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Coping behavior in depressed patients: a longitudinal study

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Abstract

The relationship of coping behavior to outcome in depressed patients was examined. Subjects ($n=105$) with major depressive disorder ($n=85$), depressive disorder not otherwise specified ($n=7$) or major depressive disorder with axis I comorbidity ($n=13$) were followed for 6 months. Their coping behavior (i.e. rumination, active distraction, cognitive distraction and dangerous activities) was defined using the Comprehensive Assessment List for Affective Disorders. Based on their Hamilton Rating Scale for Depression (HRSD) scores at 6 months, the patients were categorized as having had a good or a poor outcome. Severity of depression and coping behavior were similar among the three diagnostic groups. At baseline assessment, coping behavior was not correlated with either HRSD score or age. However, males were significantly more likely to be engaged in dangerous activity as a coping behavior than females. Patients with a good outcome at 6 months were significantly more likely to use rumination as a coping behavior while patients with a poor outcome were significantly more likely to use dangerous activity. Multiple regression analysis confirmed this finding, indicating that rumination and dangerous activity were significant predictors of outcome at 6 months. Rumination might be associated with good outcomes in depressed patients while dangerous activity might be associated with poor outcomes.

Keywords: Depression; Coping behavior; Rumination; Dangerous activity; Predictor of outcome

1. Introduction

Coping style in dealing with stressors has been suggested to be a key variable in predicting treatment outcome in depressed patients (Weissman et al., 1978; Shea et al., 1990; Alnaes and Torgersen, 1997; Mazure et al., 2000). While the effects of various coping behaviors on depression have been reported, no clear picture has emerged. Seeking social support in depressed patients is associated with good outcome, while venting of emotion is linked to poor outcome (Vollrath et al., 1996). Hopelessness is correlated with severity of depression (Cannon et al., 1999), and thoughtfulness is a risk factor for exacerbation of depressive symptoms (Hirschfeld et al., 1989).

Sex differences in coping with mood disorders have also been reported. For example, men are more likely to engage in distracting behaviors that

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dampen their depressive mood, while women are more likely to amplify their mood by ruminating (Nolen-Hoeksema, 1987). Rumination appears to be a poor coping behavior, since it is predictive of depressive disorders, including new onsets of depressive episodes (Nolen-Hoeksema, 2000).

Other studies have evaluated the effects of coping behavior in patients with subclinical depression or dysphoria. Gender differences are also apparent in these subjects, with men employing more coping techniques than women. However, for both sexes, failure to express anger (keeping anger in) was correlated with dysphoria (McDaniel and Richards, 1990). Consistent with these data, studies in victims of a natural disaster (Nolen-Hoeksema and Morrow, 1991), in the bereaved soon after loss of their partners (Nolen-Hoeksema et al., 1997), and in college students (Nolen-Hoeksema et al., 1993) have shown that rumination correlates with persistence of a depressive state and delayed recovery.

Methods used to cope with dysphoric mood have been classified into the following four categories: rumination (absorbed in thought about the dysphoric mood itself, its cause and possible results), active distracting responses (e.g. sports to remove the dysphoric mood), cognitive distracting responses (e.g. talking and reading to remove the dysphoric mood) and dangerous activities (behavior to obtain dangerous stimulation) (Nolen-Hoeksema and Morrow, 1991).

To clarify the effects of coping behaviors on outcomes in depressed patients, we conducted a prospective study to examine the relationship between severity of depression, sex, age and coping behavior. We also identified differences in coping behavior among three subtype of depression and evaluated whether coping behavior would be a predictor of outcome.

2. Methods

2.1. Subjects

This was a joint study at 23 psychiatric medical institutions. Each hospital examined a representative subset of its first-visit patients according to the study protocol. Cases ($n=1903$) were consecutively selected and a semi-structured interview based on the Psychiatric Initial Screening for Affective Disorder (PISA) was performed (Kitamura, 1992).

Patients ($n=127$) with a broad spectrum of affective disorders, such as depressive symptoms (depressive mood or loss of volition) or manic symptoms (elevated mood, expansive mood and irritable mood) that had persisted for at least 4 days before the interview, were further evaluated using a structured interview based on the Comprehensive Assessment List for Affective Disorders (COALA; Furukawa et al., 1995). Patients were included in this study if they had a diagnosis according to DSM-III-R criteria of major depressive disorder, depressive disorder not otherwise specified or major depression and a concurrent axis I comorbidity. The exclusion criteria were as follows: administration of antidepressants or drugs for psychiatric disorders during the past 3 months; age less than 18 years; IQ below 70; and severe dementia, or hearing impairment that would make assessment difficult. Informed consent was obtained from all subjects.

The final study group consisted of 105 subjects (44 males, 61 females) with major depression (MD, $n=85$), depressive disorder not otherwise specified (D-NOS, $n=7$) and MD with axis I comorbidity ($n=13$). Comorbid conditions consisted of the following diagnoses: dysthymic disorder ($n=5$), anxiety disorders ($n=5$), alcohol dependence ($n=1$), anorexia nervosa ($n=1$) and sexual desire disorders ($n=1$). Twenty-two patients were excluded because they had other psychiatric diagnoses, such as anxiety disorder ($n=5$), schizophrenia ($n=2$), bipolar disorder ($n=9$) and dementia ($n=3$). Table 1 presents the demographic and clinical features of the subjects. Ninety-five patients completed the study, but one of them had an incomplete baseline evaluation. Even if monthly evaluations were not completed, we included patients for whom 6-month assessments on the Hamilton Rating Scale for Depression were available. The 10 patients that dropped out did so early in the study.