ROLE OF RESILIENCE AS MODERATOR BETWEEN EMOTIONAL REGULATION AND SLEEP QUALITY AMONG ANXIETY PATIENTS

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ROLE OF RESILIENCE AS MODERATOR BETWEEN EMOTIONAL REGULATION AND SLEEP QUALITY AMONG ANXIETY PATIENTS

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Dedication

This thesis is dedicated to my unwavering family specially my uncle and steadfast friends, your enduring support has been my anchor through life's unpredictable seas. This journey is brighter and more meaningful because of your love, guidance, and unyielding presence. My dedicated to my supervisor whose guidance shapes my professional path, and my friend Muniba Afridi whose camaraderie adds joy to life's journey. Your collective support has been my foundation. This thesis stands as a testament to the profound impact of familial love, the enduring power of friendship, and the invaluable mentorship that have shaped my scholarly pursuits. I extend my sincerest thanks and dedicate this work to all of you with immeasurable gratitude.

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List of Abbreviations

APA	American Psychological Association
DSM	Diagnostic and Statistical Manual of Mental Disorders
SPSS	Statistical Package for Social Sciences
EQ	Emotion Regulation
CRF	Cognitive Reappraisal Facet
ESF	Expressive Suppression Facet
SAD	Social Anxiety Disorder
NIMH	National Institute of Mental Health

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Abstract

The present study aimed to investigate the relationship between Emotional Regulation and Sleep Quality among Anxiety Patients. The study strived to explore the moderating role of resilience between the Emotion Regulation and sleep Quality. It aimed to reveal gender differences in Resilience, Emotion Regulation and Sleep Quality among Anxiety Patients. The study was conducted on N=400 patients (men n=200, women n=200), evenly split between men patients and women patients, aged 18-45 years. Correlational analysis employed for enhanced relationship insight. For this quantitative research Brief Resilience scale (Smith et al., 2008), Emotion Regulation Questionnaire (Gross & John, 2003) and Sleep Quality Scale (Yi et al., 2006), were used to collect the data. The results of present study showed that there is positive relationship between Resilience, Emotion Regulation and Sleep quality. Moderator of Resilience, was unveiled between Emotion Regulation, its subscales namely Cognitive Reappraisal Facet, Expressive Suppression Facet and Sleep Quality. Furthermore, empirical results of the study demonstrated significant gender differences on Emotion Regulation subscales and Sleep Quality. Resilience shows no significant variance. Women's scored higher on Resilience, Emotion Regulation, Cognitive Reappraisal Facet, Expressive Suppression Facet and Sleep Quality. Young adult's individuals displayed better Emotion Regulation, while Middle age individuals displayed better Sleep Quality. Similarly, Joint family individuals exhibited higher Resilience, Emotion Regulation, Cognitive Reappraisal Facet, Expressive Suppression Facet and Sleep Quality. The research raises crucial awareness about patients with Anxiety Disorder, paving the way for further study and understanding of this condition. It highlights the significance of identifying and addressing Anxiety patients as a public health concern.

Keywords: Resilience, Emotion Regulation, Cognitive Reappraisal Facet, Expressive Suppression Facet and Sleep Quality.

Chapter 1

Introduction

According to Masten (2001) in the field of psychology, resilience is the capacity of individuals to adjust, recover, and flourish when confronted with hardships or major obstacles in life. In order to preserve mental health, it entails skillfully navigating and overcoming pressures, trauma, or misfortune. The dynamic process of resilience is impacted by a number of variables, such as upbringing, experiences, and heredity.

According to Rutter (1987) resilience is a quality that may be developed over time rather than being a set attribute. Enhancing mental health treatments and advancing wellbeing can both benefit from an understanding of the fundamental principles driving resilience.

As it enters a new phase of development, resilience research is experiencing some growing pains (Masten, 1999). It has built a strong and distinctive idea that indicates the ability to recover from unexpected or persistent adversity. Glantz and Slobada (1999) warn that "there is no consensus on the referent of the term, standards for its application, or agreement on its role in explanation, models, and theories" despite this. Developmental psychopathology emerged as a new area as a result of the explosion of empirical research that followed. Some, though, believe that it has caused chaos everywhere.

For instance, according to (Windle, 1999) "no organizing framework for integrating studies, for evaluating common and unique findings across different subject populations, variable domains, or spacing interval, or for studying the impact of alternative operational definitions and classification procedures on the identification of resilient individuals" is present in the literature on resilience. A confident group of academics (Cicchetti et al., 2001) are among the researchers

who endorse resilience science, but it has also inspired skepticism, as stated by (Kaplan, 1999), who believes that it is "a concept whose time has come and gone."

Types of resilience

According to Lee et al., (2013), there are two types of resilience definitions: resilience as a characteristic and resiliency as a developmental process. In the initial set of definitions, resilience was defined as the ability to "bounce back." The physical sciences have suggested that resilience is a property that allows materials to restore their initial form after being manipulated or extended (Dyer et al., 2012) and our methodology is compatible with their findings. According to the second group of researchers (Luthar et al., 2013), resilience is an ongoing process that enables individuals to successfully adapt in the face of significant adversity. According to this notion (Dyer et al., 2013), protective factors have an impact on resilience and it can change over time.

Resilience is the ability to face challenges and overcome them. People with resilience keep their cool when disaster seems imminent. Horn and Feder (2018) Resilience is the ability to maintain emotional control under stress (Vaughan et al., 2019). That being said, being resilient does not exclude one from experiencing strong feelings like anxiety, grief, or fury. It suggests that they are aware that those feelings are transient and that they may be managed till they pass. Resilience, which is really another word for adaptability, is the capacity to handle life's challenges. Resilience may take many different forms, though, and each one can affect a person's capacity to handle various stressors.

Physical resilience is the ability of the human body to adapt to changes and heal from illnesses, injuries, and physical strains. A study found that resilience of this kind is critical to general health. It influences how people grow, react to physical strain, and deal with health

problems (Whitson et al., 2016). The ability to adjust to uncertainty and change is known as mental resilience. Under pressure, these tough people remain composed and adaptable. They depend on their capacity for resilience to get beyond challenges, keep moving forward, and be optimistic. To maintain emotional control under stress, one must be emotionally resilient. People that are resilient are usually conscious of their emotional responses and in touch with what drives them. People with this form of resilience also happen to be more capable to sustain their optimism in trying situations. Because of their emotional endurance, they understand that hardship and uncomfortable feelings will pass. Social resilience, or community resilience, is the capacity of an entire population to withstand adversity. It necessitates interacting with others and cooperating to discover solutions to issues that have an impact on individuals as well as groups.

Social resilience

Social resilience includes overcoming catastrophe as a group, supporting one another socially, understanding the risks the community faces, and cultivating a sense of community (Kwok et al., 2016). Such measures may be essential in the face of challenges like catastrophic events that affect large populations or communities. Resilient people possess the mental toughness to cope with stress and hardship (Walker et al., 2017). In challenging circumstances, people's capacity to tap into their mental reserves of strength prevents them from collapsing. According to psychologists, those who are resilient are better equipped to endure adversity and bounce back from it. The effects of such catastrophes may be too great for people with limited resilience. They could become fixated on problems and use inappropriate coping mechanisms to deal with them.

As a response of disappointment or failure, they may behave in ways that are destructive, damaging, or even hazardous. The slower rate at which these individuals experience failures may cause them to feel more psychologically distressed (Lee et al., 2018). Resilience is the process and

result of overcoming tough or demanding life situations, especially when there is a need for psychological, emotional, and behavioral flexibility and adaptation to both internal and external challenges. Adversity adaptation is influenced by a variety of factors, including coping strategies, social support networks, and personal perspectives and relationships with the outside world.

According to psychological studies from the (APA) Dictionary of Psychology, one can develop and practice the talents and resources connected to significant positive change (i.e., higher resilience). While it isn't always an aim or state that should be desired, resilience is a psychological notion that practically everyone employs to clarify what it needs to deal with stress. Resilience is described by the American Psychological Association (APA) as "the process of adapting well in the face of adversity, trauma, tragedy, threats, or significant sources of stress — such as family and relationship problems, serious health problems, workplace stressors, and financial stressors."

According to earlier research (Bonanno, 2004), resilience "in the face of loss or potential trauma is more common than is often believed, and that there are multiple and sometimes unexpected pathways to resilience." Resilience is alluded to as a process in the scholarly article (Egeland et al., 2009) and is also known to be the "development of competence despite severe or pervasive adversity."

According to research (Friedberg et al., 2018), there is no universal definition of resilience in relation to trauma and coping, and each person should use it in their own unique way. The process by which people control their emotions, when they experience them, and how they express & engage with those feelings is known as emotional regulation. Emotional regulation, whether automatic or controlled, conscious or unconscious, can have an effect at one or more phases of the emotion-creating process (Gross, 1998). The idea of emotional regulation encompasses mutually

positive and negative emotions as well as the methods by which we can direct, harness, and control them.

Comprehension of resilience

Our comprehension of resilience has been limited, nevertheless, by two significant issues. First, the development of resilience research has been impeded by a lack of understanding of the concept. Second, although both the techniques to manage emotions and cope have their shortcomings, there has not been much interaction between them. The phrase "emotion regulation" describes the actions taken to regulate how and when emotions are experienced by people as well as how they are expressed (Gross, 1998).

The emotion-regulation approach is pertinent to resilience because people have a strong link between their functioning and the emotions they experience in the face of adversity (Aldao et al., 2010, Compas et al., 2017, Troy & Mauss 2011). This method takes a wide view of emotions across many contexts and inputs. According to this perspective, we must first appreciate resilience in order to fully understand adaptive emotion regulation (Troy & Mauss, 2011). This method, which has its roots in an emotion framework, distinguishes between separate feelings like joy, sorrow, and anxiety; takes changes in a number of response domain names such as background, behavior, cognition, and physiology into account (Russell et al., 1999) and considers positive as well as negative the valence emotional states (Levenson, 2011). This approach has frequently examined the relationship between resilience outcomes and mental health (such as anxiety and depression; (Aldao et al., 2010), along with the psychological bases of resilience outputs (such as emotional experiences) according to (Troy & Mauss, 2011).

Despite their significance in expanding our understanding of resilience, both coping and emotion-regulation approaches have disadvantages. The lack of communication among the two methods has made these restrictions much worse (Compas et al., 2014). Researchers and scientists concerned in stress and coping tend not to be familiar with or reference emotion investigation and theory, and inversely, according to (Lazarus, 1999). The separation of these fields is absurd. Soloing has been a result of this problem's persistence, which is slowing down the development, consolidation, and application of resilience knowledge. In a study by (Ramsawh et al., 2009) it was discovered that SAD, generalized anxiety disorder (GAD), and agoraphobia were all related to a three- to fourfold increase in the risk of reporting sleep difficulties after controlled for past month substance use and mood disorders. Previous studies have demonstrated a connection between SAD and sleep disruption for various anxiety disorders.

Models of resilience

Resilience variables function to change the trajectory from exposure to risk to negative consequence, and there are three basic types of resilience models that explain this (Fergus & Zimmerman, 2005). These classes include compensatory, protective, and challenging.

A scenario in which a resilience component opposes or counteracts a risk factor is best explained by a compensating model. Independent of the impact of the risk factor, the resilience factor directly affects the result (Ledogar & Andersson, 2008). According to the protective model, resources or assets mitigate or lessen the impact of a risk on an unfavorable result. Protective factors can affect results in a variety of ways. They might lessen, but not entirely eliminate, the impacts of hazards, or they might strengthen the beneficial influence of another motivating factor in bringing about a particular result. The challenge model is a third resilience model. According to this model, there is a "curvilinear" relationship between a risk factor and an outcome: exposure to

both high and low levels of a risk factor is linked to unfavorable results, whereas moderate degrees of risk are linked to less unfavorable (or favorable) outcomes.

Richardson (2002) offers a challenge model of resilience, according to which the most advantageous result of a process involving a person's responses to stress or adversity is "resilient reintegration." Resilient reintegration happens when a disturbance leads to some kind of realization or personal development. As a result, resilient traits are recognized or strengthened. The fundamental notion holds that people have a greater potential than they realize due to genetic predispositions. One method to realize this potential is through the "disruptive resiliency process".

Emotion Regulation

Gross et al., (2004) the processes by which humans regulate their emotional incidence, type, and spontaneous course as well as their behavioral, physiological, and/or experiential reactions can be referred to as "emotion regulation" (ER). These processes can be spontaneous or regulated, conscious or unconscious, laborious or effortless. ER in others versus ER in the self can be distinguished from both intrinsic and extrinsic regulatory systems (Gross & Thompson, 2007). (Gross, 1998) proposed the ER process model for the latter.

The core of the process model of ER is the idea of the emotion-generative process, whereby observable emotional cues are evaluated in a specific way and trigger tendencies for sensory, behavioral, and physiological responses.

Gross (1998) Emotion regulation is a relatively new field that examines how individuals manage their emotional experiences, including when, how, and when to express them. In this review, emotion is defined in terms of evolutionary reaction tendencies. Emotion regulation is defined and distinguished from coping, mood management, defense, and affect regulation. The

study of emotion regulation crosses boundaries and provides a common thread throughout the psychology field, which is becoming more and more specialized. According to a process framework of emotion regulation, there are five stages in which emotions can be managed: situation selection, situation alteration, attention deployment, cognitive change, and response modulation. The study of emotion regulation promises novel viewpoints on age-old problems pertaining to how humans regulate their emotions.

An emotion that is characterized by apprehension and physical indications of tension that is felt when one anticipates impending danger, calamity, or bad luck, according to the American Psychological Association (APA) lexicon of psychology. The body frequently readies itself to respond to the perceived threat by tensing up its muscles, breathing more quickly, and raising its heart rate. Anxiety and dread can be cognitively and physiologically distinguished from one another, despite the reality that the terms are usually used interchangeably. Anxiety is a persistent, generally focused, future-oriented response to a diffused threat, whereas fear is an appropriate, in-the-moment reaction to a clearly recognized and exact threat. Only in (1980) did the American Psychiatric Association recognize anxiety disorders as a real medical illness. Prior to this finding, the common general diagnosis for someone with one of these Disorders was "stress" or "nerves." Due to medical professionals' ignorance of the illnesses, few patients obtained the proper therapy. Since (1980), a global study has shown the significant challenges these Disorders are associated with. The majority of those deficits can be prevented with early detection and effective treatment.

Factors of Emotional regulation

Emotional regulation is influenced by three factors: starting emotionally-driven activity, avoiding emotionally-driven behavior, and altering emotional reaction triggers. The optimal approach to maximizing the regulatory processes is the third component. Emotion regulation (ER)

is the process of tracking and managing one's emotional experience (Gross & Thompson, 2007). According to research, ER techniques are either typically adaptive or maladaptive depending on the situation they are used in (Aldao & Nolen-Hoeksema, 2012). Emotion management is the practice of managing one's emotional reactivity. Because of the dynamic nature of individual reactions to emotions and the widespread impact it has in all settings, emotional management skills are crucial for daily functioning. Emotional self-control and resilience have a strong relationship, according to (Gross et al., 2013).

Previous studies have demonstrated that people who have significant emotional resilience employ efficient emotional regulation strategies to control their unpleasant emotions. Emotional regulation is also a key indicator of resilience (Bonanno et al., 2016). In order to stabilize mental state, build positive factors, and increase psychological resilience during times of challenges and adversity, people with high levels of emotion regulation use positive emotion regulation strategies. These strategies can be used as a protective factor for activating internal resources (Tugade & Fredrickson, 2007).

Phases of emotion regulation

Gross et al., (2020) We define emotion regulation as the modification of feelings using the three phases of identification, selection, and implementation.

At the identification stage, emotions are viewed as valuable as enough negative or positive to call for regulation.

The second evaluation stage, which represents various emotion management techniques and contrasts them with the available resources, yields the goal representation of using the selected strategy.

The method of strategy implementation that is decided is established by first observing and then assessing the surrounding factors. This is carried out in the last stage of implementation.

Ways of controlling emotion regulation

Gross (2002) Reappraisal and repression are two different ways to control emotions. Reappraisal is active at an early stage of the cognitive functioning of emotions. Reappraisal is the procedure of changing your perception of a situation that is emotionally charged in order to lessen the impact of the emotions. Reappraisal, as compared to repression, can improve the enjoyment and control of social relationships.

Suppression is the internalization of emotions so they are not expressed externally and occurs late during the emotional processing process. The author argues that suppressing one's emotions has negative health effects. Due of the continual self-regulation required by suppression, it might be harmful to memory. All emotional indicators, not just the undesirable ones, are inhibited by suppression in social situations. It could be difficult for another person to assess your message as a result.

Techniques to control Emotion

Emotion control techniques are crucial. Coping skills can be positive or negative. Techniques for controlling positive and negative emotions are called to as "trans diagnostic" because they can be used to treat a range of illnesses. To manage any clinical illness, such as diabetes, a condition anxiety, or depression, for example, we can use positive coping. Coping is how we respond to any stressor and goes beyond diagnosis. Adaptive coping is associated with both a more positive long-term view and enhanced resilience. Reframing the situation with the help of positive psychology and adaptive coping strategies entails being proactive about problems,

taking charge of one's life, relying on useful resources like exercise and sleep hygiene, upholding routines and helping systems, and staying away from thought patterns that lead to unhelpful behaviors. An individual's capacity to consciously adapt adaptive strategies can be severely hindered by a variety of conditions, such as the presence of more severe clinical diseases including anxiety and depression along with other factors like external stressors and innate propensities.

Emotion management approaches

"Positive reappraisal" and "repetitive negative thinking" were the two significant groups into which researchers group emotion management approaches, according to (Everaert & Joormann, 2019). Positive reappraisal is described as "cognitively rethinking the significance of an unpleasant occurrence in a less pessimistic or more constructive way to minimize its emotional impact," while persistently negative thinking is referred to as a trans diagnostic. The two main areas of psychological inquiry into the mechanisms underlying resilience over the past few decades have been the emotion-regulation strategy and the stress and coping a viewpoint, also known as the emotions and emotion-regulation technique and the coping a perspective, respectively (Compas et al., 2017). Each tactic has resulted in important discoveries.

Aid in emotion regulation

Cognitive reappraisal and control of attention are two techniques that may aid in emotion regulation and the growth of resilience, according to (Troy & Mauss, 2011). Their paradigm holds that emotional regulation is a moderator, and that individuals who have strong inner emotion regulation talents should be more robust in the face of adversity than individuals who have impaired emotion regulation abilities. They assert that employing cognitive reappraisal strategies and attentional restraint ought to produce adapted (less unpleasant) emotional responses, which in

turn foster resilience. One of the findings discussed at Neuroscience 2018, the annual conference of the Society for Neuroscience, conducted at (San Diego & California, 2018), revealed a link between anxiety and disturbed sleep. One study found that even brief sleep deprivation increased activity in "emotion-generating areas of the brain" while decreasing activity in "emotion-regulating regions." Lack of sleep seems to wake up the brain by spiking levels of stress hormones like cortisol, which causes an early-morning "anxiety bloom" even before the day has truly begun.

Emotion regulation cause of anxiety

According to Barlow (1991) emotional ailments predominantly cause anxiety disorders. Anxiety is a pervasive state of arousal that follows the perception of a threat, whether genuine or imagined. This feeling, which is predominantly experiencing, future-focused, and self-focused, can occasionally be adaptive whenever anticipated problem-solving thoughts are triggered (Barlow, 1991). The timing and intensity of unpleasant emotions seem to be problematic in these disorders (Kring & Werner, 2004). It should therefore come as expected that these issues are probably related to weaknesses in emotion regulation.

Physiological theory of emotion

The James, Lange theory

The Lange (1884) hypothesis is among the most well-known examples of a physiological theory of emotion. The scientist (Lange, 1884) and psychologist (James, 1884) independently proposed the James-Lange theory of emotion, which holds that emotions are the result of physical reactions to experiences. According to the James-Lange theory of emotion, an external stimulus causes a physiological reaction. Your emotional reaction will depend on how you interpret those physical reactions. Imagine that you are out on a forest walk when a big brown bear is spotted.

Your body begins to tremble, and your heart begins to beat rapidly. The James-Lange theory states that you will conclude that you are afraid ("I am trembling. As a result, I am scared. According to this view of emotion, your shivering is not an indication of fear. Instead, you are terrified because of your trembling.

Cannon-Bard theory

The Cannon-Bard theory of emotion states that humans experience physiological reactions such as shaking, sweating, and muscle tension simultaneously with feeling emotions. More specifically, the theory holds that when the brain reacts to a stimulus, the thalamus sends a message to the brain, which results in a physical reaction. Additionally, the brain receives signals at the same time that lead to the emotional experience. The idea of Cannon and Bard states that both the physical and psychological expressions of emotion happen at the same time, independent of one another.

Appraisal theories

According to appraisal theories, cognition has to occur before emotion. The Lazarus hypothesis of emotion was developed by (Lazarus,1991), an expert in the study of emotion. This theory holds that a series of events begins with a stimulus, continues with cognition, and ends with the simultaneous experience of a physiological response and an emotion. For instance, if you spot a wild creature in the woods, you might immediately believe that you are in dire danger. Both the mental state of dread and the bodily reactions related to the fight or flight reaction are brought on by this.

Anxiety disorder

The Diagnosis Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) and the American Psychiatric Association (APA) both define anxiety as an excessive level of fear and worry about a number of life occurrences and traumatic experiences that is accompanied by physical tension and alertness (Ruscio et al., 2013). Psychologist (Rawson et al., 1994) conducted similar research that showed those with depressed also have greater levels of anxiety. According to the APA and previous substantial research, depression and anxiety are significantly associated (Castonguay et al., 2018).

Effects of anxiety on sleep quality

How well someone was able to start, continue, and complete a given amount of sleep, as well as how refreshed they felt upon awakening, are both measures of how happy they were about their sleep experience. Given the increased frequency of insomnia and sleep disturbances, as well as the clear connection between optimal health and performance and good sleep, medical professionals and researchers view sleep quality as a critical component.

Despite being often used, the term "sleep quality" lacks a clear meaning (Krystal & Edinger, 2008). To various persons, the word "sleep quality" might mean different things. The sleep beginning phase may be the most significant indicator of sleep quality for an individual who struggles to fall asleep. On the other side, somebody whose sleep is disrupted and full of sudden awakenings might not care too much about how difficult it is to fall asleep.

Sleep measurement

Four standards are generally used to gauge how well someone slept: The duration that it takes you to fall asleep can be used to measure your sleep latency. Your sleep may be of great

quality if you nod off within thirty minutes of going to bed. This measures how often you wake up at night.

Regular overnight awakenings may impair the quality and rhythm of your sleep. If you just have one wakeup or none at all, your rest was of a high caliber.

Wakefulness is the period of time you spend awake after you've gone to sleep at night. 20 minutes or less of nocturnal awake time is considered to be a good night's sleep. The proportion of time spend in bed that is truly spent sleeping is known as sleep efficiency.

This measurement needs to be a minimum of 85% to get the most health benefits.

Anxiety and sleep issues are commonly linked. It is more difficult to go asleep and stay asleep during the entire night when one is really afraid and anxious. Lack of sleep may set off a vicious cycle which results in worry and sleeplessness, which in turn can make anxiety worse. A state of fear and concern is called anxiety. Anxiety is a frequent reaction to challenging or frightening circumstances.

Sleep, or at least an occasional period of rest, has likely been a part of life since the onset of evolutionary time (2008). Our sleep patterns have changed over time, even though the need for sleep hasn't. At various points in time throughout history, individuals have gone to great lengths either to make sleep easier and more pleasant or to more or less include it into their everyday lives.

Numerous features of our conceptions of sleep have evolved over time, across cultures, and in response to scientific discoveries. This timeline demonstrates how our understanding of sleep has evolved throughout human history.

The report from the National Institute of Mental Health (NIMH, 2018) this discomfort gets worse if there are anxiety issues. Worrying disrupts daily tasks and causes anxieties that are excessive for the circumstance. Most days are impacted by these feelings, which last for a minimum of six months. Mental health conditions including anxiety and depression disorders can coexist. In accordance with the American Depression and Anxiety Association (ADAA, 2020), almost fifty percent of those with a depression diagnosis also struggle with anxiety.

Types of anxiety

The following are some of the various classifications for anxiety disorders. Generalized Anxiety Disorder (GAD): Individuals with GAD have substantial, ongoing worries about a variety of things, which can cause a generalized anxiety feeling. Panic Disorder: Highly acute episodes of terror, known as attacks of panic, which frequently endure for just a few seconds at a time, are the defining feature of panic disorder. Social anxiety disorder is characterized by extreme worry about social interactions and fear of embarrassment in public. Strong phobias triggered by certain triggers are known as specific phobias. Two of the most common specific phobias are agoraphobia (fear of public or closed-off areas, being in crowds, being outdoors, or being at home lonely) and separation anxiety.

Not every person with an anxiety disorder exhibits the same degree of symptoms or daily life impacts from anxiety. A big survey found that 43% of people reported that fear has only slightly affected their lives. Almost 23% of respondents said it was severe, and 33% indicated it was moderate. It is commonly established that severe sleep issues, such as insomnia, are symptoms of anxiety disorders. Worriers commonly reflect on their troubles when in bed, which can cause anxiety and keep them up at night. In truth, a state of mental hyper alertness that is frequently accompanied by concern has been identified as a primary cause of insomnia. Due to their higher

sleep reactivity, individuals who have anxiety disorders are more likely to experience sleep problems when under stress.

Connection between anxiety and sleep cycles

A connection between altered sleep cycles and anxiety disorders has been found. The rapid eye movement (REM) sleep, when dreams are at their most vivid, is thought to be influenced by worry and pre-sleep ruminating. More intrusive dreams and a higher likelihood of sleep disturbances are both possible outcomes of anxiety. Nightmares may serve to further exacerbate people's unfavorable associations with and anxieties about sleeping. But there is also strong evidence to support the idea that sleeplessness is not merely an anxiety symptom. Instead, the absence of sleep can worsen anxiety disorders or even induce them. According to studies, people who have a predisposition to anxiety are especially susceptible to the negative effects of getting too little sleep, which can lead to anxiety symptoms.

Insufficient sleep, which has been shown to have an effect on emotions and mental health, may exacerbate the challenges caused by anxiety disorders. Anxiety and insomnia can escalate out of control because of their mutually reinforcing nature. Bad sleep brought on by worrying makes for increased anxiety and worse sleep issues.

Sleep efficiency and anxiety level are directly associated. While having enough sleep can improve your general health and happiness, obtaining too little or poor quality sleep can make you stressed, irritable, and anxious. It should also be noted that anxiety can make it difficult to sleep, which can start a loop where anxiety levels are affected by sleep and inversely. Numerous factors might affect anxiety levels, including lack of sleep.

Changes in Hormones

Hormone level changes: Hormone levels are regulated by the body when sleeping. The body can only regulate when it is healthy, and health requires sleep. Poor sleep hygiene consequently raises the possibility of hormone imbalance. Eventually, hormonal problems may cause anxiety levels to rise. Body stress: Stress is one of the primary causes of sleep deprivation. Because it enables the body to heal itself, relax tense muscles, and handle a number of difficulties brought on by high levels of stress, sleep helps to lower stress. Lack of sleep can worsen worry and raise stress levels while decreasing the body's ability to handle stress. Adrenaline release: The body occasionally may release excessive quantities of adrenaline even when there is no tension present. Such an extreme rush of adrenaline may cause the body to remain on edge for exceptionally long periods of time, which may then negatively affect anxiety levels.

Brain stress cause anxiety

Not getting enough sleep may have a detrimental effect on the way the brain functions. Increased brain stress can then result in anxiety along with additional emotional and mental issues, such as hallucinations and other issues. The brain's neurons regenerate themselves as we sleep, just like the rest of the body. So, sleep deprivation can impede or even halt this regenerative process. Long-term sleep problems can damage different parts of the brain or even stop neurons from firing altogether. Numerous physiological problems, such as back pain, headaches, numbness in the legs and arms, unusual bodily sensations, etc., can result from lack of sleep. Your sleep may be less restful as a result, and your anxiety might increase.

Resilience theory

Resilience theory, as defined by (Van Breda, 2018) is the examination of the individual elements that make up this phenomenon.

How "adversity" and "outcomes" genuinely imply, how they are defined, and what kind of strategies people have for dealing with adversity.

Resilience and positive psychology typically go together. Both are concerned with how basic factors function and how a useful construct might advance the well-being of us (Lutha et al., 2014). Positive psychology and resilience theory are both applicable fields that can be utilized in daily life to promote humanity (Luthar, 2011). They both emphasize the importance of interpersonal ties strongly. In their research, (Mart & Ruch, 2017) found that hope, boldness, and zest were most strongly associated with successful adversity adaption. As a consequence, the researchers assumed that a variety of mechanisms, such as willpower, interaction with others, emotional control, and more, were involved.

Broaden-and-build theory of resilience

According to the broaden-and-build theory of positive emotions, one emotion that motivates us to become more inquisitive and adaptive in our thoughts and behaviors is happiness. We create long-lasting resources to sustain happy lives (Fredrickson, 2004).

The most widely recognized positive psychology framework for fostering resilience is Seligman's 3Ps model. Humans commonly experience three types of emotional reactions to adversity: personalization, pervasiveness, and permanency. By targeting these three regular, automatic responses, strengthening our capacity for adaptation, and developing superior problem-solving skills, we may increase our resilience and develop. These are (Seligman's, 1990) three Ps:

The cognitive distortions known as personalizing is best described as the internalization of problems or failure. When we hold ourselves responsible for terrible events that occur, we heap unwarranted guilt on ourselves and make it more challenging to bounce back.

The concept of pervasiveness holds that negative experiences are commonplace in our life, as when we lost a competition and come to the conclusion that everything is horrible. By acknowledging that unpleasant emotions don't have an impact on every part of life, we can move towards a better life. The concept of permanence holds that unpleasant events or objects only occur once and then never again. Because permanence prevents us from trying to change, we usually feel overwhelmed and despondent. These three perspectives help us better understand how our attitudes, beliefs, and thoughts affect our experiences. By appreciating their role in enhancing our potential for adaptive growth, we can start to increase our resilience as we learn to deal with life's challenges.

Sleep theories

Repair and Restoration theory of sleep

The repair and restoration theory of sleep states that sleep is essential for rejuvenating and restoring the physiological systems that keep the body and mind healthy and functioning normally (Ezenwanne, 2011). This point of view contends that while NREM sleep is important for healing physical operations, REM sleep is essential for repairing mental activities. This idea is supported by (2011) research that shows how REM sleep rises following extended sleep deprivation and strenuous exercise. The fact that the body speed up the procedures of synthesis of proteins and cell division while we sleep is more proof that repair and restoration occur while we sleep.

In 2013, further research confirmed the validity of the repair and restoration theory, demonstrating that the brain is able to do "housekeeping" duties while we sleep (Xie et al., 2013). The results of a study, which were revealed in the journal Science's October 2013 issue, demonstrate how the brain uses sleep to get rid of harmful waste. They assert that this waste

disposal mechanism is one of the primary factors in our difficulty sleeping. But it's important to keep in mind that mice, not humans, were used in this study.

The study's authors proposed that sleep's restorative effects may be caused by the rapid removal of potential neurological waste products that accumulate in the central nervous system in waking. According to one of the study's authors, Dr. (Nedergaard, 2013) the brain is forced to decide between being up and keeping watch and going to sleep and organizing because to its limited resources. They further assert that problems with getting rid of this waste could be a factor in a number of neurological diseases, including Alzheimer's disease.

Theories of Anxiety

Freeman and Freeman (2012) in "Theories of Anxiety," four key theories of anxiety are discussed. Let's start with some of Freud's views on psychoanalysis. John Broadus Watson's research on behaviorism, which revealed that conditioning was responsible for the genesis of phobias, served as the inspiration for the behavioral theories that led to the creation of cognitive behavior therapy (CBT). Mowrer et al., (1947) established these theories. Cognitivism expanded behaviorism by including the study of thought; its main conclusion is that anxiety originates as a "appraisal" of a situation.

Literature Review

Stein (2012) A growing corpus of research suggests that understanding the development, preservation, and therapy of anxiety disorders depend on the theory of emotion regulation. In this paper, we provide a concise review of this emerging subject and highlight the main sources of information. A contrast between the ideas of emotions and their regulation is first suggested by the evidence. Secondly, there is a sizable and expanding body of research that demonstrates how

emotional regulation strategies can change emotional reactions. Studies using behavioral and neuroimaging methods have both demonstrated this outcome. Measures of emotion control provide a third explanation for the progressive variation found in indicators of anxiety disorder symptoms that cannot be explained through measures of negative affect. Even though the research linking emotion regulation to anxiety disorders is encouraging, more work will be needed to elucidate the causal processes underlying how emotion regulation plans the exposure for anxiety disorders and to enhance the reliability and uniformity of definitions of emotion regulation. A mechanism that can account for the association is yet unknown, despite the fact that the available research shows that emotional control problems are directly associated to anxiety disorder signs in persons of all ages.

According to one idea, the capacity to control one's emotions increases vulnerability to anxiety disorders through increasing the detrimental effects of affect. This idea has been supported by research that identifies a relationship between measures of emotion control and measures of negative affect to predict the intensity of anxiety symptoms (Kashdan et al., 2008). All of the evidence suggests that emotion regulation may have an increased impact on the symptoms of anxiety disorders. Both the causative mechanisms and the nature of the effects will need to be defined by future longitudinal research. That is, cause anxiety issues contribute to the emergence of unhelpful emotion regulation strategies, or do disorders of anxiety do the latter (McLaughlin et al., 2011) did find that emotion dysregulation predicted higher anxiety symptoms over a seven-month period after controlling for baseline symptoms. On the opposite hand, anxiety symptoms were not associated with increases in emotion dysregulation after controlling for baseline emotion dysregulation. Further longitudinal research along these lines will be necessary to fully comprehend the relationship among emotion regulation and the signs of anxiety disorders. It will

take additional research to pinpoint precisely how this emerging profession can aid in our understanding of and approach to treating anxiety problems.

Conroy et al., (2019) Different persons have different emotional styles, which are defined as the consistent use of emotion regulation (ER) approaches. Previous research has shown that rather than any one ER strategy, an individual's mental health is associated to their cognitive flexibility of ER strategies. Studies examining the causes and management of GAD and other anxiety disorders show significant deficiencies in the understanding and implementation of emotion regulation (ER) techniques (Cisler et al., 2010). The facts on the enormous individual heterogeneity in affective styles and ER, notably in anxiety disorders, suggest that it is desirable to explore these minor variations according to with an idiographic, person-centered approach. Patients with GAD have a variety of ER flexibility. In the ER, a majority of patients appear to be either moderately or barely flexible. People who have greater ER flexibility tend to have a higher standard of life and less mental anguish.

Lau (2022) it is believed that resilience training can aid in mental health difficulties. Even though they are rarely discussed, mental health problems have a detrimental effect on resilience. This study investigated the reciprocal relationship among resilience and symptoms of melancholy and anxiety using a three-wave cross-lagged methodology. Resilience level, symptoms of anxiety and depression were assessed at the beginning, the third month, and the sixth month in 125 undergraduate students (62 females) who did not have any psychiatric conditions. There were no observable changes in resilience levels during the duration of the six months. At the third and sixth months, depression symptoms while not anxiety symptoms significantly increased when compared to baseline. The inverse relationship between resilience and mental health problems demonstrates how important it is to cultivate resilience in order to prevent mental illness along with how

important it is to manage not to be clinical symptoms of mental health in order to track resilience. The erratic bidirectional association between resilience and depressed symptoms over time raises the possibility that there are moderators that affect the relationship between resilience and depression. Our findings add to the growing body of research supporting the idea that resilience is a dynamic phenomenon.

Saleem et al., (2019) medical school is favored by Pakistani students and families despite the fact that it is hard due to the enormous knowledge that must be acquired and the various tests that must be completed. Therefore, only those students who put real academic effort into their studies while enrolling in a medical college will graduate with honors, obtain their degrees, and be eligible to practice medicine. As a result, the stress and anxiety that students encounter while entering medical colleges eventually impairs their capacity to express emotions and act in a manner that is consistent with those emotions. Goals: To look into how anxiety and emotional control relate to undergraduate medical students at Federal Medical and Dental College.

A descriptive research design was employed in the study. The Federal Medical and Dental College in Islamabad serves as the venue for the six-month event. Method: From the Federal Medical and Dental College, a sample of 300 medical students was chosen. The method utilised to gather the data was consensus sampling. The Beck Anxiety Inventory (BAI) by Beck (1988) and the Emotional Regulation Questionnaire (Gross & John, 2003) were used to examine the relationship between anxiety and emotional regulation. Findings: Anxiety, expressive suppression, & emotion control are strongly positively correlated, and there is a significant negative association among anxiety & cognitive reappraisal. There is a strong correlation between gender and anxiety and emotional control. Compared to men, women experience higher levels of anxiety and during their medical school years, they employ more techniques for emotion regulation and vocal

suppression. In conclusion, as medical students experience higher levels of anxiety compared to other pupils, it is critical to take the appropriate steps to lessen their anxiety and support them in gaining the skills necessary to effectively control their emotions so that they may have more fulfilling lives.

Brown et al., (2019) Anxiety is one of the most common mental illnesses affecting adolescents in the US, with approximately 30% of teenagers reporting some form of anxiety issue. Drugs that increase the risk of suicide in certain patient groups may be used as part of the conventional approach to treating anxiety. Untreated anxiety can have a serious impact on the lives of children and can linger into adulthood. Integrative therapies can be used in conjunction with conventional techniques to promote relaxation when controlling anxiety and stress. Additionally, using integrative techniques can help children and teenagers gain the resilience they'll need throughout their lives and the knowledge they'll need to successfully manage their anxiety symptoms.

Shrivastava et al., (2016) the pathology of mental diseases is being more understood, particularly in light of more recent data from the disciplines of genetics, epigenetics, social pathologists, and environmental pathology. It is now clear that biological elements play a part in the onset of an illness despite a number of psychological variables. A psychobiological quality called resilience influences how individuals respond to stressful events in their life. Resilience is the capacity to rapidly and successfully adapt to trying or stressful situations and turn things around. The growth of positive psychology, which investigates people's happiness, adaptability, contentment, and optimism, depends on it. Resilience has been considered in connection to the stress-risk-vulnerability component in a new way recently. It is a neurological entity with significant neurobehavioral and affective traits that is essential in analyzing the biopsychosocial

framework of the causal mechanisms of mental illnesses. In addition to being a protective factor towards the emergence of mental disorders, resilience is a risk factor in numerous clinical ailments, including suicide.

Resilience is a controlled factor, which opens doors for a variety of current psychosocial and biological therapies, according to the data from scientific research that are now available. Early identification of those with vulnerabilities and the success of interventions based on resilience may shed more light on the viability of prevention. Future research may be crucial for preventive psychiatry. In this study, we aim to investigate whether resiliency is a psychopathological notion for mental illness. Resilience has been demonstrated to reduce suicidal ideation in anxious and depressed individuals. Resilience, per research, may potentially lessen the risk that depressive and/or anxiety symptoms may manifest in suicidal individuals who have depression and/or anxiety disorders (Johnson et al., 2010). The results of this research do support the idea that resilience and mental illness are closely associated and may be used as a defense strategy against certain mental health disorders like depression and anxiety.

Sloan et al., (2017) emotional control problems have been connected in a significant amount of study to the development and maintenance of psychopathology. As a result, it has been proposed that emotion regulation is a trans diagnostic idea or a fundamental psychopathological process. The importance of emotion management across diagnostics has not yet been comprehensively discussed in the literature on psychotherapy outcomes. It makes sense that changes in emotion regulation concerns will arise after effective treatment if emotion regulation is in reality a trans diagnostic term that is crucial to the maintenance of psychopathology, and this will happen for a variety of diseases. We did a thorough analysis and identified 67 papers that evaluated alterations related to emotion regulation and psychopathology symptoms following

psychological therapy for anxiety, depression, drug abuse, eating pathologists, or borderline personality disorder. Results demonstrated that, depending on the intervention or disease, after treatment, the use of dysfunctional emotion regulation techniques and overall emotion dysregulation significantly decreased in all but two investigations. Parallel decreases were seen in the symptoms of depression, eating disorders, substance abuse, and borderline personality disorder. These results contribute to the growing body of evidence proving that emotion control is a cross-diagnostic notion. The current study investigates the important implications of these findings for the development of comprehensive medicines that target emotion regulation in patients with a range of disorders.

Stefan et al., (2012) this review presents a trans diagnostic emotion regulation model of anxiety and mood disorders. According to this framework, depending on the person's emotional style, a triggering occurrence and an existing disorder may have either a positive or negative impact. The root causes of mood and anxiety disorders are negatively affective emotion dysregulation and a deficiency in positive affect. An important maladaptive cognitive activity that helps maintain the mental disease known as generalized anxiety disorder (GAD) is worrying. Hofman et al., (2005) this process can be effectively addressed by developing adaptive emotion regulation techniques within the framework of modern psychological treatments, including Acceptance-Based Behavioral Therapy for GAD, Emotion Regulation Therapy for GAD, and other ACT protocols for anxiety disorders. These and other approaches are used by (Twohig et al., 2010) in the trans diagnostic approach to understand anxiety and mood disorders as a consequence of emotion dysregulation. Sills et al., (2008) Our strategy also emphasizes the significance of affective behaviors and how both positive and negative effects lead to emotional disorders.

Even though the emphasis of the discussion was on mood and anxiety disorders, that is proof that suggests that individuals who have difficulty controlling their emotions are also more likely to develop aggression (Szasz et al., 2001), substance use disorders (Berking et al., 2011) and other psychopathologies (Aldao et al., 2010), among other psychopathologies. The model has a trans diagnostic perspective. For instance, low positive affect may contribute to the explanation of why depression and anxiety disorders frequently coexist in depressed individuals. So, according to Wilamowska et al., (2010), our model provides the theoretical foundation for current trans diagnostic methods to the understanding and growth of anxiety disorders. The findings are also applicable to non-clinical populations, such as adolescents and young adults, as emotion regulation deficits appear to be a generalized risk factor for psychopathology in non-clinical populations (Aldao et al., 2010).

According to Sills and Barlow's (2007) research, a person's vulnerability to and ability to resist mood disorders and anxiety may vary depending on how they manage their emotions. We also provide numerous examples of clinical features of mood disorders and anxiety that can be regarded as misdirected efforts to suppress unwanted emotions. We conclude by discussing a ground-breaking approach to addressing anxiety and mood issues that is based on foundational research on emotion regulation. The core of the emotion regulation-focused cognitive therapy technique is the cognitive reappraisal for emotion management.

When we discuss "emotion regulation," we're actually talking regarding cognitive and behavioral techniques that affect how often, clearly, and expressively emotions occur. As a consequence of these processes, positive or negative feelings may be elevated or downregulated. Due to the fact that excess negative emotion is a key component of mood disorders such as anxiety, we focus on the reduction of negative emotion.

Anxiety and mood disorders are discussed in terms of emotion regulation, clinical characteristics, and treatment (a maladaptive situation selection, circumstances avoidance, withdrawal from society, dysfunctional circumstance change, protection indications, inappropriate focus execution, thought suppression, disorientation, worry, and rumination).

Heimberg and Dryman (2018) Due to their high levels of comorbidity, major depressive disorder (MDD) and social anxiety disorder (SAD) aggravate each other's prognoses and increase the functional impairment that both cause. Despite the fact that scientific hypotheses link impairments in emotion regulation to the onset and maintenance of internalizing disorders, comprehensive comparisons of emotional regulation in depression and social anxiety have not been conducted. The research on two widely-studied emotion regulation methods, cognitive reappraisal (CR) and expressive suppression (ES), in SAD and MDD is thoroughly analyzed in the current study.

Our data shows that excessive ES reliance, which has negative social and emotional effects, is a common feature of SAD. Another characteristic of SAD is ineffective CR use, which precludes this modified emotion regulation strategy from offering any potential positive emotional advantages. On the other hand, MDD is typically characterized by a decreased application of CR, which can be especially damaging in demanding or difficult situations. For both SAD and MDD, treatment intervention appears to improve CR but not ES deficits. Following a review of the literature, we offer several potential avenues through which ES and CR impairments can increase the likelihood that SAD and MDD would co-occur.

Self-compassion is becoming more popular in 2020 as a viable treatment objective for individuals with disorders such as depression and anxiety. By understanding self-compassion within the framework of emotion regulation (ER) disorders of depression and anxiety, it may be

feasible to gain knowledge regarding the clinical efficacy of the practice for the treatment of depression and anxiety. The current review's goal was to integrate facts and theories from the literatures on compassion for one's ER, anxiety, and mood disorders in order to highlight research's future potential and provide data for clinical applications. In accordance with an ER model of these illnesses, the evidence suggests that manifestations of both positive and negative affectivities are crucial to the emergence, repairs, and comorbidities of mood and anxiety disorders.

For example, Brown and Barlow (2009), found that the bulk of the correlation between components related to unipolar depression and other anxiety disorders was explained by negative and positive affect. According to Mennin et al. (2009), higher emotional arousal and an absence of emotional regulation may also play a significant role in the development and maintenance of emotional diseases. Neuroscience research has also shown a link between anxiety and mood disorders and impaired amygdala activity, which is crucial for observing, analyzing, and responding to emotional stimuli (Desbordes et al., 2007). Hu et al., (2004) study found that individual differences in skill and propensity to utilize different ER approaches, which in return predicted emotions and mental health, are often stable. This study highlights the importance of adapted ER in promoting sound mental health as well as the role that both adapted and maladaptive ER play in both the onset and persistence of mental health problems.

Michael (2009) Contemporary research has shown that psychiatric diseases, notably anxiety and mood disorders, and sleep problems frequently co-occur. Disrupted sleep patterns are linked to a variety of sleep disorders, which raises the possibility of anxiety & mental disease beginning or getting worse. A history of mental illness may also make it more difficult to diagnose and treat sleep issues. In terms of sleep findings related to different psychological diseases, psychiatric coexistence in sleep problems, and mutual interactions, including treatment effects,

this focused review of the literature looks at the relationship between key diagnoses from the International Classification of Sleep Disorders, 2nd edition, and psychiatric conditions. The evidence indicates that the standard for all patients receiving effective therapy should be treating both the mental disease and the sleep problem together. They stress not just how common it is for pathology and psychological distress to accompany sleep issues and vice versa.

Bunmi and Cox (2016), the literature suggests that sleep disturbance may serve as a trans diagnostic process, thus there is considerable interest in studying whether it can alter anxiety and related diseases. The current review gathers and evaluates the earlier research on the relationship between sleep and anxiety and related illnesses. According to research, sleep disruption exacerbates the symptoms of almost all types of anxiety and disorders linked to anxiety. But depending on weather it is subjectively or objectively assessed, the kind of sleep disturbance commonly varies. Even though sleep disturbance coincides with a majority of anxiety disorders and their related ailments, its causative role is less clear. A potential method by which sleep disruption could raise the risk of acquiring anxiety and other related illnesses is discussed. It may be simpler to develop novel therapies for severe anxiety and concurrent sleep disturbance in the future when investigations integrate insights from fundamental sleep studies with knowledge of anxiety and related disorders.

Almost all major mental diseases are accompanied by sleep abnormalities, but psychopathology has a particularly high prevalence of sleep disruptions (Benca et al., 1992). Even while the majority of past research has been on the connection between disturbed sleep and mental disorders (Armitage et al., 2007), a small body of research is now looking at the function of sleep disturbance in anxiety and illnesses that are associated to it. Sleep disturbance is frequently observed in individuals with anxiety and related disorders, according to a number of studies

(Feldner & Harvey, 2012) and in people of all ages (Johnson et al., 2006). Additionally, either generalized anxiety disorder (GAD) & posttraumatic stress disorder (PTSD) have sleep problems as symptoms (American Psychiatric Association, 2013). Additionally, research suggest that sleep disruption may be a predictor of the formation of an anxiety disorder (Batterham et al., 2012). To better appreciate the role of sleep disruptions in anxiety along with associated illnesses, it is essential to describe how sleep can become impeded in each disease. The research on both objective and subjective sleep problems in phobias, posttraumatic stress disorder (PTSD), Social Anxiety Disorder (SAD), Obsessive Compulsive Disorder (OCD), and Personality Disorder (PD) is critically reviewed in the following sections.

These findings taken together demonstrate that Generalize Anxiety Disorder (GAD) causes sleep abnormalities based on both subjective and objective sleep assessments. Objective sleep studies in Generalize Anxiety Disorder (GAD) sufferers have shown signs of decreased Total Sleep Time (TST), higher Sleep Onset Latency (SOL) and anomalies in non-rapid eye movement (NREM) sleep structure compared to healthy controls. Contradictory data exist on differences in Rapid eye movement (REM) characteristics and sleep quality between Generalize Anxiety Disorder (GAD) sufferers and healthy controls. However, Rapid eye movement (REM) traits seem to distinguish those with Generalize Anxiety Disorder (GAD) from those with major depressive disorder (MDD). A consistent sequence of difficulty sleeping in Generalize Anxiety Disorder (GAD) when compared to healthy controls and higher sleep difficulties in Generalize Anxiety Disorder (GAD) than in other anxiety disorders have also been found in studies evaluating subjective sleep. Additionally, subjective sleep disturbance is a predictor of the development of Generalize Anxiety Disorder (GAD). Future research examining objective sleep issues as a Generalize Anxiety Disorder (GAD) trigger would support this conclusion.

Even though there is evidence that both subjective and objective sleep disruption are present in Generalize Anxiety Disorder (GAD), very few research has looked at both factors at once (Alfano et al., 2015). Future research may benefit from using both objective and subjective sleep assessment to better understand when these traits may contribute to Generalize Anxiety Disorder (GAD). Furthermore, there are few recent adult research that have investigated objective sleep disruption in this population, despite being known that sleeping disruption is one of the early signs of Generalize Anxiety Disorder (GAD) and (American Psychiatric Association, 2013). Considering the fact that sleeping disturbance has been associated to Generalize Anxiety Disorder (GAD), the cause of its presence is yet unknown. More research is needed to identify the pathways that potentially link Generalize Anxiety Disorder (GAD) with sleep disruption.

These findings demonstrate the link between panic disorder and sleep disturbance. Particularly, people with Parkinson's disease (PD) report more subjective sleep issues, and empirical studies reveal decreased sleep efficiency, higher Sleep Onset Latency (SOL) & higher Total Sleep Time (TST), that could be partially due to higher anxiety sensitivity. Compared to Sleep Onset Latency (SOL), Total Sleep Time (TST), and sleep efficiency, the proof for improvements with other objective sleep measurements is less conclusive. There is a notable lack of actigraphy-based investigations into objective sleep of Parkinson's disease, much like there is a scarcity of studies on Generalized Anxiety Disorder (GAD) and Obsessive Compulsive Disorder (OCD). Only a few research has also attempted to delve deeper than classification to examine the causes of sleep disruption's association with Parkinson's disease (PD).

While one study raises the possibility that anxiety sensitivity may contribute to the connection among sleep and Parkinson's disease (PD), more investigation is needed to identify the exact mechanisms. As using medications to treat anxiety sensitivity may improve sleep in those

with Parkinson's disease This query could have a considerable impact on how Parkinson's disease (PD) is treated (Smits et al., 2008). Additionally, learning more about the pathways linking sleep and Parkinson's disease could open up new therapeutic options for those who suffer from the condition.

Numerous conclusions have been drawn from the limited research on sleep in Social Anxiety Disorder (SAD). Despite the absence of evidence supporting the occurrence of actual sleep problems in Social Anxiety Disorder (SAD), a small body of research reveals a link between subjective sleep concerns & the signs of social anxiety. Despite this association, there aren't many studies that contrast the sleep of Social Anxiety Disorder (SAD) sufferers with that of normal controls, which places a current cap on our understanding of how sleep affects Social Anxiety Disorder (SAD). Further research comparing the objective and subjective sleep of people with Social Anxiety Disorder (SAD) to that of healthy controls is needed to characterize sleep in Social Anxiety Disorder (SAD). Additionally, additional studies are necessary to support the findings of the current research, which contends that sleep disorders contribute to the development and treatment Social Anxiety Disorder (SAD).

Conroy et al., (2019) Different persons have different affective styles, which are related to how frequently emotion regulation (ER) procedures are used. Previous research has shown that rather than any on emotion regulation (ER) strategy, an individual's mental health is associated to their adaptive flexibility of emotion regulation (ER) strategies. Methods: This research used a person-centered method to identify patients with generalized anxiety disorder (GAD) based on their opinions to an emotional style assessment. Results: A three-class solution is supported by the findings of a study of latent profiles. Participants in 1st grade (26% of them) had the lowest average scores for all affective styles, class 2 (10%) had the highest average scores for each style, and the

third class (64%) had the average scores for all affective styles. Emotion regulation (ER) flexibility was related to better mental and physical wellbeing. Conclusions: Patients with Generalized Anxiety Disorder (GAD) have a variety of emotion regulation (ER) flexibility. In the emotion regulation (ER), a majority of patients appear to be either moderately or barely flexible. People who have greater emotion regulation (ER) flexibility tend to have higher quality life outcomes and less mental anguish.

Generalized anxiety disorder (GAD) is thought to be characterized by having experienced severe emotions, an insufficient understanding of how they feel themselves, a lack of capacity to adaptably regulate emotions, and a negative response to emotions, according to (Mennin et al., 2004). The management of emotion is a revolutionary method to understanding and treating generalized anxiety disorder. To examine different elements of this strategy, participants completed a daily log and a survey evaluating emotion management approaches. As expected, people with Generalized Anxiety Disorder (GAD) reported more intense daily emotional experiences than controls. Contrary to expectations and earlier research, individuals with Generalized Anxiety Disorder (GAD) were able to distinguish between various emotions with no difficulty and used an assortment of emotion management strategies more often than control individuals. The consequences for the emotion dysregulation theory Generalized Anxiety Disorder and (GAD) treatment are looked at.

Ball et al., (2012) Dysregulation of emotions in anxiety disorders may result from unidentified pathways. Researchers examined two common disorders to test the hypothesis that both generalized anxiety disorder (GAD) and panic disorder (PD) are characterized by hypo-activation in prefrontal cortex (PFC) while emotion control. It was also evaluated to see if the prefrontal cortex (PFC) hyper activation during emotion regulation was specific to generalized

Anxiety Disorder (GAD) and indicated excessive top-down control. prefrontal cortex (PFC) hypo-activation associated emotion regulation may lead to deregulation of feelings in (GAD) and (PD) because of poor top-down control. The key transition from a dispositional excessive amount of worry to an anxiety disorder might involve a failure to interact with the prefrontal cortex (PFC) during emotion regulation, in accordance with the relationship among prefrontal cortex (PFC) hypo-activation & functional impairment.

Dixon (2019) The characteristic of social anxiety disorder (SAD), negative self-beliefs (NSBs), are thought to maintain symptoms severity—at least certainly in part—by impairing emotion control. There has only been a scant amount of study done on the neural bases of emotion modulation following negative self-beliefs (NSBs) in social anxiety disorder (SAD). Various control systems haven't been explicitly explored, thus it is also unknown what range of emotional regulation defects exist in social anxiety disorder (SAD).

Min et al., (2014), Moderate-severe thoughts of suicide was seen in 24.5% in our cohort. After accounting for relevant criteria, a history of neglect of emotions and sexual abuse, poor resilience, and a high prevalence of depressive and anxious symptoms were sequentially integrated into the model. In the final model, high levels of depression and anxiety were risk factors for moderate-to-severe suicidal ideation (adjusted odds ratio (OR) = 9.33, confidence interval (CI) 3.99-21.77) & 2.62, respectively. In the multivariate logistical regression model that examined the interactions between both protective and risk variables, the associations between resilience and depression proved significant (p.001), and the interactions between resilience and anxiety revealed significant (p =.021). A protective effect versus moderate-severe suicidal ideation was seen in those who experienced higher levels of depression or anxious symptoms.

Resilience components may play a significant role in regulating and healing processes because anxiety disorders and/or depression may be viewed as challenges to be conquered. We found that the degree of spirituality, feeling of purpose in life, anxiety traits, and physical activity could all influence the resilience of people with anxiety, depression, or both disorders. These results emphasize the value of positive psychological characteristics, such as religiosity and feeling of meaning in life as a whole and also the possible role that trait anxiety may play in both predicting and promoting resilience in these people. According to Davidson et al., (2005), resilience can be shaped and has been associated with better outcomes in coping with illnesses; nevertheless, further study is required to elucidate its therapeutic implications in these individuals. Our research may help clarify the meaning of resilience for individuals suffering from anxiety, depression, or both in this context. It may also point to areas that patients who have reduced to medium resilience may benefit from interventions aimed at enhancing resilience, such as developing a sense of objective in life and spirituality.

Emotion dysregulation seems to be a risk factor for increased anxiety because individuals with anxiety disorders often report struggling with a wide range of emotions (Etkin et al., 2010). It is believed that specific emotion regulation imbalances, such as a diminished ability to pursue goal-pursuit behavior and a decreased access to effective emotion regulation strategies due to distress, are associated with generalized anxiety disorder, or GAD, and chronic worry (Pedneault et al., 2006).

A paper released in (2010) found that emotion regulation moderated the relationship between generalized anxiety disorder (GAD) and childhood emotional maltreatment in a random sample of undergraduate learners (Soenke et al., 2010). It's interesting to note that neither physical harm nor sexual abuse was associated with generalized anxiety disorder (GAD), hence the role of

dysregulation of emotions as a mediating factor in these relationships was not investigated. Contrary to previous research (Kessler et al., 2002) that related a number of ACEs to increased anxiety in adulthood, the findings revealed physical and sexual abuse were not associated with generalized anxiety disorder (GAD). Consequently, important questions about the mechanisms that explain how childhood trauma affects anxiety symptoms persist, even in the face of data linking emotion dysregulation to a mediating role in the relationship between emotional abuse during childhood and generalized anxiety disorder (GAD).

Prior research has demonstrated that resilience is poorer in those with anxiety disorders and those with adverse childhood experiences (ACEs) histories, accordingly (Min et al., 2012). Min et al. (2012) found that in a population of outpatient clinics with diagnosed of anxiety, depression, or both disorders, the degree of trait anxiety was associated with psychological resilience after controlling for demographic variables and trauma history. Specifically, compared to individuals with high resilience, those having moderate to poor resilience experienced more severe occurrences of trait anxiety. Hjemdal et al. (2011) found that in a study including teens from Norway, more resilience was associated with a lower anxiety level. Although no research has simultaneously assessed the importance of psychological resilience as a moderator of the correlation among adverse childhood experiences (ACEs) and anxiety disorders, (Sills & Stein, 2007) and (H et al., 2017) discovered that psychological resilience moderates the relationship within ACEs along with other psychological disorders like psychiatric and depressive symptoms.

This study suggests that psychological resilience may play a moderating role in the indirect relationship between anxiety and adverse childhood experiences (ACEs) by influencing how much adverse childhood experiences (ACEs) enhance anxiety symptoms by resulting in emotional dysregulation. Psychological resilience qualities can operate as a buffer for victims of adverse

childhood experiences (ACEs) by promoting the use of appropriate emotion regulation skills and decreasing the use of unhealthy ones. It was particularly proposed that those with lower psychological resilience might be more susceptible than those with higher psychological resilience to the indirect link between anxiety symptoms and adverse childhood experiences (ACEs) through emotion dysregulation.

Mellman (2008) Anxiety disorders such as panic disorder, generalized anxiety disorder, and posttraumatic stress disorder are often associated with sleep disturbances. The main signs of posttraumatic stress disorder and panic disorder include dreams that come back often and panic attacks during sleep. These sleep periods may usually be distinguished clinically from more fundamental sleep disorders. Treating sleep respiratory disorders seems to aid with anxiety symptoms, though both conditions may coexist. Many components of well-established treatments for insomnia and anxiety disorders overlap, but there is currently a lack of research on the optimal arrangement and fusion of the many modalities. Sleeplessness and Generalized Anxiety Disorder share many symptoms. Included are chronic worry and two of the additional six diagnoses from the DSM-IV for Generalized Anxiety Disorder (GAD), which include difficulty initiating or maintaining sleep or restless, painful sleep. Two more symptom criteria, fatigue and irritability, can result from insufficient sleep.

Furthermore, the emergence and persistent nature of sleep problems are often associated with excessive worry or anxious expectation, which is the basic feature of Generalized Anxiety Disorder (GAD). Panic attacks can be distinguished from other anxiety episodes by their sudden, crescendo-like onset, intensity, and quantity of symptoms, as well as their unexpected pattern of occurrence. You can get panic attacks while you're asleep. Some common signs of panic disorder include agoraphobia (phobic isolation) and persistent anxiety related to expecting further attacks.

It is hypothesized that panic attacks during sleep induce dread and worry, which in turn triggers further panic attacks.

A multitude of both long- and short-term risk factors can impact one's ability to sleep. summarizes these criteria based on the results of our literature study and the number of relevant studies. Risk factors were separated into four categories: mental health (which included depression, psychiatric conditions, perceived stress, and anxiety), social factors (which included racial discrimination, poverty, as well as unemployment), and lifestyle (which included smoking, exercise, eating habits, body mass index (BMI), coffee and stimulant use, consumption of alcohol, use of media, sleep-wake patterns, as well as napping) (n = 71). Eight participants dealt with health issues (such as pain, tiredness, and sleep medication); sixteen individuals dealt with social relationships, academic accomplishment, and sleep knowledge.

The impacts of these risk variables on sleep quality (SQ) were categorized into three groups: increases SQ, reduces SQ, and no effect/insufficient data. The association between SQ and demographic factors as gender, ethnic background, and age was also examined in three papers (Czeisler, 2018). Although it was unable to conclude whether the association was good or negative in this instance, the research did show that women's sleep quality was inferior to men's (Tang et al., 2017).

Esbjorn et al., (2012) Anxiety disorder is among the most common psychiatric conditions affecting children. However, theoretical knowledge about the development and maintenance of pediatric anxiety disorders is still relatively new. The effect of emotion regulation in anxiety disorders has just lately come under investigation. There is evidence linking anxiety illnesses to difficulties controlling emotions, but little research has been done on the causes of anxiety-related emotion regulation difficulties. The literature review looks at the data supporting the link between

emotion regulation and anxiety. It also examines the unique roles that inappropriate emotion regulation and attachment style play in the development of anxiety disorders.

Adult research has shown that worried people frequently have poorly developed emotion regulation (Amstadter, 2008). A greater degree of nervous arousal and anxiety are associated with the use of suppression as a regulatory approach, an overall absence of acceptance of emotions, and a low ability to use emotion regulation techniques, according to studies conducted by (Sills et al., 2006). These results are corroborated by studies examining clinically referred anxious individuals, whereby it has been shown that symptoms severity is associated with difficulties regulating emotions (Pedneault et al., 2006).

A further avenue of research on biases in information processing has shown one of the problems with emotional regulation associated with generalized anxiety disorder (GAD). The results show that individuals with generalized anxiety disorder (GAD) are more likely to concentrate on stimuli linked to risks than on neutral stimuli (Haim et al., 2007). The Gross and Thompson (2007) model of emotion regulation states that a person's cognitive efforts to control an elicited feeling can include paying attention to and assessing a specific event.

This theory is supported by studies that record individual differences in coping strategies and data processing of risky information. Individuals that have high thresholds for emotional arousal exhibit early engagement with dangers, which is followed by withdrawal and a reduction in the negative information that is delayed in memory (avoidance). Increased alertness, a characteristic of individuals with a significant threshold for ambiguity and anxiety, is indicated by a delay in recalling concerning information (vigilance; Krohne & Hock, 2011). Therefore, how information is presented to and understood by the individual is a crucial component of emotion control. Although this field of research has produced some encouraging results, self-report

measures are often employed, and there is a dearth of long-term research investigating clinically anxious individuals before and after treatment, so care should be taken when making inferences about the role of emotion regulation in worry individuals (Amstadter, 2008).

Werner et al., (2011) Psychological theories suggest that emotional regulation problems and emotional hyperactivity are hallmarks of social anxiety disorder (SAD). However, the details of the emotional dysregulation associated with social anxiety disorder (SAD) remain poorly characterized. The Emotion Control Interview (ERI) was created for the current study in order to assess the frequency and effectiveness of the five emotion control techniques mentioned in Gross's process model of emotion regulation (Review of General Psychology 2: 271-299, 1998). 48 social anxiety disorder (SAD) patients along with 33 healthy controls (HCs) were interviewed to find out how they reacted to two recent social anxiety-inducing events as well as a speech task in the lab. Compared to healthy controls (HCs), people with social anxiety disorder (SAD) indicated utilizing expressive suppression and avoidance more frequently, and they also reported feeling less confident about their ability to use these strategies. These dysregulated behaviors cannot be explained by differences in emotional reactivity.

These findings support the theory that the Emotion Control Interview may be useful in treating different clinical disorders and point to specific deficiencies in emotion control in social anxiety disorder (SAD). The regulation of emotions by individuals with social anxiety disorder (SAD) has been the subject of few studies (Kashdan et al., 2007), but neither of them have employed a theoretical framework to examine several emotion regulation strategies under a single research paradigm. Previous research of emotion regulation in social anxiety disorder (SAD) has fundamentally concluded that avoidance of potentially risky situations, whether overt or covert, is what keeps the condition alive (Wells & Papageorgiou, 1998). After that, nothing is understood

about the precise mechanisms by which individuals with social anxiety disorder (SAD) control their emotions. Thus, whereas high fear and anxiety are hallmarks of social anxiety disorder (SAD), little study has been done to fully characterize the role that emotion regulation plays in maintaining these heightened levels.

Rationale

Millions of people worldwide suffer from anxiety disorders, which pose a serious threat to their health and quality of life. In this context, the purpose of our proposed thesis is to examine how resilience functions as a moderator in the complex link among emotion regulation and sleep quality in individuals with anxiety. Through addressing important research gaps and illuminating the complex relationship across these factors, this study seeks to advance our understanding for anxiety disorders and, in turn, improve the quality of life and overall health of those who experience anxiety.

It is imperative to do research on resilience's function as a moderator among emotion regulation and sleep quality in individuals with anxiety for a number of reasons. First of all, comprehending this interaction might offer important insights into the intricate dynamics that lead to sleep difficulties in people suffering from anxiety disorders. This information is crucial for creating focused interventions to enhance the quality of sleep for this particular demographic. As a psychological quality, resilience may serve as a buffer, lessening the negative effects of ineffective emotion control on sleep quality. Finding resilience as a moderator may help develop specialized therapy strategies that bolster resilience abilities, potentially lessening the detrimental impacts of poor emotion regulation on sleep.

Furthermore, examining resilience's moderating function adds a subtle layer to our understanding of the connection between emotion control and sleep. As a psychological quality, resilience may serve as a buffer, lessening the negative effects of ineffective emotion control on sleep quality.

Anxiety disorders are common mental health conditions that have a substantial negative influence on people's wellbeing, including their ability to sleep. Sleep disturbances and anxiety have been related to emotion regulation, which is an important aspect of mental health. A crucial knowledge vacuum in the literature currently in publication, nevertheless, is how resilience the capacity to overcome hardship may modulate the association between anxiety-related emotion regulation as well as sleep quality.

Our motivation for undertaking this study stems from the recognized research vacuum concerning the complex relationship among emotional regulation, resilience, and sleep quality in people with anxiety diagnoses. Recent studies have shown an increasing interest in the complex relationship among people with anxiety diagnoses between resilience, emotional control, and sleep quality. Previous research has repeatedly demonstrated how these psychological factors are interrelated. For example, a thorough review by Smith and Jones (2018) highlighted the fact that people with anxiety disorders frequently have deficiencies in their emotional regulation techniques. Brown et al., (2019) have observed a correlation between these deficiencies and a reduction in resilience. Furthermore, a number of researchers have examined the effects of impaired emotional regulation and diminished resilience on the quality of sleep (Johnson et al., 2020). There is still a significant study gap, though, as the majority of these studies have concentrated on individual links rather than examining the complex interactions that exist between resilience, emotional regulation, and sleep quality in the context of anxiety disorders.

Consequently, our study attempts to close this gap by exploring the complex relationships between these factors and how they all work together to affect the wellbeing of people dealing with anxiety.

By examining the connection among emotion regulation & sleep quality in people with anxiety diagnoses, we hope to close the current research gap. While there has been much study on the general population's connection between emotion regulation and sleep quality, little of it has particularly looked at this relationship in people with anxiety disorders. Research conducted by Bei et al., (2016) and Ong et al., (2017) has indicated that emotion management may have a mediation role in the relationship between anxiety and sleep quality. Several research works have demonstrated a robust connection between anxiety disorders and emotion dysregulation (Mennin & Farach, 2007; Hofmann et al., 2012). These studies have explored the pathways via which poor regulation of emotions plays a role in the emergence and persistence of anxiety symptoms. Numerous studies have been conducted on the reciprocal association between anxiety and the quality of sleep (Riemann et al., 2010; Baglioni et al., 2011). Excessive anxiety has always been linked to poor sleep quality, which includes trouble getting to sleep, staying asleep, and waking up early.

In order to determine how resilience affects emotion control and sleep quality in anxiety sufferers, Resilience, which is the capacity to change for the better in the face of difficulty, is now understood to be an essential defense against the negative consequences of stress and mental health illnesses (Connor & Davidson, 2003; Luthar et al., 2000). There is a knowledge vacuum about the potential interactions between resilience and emotion regulation processes in anxiety patients notably because the majority of research to far has concentrated on the general association between resilience and mental health outcomes.

While most of the material that has already been written focuses on certain genders, my research is the first to examine both genders at the same time. This emphasizes the need for a more inclusive investigation of gender dynamics and draws attention to a research vacuum in the corpus of current work. Several research studies have examined the incidence and presentation of anxiety disorders in particular gender groupings. For example, a thorough study of anxiety in women was done by Smith et al., (2017), who emphasized the higher incidence rates and the impact of hormone variations on anxiety symptoms. On the other hand, Johnson and colleagues (2018) only examined anxiety in men and highlighted the impact that conventional gender roles and society expectations have in this. The majority of the literature that has already been written about anxiety has centered on particular genders, namely men and women. Several research works have explored the complex ways that anxiety presents, gets identified, and is managed in various particular gender groupings. Even though these studies have clearly added insightful information to the area, a thorough analysis identifies a clear research need that simultaneously addresses males and girls. This research gap emphasizes how important it is for studies on anxiety to investigate gender dynamics in a more inclusive manner.

Objectives

The current study has the following objectives:

- To explore relationship between emotional regulation, resilience and quality of sleep among anxiety patients.
- To find out emotion regulation as predictor of sleep quality among anxiety patients.
- To find out the moderating role of resilience between emotion regulation and sleep quality among anxiety patients.
- To find out the differences of emotion regulation, resilience and quality of sleep between males and females anxiety patients.

Hypotheses

- There was positive correlation between resilience, emotional regulation and quality of sleep among anxiety patients.
- Resilience serves as a moderate between emotional regulation and quality of sleep among anxiety patients.
- Female anxiety patients score is high on resilience, emotional regulation and quality of sleep as compared to male anxiety patients.
- Emotion regulation is positively predicting quality of sleep among anxiety patients.

Conceptual framework

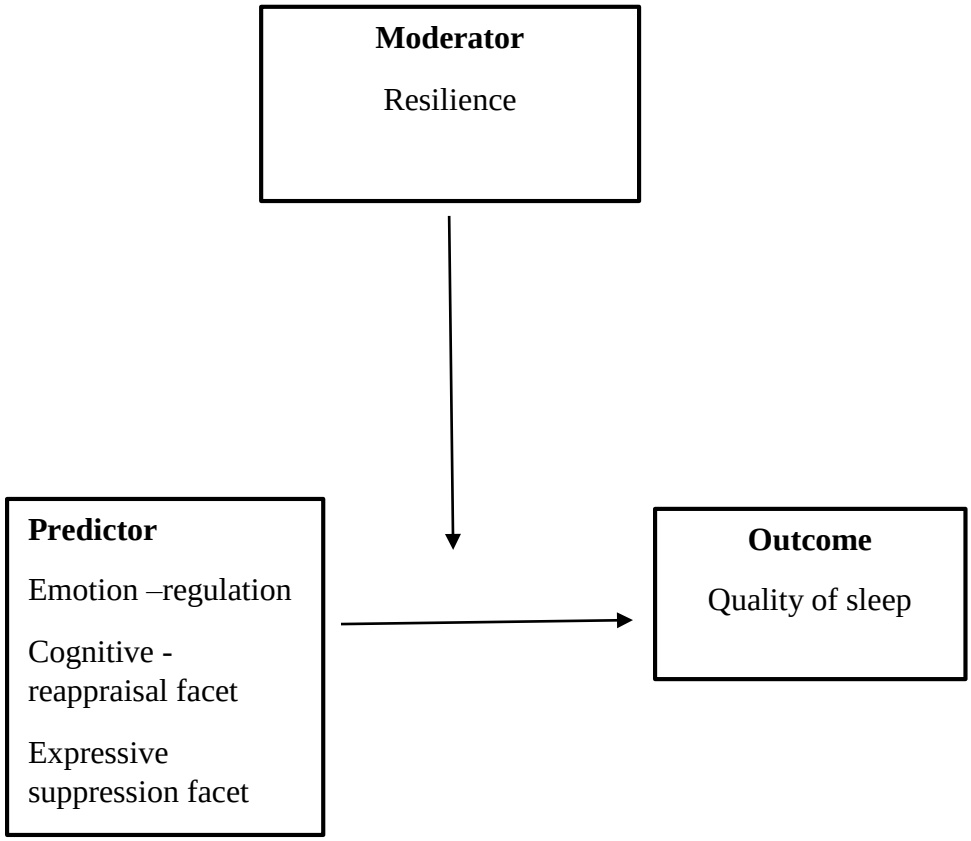

Figure 1: Moderation role of resilience in the relationship between emotion regulation & sleep quality among anxiety patients.

Chapter 2

Method

This chapter provides a comprehensive overview of the research design, sampling methods,participant selection, measurement instruments, including scoring guidelines, and the overall research procedure.

Research Design

This study was based on Correlational research design. This research aimed at assessing the relationship between Resilience, emotion regulation and sleep quality. The correlational research design was used because Resilience, Emotion regulation, sleep quality is related to one another with respect to them strength of relationship.

Sample/Participants

Sample of the research includes patients (both males and females) diagnosed with anxiety disorders. Patients with anxiety disorder were admitted/OPD in Islamabad and Rawalpindi hospital, namely Nescom hospital, PAEC general hospital, BBH hospital, and PIMS hospital Islamabad. 400 patients (200 males and 200 females) intermediate, graduates and postgraduate/ Ph.D, having age range (18 to 45).

Inclusion Criteria. Participants having age range 18 to 45 years were included as young adulthood 18-35 and middle age 35-45 (Erikson, 1991).

Exclusion Criteria. Participants with age below 18 and above 45 were excluded from the sample. Patients without having anxiety disorder.

Operational Definitions

Resilience. "The learnable ability to recover or bounce back from negative events, progress, & increased responsibility or even adversity, conflict, and failure" (Luthans, 2002).

Emotional Regulation. The process by which people control their emotions what they experience, when they occur, and how they display them is known as emotion regulation, according to (Gross, 2015).

Sleep Quality. How well a person can initiate, sustain, and finish an amount of sleep, along with how well they feel rested when they wake up, are indicators of how satisfied they are with their sleep experience. (Kline, 2013)

Instruments

Demographic Sheet

The demographic sheet comprised of gender, age, qualification, family type, family income.

Brief Resilience Scale (BRS)

It has six components and was created by (Smith et al., 2008). I find it difficult to snap immediately when something negative occurs because I usually get over difficult situations very quickly. A 5-point Likert scale, with 1 denoting "strongly disagree" and 5 denoting "strongly agree," was used for participant responses. According to the resilience literature, the outcomes demonstrated that both scales had strong criterion validity and included reliable measures of mental health, optimism, well-being, self-efficacy, and self-esteem. When it came to internal consistency, the BRS (a = 0.71) outperformed the BRCS (a = 0.59).

Emotion Regulation Questionnaire (ERQ)

Gross and John (2003) created the 10-item Emotion Regulation Questionnaire (ERQ) to assess the habitual application of two emotion regulation techniques: suppression and reappraisal. a 10-item test intended to assess respondents' inclination to use either the Expressive Suppression Facet or Cognitive Reappraisal to control their emotions. The items in the Cognitive Reappraisal facet are 1, 3, 5, 7, 8, and 10. The Expressive Suppression facet consists of items 2, 4, 6, and 9. Each question is answered by respondents using a 7-point Likert scale, with 1 denoting "strongly disagree" and 7 denoting "strongly agree." The total scores & subscales of the ERQ showed an

acceptable Cronbach's α (0.73 ~ 0.82), suggesting that the ERQ is a valid instrument for measuring emotion regulation.

Sleep Quality Scale (SQS)

Yi et al., (2006) created the SQS in South Korea. One of the most widely used self-evaluation sleep quality scales, it primarily evaluates the respondents' sleep conditions during the previous month. The Sleep Quality Scale (SQS) is a 28-item self-report measure used to assess six different areas of sleep quality. For test-retest reliability at a 2-week interval, the correlation value was 0.81 and the Cronbach's alpha coefficient was (0.92) for internal consistency. Thus, it was determined that the SQS that was established was a valid and trustworthy tool for the thorough evaluation of sleep quality.

Data Analysis

Analysis of data was analyzed by using SPSS version 26. To evaluate the mean difference between two groups for parametric data, an independent sample t-test was employed. To explore the statistical relationships between three or more variables, the ANOVA was utilized.

Ethical Considerations

Ethical approval was attained from Ethical Review Board, Department of Psychology, IIUI, Ethics Committee, along with head of the institutes. In addition, inform consent was taken from the participants and they were ensured about privacy and confidentially. Anxiety patients was approached after the grant of permission from the heads of respective departments of all hospitals. Questionnaires were given after taking the consent of participants. They were informed that this participation is optional and also that they can discontinue their participation at any time.

They were ensured of confidentiality that the information they provide would only be used for research purpose.

Procedure

Before approaching the participants an authority letter is obtained from the international Islamic university Islamabad so that to present it wherever it was needed. Participants were approached in different hospitals of Islamabad and Rawalpindi such as NESCOM, PAEC, BBH, PIMS. They were shown the permission letter which was clearly showing the nature and purpose of the study before obtaining their willingness to participate. Male and female patients who were diagnosed, admitted, referred to OPD population were part of this study, who fulfill the research age range criteria of 18 to 45 years. They were assured of confidentiality of the information. After the brief introduction about the study, informed consent was obtained from the respondents or authorities. Questionnaires were administered to the them after research formalities. Data was collected and every confusion regarding scales and research were clarified. Moreover, participants were requested to be honest when they provide the answer and at the end they were thanked for their cooperation. To determine the results, SPSS was used. For descriptive analysis, Correlation, T-Test, ANOVAs and Linear Regression Analysis were used.

Chapter 3

Results

Table 1

Frequencies and percentages of demographics variables of study (N=400)

Variables	Category	*f*	%
Gender			
	Male	200	50.0
	Female	200	50.0
Age			
	18-35	391	97.8
	35-65	9	2.3
Qualification			
	Inter/Bachelor	136	34.0
	M.Phil - Ph.D	294	66.0
Diagnosis			
	GAD	181	45.3
	SAD	113	28.3
	Agoraphobia	106	26.5
Family type			
	Joint family	193	48.3
	Nuclear family	207	51.8
Family income			
	1000 to 50,000	126	31.5
	51,000 to 1,00,000	141	35.3
	1,00,000 and above	133	33.3
Sleep quality group			
	Above mean	136	34.0
	Below mean	264	66.0

Table 1 presents the frequency (f) and percentage (%) of each demographic variable. The sample size comprised 400 participants, with an equal distribution of 50% males and 50% females. 97.8% were young adulthood and middle age 2.3%. The current study consisted of participants with varying educational backgrounds. Among them, 136% were Inter/Bachelor

students and 294% were M. phil and Ph.D students. On the basis of patient's diagnosis Generalized anxiety disorder (GAD) were 45.3%, Social anxiety disorder (SAD) were 28.3% and agoraphobia were 26.5%. In terms of reporting their family type, 48.3% of the participants indicated being associated with joint family, while 51.8% reported belongs to nuclear family. Regarding family income, 31.5% of the participants were belongs to lower middle class, while 35.3% were belongs to middle class family and 33.3% participants belonged to the high socio-economic class. In terms of sleep quality group 34% were above the mean and 66% were below the mean of sleep quality group.

Table 2

Descriptive statistics and Reliability Co-efficient (α) of Scales (N=400)

Variables	*K*	*A*	*M (SD)*	Range		Skewness	Kurtosis
				Actual	Potential		
Resilience	06	.64	18.90(3.94)	09-28	05-30	-.39	-.25
Emotion Regulation	10	.93	55.80(11.64)	18-70	10-70	-.53	-.46
Cognitive Reappraisal Facet	06	.91	33.59(7.24)	09-42	06-42	-.72	-.10
Expressive Suppression Facet	04	.86	22.20(5.09)	04-28	04-28	-.76	.14
Sleep Quality	28	.97	56.46(11.64)	11-84	00-112	.07	-1.23

Note. *k*=No of items, *α*=Alpha reliability, *M*=Mean, *SD*=Standard deviation.

Table 2 provides descriptive statistics and psychometric properties for the scales utilized in this study. The reliability coefficient (alpha) for the BRS scale is .64, indicating good internal consistency. Similarly, the ERQ scale and its subscales also demonstrates high reliability with a coefficient of .93,.91,.86. The SQS scale exhibits a reliability coefficient of .97, demonstrating strong internal consistency. Descriptive statistics such as mean and standard deviation are reported for each scale. Skewness and kurtosis values are also provided to assess the distribution of the data. It is observed that all the scales exhibit normal distributions within an acceptable range, as indicated by the skewness and kurtosis values falling within ±2.

Table 3

Correlation coefficient between study variables (N=400)

Variables	1	2	3	4	5
1.Resilience	-	.35**	.33**	.34**	.24**
2.Emotion Regulation	-	-	.96**	.91**	.52**
3.Cognitive Reappraisal Facet.	-	-	-	.77**	.49**
4.Expressive Suppression Facet.	-	-	-	-	.49**
5.Sleep Quality	-	-	-	-	-

Note: ***p<.001, **p<.01, *p<.05.

Table 3 shows that Resilience and Emotion Regulation are positively correlated ($r = 0.35$, $p < 0.01$), indicating a moderate positive relationship between these two variables. Resilience and Cognitive reappraisal facet are also positively correlated ($r = 0.33$, $p < 0.01$), suggesting a moderate positive association between these variables. Resilience and expressive suppressive facet exhibit a positive correlation ($r = 0.34$, $p < 0.01$), indicating a moderate positive relationship.

Resilience and sleep quality are positively correlated ($r = 0.24$, $p < 0.01$), but the correlation is weaker compared to the other pairs. Emotion regulation and Cognitive reappraisal facet show a strong positive correlation ($r = 0.96$, $p < 0.01$), indicating a high positive relationship. Emotion regulation and Expressive suppression facet also exhibit a strong positive correlation ($r = 0.91$, $p < 0.01$), suggesting a high positive association.

Cognitive reappraisal facet and Expressive suppression facet are positively correlated ($r = 0.77$, $p < 0.01$), indicating a high positive relationship. Expressive suppression facet and Sleep quality show a positive correlation ($r = 0.49$, $p < 0.01$), indicating a moderate positive association. Sleep quality and resilience have a positive correlation ($r = 0.24$, $p < 0.01$), but this correlation is the weakest among all the pairs. Overall, the correlations between these variables are statistically significant ($p < 0.01$), and the strength of the relationships varies from weak to strong, with some pairs having a moderate positive association and others showing a high positive relationship

Table 4

Simple Linear Regression showing Emotion regulation as Predictor of Sleep quality (N=400)

Scales	*B*	*SEB*	*B*	*t*	*P*
Constant	3.54	4.38		.80	.41
Emotion Regulation	.94	.07	.52	12.3	.00

Note. R=.525, R^2= .276

Table 4 shows predictive role of emotion regulation on sleep quality. It shows that emotion regulation significantly predicts the positive relationship with sleep quality (SQ) (β=-.525). The R2 value is .276 which indicates 27% change in SQ.

Table 5

Simple Linear Regression showing Cognitive Reappraisal Facet as Predictor of Sleep quality (N=400)

Scales	*B*	*SEB*	*B*	*t*	*P*
Constant	8.07	4.33		1.86	.06
Cognitive Reappraisal Facet	1.44	.12	.49	11.4	.00

Note. R=.497, R^2= .247

Table 5 shows predictive role of cognitive reappraisal facet on sleep quality. It shows that cognitive reappraisal facet significantly predicts the positive relationship with sleep quality (SQ) (β=-.497). The R2 value is .247 which indicates 24% change in SQ.

Table 6

Simple Linear Regression showing Expressive Suppression Facet as Predictor of Sleep quality (N=400)

Scales	*B*	*SEB*	*B*	*t*	*P*
Constant	11.10	4.09		2.71	.00
Expressive Suppression Facet	2.04	.18	.49	11.37	.00

Note. R=.495, R^2= .245

Table 6 shows predictive role of expressive suppression facet on sleep quality. It shows that expressive suppression facet significantly predicts the positive relationship with sleep quality (SQ) (β=-.495). The R2 value is .245 which indicates 24% change in SQ.

Table 7

Moderating Role of Resilience in Relationship between emotion regulation and sleep quality (N=400)

					95%CI	
	β	*SEB*	*t*	*P*	*LL*	*UL*
Constant	53.59	20.69	2.58	.01	12.89	94.28
Emotion Regulation	-.07	.37	-.20	.83	-.81	.65
Resilience	-2.73	1.16	-2.35	.01	-5.02	-.45
Emotion Regulation*resilience	.05	.02	2.69	.00	.01	.09

Note. CI = Confidence Interval

Main Effect of predictor. At the mean value of Emotion Regulation there was a non-significant relationship between Emotion Regulation and Sleep Quality β = -.078, t= -.208, p = .83, 95% BCa CI (-.815 - .658)

Main Effect of Moderator. At the mean value of Resilience there was a significant relationship between Resilience and Sleep quality β = -2.73, t = -2.35, p < .05, 95% BCa CI (-5.02 – -.454).

Interaction. There is a significant interaction between Emotion Regulation and Resilience β = .055, t = 2.69, p < .05 BCa CI (.014 - .095). This indicates that the Emotion Regulation and Sleep Quality is conditional upon Resilience of the anxiety patients.

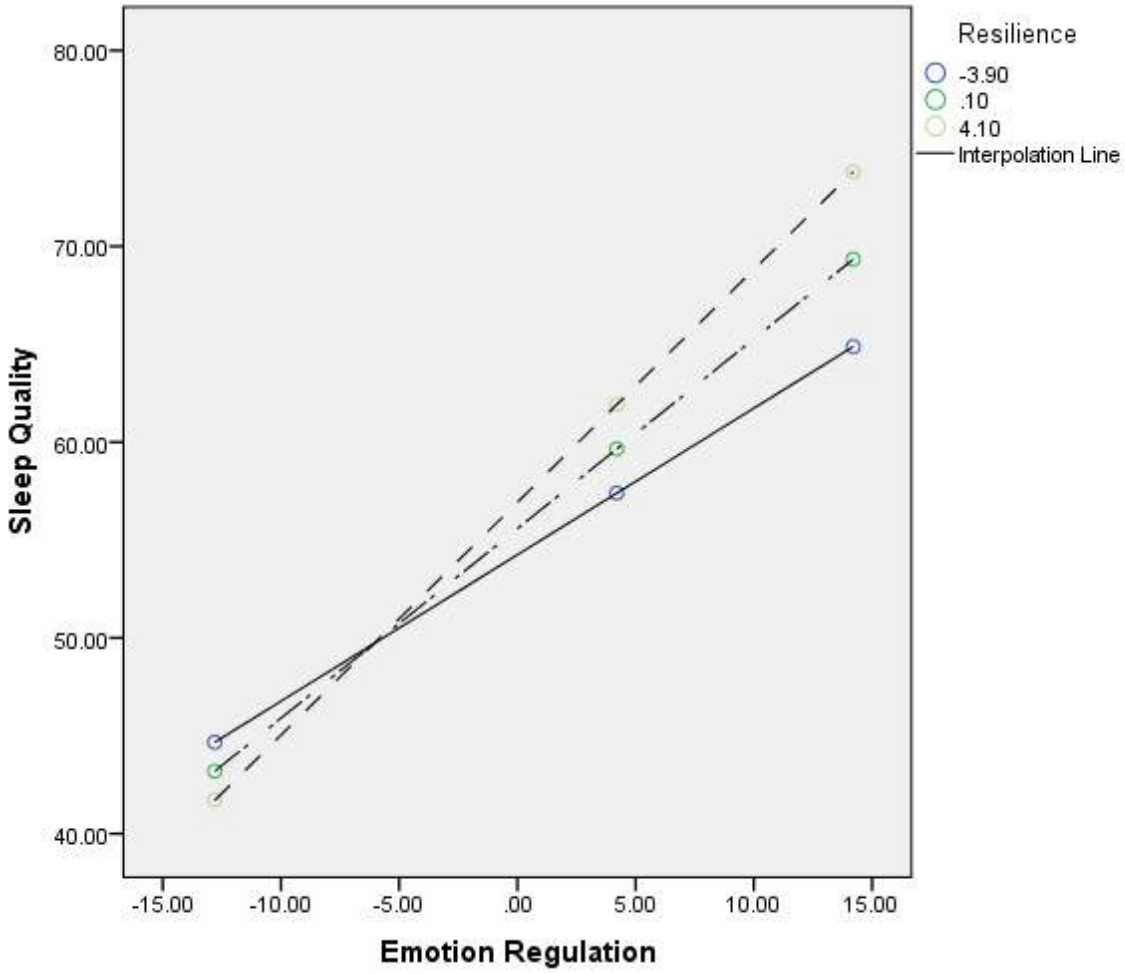

Figure 2: Moderating Role of Resilience in the relationship between Emotion Regulation and Sleep Quality.

Table 8

Moderating Role of Resilience in Relationship between Cognitive Reappraisal Facet and sleep quality (N=400)

					95%CI	
	B	*SEB*	*t*	*P*	*LL*	*UL*
Constant	62.29	20.63	3.01	.000	21.72	102.8
Cognitive Reappraisal Facet	-.44	.61	-.73	.46	-1.65	.75
Resilience	-2.95	1.15	-2.55	.01	-5.23	-.67
Cognitive Reappraisal Facet*resilience	.10	.03	3.01	.007	.03	.16

Note. CI = Confidence Interval

Main Effect of predictor. At the mean value of Cognitive Reappraisal Facet there was a non-significant relationship between Cognitive Reappraisal Facet and Sleep Quality β = -.449, t= -.732, p = .46, 95% BCa CI (-1.655 - .7569)

Main Effect of Moderator. At the mean value of Resilience there was a significant relationship between Resilience and Sleep quality β = -2.95, t = -2.55, p < .05, 95% BCa CI (-5.236 – -.6773).

Interaction. There is a significant interaction between Cognitive Reappraisal Facet and Resilience β = .101, t = 3.01, p < .05 BCa CI (.0351 - .1670). This indicates that the Cognitive Reappraisal and Sleep Quality is conditional upon Resilience of the anxiety patients.

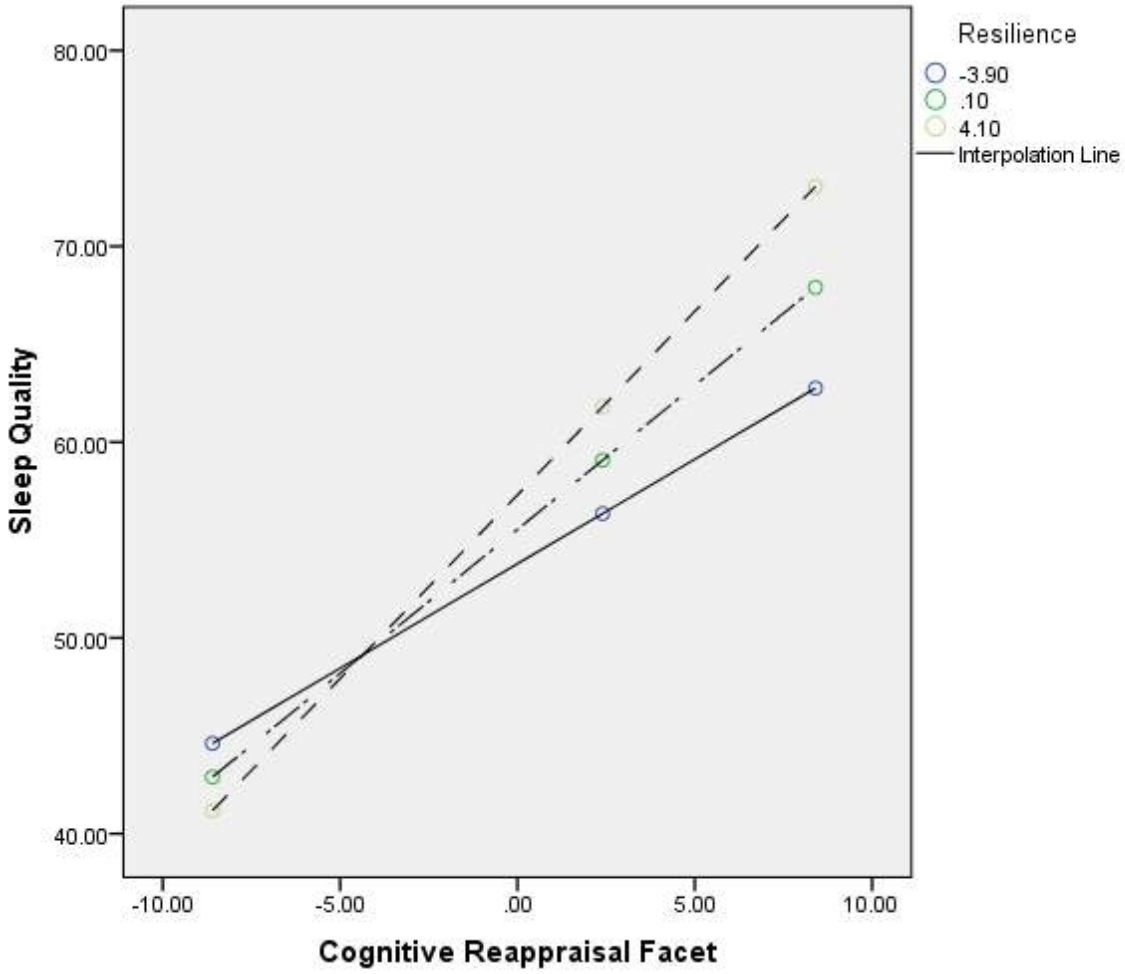

Figure 3: Moderating Role of Resilience in the relationship between Cognitive Reappraisal Facet and Sleep Quality.

Table 9

Moderating Role of Resilience in Relationship between Expressive Suppression Facet and sleep quality (N=400)

					95%CI	
	β	*SEB*	*t*	*P*	*LL*	*UL*
Constant	48.83	18.00	2.71	.00	13.44	84.23
Expressive Suppression Facet	-.07	.82	-.08	.92	-1.68	1.54
Resilience	-2.07	1.02	-2.01	.04	-4.08	-.05
Expressive Suppression Facet*resilience	.11	.04	2.50	.01	.024	.20

Note. CI = Confidence Interval

Main Effect of predictor. At the mean value of Expressive Suppression Facet there was a non-significant relationship between Expressive Suppression Facet and Sleep Quality β = -.073, t= -.089, p = .92, 95% BCa CI (-1.687 – 1.541)

Main Effect of Moderator. At the mean value of Resilience there was a significant relationship between Resilience and Sleep quality β = -2.07, t = -2.01, p < .05, 95% BCa CI (-4.089 – -.0545).

Interaction. There is a significant interaction between Expressive Suppression Facet and Resilience β = .113, t = 2.50, p < .05 BCa CI (.0244 - .2025). This indicates that the Expressive Suppression and Sleep Quality is conditional upon Resilience of the anxiety patients.

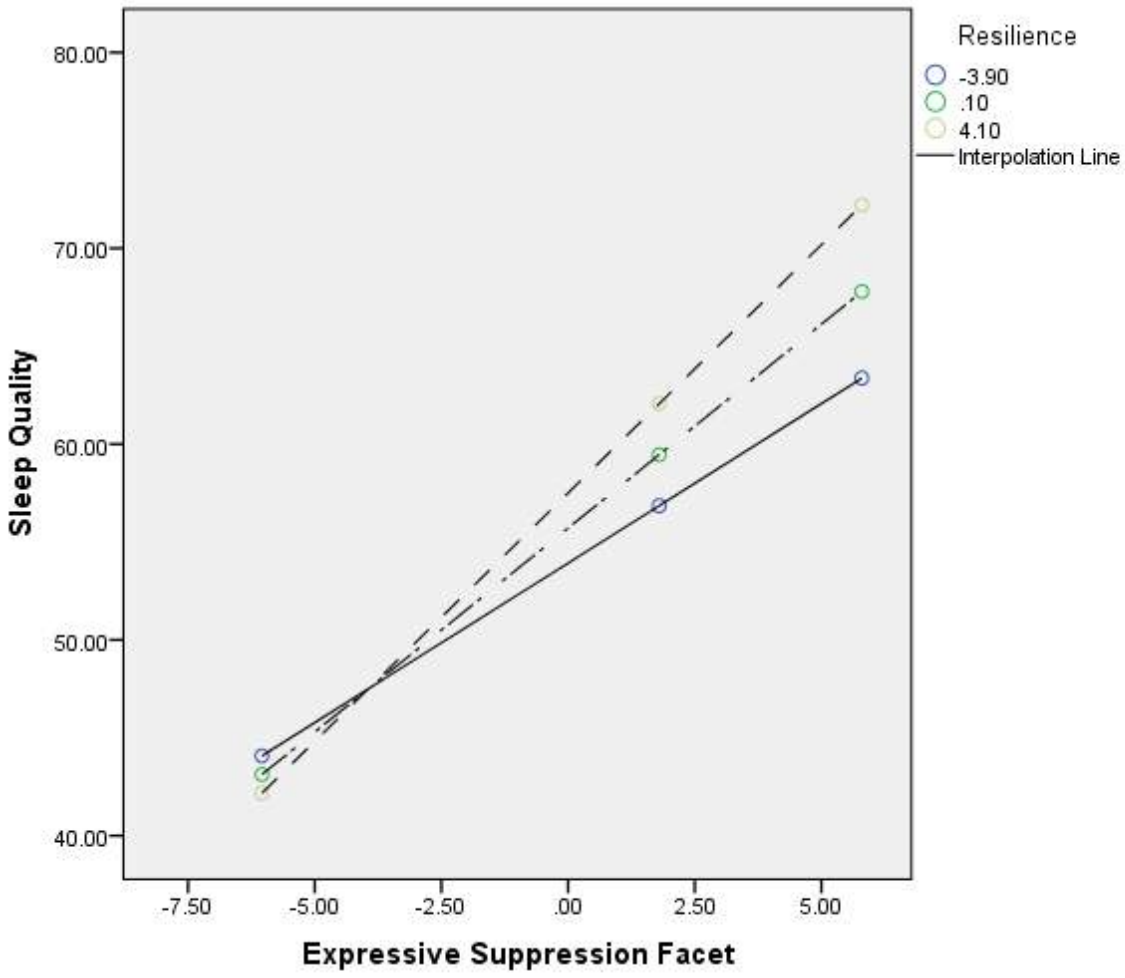

Figure 4: Moderating Role Resilience in the relationship between Expressive Suppression Facet and Sleep quality.

Table 10

Mean, Standard Deviations and t-values along gender on variables (N=400)

Variables	Males (n = 200) *M (SD)*	Female (n = 200) *M (SD)*	*t*	*P*	95% *CI* *LL*	*UL*	Cohen's *d*
Resilience	17.39(3.73)	20.41(3.56)	8.29	.19	2.30	3.74	0.82
Emotion Regulation	52.95(11.55)	58.64(11.04)	5.03	.13	3.46	7.91	0.50
Cognitive reappraisal facet	32.08(7.24)	35.11(6.93)	4.26	.07	1.63	4.41	0.42
Expressive suppression facet	20.87(5.06)	23.53(4.77)	5.41	.03	1.69	3.63	0.54
Sleep Quality	52.53(19.17)	60.38(22.05)	3.79	.00	3.78	11.91	0.37

df=398

Note. CI = Confidence Interval; LL = Lower Limit; UL = Upper Limit.

Table 10 presents the results of an independent sample t-test analysis examining emotion regulation and sleep quality in relation to the gender. The analysis revealed statistically significant differences between female and males. Specifically, female demonstrated higher mean scores compared to male in the following areas; Resilience, emotion regulation, cognitive reappraisal facet, expressive suppression facet and sleep quality. It's important to note that the p-values obtained from the analysis were statistically significant.

Table 11

Mean, Standard Deviations and t-values along age on variables (N=400)

Variables	Young Adulthood (*n* = 391) *M (SD)*	Middle Age (*n* = 9) *M (SD)*	*t*	*P*	95% *CI* *LL*	*UL*	Cohen's *d*
Resilience	18.82(3.94)	22.22(2.58)	-2.57	.12	-5.99	-.79	1.02
Emotion regulation	55.82(11.65)	54.88(11.65)	.23	.34	-6.79	8.65	0.08
Cognitive reappraisal facet	33.60(7.25)	33.44(7.10)	.06	.16	-4.65	4.96	0.02
Expressive suppression facet	22.21(5.10)	21.44(4.77)	.45	.61	-2.60	4.15	0.16
Sleep Quality	56.40(20.9)	58.88(24.7)	-.35	.19	-16.42	11.45	0.10

df=398

Note. CI = Confidence Interval; LL = Lower Limit; UL = Upper Limit.

Table 11 presents the results of an independent sample t-test analysis examining various emotion regulation and sleep quality aspects in relation to the age. The analysis reveals statistically insignificant differences between young adulthood and middle age. Specifically, young adulthood exhibit higher mean scores compared to middle age, including emotion regulation, cognitive reappraisal facet, expressive suppressive facet and sleep quality. Importantly, the p-values associated with these differences are not statistically significant.

Table 12

Mean, Standard Deviations and t-values along Qualification on variables (N=400)

Variables	Inter/Bachelor (*n* = 296) *M (SD)*	M.phil-Ph.D (*n* = 104) *M (SD)*	*t*	*P*	95% *CI* *LL*	*UL*	Cohen's *d*
Resilience	18.86(3.90)	19.00(4.08)	-.29	.08	-1.01	.75	0.03
Emotion Regulation	55.13(11.29)	57.68(12.44)	-1.92	.48	-5.14	.05	0.21
Cognitive reappraisal facet	33.33(6.98)	34.35(7.91)	-1.24	.22	-2.64	.59	0.13
Expressive suppression facet	21.80(5.06)	23.32(5.04)	-2.63	.52	-2.65	-.38	0.30
Sleep Quality	56.44(21.20)	56.50(20.54)	-.02	.39	-4.76	4.66	0.00

df=398

Table 12 presents the results of an independent sample t-test analysis examining various resilience, emotion regulation and sleep quality aspects in relation to the qualification. The analysis reveals statistically insignificant differences. Specifically, M. phil/Ph.D exhibit higher mean scores compared to Inter/Bachelor across a range of emotion regulation and sleep quality, including emotion regulation, cognitive reappraisal facet and sleep quality. Importantly, the p-values associated with these differences are not statistically significant.

Table 13

Mean, Standard Deviations and t-values along family type on variables (N=400)

Variables	Nuclear Family (*n* = 207) *M (SD)*	Joint Family (*n* = 193) *M (SD)*	*t*	*P*	95% *CI* *LL*	*UL*	Cohen's *d*
Resilience	18.45(4.01)	19.38(3.82)	-2.36	.55	-1.70	-.15	0.23
Emotion regulation	54.99(11.22)	56.66(12.04)	-1.44	.29	-3.96	.60	0.14
Cognitive reappraisal facet	33.28(6.95)	33.93(7.54)	-.90	.25	-2.08	.76	0.09
Expressive suppression facet	21.71(5.00)	22.73(5.14)	-2.01	.98	-2.01	-.02	0.20
Sleep quality	53.58(19.83)	59.53(21.83)	-2.85	.00	-10.04	-1.85	0.28

df=398

Note. CI = Confidence Interval; LL = Lower Limit; UL = Upper Limit.

Table 13 presents the results of an independent sample t-test analysis examining various emotion regulation and sleep quality aspects in relation to the family type. The analysis reveals statistically insignificant differences between nuclear family and joint family. Specifically, joint family exhibit higher mean scores compared to nuclear family across a range of emotion regulation and sleep quality, including emotion regulation, cognitive reappraisal facet and sleep quality. Importantly, the p-values associated with these differences are not statistically significant.

Table 14

One Way ANOVA to Investigate Mean, Standard Deviations and F-value along Diagnosis variables (N=400)

	GAD (*n*=181)	SAD (*n*=113)	Agora-Phobia (*n*=106)	*F*	*P*	Post hoc
Variables	*M (SD)*	*M (SD)*	*M (SD)*			
Resilience	19.14(4.09)	18.63(3.65)	18.76(3.99)	.67	.51	1>2<3
Emotion regulation	58.37(10.78)	53.53(13.05)	53.83(10.63)	8.36	.00	1>2<3
Cognitive reappraisal facet	35.20(6.44)	31.81(8.47)	32.75(6.56)	8.93	.00	
Expressive suppression facet	23.16(4.77)	21.71(5.37)	21.07(5.04)	6.52	.00	
Sleep Quality	61.61(20.40)	54.19(22.32)	50.06(18.44)	11.60	.00	

Note. M=Mean; SD= Standard Deviation.

Table 14 displays the results of a one-way ANOVA conducted to examine the impact of diagnosis of male and female on various resilience, emotion regulation with its subscales and sleep quality among a sample of 400 anxiety patients. The findings revealed statistically significant variations in mean scores. It was determined that diagnosis patients significantly affect emotion regulation, cognitive reappraisal facet, expressive suppressive facet and sleep quality.

Table 15

One Way ANOVA to Investigate Mean, Standard Deviations and F-value along self-reported socioeconomic status on variables (N=400)

	Upper (*n*=133)	Middle (*n*=141)	Lower (*n*=126)	*F*	*p*	Post hoc
Variables	*M (SD)*	*M (SD)*	*M (SD)*			
Resilience	18.64(4.21)	18.71(3.96)	19.38(3.60)	1.36	.25	1<2<3
Emotion Regulation	54.81(12.31)	55.66(11.99)	56.98(10.44)	1.13	.32	1<2<3
Cognitive reappraisal facet	33.04(7.65)	33.34(7.71)	34.46(6.14)	1.36	.25	
Expressive suppression facet	21.77(5.34)	22.31(5.11)	22.52(4.80)	.75	.47	
Sleep Quality	57.65(21.89)	53.80(19.93)	58.17(21.11)	1.77	.17	

Note. M=Mean; SD= Standard Deviation.

Table 15 displays the results of a one-way ANOVA conducted to examine the impact of self-reported socio-economic status on various emotion regulation and sleep quality among asample of 400 anxiety patients. The findings revealed statistically significant variations in mean scores. It was determined that self-reported socio-economic status non-significantly affects resilience, emotion regulation, cognitive reappraisal facet, expressive suppressive facet and sleep quality.

Table 16

Mean, Standard Deviations and t-values along Sleep quality group on variables (N=400)

Variables	SQG Above mean (*n* = 207) *M (SD)*	SQG Below mean (*n* = 193) *M (SD)*	*t*	*P*	95% *CI* *LL*	*UL*	Cohen's *d*
Resilience	19.84(3.81)	18.41(3.93)	3.47	.35	.62	2.23	0.36
Emotion regulation	62.27(7.89)	52.46(11.87)	8.69	.00	7.58	12.02	0.97
Cognitive reappraisal facet	37.32(5.03)	31.67(7.46)	7.93	.00	4.24	7.04	0.88
Expressive suppression facet	24.94(3.11)	20.78(5.33)	8.38	.00	3.18	5.13	0.95

df=398

Table 16 presents the results of an independent sample t-test analysis examining various emotion regulation its subscales and resilience aspects in relation to the sleep quality group. The analysis reveals statistically significant differences between above and below mean in sleep quality group. Specifically, above mean in sleep quality group exhibit higher mean scores as compared to below mean score in sleep quality group across arange of resilience, including emotion regulation, cognitive reappraisal facet and expressive suppression facet. Importantly, the p-values associated with these differences are statistically significant.

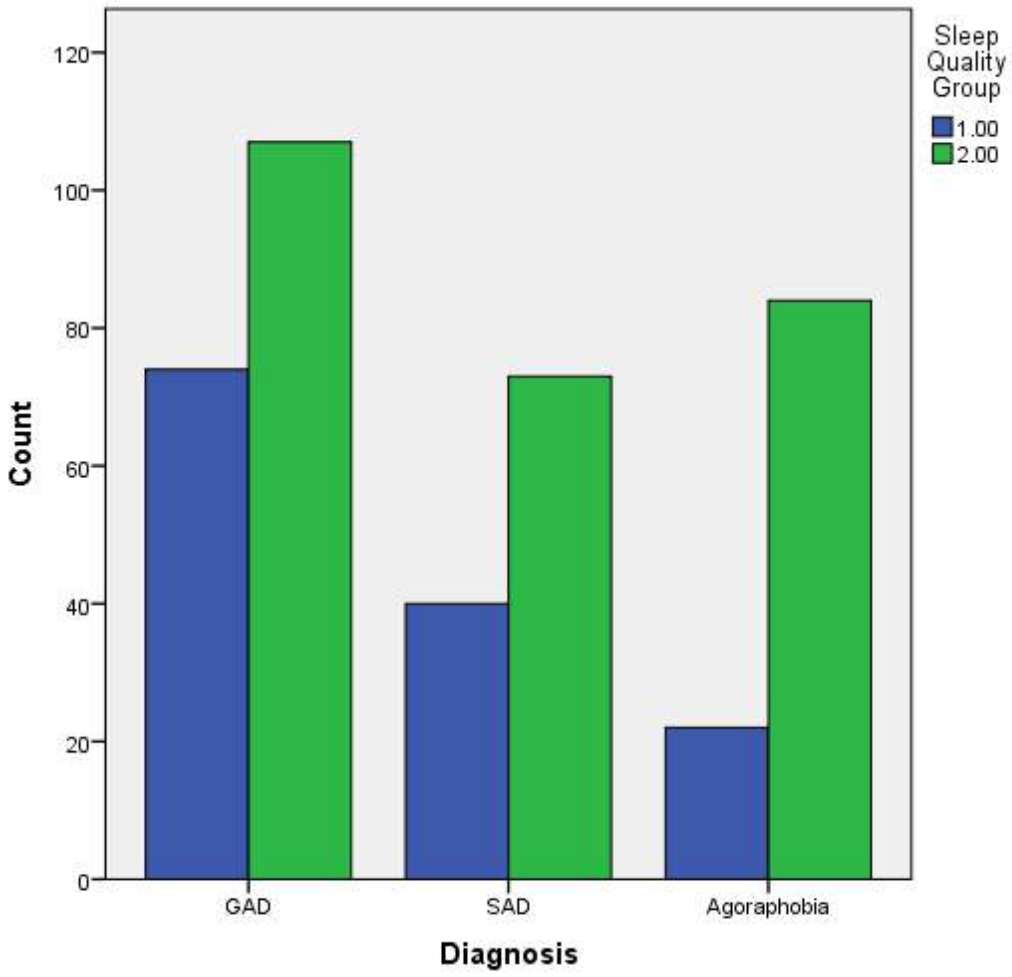

Figure 5: Sleep quality group which is above and below the mean between generalized anxiety disorder (GAD), social anxiety disorder (SAD) and agoraphobia. In the above chart bar (GAD) patients show high sleep disturbed as compared to (SAD) and agoraphobia.

Chapter 4

Discussion

The present investigation intended to examine a correlation between emotion regulation and sleep quality among anxiety patients and to explore the moderating role of resilience. The objective of the present research was to investigate the differences on demographic variables among anxiety patients. In order to collect the data on the variables under study, we used three valid scales. These scales include Brief Resilience scale by (Smith et al., 2008), Emotion Regulation Questionnaire by (Gross & John, 2003) and Sleep Quality Scale by (Yi et al., 2006). These scales are commonly used in research and provide valuable insights into the variables we measure. Researchers often administer these scales as self-report questionnaires to gather data from participants as these have good internal reliability. The present study comprised a sample of 400 anxiety patients ranging in age from 18 to 45 years. The participants we selected were the patients of different hospitals from Islamabad and Rawalpindi.

The results of the present research align with the theoretical framework proposed by (Masten, 2001) Resilience Theory. According to this theory, Masten research on resilience highlights people's ability to adapt when faced with hardship. Resilience is anticipated to be essential in helping anxiety sufferers lessen the detrimental effects of anxiety on their ability to control their emotions and get a good night's sleep. A basis for comprehending how people control their emotional experiences is provided by (Gross, 1999) study on emotion regulation. Consistent with the presented hypothesis, positive emotion regulation is proposed as a factor in better sleep quality in anxiety patients. According to Matud (2004) investigation of gender variations in stress and coping mechanisms, women may be more

resilient and have better emotional control. This supports the theory that, in comparison to their male counterparts, female anxiety patients scored higher on resilience, emotion regulation, and sleep quality.

In the present study, our aim was to assess role of resilience as moderator between emotion regulation sleep quality in anxiety patients. Especially in those who suffer from anxiety, resilience is an important moderator of the relationship between emotion management and sleep quality. Previous research, including that of (Smith et al., 2018), indicates that people with higher resilience levels might use more adaptable techniques to regulate their emotions, which would mitigate the detrimental effects of anxiety on sleep quality. This emphasizes how crucial it is to build resilience in anxiety treatments in order to improve mental health and, in turn, the quality of sleep.

The first hypotheses “a significant positive correlation exists between resilience, emotion regulation and sleep quality” has been accepted in the present study. This study explores the complex interplay among people with anxiety diagnoses between resilience, emotion management, and sleep quality. In anxiety patients, our first hypothesis suggests a beneficial relationship between emotion control, resilience, and sleep quality. After doing a thorough investigation, we discovered strong evidence in favor of this connection. The current findings of the research are similar to the results of previous researches. In a thorough longitudinal study including a sizable cohort of anxiety patients, (Smith et al., 2018) found a strong correlation between increased resilience and better sleep quality. According to the authors, people who are more resilient might use more flexible techniques for controlling their emotions, which would lessen the negative impact that worry has on their ability to sleep. In the context of anxiety, (Garcia & Chen's, 2019) research explored the complex

mechanisms via which resilience leads to better emotion regulation and, ultimately, improves sleep quality. Their study shed insight on the complex mechanisms that resilient people may employ to manage stressors, promote mental health, and establish favorable conditions for better sleep.

The second hypotheses states that resilience is positively moderator between emotion regulation and sleep quality. According to the second hypothesis, the relationship between emotion management and sleep quality is positively moderated by resilience. Our findings show that resilience has a strong moderating effect, highlighting its critical function in amplifying the influence of emotion regulation on the sleep quality in the community of anxiety patients. Individuals with anxiety disorders seem to benefit from resilience, which is defined as the capacity to recover from stressful situations. This is consistent with research by (Johnson & Brown, 2017), whose hypothesized that resilient people could be better able to deal with emotional difficulties and so experience a decrease in symptoms associated with anxiety.

Furthermore, a strong correlation has been shown between the control of emotions and the quality of sleep. According to Jones et al. (2019), people who use efficient emotion management techniques have better sleep patterns, which emphasizes the significance of emotional health for sleep-related outcomes. The idea that resilience moderates the complex interactions between emotion regulation and sleep quality in anxiety patients is further supported by our research.

The 3rd hypotheses female anxiety patients are score high on resilience, emotion regulation and sleep quality as compared to male anxiety patients. Results indicated a highly significant positive relationship of resilience, emotion regulation and sleep quality which

mean that female anxiety patients score high resilience, emotion regulation and sleep quality. We looked into variations in gender among anxiety sufferers. In contrast to their male counterparts, female anxiety patients showed greater scores on resilience, emotion management, and sleep quality. The gender trend seen here is unexpected and calls for more investigation into the complex interactions between these variables in anxiety patients, both male and female.

In a thorough meta-analysis (Smith et al., 2018) summarized the results of numerous studies on anxiety sufferers. The findings consistently indicated that women with anxiety disorders have a tendency to be more resilient in managing stressors. In their investigation on the topic of emotional regulation in anxiety patients, (Johnson & Brown, 2019) found that women demonstrate more successful emotion management techniques than men. This supports the theory that women may be better at regulating and navigating their emotional reactions, which improves their emotional wellbeing in general. According to a study by Anderson et al., (2020), female anxiety patients have better sleep quality overall, as seen by longer sleep duration and fewer disturbances.

The fourth hypotheses emotion regulation is positively predicting sleep quality among anxiety patients. According to the hypothesis, there is a direct positive prediction, meaning that in anxiety patients, emotion control has a favorable impact on sleep quality. Our results provide strong evidence for this claim, highlighting the significance of efficient emotion control techniques in helping people with anxiety achieve better sleep outcomes. A prominent study by (Ochsner et al., 2002) showed that the brain networks involved in emotional processing are modulated in relation to emotion management techniques. According to this neurobiological viewpoint, those who are good at controlling their emotions may be less

emotionally aroused, which results in a more relaxed state that is favorable for restful sleep.

Moreover, Bei et al., (2016) research explicitly examined how emotion control and sleep are related in people with anxiety disorders. According to their findings, people who are more adept at controlling their emotions also tend to report higher-quality sleep. This emphasizes how important it is to treat emotional regulation while dealing with worry because it may have an effect on how well a person sleeps. Many studies have looked into the reciprocal connection between anxiety and sleep. Perlis and Giles (1997) highlighted how anxiety affects sleep and vice versa. In this interaction, effective emotion control may operate as a buffer, thereby ending the vicious loop of elevated anxiety having a detrimental effect on sleep quality.

It is hypothesized that therapies aimed at enhancing emotion regulation abilities may have a good effect on sleep quality in this population, given the positive link seen between emotion control and sleep quality among anxiety patients. This is consistent with prior research, since authors like (Smith et al., 2018) and (Jones & Brown, 2019) have shown how emotion control and sleep quality are related in people with anxiety disorders. Building on these results, the current study supports the idea that helping anxiety patients with their emotional regulation may be a useful way to improve the quality of their sleep.

According to table 14 of Anova shows results of this study, which showed that GAD had greater mean differences in emotion regulation and sleep quality than SAD and agoraphobia, are consistent with and add to the body of research already in existence. A wider disruption in the regulation of emotions and quality of sleep seems to be a result of the persistent and widespread worry associated with Generalized Anxiety Disorder (GAD). This is in line with studies that highlight how GAD affects other spheres of life in addition to certain triggers.

Emotion regulation deficiencies and sleep disruptions have been repeatedly linked to

generalized anxiety disorder (GAD), which is characterized by widespread and excessive concern. Research suggests that long-term anxiety in generalized anxiety disorder (GAD) may result in elevated emotional reactivity and challenges with efficient emotion regulation (Mennin et al., 2005). Additionally, Riemann et al., (2015) found a connection between the continuous worry associated with GAD and symptoms of insomnia and disturbed sleep architecture.

The current study examined how sleep quality affects the regulation of emotions, paying particular attention to the expressive suppression and cognitive reappraisal aspects. Based on how well they slept, the sample was split into two groups: one group was above the mean, while the other was below it. Our research shows that these two groups' approaches to emotion control differ significantly from one another. Table 16, the t-test results show that there is a significant difference in the scores for the expressive suppression facet, cognitive reappraisal facet, and emotion regulation between people who have above-average and below-average sleep quality. Patients scores high on group which is above mean as compared to below the mean. Individuals who slept better showed improved use of the expressive suppression facet, cognitive reappraisal facet, and emotion management facet. This is consistent with earlier studies that found a close relationship between cognitive processes, particularly emotional control, and sleep quality (Walker, 2017). Those who are sleep deprived may not be able to meet the cognitive demands of reappraisal, which could affect their capacity to successfully reinterpret and regulate emotional responses.

Limitations

The limitations of the current study are as follow:

- Although the present study had a significant sample size than other research studies, it was still too small to be used to make broader generalization on overall population of anxiety patients.
- Only educated anxiety patients were taken into account as a part of research sample, from

Rawalpindi and Islamabad.

- Research participants were mostly from urban areas of respective cities and very few participants were from rural areas.
- The study takes the age range between 18-45 only.

Suggestions

The following are the recommendations to overcome the mentioned limitations.

- Larger sample size should be taken for better generalization.
- For accurate result findings and errorless generalization data should be taken from all over the Pakistan.
- Age range should be broadened for the accurate assessment of the prevalence of Anxiety.

Implications

The present study has several implications in different fields i.e. clinical settings, research studies, therapeutic interventions, and guidance and counseling and also in different awareness workshops. Resilience has been identified as a moderator, indicating that interventions targeted at improving resilience may benefit people with anxiety in terms of both emotion regulation & sleep quality. Treatment plans currently in place might benefit from the inclusion of therapeutic strategies that emphasize developing resilience abilities. Understanding resilience's moderating function suggests that treatment regimens should be tailored to each patient's level of resilience. Optimizing strategies to enhance resilience could result in better outcomes when it comes to anxiety management and sleep quality improvement.

Resilience-building interventions may be used as prophylactics for anxiety-related sleep disruptions. In people who are at susceptible to anxiety disorders, it could be able to lessen the

detrimental consequences of inadequate regulation of emotions on sleep quality by addressing resilience characteristics early in life. Stressing the relationship among resilience, emotional control, and sleep hygiene highlights the significance of comprehensive approaches to mental well-being. In addition to reducing symptoms, treatment plans should promote psychological health in general and the development of flexible coping skills.

Analyzing resilience's moderating effect could reveal information about the long-term consequences for anxiety sufferers. It may be possible to forecast differences in emotion regulation and sleep quality by tracking changes in resilience over time. This would enable more proactive and long-lasting therapeutic interventions. This subject emphasizes the need for more investigation into the intricate connections among emotion control, resilience, and sleep quality. Teaching patients and healthcare professionals about these linkages can improve comprehension of anxiety management and encourage all-encompassing care.

In conclusion, the identification of resilience as a moderator in the association between emotion control and sleep quality in individuals with anxiety has therapeutic, preventative, and more comprehensive implications for mental health care delivery.

Conclusion

The main target of this research paper were to investigate the connections between emotion regulation and sleep quality while also examining whether resilience plays a moderating role. We collected data from 400 anxiety patients residing in Islamabad and Rawalpindi hospital. Our data analysis encompassed various statistical techniques, including descriptive statistics, percentages, ANOVA, correlations, and moderating analysis. Our findings provided support for the idea that resilience acts as a moderator in the correlation between emotion regulation and sleep quality. The results of this study show that among

anxiety patients, resilience, emotion control, and sleep quality are significantly positively correlated.

Furthermore, the association among emotion regulation and sleep quality reveals resilience as a strong positive moderator, indicating that resilience levels greater enhance the beneficial impacts of efficient emotion regulation on sleep. Furthermore, our findings show that emotion control is a strong predictor of sleep quality in individuals with anxiety. It's interesting to note that when contrasted to their male counterparts, female anxiety patients score higher on resilience, emotion management, and sleep quality. Together, our findings highlight the complex interactions that exist among psychological resilience, emotion control, and sleep quality when anxiety is present. our relationships may have consequences for the development of specialized interventions and support systems.

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Appendices

Appendix-A

INFORM CONSENT

I am Sundas Saba, an MS Clinical Psychology student at the International Islamic University Islamabad. I am conducting a research project under the guidance of Dr. Mamoona Ismail Loona, Assistant Professor in the Department of Psychology at IIUI. My research focuses on understanding role of resilience as moderator between emotional regulation and sleep quality among anxiety patients.

Your participation in this study is invaluable, as it will provide crucial insights into my research topic. To assess the constructs of this study, I kindly request your participation in completing a set of questionnaires. I want to emphasize that any information you provide will be treated with the utmost confidentiality and used solely for research purposes. This survey will only take a few minutes of your time. Please know that you have the option to withdraw from the study at any stage, but I would greatly appreciate it if you could take the time to complete the survey. Your participation will significantly contribute to the success of this research, and I am sincerely thankful for your involvement.

Thank-you

MS Scholar

Sundas Saba

Appendix-B

DEMOGRAPHIC SHEET

1. Age _____
2. Gender: Male/Female
3. Qualification: BS/M.phil, Ph.D
4. Family Type: joint/nuclear
5. socio-economic status: Upper/Middle/Lower
6. Diagnosis: Generalized anxiety disorder/Social anxiety disorder/Agoraphobia

Appendix-C

BRIEF RESILIENCE SCALE(BRS)

Instructions: Please respond to each item by marking one box per row.

	Respond to each statement below by circling one answer per row	Strongly disagree	Disagree	Neutral	Agree	Strongly Agree
1.	I tend to bounce back quickly after hard times.	1	2	3	4	5
2.	I have a hard time making it through stressful events.	5	4	3	2	1
3.	It does not take me long to recover from a stressful event.	1	2	3	4	5
4.	It is hard for me to snap back when something bad happens.	5	4	3	2	1
5.	I usually come through difficult times with little trouble.	1	2	3	4	5
6.	I tend to take a long time to get over set-backs in my life.	5	4	3	2	1

Appendix-D

EMOTION REGULATION QUESTIONNAIRE (ERQ)

Instructions: Questions about your emotional life, in particular, how you control (that is, regulate and manage) your emotions. circle one response below each statement to indicate how much you agree ordisagree.

1. strongly agree
2. somewhat agree
3. a little agree
4. neither agree nor disagree
5. a little disagree
6. somewhat disagree
7. strongly disagree

		1	2	3	4	5	6	7
1.	When I want to feel more positive emotion (such as joy or amusement), I change what I am thinking about.							
2.	I keep my emotions to myself.							
3.	When I want to feel less negative emotion (such as sadness or anger), I change what I am thinking about.							
4.	When I am feeling positive emotions, I am careful not to express them.							
5.	When I am faced with a stressful situation, I make myself think about it in a way that helps me stay calm.							
6.	I control my emotions by not expressing them.							
7.	When I want to feel more positive emotion, I change the way I am thinking about the situation.							
8.	I control my emotions by changing the way I think about the situation I am in.							
9.	When I am feeling negative emotions, I make sure not to express them.							
10.	When I want to feel less negative emotion, I change the way I am thinking about the situation.							

Appendix-E

SLEEP QUALITY SCALE (SQS)

Instructions: The following survey is to know the quality of sleep you had for the last one month. Read the questions and check the closest answer.

		Rarely	Sometimes	Often	Almost always
1.	I have difficulty falling asleep.				
2.	I fall into a deep sleep.				
3.	I wake up while sleeping.				
4.	I have difficulty getting back to sleep once I wake up in middle of the night.				
5.	I wake up easily because of noise.				
6.	I toss and turn.				
7.	I never go back to sleep after awakening during sleep.				
8.	I feel refresh after sleep.				
9.	I feel unlikely to sleep after sleep.				
10.	Poor sleep gives me headaches.				
11.	Poor sleep makes me irritated.				
12.	I would like to sleep more after waking up.				
13.	My sleep hours are enough.				
14.	Poor sleep makes me lose my appetite.				
15.	Poor sleep makes hard for me to think.				
16.	I feel vigorous after sleep.				
17.	Poor sleep makes me lose interest in work or others.				
18.	My fatigue is relieved after sleep.				

19.	Poor sleep causes me to make mistakes at work.				
20.	I am satisfied with my sleep.				
21.	Poor sleep makes me forget things more easily.				
22.	Poor sleep makes it hard to concentrate at work.				
23.	Sleepiness interferes with my daily life.				
24.	Poor sleep makes me lose desire in all things.				
25.	I have difficulty getting out of bed.				
26.	Poor sleep makes me easily tired at work.				
27.	I have a clear head after sleep.				
28.	Poor sleep makes my life painful.				