ABSTRACT

Understanding of the stress-illness relationship has progressed over the past half a century, with a gradual shift in the emphasis from the so called stressful life event *per se* to person and situational variables. A host of intervening variables have been found to moderate the effect of the life event and it is found that stress-illness relationship is not uni-variate and unidirectional. Among these appraisal of life events as stressful or not (perceived stress), a predisposition to experience life events as stressful (vulnerability), personality traits as coping resources and the method of dealing with the situation (coping strategies) have been found to play a significant role in determining the causal sequence in stress-illness relationship. Many models have been proposed, emphasizing one or more of the above. Further, it has also been found that the ultimate consequence of experienced stress need not always be psychological and it can result in a host of medical conditions affecting different organ systems. The current literature suggests that among the many different conditions that can be attributed to experienced stress, depression and heart diseases seem to have overlapping symptoms because of somatization of illness manifestation, leading to difficulties in diagnosis and management.

This study is an attempt to examine the differences among depressed and CHD groups compared to healthy subjects in coping strategies, coping resources, stressful life events, perceived stress, vulnerability to experience stress and depression score. The research literature suggests that there is a relationship between coping styles and personality traits and that “The Five-Factor Model of Personality” provides a useful context for assessing individual differences in coping strategy. A second objective is to understand the relation between coping resources, coping strategies
perceived stress and vulnerability in moderating life-event stress among depressive and coronary heart disease patients as against healthy group. Finally, the study attempted to examine the role of coping resources, coping strategies, vulnerability and stressful life events as predictors of perceived stress and depression score.

To achieve the above objectives 100 depressed patients (M=35.90yrs SD=10.59 yrs); 100 CHD patients (M=46.42 yrs SD=12.52 yrs) and a group of healthy subjects (M = 37.97 yrs; SD =12.49 yrs) were selected. To screen the volunteers from general population for their general health status and to select a healthy group, *General Health Questionnaire 28* (Goldberg, 1979) was used. The following scales were used to measure different variables in the three groups of subjects:(1) Personal Data Sheet, (2) *Coping Orientations to Problems Experienced Scale* (COPE; Carver et al., 1989), (3) *Perceived Stress Scale* (Cohen, Kamarck & Mermelstein, 1983), (4) *Vulnerability to Experience Stress* (Part Three of *Stress Audit*) (Miller and Smith, 1985), (5) *Zung’s Depression Scale* (1965), (6) *Presumptive Stressful Event Scale (PSE-Scale)* (Singh, et al. 1981), (7) *NEO-Five Factors Inventory* (NEO-FFI) (Costa and McCraes’, 1992).To compare the three groups of subjects ANOVA was used. Pearson’s Correlation technique was used to examine the relation between coping resources and other study variables. Stepwise multiple regression analysis was employed to test which variables predicted perceived stress and depression scores for the three groups.

The main findings can be summarized as follows. (1) In terms of *group differences*, patient groups have experienced more stressful life events, are more vulnerable, have higher perceived stress and higher depression score than the healthy group. Among themselves patient groups did not differ much in these characteristics.
In coping resources, patient group have poor coping resources as reflected in high neuroticism, and low extraversion, openness, agreeableness, and conscientiousness as compared to healthy group. It is also found that patient groups use more of dysfunctional coping strategies as compared to healthy persons who use more of problem-focused and emotion focused coping, the latter two being more functional and positive in nature. (2) With reference to relationship between variables, it can be said that in general correlation is positive and significant between perceived stress, vulnerability to stress and Zung depression score with low coping resources and dysfunctional strategies. High coping resources have a positive correlation with problem focused and emotion focused strategies. (3) As for prediction of perceived stress and depression score (Zung) is concerned no definite trend has emerged indicating that there are a number of pathways through which stress, depression and eventual illness can precipitate. Based on these findings a heuristic theoretical model or pattern of stress-illness relationship pathways is suggested, for future exploration and confirmation.