

The Relationship of Emotional Intelligence, Perceived Stress, Religious Coping with Psychological Distress among Afghan Students

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Abstract—The aim of present research was to study of the relationship between emotional intelligence, perceived stress, positive religious coping with psychological distress to in a sample of undergraduate students in Polytechnic University in Kabul. One hundred and fifty-two students (102 male, 50 female) were included in this study. All participants completed the Emotional Intelligence Scale (EIS), General Health Questionnaire (GHQ 12), Perceived Stress Scale (PSS-10), and the Brief RCOPE. The results revealed that EI was negatively associated with perceived stress and psychological distress. Also emotional intelligence was positively correlated with positive religious coping. Perceived stress was positive related with psychological distress and negatively correlated with positive religious coping. Eventually positive religious coping was significantly and negatively correlated with psychological distress. However, emotional intelligence and positive religious coping could influence on mental health.

Keywords—Emotional intelligence, perceived stress, positive religious coping, psychological distress.

I. INTRODUCTION

EMOTIONAL INTELLIGENCE (EI) captures individual differences in identifying, processing and regulating emotion [1]. Goleman has defined as “the capacity of recognizing our own feelings and those of others, for motivating ourselves, and for managing emotions well in us and in our relationships” [2], [3]. Emotional intelligence is considered essential for one’s physical and psychological adaptation [4]. Emotional intelligence can be a significant impact on various human activities such as education, training, leadership and guidance of others, personal life, mental health and well-being [5].

Research indicated that there is significant relationship between managing emotions ability and mental health [6]. Attempts have also been made to examine the relative significance of various component of emotional intelligence (EI) in predicting stress and health. Findings in general suggest that some forms of EI may protect people from stress and lead to better adaption [6]. Attempts have also been made to examine the relative significance of various component of emotional intelligence in predicting stress and health [6], and EI has been empirically associated with better mental health [7] and few studies have statistically controlled for the influence of these conceptually-related variables in analyses. Meyer and Salovey maintained that one of the significant

benefits of regulating emotion is to improve negative emotions and nurturing pleasant and positive emotions [8].

Mental health is essential for living a full and productive life, and it is recognized as one of the crucial components of overall health [9]. According to the World Health Organization (WHO), health is defined as the bio- and psychosocial well-being of the individual and Mental health is defined as “a state of emotional and social well-being in which the individual realizes his or her own abilities, can manage the normal stresses of life, can work effectively, and is able to play a role in his or her community” [6]. A number of studies have shown that trait EI is a protective factor with respect to mental health and psychological well-being, showing for instance a negative association with depression, subjective fatigue, chronic diseases, chronic pain, substance abuse, anxiety and somatic symptom reporting, and chronic diseases, chronic pain, substance abuse, anxiety and somatic symptom reporting [10].

Perceived stress can be conceptualized as the degree to which a situation in one’s life is appraised as stressful [11] and therefore as an outcome of primary and secondary appraisals. In other words, perceived stress is a state outcome reflecting the global evaluation of the significance and difficulty in dealing with personal and environmental challenges. Children and adolescents who report high levels of perceived stress are at high risk for negative outcomes, such as depression [12]. Research evidence indicates that perceived stress is associated to both anxiety and depression [10]. Found that people who scored higher in emotional intelligence scale suffered less subjective stress, experienced better health and well-being, and demonstrated better management performance [10]. High trait EI individuals exhibit good stress management skills and an ability to appraise, express and manage their emotions [10].

To further assess the relationship between EI and perceived stress, a multinational survey was completed including dental schools in seven countries [13]. The total participants included 596 dental undergraduate students. The study found that females, younger students, those without a previous graduate education experience, and those not satisfied with their decision to study dentistry were more likely to report perceived stress when compared to their counterparts with females reporting higher levels of perceived stress compared to males. The study also found a significant inverse relationship between EI and perceived stress. The significant predictors include gender, previous higher education qualification and lack of satisfaction with the decision to enter

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dental school. Researchers concluded that a distinct inverse relationship exists between EI and perceived stress across sociocultural and academic contexts of undergraduate dental school. However, EI and positive coping skills were negatively correlated with reported stress and perceived stress [13]. Additionally one qualitative follow up study concluded younger dental students reported higher stress than older students and female dental students reported higher stress than males [13].

Religious coping: Stress and coping are interrelated concepts that are significant and substantial correlates of mental health. A large literature spanning four decades shows effective coping precipitates positive health outcomes whereas ineffective or maladaptive coping exacerbates mental disease and may lead to declines in overall health [9]. Religious coping is “the means of dealing with stress that are religious. These include prayer, congregational support, pastoral care, and religious faith,” [1]. Religious coping is defined as utilizing cognitive and behavioral skills during stressful life events that arise from one’s religion [14]. Religious coping has been linked to a number of positive outcomes such as increased self-esteem and decreased depressive and anxiety symptoms [15]. Research on religious coping has become increasingly prevalent over the past couple of decades [16]. Van Dyke et al., found that positive religious coping was associated with positive affect, and satisfaction with life, while negative religious coping was associated with negative affect and psychological distress [8].

Positive patterns of religious coping have been inversely related to symptoms of depression, especially positive forms of religious coping which involve the interpretation of stressful life events within a framework of God’s love, working collaboratively with God, and relying on support from other religious people. In terms of criterion validity, higher scores on the positive religious coping subscale were associated with greater life satisfaction, spiritual growth, and stress-related growth as well as lower levels of depression, anxiety, distress, hopelessness, and guilt [17].

In general, researchers have found significant correlations between use of religious coping strategies and mental and physical well-being [16]. The prevalence of religious coping generally depends on the type of stressor, sample characteristics and situational factors (e.g. type of illness, time since diagnosis, stage of illness, remission status and treatment) [18].

II. METHODOLOGY

A. Participants

Statistical population of this research was all students of postgraduate in Polytechnic University in Kabul, in Afghanistan. One hundred and fifty-two students, 102 male and 50 female (67.1 % male, 32.9 % female) voluntarily participated in this research. After encouraging the subjects to completed emotional intelligence scale (EIS) and the general health questionnaire (MHQ -12), perceived stress scale (PSS), and brief RCOPE. The range age of participants was from 20

to 31 (M= 22.7, SD= 2.71).

B. Measures

Emotional Intelligence Scale (EIS): The EIS is a 33-question test which has been made by Schutte et al. [19], [20]. The EIS is founded on Salovey and Mayer’s original model of emotional intelligence, as well as the revised model Mayer, Salovey, and Caruso [13]. The questions of test assess three subjects of emotional intelligence including regulation of emotion, utilization of emotion and appraisal of emotion in Likert –degree scale from score 1 (quite opposing) to score 5 (quite agreeing). Internal consistency of test questionnaire is on Chronbach alpha from 0.84 to 0.90 [19]. Test-retest reliability coefficient of scale in a 28-individual sample of students was calculated with a time interval of two weeks at 0.78 [20]. Reliability of emotional intelligence scale has been reported sufficient through its correlation with relevant structures. In Farsi form of this scale, Chronbach alpha of scale questions in a 135-individual sample of students was calculated 0.88 which shows good internal consistency of test. Correlation coefficient of the scores of 42 individuals of the said scale was calculated 0.83 with an interval of 0.83, which showed reliability of satisfactory retesting [11].

The General Health Questionnaire-12: GHQ-12 was developed by Goldberg et al. [21], [22]. It is a 12-item questionnaire which assesses the severity of a mental problem each item being followed by four possible responses, typically being “much less than usual”, “same as usual”, “more than usual”, and “much more than usual”. Many studies, however, have reported that the GHQ-12 is not unidimensional, but instead assesses psychological morbidity in two (positive and negative items) or three dimensions (“anxiety and depression”, “social dysfunction” and “loss of confidence”) [23], [24]. Five of the items assess positive mental well-being while the remaining seven items assesses negative mental well-being. Analysis used during the development of GHQ-12 ensured that it has good content validity and Internal consistency has been reported in a range of studies using Cronbach’s Alpha, with correlations ranging from 0.77 to -0.93 [25], [26].

Perceived Stress Scale: Cohen, Kamarck, and Mermelstein developed the Perceived Stress Scale (PSS) in 1983 [13]. The current 10-item scale was a shortened version of their original 14-item index and had been found to maintain the same psychometric properties. The items on this scale were based on psychological stress theory, which states that a person interacts with his or her environment, and in turn, appraises stressors in light of available coping resources. PSS-10 scores were obtained by reversing the scores on four positive items and then summing across all 10 items. Items 4, 5, 7, and 8 were the positively stated items. High PSS scores were related to harmful health behaviors such as failure to stop smoking and depression [7]. Data obtained in 1987 by a random digit dialing national area-probability sample of adults revealed that internal reliability of the PSS as measured by Cronbach’s alpha was .78 and was at least as good a measure of perceived stress as the original 14-item scale. The PSS has been used frequently to measure perceived stress among college students

[7].

Brief RCOPE: Positive religious coping was operationalized as a score on the Positive Religious Coping subscale of the Brief RCOPE. The Brief RCOPE is a 14-item measure of religious coping designed to assess positive and negative religious coping methods [8]. The Positive Religious Coping subscale of the Brief RCOPE consists of seven items that measure respondents' perceived spiritual connection, spiritual support, religious forgiveness, collaborative religious coping, benevolent religious reappraisal, religious purification, and religious focus. The instrument uses a four-point Likert scale, with responses ranging from 1 (not at all) to 4 (a great deal), to determine the degree to which respondents utilize positive religious coping practices. Previous research found a Cronach's alpha score of .90 for the Brief RCOPE's Positive Religious Coping subscale [15], [20], [27].

C. Data Analysis

The obtained data were analyzed and evaluated by using SPSS (Statistical Package for Social Sciences). Mean and standard deviation were used as descriptive analysis. Pearson's correlation coefficient was used to study the relationship between emotional intelligence, perceived stress, positive religious coping and psychological distress.

III. RESULTS

Table I presents the means and standard deviations of the study variables.

TABLE I
MEAN AND STANDARD DEVIATION OF THE STUDY VARIABLES (N=152)

Variable	Mean	SD
Emotional intelligence	121.34	20.64
Perceived stress	15.52	6.34
Positive religious coping	23.13	3.53
Psychological distress	24.13	5.60

In order to study the relationship between emotional intelligence, perceived stress and positive religious coping with psychological distress in undergraduate students, Pearson's correlation coefficient was used. The correlation is presented between research variables in Table II.

TABLE II
CORRELATION AMONG EMOTIONAL INTELLIGENCE, PERCEIVED STRESS, POSITIVE RELIGIOUS COPING, AND PSYCHOLOGICAL DISTRESS

Variable	I	II	III	IV
I- Emotional intelligence	1.00			
II- Perceived stress	-0.23*	1.00		
III- Positive religious coping	0.33*	-0.159 **	1.00	
IV- Psychological distress	-0.24*	0.59*	-0.18**	1.00

*P<0.01 **P<0.05

As expected, emotional intelligence and perceived stress were significantly and negatively correlated ($r = -0.23$, $p < .01$), and both emotional intelligence and positive religious coping were significantly and negatively correlated with psychological distress ($r = -0.24$, $p < .01$, and $r = -0.18$, $p < .05$, respectively). Perceived stress and psychological distress were

also significantly and positively correlated with each other ($r = 0.59$, $p < .01$). Eventually, positive religious coping was significantly and positive correlated with emotional intelligence ($r = 0.33$, $p < .01$) and it was significantly negative correlated with perceived stress ($r = -0.159$, $p < .05$).

As specified from correlation analysis, there was a positive and significant correlation between emotional intelligence and positive religious coping and there was a positive and significant correlation between psychological distress and perceived stress. In addition, there was a negative correlation between perceived stress, psychological distress with emotional intelligence. Eventually, positive religious coping was negative correlated with perceived stress and psychological distress.

IV. DISCUSSION

The purpose of the present research was to study of the relation between emotional intelligence, perceived stress, and religious coping with psychological distress among Afghan college students. The results of the present research indicated that there is a significant relationship between emotional intelligence, perceived stress, and positive religious coping with psychological distress.

The results of the study indicated that emotional intelligence was negatively related to psychological distress. A number of studies have shown that emotional intelligence is a protective factor with respect to mental health and psychological well-being, showing for instance a negative association with depression, subjective fatigue, anxiety and somatic symptom reporting [7], [8]. The result of this study showed a significant negative relationship between emotional intelligence and perceived stress, with respect to the influence of EI on health; indicate that EI has a mediating role in the relationship between psychological health and stress. It means people with high EI are able to deal with environmental demands better than people who score low in this variable [10], [13]. Found that people who scored higher in emotional intelligence scale suffered less subjective stress, experienced better health and well-being, and demonstrated better management performance [10]. High EI individuals exhibit good stress management skills and an ability to appraise, express and manage their emotions [10]. There positive relation between emotional intelligence and positive religious coping. However, EI and positive coping skills were negatively correlated with reported stress and perceived stress [13]. Also in this study perceived stress was positively correlated with psychological distress and previous research evidence indicates that perceived stress is associated to both anxiety and depression [10].

Additionally, in this study was positive religious coping negatively correlated with psychological distress and perceived stress. Previous research has found positive religious coping to be related to lower levels of mental health symptomatology and higher scores on the positive religious coping subscale were associated with greater life satisfaction,

spiritual growth, and stress-related growth as well as lower levels of depression, anxiety, distress, hopelessness, and guilt [17], [28]-[30].

The study of the relation between emotional intelligence, perceived stress, religious coping and psychological distress is of importance, since it allows us to understand the ways that emotional intelligence and religious coping relate to personal beliefs in shaping outcome expectations. However, emotional intelligence and positive religious coping could influence on mental health.

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