Pakistan Journal of Social and Clinical Psychology
2013, Vol. 11, No.2, 43-46

Tolerance towards Frustration, Self Esteem, Anxiety and Depression in Physically Disabled Individuals

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The study investigated tolerance towards frustration, self-esteem, anxiety and depression in physically disabled individuals. For this purpose, a sample of 15 physically disabled women and 45 men with an age range of 18-25 years from different rehabilitation centers of Lahore city was taken. *Symptom Checklist-Revised* (SCL-R), with three sub-scales (Rahman et al., 2009) ascertained frustration tolerance and vulnerability towards anxiety and depression; and a translated form of *Brief Self-Esteem Inventory* (BSEI) developed by Williams (2000) assessed self-esteem in the above participants. The results showed that self-esteem of physically disabled patients was not very low but they were having very low frustration tolerance. The participants: 12% &17% scored and above 1 SD on Depression and Anxiety Scales, respectively. The results further showed a significant negative relationship between low frustration tolerance and self-esteem as well as negative relationship between anxiety and self-esteem.

Key words: physically disabled, self-esteem, frustration tolerance, anxiety, depression

The present study explored mental health, psychological stressors and self-image of individuals who were physically handicapped. It is an area that requires extensive research in Pakistan. According to International Classification of Functional Disability (ICF) physical disability is a state with remarkable defect, limitation or inability of certain organs or processes of the body, which create hurdle in carrying out normal physical movements and thus affect normal functioning in different areas of life (WHO, 2001 as cited in Chang & Johnson, 2008). Physical disability either congenital or acquired may lead to feelings of inadequacy (Chang & Johnson, 2008).

Marschark (1993) suggested a strong relationship between physical and mental functioning in humans because any type of physical or sensory deficiency disturbs one's overall psychological functioning by creating an obstruction in normal flow of such processes, leading to an experience of the world, which is distinct in context.

Majority of early disabilities lead to disturbed and defective body image as a consequence of unresolved conflicts. If disability is acquired at a stage when a person has developed as an adult, vulnerability to its psychological consequences are fewer. The lifelong physical disability may reduce an individual's independence and lead to profound impediments in life-style (Schalock & Siperstein, 1997). People who experience physical impediments are more likely to have low frustration tolerance (McDermoort & Akina, 1972; Dell Orto & Power, 2007). Many individuals with physical disability experience anxiety (Boswell & Wingrove, 1974) and also experience depression due to loss and as well as due to the changed behaviors of people around them (Krueger, 1984).

Taleporos and McCabe (2005) found low self-esteem among those who need help to carry out activities as compared to those who do not require such assistance. Moreover, it has more adverse effects for men as compared to women (Chang & Johnson, 2008).

Disabilities are often associated with jeopardized self-esteem (Nosek et al., 2003; Gill, 1996; Cornwell & Schmitt, 1990). It has a negative effect on those who were ambitious and could have achieved their life goals easily in the absence of their present disability as compared to those who were unrealistic in goal setting even without having any disability (Goodwill & Chamberlain, 1988). Narimani and Mousazadeh (2010) also found a significant difference in the mean scores of handicapped and normal students on self-esteem. Lasker et al. (2010) noted similar severe psychosocial problems in children with disability in comparison to the healthy ones.

Puranen, Seuri, Simoli and Elo (1999) found that participants displayed symptoms of anxiety and depression more commonly than general population. Sharma, Vaid and Jamwal (2004) studied frustration in 5-13 years of children (n=10) suffering from physical defects belonged to low socio-economic class. They found low frustration in them which was displayed through blaming or resentment against others around them.

On the basis of above research evidences, it is concluded that physically disabled individuals may have low self-esteem marked by symptoms of anxiety and depression. However, limited work has been done on frustration tolerance especially in Pakistan. To explore this phenomenon in Pakistani context, present researchers investigated the above psychological constructs in people with physical disabilities.

Method

Participants

The sample consisted of 15 physically disabled women and 45 men with an age range of 18-25 years (M = 20.88, SD = 2.34). The disabilities were mainly of upper and lower limbs. Based on academic literacy, 22% of the sample was illiterate; 30% were below Matric; 28% were matriculated; 5% were educated upto intermediate and 13% were university graduates. The sample belonged to low (53%), lower middle (32%) and upper middle (15%) socioeconomic status.

Measures

The demographic information was collected by a small set of

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questions that referred to the age, gender, religion, level of education, marital status and type of relationship with significant others.

Symptom Checklist-R ([SCL-R], Rahman, Dawood, Rehman, Mansoor & Ali, 2009) SCL-R was used to assess the degree of anxiety, depression and frustration tolerance in participants. It is an indigenous scale which was originally developed by Rahman and Sitwat in 1990 and it was modified by Rahman et al, in 2009. SCL-R has a total of 148 items with six subscales. Three subscales: Depression (24 items); Anxiety (29 items) and LFT (24 items) were administered and each participant was asked to rate the intensity of each symptom on 0-3 Likert scale. Then the total score against each scale was derived and compared with the cut-off point to determine the vulnerability towards anxiety and depression as well as to see the level of frustration tolerance.

Brief Self-Esteem Inventory (BSEI)-Urdu Version. Originally developed by Williams (2000) and translated by Dawood and Mubashir in 2011. It has 20 items which assessed ten areas of Self-Esteem: Appearance; Competence; Intelligence; Personality; Success; Unconditional Worth; Self Forgiveness; Acceptance of Weakness; Self-Love; and Freedom from Guilt. The items are to be rated on 4-point Likert-type scale where "4" means "definitely 'Yes' or 'Almost Always' and '1' means 'definitely not or almost never'. Composite scores of less than 45 indicate very low self-esteem while a score of "76" and above indicative of high self-esteem.

Procedure

Pilot study was carried out on 5 physically disabled participants from Nasheman Institute, Lahore, and since the methodology worked optimally, therefore, the same steps were carried out in main study. In a period of almost one month, data was collected from five centers: Home for Disabled; Nasheman in Social Welfare Complex, Lahore; Business Association for Rehabilitation of Physically Disabled (LABARD); Pakistan Society for the Rehabilitation of Disabled (PSRD); and Social Welfare Office, Services Hospital. Each participant was recruited after taking formal permission from the above mentioned institutes as well as after taking the signed consent form from each participant.

Ethical Consideration

All personal information about each participant was kept confidential by the researchers, however, the participants were informed about the purpose of the study and no deception was involved at any stage. The participants were also told that they had the right to quit the study at any point whenever they want.

Results

The results given in Table 1 show that 10% of the participants obtained low scores on self-esteem, however majority obtained average or high scores on self-esteem.

The results given in Table 2 show that majority (28 %) of the participants with physical disability obtained score 1 SD above on LFT which showed that 28% sample was having low frustration tolerance. Furthermore, 12% sample scored high on Depression scale and 17% of the participants scored high on Anxiety which suggest that 12 & 17 % sample need psychiatric help for depression and anxiety problems.

The results in Table 3 showed a significant negative relationship between self-esteem, anxiety and LFT which clearly indicated that when some of the participant is anxious; he or she is having low frustration tolerance then his/her self-esteem would also be low. The results further indicated that anxiety and depression scores are positively related with each other and with low frustration tolerance

Table 1

Participants' scores distribution in different categories of Self-Esteem (N = 60).

Self-Esteem	*Cut Off Score*	*F*	*%*
Extremely Low	0-45	1	1.7
Low	46-55	5	8.3
Neither Low nor High	56-65	17	28.3
High	66-75	30	50.0
Very High	76-80	7	11.7

Table 2

Scores on subscales of SCL-R: Depression, Anxiety, and LFT (N = 60).

Scores	Depression		Anxiety		LFT	
	f	*%*	*f*	*%*	*f*	*%*
Above 1 SD	7	12	10	17	17	28
Below 1 SD	53	88	50	83	43	72

Table 3

Pearson Product Moment Correlation Co-efficient for Self-Esteem with Depression, Anxiety and LFT (N = 60).

	Self-Esteem	Depression	Anxiety	LFT
Self-Esteem	-			
Depression	-1.66	-		
Anxiety	-2.55*	.68**	-	
LFT	-.320*	.58**	.76**	-
M	62	18	22	25
SD	11.05	8.33	13.30	11.66

**** p<.05, **p<.01***

Table 4

Multiple Linear Regression (Enter Method) predicting Anxiety and Depression from Self Esteem and Low Frustration Tolerance (N = 60)

Variables	*Anxiety*		*Depression*	
	Model 1 *B*	95% CI	Model 1 *B*	95% CI
Constant	1.52	[-20.62, -23.65]	5.72	[-11.74, -23.18]
Self Esteem	-.02	[-.32, -.280]	.02	[-.21, -26]
LFT	.87***	[.66, -1.07]	.42***	[.25, -.58]
R^2	.58		.33	
F	39.26***		14.30***	

Note. CI=confidence interval; LFT= low frustration tolerance; *** p<.00.

which indicated that anxiety and depressive symptoms are overlapping and due to anxiety and depressive symptoms, one's tolerance towards frustration also get decreased.

Multiple regression analysis through Enter method was used to test if self esteem or level of frustration tolerance predicted anxiety and/or depression in participants with physical disability. With 'anxiety' as criterion variable, both predictors explained 58% of the variance and a significant model was emerged F (2, 57) = 39.26, p>.00. It was found that low level of frustration tolerance significantly predicted anxiety in the participants (β = .56, p>.00).Taking depression as criterion variable, both predictors explained 33% of the variance F (2, 57) = 14.30, p<.00 which showed that significant model was emerged. It was further found that low level of frustration tolerance significantly predicted depression in participants (β=.58, p>,000)

Discussion

The findings suggest that majority of the individuals with physical disability have low tolerance towards frustration and do have anxiety and depressive symptoms as significant negative relationships were found between self-esteem, anxiety and LFT, however, negative but no significant relationship was found between depression and low self esteem.

The researcher's first finding shows that self-esteem of the participants with physical disability was not significantly low because only six participants in total sample (N=60) fell in highly low and low self esteem category (See Table 1) which is contrary to our assumption. It could be supported by the findings of Narimani and Mousazadeh (2010) who found high self-esteem of physically disabled than normal. Furthermore, Goodwill and Chamberlain (1988) argued that probably physical disabled had dreams not associated with physical abilities and so their self-esteem might not be affected. Moreover, it may also be argued that faking good to overcome deficiencies could be one of the reasons for these discrepant results.

The results suggested that participants scored high i.e., above 1 SD on depression, anxiety and LFT (12%, 17% & 28 %, respectively). These results are consistent with the findings of other researches (Krueger, 1984; Boswell & Wingrove, 1974; Dell Orto & Power, 2007; Laskar, Gupta, Kumar, Singh & Sharma, 2010). Puranen, Seuri, Simoli and Elo (1999) found that participants with disability displayed symptoms of anxiety and depression more commonly than general population. Sharma, Vaid and Jamwal (2004) also reported that all physically challenged children experienced frustration in same way or the other.

The results showed that significant negative relationship of self-esteem with anxiety and LFT are also supported by several studies. Marschark (1993) emphasized on one's overall disturbance in functioning including psychological as a consequence of some sensory deficiency.

Conclusion

Out of 60 participants, 7 (12%) scored significantly high (1 SD above) on Depression while 10 (17%) participants obtained 1 SD above on Anxiety. Low frustration tolerance was reported by 17(28 %) participants. Further, self-esteem was not found to be significantly low, moreover, self esteem was found to be negatively related with anxiety (-0.26*) and frustration tolerance (-0.32*).

Limitation and Suggestions

The researcher took sample of 18-25 years of physically disabled individuals, although this age range covers adolescent and adulthood but if it would have covered till 45-50 years then results would be considered more authentic from generalization point of view.

The present findings are clearly indicating that physically disabled individuals were having vulnerability towards psychiatric problems such as anxiety and depression and were having LFT so the research would have more value if it could focus some kind of psychological intervention to reduce anxiety and depressive symptoms as well as to increase their level of frustration tolerance.

Implications

The study has future implications for introducing psychological services for disabled individuals in different rehabilitation centers of physically disabled individuals. Psychological services need to incorporate self-esteem building techniques; anger management techniques and the techniques related to the management of anxiety and depression along with the provision of adequate medical treatment in these rehabilitation centers.

References

Boswell, D., & Wingrove, J. M. (1974). *The handicapped person in the community: A reader and sourcebook.* London: The Open University

Cornwell, C.J., & Schmitt, S. (1990). Perceived self esteem, health status, and body image in women with Rheumatoid Arthritis or Systemic Lupus Erythematosus, *Research in Nursing and Health, 13*, 99- 107

Chang, E. & Johnson, A. (2008). *Chronic illness and disability: Principles for nursing care*. Australia: Elsevier.

Dawood, S., & Mubashir, A. (2011). Relationship between emotional intelligence, anger and self-esteem among adolescents (Unpublished MS Thesis), Centre for Clinical Psychology, University of the Punjab, Lahore, Pakistan.

Dell Orto, A. E., & Power, P. W. (Eds.). (2007). *The psychological and social impact of illness and disability* (5th ed.). New York: Springer Publishing Company.

Gill, C. J. (1996). Becoming visible: Personal health experiences of women with disabilities. In D.M., Kotoski, & M.A., Turk, (Eds.), *Women with physical disabilities: Achieving and maintaining health and well-being* (pp.5-15). Baltimore: Brookes.

Goodwill, C. J., & Chamberlain, M. A., (1988). *Rehabilitation of the physically disabled adult.* New York, NY: Sheridan House.

Guindon, M. H. (2010). *Self-esteem across the life span-issues and interventions*. New York, NY: Taylor & Francis.

Krueger, D. W. (1984). *Emotional rehabilitation of physical trauma and disability*. USA: Spectrum Publications

Laskar, A. R., Gupta, V. K., Kumar, D., Singh, M. M. & Sharma, N. (2010). Psychosocial disorders among children and some epidemiological correlates. *Asian Pacific Disability and Rehabilitation Journal, 21*(1), 80-89.

Marschark, M. (1993). *Psychological development of deaf children*. New York: Oxford University Press.

Mc Dermott, J. F., & Akina, E. (1972). Understanding and improv-

ing the personality of children with physical handicaps. *Clinical Pediatrics, 11,* 130-134.

Narimani, M., & Mousazadeh, T. (2010). Comparing self-esteem and self-concept. *Procedia Social and Behavioral Sciences, 2,* 1554-1557. doi:10.1016/j.sbspro.2010.03.234

Nosek, M. A., Hughes, R.B., Swedlund, N., Taylor, H.B., & Swank, P. (2003). Self esteem and women with disabilities. *Social Science & Medicine*, 56, 737-47. Retrieved from www.elsevier.com/locate/socsimed.

Puranen, N. N., Seuri, M., Simoli, A., & Elo, J. (1999). *Physically disabled at work: Need for ergonomic interventions, 9*(4), 215-225. Abstract Doi: 10.1023/A:1021375500867.

Rahman, N. K., Dawood, S., Rehman, N., Mansoor, W., & Ali, S. (2009). Standardization of Symptom Checklist-R on psychiatric and non-psychiatric sample of Lahore city. *Pakistan Journal of Clinical Psychology, 8*(2), 21-32.

Schalock, R. L. & Siperstein, G. N. (1997). *Quality of life: Application to persons with disabilities*. USA: American Association on Mental Retardation.

Sharma, N., Vaid, S., & Jamwal, Z., (2004). Frustration reaction in physically challenged institutionalized children (5-13 years). *The Journal of Disability and Medico-Pedagogy (Journal of Disability, Medicine and Education), 10*, 3-10.

Taleporos, G., & McCabe, M. (2005). The relationship between severity and duration of physical disability and body esteem. *Psychology and Health*, 20(5), 637-650.

World Health Organization 2001. The International Classification of Functioning, Disability and Health (ICF). Geneva: WHO. http://www.who.int/classifications/icf/en/

Williams, K. (2000). *Brief Self Esteem Inventory*. International Training Partner, Inc. Retrieved from http// RelationshipSkills.com

Received May 14, 2013
Revision Received September 9, 2013