AN EXPLORATORY STUDY OF COPING STYLES IN SCHIZOPHRENIC PATIENTS

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SUMMARY

The coping strategies employed by thirty schizophrenics were examined in relation to their psychopathology. A total of 251 coping styles were identified in the patient group. The commonly used techniques were behavioral control, cognitive methods and socialization. These findings suggest that schizophrenic patients employ active methods to handle the distressing symptoms experienced by them. The coping patterns were then studied in relation to specific symptoms. Schizophrenics with predominant thought disorder utilized specific task-oriented methods in addition to a wide variety of cognitive approaches; those with delusions minimized their socialization and shifted their attention away from distressing thoughts and patients with hallucinations employed distraction techniques and increased their socialization. In contrast, those with non-psychotic symptoms resorted to more direct help from outside. The common method employed by patients in relation to both psychotic and neurotic symptoms was one of indulgence, usually excessive coffee consumption or smoking. The findings are discussed in relation to their practical applications and suggestions for future studies are outlined.

INTRODUCTION

In psychiatric nosology, there are very few diagnoses that continue to indicate as ominous a predicament as that of schizophrenia. Though the outcome of this disorder has continued to improve with time (Zubin, 1983) and across cultures (WHO, 1979), a fairly significant proportion do not recover and continue to have lasting impairments in various areas of functioning (Jablensky, 1985). In order to optimally meet the requirements of this section of schizophrenics, it is important to explore the manner in which they adjust to their clinical problems. Though autobiographical accounts by schizophrenic patients have provided glimpses of the coping methods employed to handle their distressing symptoms (Keil, 1984), there is a striking paucity of information on this area in professional literature. Systematic examination of this vital perspective has been attempted by only a handful of investigators (Breier & Strauss, 1983; Cohen & Berk, 1985; Falloon & Talbot, 1981; Vaughan, 1988). In the Indian context, with the emerging trend of community in preference to custodial care, there is an overwhelming need to explore this area further. In this light, the present study was undertaken to assess the patterns of coping adopted by schizophrenics, whose symptoms were still persistent. The specific focus of enquiry was on the subjective coping strategies adopted by patients in relation to their psychopathology.

METHOD

This study was carried out at the National Institute of Mental Health and Neurosciences, Bangalore. Thirty schizophrenic patients (diagnosed according to the ICD-10), were selected from the clinical unit of the author. These patients had been attending the psychiatric out-patient services regularly and continued to be symptomatic for a long period of time. All were maintained on fortnightly fluphenazine injections and were on an average dose of 1000-1200 mg chlorpromazine equivalents of neuroleptics.

RESULTS

In order to specifically assess the coping styles of these patients in relation to their psychopathology, the questionnaire evolved by Vaughan (1988) was utilized. The items in this questionnaire had been derived from earlier empirical studies. It has two components of which the first involved determining the range of principal symptoms experienced by the patient. Six symptom groups were particularly assessed; these were thought disturbances, delusions, hallucinations, anxiety, depression and retardation/inhibition. Open ended questions were asked in relation to each of these phenomena, to comprehensively assess their presence and severity in the past year. In the second section of the questionnaire, they were required to detail the specific method of coping adopted by them in relation to the symptom. These coping techniques were examined in relation to six major areas; these were behavioral change, cognitive control, socialization, medical, symptomatic and others. The description outlined by Vaughan (1988) was adopted to cleave the coping styles of patients into distinct categories (Appendix 1). The frequencies with which these techniques were employed overall and in relation to particular symptoms, were then examined.

The socio-demographic profile of the group of schizophrenic patients examined is given in Table 1. There was an almost equal representation from both sexes and the majority of them were from a rural background. Almost half the sample had the onset of their illness in the second and third decades of life. The proportion of illiterates was considerably less compared to those who had some form of education. Half the sample had only a seasonal occupation like agriculture or manual labor. The average duration of illness was 5.5 years.

Of the symptoms which the patients reported to have experienced, thought disturbances and delusions were most frequent, followed by hallucinations, depression, anxiety and retardation. The frequency of occurrence of these symptoms is illustrated in Figure 1.
A total of 251 coping strategies were elicited in the patient sample under investigation, giving an average of 0.4 coping mechanisms per patient. This indicates that patients employ multiple coping styles in order to handle their symptoms.

An attempt was then made to discern the common coping patterns employed by the patients (Table 2). It was found that behavioral control strategies were the most common, closely followed by cognitive control mechanisms and socialization. Medical and symptomatic methods were the ones least utilized by the patients.

In order to further explore the association between individual symptoms and the specific coping mechanisms employed in response to it, the coping strategies were grouped according to individual symptom patterns. To facilitate closer examination, they were cleaved into two symptom clusters: psychotic and non-psychotic symptoms. The coping strategies employed to handle psychotic symptoms like thought disorder, delusions and hallucinations are outlined in Table 3. The techniques employed to handle depression, anxiety and retardation are listed in Table 4.

Table 2
Prevalence Of Coping Techniques Employed By Patients

| 1. BEHAVIORAL STRATEGIES: | 73% |
|---------------------------|-----|
| A. DISTRACTION            | 30% |
| B. PHYSICAL ACTIVITY      | 14% |
| C. INDULGENCE             | 9%  |
| D. TASK PERFORMANCE       | 20% |
| 2. SOCIALIZATION           | 30% |
| 3. COGNITIVE ACTIVITY     | 42% |
| 4. MEDICAL CARE            | 10% |
| 5. SYMPTOMATIC            | 8%  |
| 6. OTHERS                 | 7%  |

DISCUSSION

Since very few investigations have been carried out in this area, the findings of the present study could only be compared to those of Cohen & Berk (1985) and Vaughan (1988). Both these investigators adopted different methods of assessment of coping styles and their findings may not be comparable. In the present investigation, the more recent and detailed assessment method of Vaughan (1988), was adopted. In consonance with the findings of this study, the present investigation also indicates that schizophrenic patients, rather than being victims of their psychopathology, adopt active methods of handling their symptoms.

The more frequent usage of behavioral control strategies in response to symptoms bears testimony to this fact (Table 2).

However, the overall prevalence of coping techniques would only indicate the broad trends of coping mechanisms adopted by the patient group as a whole. It is important therefore, to enquire whether patients with
A. DISTRACTION

C. INDULGENCE

B. PHYSICAL ACTIVITY

6. OTHERS

3. COGNITIVE ACTIVITY

2. SOCIALIZATION

D. TASK PERFORMANCE

5. SYMPTOMATIC

4. MEDICAL CARE

Specific symptom profiles adopt distinct styles of coping. Such an attempt was made in the present study, for the first time, for psychotic and other symptoms, separately.

The most prevalent symptom in the group was that of thought disturbance. Disordered thinking could be a nagging problem in schizophrenics, as it hampers their communication, interferes with their inter-personal relations and clouds the clarity of thinking. It is interesting to note that schizophrenic patients in the present sample, probably aware of their handicap, resort less often to socialization compared to other coping measures like task performance, cognitive control and increased physical activity. By engaging their attention in simple well defined tasks like typing, cooking or ploughing, the interference due to thought disturbance is minimized. These are pre-programmed activities that have become routine for the individual and do not necessitate active thinking. In addition, a few of them also engage in active cognitive tasks to tackle their disordered thinking. They attempt this in two ways; in the first instance, they try to avoid any preoccupation with their thought disturbance. As one patient commented, “I force myself not think about it at all”. Or, alternatively, the patients actively evoke pleasant thoughts which are reassuring to them, “I think about the good things I did in my life and I also think about one thing at a time”. The strategy of focussing and increasing their physical activity also helps them divert their mind from deviant thought processes.

Some patients develop innovative strategies on their own to tackle this problem. One such patient who had persistent first rank symptoms in the form of thought insertion and broadcast, started to evince a keen interest in astrology. Whenever he attended our out-patient service, there would invariably be an astrological journal tucked under his arm. When asked about this interest, he simply stated, “Instead of losing my calm over being influenced by others, I thought I will start influencing others through their planets!”. Surprisingly, he became quite good at it and was much sought after by his colleagues in his office. All these coping methods indicate that Indian schizophrenics are adequately aware of their thinking disturbances and respond quite actively and appropriately to cope with them.

In the present sample, in contrast to the earlier reports, patients with delusions decreased their social interaction. This might be in response to the persecutory nature of their delusions. They also employed cognitive or distractive strategies to tackle their suspicions. The usual cognitive control strategy employed by them was one of “not thinking about it” or “ignoring it”. Paradoxically, a patient who had distressing persecutory delusions, achieved relief by reading detective fiction! It seems quite probable that he achieved relief through a process of identification.

One of the troublesome symptoms in schizophrenia is that of hallucinations. Vaughan (1986) noted that his patients predominantly employed cognitive control strategies or sought medical attention directly. In contrast, in the present study, the commonest method employed in response to hallucinations was distraction. Patients invariably had auditory hallucinations and found relief by listening to music or the radio. Falloon and Talbot (1981), who examined the coping methods in persistent auditory hallucinations, reported that shifting of attention through distraction was a very useful response. The patients in the present study, found relief not only by listening to music, but also through singing or playing musical instruments. All those who resorted to these methods of distraction, reported that the external stimulus should not be too loud. One patient noticed a striking reduction in voices when he

| Table 3 | Pattern Of Occurrence Of Coping Styles In Relation To Psychotic Symptoms |
|---------|-----------------------------|
|         | THOUGHT DISORDER | DELUSION | HALLUCINATIONS |
| 1. BEHAVIORAL STRATEGIES: |
| A. DISTRACTION | 25% | 55% | 72% |
| B. PHYSICAL ACTIVITY |
| INCREASE | 40% | 35% | 40% |
| DECREASE | 10% | 15% | 40% |
| C. INDULGENCE | 30% | 70% | 20% |
| D. TASK PERFORMANCE | 50% | 40% | 32% |
| 2. SOCIALIZATION |
| INCREASE | 50% | 40% | 60% |
| DECREASE | 50% | 60% | 50% |
| 3. COGNITIVE ACTIVITY | 25% | 20% | 35% |
| 4. MEDICAL CARE | 10% | 10% | 12% |
| 5. SYMPTOMATIC | 20% | 30% | 30% |
| 6. OTHERS | 20% | 30% | 30% |

| Table 4 | Pattern Of Occurrence Of Coping Styles In Relation To Other Symptoms |
|---------|-----------------------------|
|         | DEPRESSION | ANXIETY | MOTOR SYMPTOMS |
| 1. BEHAVIORAL STRATEGIES: |
| A. DISTRACTION | 18% | 14% | 16% |
| B. PHYSICAL ACTIVITY |
| INCREASE | 40% | 50% | 65% |
| DECREASE | 50% | 40% | 25% |
| C. INDULGENCE | 30% | 40% | 32% |
| D. TASK PERFORMANCE | 45% | 40% | 32% |
| 2. SOCIALIZATION |
| INCREASE | 65% | 60% | 60% |
| DECREASE | 10% | 5% | 12% |
| 3. COGNITIVE ACTIVITY | 20% | 30% | 30% |
| 4. MEDICAL CARE | 25% | 28% | 40% |
| 5. SYMPTOMATIC | 20% | 30% | 30% |
| 6. OTHERS | 20% | 30% | 30% |
was using a Walkman! Many female patients found some relief by covering their ears with the saree or plugging their ears with a wad of cotton. Though the latter phenomenon has been reported in the literature (McGuffin, 1979), its neurophysiological determinants still remain unclear. The common method adopted by these patients was one of increased socialization. The fact that hallucinating schizophrenics often seek out the company of others was first pointed out by Lewinsohn (1970). Subsequently, it has been observed that talking to others has a positive reducing effect on hallucinations in schizophrenia (Slade, 1974; Turner, 1977). It is probable that hallucinations bridge the gap between fantasy and reality and an increased contact with reality has a restitutive effect.

Another coping mechanism employed by patients with psychotic symptoms was one of indulgence. It was coffee drinking usually, and smoking in the males. None of them resorted to consuming alcohol to reduce their symptoms. Increased coffee consumption in schizophrenics has been observed for long in psychiatric practice. This coping mechanism in particular emphasizes that useful insights very often emerge from day to day clinical observations. It is now known that persistent coffee consumption increases the neuroleptic dosage requirements in schizophrenics. In contrast to the profile of coping exhibited in relation to psychotic symptoms, those with non-psychotic symptoms resorted to more direct help from outside. They engaged in symptomatic behavior, had a tendency to alter medications on their own and expected medical help to resolve their problem.

Patients often have an admixture of symptoms and as a consequence, resort to multiple methods to cope with them, either sequentially, or together. For instance, patients with distressing hallucinations who manifest depression in addition, employ not only distraction to handle their hallucinations, but also increase their physical activity or employ cognitive methods to combat their depressed affect.

In the present study, coping styles were examined principally in relation to clinical psychopathology. In addition, it is important to explore other determinants and associations of coping styles like literacy and socioeconomic status. The constraints of a small sample size limited such an exploration. These and other background variables need to be examined in detail, in later studies. During the study, the investigator was struck by the response of the patients. They were pleasantly surprised to share their own private ways of healing themselves, for the first time, with a clinician. Their only wonder was, as to why we delayed asking them about this, for so long!

It is to be remembered that schizophrenic patients suffer from tremendous stress and anxiety as they have to 'struggle negotiating between the world as others know it and the world of their own inner reality' (Hatfield, 1989). This negotiation becomes easier, if the clinician shows a sufficient degree of interest in the internal world of the patient to understand his own ways of responding to distressing experiences. In addition, exploration of the many creative ways in which schizophrenics cope with their distressing symptoms, would facilitate evolution of innovative methods of helping them. Such a process would also enrich the existing psycho-educational programs and in addition, would help further development of self-help groups for schizophrenics. Understandably, this area is still in its infancy. Further efforts in this area should aim at refining the methodology and particularly contribute to the development of reliable instruments for measuring coping techniques. While schizophrenia is universal in terms of its occurrence, the ways of coping with it have to be studied intensively within a particular cultural context. The most promising potential of this line of enquiry would be to evolve therapeutic interventions to increase the range and efficacy of coping techniques in schizophrenics. Thus, examination of coping strategies provides a very useful framework for future research in schizophrenia.

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