Coping, Treatment Planning, and Treatment Outcome: Discussion

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The articles presented in this issue are discussed within the context of the general literature on coping and coping style. The focus of this special issue was to determine if these articles are both consistent with extant research and advance the field. We identify at least two general definitions of coping, as used in these articles. We refer to one definition as reflecting one’s “coping style.” This is largely a descriptive concept and closely related to one’s enduring behavioral traits. It is closely related to other personality characteristics such as introversion–extroversion, stability, etc. The other definition of “coping” in the literature is much more specific to stressful environments and to the changes noted in one’s behavior and cognitions during times of stress, than the first definition. We refer to this broad stress response as one’s “coping response.” Coping response, unlike coping style, includes both a cognitive and an affective component. We conclude that it may be advantageous to differentiate between these two broad definitions in future research. We also conclude that the articles in this issue provide information that advances the field’s understanding of coping styles and coping responses. © 2003 Wiley Periodicals, Inc. J Clin Psychol 59: 1151–1167, 2003.

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“Coping” is a complex concept. As one can observe in reading the articles in this special series, it is a concept that is used differently by different theorists, each of whom apply different terms to the descriptions of behavior. Some rely on behavioral observations while others emphasize aspects of thought and cognitive structure. Similarly, some theoretical definitions emphasize the style or pattern that characterizes coping while others emphasize responses to specific stressful circumstances, and still others focus primarily on the adequacy with which one copes. These distinctions all have some value, but developing a comprehensive view of coping has not yet been achieved. In this article, we explore some of the ways that coping responses and styles have been defined and seek some consolidated perspective of these processes. We explore two of the more comprehensive views: one that tends to place more emphasis on consistent patterns or styles and one that places relative weight on specific responses or skills. For convenience, we have chosen to discuss consistent patterns as reflective of “coping styles” while more specific responses are described here by the more general term “coping skills.”

For the task of assessing general coping skills, measures that assume broad definitions of coping adequacy are required (e.g., Lazarus & Folkman, 1984). These specific coping measures adopt a definition of coping that includes both behavioral aspects of coping style and cognitive and adaptive functions that allow one to determine the adequacy of coping efforts as well as the cognitive and emotional patterns associated with them. Thus, these instruments can be used as measures of processes associated with therapeutic change. They are useful in tracking treatment efforts to engender change in coping responses.

In contrast, measures of the more limited concept, coping style, are more heavily laden with behavioral descriptions and give relatively less weight to the adequacy of coping or to the emotional and cognitive correlates of coping. Measurement of these concepts is usually accomplished by the use of omnibus personality and psychopathology measures such as the Minnesota Multiphasic Personality Inventory (MMPI-2; Butcher, 1990), supplemented by reviewing the patients past and present reactions to problems. These methods are useful for predicting outcome and for the assignment of treatment, but are not sufficiently reactive to use as measures of treatment change.

The relative weight placed on behavioral and cognitive patterns in defining these concepts should not be taken to reinforce the view that they are mutually exclusive or exhaustive. The categories simply reflect a relative emphasis on one or the other of these elements. As we hope to illustrate, an adequate definition of coping invokes both coping styles and skills and their adequacy.

Coping Skills

While information about patients’ coping styles, such as introversion-extroversion, may help match them to specific effective treatment orientations, the adequacy and effectiveness of individuals’ cognitive coping skills are associated with entry into and participation in treatment; in turn, participation in treatment is associated with changes in coping responses, which are linked to ultimate treatment outcomes, such as improvement in depression and substance use.

Most of the research in this area has measured cognitive coping responses by using inventories that ask individuals to identify specific stressors and to describe how they appraised and managed these stressors. Many dimensions of coping have been measured in these studies; however, the underlying distinctions typically involve approach versus avoidance coping and/or cognitive versus behavioral coping. After reviewing some of
this literature, we comment on connections between the work on coping styles and coping skills and on some directions for future research.

**Coping Skill as a Predictor of Participation in Treatment**

Greater reliance on approach coping is associated with entry into professional treatment. For example, among individuals with alcohol use disorders who had never been in treatment, Timko, Moos, Finney, and Lesar (2000) found that those who relied more on approach coping, which encompasses the tendency to seek information, guidance, and support, were more likely to subsequently obtain treatment. Avoidance coping also has been associated with treatment entry (Avants, Warburton, & Margolin, 2000); however, this finding seems to be due to the association between avoidance coping, depression, and other aspects of dysfunction, which impel individuals to enter treatment.

Among individuals who enter treatment, those who rely more heavily on avoidance coping are at higher risk for early dropout. In this vein, Kohn, Mertens, and Weisner (2002) found that patients who rely more on emotional discharge coping have shorter episodes of substance abuse care. Similarly, Avants et al. (2000) noted that patients who relied more on emotional discharge, and more overall on avoidance coping, were more likely to drop out of treatment.

In another study, patients’ reliance on avoidance coping responses was used to predict participation in individualized relapse prevention and in standard outpatient aftercare. Individualized relapse prevention was oriented toward identifying high-risk situations and improving coping responses whereas standard aftercare was oriented toward addictions counseling and 12-step recovery practices. Patients who favored avoidance coping participated less in relapse prevention; however, such patients participated more in standard aftercare (McKay et al., 1998). This finding may be due to a matching process: Patients who rely on avoidance may find the emphasis on personal control and the directive coping-skills training involved in relapse prevention somewhat aversive whereas the emphasis on lack of personal control in 12-step recovery practices matches more closely with their preferred coping style.

**Participation in Treatment and Changes in Coping Skill**

One of the strongest foci in psychological treatment, especially cognitive-behavioral approaches, involves structured attempts to teach patients new coping skills. The theory underlying these approaches is that changes in coping skills are a key proximal outcome of treatment, and that, to the extent individuals employ new, more effective coping skills in their daily life, they will experience better functioning and treatment outcome. In one of the articles reprinted here, Franken, Hendriks, Haffmans, and Van der Meer (2001) showed that, among patients with substance use disorders who had three months of cognitive-behavioral treatment, socialization (seeking comfort and help, which are approach strategies) increased and palliative and passive reactions (distraction from problems and rumination, which are avoidance strategies) declined. The results of Franken et al. also potentially relate to the area of confounds in the study of coping. A brief empirical cautionary tale: There was a strong association found between coping skills and psychopathological symptoms (e.g., depression, anxiety, and substance abuse) looked at in the study. In addition, it was found that the sharp change from predetoxification to pretreatment was because of state factors related to psychoactive substance withdrawal. However, the results of the Franken et al. study tend to indicate that stress and state factors resulting from
anxiety and depression also can effect change in coping skills over the course of psycho-
therapeutic treatment. Several other studies have identified comparable changes in patients' coping skills during acute treatment and continuing care. For example, Chung et al. (2001) found that patients with alcohol use disorders showed an increase in behavioral approach coping and a decline in cognitive and behavioral avoidance coping between treatment intake and a 12-month follow-up. In another study of individuals with alcohol use disorders, those who obtained help increased their reliance on approach coping between baseline and the one- and three-year follow-ups (Timko et al., 2000). Time in treatment also makes a difference: Ouimette, Ahrens, Moos, and Finney (1998) noted that patients who received more counseling sessions tended to increase more in approach coping, indicating that longer treatment episodes may be associated with more improvement in coping skills.

Two studies have shown that patients with both substance use and anxiety disorders have more coping deficits and experience less change in coping skills with treatment. According to Franken et al. (2001), those who had anxiety disorders improved less on several indices of approach and avoidance coping compared to patients with substance use disorders who did not have anxiety disorders. Similarly, Ouimette, Ahrens, Moos, and Finney (1997) found that, compared with patients who had only substance use disorders, patients who had both substance use and posttraumatic stress disorders improved less in coping skills (less increase in approach coping and less decline in avoidance) during an acute treatment episode. Moreover, at treatment intake, these patients reported more reliance on cognitive avoidance and emotional discharge coping, indicating that they had more pronounced coping deficits.

Just as is true for patients with substance use disorders, patients with psychiatric disorders experience improvements in coping responses during treatment. For example, Milne, Ellis, and Shaw (1997) found that psychiatric patients in inpatient or residential care showed an increase in cognitive and behavioral approach coping and a decline in reliance on avoidance coping between treatment intake and a three-month follow-up. In another project in a community health center, clients with psychiatric disorders showed a rise in logical analysis and a decline in cognitive avoidance coping during the first three months of treatment (Milne, Eminson, Wood, Hamilton, & Giobson, 1995). Similar to Franken et al. (2001) and Ouimette, Ahrens, Moos, and Finney (1997), more anxious clients improved less than those with low anxiety.

Coping Skills and Treatment Response

There is a relatively robust connection between patients’ coping skills and their treatment outcome. This finding holds for patients with substance use disorders and patients with depressive disorders; it is somewhat less strong among patients with both psychiatric and substance use disorders. Connections also have been reliably drawn between coping, behavior, and moderators such as a sense of meaning in life. Edwards and Holden (2001) looked at measures designed to assay the presence of a psychological “existential vacuum” in subjects, and found that having a purpose in life, or a sense of personal coherence, tended to provide a buffer against the likelihood of suicide. Focus on existential issues, then, would seem to be a potentially fruitful area for therapeutic intervention. However, while for women the interaction between the sense of meaning in life (“sense of coherence”) and emotion-focused coping tended to predict both suicidal behavior and ideation, only suicidal ideation could be predicted in men—a somewhat unexpected find-
The relationship between coping skill and outcomes relative to physical and psychological health extends to a variety of subjects and conditions. In a study reproduced in this special series, Marlowe (1998, this issue) looked at the relationship between primary appraisals (i.e., “does the event matter to me?”), stressful events, and migraine headaches. Coping skills that were evident immediately preceding and just after migraine headaches were found to be significantly related to headache presence and intensity. The results such as the above are consistent with a relatively large body of data. For example, Tomaka, Blascovich, Kelsey, and Leitten (1996), in a study of coping and cardiac reactivity, found support for the view that avoidance coping (in both active and passive coping paradigms; that is, where a stressor is controllable or uncontrollable) may lead to negative health outcomes. An unresolved question is the degree of control that is possible over such phenomena as migraine headaches.

**Coping Skills and Treatment Outcome Among Patients With Substance Use Disorders**

In a study of patients with alcohol use disorders in residential treatment, an increase in behavioral approach coping predicted less severe alcohol problems at a 12-month follow-up. A decline in avoidance coping between baseline and follow-up was associated with better alcohol-related outcomes and better psychological and family functioning (Chung et al., 2001). According to Finney, Moos, and Humphreys (1999), patients who relied more on approach compared to avoidance coping at discharge from an episode of acute treatment were more likely to be free of substance use problems at a one-year follow-up. Similarly, Avants et al. (2000) found that patients with heroin use disorders who relied less on cognitive avoidance, resigned acceptance, and overall avoidance coping were more likely to achieve abstinence during treatment. An increase in approach coping and a decline in avoidance coping during treatment were associated with longer abstinence during treatment, which, in turn, was associated with a higher likelihood of abstinence at a six-month follow-up.

Substance use disorder patients’ coping skills also are related to their longer term outcomes. In a comparison of older patients and matched groups of young and middle-aged patients treated in residential alcoholism programs, Lemke and Moos (2002, 2003) found that the three groups showed comparable increases in approach coping during treatment. More important, patients who relied more on approach coping at discharge from the acute episode of treatment reported less alcohol consumption, fewer drinking problems, and less distress at both one- and five-year follow-ups.

As described earlier, compared to patients with only substance use disorders, patients with both substance use and posttraumatic stress or other anxiety disorders are more likely to rely on avoidance coping response. According to Ouimette and colleagues (Ouimette et al., 1997; Ouimette, Finney, & Moos, 1999), these comorbid patients had more substance use problems at a one-year follow-up after acute treatment, in part because they were more likely to rely on emotional discharge coping. At the one-year follow-up, patients with both substance use and posttraumatic stress used less problem-solving coping and more cognitive avoidance and emotional discharge coping than did patients with only substance use disorders. Patients with posttraumatic stress had poorer two-year outcomes, in part because they relied more heavily on avoidance coping strategies and less on approach coping at the one-year follow-up.
One reason that coping skills are related to longer term outcomes is that they help patients overcome relapse crises. In this respect, Moser and Annis (1996) found that the number of coping strategies patients with alcohol use disorders employed when confronted by high-risk, crisis situations was a strong predictor of continued abstinence. The use of approach strategies was more closely associated with abstinence than was the use of avoidance strategies. However, once relapse-to-drinking occurred, behavioral avoidance strategies were most effective in ending the relapse episode. More specifically, the best way to stop using alcohol was for the individual to physically leave the drinking situation, which was the most common behavioral avoidance strategy employed.

Coping Skills and Treatment Outcome Among Patients With Depressive Disorders

There is considerable evidence that depressed patients have deficits in both coping styles and coping skills. Two studies reprinted here identified relationships between a sociotropic coping style (as defined by dependency, concerns about disapproval and pleasing others, and separation) and depression (Alford & Gerrity, 1995; Şahin, Ulusoy, & Şahin, 1993). Results such as these add weight to the larger pattern found in the literature that, with respect to coping behaviors, depressed persons tend to rely less on problem solving and more on emotional discharge, wishful thinking, and avoidance than nondepressed persons (Cronkite & Moos, 1995).

Of course, one of the open questions about the concepts of sociotropy (and its contrasting concept, autonomy) is its specificity to depression. Şahin, Ulusoy, and Şahin (1993) certainly did find a significant and reliable relationship between traditionally depressogenic cognitive phenomena as automatic thoughts and dysfunctional attitudes while they found no such relationship with the concept of autonomy as they measured it. (In fact, the authors expressed significant concerns as to whether autonomy is even a concept properly conceptualized as being orthogonal to sociotropy, as it is traditionally conceptualized in previous literature.) However, Alford and Gerrity (1995) found that the relationship of sociotropy to mood disorder symptoms was not specific to anxiety. However, the role of sociotropy as a powerful predictor and risk factor for depression has achieved powerful support in the literature (Şahin et al., 1993); the question is how it fits with the larger issue of coping and psychological well being in general.

Reliance on the more general category of avoidance coping at entry to treatment for depression is a significant risk factor for nonremission. Krantz and Moos (1988) found that 41% of patients who relied heavily on avoidance coping prior to treatment were nonremitted at one year, compared to a 26% nonremission rate among patients who relied less on avoidance coping. In a ten-year follow-up of this sample of depressed patients, more reliance on avoidance coping was associated with higher odds of experiencing a course of partial remission or nonremission rather than a course of stable remission (Cronkite, Moos, Twohey, Cohen, & Swindle, 1998). Similarly, Parker, Brown, and Bliignault (1986) found that depressed patients who relied more on self-consolation and distraction at baseline showed poorer treatment outcome.

Some depressed individuals consume alcohol to manage the negative emotions aroused by stressful life circumstances. Holahan, Moos, Holahan, Cronkite, and Randall (2003) examined drinking to cope with distress and drinking behavior in a group of depressed patients assessed four times over a ten-year interval. The tendency to drink to cope with tensions, as assessed at baseline, was a prospective risk factor for more alcohol consump-
tion and drinking problems at one- and four-year follow-ups and for more alcohol consumption at the ten-year follow-up. Additional analyses identified a key mechanism in this process by showing that drinking to cope strengthened the link between depressive symptoms and drinking behavior. There was a stronger connection between depressive symptoms and both alcohol consumption and drinking problems among depressed patients who were more prone to drink to cope at baseline.

Coping Styles

Defining Coping Styles

While there is no common definition, most views of coping styles have certain things in common. For example, the term “coping styles” generally is applied to behaviors that are observed when a person is distressed. These behaviors also are thought to be manifest with some degree of regularity and predictability, and they are thought to distinguish one individual from another when distress is evoked. While most measures of coping style include some description of the nature of the subject’s cognition, they tend to give relative weight to interpersonal behaviors that are related to how adequately one’s coping efforts serve to help the person reduce levels of distress.

However varied, these definitions of coping style raise a number of thorny issues. First, it is difficult to establish that the observed coping style is the result of either stress in the environment or the distress experienced by the person in that environment. The relationship between a stressful environment and the distress experienced by a person is neither linear nor direct and, assumedly, is moderated by one’s coping style itself. Thus, in a given environment, some coping styles may attenuate one’s level of distress while other coping styles may not. Therefore, determining if a given behavior is an effort to cope with a given level of distress or with the presence of a given stressor is difficult to establish reliably. Even if one can establish that distress is present, the question still arises as to the point at which the observed behavior is an effort to cope with this distress—how much distress is needed before the associated behavior can legitimately be called a “coping style” rather than an attribute of personality. The problem is further complicated by the assumption that coping style itself differentially affects the level of distress that one might experience in a given environment.

Thus, identifying and coming to understand coping styles from within a definition that asserts that these concepts reflect common behaviors that occur during times of distress require one simultaneously to monitor and accurately assess both the environment, the internal state of the person, and the effect of coping itself. This is a nearly impossible task.

It is no wonder that, as one can observe in the articles in this section, coping style often is treated as if it were an aspect of one’s personality. While conceptually coping style is considered to be more transitory and more specific to a particular kind of environment than is personality, maintaining this distinction is difficult at best. Indeed, it is very difficult to conceptualize a person’s personality without invoking some description of the characteristic ways that he or she deals with stressful events, and there is a powerful draw to the idea that how a person deals with stressful events is closely associated with how he or she behaves generally. Thus, after reviewing the many perspectives on what constitutes “coping style” and distinguishes these styles from personality traits, Beutler and Clarkin (1990) concluded that making distinctions between behaviors that arise in stressful and nonstressful events are unnecessary. They concluded that coping
styles reflect both characteristic ways of responding to changes of any type in the environment and a reflection of the degree of stimulation and change that is needed to evoke a characteristic response of a given magnitude. Thus, they define coping style as a construct that is captured in different ways by measures of such traitlike qualities as impulsivity, level of affective control or restriction, gregariousness, stimulation seeking, social avoidance, self-reflection, social avoidance, and the balance of aggressiveness and passivity in social relationships. These behavioral qualities represent pervasive attributes of a person’s adaptive behavior, including many so-called personality characteristics.

The articles reprinted in this special section frequently present coping styles as reflections of constructs that are reminiscent of the what is frequently called “introversion” and “extraversion.” Following the description of Eysenck (1957), the quality that distinguishes internalizing traits and dispositions from other coping styles is that the forces of inhibition govern them. In contrast, the forces of expression and excitation govern “externalizers,” the contrasting coping style group. The cluster of behavioral traits comprising this latter group include impulsivity, gregariousness, expressiveness, a propensity to blame others, external attributions of cause, and needs for action. Eysenck (1967) proposed that conditioning differed in groups of introverts and extroverts, a view that can be extended to the more general concepts of externalizing and internalizing. Eysenck viewed these differences as reflecting inherent differences in the reticular activating system. Introverts were viewed as having a lower level of inherent arousability and were characterized by traits such as restraint, inhibition, and introversion. Extroverts, in contrast, were seen as being disposed to high arousal that was, in turn, reflected in traits such as impulsivity and other-directedness. Animal behaviorists have extended these qualities to a dimension of active to passive, or proactive versus reactive behaviors (Koolhaas et al., 1999), and others have incorporated similar concepts into the big five personality factors (Costa & McCrae, 1985).

In treatment planning literature, externalizers are defined as those who are impulsive, action or task oriented, gregarious, aggressive, hedonistic, stimulation seeking, and lacking in insight. In contrast, internalizers are described as shy, retiring, self-critical, withdrawn, constrained, overcontrolled, self-reflective, worried, and inhibited. While most people can be easily grouped into one of these behavioral groups, coping styles exist at various extremes between the two poles that define the prototypic categories.

Empirically, coping style may be considered to reflect the degree of overlap (or “common variance”) that exists among multiple ways of identifying these characteristic behaviors. This empirically based definition of coping style has the advantage of removing the requirement that coping styles only be observed during and following stressful situations. It thereby eliminates the need to judge the level of distress being experienced by a given person as well as the degree of stress present in the environment.

From this broadened perspective, “coping styles” can be considered to be relatively habitual and enduring patterns of behavior that characterize the individual when confronting situations that require some response. These situations may include but are not restricted to those that are novel, problematic, or intense. Thus, coping styles are aspects of personality and are better described as reflecting classes of behaviors than of being comprised by any specific and precise behaviors. That is, it is the cluster of behaviors that reflect general coping styles rather than the discrete behaviors, per se (e.g., Eysenck, 1990; Koolhaas et al., 1999; McGue & Bouchard, 1998). For example, a given person may be angry in one situation, excited in another, blaming in still another, and gregarious in social situations. While none of these qualities are required to define a given coping style, collectively they suggest the presence of an impulsive, externalizing coping style.
For the purpose of treatment planning, the Internalization Index formula that has been used by our own research group (e.g., Beutler, Engle, et al., 1991; Beutler & Mitchell, 1981; Beutler, Mohr, Grawe, et al., 1991), for example, is a modification of a ratio measure that was originally proposed by Welsh (1952) and is based on eight MMPI-2 subscale scores entered as standard T scores: The sum of four internalizing scales (Hs, D, Pt, Si) are subtracted from the sum of four externalizing scales (Hy, Pd, Pa, Ma) plus a constant (e.g., 50) to yield a continuous index of externalization.

An Internalization Index whose value is less than the constant indicates a tendency toward internalization, while one that is larger than the constant indicates that the predominant method or style of coping is through externalized behavior. Individuals of the latter type blame others for their feelings (Pa); they display active, dependent behaviors (Hy), high levels of unfocused energy (Ma), are impulsive, and frequently have social adjustment problems (Pd).

The content as well as the clinical scales of the MMPI have been found to be potentially useful for the purposes of yielding additional information on a particular patient’s coping styles. Endler, Parker, and Butcher (1993) found in their study of high-functioning normal adult males that a number of content scales seemed to be reliably associated with emotion-focused coping, including ones that indexed behaviors characterized by external aggressive behaviors, general problem areas, negative self-views, work interference, and negative treatment indicators.

Coping styles, like all aspects of personality, distinguish among people because they are both readily referenced to observable behaviors and are stable across situations and events. That is, they are enduring, and observable. Descriptively, the specific behaviors that form the clusters include both stable situational responses such as impulsivity, withdrawal, and other discrete behaviors and general emotional responses or “temperaments” that are manifest across situations. Of course, described in this way, as interrelated correlates, the concepts of coping styles, like other personality constructs, are descriptive of behavior and not explanatory. They do not explain why behavior occurs; they are useful only for identifying when a given type of behavior has occurred or is occurring.

Applying this latter definition to the task of defining and cataloging specific coping styles has resulted in a surprising degree of accord in the literature. For example, most factor analytic studies of behavior have found several discrete types of behavior that might be considered to be coping styles. Most frequent among these efforts is the presence of a dimension that varies from introverted/introspective behaviors to extroverted/extatensive behaviors. For example, Eysenck’s (1957) initial concepts of “introversion” and “extroversion” have been adopted by what is often referred to as the “big five” factor theory because of the consistency of these dimensions in research literature on personality constructs (Costa & McCrae, 1985). Beyond this single dimension, at least two other of the touted “big five” factors are conceptually related to coping. The other dimensions include orderliness and agreeableness. The two remaining dimensions, neuroticism and intelligence, may be aspects of the other dimension of coping that we have identified in this article—that of coping adequacy. The relationship of these latter factors to the narrower view of coping style is seen in several ways in research literature. Gray (1981), for example, found that neuroticism and extroversion-introversion were orthogonal dimensions, which if rotated 45 degrees, seemed to reflect measures of impulsivity (orderliness) and anxiety or distress, the latter of which may more reasonably be viewed as an index of the adequacy with which one copes rather than as a coping style, per se. Such an interpretation would bring four of the basic five personality concepts (all but intelligence) into line with the extended concepts of externalization (extroversion), internalization (orderliness), distress, and resistance (agreeableness) identified by Beutler and Clarkin (1990).
In their review of the role of coping style on treatment planning, Beutler, Harwood, Alimohamed, and Malik (2002) identified 19 studies that had explored the role of coping style in the prediction of treatment response. Fifteen of these 19 studies demonstrated that coping style differentially affected the relative value of treatments that were designed to address symptomatic presentations and to develop behavioral skills on one hand, and those that sought to improve one’s level of insight and personal awareness on the other. In all 15 studies, interpersonal and insight-oriented therapies were observed to be most effective among patients whose behavioral coping strategies emphasized internalizing patterns whereas symptom-focused and skill-building therapies were most effective among patients whose behavioral coping patterns emphasized externalizing styles.

For example, Beutler and Mitchell (1981) found an interaction effect between patient coping style and the effectiveness of experiential, behavioral, and analytic therapy. Internalization and externalization were assessed using the MMPI. Externalizing outpatients were found to achieve greatest benefit from experiential treatment compared to that achieved with insight-based treatment. Among internalizing patients, in contrast, insight-oriented treatment achieved better effects than behavior therapies. These general findings were further supported by evidence that experiential therapies induced negative effects among acutely distressed and disorganized psychiatric inpatients (Beutler, Frank, et al., 1984). Interestingly, the effectiveness of treating these latter patients once they were released and transferred to an outpatient facility, were differentially responsive to treatment as a function of their coping style. Internalizers were most responsive to insight-oriented, individual therapy while externalizers were more responsive to symptom-focused behavioral and cognitive therapies delivered in an individual format.

Further support for this latter internalization was obtained in several studies. Beutler, Engle, Mohr, and associates (1991) conducted a randomized clinical trial (RCT) on manualized treatments that were delivered to patients who varied in coping style. Cognitive therapy (CT; Yost et al., 1986) was symptom focused while Focused Experiential Psychotherapy (FEP; Daldrup et al., 1988) was designed to be insight focused. Internalizing patients responded best to insight-oriented therapies and externalizing patients responded better to cognitive-behavioral therapies.

A one-year analysis of maintenance effects found even stronger results (Beutler, Machado, Engle, & Mohr, 1993). Patients whose coping style matched the level of symptom versus insight focus not only maintained their gains but continued to improve while those who were mismatched did poorly and frequently relapsed. In still another extension of this, the cross-cultural transportability of the previous findings were demonstrated among a Swiss sample (Beutler, Mohr, Grawe, Engle, & MacDonald, 1991). This latter study indicated that internalizing patients who were exposed to insight-focused treatments had better outcomes than those who were exposed to behaviorally focused treatments. Likewise, externalizing patients had better outcomes when provided with behaviorally focused interventions than when exposed to insight-focused treatments.

Kadden et al. (1989) utilized the California Personality Inventory (CPI) in an examination of Aptitude Treatment Interaction (ATI) effects that involved 96 inpatients diagnosed with alcohol dependence or abuse. This investigation examined differential patient outcome relative to two contrasting treatments and the patient coping style dimension. That is, outcomes for patients with differing coping styles were compared among those assigned to two differing treatments. Patients in coping skills training (CS), a behaviorally oriented treatment, were contrasted with those assigned to interactional group ther-
apy (IG), an interpersonally oriented treatment. The CPI’s Socialization subscale (CPI-SO) was the indicator of externalizing/impulsive or internalizing/introspective coping styles among this patient population. The investigators found that patients’ levels of external coping were directly related to the degree of benefit in the behaviorally focused treatment while it was negatively associated with benefit in the interpersonal treatment.

Cooney et al. (1991), in a follow-up to the Kadden et al. (1989) study, reexamined the ATI effects of behavior therapy (CS) or interpersonal therapy (IG) and coping style at two-years posttreatment. Impulsive patients who received the behavioral treatment continued their improvement at a greater rate when compared to impulsive patients who received IG. Moreover, patients with introspective and socially sensitive styles continued to respond best to previous interpersonal therapy when compared to patients low on impulsivity who had received CS.

These results have been independently confirmed by three other studies. In a placebo-controlled RCT involving three active treatments (cognitive therapy, interpersonal therapy, and imipramine with clinical management) and 250 outpatients with major depressive disorder, Barber and Muenz (1996) found that cognitive therapy achieved better results among patients who employed direct behavioral avoidance (a coping strategy that is characteristic of externalizers) while patients who utilized obsessive coping (a strategy that is characteristic of internalizers) responded best to interpersonal therapy. Likewise, Longabaugh et al. (1994) found that externalizing, alcohol-abusing outpatients showed significantly more reductions of drinking after receiving cognitive-behavioral treatment than after relationship-enhancement therapy. Findings were reversed for alcoholic patients who were low on externalizing traits (i.e., patients who were characterized by internalization). These latter patients improved more with relationship enhancement therapy than with cognitive therapy.

Finally, in a study of 40 comorbid depressed and stimulant-abusing patients, Beutler et al. (2003) found that good matches between patient variables and type of treatment was a positive predictor of outcome. In this study, the collective contributions of patient matching dimensions (including coping style matched with therapy focus) were explored as a complete rendition of the Systematic Treatment Selection (STS) model (Beutler, Clarkin, & Bongar, 2000; Beutler & Harwood, 2000). Although not broken down by actual matching dimension due to small sample sizes, patient outcome improved dramatically as adherence to the guidelines proposed by the STS model increased. Based on initial analysis of the full therapy model using patient treatment and matching variables together, the prescriptive therapy model accounted for from 80 to 93% of the variance in six-month follow-up depression scores and from 57 to 79% of the six-month variance in drug use.

However, not all studies have found significant, confirmatory effects. For example, null effects of coping style were found in a randomized controlled study involving cognitive and systems therapy among problem drinking couples (Karno, Beutler, & Harwood, 2002). Similarly, Project Match (1997) also found few effects of fitting coping style to type of therapy among 952 outpatients and 774 inpatients diagnosed as alcohol dependent. The failure to find significant ATI effects for coping style among this large population of alcoholic patients, as of yet, is surprising given the consistency of significant findings from previous well-designed studies based on similar populations.

Linkages Between Coping Styles, Coping Skills, and Treatment

Several articles in this special issue focused on the linkages between coping styles, psychological distress, and specific diagnostic entities. By and large, these articles have
produced results that are consistent with extant literature. In our discussion, we have commented on how matching individuals’ coping styles, especially introversion-extroversion, with an appropriate treatment orientation can contribute to better treatment outcome and on how treatment is associated with changes in coping skills, which are linked to better ultimate outcomes. This overview raises several important issues for future research.

First, although there is overlap, most researchers have focused primarily either on coping styles or coping responses; however, there are important connections between conceptually common dimensions in these two domains.

Vollrath, Alnaes, and Torgersen (1996) conducted an observational study whereby they followed 155 psychiatric inpatients for a lengthy six and seven years after their initial enrollment in the study. In this case, coping styles were assessed with the COPE, a 60-item self-report inventory, as well as DSM diagnoses. The authors found that, collectively, coping style accounted for up to 16% of the unexplained variance in psychiatric and problematic substance use found in their sample. However, while the more general proposition of coping style being a significant prospective predictor of symptom change was supported in this case, there were some inconsistencies in the results—namely, that negative and positive forms of coping appeared to effect subjects differentially, with active coping being beneficial for patients with thought disorder, somatoform disorder, and anxiety disorder, but not for depression. The exception of depression from the list of other significant results is somewhat at odds with the literature.

We note that there is a growing body of research being conducted that concerns the relationship of overtly psychodynamic concepts such as repression and dissociation with the concept of coping. Wolfradt and Engelmann (1999) looked at these mechanisms in relation to a standard coping-response measure in their study of 200 adults (drawn from equal parts clinical and nonclinical populations) and found a significant interaction between psychopathology and the use of drugs, isolation, and daydreaming; the latter three of which are the kind of emotion-focused, internalizing behaviors commonly associated with psychopathology. In addition, the authors found some fascinating connections between the content of daydreams and coping behaviors: For example, the authors found a significant correlation between the content of subjects’ daydreams and their assessed coping behaviors.

This brings up the yet-unsolved quandary in psychoanalytical thinking related to the subject of dissociation: As a defense mechanism it is unconscious whereas coping is conscious? Basically, are dissociation and/or fantasy more similar to active or passive coping? Greenwald and Harder (1997) found strong associations between certain kinds of internalizing coping behaviors, psychopathology, and the content of certain “sustaining fantasies” they assessed for in their subjects. The authors found a consistent relationship between emotion-focused coping behaviors that could be seen as somewhat avoidant such as the use of tranquilizers, daydreaming, isolation, and “not functioning.” The authors concluded that their findings were largely consistent with the findings of Endler and Parker (1990), which makes a link between subjective stress and the general quality of neuroticism. There were some fascinating connections found by the authors between the internalizing coping behaviors and depersonalization experiences, which supports the view of coping as a broad category which could potentially involve using any number of diverse cognitive mechanisms.

Haines and Williams (1997) noted that fewer coping resources and more avoidance coping were related to self-mutilation, but they did not examine the associations between coping resources and avoidance coping. In this regard, Chung and colleagues (2001) found that Type B alcoholic patients (i.e., those who are more impulsive and hyperactive
and more likely to have borderline, antisocial, narcissistic, and histrionic personality features) relied more on avoidance coping than did Type A patients; however, these two subtypes did not differ in the amount of improvement in coping with treatment.

One way to conceptualize this issue is to think about coping styles as determinants or predictors of coping responses. Following this logic, dimensions of personality or coping styles derived from the five-factor model, such as extroversion, agreeableness, and conscientiousness, are predictably related to approach and avoidance coping responses (McWilliams, Cox, & Ennis, 2003; O’Brien & DeLongis, 1996; Shewchuk, Elliott, MacNair-Semands, & Harkins, 1999). In addition, personality dispositions such as self-confidence and an easygoing manner have been associated with more reliance on both approach and avoidance coping responses (Holahan & Moos, 1987). Similarly, Friedman et al. (1992) found that cancer patients who were higher on dispositional optimism were more likely to utilize both approach and avoidance coping responses. Individuals who have more coping resources, such as those who are more self-confident and optimistic, may have a more varied coping repertoire.

Second, the often-replicated finding that coping styles are associated with psychological distress and social inhibition (Alford & Gerrity, 1995; Edwards & Holden, 2001; Endler, Parker, & Butcher, 1993; Şahin, Ulusoy, & Şahin, 1993) raises questions about the reasons for these relationships. An important issue for future research is to examine the extent to which specific coping responses, such as wishful thinking or emotional discharge, mediate or moderate the relationship between coping styles and psychological distress.

A third issue is how much the match between coping style and treatment orientation is a function of common factors in treatment, such as the development of a working alliance, the emphasis on autonomy or self-understanding, and the amount of structure. As noted earlier, patients who favor avoidance coping may do better in treatments that play down personal control and responsibility, such as 12-step facilitation, whereas patients who favor approach coping may do better in treatments that emphasize taking control of situations, such as coping skills training. In this vein, Moggi, Ouimette, Finney, and Moos (1999) found that relatively disturbed and dually diagnosed patients treated in programs high in support, practical orientation, and structure gained more in approach coping than did comparable patients in less supportive and structured programs.

Depressed patients who have high needs for affiliation and dependency (sociotropy) may engage in demand–withdraw interaction patterns (Lynch, Robins, & Morse, 2001) and thus find it more difficult to develop a satisfactory treatment alliance. In addition, depressed patients who rely more heavily on avoidance coping are less able to form a positive relationship with a therapist in short-term psychotherapy (Gaston, Marmar, Thompson, & Gallagher, 1988). These findings suggest that sociotropy and avoidance coping may be common risk factors that reduce the likelihood of forming a therapeutic relationship and continuing in treatment.

A related question involves the role of the therapist in this context and, specifically, whether more competent and well-trained counselors can facilitate improvements in their patients’ coping skills. To focus on this issue, Milne, Baker, Blackburn, James, and Reichelt (1999) evaluated a training program in cognitive therapy for mental health counselors, both with respect to the counselors’ competence and to whether their increased competence led to changes in patients’ coping responses. Counselors became more competent in cognitive therapy; moreover, their patients reported more reliance on positive appraisal and problem solving and less reliance on cognitive avoidance and emotional discharge.

Finally, information about coping styles and coping skills can help to test the adequacy of the theory underlying specific treatment orientations. For example, the theory
underlying cognitive-behavioral (CB) treatment assumes that it will lead to improvements in coping skills and, presumably, that such improvements will be more extensive among patients in CB treatment than among patients in a treatment that does not explicitly target improving coping skills.

To examine this theory of treatment, Finney, Noyes, Coutts, and Moos (1998) compared changes in patients’ coping responses in three types of treatment programs: CB, 12-step facilitation, and eclectic (a combination of CB and 12-step approaches). Patients in all three sets of programs increased their use of approach coping and decreased their use of avoidance coping between intake and discharge from the acute phase of treatment. In general, patients in the three sets of programs showed comparable changes in coping; however, unexpectedly, patients in 12-step programs increased more in problem-solving skills than did patients in CB programs. Accordingly, an improvement in coping skills may be a general outcome of treatments that emphasize broad personal change, such as 12-step approaches, as well as treatments that focus specifically on increasing coping skills, such as CB approaches.

References


