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Coping Styles among Patients with Depression

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ABSTRACT

Background: Several individuals employ various coping styles to adapt to their problems. These have significant implications for patients with depression. Coping styles are essential for depression management and recovery process. The patients may benefit from some of these coping mechanisms, which were inversely correlated with severity of depression. However, some of these coping mechanisms could be seen maladaptive and could lead to poor health outcomes. **Aim:** To assess coping styles among patients with depression. **Method:** A descriptive cross sectional study design was utilized with sixty patients with depression at Mansoura University Hospital Psychiatry Inpatient Department. Data was gathered using three instruments: socio-demographic characteristics and clinical data sheet; Coping Orientation to Problems Experienced Inventory–Brief (BRIEF–COPE) and Beck Depression Inventory (BDI). **Results:** Most of study's patients employed maladaptive coping styles with higher scores on self-blame; self-distraction; behavioral disengagement; venting and religion respectively. All these styles are dysfunctional coping except religion that is an adaptive coping style. Adaptive coping styles had a significant negative correlation with severity of depressive symptoms and maladaptive coping styles were significantly positively correlated with severity of depressive symptoms. **Conclusion:** Most of the study's patients adopted maladaptive coping styles. The correlations reflect that higher severity of depressive symptoms was linked with more maladaptive coping styles and less adaptive coping styles. **Recommendations:** This study suggested that patients with depression need interventions that improve adaptive coping styles and reduce maladaptive ones; and provide an educational program to depressed patients and their families on how to prevent and/or manage depression and stressful situations.

Keywords: *Coping Styles, Depression.*

Introduction:

Depression is considered a significant worldwide social and clinical issue that is significantly endangering an individual's quality of life. Depression is closely linked to psychological factors of the individual. Depression is frequently characterized by low mood, cognitive impairment, sleep disturbances, and other somatic symptoms. Cognitive decline and low mood are linked to impaired psychosocial functions which is the main performance of depression **(Zhang & Wu, 2021).** It is well recognized that Depression led to maladaptive coping **(Reich & Schatzberg, 2023).**

People with depression who use maladaptive coping styles may experience negative mental health consequences, such as internalization symptoms including anxiety, psychological discomfort, and worsening of depression **(Rodrigues et al., 2022).** Coping styles are the behavioral and cognitive actions that individuals used to use when they adjust to stress to alleviate its negative consequences. Coping styles are various; some of them include constructive elements, like asking for help and problem solving, while others include more destructive elements like venting and avoidance **(Huang, 2021)**.

Coping is also regarded one of the factors that lead to depression. Coping styles can be generally divided into three styles; emotion-focused coping that involves thoughts and actions intended to reduce emotional effects of stress; problem-focused coping, which involves actions to alter stressful situations brought on by interactions between individuals and environment; and dysfunctional coping which includes cognitions and behaviors meant to distract stress and attention from its source (**Ho, Chua, & Tay, 2022).** These styles may also be categorized as either adaptive (active coping, positive reframing, use of instrumental support, acceptance, use of emotional support, planning, humor, and religion) or maladaptive (denial, self-distraction, venting, substance use, behavioral disengagement and self-blame) **(Tan-Kristanto & Kiropoulos, 2015)**.

Research has shown that the use of dysfunctional coping styles, such as behavioral disengagement, self-blame and denial is closely related to the emergence of depressive symptoms. Consequently, people who use maladaptive coping styles are more probable to experience depression **(Fischer et al., 2021; Rao et al., 2022).** Ineffective coping mechanisms among depressed patients might lead to suicidality **(Rosenbaum et al., 2020).** Drug and alcohol misuse; as examples of negative coping styles have a detrimental effect on a person's general well-being because, in addition to the burden of depression, the individual experiences the negative effects of the maladaptive coping style (**Curran et al., 2021).**

Ineffective treatment of depression has negative effects on both the afflicted person and the medical system. It is noteworthy that untreated or inadequately managed depression can put a strain on a patient's coping mechanisms, leading to maladaptive coping and higher medical expenses. People who utilize maladaptive coping styles may face long term depression outcomes and may be associated with negative health effects **(Almeida, Monteiro, & Rodrigues, 2021).**

2.1 Aim of the Study

The aim of this study is to assess coping styles among patients with depression.

3. Method

3.1 Design

Research design employed for conducting the study was descriptive cross-sectional one.

3.2 Setting

The study was implemented at Mansoura University Hospital psychiatric inpatient department.

3.3 Subjects

The study's subjects were 60 patients with depression who met the following standards: all diagnosed patients with depression based on their records, aged between 18 to lower than 60 years old, both gender, able to communicate and agreed to participate in the research.

3.4 Data Collection Tools

Data was gathered using three instruments, which are as follows:

Tool (1): Socio-demographic characteristics and clinical data sheet:

This tool is developed by the investigator after examining the most recent pertinent research.

- Socio-demographic data: age, sex, level of education, place of residence …etc.
- Clinical data: family history, previous admission, illness duration, treatment adherence …etc.

Tool II: Coping Orientation to Problems Experienced Inventory–Brief (BRIEF–COPE):

Carver (1997) developed Coping Orientation to Problems Experienced Inventory–Brief (BRIEF–COPE). It is employed to evaluate various coping thoughts and behaviors an individual can adopt in a reaction to circumstance. It included 28 items (14 subscales) 2 items for each subscale scored on the participant's frequency of use from 1 ("I hadn't been doing this at all") to 4 ("I had been doing this a lot"). The 14 subscales grouped into three groups: 3 subscales (six items) were problem-focused (using instrumental support, active coping, and planning); 5 subscales (ten items) were emotion-focused (acceptance, humor, religion, using emotional support, and positive reframing); and 6 subscales (twelve items) were dysfunctional (behavioral disengagement, venting, self-blame, substance use, denial, and self-distraction) **(Bayuo & Agbenorku, 2018).**

The brief COPE scale revealed suitable construct validity and a high degree of reliability (Cronbach's alpha: 0.72 to 0.82) **(Wise, 2023).** Emotion-focused and problem-focused are categorized as adaptive coping styles. The dysfunctional coping is considered maladaptive coping styles. Both the adaptive coping strategies ($\alpha = 0.83$) and the maladaptive coping strategies ($\alpha = 0.75$) exhibit high reliability values **(Sehsah et al., 2021).** The Arabic version was translated and validated by **Baleegh & Selim, (2022).**

Tool III: Beck Depression Inventory (BDI-II):

Beck Depression Inventory (BDI-II) was developed by Beck et al., (1996). This instrument is intended to measure depressive symptoms severity. This tool includes 21 items, each item allows four options from no or mild symptoms to severe symptom. The BDI-II scoring system involves four categories: (0 - 13) no depression; (14 -19) mild depression; (20 – 28) moderate depression and (29 - 63) severe depression.

Ghareeb (2000) translated this tool into Arabic, and the analysis of its validity and reliability was conducted. It is a reliable and valid instrument to assess depression severity. Additionally, **Gliem & Gliem, (2003)** analyzed instrument's reliability with Cronbach's Alpha (0.947) that indicates excellent internal consistency and according to **Cuchna, Hoch, & Hoch, (2016)** the intra-rater reliability evaluation that equalized 1 indicates perfect agreement.

3.5 Ethical Considerations

Faculty of Nursing's Research Ethical Committee at Mansoura University's provided an ethical approval with no. 325. The study's conduct was officially approved by the head of Mansoura University Hospital's psychiatric department. The aim, risks, and procedure were explained to the patients. They were also made aware that taking part in the study is entirely voluntary. Those who agreed to participate provided informed consent. They obtained guarantees that the privacy of their personal information would be protected. They were also notified that they can leave the research at any time without any negative outcomes.

3.6 Statistical analysis

SPSS version 22 was used to analyze the study's results. Qualitative data was presented using percentages and numbers. For parametric data, "Mean ± SD (standard deviation)" was used to describe continuous variables.

4. Results

Table (1) shows that more than two thirds of (70%) the patients in the study were in the 30- to 45-year-old age range. Female made up over half of the patients in the study (53.3%). Concerning education level, over two thirds of the study's patients (63.3%) had Diplome (or completed secondary school) and high education. In terms of marital status, over half of the study's patients (53.3%) were either single or divorced. Regarding occupation, over two thirds (65%) of the study's patients were without work. Concerning residence place, more than half (53.3%) of the study's patients dwell in rural areas. In accordance with income sufficiency, over three quarters (76.7%) of the patients report that there is no sufficient income.

Table (2) shows that about half (43.3%) of the study's patients had positive family history of mental illness. As regards illness duration, half (50%) of the patients stated that they had been depressed for five to over 10 years. Over half (56.7%) of the study's patients were entered the hospital against their will, and over two thirds (65%) of the sample were entered the hospital two or three times. Most of the sample (93.3%) administered psychiatric medications previously. In terms of treatment adherence, (55%) of the patients didn't compline with treatment.

Table (3) shows that most of the study's patients suffer from moderate to severe depression (68.3% & 16.7% respectively).

Table (4) demonstrates the different coping styles adopted by depressed patients. The often-utilized coping styles were self-blame (6.17±1.22), self-distraction (6.05±1.34), behavioral disengagement (5.38±1.38), venting (5.7±0.92), Denial (5.31±1.18), substance use (5.28±1.43) and religion (4.31±1.62). With the exception of religion coping that is an adaptive/emotion focused coping style, all these coping styles are maladaptive coping. Humor (2.90±0.98) and use of emotional support (2.58±0.91) had the lowest scores.

Table (5). illustrates that adaptive coping styles were significantly positively correlated with treatment adherence and social interaction; and significantly negatively correlated with illness duration and number of hospitalizations. While maladaptive coping styles were significantly positively correlated with illness duration and number of hospitalizations; and were significantly negatively correlated with treatment adherence and social interaction.

Table (6) reveals that adaptive coping styles were significantly negatively correlated with severity of depressive symptoms ($r=-0.265$, $P=0.040$); and between maladaptive coping and severity of depressive symptoms there was a significant positive correlation ($r=-.317$, $P=.014$).

Table (1). Participant's Distribution Based on Their Socio-Demographic Characteristics:

Socio-demographic Characteristics	No (60)	(100) %
Age		
18 < 30 years	10	16.7%
30 < 45 years	42	70%
45 < to less than 60 years	8	13.3%
Mean ± SD = 36.87 ± 5.86 years		
Sex		
Males	28	46.7%
Females	32	53.3%
Educational level		
Illiterate	8	13.3%
Read and write	14	23.3%
Diploma or secondary school	27	45%
University	11	18.3%
Marital status		
Single	17	28.3%
Married	28	46.7%
Divorced/Separated	15	25%
Occupation		
Not working	14	23.3%
House wife	25	41.7%
Manual work	18	30 %
Professional work	3	5 %
Residence place		
Urban	28	46.7 %
Rural	32	53.3 %
Income		
Insufficient	46	76.7 %
Sufficient	14	23.3 %
total	**60**	**100 %**

Table (2). Patient's Distribution Based on Their Clinical Data:

clinical data	No (60)	(100) %
Family history of mental illness		
No	34	56.7%
Yes	26	43.3%
Duration of disease		
1 years < ٣ years	20	٣3.3%
٣ < 5 years	11	18.3%
٥ < 10 years	15	25%
10 +	14	23.3%
Mode of hospital admission		
Involuntary	34	56.7%
Voluntary	26	43.3%
Number of hospitalization		
No	7	11.7%
Once	14	23.3%
Twice	25	41.7%
Three times and more	14	23.3%
Previous psychiatric treatment		
No	4	6.7%
Yes	56	93.3%
Medication adherence		
No	33	55%
If Yes	27	45%
Yes regularly	9	15%
Yes interrupted	18	30%
total	60	100 %

Table (3). The studied Patients' Distribution Based on How Severe their Depression Symptoms were:

Severity of Depressive Symptoms	N (60)	100%
Mild Depression	9	15 %
Moderate depression	41	68.3 %
Severe Depression	10	16.7 %
total	60	100 %

Table (4). The Study Participants' Frequency Distribution Based on Their Coping Styles

Brief COPE Questionnaire subscales	Mean ± SD	Mini-Max
I. Adaptive coping	24.15 ±4.58	16-40
• ***Problem-focused:***	9.10± 1.99	6-16
Active coping	3.15±1.1	2-6
Use of instrumental support	2.83±1.01	2-6
Planning	٣.11±.099	2-5
• ***Emotion-focused:***	15.05±3.07	10-25
Use of emotional support	2.58±0.91	2-5
Positive reframing	2.91±0.98	2-5
Humor	2.23±0.62	2-4
Acceptance	2.90±1.08	2-6
Religion	4.31±1.62	2-8
II. Maladaptive/dysfunctional coping	34.17±4.52	19-42
Self-distraction	6.05±1.34	3-8
Denial	5.31±1.18	2 - 8
Substance use	٥.28±1.43	2-8
Behavioral disengagement	5.38±1.٣٨	2-8
Venting	5.7±0.٩٢	4-8
Self-blame	6.٢٥±1.٢٤	4-8

Table (5). Correlation between subjects' coping Styles and their socio-demographic characteristics & clinical data

Socio-demographic characteristics and clinical data	Coping Styles Test of Significance			
	Adaptive Coping		Maladaptive Coping	
	R	P	R	P
Age	0.230	0.077	0.011	0.932
Education	0.35	0.789	0.073	0.578
Duration of illness	-0.280*	0.030	0.410**	0.001
Treatment adherence	0.402**	0.001	-0.317*	0.015
Number of Hospitalization	-0.383**	0.003	0.35٠**	0.00٦
Social Interaction:				
Social Initiation	0.473**	0.000	-0.353**	0.0٠٦
Social Maintenance	0.325*	0.011	-0.2٧٣*	0.0٣٥

Table (6). Correlation Between Studied Subjects′ Coping Styles and Degree of Depressive Symptoms as Measured by Beck Depression Inventory (BDI-II)

Variables	Adaptive Coping		Maladaptive Coping	
	R	Sig.	R	Sig.
Severity of Depressive Symptoms	**-.265***	.040	**.٣١٧***	.0١٤

5. Discussion

Regarding socio-demographic characteristics, results of current study revealed that over two-thirds of the patients were in 30- and 45-years age range. This outcome could be due to that middle-age is associated with many challenges such as careers or schooling, family conflict, and marital relationships; these stressors can result in depression. This is consistent with findings of **Abdelmotaleb et al. (2020),** who revealed that over half of the patients in the study were in the 30- to 45-year-old age group. In contrast, **Iqbal et al. (2015)** showed that half of their study patients were younger than 22 years old.

Females made up over half of the study's patients. This may be due to hormonal changes that undergo throughout their lives. This finding is in concordance with **Li et al. (2022),** who found that females are more potential to experience depression than males. However, **El-Azzab, Taha, and Hussein (2020)** found that over half of the studied patients in their research were male.

Concerning educational level, over two thirds of study's participants had secondary school and high education. This can be explained by the fact that education is considered as a guarantee to maintain social status and good job opportunities. Additionally, education can enhance individuals' coping skills and understanding of mental health issues. But it doesn't always protect against depression; the demands and expectations of academic success might occasionally exacerbate mental health issues. This result was in line with **Osama, Sabra, & Barakat (2023)** who revealed that two thirds of the study's patients had secondary and higher education. However, **Zein-Elabdeen, Ibrahim, and Elbilsha (2024)** reported that most of the patients in the study were either read and write or illiterate.

Regarding marital status, over half of the study's patients were either divorced or single. It can be explained by those consequences of depression as social withdrawal, difficulty in maintaining relationships, communication problems and emotional instability, making it more difficult for couples to deal with mental health problems; which can eventually cause relationships to fail. Furthermore, the stigma associated with mental illness can result in people to put off or refuse getting married. In a similar way, **Zhao et al. (2022)** viewed that patients who have never been married or who have divorced are more potential than married to experience depression. This finding conflicted with research by **Abdelmotaleb et al. (2020)** and **Osama et al. (2023),** which found that over half of their study's patients were married.

In terms of occupation, almost two-thirds of the patients in the study were without work; this could be because of interpersonal skills deficiency and attention disturbance influence their ability to work and productivity as well as the stigma associated with the illness makes people refuse to hire someone with mental illness. This supported by the findings of **Amiri (2022),** who found that almost two-thirds of their sample did not have job. This result contradicted with **Zhou et al. (2020),** who reported that most of the study's patients are either a permanent or temporary employee.

Concerning income sufficiency, more than two thirds of the patients in the study reported insufficient income. This is related to current results that almost two-thirds of patients were without work, which had an impact on their income and make them unable to cover treatment or living expenses. This outcome is in concordance with **Rady et al. (2021),** who reported that most of patients in their study reported low income. In contrast to the current findings **Mumang et al. (2020)** reported that compared to low-income group, depression is more common in high-income group.

According to the study's findings on the clinical data of the participants, about half of patients in the current study had a family history of mental illness. The impact of genetic and inherited variables, which are risk factors for mental illness, may be connected to this. The current findings concur with those of the **Parami et al. (2021)** study.

With regard to illness duration, around half of the patients in the study stated that they had been depressed for five to over ten years. This could be as a result of the fact that over half of the study's patients did not compline to treatment, and roughly one-third of them took the medication sporadically, which made their symptoms worse and made their depression more chronic. This finding is in concordance with the study of **Hamzaa and Wahba (2022).**

Regarding mode of admission, over half of the study's patients were hospitalized against their will. As people may refuse to enter psychiatric hospital because of mental illness stigma and how society views them. This finding was consistent with that of **Nordenskjöld et al. (2018) and**

Correll et al. (2023) who found that roughly half of their sample was admitted against their will. But according to **Osama et al. (2023),** every patient in their study was admitted voluntarily.

According to the number of hospitalizations, over two-thirds of the patients under study were hospitalized twice or three times. This might be because over half of the study's patients didn't take their medication as prescribed. The finding is compatible with **Eissa et al. (2020),** who found that most of the patients in the study were admitted to mental hospitals three times. This outcome runs counter to the findings of **Husain et al. (2020),** who asserted that over two-thirds of the study's sample had never been admitted to a mental health facility.

The present finding viewed that the most of the study's patients had previously taken psychiatric medications, and over half of them did not take their psychiatric medication as instructed. This may be explained by the finding of our study including poor income. Furthermore, our culture's perceptions about psychiatric drugs, as depressed patients held a concept that antidepressant drug may cause dependence and addiction. The finding aligned with two other studies that revealed lower levels of antidepressant drugs adherence **(Abegaz et al., 2017; Marasine et al., 2020).**

As regard to coping styles, most of the patients in the study employed maladaptive styles; the elevated scores on self-blame and self-distraction. This can be explained by their feelings of hopelessness and negative thought patterns. Self-blame might result from internalizing their difficulties and thinking that they are blamed for their emotional state. This not only perpetuating their depression but also lowers their self-esteem. Self-distraction, on the other hand, provides a momentary relief from upsetting feelings, but it keep individuals from addressing the underlying issues that contribute to their depression. This is in line with **Suciu, Păunescu, & Micluţia (2021)** and **Li and Xu (2023)** showing that depressed people frequently use maladaptive coping styles as self-distraction and self-blame.

Among maladaptive coping styles, Substance use coping styles was minimal. The most likely explanation for that is, data represents the sample was mainly women and almost of the sample was low socioeconomic. Substance abuse is more common among men, as some people using substances or other drugs as self-medicating to feel better or get through their symptoms. This outcome was in line with **Saniah and Zainal (2010),** who demonstrated that substance use got the lowest score.

Regarding adaptive coping styles, religious coping styles is the most prevalent behavior, with lowest rating were on humor and use of emotional support; as considerable percentage of people use different religious practices for relief and comfort. This was in agreement with **Kasi et al., (2012).**

The study's findings showed that maladaptive coping was significantly negatively correlated with treatment adherence and significantly positively correlated with illness duration, while adaptive coping was significantly positively correlated with treatment adherence and negatively correlated with duration of illness. As patients who employ adaptive styles, as problem-solving, are more potential to compline with to treatment regimens, which in turn shorten illness duration and promote recovery. Otherwise, those with maladaptive coping styles, such as denial or avoidance, may struggle to adhere with prescribed treatments, leading to poor outcomes and may exacerbate their symptoms and hinder recovery. This is in concordance with **Jeżuchowska et al., (2024).**

According to the current findings, most of the study's patients experienced moderate to severe depressive symptoms that positively correlated with maladaptive coping styles and negatively correlated with adaptive coping styles. Because of ineffectively managing the causative factors of depression increases a person's risk and ineffectively managing depression exacerbates the symptoms and illness outcomes. In a similar way, **Eita & Aboshereda, (2021)** and **Almeida et al., (2021)** reported that individuals who use adaptive coping styles are less possible to experience depressive symptoms.

6. Conclusion

It could be deduced from the present study's results that most of the study's patients adopted maladaptive/dysfunctional coping styles. The correlations reflect that higher severity of depressive symptoms was linked with more maladaptive coping styles and less adaptive coping styles. Consequently, it could be essential to empower patients with adaptive coping styles and discourage negative ones to enhance their wellbeing and coping mechanisms.

7. Recommendations

The following suggestions are made in view of the current findings:

- Further researches regarding development of educational programs that aim to improve coping styles may help to decrease severity of symptoms and rate of relapse among depressed patients.
- Implementing training program to empower depressed patients to manage their problems and symptoms better and enhance their well-being.

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