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Coping and Schizophrenia: A Re-analysis

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Standard notions of coping have not been particularly fruitful in the study of schizophrenia. However, facilitation of adaptive coping with serious mental illnesses such as schizophrenia is an important part of mental health care in general and of psychiatric nursing in particular. This study explored factors of coping and examined their relation with symptom severity and with quality of life of outpatients with schizophrenia. Data were analyzed from a previous cross-sectional study, using the Ways of Coping Checklist, the Positive and Negative Syndrome Scale, and the Wisconsin Quality of Life Index. A principal component factor analysis was performed on the Ways of Coping Checklist scores, and the resulting six coping factors were then tested for correlations with Positive and Negative Syndrome Scale and Wisconsin Quality of Life Index scores. Factors conceptually linked with emotion-focused coping were more strongly associated with symptom severity and with quality of life than were factors conceptually linked with problem-focused coping. The emotion-focused versus problem-focused coping framework was only partly explanatory. It may be fruitful to study whether supportive counseling enhances beneficial factors conceptually linked with emotion-focused coping of individuals with schizophrenia.
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INDIVIDUALS WITH SCHIZOPHRENIA may manifest emotion-focused or avoidance coping, such as social withdrawal, which may be maladaptive in various circumstances (Rollins, Bond, & Lysaker, 1999). Problem-focused coping attempts to resolve problems, whereas emotion-focused coping attempts to address emotions raised by problems. Research has shown problem-focused coping to be more effective in many circumstances for various populations (Lazarus & Folkman, 1984). Recent research does not support either problem-focused or emotion-focused coping as particularly useful strategies to reduce symptom severity or to improve the quality of life (QoL) of individuals with schizophrenia (Rudnick, 2001). Yet coping can be helpful, and facilitation of adaptive coping with serious mental illnesses such as schizophrenia is an important part of mental health care in general and of psychiatric nursing in particular. Hence, alternative frameworks of coping have been recently explored in the context of schizophrenia.

One such alternative framework of coping was recently generated and studied by Lysaker et al. (2004), who suggested six coping categories based on the Ways of Coping Questionnaire: Considering, Acting, Ignoring, Resigning, Positive Reappraising, and Self-soothing. The Ways of Coping Questionnaire was originally generated to study problem-focused and emotion-focused coping

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(Lazarus & Folkman, 1984). The coping construct of Lysaker et al. demonstrated high internal consistency, and the Considering and Acting categories were shown to be predictors of improved work performance. To determine how well this coping construct is related to other important outcomes in schizophrenia, particularly to symptom severity and to QoL of individuals with schizophrenia, a reanalysis of cross-sectional data from a previous study was conducted (Rudnick, 2001). The results indicated that the six coping strategies of Lysaker et al. were not significantly associated with symptom severity or with QoL of individuals with schizophrenia (Martins & Rudnick, 2007). Therefore, the coping framework proposed by Lysaker et al. may not be suitable to predict symptom severity or QoL of individuals with schizophrenia.

The objective of this study was to attempt to generate a novel framework of coping relevant to schizophrenia and, if successful, to determine if these new coping factors are associated with symptom severity and with QoL of individuals with schizophrenia.

METHOD

Design and Participants

Data from a sample of 58 adult outpatients from a previous cross-sectional study were used (Rudnick, 2001). All study participants had a diagnosis of schizophrenia without comorbid psychiatric disorders (which was an exclusion criterion) according to the Structured Clinical Interview for *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* (*DSM-IV*) Axis I disorders (SCID-I). SCID-I is a semistructured interview used for diagnosis of *DSM-IV* Axis I disorders (First, Spitzer, Gibbon, & Williams, 1995). Demographic and clinical information is noted in a previous study (Rudnick, 2001). Research ethics board approval and informed consent were obtained before data collection.

Instruments and Analysis

An exploratory principal component factor analysis with Varimax rotation was performed on all the 50 items from the Ways of Coping Checklist (Lazarus & Folkman, 1984). Only factors with an Eigenvalue of 2 or greater were considered, and only items that loaded .5 or greater on these factors were used. After the factor analysis was performed, two-tailed Pearson correlations were conducted using an α level of .05 or less as the statistical significance threshold. The coping factors found were each analyzed for correlations with each of the 10 domains of QoL from the Wisconsin Quality of Life Index (Becker & Diamond, 1997): life satisfaction, occupational QoL, distress from symptoms, psychological well-being, physical QoL, social QoL, financial QoL, activities of daily living, general QoL, and mean QoL. The coping factors found were also each analyzed for correlations with each of the four domains of symptom severity as per the Positive and Negative Syndrome Scale (Kay, Fiszbein, & Opler, 1987): positive symptoms, negative symptoms, general (comorbid) symptoms, and total symptoms (all symptom scores summed).

RESULTS

The findings from the factor analysis revealed six coping factors. These factors include (variance accounted for is addressed in parentheses): support and passive coping (14.30%), activity coping (8.76%), hope-related coping (6.93%), wishful-thinking coping (5.95%), guilt and indirect coping (5.19%), and nonimpulsive coping (4.21%). These factors, the items that loaded on each factor, and the reliability—internal consistency (Cronbach's α)—of each factor are listed below.

Support and passive coping (α = .807): Talk to someone to find out more about the situation; keep my feelings to myself; accept sympathy and understanding, try to forget the whole thing; look for emotional support and understanding; keep others from knowing how bad things are; accept the situation as nothing can be done; ask advice from a relative or friend I respect.

Activity coping (α = .675): Try to work on another activity to take my mind off things; read about such problems; change something so things would turn out alright; know what has to be done so double my efforts to make things right; jog or exercise.

Hope-related coping (α = .675): Sometimes, I have bad luck; think I would come out of the experience better than I came in; maintain my pride; avoid being with people; not let it get to me and refuse to think too much about it;

remind myself how much worse things could be.

Wishful-thinking coping (α = .779): Wish I could change how I feel; daydream or imagine a better place than the one I am in; wish that the situation would go away or somehow be over with.

Guilt and indirect coping (α = .713): Try to analyze the problem to understand it better; criticize or lecture myself; express anger to person(s) who caused the problem; realize that I had brought the problem on myself; try to make myself feel better by eating, drinking, smoking, using drugs or medications; get professional help; prepare myself for the worst.

Nonimpulsive coping (α = .527): Wait to see what would happen before doing anything; stand my ground and fight for what I want; think about how a person I admire would handle the situation and use that as a model.

Four coping factors were significantly correlated with symptom severity and with QoL (df = 56). Support and passive coping was inversely correlated with severity of negative symptoms ($r = -.285$, $P = .03$). Activity coping was directly correlated with the QoL domain of psychological well-being ($r = .276$, $P = .04$). Hope-related coping was inversely correlated with severity of negative symptoms ($r = -.444$, $P < .001$), with severity of general symptoms ($r = -.427$, $P = .001$), and with severity of total symptoms ($r = -.474$, $P < .001$). In addition, hope-related coping was directly correlated with the QoL domain of psychological well-being ($r = .305$, $P = .02$) and with the QoL domain of activities of daily living ($r = .303$, $P = .02$). Guilt and indirect coping was inversely correlated with the QoL domain of life satisfaction ($r = -.432$, $P = .001$), with the QoL domain of distress from symptoms ($r = -.414$, $P = .001$), with social QoL ($r = -.397$, $P = .002$), with financial QoL ($r = -.383$, $P = .003$), and with mean QoL ($r = -.452$, $P < .001$).

DISCUSSION

General Conclusions

All six coping factors found here can be conceptually linked with either emotion-focused coping (support and passive coping, wishful-thinking coping, hope-related coping, guilt and indirect coping), problem-focused coping (nonimpulsive coping), or mixed emotion-focused and problem-focused coping (activity coping). Support and passive coping, activity coping, and particularly hope-related coping were associated with a good outcome. In contrast, guilt and indirect coping was associated with a poor outcome. Wishful-thinking coping and nonimpulsive coping were not associated with outcome.

These findings suggest that the problem-focused versus emotion-focused coping framework may be partly helpful in schizophrenia. However, our findings do not support that the approach widely endorsed for the general population, according to which problem-focused coping may be more effective than emotion-focused coping in many circumstances (Lazarus & Folkman, 1984), is helpful for individuals with schizophrenia. Our results suggest that factors conceptually linked to emotion-focused coping, particularly hope-related coping, may be more helpful for individuals with schizophrenia in many circumstances, such as in relation to difficulties at work and in interpersonal relationships (Lysaker & Buck, 2007). This is consistent with the finding that entertaining hope has been shown to predict good outcome in other health care areas, such as reduced morbidity and mortality after a myocardial infarction (Rustoen, Howie, Eidsmo, & Moum, 2005), as well as with the finding that hope is associated with a high level of QoL in individuals with schizophrenia (Landeen, Pawlick, Woodside, Kirkpatrick, & Byrne, 2000). Our findings also suggest that guilt and indirect coping can be detrimental to good outcome of individuals with schizophrenia. This is not surprising either, considering that guilt takes a toll on most people, including individuals with schizophrenia (Suslow, Roestel, Ohrmann, & Arolt, 2003).

Schwarzer's proactive coping theory integrates four coping modes that have been applied to severe mental illness: reactive, anticipatory, preventative, and proactive (Roe, Yanos, & Lysaker, 2006). Reactive coping incorporates both emotion-focused and problem-focused strategies. The present findings suggest that part of reactive coping may be relevant to schizophrenia, as some aspects of emotion-focused and problem-focused coping were associated with outcome. However, wishful-thinking and nonimpulsive coping, which are conceptually linked with emotion-focused and

problem-focused coping, respectively, were not related to outcome, which suggests that the general notions of reactive coping of emotion-focused coping versus problem-focused coping may not be sufficient for the understanding of coping of individuals with schizophrenia. These results emphasize the importance of generating and confirming a novel framework of coping, perhaps addressing more unique features of coping of individuals with schizophrenia, as suggested elsewhere (Farhall, Greenwood, & Jackson, 2007).

Implications for Nurses

To overcome challenges associated with living with schizophrenia, many individuals with this disorder seek help in the mental health care system, such as help from psychiatric nurses. Psychiatric nurses are involved in educating individuals on the importance of psychiatric medications, helping to create goals, creating a trustworthy interpersonal relationship with the patient, and teaching adaptive coping strategies (Roe & Swarbrick, 2007). According to the recovery alliance theory, which is based on humanistic philosophy, a nurse's role is to help patients utilize their existing adaptive coping strategies and to help them in the development of new adaptive coping strategies if needed (Shanley & Jubb-Shanley, 2007). Psychiatric nurses can facilitate adaptive coping by promoting hope, which is consistent with this study's finding that hope is related to an increased QoL. In a similar vein, psychiatric nurses can facilitate adaptive coping by identifying and alleviating guilt, which is also consistent with this study's findings that guilt is related to a decreased QoL.

Limitations and Future Directions

A limitation of this study is the use of cross-sectional data; hence, it is difficult to make causal inferences from the associations found. Another limitation is that the sample size was relatively small, particularly compared with the number of questions in the Ways of Coping Checklist, so that a Type 2 error (false–negative findings) may be likely. Yet another limitation is that the participants did not have psychiatric comorbidity, which is common in schizophrenia, making it difficult to generalize the findings to all patients with schizophrenia. However, these findings are promising and may have therapeutic implications. For instance, if the findings are corroborated with larger samples and in other study designs, such as longitudinal research, interventions designed to promote hope and to alleviate guilt experienced by individuals with schizophrenia could be studied. This may be possible within the framework of supportive counseling, which has demonstrated some success with individuals with schizophrenia (Penn et al., 2004). Also, this may be possible within stage-specific coping–enhancing interventions that could be designed and studied based on recent findings about stages of coping of individuals with schizophrenia and with other psychotic disorders (Roe et al., 2006). Be that as it may, further research on coping of individuals with schizophrenia is required.

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