Coping Strategies and Difficulties in Emotion Regulation Among Allied Mental Health Professionals in India: A Correlational Study

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Abstract: This cross-sectional, correlational study investigated the relationships between specific coping strategies and difficulties in emotion regulation among Allied Mental Health Professionals (MHPs) in India. A sample of MHPs completed the COPE Inventory (measuring Problem-Focused Coping [PFC], Emotion-Focused Coping [EFC], and Avoidant Coping [AC]) and the Difficulties in Emotion Regulation Scale (DERS). The sample reported low overall DERS difficulties (Mean = 1.82) and favoured Problem-Focused Coping (Mean = 3.06) as their primary strategy. Hypothesis testing revealed a strong, highly significant positive correlation between Avoidant Coping (AC) and Total DERS ($r = 0.694$, $p<0.001$). Conversely, the relationships between the more adaptive strategies – PFC ($r = -0.108$) and EFC ($r = 0.033$)—and DERS were weak and non-significant. These findings emphasize that AC is the critical maladaptive factor linked to difficulties in emotional stability for this professional group.

Key words: Avoidant Coping, Emotion Regulation (or Emotional Dysregulation), Allied Mental Health Professionals (MHPs), Coping Strategies, Clinicians, India, Professional Well-being, DERS (Difficulties in Emotion Regulation Scale), COPE Inventory.

1. INTRODUCTION

The mental health of professionals who serve in high-stress clinical roles is a global concern, yet research on these dynamics is less prominent in contexts like India, where MHPs often face unique resource and stigma challenges (Gopinath & Ponnusamy, 2020). Allied Mental Health Professionals (MHPs)—including counsellors, social workers, and psychologists—are continuously exposed to vicarious trauma and high emotional demands. Their ability to effectively regulate personal emotions is essential for ethical practice and preventing burnout (Orlinsky & Rønnestad, 2005).

1.1 THEORETICAL FRAMEWORK: COPING AND EMOTION REGULATION

Coping is traditionally viewed through the lens of transaction theory, defining it as cognitive and behavioural efforts to manage internal and external demands (Lazarus & Folkman, 1984). This framework primarily distinguishes between Problem-Focused strategies (aimed at changing the stressor) and Emotion-Focused strategies (aimed at modifying one's reaction). Avoidant Coping (AC), a third category often considered maladaptive, involves behavioural or cognitive efforts to disengage from the stressor through denial, withdrawal, or substance use.

Emotion Regulation (ER) encompasses the processes by which individuals influence their emotional experiences and expressions (Gross, 1998). Difficulties in emotion regulation (DERS) are characterized by the inability to manage emotional intensity, duration, and appropriateness. Given the occupational demands on MHPs, understanding how specific coping styles predict DERS is crucial. While avoidance is consistently linked to poor ER, the relationship between adaptive coping (PFC/EFC) and ER outcomes is often context-dependent.

1.2 PROFESSIONAL CONTEXT IN INDIA

The Indian MHP community operates within a unique environment characterized by high patient load, limited public health resources, and persistent mental health stigma. Understanding how Indian MHPs cope is vital for developing culturally sensitive and effective professional support systems. Furthermore, examining their rates of supervision and personal therapy provides context on self-care and professional integrity.

1.3 HYPOTHESES

This study aimed to clarify the relationships between coping strategies (PFC, EFC, AC) and difficulties in emotion regulation (DERS) within a sample of practicing AMHPs in India. Based on established literature linking avoidance to dysregulation:

- **H1:** Avoidant Coping (AC) strategies and Total DERS will be **positively correlated** (indicating AC is maladaptive).
- **H2:** Problem-Focused Coping (PFC) and Total DERS will be **moderately negatively correlated** (indicating PFC is adaptive).
- **H3:** Emotional Focused Coping (EFC) and Total DERS will be **weak or non-significantly correlated** (reflecting the mixed literature on this style).

2. METHOD

2.1 PARTICIPANTS AND PROCEDURE

A convenience sample of Allied Mental Health Professionals practicing in India participated in this study. Recruitment was conducted primarily through professional networks and mailing lists associated with clinical practice. Participants completed an anonymous online survey after providing informed consent. The study employed a cross-sectional design.

Inclusion Criteria: Professional status of Allied mental health (counsellor, therapist), active clinical practice, clinical experience, informed consent, English language fluency for this study in India.

Exclusion Criteria: Individuals in purely academic, research, retired or administrative roles without current clinical client contact.

2.2 MEASURES

1. **COPE Inventory:** The 60-item COPE Inventory measured typical responses to stress using a 4-point Likert scale (1 = I usually don't do this at all; 4 = I usually do this a lot). The study utilized three composite subscales: Problem-Focused Coping (PFC), Emotion-Focused Coping (EFC), and Avoidant Coping (AC).
2. **Difficulties in Emotion Regulation Scale (DERS):** The DERS measured the severity of difficulties in emotion regulation using a 5-point Likert scale (1 = Almost Never; 5 = Almost Always). Higher scores indicate greater difficulty. The Total DERS score was used as the primary outcome measure.
3. **Professional Indicators:** Single-item questions assessed the Regularity of Supervision (e.g., Weekly, Monthly, None) and Personal Therapy Status (e.g., Yes, Yes in Past, No).

2.3 DATA ANALYSIS

Data analysis was conducted using statistical software. Descriptive statistics (Means, Standard Deviations, Frequencies, Percentages) were calculated. Bivariate Pearson correlation coefficients (r) were computed to test the hypotheses regarding the relationships between the COPE subscales and Total DERS. Significance was set at $p<0.05$

3. RESULTS

3.1 DESCRIPTIVE STATISTICS AND PROFESSIONAL CHARACTERISTICS

A. DERS and COPE Means

The overall descriptive statistics (Table 1) revealed that the sample generally reported low levels of emotional distress and favoured problem-solving approaches.

Table 1 Descriptive Statistics

Scale/Subscale	Mean Score	Standard Deviation (SD)	Scale Range	Interpretation
Total DERS	1.8230057	0.9411979	1-5	Low difficulties with emotion regulation.
PFC	3.057692	0.836906	1-4	High frequency of active, problem-focused coping.
EFC	2.582265	1.071304	1-4	Moderate use; highest variability in use.
AC	1.534615	0.832367	1-4	Low frequency of avoidant coping.

B. PROFESSIONAL CHARACTERISTICS

The sample showed high professional engagement regarding self-care and supervision:

- **Supervision:** 78.1% of MHPs reported receiving supervision at least monthly (Weekly: 26.9%, Monthly:51.2%). Only 8.3% reported taking no supervision (Orlinsky & Rønnestad, 2005).
- **Personal Therapy:** A large majority (93.6%) reported having engaged in personal therapy (Currently: 75.9%, In Past: 17.7%).

3.2 HYPOTHESIS TESTING (CORRELATIONS)

Pearson correlation analysis was used to test the three hypotheses (Table 2).

Table 2 Hypotheses

Hypothesis (H)	Relationship Tested	Pearson r	Significance (p)	Result
H1	AC and Total DERS	0.694	< 0.001	**Supported**
H2	PFC and Total DERS	0.108	= 0.089	**Not Supported**
H3	EFC and Total DERS	0.033	= 0.68	**Supported**

The analysis provided a clear pattern of results:

- **H1 (Avoidant Coping):** The strong positive correlation (r = 0.694) was highly significant, indicating that as MHPs report using more avoidant strategies (denial, behavioural disengagement), their difficulties with emotion regulation increase dramatically.
- **H2 (Problem-Focused Coping):** The relationship was weak (r= -0.108) and did not reach statistical significance, failing to support the hypothesis of a moderate negative correlation.
- **H3 (Emotion-Focused Coping):** The correlation was near zero (r= 0.033) and non-significant, supporting the hypothesis of a weak or non-significant link.

4. DISCUSSION

4.1 INTERPRETATION OF KEY FINDINGS

The results offer a robust insight into the emotional dynamics of the Indian MHP community.

Firstly, the descriptive data confirms that this sample is highly dedicated to professional self-care and oversight, as evidenced by the high rates of monthly supervision and personal therapy engagement. This dedication may partly explain the low overall DERS mean score (Mean = 1.82), suggesting the sample is generally well-adjusted in their emotional competence.

Secondly, the correlational findings provide a crucial clinical target: Avoidant Coping is the single most important predictor of emotion regulation difficulties (Gross, 1998). The central finding of this study is the robust and highly significant positive correlation between Avoidant Coping and Total DERS (r=0694). This finding aligns with general psychological theory (Gross, 1998) and confirms that for MHPs, coping strategies involving denial, disengagement, and avoidance are powerfully linked to an impaired ability to manage emotions effectively. This maladaptive cycle suggests that when emotional demands are high, the MHP's internal emotional stability is compromised by a reluctance to fully engage with the discomfort.

Thirdly, the non-significant findings for PFC and EFC are particularly noteworthy. Despite being the most frequently used strategy (PFC Mean = 3.06), PFC showed no significant relationship with DERS. This suggests that while MHPs may be highly effective at solving *external, technical problems* (e.g., managing research deadlines, or client case formulation), this skill does not transfer to the domain of *internal, emotional regulation*. This disconnect highlights that emotional stability is compromised by avoidance, not merely a lack of problem-solving (Dugas et al., 1998).

4.2 LIMITATIONS AND FUTURE DIRECTIONS

The study's cross-sectional design prevents any conclusion of causality; while avoidance is linked to poor ER, the reverse could also be true. The relatively low DERS scores likely introduced a restriction of range, potentially obscuring moderate relationships between adaptive coping and emotion regulation that might exist in more clinically distressed populations. Furthermore, reliance on self-report measures carries the risk of social desirability bias, where MHPs may underreport maladaptive traits.

Future research should employ longitudinal designs to clarify the temporal sequence of the AC-DERS relationship. Further analysis should also investigate the specific DERS subscales (e.g., Lack of Emotional Clarity, Impulse Control Difficulties) to pinpoint which aspects of dysregulation are most highly predicted by AC. Replicating this study in a clinical sample of MHPs seeking treatment for burnout could provide a necessary contrast to this well-adjusted professional sample.

4.3 CLINICAL IMPLICATIONS

The findings have clear implications for MHP training and supervision in India. Supervision (Orlinsky & Rønnestad, 2005) and continuing education should move beyond reinforcing merely problem-focused skills and instead focus on therapeutic techniques aimed at reducing Avoidant Coping. Training in acceptance-based strategies, emotional exposure, and present-moment awareness can help clinicians tolerate the distress and uncertainty inherent in their work, directly targeting the mechanism most powerfully linked to emotional dysregulation.

4.4 CONCLUSION

This study confirms that among Allied Mental Health Professionals in India, Avoidant Coping is powerfully and positively linked to difficulties in emotion regulation. These findings provide a focused target for professional development, suggesting that therapeutic training and self-care efforts must emphasize emotional acceptance and engagement over avoidance.

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