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Coping Strategies and Effectiveness Among Low-Income, Primary Care Patients With Anxiety Disorders.

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COPING STRATEGIES AND EFFECTIVENESS AMONG LOW-INCOME, PRIMARY CARE PATIENTS WITH ANXIETY DISORDERS

A Dissertation

Submitted to the Graduate Faculty of the Louisiana State University and Agricultural and Mechanical College in partial fulfillment of the requirements for the degree of Doctor of Philosophy in

The Department of Psychology

by

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ABSTRACT

This study examined the patterns and effectiveness of coping strategies utilized by individuals in a low-income, primary care environment. Documented relationships among coping strategies and the characteristics of this population suggest that the population should be marked by high levels of emotion-focused coping and low levels of problem-focused coping relative to the normal population. Descriptive statistics (N = 516) confirmed high levels of emotion-focused coping but failed to demonstrate low levels of problem-focused coping within the study sample. The influence of control (actual and perceived) on the patterns and effectiveness of coping strategies was also studied. Regression analyses (N = 516) indicated that, in the low-control environment of the study population, the use of problem-focused coping was positively associated with psychological distress. This finding supports the theory that problem-focused coping may be ineffective in environments that offer little opportunity for change and decision-making. In contrast, emotion-focused coping subscales revealed no consistent relationship between psychological distress and emotion-focused coping. This result suggests that the emotion-focused subscales may be sufficiently independent to resist any attempts at discovering meaningful commonalities among them with regard to their impact on psychological distress. Thus, while the global category of emotion-focused coping may provide a useful contrast to problem-focused coping in studying the implementation of coping strategies, this category may be less useful when examining strategy effectiveness. Finally, analysis of variance and appropriate post hoc procedures (N = 382) were utilized to examine differences among diagnostic categories on the set
of coping subscales. The perceptions of uncontrollability that characterize anxiety disorders were reflected in increased emotion-focused coping for individuals with these conditions. However, persons with anxiety disorders also reported increased levels of problem-focused coping relative to persons with no diagnosis. Furthermore, the strategies implemented were not useful in predicting membership in either the anxiety disorder or the depressive disorder categories. These findings raise important questions regarding the role of controllability perceptions in the implementation of coping strategies. In addition, the findings suggest that coping subscales may simply differentiate individuals with a diagnosis from individuals with no diagnosis rather than differentiating among specific diagnostic categories.
INTRODUCTION

The role of coping in adaptation to stress and the development of mental disorders was proposed many years ago (Cohen & Lazarus, 1979; Woodruff, Goodwin, & Guze, 1974). Since that time, research has continually demonstrated an association between deficient coping skills and psychological distress. Conversely, treatment strategies that target these deficiencies and teach coping skills to patients typically report significant improvements. As a result, basic stress adaptation theories maintain that psychological well-being is influenced by how an individual copes with stress in addition to the experience of stress itself (Folkman & Lazarus, 1988).

Over the years, researchers have made a concerted effort to achieve a better understanding of the nature of coping. Their work has yielded multiple definitions of the construct based on a variety of different conceptualizations. The most popular and widely used description of coping is based on the functional dimensions that underlie coping strategies. This description distinguishes between emotion-focused and problem-focused strategies (Lazarus & Folkman, 1984). Other descriptions identify coping strategies in terms of their form (e.g., behavioral or cognitive) or the responses they engender (e.g., engagement or disengagement). These distinctions continue to prove useful in theoretical discussions and empirical studies designed to explore patterns in coping skills and potential connections between those skills and psychological functioning (Whatley, Foreman, & Richards, 1998).

The classification methods, while informative, provide no information concerning why an individual chooses particular strategies or why particular strategies...
are successful in any given situation. Investigators have attempted to target these questions and to identify specific variables that may influence the selection and effectiveness of coping strategies. These researchers have routinely concluded that the choice and success of coping strategies is dependent on an interaction among multiple environmental and personal factors. Environmental variables may influence the selection and effectiveness of coping strategies via their impact on the development of certain coping skills or the availability of coping. Similarly, the personality and emotional characteristics of an individual have been linked to coping choices and outcomes (Cooper & Payne, 1991; Folkman & Lazarus, 1988).

Despite advancements in our knowledge regarding the complexity of coping skills, treatment packages for psychological disorders continue to incorporate nonspecific coping skills training components. This may be due, in part, to the paucity of research examining populations that possess critical attributes. For example, researchers have suggested that the generally reported superiority of problem-focused coping to emotion-focused coping may be limited to environments that offer many opportunities for initiating change, making decisions, and exerting control (Whatley, Foreman, & Richards, 1998). However, the hypothesis that low-control environments may produce opposite results has not been adequately researched. The present study proposes that the environment of low-income, primary care patients represents a low-control environment. While the lack of coping resources and the need for specialized coping skills among low-income populations are widely recognized, research has failed
to systematically investigate the pattern and effectiveness of coping strategies within this population (Stegelin & Frankel, 1993).

The literature has also failed to test the applicability of findings regarding relationships between personal characteristics and coping to specific populations. Personal attributes critical to the selection of coping strategies include perceptions of control and the presence of symptoms of psychopathology. Research has demonstrated that low levels of perceived control and the presence of anxiety symptoms are associated with high rates of emotion-focused coping and low levels of problem-focused coping (Cooper & Payne, 1991; Smari, Aranson, Hafsteinsson, & Ingimarsson, 1997). Research has also suggested that the condition of anxiety is marked by particular action tendencies and efforts to cope (Barlow, 1988). While these characteristics are common to individuals with an anxiety disorder diagnosis, the utility of coping processes for validating this, specific diagnostic category has not been extensively investigated. This concern is especially relevant to low-income, primary care individuals as this population is characterized by high prevalence rates of both anxiety disorders and psychopathology in general (Holzer et al., 1986; Jeffries et al., 1999; Perez-Stable, Miranda, Munoz, & Ying, 1990). Evidence of differential profiles of coping strategies and differential levels of effectiveness for those strategies within specific populations would suggest that anxiety management training programs be tailored for particular populations.
Coping

**Definition.** Coping is best understood in the context of the stress process. The stress process, according to Lazarus and Folkman (1984), is composed of three stages involving two main processes. These two processes, which mediate the relationship between an individual and their environment, are cognitive appraisal and coping. In the first stage of the stress process, primary appraisal, an individual determines the degree of threat, harm, or opportunity associated with a situation. A secondary appraisal process follows. In this second stage, capacities and resources are evaluated against the demands of the situation. Finally, in the coping phase of the stress process, an individual attempts to master, reduce, or manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person. These efforts may consist of either cognitive or behavioral strategies. Thus, coping is a multifaceted phenomenon involving a range of responses, not all of which are necessarily adaptive. The fact that this definition of coping makes no implication concerning the success of coping efforts is noteworthy. Although experimental animal studies and everyday usage of the term often equate coping with effective coping, definitions of the term must be independent of outcome for the purposes of research. While this broad definition of coping serves as an adequate starting point, it offers little information regarding the nature and organization of coping responses.

**Coping Styles vs. the Coping Process.** Research aimed at more thoroughly examining the nature of coping responses generally follows one of two approaches. The trait or dispositional approach attempts to identify the usual, or most likely,
responses of an individual. These styles of coping are described as trait-like combinations of cognitive and behavioral strategies that are implemented to combat stress somewhat independently of the nature of the situation. This method of assessment, however, has proven problematic as measures of such characteristics fail to have predictive value with respect to the actual coping processes (Cohen & Lazarus, 1973; Kaloupek, White, & Wong, 1984). Moreover, this approach tends to underestimate the complexity and variability of actual coping processes (Folkman & Lazarus, 1988).

The process-oriented approach focuses on an individual’s responses within the context of specific encounters and the changes in those responses as the encounter unfolds. The coping process is marked by dynamics and changes that are a function of appraisals and reappraisals of the shifting person-environment relationship. This approach rejects the notion that each individual possesses a fixed style of coping. Instead, the approach advocates the notion that a small number of functional dimensions exist that underlie the infinite number of potential coping options and strategies. The process-oriented approach has garnered wide acceptance among coping researchers and will serve as the theoretical position behind the present project.

The Focus of Coping: Problem-Focused and Emotion-Focused Coping. Defining the functional dimensions that underlie coping responses depends largely on the theoretical perspective in which coping is conceptualized and the context in which coping is examined. However, Lazarus and Folkman (1984) offer a distinction that they feel is of overriding importance and that has become the most popular and widely

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adopted description of the functional architecture of coping. These researchers distinguish between problem-focused coping and emotion-focused coping, a distinction based on the focus of coping responses. While other, more recent factor analytic studies have proposed slight modifications to this conceptualization, they remain consistent with the original formulation (Endler & Parker, 1990; Moos & Billings, 1990).

Problem-focused coping includes strategies that are directed at managing or altering the problem. Problem-focused strategies are similar to strategies used for problem-solving. These strategies are usually aimed at defining the problem, generating alternative solutions, weighing the costs and benefits of those alternatives, choosing from among the alternatives, and engaging in some action based on that choice. However, in addition to general problem-solving strategies, problem-focused coping may include strategies directed inward. Techniques designed to facilitate motivational or cognitive changes, the discovery of alternate channels of gratification, the development of new standards of behavior, or the adoption of new skills and procedures are not typical problem-solving strategies, but are clearly directed at assisting the person to manage or to solve a problem.

Emotion-focused coping, on the other hand, is directed at regulating the emotional response to the problem. These strategies may either increase or decrease the emotional response of an individual. Certain cognitive processes such as avoidance, minimization, distancing, selective attention, positive comparisons and positive reappraisal clearly act to lessen the emotional distress associated with particular
situations. Although perhaps counterintuitive, other cognitive, emotion-focused strategies may actually serve to increase emotional distress. For example, individuals may intentionally increase their emotional distress in order to mobilize themselves for action (i.e., "psych themselves up"). Others, motivated by a need to experience their stress acutely prior to achieving relief, engage in self-blame or additional forms of self-punishment (Lazarus & Folkman, 1984). Empirical evidence exists for these dimensions and, over the years, numerous researchers have continued to utilize the distinctions. The initial inventories designed to describe coping used both rational and empirical methods to classify items as either problem-focused or emotion-focused (Lazarus & Folkman, 1984). In addition, multiple factor analytic studies have yielded dimensions commonly labeled emotion-focused coping and problem-focused coping (Endler & Parker, 1990; Moos & Billings, 1990, Pearlin & Schooler, 1978). More recently, Lazarus and Folkman (1984) factor analyzed their Ways of Coping Questionnaire data and discovered 1 problem-focused scale, 6 emotion-focused scales, and 1 scale that represented a combination of both forms of coping. Although some have suggested that this distinction oversimplifies the coping process and have expressed concern regarding certain responses that appear to serve both functions, there is general agreement concerning the utility of this distinction as a first step (Cooper and Payne, 1994; Folkman & Lazarus, 1988; Vitaliano, Russo, Carr, Maiuro, & Becker, 1985). Whatley, Foreman, and Richards (1998) outline the continued application of the concepts and their usefulness in both theoretical expositions and empirical investigations.
The implementation of one form of coping does not preclude the employment of strategies from the other domain. In fact, the ubiquity of these dimensions is well-documented. Folkman and Lazarus (1980) collected data on methods of coping with stressful events for 100 middle-aged, community-residing adults. Each individual reported an average of 14 stressful events, which included both minor concerns and major life stressors. Findings indicated that both emotion-focused and problem-focused functions were utilized by virtually every person in virtually every stressful encounter. Which strategies were applied appeared to be determined by an interaction among situational and personal variables and preferences.

In general, problem-focused forms of coping are more likely to be utilized in situations where conditions are appraised as amenable to change. In contrast, emotion-focused strategies are more probable when harmful, threatening, or challenging environmental conditions are deemed to be unchangeable.

**The Response to Coping Strategies: Behavioral Engagement vs. Disengagement.** Cooper and Payne (1991) offer a categorization of coping based, in part, on the result of coping responses. These researchers distinguish strategies that lead to behavioral engagement from strategies that foster behavioral disengagement. For example, planful problem solving strategies or confrontive techniques tend to be associated with active, engagement responses. In contrast, strategies of distancing are associated with behavioral disengagement.

This distinction is not entirely new and appears to have historical roots in the approach-avoidance dichotomy of the early literature. Roth and Cohen (1986) point out
the extent to which these concepts underlie the dimensions of coping studied in stress reaction research. The distinction has been emphasized by other investigators, including Tobin, Holroyd, Reynolds, and Wigal (1989), who highlighted the dichotomy in factor-analyzed data using the Coping Strategies Inventory. Conceptualizations of coping continue to separate coping techniques on the basis of the responses they engender (Cooper & Payne, 1991). Again, the techniques chosen and their effectiveness are dependent on an interaction between environmental and personality factors.

**Coping Strategies and the Environmental Characteristics of Low-Income, Primary Care Populations**

One environment that may impact coping, but has been neglected in the literature, is the environment of low-income, primary care patients. This population consists of individuals with low levels of education and there is evidence to suggest that education level may be associated with an individual’s choice of coping strategies. It makes theoretical sense to suggest that both verbal and practical problem-solving abilities are developed through schooling and to argue that these skills will be deficient among individuals with low levels of education. There is some indirect evidence for a negative relationship between problem-solving ability and the use of emotion-focused coping. Moreover, both intelligence and level of education are negatively correlated with external locus of control (Lefcourt, 1976); external locus of control is positively associated with the use of emotion-focused coping (Anderson, 1977). In addition, high verbal and practical problem-solving abilities, developed through education, are likely to facilitate the appraisal process and the effective implementation of problem-focused coping.
coping strategies. The success of these processes, in turn, is likely to increase the future use of problem-focused coping strategies. Thus, lower levels of education and the resultant deficiencies in verbal and practical problem-solving skills among low-income populations are likely to be reflected in increased levels of emotion-focused coping and decreased levels of problem-focused coping.

In addition to low levels of education, the low-income, primary care population is characterized by high rates of unemployment, low rates of health insurance coverage, and severe financial problems. These defining features create a lack of available coping resources and constitute significant barriers to control over the most prevalent stressors (financial, medical/health, social/interpersonal) in their environment. A lack of resources and the presence of significant barriers to control have both been linked to increases in emotion-focused coping. The lack of available coping resources limits choices and necessitates the employment of pragmatic solutions (Stegelin & Frankel, 1993). Moreover, researchers have suggested that an unavailability of coping resources translates into a higher frequency of emotion-focused coping techniques (Folkman & Lazarus, 1980). The frequency of emotion-focused coping strategies is also heightened in conditions in which problems are difficult to control (Cooper & Payne, 1991). This latter characteristic of the low-income, primary care population has received much attention in the literature and warrants further discussion.

Environmental Control and Coping

The idea that emotion-focused coping is more common when situations are difficult to control is not new. Lazarus and Folkman (1984) discuss the role of control
in the appraisal and coping processes at length. More specifically, Folkman (1984) implicates situational control in the secondary appraisal process and generalized control beliefs in the primary appraisal process. Other researchers have examined coping strategies in situations of high and low control and concluded that high control situations are associated with the use of problem-focused coping while low-control situations are associated with the use of emotion-focused coping (Cooper & Payne, 1991; Goldberger & Breznitz, 1993; Lazarus, 1993; Whatley, Foreman, & Richards, 1998). Thus, environmental control appears to be strongly associated with the selection of coping strategies.

The degree to which environmental situations are amenable to change also appears to influence the effectiveness of particular coping processes. Problem-focused coping appears to work best in environments that are realistically conducive to change, whereas emotion-focused coping appears to be most effective in situations that are not realistically changeable. For example, Whatley, Foreman, and Richards (1998) discovered an inverse relationship between problem-focused coping and psychological distress among college students. In contrast, emotion-focused coping was significantly positively associated with ratings of psychological distress among these individuals. The researchers noted that a college campus affords students many opportunities to exert control over their environment and to initiate change. They cautioned that very different environments, marked by limited opportunities for change, might yield opposite results. Although this hypothesis has not been tested within environments
where opportunities for control are conspicuously absent (e.g., prisons and war zones), evidence does exist to support the theory.

Strentz and Auerbach (1988) exposed subjects to a simulated abduction and 4 days of captivity. They found that individuals who used emotion-focused coping techniques in this situation reported the lowest levels of anxiety, emotional distress, and behavioral disturbance during captivity. Collins, Baum, and Singer (1983) examined the effectiveness of different coping strategies following the accident at Three Mile Island, a chronic and unique stressor that offered little opportunity for control. The findings of this study demonstrated that emotional management was particularly effective at reducing the psychological and behavioral consequences of stress. Conversely, the use of problem-oriented modes of coping under those conditions was not very useful at reducing stress. Thus, the efficacy of emotion-focused processes in obviously low-control situations has been demonstrated.

The Low-Income, Primary Care Population as a Low-Control Environment

The environment of low-income, primary care patients represents another setting that offers little opportunity to effect change. Past research has revealed that this population is plagued by an unusually high number of stressors and that these stressors are particularly chronic and resistant to habituation (Scarinci, Ames, & Brantley, 1999). Financial and interpersonal issues dominate their lists of concerns. However, a high rate of unemployment, an absence of adequate financial resources, and a lack of education are common to this population. These circumstances reduce the likelihood that individuals in the population will be able to significantly decrease their...
stress by gaining additional money or by relocating to an environment that has less
noise, less crime, and less overcrowding. Moreover, the average number of chronic
illnesses among low-income, primary care patients exceeds the average of the general
population (U.S. Department of Health and Human Services, 1985). Numerous
barriers to health care (e.g., financial barriers, lack of transportation, poor access to
care, lack of health insurance, and lack of knowledge concerning medical conditions)
are prevalent within the population of low-income primary care patients. These barriers
to care preclude the achievement of optimal health care and increase the likelihood that
significant concerns regarding health and illness will persist. While the low-income,
primary care population is marked by chronic stressors that are not amenable to change,
the profile and relative effectiveness of coping strategies within their low-control
environment has yet to be empirically investigated.

Perceptions of Control and Coping

The relation of control to the coping process is not limited to the degree of
actual control available within an environment. Folkman (1984) noted the pertinence
of beliefs about personal control to stress and coping. In fact, several researchers have
argued that the negative effects produced by limited control depend more on the
attributions people make concerning the controllability of events than on the actual
controllability of events (Abramson, Seligman, & Teasdale, 1978). This idea is echoed
by those who emphasize the role of appraisal in adaptation to stress and the coping
process.
As mentioned earlier, past research has indicated that particular forms of coping may differ in their usefulness depending on the potential for actual control in the situation (Collins, Baum, & Singer, 1983; Kaloupek & Stoupakis, 1985). Similarly, research has suggested an association between perceived control and the use and effectiveness of coping techniques. Although some studies have found no relation between control beliefs and coping processes (Averill & Rosen, 1972; Folkman, Aldwin, & Lazarus, 1981), many others have reported associations between problem-focused coping and internality (the belief that events are controlled by one’s own behavior), between emotion-focused coping and externality (the belief that events are controlled by others or by luck), or both (Anderson, 1977; Silver & Auerbach, 1986; Silver, Auerbach, Vishniavsky, & Kaplowitz, 1986; Strickland, 1978).

Strentz and Auerbach (1988) obtained a measure of expectation for control from subjects prior to conditions of simulated captivity. This measure permitted an assessment of the relations among control beliefs, coping processes, and adaptation to stress. In the study, differences in locus of control significantly contributed to the selection of coping processes. Externals engaged in more emotion-focused coping than internals. Moreover, the implementation of emotion-focused coping by these individuals resulted in lower levels of anxiety, lower overall emotional distress, and lower levels of behavioral disturbance during captivity. In contrast, externals who used greater levels of problem-focused coping exhibited the poorest response of all subjects on all measures. Several other studies and reviews have reported differential rates of effectiveness for emotion-focused and problem-focused coping depending on the degree
to which a stressor is perceived as controllable (Forsythe & Compas, 1987; Roth & Cohen, 1986). Specifically, these works conclude that an individual who perceives a stressor as controllable may benefit most from the implementation of a problem-focused strategy; an individual who perceives a stressor as uncontrollable may benefit most from the implementation of an emotion-focused strategy.

**Anxiety and Perceptions of Control**

Perceptions of uncontrollability are thought to be a central component of the basic anxiety process. A core or fundamental process in all anxiety disorders has been labeled anxious apprehension and has been defined as a future-oriented mood state in which a person becomes ready or prepared to cope with upcoming negative events. The state of anxious apprehension is marked by high negative affect, chronic overarousal, attentional focus on threat-related stimuli, and a sense of uncontrollability. This sense of uncontrollability is commonly cited as a key feature of anxiety disorders. A related construct, external locus of control, has also been linked to anxiety symptomatology. The idea that events are controlled by outside forces has been associated with specific anxiety conditions, including Agoraphobia and phobic anxiety (Brodbeck & Michelson, 1987; Emmelkamp & Cohen-Kettenis, 1975). Moreover, Brantley, Mehan, Ames, and Jones (1999) found that individuals with Generalized Anxiety Disorder (GAD) tended to report a greater number of routine life events and to perceive those events as more stressful when compared to controls. These researchers suggested that individuals with GAD might experience their events as more stressful secondary to perceived limitations
in control. Thus, the prominence of uncontrollability perceptions in anxiety disorders is undisputed.

**Anxiety and Coping**

The relationship between anxiety symptoms and the coping process has been examined in numerous studies. Whatley, Foreman, and Richards (1998) studied university college students and found that elevations in anxiety symptoms were associated with a high frequency of emotion-focused coping. In the same study, a negative association between anxiety symptoms and problem-focused coping was revealed. Vitaliano, Maiuro, Russo, and Mitchell (1989) found that first year medical students’ ratings of distress were associated with increased use of emotion-focused coping and decreased use of problem-focused techniques. Specific psychiatric populations (groups with Panic Disorder, Major Depression, and comorbid Panic Disorder and Major Depression) have also demonstrated an inverse relationship between problem-focused coping and anxiety symptoms (Roy-Byrne et al., 1992). Feifel, Strack, and Nagy (1987) found that these different coping efforts were related to psychological adjustment in response to medical illnesses as well. Certain longitudinal studies have even posited a causal relationship between evasive, emotion-focused strategies (i.e., wishful thinking, fantasizing about escape) and an increase in anxiety symptoms (Vollrath & Angst, 1993).

Given the tendency of individuals with anxiety disorders to possess low levels of perceived control and the documented relationship between control perceptions and coping techniques, persons with anxiety disorders might be expected to demonstrate
high levels of emotion-focused coping and low levels of problem-focused coping.
While the research on coping and anxiety symptomatology is consistent with these
expectations, patterns of coping strategies within specific diagnostic categories have not
been extensively investigated. Preliminary studies have suggested unique coping
behaviors among individuals with Panic Disorder and Agoraphobia (Hoffart &
Martinsen, 1990; Roy-Byrne et al., 1992; Vitaliano, Katon, Russo, Maiuro, Anderson,
& Jones, 1987; Vollrath & Angst, 1993). However, these studies have been limited to a
specific anxiety disorder diagnosis or have compared different anxiety disorder
diagnoses to one another. More importantly, the studies often yielded no difference in
the coping patterns among separate anxiety disorder groups (Vollrath & Angst, 1993).
Research has neglected to investigate anxiety disorders as a group in order to explore
patterns that may underlie the basic processes of these conditions.

Differentiating Anxiety and Depression

There has been much debate regarding the extent to which anxiety conditions
may be differentiated from depression. Initial investigations of anxiety and depression
measured the constructs using self-report, rating scales designed to tap characteristic
features of each condition. Results only served to demonstrate the high correlations,
considerable shared variance, and poor discriminant validity of the rating scales. In
fact, the findings of these preliminary studies led some to suggest that the overlap
between anxiety and depression is so great that the entities should not be considered
distinct.
Despite evidence to suggest significant similarities between the affective states labeled "anxiety" and "depression", clinical experience suggests true differences between the conditions and pure cases of each affective state seem to exist. Tellegen (1985) sought to distinguish the states by focusing on self-report of affect and produced some promising results. The dimensions of positive and negative affect appeared to clearly differentiate anxiety from depression. In addition, following an extensive review of the literature and independently conducted field trials, recent revisions to the Diagnostic and Statistical Manual of Mental Disorders retained separate categories for disorders associated with each affective state. Research indicates that the resultant DSM criteria for anxious and depressive conditions are reliable.

Barlow (1988) believes that fundamental differences between anxiety and depression may also be discovered in action tendencies. Evidence from previous studies links specific action tendencies to specific emotions and indicates that the expression of action tendencies intensifies the specific emotion with which they are associated (Barlow, 1988; Izard, 1971; Fridlund, Hatfield, Cottam, & Fowler, 1986). While the state of anxiety is associated with activation, the state of depression is marked by inactivity and disengagement. Findings regarding such characteristic behavioral tendencies clearly suggest that anxious and depressed individuals should differ in their methods of coping with stress.

**Coping Differences Between Anxiety and Depressive Disorders: A Proposal**

Only a few studies have attempted to discern such differences in coping strategies between groups of individuals with DSM-diagnosed anxiety or depressive...
disorders. Vitaliano et al. (1990) showed that coping strategies could distinguish subgroups of panic disorder patients more reliably than symptom severity. In contrast, Roy-Byrne et al. (1992) examined individuals with Major Depression and/or Panic Disorder and concluded that differences in coping relate more to differences in personality or to cognitive factors than to differences in symptom types that determine an Axis I diagnosis. However, this latter study utilized a psychiatric population and noted the possible presence of a “ceiling effect” for changes in coping strategies. In other words, a threshold may exist that makes coping changes easier to detect in transitions from “normal” to “abnormal” states than in transitions from one “abnormal” state to another. Past research has neglected to investigate differential coping strategies among diagnostic groups in primary care populations. In addition, initial attempts to identify relationships between psychopathology and coping have focused on specific, individual diagnoses rather than targeting patterns among certain, more global, diagnostic classifications.

The tendency for anxiety to manifest as activation and for depression to manifest as deactivation suggests that individuals with anxiety disorders should attempt to implement more overall coping strategies. Moreover, this distinction suggests that the strategies employed by individuals with an anxiety disorder should engender behavioral activation responses. Finally, the perceived lack of control and the perceived lack of available resources that plague persons with anxiety dictate that they should engage in more emotion-focused coping strategies.
Summary: Research Questions and Rationale of the Present Study

The present study investigated the following research questions:

Question 1: What is the profile of coping strategies utilized by a population of low-income, primary care patients? Hypothesis 1: It was hypothesized that the low-income, primary care population would be marked by a greater use of emotion-focused coping and a lower rate of problem-focused coping as compared to the general population. Although extensive research has investigated individual differences and personality variables that may impact the strategies utilized, studies have neglected to systematically examine patterns of coping responses among specific populations.

The low education level of the low-income, primary care population hinders the development of skills associated with increased problem-focused coping. Low levels of education have also been linked to increases in emotion-focused coping. Moreover, high rates of unemployment, low rates of health insurance coverage, and severe financial problems create a lack of available coping resources and constitute significant barriers to control over the most prevalent stressors (financial, medical/health, social/interpersonal) in this environment. Cooper and Payne (1991) indicate that emotion-focused coping is more common when problems are seen as difficult to control or when the environment offers few, available coping resources. Thus, the relationships among coping strategies and characteristics that define the low-income, primary care population support the first hypothesis of the present study.

Question 2: Is the degree of experienced psychological distress associated with the use of problem-focused or emotion-focused coping in this population? Hypothesis
2: It was hypothesized that problem-focused coping would be positively associated with psychological distress (Hypothesis 2, Part 1) and that emotion-focused coping would be negatively associated with psychological distress (Hypothesis 2, Part 2).

The theory of coping advocated by Lazarus and Folkman (1984) proposes that problem-focused coping should be particularly effective in reducing distress when an environment affords many opportunities for change and decision-making. In contrast, emotion-focused coping should be positively associated with distress in such environments. Past research has consistently confirmed these relationships (Goldberger & Breznitz, 1993; Lazarus, 1993; Whatley, Foreman, & Richards, 1998).

Whatley, Foreman, and Richards (1998) caution that environments that provide few opportunities for control might yield the opposite results. Previous research has suggested that emotion-focused coping is, indeed, more effective in these environments (Collins, Baum, & Singer, 1983; Strentz & Auerbach, 1988). The population of low-income, primary care patients exists in a low-control environment. Studies have demonstrated that these individuals endure stressors that are particularly chronic and resistant to habituation (Scarinci, Ames, & Brantley, 1999). In addition, various circumstances (e.g., limited financial resources and education, significant barriers to optimal health care) preclude attempts to initiate change in this environment. Therefore, there is empirical support for the characterization of this environment as low-control and theoretical support for the proposed relationships among coping techniques and psychological distress in this population.
Questions 3A & 3B: The final questions of the present study concern the utility of coping processes for differentiating specific, diagnostic classifications of psychological disorders:

Question 3A: Do low-income, primary care patients who meet DSM-IV criteria for an anxiety disorder differ from normal controls with regard to patterns of problem-focused and emotion-focused coping strategies? Hypothesis 3A: It was hypothesized that individuals with an anxiety disorder would utilize fewer problem-focused and more emotion-focused coping strategies when compared to normal controls.

Theories of anxiety suggest that this condition is marked by a sense of uncontrollability (Rapee & Barlow, 1991). Individuals with low levels of perceived control tend to use more emotion-focused strategies and fewer problem-focused strategies (Lazarus & Folkman, 1984). In addition, researchers have suggested that people with anxiety may have particular coping defects. Specifically, for these individuals, emotional distress may not be channeled adaptively into problem-solving strategies. Instead, these people spend more time “handling” the distress rather than taking active steps to alter the circumstances that help to create and to maintain that distress (Roy-Byrne et al., 1992). Numerous studies have demonstrated that increased symptoms of anxiety are associated with an increase in the implementation of emotion-focused coping and a decrease in the implementation of problem-focused coping (Roy-Byrne et al., 1992; Vitaliano, Maiuro, Russo, & Mitchell, 1992; Whatley, Foreman, & Richards, 1998). Efforts to demonstrate consistent findings among specific diagnostic categories are more rare. There is evidence to suggest that depressives use less
problem-focused coping and more emotion-focused coping when compared to normal controls (Billings, Cronkite, & Moos, 1983). In contrast, the findings with regard to anxiety disorders are equivocal. Vollrath and Angst (1993) demonstrated that individuals with Panic Disorder use more emotion-focused strategies than normal controls. However, these researchers failed to find the same results with other anxiety disorders. Moreover, there is a lack of data examining the prevalence of problem-focused strategies among individuals diagnosed with an anxiety disorder.

Question 3B: Do low-income, primary care patients with anxiety disorders differ in the overall level and functional architecture of coping when compared to individuals with depressive disorders? Hypothesis 3B: It was hypothesized that persons with anxiety disorders would implement more overall strategies and more strategies of behavioral activation when compared to persons with depressive disorders.

Despite commonalities among anxiety and depression syndromes with regard to generally deficient coping skills and other characteristics, these affective states are clearly distinct. Fundamental differences between anxiety and depression may be found in action tendencies (Barlow, 1988). Anxiety suggests activation and subsequent efforts to cope with difficult situations. Depression is marked by behavioral deactivation, coupled with physiological changes that reduce an individual's capacity for coping efforts. This fundamental difference in action tendencies suggests that individuals with anxiety disorders ought to utilize more coping techniques and that those techniques ought to be more active and behavioral in nature when compared to those employed by depressed persons.

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The utility of these coping processes for differentiating groups of patients with discrete diagnoses has not been extensively investigated. One study examined anxiety and depressive disorders within a psychiatric population and concluded that diagnostic category was not an important predictor of coping processes (Roy-Byrne et al., 1992). However, the authors of the study acknowledged the limitations of using a psychiatric population, noting that coping changes may be more recognizable in transition from "normal" to "abnormal" states. They recommended evaluating the associations among psychiatric diagnoses and coping processes within non-psychiatric populations.

Epidemiological samples and samples drawn from primary care settings have, indeed, yielded different results. Vitaliano et al. (1987) illustrated differences in coping processes between subgroups of Panic Disorder patients. Vollrath and Angst (1993) studied the coping processes among young adults with Panic Disorder, with another anxiety disorder, and with no psychiatric diagnosis. The results supported the notion that the study of coping may be useful in validating diagnostic distinctions of psychiatric disorders. The present study represents the first attempt to determine whether differences exist between anxiety disorders and depressive disorders in the functional dimensions of coping strategies.
METHOD

Participants

Participants included approximately 400 adult patients from the Family Practice and Internal Medicine Clinics at Earl K. Long Medical Center. While the sample was restricted to individuals attending clinic, subjects were randomly selected from among the clinic attenders. Earl K. Long Medical Center is a public medical facility in Louisiana that serves a population that is primarily low socio-economic status (95.3%), African American (77.2%) and female (64.7%). The Family Practice and Internal Medicine Clinics are primary care clinics within the medical center that serve low-income patients. The U.S. Bureau of the Census classifies adults at or below 200% of the poverty line in the low-income bracket. In 1996, the poverty threshold was an annual income of $7,995 for one person in the household (U.S. Bureau of the Census, 1998). Therefore, individuals earning $15,990 or less qualify as low-income. The poverty threshold for families employs a formula that considers the total number of individuals in the family. For example, the poverty threshold for a family of three is set at $12,516. Accordingly, a family of three is considered low-income if their total annual income does not exceed $25,032.

Measures

Demographic Questionnaire. A 16-item questionnaire designed to gather information on various demographic factors was used. The form includes questions regarding age, gender, race, marital status, education level, occupation, income,
previous mental health contact, history of treatment for drug and/or alcohol abuse, and insurance coverage.

**Ways of Coping Questionnaire (WOC).** (Folkman & Lazarus, 1988). The Ways of Coping Questionnaire is a 66-item measure designed to assess the manner in which individuals cope with everyday situations. Participants are asked to indicate, on a 4 point Likert scale, the extent to which they utilized certain coping strategies in a stressful situation. The Likert scale ranges from 0 (does not apply or not used) to 3 (used a great deal).

The questionnaire contains a broad range of coping strategies that people use to manage internal and external demands in a stressful encounter. Folkman and Lazarus (1980) proposed that a distinction of overriding importance in the assessment of coping functions is the distinction between problem-focused coping and emotion-focused coping. The former refers to coping efforts directed at managing or altering the problem causing the distress. The latter denotes coping efforts directed at regulating the emotional response to the problem. The researchers noted that these major functions of coping had been mentioned by several researchers (Kahn, Wolfe, Quinn, Snoek, & Rosenthal, 1964; Mechanic, 1962; Murphy, 1974; Murphy & Moriarty, 1976) and were implicit in the models of numerous others (Mechanic, 1974; Pearlin, Menaghan, Lieberman, & Mullan, 1981; Pearlin & Schooler, 1978; White, 1974).

A factor analysis of the WOC scale revealed 8 coping subscales: confrontive coping (CC), distancing (D), self-controlling (SC), seeking social support (SS), accepting responsibility (AR), escape-avoidance (EA), planful problem solving (PP),
and positive reappraisal (PR) (Folkman & Lazarus, 1988). One of these subscales is representative of problem-focused coping (planful problem solving), 6 of the subscales are representative of emotion-focused coping strategies (distancing, self-controlling, accepting responsibility, escape-avoidance, confrontive coping, and positive reappraisal) and 1 subscale contains both problem-focused and emotion-focused items (seeking social support). The Ways of Coping Questionnaire also yields a total coping score, which is the sum of all 8 subscales. The present study examined these subscales independently and examined differences between the more global categories of problem-focused coping and emotion-focused coping. For this latter purpose, the 6 emotion-focused coping subscales were entered into analyses as a set.

The Ways of Coping Questionnaire has demonstrated adequate internal consistency. Alpha coefficients have ranged from .61 (distancing) to .79 (positive reappraisal). Evaluations of the stability of the factor structure suggest a good deal of convergence with respect to some, but not all, factors (Aldwin & Revenson, 1987; Vitaliano, Russo, Carr, Maiuro, & Becker, 1985). Traditional test-retest estimates are not applicable given the nature of coping as a process, which, by definition, changes. Folkman and Lazarus (1988) attest to the face validity and construct validity of the measure. The questionnaire has been widely used in a variety of studies examining the relationships among coping strategies and particular environmental and personal attributes, specific populations, and a variety of psychological symptoms (Aldwin & Revenson, 1987; Felton, Revenson, & Hinrichsen, 1984; Folkman, Lazarus, Gruen, & DeLongis, 1986; Kirmeyer & Diamond, 1985; McCrae, 1984; McCrae & Costa, 1986;
Nicholson & Long, 1990; Parkes, 1984; Parkes, 1986; Roy-Byrne et al., 1992; Vitaliano, Katon, Russo, Maiuro, Anderson, & Jones, 1987; Vitaliano et al., 1990; Vitaliano, Russo, Carr, Maiuro, & Becker, 1985; Vollrath & Angst, 1993). The Ways of Coping Questionnaire has been used without difficulty in other samples with age ranges (Roy-Byrne et al., 1992; Strentz & Auerbach, 1988) and educational levels (Horowitz, Boardman, & Redlener, 1994; Pusker & Lamb, 1999) consistent with those of the study sample.

Cooper and Payne (1991) provide the framework for characterizing coping strategies on the basis of the responses they engender. Strategies characterized by behavioral activation (e.g., planful problem solving, confrontive coping) can be distinguished from strategies that are associated with behavioral deactivation (e.g., distancing).

General Health Questionnaire (GHQ) (Goldberg & Hillier, 1979). The General Health Questionnaire is a 28-item, self-report instrument used as a screening measure of psychological distress. The measure was developed to identify psychiatric complaints in an adult medical population. Previous research findings dictate that a diagnostic interview is warranted in cases where a score of 5 or greater is achieved (Gage & Leidy, 1991; Von Korff et al., 1987). Goldberg and Hillier (1979) found sensitivity and specificity rates of 88% and 84.2%, respectively, for this cutoff score. Internal consistency estimates of the GHQ have ranged from .78 to .98 and test-retest estimates have varied between .51 and .90 (Vieweg & Hedlund, 1983).
Diagnostic Interview Schedule for the DSM-IV (DIS-IV) (Robins, Cottier, Bucholz, & Compton, 1995). The DIS-IV is a structured psychiatric interview developed to provide reliable and valid diagnoses based on the Diagnostic and Statistical Manual of Mental Disorders-IV (American Psychiatric Association, 1994). Although there is currently a lack of research using the DIS-IV, a number of studies have examined the reliability and validity of the original version of the DIS. Test-retest reliability for lifetime psychiatric diagnoses has ranged from .37 to .59. Evidence for the validity of the measure consists of high concordance (i.e., kappa coefficients from .47 to 1.00) between the diagnoses of psychiatrists and the diagnoses of lay interviewers (Helzer, Spitznagel, & McEvoy, 1987; Robins, Helzer, Croughan, & Ratcliff, 1981; Vandiver & Sher, 1991).

Procedure

This study was conducted as part of a larger, ongoing study of stress and psychopathology in medical utilization funded by the National Institute of Mental Health [NIMH] (1 R01 MH51194-01A1). A table of random numbers was used to select patients based on their order of appearance on the clinic schedule. These patients were approached in the clinic waiting rooms and asked to participate in the study. Potential participants were offered an explanation of the project and questions were answered. Individuals who agreed to participate signed an informed consent form indicating that they understood the procedures involved in the study and their rights and privileges as research participants. Participants then completed a battery of self-report inventories that included the Demographic Questionnaire, the General Health...
Questionnaire, and the Ways of Coping Questionnaire. The battery was completed in a private clinic room with minimal distractions. When a subject evidenced difficulty reading the material, the interviewer offered assistance with reading. Participants were compensated $35 for the completion of these forms. One year later, participants were interviewed (again, in a private clinic room) with the Diagnostic Interview Schedule for the DSM-IV in order to determine the presence of an anxiety or depressive disorder during the course of the year. Participants were compensated $50 for the completion of this interview and several, shorter inventories that were not utilized in the current study.
RESULTS

Demographic Data

A total of 573 participants were recruited for the study. Five hundred and sixteen of those participants provided consent and sufficient data to be considered in the analyses of coping strategies and level of psychological distress; a total of 382 participants provided sufficient data to be considered in the analyses of DSM diagnostic categories. The demographic characteristics of both samples were similar and were consistent with data from previous studies of public primary care patients in Louisiana and the United States (Carmack, Boudreaux, Scarinci, & Brantley, 1997; Von Korff et al., 1987). Those who failed to complete the DIS did not differ from individuals who completed the measure with regard to demographic characteristics. Descriptive statistics were used to generate a profile of the larger sample and the demographic characteristics of that sample appear in Table 1.

The participants were primarily female (80.0%) and African American (75.4%). The average age of subjects was 44.5 (SD = 14) years and the mean level of education was 11.2 (SD = 2.7) years. One hundred seventy-four (33.7%) individuals were married, 159 (30.8%) were single, 102 (19.8%) were divorced, 43 (8.3%) were widowed, and 36 (7.0%) were separated. The mean individual monthly income was $515.0 (SD = $454.2). The majority of subjects were uninsured (75.8%) and unemployed (57.4%).

<table>
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<th>Variable</th>
<th>M (SD)</th>
<th>Range</th>
<th>N (%)</th>
</tr>
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<tr>
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Table 1. Descriptive Features of the Sample (N = 516)
"(table cont.)"

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<th>Maximum</th>
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<td>(20)</td>
<td></td>
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<tr>
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<td>413</td>
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<tr>
<td>Caucasian</td>
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<td>(24.0)</td>
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<td>(33.7)</td>
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<tr>
<td>Separated</td>
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<td>(7.0)</td>
<td></td>
<td></td>
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<tr>
<td>Divorced</td>
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<td>391</td>
<td>(75.8)</td>
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<td>(.2)</td>
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<td>(40.2)</td>
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<tr>
<td>Unemployed</td>
<td>297</td>
<td>(57.4)</td>
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<tr>
<td>Data Missing</td>
<td>11</td>
<td>(2.1)</td>
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**Psychological Variables**

The average level of reported psychological distress as measured by the GHQ was 6.5 (SD = 6.3). This mean score is above the threshold designated as a cutoff for cases in which a diagnostic interview is warranted. The result is consistent with the high prevalence rates of psychopathology reported for this population. The sample that completed the DIS was examined to determine the distribution of subjects among the diagnostic classifications to be employed in additional analyses. This examination revealed that 29 (7.6%) individuals qualified for a depressive disorder diagnosis, 56
(14.7%) individuals qualified for an anxiety disorder diagnosis, 36 (9.4%) individuals qualified for both types of diagnosis, and 261 (68.3%) individuals qualified for neither diagnosis. All persons included in the aforementioned groups were free of comorbid Axis-I psychopathology.

Pattern of Coping Strategies

In order to address Hypothesis 1 regarding the pattern of coping strategies within the low-income, primary care population, descriptive statistics were computed for the study sample. The results of this analysis are presented in Table 2. The most frequently employed strategy was positive reappraisal (M = 10.1, SD = 5.3). In contrast, participants employed the strategy of accepting responsibility least often (M = 4.6, SD = 3.0). Problem-focused strategies ranked fifth out of eight in terms of frequency of utilization (M = 8.1, SD = 4.3).

<table>
<thead>
<tr>
<th>Strategy</th>
<th>N</th>
<th>Range</th>
<th>Mean (Norm. Sample)</th>
<th>Mean (Study Sample)</th>
<th>(SD)</th>
</tr>
</thead>
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<td>Accepting Responsibility</td>
<td>516</td>
<td>0-12</td>
<td>4.57</td>
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<td>(3.02)</td>
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<tr>
<td>Confrontive Coping</td>
<td>516</td>
<td>0-18</td>
<td>6.39</td>
<td>3.94</td>
<td>(3.97)</td>
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<tr>
<td>Seeking Social Support</td>
<td>516</td>
<td>0-18</td>
<td>7.37</td>
<td>5.40</td>
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<td>Distancing</td>
<td>516</td>
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<td>7.91</td>
<td>3.05</td>
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<td>Planful Problem Solving</td>
<td>516</td>
<td>0-18</td>
<td>8.09</td>
<td>7.25</td>
<td>(4.30)</td>
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<td>Escape and Avoidance</td>
<td>516</td>
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<td>8.29</td>
<td>3.18</td>
<td>(5.40)</td>
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<td>Self-Control</td>
<td>516</td>
<td>0-21</td>
<td>9.69</td>
<td>5.77</td>
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<td>Positive Reappraisal</td>
<td>516</td>
<td>0-28</td>
<td>10.06</td>
<td>3.48</td>
<td>(5.28)</td>
</tr>
</tbody>
</table>

The first hypothesis of the project was further evaluated by comparing the pattern of coping strategies in the study sample with the pattern observed in the normative sample investigated by Folkman and Lazarus (1988). The pattern obtained in the normative sample was markedly different from the pattern obtained in the study.
sample. While the normative sample also utilized accepting responsibility the least, this sample utilized planful problem solving more frequently than any other coping strategy. Positive reappraisal ranked fifth out of eight in terms of frequency of utilization.

**Coping Strategies: Study Sample vs. Normative Sample**

An additional comparison between the study and normative samples was achieved by performing independent samples t-tests to delineate any differences that might exist between the study and normative samples with regard to each coping subscale (Hypothesis 1). In only one case, planful problem solving, was there no significant difference between the means. The study population reported significantly greater use of all other coping strategies when compared to the normative sample.

**Relationships among Demographic Data and Psychological Constructs**

Bivariate correlations were computed for age, level of education, individual monthly income, GHQ scores, and the 8 different coping strategies in order to determine whether particular variables should be controlled in additional analyses. Age was significantly negatively associated with GHQ score ($r = -0.11, p < 0.05$) and the escape and avoidance coping strategy ($r = -0.12, p < 0.01$). Level of education was not associated with GHQ scores, but did demonstrate a significant negative association with the following 3 coping strategies: confrontive coping ($r = -0.09, p < 0.05$), distancing ($r = -0.16, p < 0.01$), and self-control ($r = -0.09, p < 0.05$). Individual monthly income was negatively associated with GHQ scores ($r = -0.13, p < 0.01$), but was not associated with any coping strategy. Chi-square analyses were conducted to assess for differences in gender, race, or marital status with regard to GHQ scores and coping strategies. For
these analyses, race was restricted to 2 categories (African American and Caucasian) in order to satisfy the assumptions of chi-square analyses and because other categories of race contained a negligible number of subjects. GHQ scores and WOC variables were unrelated to gender, race, and marital status.

A correlation matrix was constructed for the subscales of the WOC Questionnaire and is presented in Table 3. Substantial correlation exists among the WOC subscales. The correlations between the problem-focused subscale and each of the emotion-focused subscales range from .539 to .597. Because both problem-focused and emotion-focused subscales measure processes thought to be used together in normal coping, the relationship between the 2 was expected. Nonetheless, high interrater agreement concerning the focus of items and acceptable internal consistency scores for the different subscales have been demonstrated (Folkman & Lazarus, 1980). Moreover, there is enough variance not shared by the emotion-focused and problem-focused subscales and there are enough theoretical and rational reasons to support their independent use.

Table 3: Correlation Matrix for WOC Questionnaire Subscales

<table>
<thead>
<tr>
<th></th>
<th>AR</th>
<th>CC</th>
<th>D</th>
<th>EA</th>
<th>PP</th>
<th>PR</th>
<th>SC</th>
<th>SS</th>
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<td>AR</td>
<td>.554</td>
<td>.560</td>
<td>.625</td>
<td>.597</td>
<td>.593</td>
<td>.654</td>
<td>.460</td>
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<tr>
<td>CC</td>
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<td>.537</td>
<td>.553</td>
<td>.716</td>
<td>.595</td>
<td>.553</td>
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<tr>
<td>D</td>
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<td>.659</td>
<td>.662</td>
<td>.610</td>
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<tr>
<td>EA</td>
<td>.539</td>
<td>.486</td>
<td>.616</td>
<td>.596</td>
<td>.510</td>
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</table>
Differences in Demographic Data among Diagnostic Categories

Univariate analysis of variance procedures were conducted in order to uncover any differences among diagnostic groups with respect to demographic variables. These procedures revealed no significant differences among diagnostic groups (depressive, anxiety, both, none) in terms of age, level of education, or individual monthly income. Chi-square tests indicated that the groups did not differ in terms of gender, race, or marital status.

The Utility of Problem-Focused and Emotion-Focused Subscales for Predicting Psychological Distress

In order to address Hypothesis 2, regression analyses were used to determine whether problem-focused or emotion-focused subscales from the WOC Questionnaire would serve as predictors of psychological distress as measured by GHQ scores. For these analyses, GHQ scores were log-transformed in order to achieve a more normal distribution of scores. As noted earlier, significant relationships were discovered among age, individual monthly income, and GHQ scores. The same relationships were found using the transformed GHQ scores. Therefore, age and individual monthly income were entered as the first step in the regression analyses in order to statistically control for possible confounding effects of these variables.

In the first regression procedure (Hypothesis 2, Part 1), problem-focused coping was a significant predictor of psychological distress. After controlling for the effects of age and income, the planful problem solving subscale predicted level of psychological distress ($R^2$ Change = .03, $p < .01$). The obtained beta weight revealed that an increase in problem-focused coping was associated with an increase in GHQ score (Table 4). In
the second regression analysis (Hypothesis 2, Part 2), emotion-focused coping also proved to be a significant predictor of psychological distress. Age and individual monthly income were again entered as the first step in the regression. Next, the 6 emotion-focused subscales of the WOC Questionnaire were entered as a set. This set of subscales successfully predicted level of psychological distress ($R^2$ Change = .154, $p < .01$). However, an examination of the beta weights obtained in this analysis did not reveal a consistent pattern in the relationships between GHQ scores and each individual emotion-focused subscale (Table 4). While increased scores on most emotion-focused subscales (i.e., confrontive coping, accepting responsibility, distancing, self control, and escape and avoidance) were associated with increased GHQ scores, increased scores on 1 emotion-focused subscale (i.e., positive reappraisal) was associated with decreased GHQ scores. Moreover, the associations were significant for only 2 of the 6 emotion-focused subscales, namely positive reappraisal and escape and avoidance (Table 4).

<table>
<thead>
<tr>
<th>Variable</th>
<th>$R^2$ Change</th>
<th>$R^2$ Change</th>
<th>Sig. F Change</th>
<th>$t$</th>
<th>Beta</th>
<th>Sig.</th>
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<tr>
<td>Planful Problem Solving</td>
<td>.058</td>
<td>.030</td>
<td>.000</td>
<td>.174</td>
<td>4.03</td>
<td>.000</td>
</tr>
<tr>
<td>(Regression 2)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emotion-Focused Coping (Set)</td>
<td>.182</td>
<td>.154</td>
<td>.000</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Confrontive Coping</td>
<td>.052</td>
<td>.943</td>
<td>.346</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accepting Responsibility</td>
<td>.032</td>
<td>.528</td>
<td>.598</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Distancing</td>
<td>.051</td>
<td>.826</td>
<td>.409</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self-Control</td>
<td>.010</td>
<td>.143</td>
<td>.507</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Seeking Social Support</td>
<td>.088</td>
<td>1.47</td>
<td>.887</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Positive Reappraisal</td>
<td>-2.01</td>
<td>-3.61</td>
<td>.000</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Escape and Avoidance</td>
<td>.376</td>
<td>5.94</td>
<td>.000</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

After appropriately addressing Hypothesis 2, additional regression analyses were conducted in order to examine the individual purity of the problem-focused and...
emotion-focused coping subscales. Specifically, utility analyses were performed to
determine whether either the problem-focused method of coping or the emotion-
focused method of coping could predict level of psychological distress after the effects
of the other method had been appropriately controlled. In one regression analysis, the
first set of predictors consisted of age and individual monthly income. The second set
consisted of the 6 emotion-focused strategies. Finally, the planful problem solving
subsacle was entered. The problem-focused subscale failed to predict GHQ scores in
this analysis. In a similar regression analysis, the emotion-focused strategies were
entered as a third set of predictors, after age and income (set 1) and planful problem
solving (set 2) had been entered. The set of emotion-focused coping subscales
remained a predictor of psychological distress in this analysis.

Differences in Total Coping Efforts among Diagnostic Groups

A one-way analysis of variance was conducted to explore differences in overall
(total) coping efforts among the diagnostic groups (Hypothesis 3B). The overall F was
significant (F = 3.09, p < .05). However, post hoc analyses using the Tukey HSD
procedure failed to yield a significant difference between any two groups. The general
trend in the use of coping strategies was as follows: individuals with an anxiety disorder
utilized the most strategies, followed by individuals with a depressive disorder,
individuals with both diagnoses, and, lastly, individuals with no diagnosis. The only
group difference that approached statistical significance was the difference between the
anxiety disorder group and the no diagnosis group (p = .059).
Differences in Coping Techniques among Individuals with Selected DSM-IV Diagnoses

As a test of Hypothesis 3A, a MANCOVA was conducted to determine if there were differences among the diagnostic categories on the set of coping subscales. Since previous analyses showed age and education level to be significantly related to coping subscales, this procedure controlled for the potential effects of those variables. The MANCOVA was significant (F (24,1070) = 2.249, p < .001). Univariate follow-up tests revealed that 5 subscales from the WOC Questionnaire (confrontive coping, self-control, accepting responsibility, escape and avoidance, and planful problem solving) differed among the diagnostic category groups. Post hoc comparisons were made utilizing the Tukey procedure. Individuals with a depressive disorder diagnosis endorsed more confrontive (p < .05), accepting responsibility (p < .05), and escape and avoidance (p < .05) strategies than did individuals with no diagnosis. When compared to persons with no diagnosis, persons with an anxiety disorder diagnosis endorsed more planful problem solving (p < .05), self-control (p < .05), accepting responsibility (p < .05), and escape and avoidance (p < .05) strategies. Finally, participants with a diagnosis from both categories yielded higher scores than participants with no diagnosis on 2 scales, namely escape and avoidance (p < .05) and planful problem solving (p < .05). There were no differences among the depressive disorder, anxiety disorder, and comorbid disorder groups.

Coping Subscales as Predictors of Diagnostic Categories

As a test of Hypothesis 3B, a discriminant function analysis was performed in order to determine whether anxiety and depressive disorders differed in their functional
architecture of coping. More specifically, the analysis sought to determine whether coping strategies might prove useful in classifying individuals into diagnostic categories. The analysis produced 3 canonical variables. The first of these variables accounted for most of the dispersion (76.3%). The second and third variables accounted for an additional 15.8% and 7.9% of the spread, respectively. The escape and avoidance subscale had the largest correlation with the first canonical variable, followed by the planful problem solving and seeking social support subscales. The self control coping subscale correlated highest with the second canonical variable. Other subscales that correlated highest with the second canonical variable were the accepting responsibility, confrontive, and distancing subscales. Only the positive reappraisal subscale had its largest correlation with the third canonical variable.

Overall, 68.1% of the cases were correctly classified. While this result represents a significant improvement over the result that would have been obtained through random assignment (i.e., 25%), assignment based on group sizes could have correctly classified approximately 68% of cases. In other words, if all cases were assigned to the largest (no diagnosis) category, two-thirds of the individuals would be correctly classified. Thus, the discriminant function procedure indicated that the subscales do not assist in the classification process. Since the no diagnosis category had such a large sample size relative to the other groups, a second discriminant function procedure, which removed this category from the analysis, was performed. This procedure further explored the ability of WOC variables to discriminate among diagnostic groups. Again, the procedure performed poorly. The percentage of cases
correctly classified (50.4%) represented moderate improvement over the process of random assignment (33.3%), but only minimal improvement over classification based on group sizes (46.3%).
DISCUSSION

This study demonstrates that individuals from the low-income, primary care population endorse the utilization of a large number and a wide variety of coping strategies. Both emotion-focused and problem-focused techniques are implemented. This result mirrors the findings of Folkman and Lazarus (1980), who concluded that both problem-focused and emotion-focused strategies are utilized in coping with virtually any stressor. The mean value obtained for each subscale exceeded the value obtained from the normative sample on all subscales save planful problem solving. This pattern of responding is consistent with one hypothesis of the present investigation and suggests that the population studied is characterized by a tendency to make more attempts than normal populations at particular forms of coping. Specifically, this population is marked by a tendency to engage in more emotion-focused forms of coping than normal populations. There are several potential explanations for this pattern of coping. Low education levels have been indirectly linked to increases in emotion-focused coping (Cooper & Payne, 1991). Emotion-focused coping is also thought to increase when an environment offers few, available coping resources or when a problem is seen as difficult to control (Cooper & Payne, 1991; Goldberger & Breznitz, 1993; Whatley, Foreman, & Richards, 1998). High rates of unemployment, low rates of health insurance coverage, and severe financial problems create a lack of available coping resources and constitute significant barriers to control over the most prevalent stressors (financial, medical/health, social/interpersonal) in the study environment.
There are several other lines of research that support the notion that this population attempts particular coping strategies with greater frequency than the normal population. Past research has found that people draw on emotion-focused coping more heavily in health encounters than in other types of encounters (e.g., work encounters). Moreover, women tend to report more health encounters than men on measures of coping (Folkman & Lazarus, 1980). Given the prevalence of medical illness in this population, the likelihood is high that a large number of encounters reported are health-related. The fact that the population is predominately female further increases this likelihood. These facts form another possible explanation for the high level of reported emotion-focused coping strategies. Unfortunately, this study did not examine the particular types of encounters reported on the WOC scale. Thus, the idea that many of these encounters were health-related remains a hypothesis that cannot be confirmed. Future research should analyze this possibility.

The hypothesis that the study population would be marked by a lower rate of problem-focused coping than the normative sample was not supported by the results of the present investigation. The 2 samples did not differ in their utilization of this form of coping. While it makes theoretical sense to argue that a low level of education should be associated with a decrease in the development of problem-solving skills and a consequent decrease in the use of problem-focused coping, this theory has not been empirically tested. The current study failed to find empirical support for the theory.

Some researchers have suggested that African-American, female populations may be characterized by unique patterns of response on the Ways of Coping
Questionnaire, including a tendency to overreport the use of coping techniques (Plummer & Slane, 1996; Smyth & Yarandi, 1996). While these findings offer an alternative explanation for the consistently high scores on most subscales, they fail to account for the similarity in scores on the problem-focused subscale. Furthermore, they provide no theoretical rationale by which to expect overreporting on only the subscales that include emotion-focused items.

As hypothesized, the utilization of problem-focused coping appears to predict increased psychological distress in this population. Specifically, individuals who endorsed a large amount of problem-focused coping also reported high levels of subjective psychological distress. While the finding is consistent with theories suggesting that problem-focused coping may be ineffective in low-control environments (Collins, Baum, & Singer, 1983; Whatley, Foreman, & Richards, 1998), conclusions are limited by the relatively low effect size obtained in the regression analysis. Past research has established the effectiveness of problem-focused coping in environments that afford opportunities for change and decision-making (Whatley, Foreman, & Richards, 1998). Although researchers have speculated that problem-focused coping may be ineffective in environments that do not offer such opportunities for control, this hypothesis has not been extensively tested. This study represents an initial attempt to examine the relationship between subjective levels of psychological distress and the implementation of problem-focused coping techniques in a low-control environment. The findings suggest that problem-focused coping may indeed be counterproductive in situations where directly addressing problems is largely a futile endeavor. However,
given the low strength of the relationship in the present study, future research should investigate whether the statistically significant findings are clinically meaningful. Moreover, conclusions are limited by the degree to which the problem-focused subscale overlaps with the emotion-focused subscales.

The set of emotion-focused coping subscales also accounted for a significant portion of the variance in psychological distress. Again, the obtained effect size was low and the correlations between the problem-focused subscale and many of the emotion-focused subscales were high, dictating that conclusions be made with caution. Moreover, while the finding is initially encouraging, an examination of the individual emotion-focused coping subscales makes conclusions difficult to reach. The majority of these subscales were positively associated with psychological distress; however, 1 of the subscales was negatively associated with psychological distress. Furthermore, the associations were significant for only 2 of the 6 emotion-focused subscales. Greater utilization of escape-avoidance strategies was associated with increased psychological distress. Greater utilization of positive reappraisal techniques was associated with decreased psychological distress. The different directional relationships between each emotion-focused subscale and the reported level of psychological distress point to limitations in examining the subscales as a set of emotion-focused strategies. In other words, conceptualizing all these subscales as measures of a more global emotion-focused coping category may neglect important, perhaps critical, aspects of the individual subscales. While the emotion-focused label provides an appealing contrast with strategies aimed at directly managing or altering problems, the techniques
comprising separate emotion-focused subscales appear to possess very different relationships with subjective levels of psychological distress.

The inconsistency among emotion-focused subscales is not entirely surprising in light of past research. The early work of Folkman and Lazarus had noted the difficulties inherent in dichotomizing coping strategies into 1 problem-focused category and 1 emotion-focused category. These investigators reasoned that such a practice failed to reflect the complexity of the coping process. Consequently, they turned to the empirical derivation of subscales, a process that generated the 8 subscales utilized in the present study. Additional studies were performed and, in virtually every case, the results of factor analysis yielded 1 problem-focused subscale and multiple subscales labeled as emotion-focused. The generation of numerous subscales, particularly within the emotion-focused grouping, suggested the complexity of the coping process that Folkman and Lazarus had noted in their early work. Still, the subscales obtained in these studies were often subsumed under the original problem-focused and emotion-focused categories. The overarching distinction was widely regarded as a useful first step in the investigative process. The assumption was that the dichotomy made theoretical sense and accurately reflected the general strategies of coping implemented in a given situation. The present study seems to suggest, however, that strategy effectiveness cannot be viewed in terms of this dichotomy. With regard to strategy effectiveness, the problem-focused and emotion-focused categories may not merely oversimplify the coping process, they may misrepresent the process. The emotion-focused subscales appear to be sufficiently independent to resist any attempts at
discovering meaningful commonalities among them with regard to their impact on psychological distress. Thus, while the dichotomy between problem-focused and emotion-focused coping may accurately reflect strategy implementation, the distinction may be less useful when examining strategy effectiveness. Future research should examine relationships between individual emotion-focused subscales and psychological distress in order to clarify the nature of each subscale and the associations between each subscale and psychological distress. Preliminary evidence from the present study seems to suggest that positive reappraisal techniques may be most effective at reducing psychological distress among individuals in the low-income, primary care environment.

A limitation of the present study is the inability to directly compare the effectiveness of emotion-focused and problem-focused forms of coping. Although the present study is able to provide insight into the effectiveness of emotion-focused and problem-focused forms of coping for this population, the study is unable to draw conclusions regarding the relative effectiveness of each form of coping. An examination of psychological distress among those individuals who implement a high level of problem-focused strategies compared to those who implement a high level of emotion-focused strategies might provide useful information regarding the relative effectiveness of each form of coping. Significant differences among the subscales (i.e., type and number of items) preclude the performance of such analyses in the present study. This, however, appears to be a limitation of coping measures in general rather than a drawback specific to the measure used in the present investigation. Vitaliano, Maiuro, Russo, and Becker (1987) have established an alternative method of scoring the
WOC Questionnaire that may help to satisfy the limitations of current coping measures. This method of scoring considers the contribution of each subscale to all the subscales combined. While the use of this method has been restricted to studies with a conceptualization of coping that differs slightly from the conceptualization used in the present study, a more widespread application of the scoring method would be informative. Employment of this scoring strategy in future research may permit an examination of relationships among different forms of emotion-focused and problem-focused coping.

In general, the presence of an anxiety disorder was associated with increased scores on the emotion-focused subscales. This result is consistent with findings from previous studies of both anxiety symptoms and categories of certain anxiety disorder diagnoses. Thus, the association between anxiety symptoms and emotion-focused coping seems to be reflected in differences between persons with an anxiety disorder and persons with no DSM diagnosis. The anxiety disorder group scored higher than the no diagnosis group on 3 of the 6 emotion-focused subscales. While the 2 groups failed to demonstrate clear differences on the other 3 emotion-focused subscales, the mean scores of the anxiety disorder group did exceed those of the no diagnosis group for each of these remaining subscales.

Given the documented relationship between low levels of perceived control and high levels of emotion-focused coping, the high level of reported emotion-focused coping among individuals with an anxiety disorder is expected. Anxiety disorders are, after all, marked by perceptions of uncontrollability. Nevertheless, perceptions of
control were not measured directly in the present study and the proposed explanation of these results remains a theoretical argument. Future research may wish to examine the relationship between perceptions of control and coping strategies directly.

Although the relationship between anxiety symptoms and problem-focused coping has not been extensively studied, prior investigations have generally shown a negative association between the two (Collins, Baum, & Singer, 1983; Whatley, Foreman, & Richards, 1998). The findings of the present study contradict these previous findings. Persons with an anxiety disorder diagnosis endorsed more problem-focused coping techniques than persons with no diagnosis. These results indicate that individuals with anxiety disorders may, in fact, channel emotional distress into problem-solving strategies. In some cases, then, the development of significant anxiety problems may not simply result from a lack of effort to alter the circumstances that help to create and to maintain distress as some researchers have postulated (Roy-Byrne et al., 1992). Rather, the problems may be a consequence of deficiencies in the ability to implement problem-focused strategies effectively. The very presence of anxiety may be a source of interference for effective problem-solving. Moreover, there may be an interactive effect among this anxiety and other demographic factors (e.g., low education level) that are thought to interfere with effective problem-solving.

The results also raise questions regarding the role of controllability perceptions in the implementation of coping strategies. Researchers have theorized that increases in emotion-focused coping associated with anxiety conditions are driven by the perceptions of uncontrollability that accompany anxiety states. The present study found
that anxiety conditions were associated with increases in both emotion-focused and problem-focused coping. Thus, evidence to support a special relationship between anxiety and the implementation of a particular form of coping (emotion-focused) was not discovered. Although certain forms of coping may prove more effective than others at reducing anxiety or general psychological distress, this does not appear to influence the choice of strategies implemented by the population of the current study.

Based on theoretical conceptualizations of anxiety syndromes and limited research of the coping processes associated with these syndromes, the present study sought to elucidate patterns of coping that were unique to the anxiety disorder classification. However, no such patterns were revealed when anxiety conditions were compared to depressive conditions. Coping processes as measured by the WOC Questionnaire were not useful in differentiating these specific diagnostic classifications of psychological disorders. Multivariate analysis of variance and appropriate follow-up procedures failed to produce significant differences between the anxiety disorder group and the depressive disorder group with respect to any coping subscale. Moreover, discriminant function analyses revealed no combination of coping subscales that effectively predicted the classification of individuals into diagnostic categories. While anxiety syndromes are conceptualized as affective states characterized by activation and subsequent efforts to cope, for persons in this population, these efforts to cope do not appear to be limited to any particular forms. In the low-income, primary care population the presence of an anxiety disorder is marked by significant efforts to
implement both emotion-focused and problem-focused strategies. Moreover, these coping efforts are not restricted to active, behavioral strategies.

As previously mentioned, individuals in the anxiety disorder group did, in fact, utilize more forms of emotion-focused coping than individuals with no diagnosis. Specifically, they scored higher on self-control, accepting responsibility, and escape-avoidance. However, persons with a depressive disorder diagnosis also reported greater use of the latter 2 strategies when compared to persons with no diagnosis. Individuals in the depressive diagnosis group also endorsed more confrontive coping than individuals in the no diagnosis group. These findings are consistent with past research which concluded that diagnostic category (anxiety versus depression) was not an important predictor of coping processes within psychiatric populations (Roy-Byrne et al., 1992). The present study extends those findings to a non-psychiatric population and suggests that there are no unique changes in coping processes that occur between “normal” and specific “abnormal” states. The number of attempted coping strategies may simply differentiate individuals with a diagnosis from those without a diagnosis rather than differentiating among specific diagnostic classifications.

One final, potential limitation of the present study is the fact that anxiety and depressive conditions were examined within 2 global categories. While there are commonalities among the individual conditions in these categories, considering the conditions as a group may mask the effects of traits that are unique to each disorder. Moreover, specific diagnoses may be further differentiated based on symptom presentations (e.g., vegetative versus non-vegetative depressions) and these differences
may be reflected in coping processes (e.g., emotion-focused versus problem-focused; active, behavioral strategies versus inactive, cognitive strategies).

In conclusion, the present study demonstrated that the low-income, primary care population is marked by the increased use of emotion-focused coping strategies relative to the normative sample. Although causative factors cannot be determined from the current investigation, a hypothesized explanation for this phenomenon is the limited amount of control over stressors that characterizes the study population. The effectiveness of these emotion-focused strategies for reducing psychological distress is inconclusive and the uniqueness of the individual techniques suggests significant limitations in examining them as a global set of emotion-focused strategies. In contrast, the utilization of problem-focused strategies among individuals in this population appears counterproductive and is associated with increases in psychological distress. This finding has important implications for coping skills training within low-income, primary care populations. The result suggests that such training may be most effective if the focus is placed on teaching emotion-focused strategies rather than problem-focused strategies. Finally, both anxiety and depressive conditions are marked by the increased implementation of emotion-focused and problem-focused strategies and these coping processes do not appear to be important predictors of diagnostic category.
REFERENCES


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Daniel J. Mehan, Jr., is the second of 3 children born to Daniel and Helen Mehan. He was born on July 5, 1970, in Neptune, New Jersey. He lived in New Jersey with his older sister, his younger brother, and both his parents until attending college in Washington, D.C., at Georgetown University (B.A., 1992). Subsequently, he attended Villanova University (M.S., 1995) and Louisiana State University (Ph.D., Anticipated Date of Graduation, August, 2000). He married Kathleen Mary Bradley at the age of 26 and they were blessed with their first child, a daughter named Jordan Bradley Mehan, on June 29, 1998. Jordan is expecting the arrival of her first sibling in October, 2000.

Daniel’s primary areas of interest throughout graduate school have been behavioral medicine and organizational issues and management. He has worked closely with Internal Medicine and Family Practice residents and physicians. He has provided assessment, consultation, and treatment services in an effort to assist physicians in the management of difficult patients with psychological problems. At the same time, he has successfully integrated business-related experiences into his degree program. These experiences included a minor (MBA classes) in Organization Change and Management, work in 2 different Employee Assistance Programs, and service on multiple hospital-wide committees.

At the time this vita was written Daniel was considering potential options for the continued pursuit of his career in psychology. Although he is uncertain of the exact path his career will take, he is confident that path will be traveled with loving and supportive family and friends close by his side.
DOCTORAL EXAMINATION AND DISSERTATION REPORT

Candidate: Daniel J. Mehan, Jr.

Major Field: Psychology

Title of Dissertation: Coping Strategies and Effectiveness among Low-Income, Primary Care Patients with Anxiety Disorders

Approved:

[Signature]
Major Professor and Chairman

[Signature]
Dean of the Graduate School

EXAMINING COMMITTEE:

[Signatures]

Date of Examination:

May 9, 2000

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