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Preventive coping among people with severe mental illness in daily life: Strategies used and associations with mood

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Abstract

Background—Preventive coping refers to efforts that are taken to reduce the likelihood of experiencing, or lessen the impact of, stress in the future.

Aims—The present investigation explored the use of preventive strategies in daily life among people with severe mental illness, and examined the association between types of preventive strategies used and end-of-day mood.

Methods—Participants included 27 adults diagnosed with severe mental illness who completed up to 20 daily interviews each (375 interviews were completed in total), which assessed preventive coping and end-of-day mood.

Results—The most commonly (across participants) and frequently (within participant days) endorsed preventive strategies were accessing social support and engaging in activities/hobbies. Participants tended to have less positive mood at end-of-day on days in which either no, or more passive, strategies were used.

Conclusions—Findings supported that preventive strategies are frequently used by members of this population, and that accessing social support and engaging in activities/hobbies are the most frequently used preventive strategies. Findings also suggest that the use of no or more passive preventive strategies was associated with less positive mood at end of day.

Keywords

Coping; severe mental illness; mood; daily interviewing

The literature on coping has evolved from an early exclusive focus on individuals' reactions to stressors (Lazarus & Folkman, 1984) to include strategies used in the absence of stressors (Aspinwall & Taylor, 1997; Schwarzer & Taubert, 2002), which are taken to reduce the likelihood of experiencing, or lessen the impact of, stress in the future. Initially referred to as 'proactive' coping, more recent conceptualizations suggest that the term 'preventive' might

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Conflicts of interest

The authors declare that there is no conflict of interest.

be more appropriate if referring to activities aimed at reducing the likelihood of experiencing stress, while the term 'proactive' might be more appropriately applied to instances where new challenges are sought out (Schwarzer & Taubert, 2002). Among people with severe mental illness, previous research and theoretical discussions have highlighted the potential importance of preventive coping for recovery and wellness (Roe, Yanos, & Lysaker, 2006), and have documented that the majority of persons in this population report using preventive strategies (Yanos, 2001). Commonly reported preventive strategies included accessing social support, attending professional services, following a routine for taking medication, exercising and attending to personal hygiene and sleep (Yanos, 2001). As only one study has been published on the topic, additional documentation of the types of strategies that people with severe mental illness use, including exploration of the relative effectiveness of different strategies, is needed. The present investigation explored the use of preventive strategies in daily life among people with severe mental illness, and examined the association between types of preventive strategies used and end-of-day mood.

Method

Participants

Participants included 27 adults (16 males and 11 females) recruited from two locations: a day treatment program (14 participants), and assertive community treatment team (13 participants). Participants had a mean age of 45.37 ($SD = 9.13$) years and 11.18 ($SD = 2.17$) mean years of education. Four (14.3%) participants identified themselves as European-American, 16 (59.3%) as African-American, 6 (22.2%) as Latino and 1 (3.7%) as Asian-American. Chart diagnoses were schizophrenia or schizoaffective disorder (16; 59.3%), bipolar disorder (3; 11.1%), major depression or mood disorder, not otherwise specified (NOS) (6; 22.2%) and posttraumatic stress disorder (2; 7.1%). While no information on the general functioning level of participants was available from charts, separate analyses from this study suggested that the great majority of participants were unemployed and spent a larger proportion of their time sleeping or involved in 'passive leisure' activities than typical US residents (Yanos & Robilotta, 2011). Institutional Review Board approval was received, and all participants provided informed consent.

Assessments

Participants completed structured 15- to 20-minute telephone interviews each day for 10 straight days on two different occasions (up to 20 days total per participant). Two periods of 10 straight days were selected as there was concern that participants would be overly fatigued by more than 10 days of consecutive interviews. The two periods were separated by a span of roughly 3 months. Daily interviews began on a Tuesday and ended on the following Thursday, and were made at a mutually agreed-upon time between 8:00 and 10:00 p.m. As there is no established manner for eliciting information on preventive coping among people with severe mental illness, we developed a question to elicit this information after consultation and an initial pilot interview phase: 'Please tell me about any things you did today as a way of "keeping steady" or preventing problems from starting'. Responses were not audio-recorded but were transcribed verbatim by the interviewer. Mood ratings were based on the degree of agreement on a 1–7 scale with seven adjectives derived from

previous research (Delespaul, 1995) (cheerful, lonely, guilty, satisfied, irritated, relaxed and sad) concerning how the participant was feeling at the moment. The validity of these specific mood adjectives has been supported in a number of studies (e.g. Myin-Germeys et al., 2003). Negative mood items were reverse-coded and combined into a single scale with the positive items; the overall scale was found to have good internal consistency ($\alpha = .80$).

Responses to the question on preventive coping were coded by a research assistant and the principal investigator using an open-coding grounded theory approach (Strauss & Corbin, 1990). First, responses were read and general categories of response topics were derived. Groups of text were placed within these categories, reread and then regrouped into subcategories. Inter-rater reliability was not assessed, but rather, the two raters discussed instances where there was disagreement in coding and attempted to reach a consensus. Six general categories of strategies were created: accessing social support (speaking to family members, peers or friends), activities/hobbies (engaging in exercise, artistic activity, listening to music, etc.), daily routine (maintaining personal hygiene and home cleaning), cognitive (e.g. thinking encouraging thoughts such as 'my road to wellness is staying busy and productive'), treatment (taking medication or attending professional programs) and religion or spirituality (prayer or reading spiritual texts). In instances where more than one strategy was reported, for the purpose of analyses, raters identified a single strategy as the primary strategy for the day.

Results

Table 1 reports findings on primary preventive coping strategies. Both the most commonly (across participants) and frequently (within participant days) endorsed preventive strategy was accessing social support, with 81% of the sample reporting the strategy at least once, and nearly 30% of the sample reporting it on most of their interview days. Activities/hobbies and cognitive strategies were also commonly used, while treatment was reported less frequently. The report of no strategy used within a day was common across participants, but did not represent a large proportion of the overall daily interviews. Religious/spiritual strategies were less commonly reported and were concentrated among a small group of participants. In addition to the primary strategies reported in Table 1, secondary strategies were reported on 43 participant days (11% of total days) and tertiary strategies were reported on an additional 7 days. The most common secondary strategies were accessing social support, cognitive strategies and activities/ hobbies.

Table 2 reports mean mood ratings for study days by type of preventive strategy reported for the day. There was a pattern for participants to report less positive mood on days in which they used no strategy, a strategy categorized as 'daily routine', or 'religion and spirituality'. To increase statistical power, we created a dichotomized version of the preventive coping variable, combining 'none' and 'daily routine' and contrasting it with all other categories. We considered this category to be consistent with Aspinwall and Taylor's (1997) concept of more 'passive' preventive coping, as these types of strategies show least evidence of the anticipation of the possibility of future stress. Using a one-way analysis of variance (ANOVA), we found a significant difference between days in which these categories of

preventive coping were used and all other days ($F = 5.89$, $df = 380, 1$, $p = .016$). This suggests that, on days in which either no, or what we consider to be more passive, strategies were used, participants tended to have less positive mood at end of day.

Discussion

Findings are consistent with those from the earlier empirical report (Yanos, 2001), but provide important new information about the use and impact of preventive strategies in the lives of people with severe mental illness. While the earlier study simply asked participants whether they ever used such strategies, findings from this study suggest that preventive strategies are frequently used by members of this population, with no preventive strategy being reported on only 9% of participant days. In addition, findings support that accessing social support and engaging in activities/hobbies are the most frequently reported and frequently used preventive strategies, while strategies such as religion and treatment are less frequently called upon. Findings also suggest that the use of no or more passive preventive strategies is associated with less positive mood at end of day. This suggests that, consistent with Aspinwall and Taylor's (1997) hypothesis that active preventive strategies may be more adaptive, using more active preventive strategies can potentially help persons with severe mental illness to have more positive moods in the days in which they are used. However, as it is possible that positive moods began earlier in the day and led participants to engage in more active preventive strategies, further research is needed to determine if there is a causal relationship between preventive coping and adaptive outcomes.

An important implication of this study is that people with severe mental illness can benefit from the use of preventive coping strategies that are more 'active' in nature. Clinical interventions which instruct individuals in the use of coping strategies already emphasize reactive coping, but could place a greater benefit on preventive coping. Notable limitations of this study include that the sample size was relatively small, and that analyses only examined the association between preventive coping and daily mood. A larger investigation that investigates the long-term effects of preventive coping on mood and functioning is therefore warranted.

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Table 1Preventive strategies reported in daily interviews (sample $n = 27$, days $n = 375$).

Category	n (%) of sample reporting	n (%) of days reported	n (%) of sample reporting for most days
Accessing social support	22 (81.5)	90 (24)	8 (29.6) ^a
Activities/hobbies	21 (77.7)	75 (20)	5 (18.5) ^a
Daily routine	13 (48.1)	31 (8.3)	4 (14.8) ^a
Cognitive	21 (77.7)	72 (19.2)	4 (14.8) ^a
Treatment	15 (55.5)	54 (14.4)	3 (11.1) ^a
Religion and spirituality	8 (29.6)	19 (5)	2 (7.4)
Nothing	17 (62.9)	34 (9)	3 (11.1)

^a Indicates two strategies were tied for being used on most days.

Table 2

Mean end-of-day mood by type of preventive coping strategy.

Primary preventive coping strategy used in day	Mood (1–7), (<i>M</i> ± <i>SD</i>)
Accessing social support	5.34 ± 1.25
Activities/hobbies	5.48 ± 1.15
Daily routine	4.97 ± 1.51
Cognitive	5.16 ± 1.27
Treatment	5.39 ± 1.04
Religion and spirituality	5.03 ± 1.34
Nothing	4.83 ± 1.44