2008:12) revealed that there was a prevalence of stress among tertiary students and it was also found that there was severe stress among medical students, 57% and 19.6% respectively. The medical students in the study were from the College of Medicine at the King Saud University. The researcher used different kinds of tools to assess the stress level of respondents. The tools used were Becks Depression Inventory, General Health Questionnaire and Kessler10 Psychological Distress. Sherina, Lekhraj and Nadarajan (2003:213) investigated the prevalence of emotional disorders among medical students in a Malaysian university using the 12 item General Health Questionnaire (GHQ-12). Results of the study show that 41.9% of the medical students surveyed experienced emotional disorders. The researchers used a cut-off point of 4/5 on the GHQ-12 to determine whether the respondent could be categorized as positive or negative for emotional disorders.

Researchers view coping as ongoing strategies used in particularly stressful situations and they focus on the multidimensionality of coping (Folkman, et al., 1986: 571; Lazarus & Folkman, 1984; Schiff, El-Bassel, Engstrom, & Gilbert, 2002:302). Lazarus and Folkman (1984) define coping as "the persons constantly changing cognitive and behavioral efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the person s resources". In their view, coping is "process oriented," contextually influenced by personal situation," and "a persons efforts to manage demand without a prior assumption about what constitutes good or bad coping" (Folkman, et al., 1986:573).

Coping is also conceptualized as a multidimensional process, which includes cognitive and behavioral efforts (Ptacek, Pierce, & Ptacek, 2002: 61). Although there are a variety of ways of coping, such as confrontive coping, distancing, seeking social support, accepting responsibility, avoidance, and religious coping (Fox, Blanton, & Morris, 1999: 673; Vitaliano, Russo, Carr, Maiuro, & Becker, 1985: 92), researchers tend to dichotomize these coping strategies as active vs. passive, or emotion-focused vs. problem-focused, especially when they examine the impact of coping on psychological health. For example, Lazarus and Folkman (1984) divide coping into two dimensions: emotion-focused coping, which "regulates stressful emotions," and problem-focused coping, which "modifies the circumstance creating the harm, threat, or challenge". Billings and Moos (1985: 94) group different coping strategies into three categories: active behavioral coping, which "reflects behavioral attempts to directly deal with the problem," active cognitive coping, which "indicates attempts to manage ones appraisal of the stressfulness of the event," and avoidance coping, which "includes avoidance, denial and tension reduction". Similar to Billings and Moos distinction, Suls and Fletcher (1985p249) classify coping as approach coping, which refers to "strategies that focus on the source of stress and reaction on it," and avoidant coping, which is "strategies that place the focus away from both the sources of stress and reaction to it". Finn (1985: 341) categorizes "observable, behavioral efforts" as active strategies and "unobservable, cognitive or emotional efforts" as passive strategies (Yoshihama, 2002: 429). Kemp, et al. (1995: 43) classify coping as engagement, which refers to problem-focused behaviors, versus

disengagement, which includes problem avoidance, self-criticism, and social withdrawal. Kenneth et al. (2004: 81) investigated coping resources (Coping Resources Inventory for Stress), perceived stress (Perceived Stress Scale), and life satisfaction (Satisfaction with Life Scale) among American and Turkish university students. Results supports the use of transactional stress constructs in studying life satisfaction with students in both countries. American and Turkish students did not differ significantly in regard to perceived stress, life satisfaction, or an overall measure of coping resources; however, they did differ significantly regarding specific coping resources. There were significant sex differences for both countries, generally favoring males, in regard to specific coping resources. The most widely used dimensions of coping are problem- versus emotion-focused coping (Compas, Malcarne & Fondacaro, 1988: 405), approach versus avoidance coping and primary versus secondary control coping (Compas et al., 2001: 87; Ebata & Moos, 1994: 99).Although these models of coping do have some similarities and overlap in the categorization of specific coping responses; they are conceptually distinct (Ebata & Moos, 1994: 101).The problem-versus emotion focused model organizes coping responses in terms of their hypothesized function (Ebata & Moos, 1994: 102). Problem focused coping responses can be seen as attempts to modify a stressor. Emotion-focused coping responses can be seen as attempts to manage or regulate emotional states that may accompany or result from a stressor.

As mentioned earlier, there are various types of coping strategies, such as problem or task-focused coping, emotion-focused coping, and appraisal or avoidant-focused coping. A number of studies have found emotion-focused coping to be positively correlated to poor mental health. One such study was conducted by Solomon, Avitzur and Mikulincer (1990: 451), who found emotion-focused coping to be related to the presence of psychiatric symptoms in soldiers who had been involved in a war. Another was carried out by Roy-Byrne et al. (1992: 179) who found that emotion-based coping was related to increased subjective distress in people with panic and major depressive disorder. Further research by Aspinwall and Taylor (1992: 989) illustrated that students who employed avoidant coping were expected to be less successful at adjustment to college, while those who

employed active coping were more likely to be more successful in adjustment. Stewart et al. (1997: 163) found that individuals who used avoidant coping strategies had higher rates of depression and anxiety, whereas those who used active coping and positive reinterpretation had a decrease in depression and anxiety. In their study on daily hassles and depressive symptoms among first year psychology students in a French university, Bouteyre, Maurel, and Bernaudl (2007:193) found that task-centered coping was negatively correlated with depression, whereas emotion-centered coping was positively correlated with depression. They also found avoidant coping to be unrelated to depression. The effectiveness of a certain type of coping may depend on whether the stressor faced is controllable or incontrollable (Dressler, 1985:299; Forsythe & Compas, 1987:473; Littrell & Beck, 2001:15). Forsythe and Compas (1987:474) argue that for controllable stressors, active or problem-focused coping may be helpful, while for uncontrollable stressors, active coping mechanism may be less effective. In a study of a sample of 285 residents of a Black community in the rural area, Dressler (1985:499) found that African-American males with active coping had more psychological symptoms that those with less active coping; the author argues that active coping may not be effective under high levels of economic stress. The above mentioned studies reveal a clear relationship between problem-centered coping strategies and psychological well-being, while on the other hand emotion-based strategies are related to poor mental health. When researchers consider various coping mechanisms instead of dichotomizing them, the results display a more complex pattern. Penley et al. s(2002:551)meta-analysis reported that although previous studies (e.g., Bjorck, et al., 2001 :421; Finn, 1985:341; Yoshihama, 2002: 429) considered confrontive coping and seeking social support as active coping strategies,which is assumed to give benefits to psychological outcomes, confrontive coping itself was related to negative mental heath outcomes, and the relationship between seeking social support and mental health outcomes was weak across studies. However, Penley et al. (2002:551) found that another type of active coping strategy, problem-focused coping, was strongly related to positive mental health outcomes across studies. College students form the cream of student population. Studies have shown that about 50% students in India suffer from health problems. 15% of the students suffer from mental disorders like Depression, Anxiety,

Hysteria, Somatoform disorders,Adjustment reactions, alcohol and drug abuse. In addition, many more students may have emotional problems related to their family and college life (Chandrashekar et al.,2007)Over 16000 school and college student in India committed suicide in the last three years.(ParashantK.Nanda, 2008).

Purpose of the Study

To investigate the relationship between coping strategies and mental health in Iranian and Indian students.

Hypotheses

Students who employ problem-focused coping strategies would have significantly better mental health than students who employ emotion-focused and avoidance-focused coping strategies.

Sample

The sample of this study is comprised of 800 university students, 400 students from Iran (Sistan and Baluchestan University) and 400 students from India (Aligarh Muslim University). At first 8 faculties of Sistan and Baluchistan University (Iran) and 8 facilities of Aligarh Muslim University, Aligarh (India) and 50 students from each faculty were selected by random sampling. The age range of the students was 19-29 years.

Tools

Coping Inventory for Stressful Situations (CISS)

This is a 48-item self-report inventory that evaluates the coping strategies normally used in a stressful situation. The items are divided into 3 separate coping scales, which measure problem-focused coping, emotion-focused coping, and avoidance-focused coping. The respondent answers each item through a 5-point Likert-type rating scale ranging from 1 (not at all) to 5 (very much). The CISS displays high construct reliability and validity. Internal reliability is very high, The alpha coefficients for the CISS are reported separately for males and females and are as follows. For males, alpha levels for the task coping ranged from .90 to .92, for females the range was .87 to .90. The

emotion coping alpha ranges were from .82 to .90 for males and .83 to .89 for females. For avoidant coping, alphas ranged from .81 to .85 for males and .76 to .83 for females. Tests- retest reliabilities computed for the CISS for university undergraduates were .73 for males and .72 for females for task coping; .68 for males and .71 for females for emotion coping; .55 for males and .60; for females for avoidance coping; .51 for males and .59 for females for distraction coping; and .54 for males and .60 for females for social diversions (Endler & Parker, 1990).

General Health Questionnaire

The General Health Questionairre-28 (GHQ-28; Goldberg & Hillier, 1979:191) was developed to measure psychological health in large non-psychotic populations. The 28-item GHQ-28 is a shortened version of the original 60-item GHQ derived from factor analyses. The GHQ-28 is scored on a Likert scale of 0-3, producing a maximum total score of 84. Lower scores indicate higher mental health and functioning, while higher scores indicate psychological distress. Goldberg and colleagues (1997:191) reported that test-retest reliabilities range from .61 to .90, and Cronbach's alpha range from .71 to .88. The Cronbach's alpha in the present study was .93. The convergent validity of this scale has been supported by correlations with several other extant measures of psychological distress (Cano, Sprafkin, Saturo, Lantinga, Fiese, & Brand, 2001: 206). The construct validity of this scale has been supported by the ability of this scale to detect psychopathology as independently diagnosed by structured interviews designed to generate diagnoses according to the ICD-10 and DSM-IV (Goldberg et al., 1997:191). This questionnaire also contains four subscales, measuring somatic complaints, anxiety and insomnia, social dysfunction, and severe depression, respectively.

Results

Data was analyzed using SPSS 16. Parametric tests such as Pearson correlation coefficient, step-wise multiple regression were calculated to analyze the data.

In order to test the hypothesis correlation matrix (Pearson correlation), and after that Regression analysis has been applied which are as follows:

Table 1. The Correlation Matrix of Mental Health, Coping Strategies and its Subscales in Indian Sample (N=400)

Variables	1	2	3	4
1. Problem-focused coping strategies	1	-	-	-
2. Emotion-focused coping strategies	0.09	1	-	-
3. Avoidance-focused coping strategies	0.19**	0.26**	1	-
4. Mental health	-0.23**	0.23**	0.04	1

**p<0.01

As can be seen from table 1 in Indian samples all variables are significantly correlated with each other at 99% of confidence, except the correlation between emotion-focused coping strategies and problem-focused coping strategies, mental health and avoidance-focused coping strategies. Also, in order to predict mental health on the basis of coping strategies regression analysis has been applied which is as follows:

Table 2. Stepwise Multiple Linear Regressions: Predicting Mental Health on Coping Strategies Subscales in Indian Sample (N=400)

Model	Unstandardized coefficients			Standardized coefficients		R	R^2	F
	Predictors	B	S.E	Beta	t			
1	(Constant)	12.40	3.20	-	3.871**	0.231	0.053	22.39**
	E.F.C.S (a)	0.295	0.06	0.231	4.732**			
2	(Constant)	30.78	4.62	-	6.661**	0.342	0.117	26.34**
	E.F.C.S (a)	0.324	0.06	0.254	5.364**			
	P.F.C.S (b)	-0.339	0.06	-0.254	-5.360**			

** P < 0.01

(a): Emotion-Focused Coping Strategies, (b): Problem-Focused Coping Strategies

As can be seen from table 2 emotion focused coping strategies which entered the first step alone accounted for 5.3% of the variance in total mental health scores of Indian students and came out to be the strongest predictor variable (β=0.254, p=0.000<0.01) as compared to problem focused coping strategies which accounted for only 6.4% of the variance of the total mental health scores of Indian students. However, problem focused coping strategies is second important predictor (β= -0.254, p=0.000<0.01), and together emotion focused coping strategies and problem focused coping strategies accounted for only 11.7% of variance in total mental health scores of Indian students, as it mentions emotion focused coping strategies and problem focused coping strategies are significant predictors of mental health in Indian students. The rest variable could not enter in regression equation because they could not satisfy the criterion of entrance. The following regression equation is as follow:

Mental Health = 0.254 (Emotion focused coping strategies) - 0.254 (Problem focused coping strategies)

Table 3 The Correlation Matrix of Mental Health, Coping Strategies and its

Subscales in Iranian Sample (N=400)

Variables	1	2	3	4
1. Problem-focused coping strategies	1	-	-	-
2. Emotion-focused coping strategies	0.20	1	-	-
3. Avoidance-focused coping strategies	0.36**	0.36**	1	-
4. Mental health	-0.20**	0.32**	-0.02	1

**p<0.01

As can be seen from table 3 in Iranian sample all variables are significantly correlated with each other at 99% of confidence, except the correlation between Emotion-focused coping strategies and Problem-focused coping strategies, mental health and Avoidance-focused coping strategies. Also, in order to predict mental health on the basis of coping strategies regression analysis has been applied which is as follows:

Table 4. Stepwise Multiple Linear Regressions: Predicting Mental Health on Coping Strategies Subscales in Iranian Sample (N=400)

Model	Unstandardized coefficients			Standardized coefficients		R	R^2	F
	Predictors	B	S.E	Beta	t			
1	(Constant)	3.42	3.41	-	1.005	0.317	0.101	44.52**
	E.F.C.S (a)	0.480	0.07	0.317	6.673**			
2	(Constant)	18.21	4.133	-	4.406**	0.415	0.172	41.30**
	E.F.C.S (a)	0.563	0.07	0.372	7.976**			
	P.F.C.S (b)	-0.366	0.06	-0.273	-5.861**			

** $p < 0.01$

(a): Emotion-Focused Coping Strategies, (b): Problem-Focused Coping Strategies

As can be seen in the table 4 emotion focused coping strategies which entered the first step alone accounted for 10.1% of the variance in total mental health scores of Iranian students and came out to be the strongest predictor variable (β= 0.372, p=0.000<0.01) as compared to problem focused coping strategies which accounted for only 7.1% of the variance of the total mental health score of Iranian students.

However, problem focused coping strategies is second important predictor (β= -0.273, p=0.000<0.01), together emotion focused coping strategies and problem focused coping strategies accounted for only 17.2% of variance in total mental health scores of Iranian students, as it mentions emotion focused coping strategies and problem focused coping strategies are significant predictor of mental health in Iranian students. The rest variables could not enter in regression equation because they could not satisfy the criterion of entrance. The following regression equation is as follow:

Mental Health = 0.372 (Emotion focused coping strategies) - 0.273 (Problem focused coping strategies)

Table 5. The Correlation Matrix of Mental Health, Coping Strategies and its Subscales in Indian-Iranian Sample (N=800)

Variables	1	2	3	4
1. Problem-focused coping strategies	1	-	-	-
2. Emotion-focused coping strategies	0.21**	1	-	-
3. Avoidance-focused coping strategies	0.39**	0.36**	1	-
4. Mental health	-0.17**	0.28**	0.03	1

**p<0.01

As can be seen from table 5 in total sample all variables are significantly correlated with each other at 99% of confidence, excluded the correlation between mental health and Avoidance-focused coping strategies. Also, in order to predict mental health on the basis of coping strategies regression analysis has been applied which is as follows:

Table 6. Stepwise Multiple Linear Regressions: Predicting Mental Health on Coping Strategies Subscales in Indian-Iranian Sample (N=800)

Model	Unstandardized coefficients			Standardized coefficients		R	R^2	F
	Predictors	B	S.E	Beta	t			
1	(Constant)	8.004	2.29	-	3.494**	0.280	0.078	67.85**
	E.F.C.S (a)	0.382	0.05	0.280	8.237**			
2	(Constant)	21.28	2.87	-	7.412**	0.369	0.136	62.70**
	E.F.C.S (a)	0.453	0.046	0.332	9.854**			
	P.F.C.S (b)	-0.305	0.042	-0.246	-7.288**			

** $p < 0.01$

(a): Emotion-Focused Coping Strategies, (b): Problem-Focused Coping Strategies

As can be seen in the table 6. emotion focused coping strategies which entered the first step alone accounted for 7.8% of the variance in total mental health scores of both Indian and Iranian students and came out to be the strongest predictor variable (β= 0.332, p=0.000<0.01) as compared to problem focused coping strategies which accounted for only 5.8% of the variance of the total mental health score of both Indian and Iranian students. However, problem focused coping strategies is second important predictor (β= -0.246, p=0.000<0.01), together emotion focused coping strategies and problem focused coping strategies accounted for only 13.6% of variance in total mental health scores of both Indian and Iranian students, as it mentions emotion focused coping strategies and problem focused coping strategies are significant predictor of mental health in both Indian and Iranian students. The rest variables could not enter in regression equation

because they could not satisfy the criterion of entrance. The following regression equation is as follow:

Mental Health = 0.332 (Emotion focused coping strategies) - 0.246 (Problem focused coping strategies)

Conclusions

The purpose of this study was exploring relationship between coping strategies and mental health among Iranian and Indian students. For this purpose one hypotheses have been formulated. Pearson correlation, step-wise multiple regression and enter multiple regression are used to evaluate research hypothesis. Hypothesis in this research was Students who employ problem-focused coping strategies would have significantly better mental health than students who employ emotion-focused and avoidance-focused coping strategies. Responding to this hypothesis the stepwise regression was applied for students of India and Iran and total sample of both countries. Mental health is as criterion variable and problem-focused, emotion-focused and avoidance-focused are as the predictor variables. Emotional focused coping strategies accounted for 5.3% of the variance in step 1; problem focused coping strategies accounted for 6.4% of the variance in step 2. Collectively these variables accounted for 11.7% of the variance in mental health in Indian students. In the regression, emotional focused coping strategies was first important predictor ($\beta = 0.254$, $p = 0.000 < 0.01$) and problem focused coping strategies ($\beta = -0.254$, $p = 0.000 < 0.01$) was second significant predictor, and the third predictor variable was the avoidance focused coping strategies that did not emerge as significant predictor for mental health. Also, in Iranian students Emotional focused coping strategies accounted for 10.1% of the variance in step 1, problem focused coping strategies accounted for 7.1% of the variance in step 2. Collectively these variables accounted for 17.2% of the variance in mental health in Iranian students. In the regression, emotional focused coping strategies was first important predictor ($\beta = 0.372$, $p = 0.000 < 0.01$) and problem focused coping strategies ($\beta = -0.273$, $p = 0.000 < 0.01$) was second significant predictor, and the third predictor variable was the avoidance focused coping strategies that did not emerge as significant predictor for mental health.

In total sample Emotional focused coping strategies accounted for 7.8% of the variance in step 1, problem focused coping strategies accounted for 5.8% of the variance in step 2. Collectively these variables accounted for 13.6% of the variance in mental health. In the regression, emotional focused coping strategies was first important predictor ($\beta = 0.332$, $p = 0.000 < 0.01$) and problem focused coping strategies ($\beta = -0.246$, $p = 0.000 < 0.01$) was second significant predictor, and the third predictor variable was the avoidance focused coping strategies that did not emerge as significant predictor for mental health in total sample.

Altogether, results showed that emotion-focused coping strategies was first, and problem-focused coping strategies was second important predictor for mental health, but avoidance –focused coping strategies was not a predictor for mental health.

These results have been endorsed in a number of studies. For instance, Bouteyre, Maurel, and Bernaudl (2007: 93) in their study on daily hassles and depressive symptoms among first year psychology students in a French university found that emotion-centered coping was positively correlated with depression. Another such study was conducted by Solomon, Avitzur and Mikulincer (1990: 451), who found emotion-focused coping to be related to the presence of psychiatric symptoms in soldiers who had been involved in a war. Roy-Byrne et al. (1992: 179) also found emotion-based coping to be related to increased subjective distress in people with panic and major depressive disorder. DeGenova et al. (2001: 655) reported that those who used more emotion-focused coping exhibited more depression. Billings and Moos (1984: 140), Carver et al (1989: 267) found positive correlation between emotion-focused coping g and psychological distress in large samples sizes.

To explain why emotion-based coping strategies are related to poor mental health, Windle and Windle (1996: 551) reported that emotion-centred coping is characterised by internalising one's cognitive processes, such as thoughts/ruminations and self blame. Subsequently, reacting in this way extends and worsens the effects of the adverse situation, triggering the onset of depressive symptoms.

The finding that problem-focused coping was negatively associated with GHQ-Total confirms hypothesis 1 and is consistent with past research (Billings & Moos, 1985: 140; Knibb & Horton, 2008: 103; Penland et al., 2000: 963; Sherbourne et al., 1995: 345; Wijndaele etal., 2007:425). Negative associations between problem-focused coping and mental disorders symptoms have been shown in clinical samples (Billings & Moos, 1985:140; Sherbourne et al., 1995: 345), community samples (Knibb & Horton, 2008: 103; Wijndaele et al., 2007:425) and university samples (Ben-zur, 1999: 923; Penland et al., 2000: 963). The negative correlation between problem-focused coping and depressive symptoms found in the current study is similar to that found in Wijndaele et al's (2007: 425) community study and Ben Zur's (1999: 923) university sample. Problem-focused coping appears to be associated with reduced mental disorders symptoms as this style actively removes or resolves stressors (Carver et al., 1989:267). As stressors are removed before they develop into functionally inhibiting stressors, this may reduce stress levels and prevent individuals from experiencing more severe psychological distress (Lazarus, 1966p572). Cosway, et al. (2000:121) Found a significant negative correlation between GHQ-Total and problem-focused ($r = -0.17$, $p < 0.01$), a significant correlation positive between GHQ-Total and emotion-focused ($r = 0.46$, $p < 0.01$), and didn't find significant relationship between GHQ-Total and avoidance –focused coping strategies ($r = 0.10$,$p > 0.05$) in 730 Scottish consultant doctors and farmers.

Altogether result of this study showed that emotion-focused and problem-focused coping strategies are predictor variables for mental health similar finding were reported by(Ben-zur, 1999:923; Billings & Moos, 1985:140; Bouteyre et al., 2007:93; Carver et al., 1989:267; Knibb & Horton, 2008:103;; Penland et al., 2000:963; Sherbourne et al., 1995:345; Wijndaele et al., 2007:425).

Also the result of this study showed that avoidance-focused coping strategies is not predictor variable for mental health similar finding was reported by (Cosway et al., 2000:121) but some researchers found positive coloration between avoidance coping strategies and mental disorders for example (Wijndaele et al., 2007:427).

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