



# Testing of the coping flexibility hypothesis based on the dual-process theory: Relationships between coping flexibility and depressive Symptoms



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## ABSTRACT

According to the dual-process theory of coping flexibility (Kato, 2012), coping flexibility is the ability to discontinue an ineffective coping strategy (i.e., evaluation coping process) and implement an alternative strategy (i.e., adaptive coping process). The coping flexibility hypothesis (CFH) proposes that the ability to engage in flexible coping is related to better psychological functioning and physical health, including less depression. In the present study, participants were 393 American Whites, 429 Australian Whites, and 496 Chinese, selected from the data pool of the 2013 Coping and Health Survey (see Kato, 2014b). They completed both the Coping Flexibility Scale (Kato, 2012), which is based on the dual-process theory of coping flexibility, and the Center for Epidemiologic Studies Depression Scale (CES-D). For all nationalities and genders, evaluation coping and adaptive coping were significantly correlated with lower levels of depressive symptoms. Structural equation modeling revealed that evaluation coping was associated with lower depressive symptoms for all nationalities and genders, whereas no significant relationships between adaptive coping and depressive symptoms were found for any nationalities. Our results partially supported that the CFH fits with the dual-process theory of coping flexibility.

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## 1. Introduction

Depression is a leading cause of disability worldwide. According to face-to-face household surveys of 60,463 community-dwelling adults conducted by the World Health Organization (WHO, 2004), the prevalence of mood disorders ranges from 0.8% in Nigeria to 9.6% in the United States. Further analyses by the WHO (2001) revealed that among individuals aged 15–44 years worldwide, unipolar depressive disorders are the leading causes of the burden of disease, accounting for 8.6% of total disability-adjusted life years and 16.4% of years of life lived with disability.

Coping flexibility, which generally refers to individuals' ability to effectively modify coping behavior according to the specific nature of stressful situations (Kato, 2012), is a key concept in research on coping with psychological or physiological distress. Researchers have assumed that the ability to engage in flexible coping results in better psychological functioning and physical health, including less depression (e.g., Lazarus, 1999; Folkman and Moskowitz, 2004; Rozanski et al., 2005; Bonanno and Burton, 2013; Cheng et al., 2014); this hypothesis is generally referred to as the coping flexibility hypothesis (CFH). According to flexibility theory and research, particularly that pertaining to coping and emotional flexibility, no one

behavior or strategy is always effective, and the costs of using a given strategy or behavior in a particular situation can often outweigh the benefits (Bonanno and Burton, 2013). For example, transactional theory (Lazarus, 1999), perhaps the most widely used theory in coping research, hypothesizes that effective coping strategies can change over time and in accordance with the demands of a particular stressful situation; notably, the inability to successfully cope with stressors or recognize that a coping strategy is ineffective contributes to long-term dysfunction among those struggling with chronic stress. Additionally, Caldwell et al. (2013) state that depressed individuals are relatively inflexible in their choice of coping strategies, whereas individuals who are flexible and able to change coping strategies to fit situational demands are less likely to be depressed. According to Rozanski and colleagues' (Rozanski and Kubzansky, 2005; Rozanski et al., 2005) paradigm on how flexibility relates to pathophysiology being able to flexibly respond to stressors is associated with better clinical outcomes; additionally, depression states can be viewed as a long-term and escalating inability to respond flexibly to chronic stress.

### 1.1. The dual-process theory of coping flexibility

Although the primary definition of coping flexibility is relatively consistent, its operational definition often differs between

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studies (for reviews, see Kato, 2012; Cheng et al., 2014). In particular, the definition of coping flexibility used in the dual-process theory of coping flexibility (Kato, 2012) has received much attention from researchers (e.g., Bonanno and Burton, 2013; Cheng et al., 2014). This theory defines coping flexibility as “the ability to discontinue an ineffective coping strategy and produce and implement an alternative coping strategy” (p. 263); according to this theory, coping comprises two reciprocal processes: evaluation coping and adaptive coping. Evaluation coping begins when an individual decides to abandon an ineffective strategy, and includes various strategies, such as comprehending the environment, monitoring and evaluating the outcomes of coping, and abandoning ineffective coping strategies if they produce unfavorable outcomes. Individuals who continue with the ineffective coping strategy are unlikely to alleviate their stress and can even increase it (Kato, 2012). Adaptive coping is both the consideration of viable alternative strategies and their subsequent use after an ineffective strategy has been abandoned (Kato, 2012). If adaptive coping is ineffective, the process of evaluation and adaptive coping is repeated until the desired outcomes are obtained. In the dual-process theory, the concept of meta-coping (e.g., grasping a situation, monitoring during coping efforts, and evaluating coping outcomes), which existing approaches to coping flexibility do not consider, is introduced (Kato, 2012).

The core process of the dual-process theory is attempting to flexibly cope with various stressors. Notably, Cheng et al. (2014) devised a multi-theoretical model of coping flexibility, proposing that flexible coping comprises three stages: planning, execution, and feedback. The planning stage involves selecting what strategies are optimal for a given stressful situation. The execution stage comprises the individual processes of *evaluation* and *adaptation* processes. Finally, the feedback stage involves monitoring the efficacy of a chosen strategy. Cheng et al.'s model proposes that these three meta-coping skills—evaluation, adaptation, and monitoring—play major roles in the execution and feedback stages. Interestingly, evaluation and adaptation are aspects of the execution stage, while the feedback stage is part of the definition of coping flexibility according to the dual-process theory (Bonanno and Burton, 2013; Cheng et al., 2014); the meta-coping skills were also initially part of the dual-process theory's definition of coping flexibility. Therefore, according to the dual-process theory, coping flexibility can be viewed as an executive process including a feedback function and a core process of flexibly coping with stressors.

The find support for the CFH, Cheng et al. (2014) conducted a meta-analysis examining the relation between coping flexibility (including Kato's (2012) definition) and psychological adjustment; the results showed a mean effect size ( $r$ ) of 0.32 (95% confidence interval (CI) [0.26, 0.37],  $k=108$ ,  $N=28,145$ ). Specifically, both evaluation coping and adaptive coping were strongly and negatively associated with depressive symptoms longitudinally (Kato, 2012). Additionally, in a study among chronic headache sufferers (Kato, 2014a), coping flexibility based on the dual-process theory in response to headache pain, was associated with reduced depressive symptoms after controlling for the effects of coping strategies for headache pain. Although several studies in Japan (Kato, 2012, 2014a, 2015) and one study in Hong Kong (Ng et al., 2014) have tested how the CFH fits with the dual-process theory of coping flexibility, the CFH may be applicable to the dual-process theory in populations of other countries as well. Therefore, in the current study, we tested the CFH using the dual-process theory of coping flexibility as a framework in the United States, Australia, and China.

## 2. Method

### 2.1. Procedure

The raw data for this study were taken from the 2013 Coping and Health Survey (2013 CHS; Kato, 2014b). The 2013 CHS used the polling organization Rakuten Research (Tokyo, Japan) to access this organization's web panel (see <http://research.rakuten.co.jp/en/>) of over 4.01, 0.83, and 1.43 million members in the United States, Australia, and China, respectively. The survey details were sent via e-mail to potential participants (people aged between 18 and 79 years). Those who agreed to participate clicked on a link to view the survey and could begin taking it by entering their IDs. Participants were not able to skip any of the survey items. We ensured that samples were virtually evenly divided by gender and age bracket for each country. Ultimately, the 2013 CHS obtained data from 1,500 participants. In order to examine the cultural differences in coping flexibility, we selected sample of American Whites, Australian Whites, and Chinese from the 2013 CHS as participants in this study.

All procedures followed were in accordance with the ethical standards of the responsible committee on human experimentation and with the Helsinki Declaration of 1975, as revised in 2000. The study was approved by Rakuten Research in Japan. Informed consent was obtained through a Web-based survey from all individual participants included in the study.

### 2.2. Participants

In all, 393 American Whites, 429 Australian Whites (including 146 European Australians), and 496 Chinese were selected from their respective samples in the 2013 CHS. Participants in the American sample comprised 192 men and 201 women aged 18–79 years (mean age 47.18,  $SD=15.33$ ). Approximately 54.5% of the participants were married, 26.5% had never been married, and 19.1% were divorced, separated, or widowed. Participants in the Australian sample comprised 198 men and 231 women aged 18–79 years (mean age 47.37,  $SD=14.40$ ). Approximately 54.3% of the participants were married, 30.3% had never been married, and 15.4% were divorced, separated, or widowed. The Chinese sample comprised 263 men and 234 women aged 18–76 years (mean age 40.17,  $SD=11.92$ ). Approximately 86.9% of the participants were married, 11.7% had never been married, and 1.4% were divorced, separated, or widowed.

A chi-square test revealed no significant differences in gender between the three samples at a significance level of  $p < 0.05$ . A Kruskal–Wallis rank analysis indicated that the median age in the Chinese sample was significantly lower than for the American and Australian samples, but no significant difference existed between the American and Australian samples at  $p < 0.05$ .

### 2.3. Measures

#### 2.3.1. Coping flexibility

Coping flexibility was measured using the Conflict Flexibility Scale (CFS; Kato, 2012), which was developed based on the dual-process theory of coping flexibility. The CFS consists of two 5-item subscales that pertain to evaluation coping (e.g., If I feel that I have failed to cope with stress, I change the way in which I deal with stress) and adaptive coping (e.g., When a stressful situation has not improved, I try to think of other ways to cope with it). Each coping score is associated with theoretically related constructs and predicts high scores on an insight problem-task that requires flexible thinking (Kato, 2012). Moreover, the CFH has been supported by some studies using the CFS in samples of chronic pain patients (Kato, 2014a), employees (Kato, 2012), and college

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