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Coping strategies related to treatment in substance use disorder patients with and without comorbid depression

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ABSTRACT

Coping strategies exert an important influence in the development and course of both substance use disorder (SUD) and major depressive disorder (MDD) and its treatment outcomes. We examined the coping strategies related to treatment in SUD and SUD-MDD patients and their associations with clinical characteristics. Forty SUD and 40 SUD-MDD males, each group composed by 20 therapeutic community and 20 ambulatory treatment patients, were assessed through the Coping Strategies Inventory and clinical characteristics questionnaires. SUD-MDD patients scored higher in Disengagement strategies such as Social Withdrawal and lower in Engagement ones such as Problem Solving, Cognitive Restructuring and Social Support, as well as in self-perceived capacity for coping. No differences for treatment were found. SUD and, specially, SUD-MDD patients scored higher than norms in maladaptive strategies. Time of abstinence, age of onset and severity of SUD were related to maladaptive coping. SUD and SUD-MDD patients are prone to employ Disengagement coping strategies and SUD-MDD patients coping repertory is more maladaptive than the SUD ones. Likewise, clinical characteristics associated to maladaptive coping might differ by diagnosis and modality of treatment in male patients. These findings could be considered for the treatment design and to improve the recovery and prevent relapses.

1. Introduction

Coping strategies, defined as the cognitive and behavioral efforts aimed to manage the internal and external demands of a person or environment (Lazarus and Folkman, 1984), are classified as engagement, which are adaptive and targeted to deal with the stressor or/and their related emotions, and disengagement, maladaptive and directed to avoid the stressful situation and/or their related emotions (Carver and Connor-Smith, 2010; Tobin et al., 1989). These strategies are considered as an important influence in the development, course and treatment outcome of diverse mental disorders such as substance use disorder (SUD) (Kommescher et al., 2016; Marquez-Arrico et al., 2015). In fact, several studies have observed that SUD patients tend to show a lower use of adaptive coping strategies as compared to normal population (Coriale et al., 2012; Marquez-Arrico et al., 2015; Pence et al., 2008). Likewise, there has also been found a relationship between the use of adaptive coping strategies and a lower substance use, better adherence to treatment (Chung et al., 2001; Forys et al., 2007; Hasking et al., 2011), and lower relapse rates (Anderson et al., 2006; Kiluk et al., 2011). Moreover, the use of maladaptive strategies has been linked to an increase of severity of dependence (Hruska et al., 2011).

Dual diagnosis has been defined as the comorbidity between a substance use disorder (SUD) and other mental illness (Nesvåg et al., 2015; Toftdahl et al., 2016). Dual patients, with a higher prevalence in males, tend to show higher use of medical services (Martín-Santos et al., 2006), higher rates of mortality (Hjorthøj et al., 2015) and treatment failure (Carey et al., 2001; Lambert et al., 2005), higher cognitive impairment (Benaiges et al., 2013) and a lower quality of life (Benaiges et al., 2012) as compared to the SUD ones. Major depressive disorder (MDD) is a common comorbidity associated to SUD, with a prevalence around the 11–27% in community studies (Kessler et al., 2003; Nesvåg et al., 2015). Diverse studies have observed associations between depressive symptoms and the use of maladaptive coping strategies (Bettis et al., 2016; Kiral et al., 2015) as well as between the use of adaptive coping strategies and a lower depressive symptomatology (Kiral et al., 2015; Morris et al., 2014). Furthermore, the use of disengagement coping strategies have been linked to the risk for the development (or relapse) of a MDD (Aarts et al., 2015; Morris et al., 2014). The co-occurrence of a SUD with a MDD (SUD-MDD) is

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associated with higher impairment and worse course of both disorders, worse functioning, and higher risk of suicide as compared to patients without comorbidity (Antúnez et al., 2016; Blanco et al., 2012; Conway et al., 2006; Hasin et al., 2002; Magidson et al., 2013; Worley et al., 2012). However, no previous work has explored possible differences in treatment strategies between SUD and SUD-MDD patients.

Therapeutic community and ambulatory treatment are currently the two main ways for treating SUD and its comorbidity. The first is based in a living-learning situation (Kennard, 2004) where everything that happens, mainly crisis, between the community members is employed as a learning opportunity (Magor-Blatch et al., 2014). Ambulatory treatment, by the other hand, provides a situation where the patient lives in his habitual ambient and which is close to the treatment location. Both modalities are focused on psychosocial treatments which included group and individual sessions (Kleber et al., 2006). Treatment in a therapeutic community involves a more intense approach and a greater control of patients, which has been shown to be beneficial in the circadian rhythmic reorganization (Antúnez et al., 2016). This treatment is especially indicated in patients with greater clinical severity and/or less social support (Maremmani et al., 2016). However, there are no studies examining its influence on the coping strategies of patients after detoxification.

Considering the importance of coping strategies to the treatment in SUD and MDD this study aims to examine the coping strategies employed by male SUD and SUD-MDD individuals, in both therapeutic community and ambulatory treatment. More specifically, our objectives are to compare the use of coping strategies across both diagnoses (SUD *vs* SUD-MDD) and treatment modalities (therapeutic community *vs* ambulatory treatment), as well compare the utilization of coping strategies in these clinical populations with a normative sample. Additionaly, we explored the associations between coping strategies and clinical variables in function of diagnosis and type of treatment. We hypothesize that dual (SUD-MDD) and therapeutic community patients will exhibit worse coping strategies that SUD without comorbidity and ambulatory patients, respectively.

2. Method

2.1. Participants

Eighty male patients (40.05 ± 9.29 years) under SUD treatment were enrolled in a cross-sectional design and divided into two groups: one with SUD without comorbid psychopathology (n =40) and another with SUD and comorbid major depressive disorder (SUD-MDD; n =40). Each group included 20 patients from therapeutic community and 20 from ambulatory treatment.

2.2. Materials and measures

Patients were derived by medical centers from Barcelona and Málaga, Spain, according to the inclusion/exclusion criteria required. However, current diagnosis of SUD and MDD was confirmed in the first evaluation session using the Structural Clinical Interview for the DSM-IV Axis I Disorders (SCID-I; First et al., 1999). Sociodemographic (age, marital status, social class, schooling and economic status) and clinical variables (psychiatric and substance use family history, age of onset of each disorder, relapses, abstinence periods, drugs used, suicidal attempts, presence of organic pathology and medication consumption) were collected with the SCID-I and a clinical interview designed for our study. From initially derived sample (n =85) five patients were discarded for failing to meet the inclusion criteria.

Severity of SUD was assessed using the Drug Abuse Screening Test-20 (DAST-20; Skinner, 1982) through its Spanish version (Gálvez and Fernández, 2010), which provides a total score from 0 to 20 (0 no addiction, 1–5 low, 6–10 intermediate, 11–15 substantial, and 16–20 severe addiction). Depressive symptomatology in MDD patients was assessed using the Hamilton Depression Rating Scale (HDRS; Hamilton, 1967) through its Spanish version (Ramos-Brieva and Cordero, 1986), which provides a total scoring from 0 to 52 (0–7 absence, 8–13 low, 14–18 moderate, 19–22 substantial, and 22–52 severe depression). The internal reliability (Cronbach's α) was adequate both for DAST-20 (α=0.91) and HDRS (α=0.75) in our sample.

Coping strategies were assessed by means of the Coping Strategies Inventory (CSI; Tobin et al., 1989) in its Spanish version (Cano et al., 2007). This inventory requires the evocation of any stressful situation, patients were required to describe the coping strategies used to deal with SUD treatment in our study, for answering the 41 self-reported items. This inventory assesses a total amount of eight primary scales Problem Solving (i.e, “I struggled to resolve the problem”); Cognitive Restructuring (i.e, “I went over the problem again and again in my mind and finally saw things in a different light”); Social Support (i.e, “I found somebody who was a good listener”); Express Emotions (i.e, “I let out my feelings to reduce the stress”); Problem Avoidance (i.e, “I didn't let it get to me; I refused to think about it too much”); Wishful Thinking (i.e, “I wished that the situation had never started”); Social Withdrawal (“I spent some time by myself”), and Self-Criticism (i.e, “I blamed myself”) as well as the ability to cope or not the evoked situation. There are four secondary scales: Problem Focused Engagement (composed by Problem Solving and Cognitive Restructuring), Emotion Focused Engagement (Social Support and Express Emotions), Problem Focused Disengagement (Problem Avoidance and Wishful Thinking) and Emotion Focused Disengagement (Social Withdrawal and Self Criticism). Finally, there are two tertiary scales: Engagement (composed by Problem and Emotion Focused Engagement) and Disengagement (Problem and Emotion Focused Disengagement). The internal reliability (Cronbach's α) for primary scales in our sample was 0.78 for Problem Solving, 0.62 for Cognitive Restructuring, 0.89 for Social Support, 0.72 for Express Emotions PS, 0.65 for Problem Avoidance, 0.70 for Wishful Thinking, 0.74 for Social Withdrawal and 0.85 for Self-Criticism.

2.3. Procedure

Participants were included according to these inclusion criteria: 1) male gender, based on the low frequency of females at centers we restricted eligibility to only males to avoid confounding findings due to gender differences on coping strategies which has been found among drug users (Pelissier and Jones, 2006); 2) aged 19–55; 3) According to DSM-IV-TR criteria (American Psychiatric Association, 2000) current diagnosis of a SUD, in remission and without relapses for at least three months and for the SUD-MDD group the additional criterion of MDD stabilized. The stabilization situation in 72.5% of patients still required treatment with antidepressants, and only 45% were asymptomatic (HDRS < 8) (see Table 1). Exclusion criteria were: 1) presence of any other psychopathology different from SUD or MDD (the latter only for the SUD-MDD group); 2) altered consciousness status, global cognitive deterioration, language comprehension problems or any other problem which could difficult the assessment. Patients were recruited until we reached the n=20 for each condition, derived by the clinicians of the centers according to the inclusion and exclusion criteria. The assessment protocol was approved by the Research Committee of the University of Barcelona, the present study complied with the tenets of the Declaration of Helsinki and all patients signed the informed consent prior their inclusion in the study. Participants were not compensated for their participation in the study and the only benefit that obtained was a report of their results.

2.4. Data analysis

Group differences in demographic and clinical variables were explored with independent sample *t*-test for continuous data, and