The research of proactive coping behavior of patients with schizotypal personality disorder

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Abstract

Purpose: The purpose of the research was to study the patterns of using proactive coping and adherences to it's different types in patients with schizotypal personality disorder. Participants of the study (N=30) were 31 to 50 years old.

Methods: The Proactive Coping Inventory was used to assess the patients psychological status.

Results: According to the results of the study patients with schizotypal personality disorder show a rare use of proactive strategies for coping behavior. Patients with schizotypal personality disorder have defesit planning skills, they have not formed an idea of the progress of the selection is limited and effective ways of coping with stressful and problematic situations. They observed a rare use of instrumental and emotional forms of social support.

Discussion: The results of the study may be useful in developing educational systems of proactive coping behavior skills for patients with schizotypal personality disorder for their health and well-being.

Keywords: coping behavior, proactive coping, adaptation, schizotypal personality disorder.

Bibliographic reference


Introduction

Numerous results of foreign and domestic research indicates the high importance of coping in psychosocial adjustment and maladjustment of patients with chronic mental and physical illnesses, which leads to a detailed study of the problem of finding productive and non-productive components of coping behaviors that affect the health, quality of life [5, 6, 7, 9, 11, 18]. "Coping behavior — is a type of behavior focused on adaptation to circumstances, which presupposes the ability to use certain means to overcome emotional stress" [1]. The effectiveness of Coping Strategy depends on personality values and aims, type and phase of stressful event and specific results selected for estimation [8, 20]. It was established that use of one or another coping behavior strategy depends on personality [12] and environment type [24]. There is no universal theory of coping behavior. One of the most popular classifications named after Lazarus R.S., Folkman S. includes problem-focused and emotion-focused coping [19]. Problem-focused coping assumes that the efforts are made to improve the "person-environment" relation by changing cognitive evaluation of the situation. Emotional-oriented coping supposes thoughts and actions targeted to reduce physical and psychological stressful influence [19]. Lazarus R.S. mentions that although problem-focused and emotion-oriented types of coping are conceptually distinguishable they shouldn't be considered separately, for they are commonly used together [23]. Coping strategies are determined by cognitive evaluation of the stressor, particularly by rationality and flexibility of judgements and expectation of certain result [25]. Besides coping behavior strategies there
are coping recourses. These are personality traits, social or material recourses accessible for an individual to cope with inconveniences [17]. Most foreign and domestic researchers consider a constructive and non-constructive coping activities [2, 16]. Constructive (adaptive) coping — strategies aimed at resolving the problem situation. These include the following types of coping [13, 14]: active steps to eliminate the source of stress, search for social support, positive reappraisal of the situation, the recognition and acceptance of reality, planning of its activities in respect of the current the problem situation.

Sirota N.A., Yaltonskyi V.M. in the model of maladaptive behaviors are the following attributes [4]:

a) the prevalence of avoiding strategies on strategies to find social support and problem-solving, heavy use of defense mechanisms, unbalanced operation of cognitive, behavioral and emotional components of coping — mechanisms, lack of social skills problem-solving;

b) the prevalence of avoidance motivation on the motivation to succeed, lack of willingness to actively confront the environment, subordination to her; assessment of the problem as threatening, negative, defensive nature of behavioral activity, the low level of functional coping — behavior;

c) lack of focus coping — behavior to a stressor as the cause of the adverse effects and the impact of emotional stress as a result of the negative impact of the stressor to its reduction, poor awareness of the impact of the stress;

g) the low efficiency of the personality of environmental resources (low perception of social support, the prevalence of internal locus of control, etc.).

In this model, there is a direct indication of the close cooperation and continuous transition from the psychological defenses to coping behavior in the case of maladjustment, the mismatch of personal goals and objectives, low-level organization structure and resources of the self-construction. In persons suffering from the diseases, unproductive behavior strategies are considered, those that impair their condition and increase the symptoms [3].

Proactive coping is a special part of the rapidly developing psychological science that studies coping behavior. Proactive coping is a future-oriented (prospective) multidimensional way to overcome difficulties that unites quality of life management and self-control necessary for objective fulfillment [21]. Proactive coping behavior represents a method of estimating future goals and creating conditions for their successful achievement [26]. Aspinwall and Taylor assume that proactive coping is a process that provides preparation for potential future stressors and possibility to prevent them [10].

Proactive coping behavior differs from conventional coping perceptions in three ways [21]:

1. Conventional coping behavior types are reactive i.e. they deal with stressful events that have already occurred, their purpose is to indemnify the loss or to reduce the harm. Proactive coping is oriented in the future. It consists of the efforts directed on creation of general recourses that contribute to fulfilling the tasks and personal growth.

2. Reactive coping is considered as risk management and proactive coping is the aim of management. While using proactive coping an individual perceives an inconvenient situation as a challenge. One can see the risks, requirements and possibilities associated with one or another Coping Strategy or another for a problematic situation solving in future, but doesn't see it as threat, harm or loss. Proactive coping becomes means for managing the goal instead of managing the risk.
3. Motivation for proactive coping behavior in comparison to conventional coping is more positive, for the situation is perceived as challenge and stimulus, whereas reactive coping comes from the risk estimation, which means requirements are often estimated negatively as threats.

Proactive coping behavior is actively studied in the western countries [10, 15, 20, 21] but remains one of the least studied phenomena in the field of domestic medicine and psychology, in particular in patients with schizotypal personality disorder. The purpose of the research is to study the patterns of using proactive coping and adherence to its forms in patients with schizotypal personality disorder.

**Experimental group characteristic and methods**

Participants of the study (N=30) were 31 to 50 years old with a diagnosis according to ICD-10 F21 "schizotypal personality disorder". Patients were treated at a psychiatric hospital number 12. The sample of 30 patients were divided into 2 groups. The first group included 15 males, mean age — 40,7 ± 7,04. The comparison group consisted of 15 female, mean age — 40,4 ± 6,15.

The technique The Proactive Coping Inventory was used to assess the frequency and effectiveness of using Coping Strategies (Aspinwall, Schwarzer, Taubert, 1999, adaptation E. Starchenkova in V. M. Yaltonskyi modification, 2009).

**Statistical analysis of study results**

While processing the results of the study arithmetic mean values were calculated as well as the standard deviations and reliability of distinctions between groups. The last indicator was calculated with U-criterion Mann-Whitney test. Computer-based statistical program "Statistica 6.0" and MICROSOFT EXCEL 2003 were used for processing the results. Calculations were made with reliability p ≤ 0,05.

**Method description**

The Proactive Coping Inventory (PCI) was designed by Greenglass, Schwarzer, Aspinwall, Jakubiec, Fiksenbaum, Taubert in 1999. The Inventory evaluates the evidence of one or another coping strategy in individuals. The participant is given the instruction: "The following statements reflect your reactions to different reality situations. Please, leave a mark in the block that corresponds with your opinion". The Inventory consists of 55 statements and includes 6 subscales:

1. The proactive coping subscale
2. The reflective coping subscale
3. The strategic planning subscale
4. The preventive coping subscale
5. The instrumental support seeking subscale
6. The emotional support seeking subscale

Each statement suggests a certain answer. The answers are estimated in a 4-grade scale: "not at all true" — 1 point, "barely true" — 2 points, "somewhat true" — 3 points, "completely true" — 4 points. Tasks 2, 9, 14 are reversed items. The scales are interpreted according to expected value in the study sample.
Study results and discussion

The results of research strategies in groups 1 and 2 are shown in the chart number 1. In general, patients with schizotypal personality disorder were low values for all parameters of the test, indicating a lack of recourse to forms of proactive coping.

The Proactive Coping Subscale

The definition of objection process is significantly less developed (P = 0.01) in women, the mean score for this group was 31.9, ± 4.3 in comparison to men — 37 ± 2.8. I. e. female patients with schizotypal personality disorder less frequently use an ability that plays an important role in preparation and prevention of potential future stressors than male patients do.

The Reflective Coping Subscale

There were no reliable differences (P > 0.05) when comparing the males and females scale "reflexive coping". Received virtually identical values in groups. Average score for men was — 23.07 ± 2.15, for women — 23.1 ± 2.02. These findings point to a rare appeal to overcome the reflective coping strategy in patients with schizotypal personality disorder, which can lead to a less — generated views on progress, lack of planning skills, selection of more effective ways of coping with stressful situations and therefore a less successful and prolonged solving of inconvenient situations. So the above stated may be a risk of emotional tension and as a consequence of worsening mental state.
**The Strategic Planning subscale**

Significant differences when comparing the results between men and women has not been revealed (P > 0,05), the average for males was — 8,3 ± 0,9, for females — 8 ± 1,25, indicating a rare reference to the strategic planning. This may cause disorganization of their activity in solving problematic situations.

**The Preventive Coping Subscale**

Significantly (P=0,01) higher scores were obtained for men — 30,6 ± 2,03, compared to women — 26,1 ± 2,2. Considering the above mentioned it is possible to assume that male patients in comparison to female are more responsible in arranging their actions directed on maintaining their health and well-being such as saving money, taking medication on schedule and regular examinations in order to prevent mental recrudescence.

**The Instrumental Support Seeking Subscale**

When compared with Groups 1 and 2 were obtained almost identical values (P > 0,05): for men the average score was — 9,2 ± 1,4, for women — 9,13 ± 1,25. In accordance with the study results an assumption can be made: an underdeveloped instrumental support seeking strategy in patients with schizotypal personality disorder may narrow patient's horizons in problem-solving and stress-management and limit coping ability. Providing awareness of instrumental support seeking coping strategy for patients may create a perception of successful problem managing. Knowing that these recourses are available should level down the subjective threat caused by stressful situations.

**The Emotional Support Seeking Subscale**

Average figures for male were on a scale of — 7,8 ± 1,3, for female — 7,3 ± 1,1 (P > 0,05). The data obtained indicate the rare use of schizotypal personality disorder patients to the nearest environment for emotional support. They are not satisfied with the existing emotional connection, it is difficult to discover and trust their feelings and experiences of others that is likely due to the peculiarities of mental patients' organizations, so that they find it difficult to adequately assess and recognize other people's emotional expressions.

On the basis of obtained findings, the following conclusions:

1. In patients with schizotypal personality disorder, there is inadequate treatment to proactive strategies to coping behavior.

2. Patients with schizotypal personality disorder have defetsit planning skills, they have not formed an idea of the progress of the selection is limited and effective ways of coping with stressful and problematic situations.

3. At female patients with schizotypal personality disorder less frequently use an ability that plays an important role in preparation and prevention of potential future stressors than male patients do.

4. Underdeveloped instrumental support seeking strategy in patients with schizotypal personality disorder may cause these insufficiency in solving difficult and stressful situations and thus a higher risks for disadaptation reactions in inconvenient atmosphere.

5. Rare reference to the strategy of "seeking emotional support" sick schizotypal personality disorder may be associated with features of mental patients' organizations, so that they find it difficult to adequately assess and recognize other people's emotional expressions.
Summary:

The study enables us to expand the scientific understanding of the role of the repertoire of coping behavior in stress, the flow and treatment of mental disorders, especially in patients with schizotypal personality disorder; develop sound theoretical model for psychological treatment and psychotherapeutic intervention.

References:


