The Effect of Personality, Resilience and PTSD on the Quality of Life

A

Thesis submitted

In the partial fulfillment of the requirement of the degree of

MASTER OF ARTS

IN PSYCHOLOGY

(Clinical)

SUBMITTED BY:

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UNDER THE GUIDANCE OF

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CERTIFICATE

This is certify that the thesis entitled "The effect of Personality, Resilience and PTSD on Quality of Life" being submitted in partial fulfillment of requirements for the award of degree of Master of Arts in Psychology, submitted in the School of Humanities and Social Sciences, Thapar Institute of Engineering and Technology , Patiala is a bonafide work carried out under the supervision of Dr. Santha Kumari, Professor, School of Humanities and Social Sciences, Thapar Institute of Engineering and Technology, Patiala and that no part of this project has been submitted for the award of any other degree.

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This is to certify that above statement made by the student concerned is correct and true to the best of my knowledge.

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CANDIDATE'S DECLARATION

I hereby declare that the work presented in this thesis entitled, "The Effect of Personality, Resilience and PTSD on the Quality of Life" in partial fulfillment of the requirement for the award of Degree of Master of Arts in Psychology, submitted in the School of Humanities and Social Sciences, Thapar Institute of Engineering and Technology, Patiala, is an authentic record of my own work carried out under the supervision and guidance of Dr. Santha Kumari, Professor, School of Humanities and Social Sciences, Thapar Institute of Engineering and Technology, Patiala and refers other researcher's work which are duly listed in the reference section.

The matter embodied in this thesis has not formed the basis for the award of any other degree of this or any other university.

Date: May, 2022

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ABSTRACT

The Big Five Personality Factors plays an important role for the smooth functioning of an individual's Quality of Life on a routine basis. Resilience as well as the PTSD affects the Quality of life of an individual. The present study aimed to investigate this unique association shared between the Personality, Resilience, PTSD and Quality of Life, in a sample of 202 consisting both males and females. It was hypothesized that personality factors Extroversion, Agreeableness, Conscientiousness and openness to Experience as well as Resilience are positively related to the Quality of Life. Whereas, personality factor Neuroticism and PTSD are negatively related to Quality of Life. Also the objective of the study is to find the best predictor of the four domains of the Quality of Life.

Keywords: Big Five Personality Factors, Extroversion, Agreeableness, Neuroticism, Conscientiousness, Openness to Experience, Resilience, PTSD, Quality of Life

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CHAPTER- 1

INTRODUCTION

1.1 Personality

Personality is the trademark sets of practices, discernments, and feelings designs that develop from organic and ecological variables. While there is no commonly settled upon meaning of personality, most speculations center around inspiration and mental collaborations with the climate one is encircled by. Attribute based personality speculations, for example, those characterized by Raymond Cattell, characterize personality as characteristics that anticipate a singular's conduct. Then again, more typically based approaches characterize personality through learning and propensities.

Personality is often broken into variables or aspects, measurably separated from enormous polls through Factor examination. When taken back to two aspects, regularly the components of self-observer outgoing person and neuroticism (impulsive stable) are utilized as first proposed by Eysenck during the 1960s.

Personality appraisal inside the lexical custom, with the Big Five model as the most conspicuous, is an inescapable and approved technique (McCrae & Costa, 1997). As per this model, individual contrasts in personality might be adequately depicted utilizing five by and large factors: neuroticism (likewise alluded to as nonappearance of 'passionate steadiness'), extroversion, transparency, appropriateness and honesty. In spite of analysis (Block, 1995), it has gotten significant observational help across societies (McCrae & Costa, 1997).

1.2 Resilience

The relationship of resilience to personality was mentioned in many studies and the findings have a great degree of congruence. In this respect, most investigations were conducted by means of inventories and surveys based on the Five Factor model. Below, we shall refer to this type of research. For example, Nakaya, Oshio and Kaneko (2006) examine the

relationship of resilience, measured by the Adolescents Resilience Scale to personality traits measured by the Big Five Inventory in the case of a sample of 130 teenagers. The findings show that the neuroticism of the Big Five Inventory is significantly negatively correlated with resilience (r = –.59). Therefore, the respondents with high scores on resilience do not show neurotic tendencies such as anxiety and depression. Between the dimensions of conscientiousness and openness to experience and resilience there is a moderately positive correlation (r = .37, respectively .40). Thus, resilience is negatively associated with neuroticism and positively associated with extraversion and conscientiousness. All the three traits contribute to the prediction of resilience (Campbell-Sills, Cohan & Stein, 2006). Also, in the case of adolescents (N = 397), (Fayombo, 2010) finds conscientiousness as the best predictor of resilience, whereas agreeableness, neuroticism and openness to experience are its other 3 secondary predictors.

Resilience is generally characterized as the capacity to adapt to interior and outside stressors (Connor & Davidson, 2003). It has been displayed to considerably diminish the gamble of creating mental issues, including melancholy, uneasiness issues, and posttraumatic stress issues (Davydov, Stewart, Ritchie, & Chaudieu, 2010). With resilience being a significant defensive element, there has been extensive examination into its etiology.

Studies relating the personality elements to resilience (quicker recuperation and less symptomatology after injury) have been over and over related with a high score on emotional stability, extroversion, openness and conscientiousness (Riolli, Savicki & Cepani, 2002), as well as agreeableness (Davey, Eaker & Walters, 2003). In accordance with these discoveries, there is aggregating support for applying the Big Five measure to group people into composed (tough) and more weak subgroups (Asendorpf, Borkenau, Ostendorf & Van Aken, 2001; Rammstedt, Riemann, Angleitner & Borkenau, 2004). All reviews show proof for the versatile personality profile being described by a high score on all the Big Five elements.

As ongoing investigations show, resilience is impacted by a large number of personality, which can contrast in different sorts of populaces and can fluctuate as far as affliction levels and social setting. (Eley, Clonninger, Walters et al, 2013).

Investigating develops which are firmly connected with resilience, studies investigating personality characteristics appear to offer encouraging outcomes: in the field of personality research, late longitudinal examinations have shown that neuroticism and extraversion can be formed by significant life occasions (Jeronimus, Ormel, Aleman, Penninx, & Riese, 2013; Ogle, Rubin, & Siegler, 2014): Positive life occasions go inseparably with higher scores in extraversion and lower scores in neuroticism, while pessimistic life occasions are related with lower scores in extraversion and higher scores in neuroticism.

Rutter (2007) contended that resilience can't be a personality attribute, as individuals might be versatile to certain dangers yet not others, and to certain results but rather not others; besides, an individual may be tough despite affliction, injury, or stress. Various ideas of resilience brought about an assortment of procedures and scales to gauge it.

1.3 PTSD

Post-traumatic stress disorder, or PTSD, is the psychiatric disorder that can result from the experience or witnessing of traumatic or life-threatening events such as terrorist attack, violent crime and abuse, military combat, natural disasters, serious accidents or violent personal assaults. Exposure to environmental toxins (e.g. Agent orange, electromagnetic radiation) may result in immune symptoms akin to PTSD in many susceptible patients.

Whereas the terminology of PTSD arose relatively soon following the Vietnam conflict, the observation that traumatic events can lead to this plethora of psychobiological manifestations is not new. During the Civil War, a PTSD-like disorder was referred to as the ‘Da Costa's Syndrome’ from the American internist Jacob Mendez Da Costa (1833–1900; Civil War duty: military hospital in Philadelphia).

The syndrome was first described by ABR Myers (1838–1921) in 1870 as combining effort fatigue, dyspnea, a sighing respiration, palpitation, sweating, tremor, an aching sensation in the left pericardium, utter fatigue, an exaggeration of symptoms upon efforts and occasionally complete syncope. It was noted that the syndrome resembled more closely abandonment to emotion and fear, rather than the ‘effort’ that normal subjects engage to overcome challenges.

Psychosocial issues and mental diseases such as posttraumatic stress disorder can emerge in people who have been subjected to psychological trauma and continuous or intense stress (PTSD). PTSD is defined as an anxiety disorder that includes three symptom clusters: re-experiencing of the traumatic event, avoidance of trauma-related thoughts and cues, numbing of general responsiveness, and hyperarousal and hyper vigilance symptoms, according to the Diagnostic and Statistical Manual of Mental Disorders (4th ed., text rev. ; DSM-IVTR; American Psychiatric Association, 2000). Among the general population, estimates of PTSD prevalence vary from 1.9 percent to 8% (Alonso et al., 2004; Kessler et al., 2005; Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995), compared to prevalence rates of 3 percent to 13 percent in soldiers sent to recent operations in Iraq and Afghanistan (Engelhard et al, 2007 & Hoge et al., 2004).

Trauma intensity, per traumatic dissociation, past exposure to trauma (including childhood abuse), lack of social support, family history, psychiatric history, and prior psychological adjustment are all risk factors for PTSD, according to research (Brewin, Andrews, & Valentine, 2000; Ozer, Best, Lipsey, & Weiss, 2003). Regrettably, the majority of published outcomes are based solely on cross-sectional or retrospective data. Few studies have looked at the role of numerous risk variables in the genesis of PTSD in a prospective manner.

Pre-traumatic personality is a key factor in post-traumatic adjustment. Neuroticism and extraversion are two broad personality traits that have repeatedly been associated to psychopathology (Watson, Gamez, & Simms, 2005). Bienvenu & Stein, 2003; Hettema, Neale, Myers, Prescott, & Kendler, 2006; Khan, Jacobson, Gardner, Prescott, & Kendler, 2005; Watson et al, 2005) have proposed that neuroticism or negative affectivity, or the propensity to experience aversive emotional states (Watson & Clark, 1984), reflects an intrinsic vulnerability—or endophenotype—for a variety of psychological problems (B (e.g., Parslow, Jorm, & Christensen, 2006). In addition, there is evidence that trait introversion plays a role in the development of mental illnesses, including PTSD (Watson et al., 2005). (Carlier, Lamberts, & Gersons, 1997). Furthermore, it has been claimed that combining high neuroticism with trait introversion raises the likelihood of mental problems compared to either trait alone (Jorm et al., 2000).

As a result, Denollet (2000) proposed that the combination of high negative affectivity or

neuroticism (Na) and marked social inhibition (Si), for which he coined the term Type D (distressed) personality, constitutes a unique and independent risk factor for adverse health outcomes, following the original conceptions of Eysenck (1967) and Gray (1987). In a later research, Pedersen and Denollet (2004) found that people with high levels of negative affectivity combined with a propensity to suppress emotional expression in social interactions (Si) are more likely to develop PTSD.

The Type D personality trait has been chastised for its tendency to rebrand personality traits (such as neuroticism and introversion) with new nomenclature (Smith & MacKenzie, 2006).

However, only a few studies have looked at how these traits interact in terms of health outcomes (e.g., Kendler, Gatz, Gardner, & Pedersen, 2006; Miller, Schmidt, Vaillancourt, McDougall, & Laliberte, 2006), and the Type D personality construct appears to have sparked interest in the potential synergistic effect of neuroticism and introversion on the development of health problems.

Among one study, OgiiskaBulik & Langer (2007) found a link between Type D personality and PTSD in Polish firefighters.

1.4 Quality Of Life

There have been more efforts in the last decade to define and describe quality of life. On two key areas, there is now widespread consensus. To begin with, health-related quality of life is a multifaceted concept that encompasses functional status, psychological and social well-being, health perceptions, and disease and treatment-related symptoms. Each of these major categories can be split further to incorporate quality of life components particular to the community under study and the research topic at hand. For example, psychological well-being might encompass mental health, good mood, and energy, while functional status could include assessments of particular elements of physical, social, and role performance. Single quality-of-life dimensions have typically been the focus of research in the United States, but in Europe and Canada, a multidimensional approach has dominated. While a full assessment of quality of life necessitates consideration of several domains, more focused study can help answer particular research objectives.

Second, the working group and most academics in the area agree that assessing quality of life is primarily subjective, with the target individual being the major source of information on his or her own life quality. Family members and medical staff can frequently provide important information, but the main focus should be on determining the subjective experience of the individual whose quality of life is in doubt.

Quality of life research will be of little utility unless the findings are put to use by agencies, organizations, and physicians in ways that benefit patients. Progress has been achieved in at least four areas toward the transfer of knowledge regarding quality of life into practice over the last decade.

For starters, knowledge has been transferred within the research community as a result of cross-fertilization and multidisciplinary research collaboration. Quality of life research used to be done with just a limited amount of cross-disciplinary input, but today's psychosocial research teams are far more likely to include investigators from a variety of specialties and fields, broadening the scope and framework of inquiry.

Second, changes in FDA regulations for evaluating therapeutic efficacy have resulted in a greater use of quality of life research in drug studies. The FDA decided in 1985 that new medicine approval would need proof of enhanced survival or quality of life, prompting pharmaceutical firms to place a greater emphasis on analyzing quality of life.

Third, research on the effects of different therapies on quality of life has led to improvements in clinical practice. Although it is not always expected that quality of life research will lead to changes in clinical practice, quality of life findings have led to changes in the administration of CNS radiation for children with acute lymphocytic leukemia (ALL), surgical treatment of early breast cancer, and soft tissue sarcoma treatment.

Finally, studies on specific aspects of quality of life, such as pain, nausea and vomiting, sleeplessness, and psychological distress, have resulted in symptom control improvements.

The World Health Organization's (WHO) ambition to establish a quality of life evaluation emerged for a variety of reasons. Beyond traditional health indicators such as mortality and morbidity, there has been a shift in focus in recent years in the measuring of health, e.g. World Bank, 1993; World Health Organization, 1991, to incorporate measurements of sickness and impairment's influence on everyday activities and behaviour, e.g. Bergner, Bobbitt, Carter, et al., 1981, Sickness Impact Profile, subjective health measurements and disability / functional status

assessments. While these measurements begin to quantify the effect of disease, they do not estimate quality of life, which has been eloquently defined as "the missing measurement in health" (Fallowfield, 1990). Second, most health-status measures were created in North America and the United Kingdom, and translating them for use in other countries is time-consuming and unsatisfactory for a variety of reasons (Sartorius and Kuyken, 1994; Kuyken, Orley, Hudelson & Sartorius, 1994). Third, the increasingly mechanistic paradigm of medicine, which focuses solely on the elimination of illness and symptoms, emphasises the necessity for a humanistic component to be incorporated into health treatment. By urging health-care providers to do quality-of-life evaluations, more attention is drawn to this component of health, and subsequent interventions will pay greater attention to this aspect of patients' well-being. The WHO's ambition to create a quality of life assessment stems from a need for a truly worldwide measure of quality of life as well as a commitment to continuing to promote a holistic approach to health and health treatment.

The WHOQOL-100 provides for a thorough examination of each aspect of quality of life. However, the WHOQOL-100 may be too long for practical usage in some cases. As a result, the WHOQOLBREF Field Trial Version was created to give a short form quality of life assessment that looks at Domain level profiles, utilising data from the pilot WHOQOL assessment as well as all accessible data from the WHOQOL-100 Field Trial Version. Domains with WHOQOL-BREF include

1. Physical health (Q1) - Activities of daily living, Dependence on medicinal substances and medical aids Energy and fatigue, Mobility Pain and discomfort, Sleep and rest, Work Capacity
2. Psychological (Q2) - Bodily image and appearance, Negative feelings, Positive feelings, Self- esteem, Spirituality / Religion / Personal beliefs, Thinking, learning, memory and concentration
3. Social relationships (Q3) - Personal relationships, Social support, Sexual activity
4. Environment (Q4) - Financial resources, Freedom, physical safety and security, Health and social care: accessibility and quality, Home environment, Opportunities for acquiring new information and skills, Participation in and opportunities for recreation / leisure activities, Physical environment (pollution / noise / traffic / climate), Transport

Chapter-2

Review of Literature

2.1 Quality of Life and Personality

The study (Schneider- Matyka, Jurczak, Samochowiec & Karakiewicz, 2016) examined 214 postmenopausal women from northwest Poland to assess the impact of personality on postmenopausal women's quality of life. Personality qualities may have a role in determining one's quality of life. There was a link between quality of life and neuroticism and extroversion, as well as some quality of life areas and agreeableness and conscientiousness.

The term "quality of life" refers to a subjective assessment of several elements of human functioning. Personality is a characteristic that influences people's behavior and their predisposition to interpret reality in a certain manner. As a result, it appears plausible to assume that personality may impact QOL evaluation.

Neuroticism is a significant personality attribute that shows an individual's emotional stability. Neuroticism has been shown to be adversely connected with and predict quality of life (Gunzerath et al., 2001). The average neuroticism score peaks in late adolescence and then gradually declines throughout adulthood (Roberts & Mroczek, 2008).

Openness as a trait has been depicted as far as being available to experience, scholarly, inventive and autonomous leaning (John OP & Srivastata S, 1999). Discoveries for this trait corresponding to QOL in clinical sickness have been conflicting, with 1 review tracking down no critical outcome, and one more finding high openness related with better useful status in an essential consideration test (Duberstein, Sörensen, Lyness, King, Conwell & Seidlitz, Caine, 2003). Considering longitudinal investigations, openness was related with decrease of tension in a 6-month follow-up in patients with coronary illness (Trzcieniecka-Green & Steptoe; 1994) as well as in an adjustment of QOL more than 8 weeks in an example with disease (Kohda, Otsubo, Kuwakado, Tanaka, Kitahara, Yoshimura & Mimura, 2005). The two discoveries show some coinciding with our outcomes. Patients with low openness might experience issues getting to their feelings and finding the words that relate to these feelings (Wise, Mann & Shay, 1992). Along these lines, they might will generally direct their feelings by concealment when they are

compromised (John & Gross, 2004).

Some personality qualities, like neuroticism and extraversion, are thought to be factors that add to the view of wellbeing status and subsequently lead to a more terrible impression of QOL by individuals with a several ongoing disease (Kempen, Jelicic, & Ormel, 1997). Individuals who score high on the neuroticism scale manifest more concerns, vulnerabilities and tension (Eysenck, & Eysenck, 1994). Since these individuals are bound to excessively act emotionally and respond too firmly to a wide range of improvements, their neuroticism is by all accounts related to psychological dysfunction(Ruggeri, Pacati, & Goldberg, 2003). A few creators have revealed that neuroticism additionally has all the earmarks of being related with the propensity to review physical side effects as being more awful than they, truth be told were , in this manner in a roundabout way adding to a lower apparent QOL (Larsen, 1992) . Personal satisfaction of patients with persistent illnesses may likewise be impacted in a roundabout way by extraversion. Extravertly arranged individuals tend to be agreeable what's more, to lean toward changes, and there is a high likelihood that they will hunger for energy and act imprudently (Eysenck, & Eysenck, 1994). It has been seen that individuals with a low score in extraversion are more conceited and are more sensitive to stretch than extraverted individuals. Subsequently, it very well may be conjectured that extraversion impacts the degree of adapting to ongoing sickness and can consequently impact the degree of QOL (Ramı´rez-Maestre, Martinez & Zarazaga, 2004).

There has been moderately little examination researching the job of personality in the course and anticipation of stroke (Morris, & Robinson, 1995). High neuroticism has been viewed as a gamble factor for post stroke wretchedness, and high neuroticism and low agreeableness have been related with post stroke unsettling and crabbiness and score low on Quality of Life (Greenop, Almeida, Hankey, van Bockxmeer & Lautenschlager, 2009).

Extraversion and conscientiousness additionally altogether affected the psychological dimension of QOL. Extraversion is accepted to influence QOL in light of a higher inclination to encounter positive feelings, and principled individuals might accomplish more objectives through arranging and constancy, bringing about a superior QOL (Masthoff, Trompenaars, Van Heck, Hodiamont, & De Vries J, 2007). Extraversion in asthma is related with lower aversion conduct, bringing about better in general QOL (Van, & Engels, 2011) . Both extraversion and conscientiousness

were related with better QOL in patients with AIDS (Penedo, Gonzalez, Dahn, Antoni, Malow, Costa, & Schneiderman, 2007).

2.2 Quality of life and Resilience

Many studies have shown that resilience has a direct and beneficial impact on patients' quality of life (Liu, & Xu, 2017). In particular, resilience was shown to be highly and positively connected to QOL among infertile women (Herrmann, Scherg, Verres, von Hagens, Strowitzki, & Wischmann, 2011).

Prior research has also shown that resilience resources have a moderating influence on QOL. Resilience can also operate as a buffer, reducing the impact of antecedent indicators on quality of life. Palm-Fischbacher et al., for example, found that resilience may operate as a moderator in the relationship between chronic stress and physical health in young women. Rainone et al. found that resilience might mitigate the link between emotional disorders and QOL in individuals with multiple sclerosis in another investigation (Rainone, Chiodi, Lanzillo, Magri, Napolitano, & Morra, et al., 2017). Since resilience's protective impact on QOL and its negative effect on perceived stress have been well documented, resilience appears to be able to modulate the relationship between infertility-related stress and fertility QOL. In other words, the impact of infertility-related stress on fertility QOL is influenced by patients' degrees of resilience.

In the general population, higher levels of resilience have been consistently related to enhanced mental and physical health (Schure, Odden, & Goins, 2013; Costa de Robert, Barontini, Forcada, Carrizo, & Almada, 2010). Chronic disease, health-care behaviours, and disability have all been linked to this. Large longitudinal studies have also shown evidence that resilience may protect against the development of disability, chronic disease, depression, or low Health-related Quality of Life (HrQOL), implying a causal connection between strong resilience and general well-being. Furthermore, numerous resilience studies have discovered evidence that it is feasible to acquire or sustain resilience despite poor physical health in chronically sick populations. This means that resilience can be employed to help chronically unwell people feel better.

Psychological resilience can be thought of as a trait or as a process or consequence (Fletcher, & Sarkar, 2013). It was described as a dynamic process comprising positive adaptation in the face of considerable hardship by researchers (Luthar, Cicchetti, & Becker, 2000). Resilience is a

personality attribute that entails a set of qualities that help people to adjust to the situations they find themselves in, and it has a good influence on mental health (Ai, & Hu, 2016). According to a meta-analysis, resilience may help to safeguard mental health, speed recovery, and reduce the harmful impacts of a crisis. Tugade and Fredrickson, for example, define resilience as a speedy and successful recovery from stress, whereas Patel and Goodman define it as maintaining mental health in the face of hardship. As a result, psychological resilience is an important quality in preventing the harmful effects of a crisis.

For its simplicity of assessment and evidence that it is a stronger predictor of resiliency and mental health than other measures, perceived social support is the most routinely assessed index of social support. Perceived social support has been shown to preserve mental health in stressful settings in a slew of studies.

When it comes to resilience as a process/outcome, research reveals that social support is crucial. However, given there are individual disparities in social support and psychological resilience, we can't help but wonder if an excess of perceived social support can compensate for a lack of psychological resilience. In one study, sources of social support (family, friends, and others) significantly moderated the relationship between resilience and subjective well-being in college students (Khan, & Husain,2010), whereas in another study, social support had no effect on the relationship between resilience and psychological distress in cancer patients (Khan, & Husain,2010) (Matzka, Mayer, Kock-Hodi, Moses-Passini, Dubey, Jahn, Schneeweiss, & Eicher, 2016). Researchers argued that social support served as a buffer to decrease the harmful impact of stress on well-being, according to the stress-buffering hypothesis (Cohen, & Wills, 1985).By evaluating the many forms of support, environmental scholars discovered that family support had a unique role in buffering the detrimental impacts of stress (Raffaelli, & Andrade, 2013). Furthermore, Anschuetz discovered that social support mitigated the detrimental impacts of a variety of trait vulnerabilities (such as neuroticism and introversion). We suggest that, based on the stress-buffering theory, social support from various sources can also buffer the detrimental impact of low resilience (trait vulnerability) on mental health, especially in a novel situation like the COVID-19 pandemic.

2.3 Quality of life and PTSD

The harmful influence of PTSD on QOL was demonstrated in severely damaged accident

patients 12 months after trauma (Baranyi et al., 2010). Despite the fact that the PTSD group had significant levels of dissociation, no additional research into the link between dissociation and poor QOL was done. Another study looked at the possible links between lifetime PTSD diagnoses, childhood psychological trauma, and dissociation and poor QOL in alcohol-dependent men. A history of childhood trauma and persistent dissociation, in addition to a lifetime diagnosis of PTSD, were thought to contribute to poor QOL. Patients with long-term PTSD had worse QOL on multiple measures, as expected. Lifetime PTSD patients with dissociative events exhibited a higher rate of QOL impairment.

There is growing evidence that PTSD results in an enormous burden of disease and gravely impacts Quality of Life (QOL) in both veteran and civilian populations (Krauseneck, & Rothenhausler, 2005). Furthermore, PTSD is associated with high rates of comorbid psychiatric and medical disorders as well as alcohol and drug abuse, resulting in poor physical health and subsequently diminished QOL (Schnurr, Hayes, & Lunney, 2006)

It has also been demonstrated that people who had a worse quality of life previous to war exposure are more likely to acquire PTSD, which will further degrade their quality of life. Furthermore, PTSD symptomatology was shown to be associated with.

In many kinds of traumatic injuries, is a better predictor of poor QOL than the severity of the injury itself. While it is known that different subtypes of traumatic injuries have different impacts on QOL, the exact reasons for why these observations occur are still lacking in the literature, and further research is needed. This knowledge would close the gap and give a better understanding of why a trauma's perceived danger to safety has a greater impact than the actual outcome.

Overall, the quality of life of persons suffering from PTSD is severely harmed, with different patterns of impairment in different PTSD populations. CBT-based psychotherapy is beneficial in improving QOL in PTSD patients. Pharmacological treatment, particularly SSRIs, appears to have the potential to improve QOL, according to preliminary studies.

CHAPTER- 3

RESEARCH GAP, MOTIVATION FOR THE STUDY, OBJECTIVES, CONCEPTUAL FRAMEWORK, AND HYPOTHESES

3.1 RESEARCH GAP

With the response to the review of literature many studies have stated the relationship between Personality and Resilience or Personality and PTSD as well as with Quality of Life and Resilience or Quality of Life and PTSD. Many have included the gender difference as one of the main components in order to reduce any future complications. As the research gap is concerned on the basis of our study, there are not many studies conducted which has included the Quality of Life and all the five subtypes of personality factors and studied it with Resilience and PTSD.

Numerous studies have been conducted to explain the relationship. These studies are usually done in western countries and their results cannot be fully generalized to eastern population, due to cultural differences. So, taking inspiration from various literature sources and research findings, the present study aims at establishing relationship between Personality factors, Resilience, PTSD and Quality of Life during the ongoing pandemic situation.

3.2 MOTIVATION OF THE STUDY

Given the current virulent pandemic, people are suffering from a lot of Trauma and which is affecting the various domains of the Quality of life. Resilience acts as variable to enhance the Quality of Life, prior studies have supported the mediating effect of resilience resources on QOL. Resilience can also act as a moderator to buffer the effect of antecedent indicators on QOL. For example, Palm-Fischbacher et al. reported that resilience could act as a moderator in the association of chronic stress with physiological health among young women. Also, according to a study by Annie Tanas, the effects of PTSD is Lifelong, Chronic and highly variable and affects negatively on various domains of the Quality of Life. Therefore PTSD or cPTSD following trauma is influenced by many factors which includes, individual resilience, personality, prior history of trauma, severity/intensity of trauma, duration of trauma and availability of emotional support.

Hence, stemmed the motivation of the study the relationship between the big five personality factors, resilience, PTSD and quality of life. Due to lack of much research on the relationship between variables Big Five Personality factors, resilience, PTSD and Quality of Life, one of the objectives is also to find the relationship between them in an ongoing pandemic situation in Indian context.

3.3 Objectives

1. To study the relationship between personality attributes and Quality of life
2. To study the relationship between Resilience and Quality of life
3. To study the relationship between PTSD and Quality of Life
4. To identify the best predictor of Physical domain of Quality of Life
5. To identify the best predictor of Psychological domain of Quality of Life
6. To identify the best predictor of Social domain of Quality of Life
7. To identify the best predictor of Environmental domain of Quality of Life

3.4 Hypotheses

H_1 Extraversion is positively related to Physical, Psychological, Social and Environment domains of Quality of Life.

H_2 Agreeableness is positively related to Physical, Psychological, Social and Environment domains of Quality of Life.

H_3 Conscientiousness is positively related to Physical, Psychological, Social and Environment domain of Quality of Life.

H_4 Neuroticism is negatively related to Physical, Psychological, Social and Environment domain of Quality of Life.

H_5 Openness to Experience is positively related to Social relationship domain of Quality of

Life.

H_6 Resilience is positively related to Physical, Psychological, Social and Environment domain of Quality of Life.

H_7 PTSD is negatively related to Physical, Psychological, Social and Environment domain of Quality of Life.

CHAPTER- 4

METHODOLOGY

4.1 SAMPLE

A total of 202 adults comprising 120 females and 82 males in the age range of 18 to 50 years participated in the study. Only those were included who could use a mobile phone or laptop/desktop for the purpose of the study so that uniformity could be ensured. The collection of samples was via Google forms due to the COVID 19 restrictions.

4.2 DESIGN

Independent Variable – Personality Factors, Resilience and PTSD

Dependent Variables – Quality of Life

A correlational design was used in the study. Personality (extraversion, agreeableness, neuroticism, openness and conscientiousness), Resilience and PTSD was taken as predictor variable. Quality of Life (Physical, Psychological, Social Relationship and environmental domain) was used as the criterion variable.

4.3 STATISTICAL ANALYSIS

The data was analyzed using Statistical Package for Social Science (SPSS 21.0) where correlation and stepwise regression was computed to describe the results.

4.5 TOOLS USED:

Big Five Inventory (BFI)

The BFI (John, & Srivastava, 1999) is a 44- item questionnaire based on the Big Five dimensions of Personality (Goldberg, 1993). A self-report scale, it measures the five personality traits - extraversion, agreeableness, conscientiousness, neuroticism and openness. The subject is asked to rate each statement on a scale of 1 (Strongly Disagree) to 5 (Strongly Agree). The scale consists of 28 positive statements and 16 negative statements. Thus, the final score is obtained by adding up straight scores of the positive statements and the reverse scores of the negative statements for each of the five dimensions of personality. The test has yielded excellent internal reliability for each dimension (above the minimum acceptable level of 0.7) in the initial pilot test, however, the validity test pulled out only four dimensions (extraversion, conscientiousness, neuroticism and openness to experience) which showed factor loadings ranging from 0.573 to 0.803 and had reliability above 0.7 (Hee, 2014).

NMHRQ

NMRQ consists of 12 items measuring resilience. It is a self-reported questionnaire, while each respective item is measured through a 5-Likert scale point system. The scoring scheme is between 1 and 5, with 1= strongly disagree and 5= strongly agree.

Davidson Trauma Scale

The DTS is composed of 17 items corresponding to each of the 17 DSM-IV symptoms. Items can be categorized as follows: items 1–4, 17: criteria B (intrusive re-experiencing); items 5–11: criteria C (avoidance and numbness); and items 12–16: criteria D (hyperarousal). For each item, the subject rates both frequency and severity during the previous week on a 5-point (0 to 4) scale for a total possible score of 136 points. Subscale scores can be computed separately for frequency and severity. The DTS is designed to evaluate symptoms of PTSD in individuals with a history of trauma. Its primary purposes are to measure symptom frequency and severity and to evaluate treatment, for example, measurement of symptom change over time, response prediction, and evaluation of differences between therapy modalities in the research setting.

WHOQOL-BREF

The WHOQOL-BREF contains a total of 26 questions. To provide a broad and comprehensive assessment, one item from each of the 24 facets contained in the WHOQOL-100 has been included. WHOQOL-BREF domains includes

1. Physical health- Activities of daily living, Dependence on medicinal substances and medical aids Energy and fatigue, Mobility Pain and discomfort, Sleep and rest, Work Capacity

2. Psychological- Bodily image and appearance, Negative feelings, Positive feelings, Self-esteem, Spirituality / Religion / Personal beliefs, Thinking, learning, memory and concentration.

3. Social relationships- Personal relationships, Social support, Sexual activity

4. Environment- Financial resources, Freedom, physical safety and security, Health and social care: accessibility and quality, Home environment, Opportunities for acquiring new information and skills, Participation in and opportunities for recreation / leisure activities, Physical environment (pollution / noise / traffic / climate), Transport.

4.5 PROCEDURE

The subjects were explained in detail about the aims of the study and an online consent was obtained from them. Due to the ongoing pandemic situation, the survey was conducted online via Google Forms was used as the platform for administering the questionnaire and recording the responses. They were made to sit in a quiet atmosphere, instructions were instructed to them and they were asked to fill up the questionnaires instantly with utmost honesty. They were informed that no response was right or wrong and that the responses given by them would be kept confidential.

CHAPTER-5

RESULTS

The data was analyzed using descriptive statistics, correlation and stepwise regression analysis.

Table 1: *Mean and Standard Deviation values for Extroversion, Agreeableness, Conscientiousness, Neuroticism, Openness to Experience, Resilience, PTSD and Q1, Q2, Q3,Q4 dimensions of Quality of Life.*

	Mean	Std. Deviation	N
Extroversion	26.51	4.771	202
Agreeableness	33.61	5.100	202
Conscientiousness	29.47	3.953	202
Neuroticism	25.38	5.450	202
Openness to Experience	37.12	4.345	202
Resilience	43.32	7.906	202
PTSD	33.38	18.037	202
Q1(Physical)	65.52	19.493	202
Q2(Psychological)	62.16	20.838	202
Q3(Social)	60.61	26.891	202
Q4(Environment)	73.01	19.673	202

The table above constitutes the mean and standard deviation values obtained by the entire variable s under this study. As it is indicated above, the mean value obtained by the sample personality trait Extroversion is 26.51, standard deviation of 4.771. Mean scores of personality traits Agreeableness, Conscientiousness, Neuroticism and openness to Experience as 33.61, 29.47, 25.38 and 37.12 respectively, and their standard deviation were 5.100, 3.953, 5.450 and 4.345 respectively. The mean score of Resilience was found to be 43.32 and standard deviation

7.906. Mean score of PTSD was found to be 33.38 and standard deviation of 18.037. The mean score for 1 to 4 domain of Quality of Life were 65.52, 62.16, 60.61and 73.01 respectively, having standard deviation of 19.493, 20.838, 26.891 and 19.73.

Table 2: *Correlation values between Extroversion, Agreeableness, Conscientiousness, Neuroticism, Openness to Experience, Resilience, PTSD and Q1, Q2, Q3, Q4 dimensions of Quality of Life.*

		Extroversion	Agreeableness	conscientiousness	Neuroticism	Openness to Experience	Resilience	PTSD	Q1	Q2	Q3	Q4
Extroversion	Pearson Correlation	1	.209**	.264**	-.151*	0.119	.263**	-.267**	.218**	.303**	.319**	.167*
	Sig. (2-tailed)		0.003	0	0.032	0.092	0	0	0.002	0	0	0.017
	N	202	202	202	202	202	202	202	202	202	202	202
Agreeableness	Pearson Correlation	.209**	1	.282**	-.246**	.282**	.266**	-.317**	.299**	.233**	.187**	.245**
	Sig. (2-tailed)	0.003		0	0	0	0	0	0	0.001	0.008	0
	N	202	202	202	202	202	202	202	202	202	202	202
Conscientiousness	Pearson Correlation	.264**	.282**	1	-.285**	.255**	.457**	-.284**	.366**	.418**	.227**	.300**
	Sig. (2-tailed)	0	0		0	0	0	0	0	0	0.001	0
	N	202	202	202	202	202	202	202	202	202	202	202
Neuroticism	Pearson Correlation	-.151*	-.246**	-.285**	1	0.026	-.326**	.318**	-.389**	-.350**	-.248**	-.151*
	Sig. (2-tailed)	0.032	0	0		0.709	0	0	0	0	0	0.032
	N	202	202	202	202	202	202	202	202	202	202	202
Openness to Experience	Pearson Correlation	0.119	.282**	.255**	0.026	1	.538**	-.163*	.155*	0.049	-.138*	0.057
	Sig. (2-tailed)	0.092	0	0	0.709		0	0.021	0.027	0.49	0.05	0.422
	N	202	202	202	202	202	202	202	202	202	202	202
Resilience	Pearson Correlation	.263**	.266**	.457**	-.326**	.538**	1	-.300**	.361**	.286**	0.059	.196**
	Sig. (2-tailed)	0	0	0	0	0		0	0	0	0.403	0.005
	N	202	202	202	202	202	202	202	202	202	202	202

PTSD	Pearson Correlation	-.267**	-.317**	-.284**	.318**	-.163*	-.300**	1	-.467**	-.375**	-.327**	-.283**
	Sig. (2-tailed)	0	0	0	0	0.021	0		0	0	0	0
	N	202	202	202	202	202	202	202	202	202	202	202
Q1	Pearson Correlation	.218**	.299**	.366**	-.389**	.155*	.361**	-.467**	1	.691**	.373**	.582**
	Sig. (2-tailed)	0.002	0	0	0	0.027	0	0		0	0	0
	N	202	202	202	202	202	202	202	202	202	202	202
Q2	Pearson Correlation	.303**	.233**	.418**	-.350**	0.049	.286**	-.375**	.691**	1	.575**	.671**
	Sig. (2-tailed)	0	0.001	0	0	0.49	0	0	0		0	0
	N	202	202	202	202	202	202	202	202	202	202	202
Q3	Pearson Correlation	.319**	.187**	.227**	-.248**	-.138*	0.059	-.327**	.373**	.575**	1	.559**
	Sig. (2-tailed)	0	0.008	0.001	0	0.05	0.403	0	0	0		0
	N	202	202	202	202	202	202	202	202	202	202	202
Q4	Pearson Correlation	.167*	.245**	.300**	-.151*	0.057	.196**	-.283**	.582**	.671**	.559**	1
	Sig. (2-tailed)	0.017	0	0	0.032	0.422	0.005	0	0	0	0	
	N	202	202	202	202	202	202	202	202	202	202	202

** Correlation is significant at the 0.01 level (2-tailed).

* Correlation is significant at the 0.05 level (2-tailed).

In the table 2 we see that Extroversion is highly positively correlated to Agreeableness, Conscientiousness, Resilience and dimension Q1, Q2 and Q3 of quality of life (0.209,0.264,0.263,0.218, 0.303, 0.319; $p<0.01$). It is also positive correlation with dimension Q4 of quality of life (0.164; $p<0.05$) and it highly negatively correlated with PTSD (-0.267; $p<0.01$) and has negative correlation with Neuroticism (-0.151; $p<0.05$). Agreeableness has been noted to have a high positive correlation with conscientiousness (0.282; $p<0.01$), openness to experience (0.282; $p<0.01$), resilience (0.266; $p<0.01$), and Q1, Q2, Q3 and Q4 dimension of Quality of life (0.299, 0.233, 0.187, 0.245; $p<0.01$) whereas has high negative correlation with neuroticism (-0.246; $p<0.01$) and PTSD (-0.317; $p<0.01$). Conscientiousness has high positive correlation with openness to experience, resilience and Q1, Q2, Q3 and Q4 dimensions of Quality of Life (0.255, 0.457, 0.366, 0.418, 0.227, 0.300; $p<0.01$) and is highly negatively

correlated to Neuroticism and PTSD (-0.285, -0.284; $p<0.01$). Neuroticism is highly positively correlated to PTSD (0.318, $p<0.01$), on the other hand, it is highly negatively correlated to resilience and Q1, Q2, Q3 and Q4 of Quality of Life (-0.326, -0.389, -0.350, -0.248, -0.151; $p<0.01$). Openness to Experience had a positive correlation with resilience (0.538; $p<0.01$) and positive correlation with Q1 dimension of Quality of Life (0.155; $p<0.05$). On the other hand, has negative correlation with PTSD and Q3 dimension of Quality of Life (-0.163, -0.138; $p<0.05$).

Resilience had a high positive correlation with Q1, Q2 and Q3 domain of quality of life (0.361, 0.268 and 0.198; $p<0.01$) and high negative correlation with PTSD (0.300; $p<0.01$). PTSD has been noted to have high negative correlation with Q1, Q2, Q3 and Q4 domain of quality of life (-0.467, -0.375, -0.327, -0.283; $p<0.01$). Q1 domain of Quality of Life is noted to have high positive correlation with Q2, Q3 and Q4 domain of Quality of Life (0.691, 0.373, 0.582; $p<0.01$). Q2 domain of Quality of Life was noted to have high positive correlation with Q3 and Q4 domain of Quality of Life (0.575, 0.71; $p<0.01$). Q3 dimension of Quality of Life has a high positive correlation with Q4 domain of Quality of Life (0.559; $p<0.01$).

Table 3: *Regression model summary of Q1 (Physical Health) of Quality of Life*

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.467[a]	.218	.214	17.279
2	.532[b]	.283	.275	16.593
3	.566[c]	.320	.310	16.195

a. Predictors: (Constant), PTSD

b. Predictors: (Constant), PTSD, Neuroticism

c. Predictors: (Constant), PTSD, Neuroticism, conscientiousness

Table 3 shows the value of R^2. 21.4% variance in Physical Health (Q1) domain of Quality of Life can be attributed to PTSD. 27.5% variance in Physical Health (Q1) domain of Quality of

Life can be attributed to PTSD and Neuroticism taken together. Whereas 31.0% variance in Physical Health (Q1) domain of Quality of Life can be attributed to PTSD, Neuroticism and Conscientiousness taken together.

Table 4: *Coefficients*[a]

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	82.369	2.562		32.151	.000
	PTSD	-.505	.068	-.467	-7.472	.000
2	(Constant)	103.601	5.592		18.527	.000
	PTSD	-.413	.068	-.382	-6.030	.000
	Neuroticism	-.958	.227	-.268	-4.228	.000
3	(Constant)	67.924	12.108		5.610	.000
	PTSD	-.365	.068	-.337	-5.335	.000
	Neuroticism	-.798	.226	-.223	-3.525	.001
	conscientiousness	1.019	.309	.207	3.301	.001

a. Dependent Variable: Q1

Table 4 above shows a unit increase in PTSD results in 0.505 decrease in Physical Health (Q1) domain of Quality of Life. When PTSD and Neuroticism taken together, a unit increase in PTSD causes 0.413 decrease in Physical Health (Q1) domain of Quality of Life, a unit increase in Neuroticism causes 0.958 decrease in Physical Health (Q1) domain of Quality of Life. When PTSD, Neuroticism and Conscientiousness taken together a unit increase in PTSD causes 0.365 decrease in Physical Health (Q1) domain of Quality of Life, a unit increase in Neuroticism causes 0.798 decrease in Physical Health (Q1) domain of Quality of Life and a unit increase in conscientiousness results in causes 1.019 increase in Physical Health (Q1) domain of Quality of Life. Extraversion, Agreeableness, Openness to Experience and Resilience are present but not contributing and acting as predictor variable.

Table 5: *Regression model summary of Q2 (Psychological) of Quality of Life*

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.418[a]	.174	.170	18.982
2	.496[b]	.246	.238	18.187
3	.527[c]	.277	.267	17.846
4	.546[d]	.298	.284	17.638

a. Predictors: (Constant), conscientiousness

b. Predictors: (Constant), conscientiousness, PTSD

c. Predictors: (Constant), conscientiousness, PTSD, Neuroticism

d. Predictors: (Constant), conscientiousness, PTSD, Neuroticism, Extroversion

Table 5 shows the value of R2. 17.4% variance in Psychological (Q2) domain of Quality of Life can be attributed to Conscientiousness. 24.6% variance in Psychological (Q2) domain of Quality of Life can be attributed to Conscientiousness and PTSD taken together. Whereas 27.7% variance in Psychological (Q2) domain of Quality of Life can be attributed to Conscientiousness, PTSD and Neuroticism taken together. 29.8% variance in Psychological (Q2) domain of Quality of Life can be attributed to Conscientiousness, PTSD, Neuroticism and Extroversion taken together.

Table 6: *Coefficients*[a]

Model		Unstandardized Coefficients		Standardized Coefficients	T	Sig.
		B	Std. Error	Beta		
1	(Constant)	-2.707	10.071		-.269	.788
	conscientiousness	2.201	.339	.418	6.499	.000
2	(Constant)	20.339	11.013		1.847	.066

	conscientiousness	1.784	.338	.338	5.271	.000
	PTSD	-.322	.074	-.279	-4.343	.000
3	(Constant)	43.394	13.342		3.252	.001
	conscientiousness	1.570	.340	.298	4.616	.000
	PTSD	-.265	.075	-.229	-3.514	.001
	Neuroticism	-.735	.249	-.192	-2.946	.004
4	(Constant)	28.929	14.513		1.993	.048
	conscientiousness	1.412	.342	.268	4.122	.000
	PTSD	-.230	.076	-.199	-3.028	.003
	Neuroticism	-.717	.247	-.188	-2.907	.004
	Extroversion	.660	.276	.151	2.386	.018

a. Dependent Variable: Psychological (Q2) domain of Quality of Life

Table 6 above shows a unit increase in conscientiousness results in 2.201 increase in Psychological (Q2) domain of Quality of Life. When Conscientiousness and PTSD taken together, a unit increase in Conscientiousness causes 01.784 increase in Psychological (Q2) domain of Quality of Life, a unit increase in PTSD causes 0.322 decrease in Psychological (Q2) domain of Quality of Life. When Conscientiousness, PTSD and Neuroticism and taken together a unit increase in conscientiousness causes 1.574 increase in Psychological (Q2) domain of Quality of Life, a unit increase in PTSD causes 0.25 decrease in Psychological (Q2) domain of Quality of Life and a unit increase in Neuroticism results in causes 0.735 decrease in Psychological (Q2) domain of Quality of Life. And when Conscientiousness, PTSD, Neuroticism and Extroversion taken together, a unit increase in conscientiousness increases 1.412 increase in Psychological (Q2) domain of Quality of Life, a unit increase in PTSD causes 0.230 decrease in Psychological (Q2) domain of Quality of Life, a unit increase in Neuroticism

causes 0.717 decrease in Psychological (Q2) domain of Quality of Life and a unit increase in Extroversion causes 0.660 increase in Psychological (Q2) domain of Quality of Life. Agreeableness, Openness to Experience and Resilience are present but not contributing and acting as predictor variable.

Table 7: *Regression model summary of Q3 (Social relationships) of Quality of Life*

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.327[a]	.107	.102	25.480
2	.405[b]	.164	.156	24.704
3	.458[c]	.210	.198	24.081
4	.480[d]	.230	.214	23.836

a. Predictors: (Constant), PTSD

b. Predictors: (Constant), PTSD, Extroversion

c. Predictors: (Constant), PTSD, Extroversion, Openness to Experience

d. Predictors: (Constant), PTSD, Extroversion, Openness to Experience, conscientiousness

Table 7 shows the value of R^2. 10.2% variance in Social Relationship (Q3) domain of Quality of Life can be attributed to PTSD. 15.6% variance in Social Relationship (Q3) domain of Quality of Life can be attributed to PTSD and Extroversion taken together. 19.6% variance in Social Relationship (Q3) domain of Quality of Life can be attributed to PTSD, Extroversion and Openness to Experience. Whereas 21.4% variance in Social Relationship (Q3) domain of Quality of Life can be attributed to PTSD, Extroversion, Openness to Experience and Conscientiousness.

Table 8: *Coefficients*[a]

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	12.977	10.177		1.275	.204
	Extroversion	1.796	.378	.319	4.755	.000
2	(Constant)	43.231	13.989		3.090	.002
	Extroversion	1.622	.374	.288	4.333	.000
	Neuroticism	-1.010	.328	-.205	-3.082	.002
3	(Constant)	78.060	19.225		4.060	.000
	Extroversion	1.742	.372	.309	4.685	.000
	Neuroticism	-.972	.323	-.197	-3.006	.003
	Openness to Experience	-1.050	.404	-.170	-2.600	.010
4	(Constant)	53.693	21.771		2.466	.015
	Extroversion	1.562	.376	.277	4.151	.000
	Neuroticism	-.761	.333	-.154	-2.287	.023
	Openness to Experience	-1.291	.413	-.209	-3.126	.002
	Conscientiousness	1.111	.483	.163	2.300	.022

a. Dependent Variable: Q3

Table 8 above shows a unit increase in Extroversion results in 1.796 increase in Social relationship (Q3) domain of Quality of Life. When Extroversion and Neuroticism taken together, a unit increase in extroversion causes 1.622 increase in Social relationship (Q3) domain of Quality of Life, a unit increase in Neuroticism causes 1.010 decrease in Social relationship (Q3) domain of Quality of Life. When

Extroversion, Neuroticism and Openness to Experience taken together, a unit increase in Extroversion causes 1.742 increase in Social relationship (Q3) domain of Quality of Life, a unit increase in Neuroticism causes 0.972 decrease in Social relationship (Q3) domain of Quality of Life and a unit increase in Openness to Experience causes 1.050 decrease in Social relationship (Q3) domain of Quality of Life. And when Extroversion, Neuroticism, Openness to Experience and Conscientiousness, a unit increase in Extroversion causes 1.562 increase in Social relationship (Q3) domain of Quality of Life, a unit increase in Neuroticism causes 0.761 decrease in Social relationship (Q3) domain of Quality of Life, a unit increase in Openness to Experience causes 1.291 decrease in Social relationship (Q3) domain of Quality of Life and a unit increase in Conscientiousness causes 1.111 increase in Social relationship (Q3) domain of Quality of Life. Agreeableness, PTSD and Resilience are present but not contributing and acting as predictor variable.

Table 9: *Regression model summary of Q4 (Environment) of Quality of Life*

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.300[a]	.090	.085	18.814
2	.364[b]	.132	.124	18.417

a. Predictors: (Constant), conscientiousness

b. Predictors: (Constant), conscientiousness, PTSD

Table 9 shows the value of R^2. 8.5% variance in Environmental (Q4) domain of Quality of Life can be attributed to Conscientiousness. 12.4% variance in Environmental (Q4) domain of Quality of Life can be attributed to Conscientiousness and PTSD taken together.

Table 10: *Coefficients*[a]

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	29.024	9.982		2.908	.004
	Conscientiousness	1.493	.336	.300	4.446	.000
2	(Constant)	45.781	11.152		4.105	.000
	Conscientiousness	1.189	.343	.239	3.470	.001
	PTSD	-.234	.075	-.215	-3.118	.002

a. Dependent Variable: Q4

Table 10 above shows a unit increase in conscientiousness results in 1.493 increase in Environmental (Q4) domain of Quality of Life. When Conscientiousness and PTSD taken together, a unit increase in Conscientiousness causes 1.189 increases in Environmental (Q4) domain of Quality of Life, a unit increase in PTSD causes 0.234 decreases in in Environmental (Q4) domain of Quality of Life. Extroversion, Agreeableness, Neuroticism, Openness to Experience and Resilience are present but not contributing and acting as predictor variable.

CHAPTER- 6

DISCUSSION

6.1 Discussion

The aim of the present study is to study the relationship between personality attributes, resilience PTSD and Quality of Life. The first hypotheses states that extraversion is positively related to the domain one to four domain of quality of life that is Physical, Psychological, Social Relationship and Environmental. The hypothesis was accepted as statistically the results were found to be significant. In a research by Eysenck, & Eysenck, in year 1994 suggested that individuals with a low score in extraversion are more conceited and are more sensitive to stretch than extraverted individuals. Subsequently, it very well may be conjectured that extraversion impacts the degree of adapting to ongoing sickness and can consequently impact the degree of QL.

The hypotheses second states that agreeableness is positively related to the domain one to four of quality domain of life that is Physical, Psychological, Social Relationship and Environmental. The hypotheses was accepted as the data was found to be significant, this shows that individuals who have an agreeable personality score high on WHO Quality of Life scale. In a study by Greenop, Almeida, Hankey, van Bockxmeer, Lautenschlager, in year 2009 it was found that high neuroticism has been viewed as a gamble factor for post stroke wretchedness, and high neuroticism and low agreeableness have been related with post stroke unsettling and crabbiness and score low on Quality of Life.

From hypotheses third stated that conscientiousness is positively related to the domain one to four domain of quality of life that is Physical, Psychological, Social Relationship and Environmental. The hypotheses was accepted as the data was found to be significant. In year 2007, research conducted by Penedo, Gonzalez, Dahn, Antoni, Malow, Costa, & Schneiderman, it was found that both extraversion and conscientiousness were related with better QOL in patients with AIDS.

The hypotheses fourth states that neuroticism is negatively related to the domain one to four of quality domain of life that is Physical, Psychological, Social Relationship and Environmental. These hypotheses was accepted as the data was found to be significant, this shows that people who score high on Neuroticism, score low on various domains of Quality of Life. In a research

done by Kempen, Jelicic, & Ormel in year 1997, it was found that some personality qualities, like neuroticism and extraversion, are thought to be factors that add to the view of wellbeing status and subsequently lead to a more terrible impression of QOL by individuals with a several ongoing disease. Another research conducted in year 1994 by Eysenck & Eysenck, found that individuals who score high on the neuroticism scale manifest more concerns, vulnerabilities and tension which ultimately results low on Quality of Life.

The fifth hypotheses states that, "Openness to Experience is positively related to Social relationship domain of Quality of Life." This hypothesis was rejected as the results calculated were found to be insignificant.

The sixth hypothesis states the positive relation between Resilience and the domain one to four of quality domain of life that is Physical, Psychological, Social Relationship and Environmental respectively. Hypotheses was partly accepted as the results calculated were found to be significant which stated that, Resilience is positively related to Physical, Psychological and Environmental domain of the Quality of Life. On the other hand Resilience is positively related to social domain of Quality of Life was not accepted as the results calculated were not significant. Large longitudinal studies have also shown evidence that resilience may protect against the development of disability, chronic disease, depression, or low Health-related Quality of Life (HrQOL), implying a causal connection between strong resilience and general well-being. Furthermore, numerous resilience studies have discovered evidence that it is feasible to acquire or sustain resilience despite poor physical health in chronically sick populations. This means that resilience can be employed to help chronically unwell people feel better.

Hypotheses seventh states that PTSD is negatively related to Physical, Psychological, Social and Environmental domain of quality of Life. The hypothesis was accepted as the results calculated were found to be highly significant. This shows that people, who score high on PTSD, score low on various domains of Quality of Life. In year 2000 a research conducted by Schnurr, Hayes and Lunney it was found that PTSD is associated with high rates of comorbid psychiatric and medical disorders as well as alcohol and drug abuse, resulting in poor physical health and subsequently diminished QOL. It has also been demonstrated that people who had a worse quality of life previous to war exposure are more likely to acquire PTSD, which will further

degrade their quality of life. Furthermore, PTSD symptomatology was shown to be associated with.

CHAPTER 7

CONCLUSION, IMPLICATIONS, LIMITATIONS AND SCOPE FOR FUTURE RESEARCH

7.1 Conclusion

The aim of the present study is to study the relationship between personality attributes, resilience, PTSD and Quality of Life. The study was designed taking into context how various personality attributes, resilience and PTSD affects the Quality of Life.

Keeping in mind the results, it can be said that, the Physical, Psychological, Social and Environmental domain of Quality of life has a high positive Correlation with Extroversion, Agreeableness and Conscientiousness. Whereas it was found that Neuroticism is highly negatively correlated with all the four domains of Quality of life therefore it can be said that Neuroticism was found to be negatively correlated with the Quality of Life. Resilience was also found to have high positive correlation with the Physical, Psychological and Environmental domain of Quality of Life. It was also seen that PTSD had a high negative correlation with four domains that is physical, psychological, social and environmental domain of life.

Furthermore, the results show that PTSD, Neuroticism and conscientiousness were significant in predicting Physical (Q1) domain of Quality of Life. Extraversion, Agreeableness, Openness to Experience and Resilience are present but not contributing and acting as predictor variable. Conscientiousness, PTSD, Neuroticism and Extroversion were significant in predicting Psychological (Q2) domain of Quality of Life. Agreeableness, Openness to Experience and Resilience are present but not contributing and acting as predictor variable. Extroversion, Neuroticism, Openness to Experience and Conscientiousness were significant in predicting Social Relationship (Q3) domain of Quality of Life. Agreeableness, PTSD and Resilience are present but not contributing and acting as predictor variable. Also Conscientiousness and PTSD were significant in predicting Environmental (Q4) domain of Quality of Life. Extroversion, Agreeableness, Neuroticism, Openness to Experience and Resilience are present but not contributing and acting as predictor variable.

7.2 Implications

Studies on Personality factors, Resilience and PTSD have important role to play in the study on how they affect various domains of Quality of Life. The present study aims to study the effects Big Five Personality Factors, Resilience and PTSD on the domains of the Quality of Life. Thus, this area is relatively less researched and has implications for researchers, clinicians.

7.3 Limitations

It is important to acknowledge that this study had its own set of shortcomings. The sample size was very small which makes it difficult to give generalize results. The ratio of males to females was also very less because of which gender differences could not be taken into account. . And also there was no control over the environmental stimuli that might have impacted responding. It is also important to keep in mind that the study was done during a very crucial time in the life of humans, during COVID-19, and given the nature of the study there remains room for suspicion regarding the generalization of the phenomenon observed.

7.4 Scope for Future Research

This study has great scope for future research. Increasing the sample size and keeping the equal ratio of males to females and left to right, it can yield better results. Effect of factors of Personality, Resilience and PTSD on Quality of Life can be collected both during the pandemic situation and then compared with the data which would be collected during non-pandemic or normal situation and can be explored more.

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Appendix A

BIG FIVE INVENTORY (BFI)

Here are a number of characteristics that may or may not apply to you. For example, do you agree that you are someone who likes to spend time with others? Please write a number next to each statement to indicate the extent to which you agree or disagree with that statement.

1 - Disagree strongly
2 - Disagree a little
3 - Neither agree nor disagree
4 - Agree a little
5 - Agree Strongly

I see Myself as Someone Who...

i. Is talkative
ii. Tends to find fault with others
iii. Does a thorough job
iv. Is depressed, blue
v. Is original, comes up with new ideas
vi. Is reserved
vii. Is helpful and unselfish with others
viii. Can be somewhat careless
ix. Is relaxed, handles stress well
x. Is curious about many different things
xi. Is full of energy
xii. Starts quarrels with others
xiii. Is a reliable worker
xiv. Can be tense
xv. Is ingenious, a deep thinker

xvi. Generates a lot of enthusiasm

xvii. Has a forgiving nature
xviii. Tends to be disorganized
xix. Worries a lot
xx. Has an active imagination
xxi. Tends to be quiet
xxii. Is generally trusting
xxiii. Tends to be lazy
xxiv. Is emotionally stable, not easily upset
xxv. Is inventive
xxvi. Has an assertive personality
xxvii. Can be cold and aloof
xxviii. Perseveres until the task is finished
xxix. Can be moody
xxx. Values artistic, aesthetic experiences
xxxi. Is sometimes shy, inhibited
xxxii. Is considerate and kind to almost everyone
xxxiii. Does things efficiently
xxxiv. Remains calm in tense situations
xxxv. Prefers work that is routine
xxxvi. Is outgoing, sociable
xxxvii. Is sometimes rude to others
xxxviii. Makes plans and follows through with them
xxxix. Gets nervous easily
xl. Likes to reflect, play with ideas
xli. Has few artistic interests
xlii. Likes to cooperate with others
xliii. Is easily distracted
xliv. Is sophisticated in art, music, or literature

Appendix B

This is an abbreviated version of the Nicholson McBride Resilience Questionnaire (NMRQ). For each question, score yourself between 1 and 5, where 1 = strongly disagree and 5 = strongly agree. Be honest: understanding the specific areas in which you lack resilience will enable you to get the most out of our 10 point booster plan.

1. In a difficult spot, I turn at once to what can be done to put things right.
2. I influence where I can, rather than worrying about what I can't influence.
3. I don't take criticism personally.
4. I generally manage to keep things in perspective.
5. I am calm in a crisis.
6. I'm good at finding solutions to problems.
7. I wouldn't describe myself as an anxious person.
8. I don't tend to avoid conflict.
9. I try to control events rather than being a victim of circumstances.
10. I trust my intuition.
11. I manage my stress levels well.
12. I feel confident and secure in my position.

Appendix C

Keeping in mind, respond to the following questions. Here, 0 represents not at all and 4 represents every day. Your response can be in a range of 0-4 where 2 represent neutral.

1. Have you had painful images, memories or thoughts of the event?
2. Have you had distressing dreams of the event?
3. Have you felt as though the event was re-occurring?
4. Have you been upset by something which reminded you of the event? 5 Have you been avoiding any thoughts or feelings about the event?
5. Have you been avoiding doing things or going into situations which remind you about the event?
6. Have you found yourself unable to recall important parts of the event? 8 Have you had difficulty enjoying things?
7. Have you felt distant or cut off from other people?
8. Have you been unable to have sad or loving feelings?
9. Have you found it hard to imagine having a long life span fulfilling your goals? 12 Have you had trouble falling asleep or staying asleep?
10. Have you been irritable or had outbursts of anger? 14 Have you had difficulty concentrating?
11. Have you felt on edge, been easily distracted, or had to stay ‘on guard’? 16 Have you been jumpy or easily startled?
12. Have you been physically upset by reminders of the event?

Appendix- D

This assessment asks how you feel about your quality of life, health, or other areas of your life. Please answer all the questions. If you are unsure about which response to give to a question, please choose the one that appears most appropriate. This can often be your first response. Please keep in mind your standards, hopes, pleasures and concerns. We ask that you think about your life in the last two weeks. For example, thinking about the last two weeks, a question might ask:

1. Do you get the kind of support from others that you need? Do you get the kind of support from others that you need?
2. You would circle number 1 if you did not get any of the support that you needed from others in the last two weeks.
3. How would you rate your quality of life? How satisfied are you with your health?

The following questions ask about how much you have experienced certain things in the last two weeks.

4. To what extent do you feel that physical pain prevents you from doing what you need to do? How much do you need any medical treatment to function in your daily life?
5. How much do you enjoy life?
6. To what extent do you feel your life to be meaningful? How well are you able to concentrate?
7. How safe do you feel in your daily life? How healthy is your physical environment?

The following questions ask about how completely you experience or were able to do certain things in the last two weeks

8. Do you have enough energy for everyday life? Are you able to accept your bodily appearance? Have you enough money to meet your needs?
9. How available to you is the information that you need in your day-to-day life? To what extent do you have the opportunity for leisure activities?
10. How well are you able to get around?

The following questions ask you to say how good or satisfied you have felt about various aspects of your life over the last two weeks

11. How satisfied are you with your sleep?
12. How satisfied are you with your ability to perform your daily living activities? How satisfied are you with your capacity for work?
13. How satisfied are you with yourself?
14. How satisfied are you with your personal relationships? How satisfied are you with your sex life?
15. How satisfied are you with the support you get from your friends? How satisfied are you with the conditions of your living place?
16. How satisfied are you with your access to health services? How satisfied are you with your transport?

The following question refers to how often you have felt or experienced certain things in the last two weeks

17. How often do you have negative feelings such as blue mood, despair, anxiety, depression?