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# Coping strategies in schizoaffective disorder and schizophrenia: Differences and similarities

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ABSTRACT

Aims of the current study were to explore differences in coping between 58 patients with schizoaffective disorder (SAD) and 89 with schizophrenia (SZ) and to identify factors associated with coping in both disorders. The demographic and clinical characteristics of patients with SAD and with SZ were compared using ANOVA and $\chi^2$. Pearson's correlations were calculated between coping styles and socio-demographic and clinical variables in each group. The significant ones were subsequently analyzed using multiple regressions. Patients with SAD used emotion oriented coping more frequently than patients 2016with SZ. In patients with SAD, self-esteem contributed to task-oriented; avolition-anhedonia (AA) to emotion-oriented; duration of illness and years of education to distraction; AA to social diversion. In patients with SZ, AA, the mental component summary score of the Short Form - 36 Health Survey (SF-36) and self-esteem contributed to emotion oriented coping; the mental component summary score of SF-36 to distraction; AA to social diversion. Our results suggest that patients with SAD and SZ use diverse coping strategies. A greater attention must be given to the presence of self-esteem and AA in individuals with both disorders. These factors are potentially modifiable from specific therapeutic interventions, which can produce effects on coping strategies.



## 1. Introduction

The importance of coping strategies in schizophrenia (SZ) is widely acknowledged, given their relevance for the development and maintenance of psychopathology, their effects on quality of life (QOL) and social functioning.

Researchers have frequently classified coping strategies into three categories: problem focused (i.e. strategies to actively solve an underlying problem, cognitively reconceptualize it and potentially minimize its adverse effects), emotion-focused (i.e. strategies to restructure cognitions to modify the emotional response; it involves emotional regulation without attempts to change the situation but rather by changing the way the situation is attended to, or by altering the subjective appraisal of the situation, e.g. positive appraisal or acceptance), and avoidance-focused (avoidant-distracted coping, i.e. strategies to avoid a stressful situation via self-distraction from stressful situation, e.g. “giving up” denial, or engaging in a substitute task; avoidant-social coping, i.e. strategies to avoid a stressful situation by using social diversion, i.e. choosing to be with other people and seeking emotional support) (Folkman and Lazarus, 1984; Skinner et al., 2003).

Adaptive coping is understood as flexible and efficient, while maladaptive coping is rigid or socially inappropriate. It has been suggested that the type or amount of coping that is most adaptive for patients with SZ may depend on personal physiological characteristics and that there is neither coping style, nor amount of coping effort, that is best for all (Brenner et al., 2011). Moreover, it is noteworthy that there is no consensus among researchers regarding which coping strategy is most effective in reducing psychopathological symptoms and distress symptoms, since the appropriateness of any coping strategy may depend on the situation (Aldwin and Revenson, 1987; Austenfeld and Stanton, 2004; Carr, 1988; Lazarus, 2000; Thoits, 1995). Though task-oriented coping is considered more adaptive, when situations are manageable (Parker and Endler, 1992), sometimes other avoidant- or emotional-related strategies may be more adaptive depending on the situation. When one faces unchangeable situations or symptoms experienced as uncontrollable situations, task coping becomes ineffective and emotion or avoidance coping may be the most effective option. According to Lazarus and Folkman (1984) the cognitive appraisal of a situation guides the action, thus stressors or

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situations that cannot be changed or acted upon should trigger coping responses that are less active and more passive or internal. Also, individuals with higher levels of insight and high hope about the future demonstrated the most adaptive coping strategies whilst those with high insight and lower hope demonstrated the least (Lysaker et al., 2005).

Patients with SZ often report chronic difficulty to cope effectively with both major and minor stresses (Corrigan and Toomey, 1995; Mueser et al., 1997). They have been found to use less frequently problem-focused coping strategies to deal with stress than non psychiatric controls (Horan et al., 2005; Van Den Bosch et al., 1992). They generally use more passive emotion-focused coping strategies, such as avoiding, ignoring, and not thinking about the problem (Aghevli et al., 2003; Jansen et al., 2000; Mueser et al., 1997; Phillips et al., 2009; Wilder-Willis et al., 2002).

According to the literature, studies on coping strategies in patients with SZ focused on their effects on clinical variables and outcome (Ritsner et al., 2003; Ritsner et al., 2006).

Indeed, QOL demonstrates a strong and positive relationship with the task- and avoidance-oriented coping styles and somewhat negative relationship with emotion-oriented coping. Moreover, emotion-oriented coping mediated the connection between the severity of the anxiety/depression symptoms and QOL, while avoidance-oriented coping (distraction) influenced the interaction between QOL and paranoid symptoms (Holubova et al., 2016).

Symptom severity has been related to maladaptive coping patterns (Lee et al., 2011; Lysaker et al., 2006; Strous et al., 2005; Wield, 1992; Zappia et al., 2012). The relationship between negative symptoms and emotion-focused coping was repeatedly reported in studies of patients with SZ (Lysaker et al., 2006; Martins and Rudnick, 2007; Montemagni et al., 2014; Rudnick and Martins, 2009; Wield, 1992; Wilder-Willis et al., 2002). Subjects with severe negative symptoms might have difficulties in using a problem-focused coping because it demands volition, attention, and more cognitive functions (Lysaker et al., 2004; Wilder-Willis et al., 2002). Tsai et al. (2010) have found that clients with particularly high negative symptoms are more isolated, and engage in more maladaptive coping than others. Meanwhile, subjects who relied on maladaptive coping strategies would not be tolerable to various stressful circumstances, and as a consequence, they could be more depressed, anxious, and symptomatic (e.g. avoid social interactions).

Despite accumulating evidence of the important role of coping with stress, there are limited data on coping strategies in different psychotic disorders. To the best of our knowledge, there are no studies analyzing coping strategies in a population of patients with schizoaffective disorder (SAD).

Thus, aims of the current study were twofold: first to explore differences in coping strategies between patients with SAD and SZ, second to identify contributors of coping styles. As studies on coping in patients with schizophrenia spectrum disorders analyzed mainly the relationship among coping, clinical variables and outcome, we decided to focus our attention on symptoms, and health related QOL, and their relationships with coping strategies.

## 2. Methods

### 2.1. Participants

The study has been conducted at the Department of Neuroscience, University of Turin, Struttura Semplice di Coordinamento a Valenza Dipartimentale (SSCVD), Department of Mental Health ASL TO1- A.O.U. Città della Salute e della Scienza di Torino, Italy during the period between July 2012 and January 2014.

Patients were initially evaluated by a clinician-psychiatrist, and if they met Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) (American Psychiatric Association, 2000) criteria for SZ or for SAD, they were seen subsequently by two expert clinicians (C.M. and C.M.). All consecutive patients fulfilling the following criteria were included in the study:

1. men and women in the 18–65 years age group;
2. diagnosis of SZ or SAD according to the DSM-IV-TR, confirmed by the treating consultant psychiatrist (C.M. and C.M.) using the Structured Clinical Interview for DSM-IV disorders (SCID) (First et al., 1997). The two psychiatrists were aware of previous diagnosis and they could also review the previous clinical charts, available for all the patients. Subjects were excluded if they had a current disorder other than SZ or SAD on Axis I and II of the DSM-IV-TR, a current or past codiagnosis of autistic disorder or another pervasive developmental disorder, a history of severe head injury (coma $48 \geq$ h) or a diagnosis of a psychiatric disorder due to a general medical condition;
3. patients had been clinically stable as judged by the treating psychiatrist, i.e. during this period all patients had to be treated as outpatients, and treatment regimen had not been modified for the last six months. In addition to medical records, patients were considered to be in stable phase as assessed from reports from patients themselves, and observations of the psychiatric staff, relatives and personnel in the psychiatric community.

Patients were evaluated using a semi-structured interview to assess demographic and clinical features. Data were collected to determine age, gender, years of education, status of employment, marriage or an equivalent long-term relationship, length of illness, number of hospitalizations and antipsychotic treatment. All patients were submitted to standard care provided in community mental health centers in Italy (pharmacological treatment, clinical monitoring at least on a monthly basis, home care when required, and psychosocial and rehabilitation interventions tailored to patient's needs).

Written informed consent was obtained from all subjects after a complete description of the study. The study was carried out in accordance with Declaration of Helsinki (with amendments) and was approved positively by the Local Research Ethics Committee (LREC).

### 2.2. Psychiatric assessment

The Scale for Assessment of Negative Symptoms (SANS) (Andreasen, 1982) was used to evaluate negative symptoms during the preceding month. This interview-based rating scale contains anchored items that lead to global ratings of 4 negative symptoms (excluding the Attention scale) (Blanchard and Cohen, 2006): Affective flattening, Alogia, Anhedonia-Asociality, and Avolition-Apathy. We separated negative symptoms into the AA (avolition and anhedonia) and DE (affective flattening and alogia) components. The Scale for Assessment of Positive Symptoms (SAPS) ascertained positive symptom scores (Andreasen and Olsen, 1982), and the Calgary Depression Scale for Schizophrenia (CDSS) was used to measure depressive symptoms (Addington et al., 1990).

We used the Scale for the Assessment of Unawareness of Mental Disorder (SUMD) to assess insight (Amador, and Strauss, 1990). The patients were categorized as having generally preserved or impaired insight based on a threshold mean score of $\leq 3.0$. The threshold score is identical to those used in other studies (e.g., Larøi et al., 2000; Varga et al., 2006). For the purpose of the present study, data analysis focused on awareness of specific current and retrospective symptoms and attribution of specific current and retrospective symptoms. We considered current