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REVIEW ARTICLE

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The role of coping strategies and psychosocial factors in epilepsy: a systematic review

ABSTRACT
This study aimed to identify the coping strategies of adults with epilepsy and to describe their relationships with psychosocial factors. These aspects are relevant to quality of life and psychosocial adaptation in epilepsy. A systematic review was conducted following PRISMA guidelines, using the databases PubMed, Cochrane Library, SciELO, Science Direct, and Lilacs. Ten studies met the inclusion criteria. People with epilepsy employed a variety of coping strategies, most frequently emotion-focused approaches. Coping was associated with levels of psychopathology, quality of life, illness perception, and clinical and sociodemographic variables. The findings underscore the role of coping in overall well-being in epilepsy. However, the absence of longitudinal studies limits a deeper understanding of these strategies. Future research assessing the effectiveness of interventions aimed at promoting adaptive coping could enhance clinical care and contribute to improved outcomes for people living with epilepsy.

KEY WORDS
chronic illnesses; epilepsy; coping strategies; systematic review; psychosocial adaptation

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BACKGROUND

Epilepsy is one of the most common neurological diseases, affecting more than 50 million people of all ages worldwide (Fisher et al., 2014; World Health Organization [WHO], 2019). It is characterized by recurrent unprovoked seizures due to excessive or abnormal neuronal activity in the brain (Fisher et al., 2014). Although 70% of patients manage to live seizure-free with appropriate pharmacological treatment, epilepsy continues to represent a considerable challenge in the lives of those affected by the condition (GBD Epilepsy Collaborators, 2025).

This disease has serious physical, social, economic, and psychological consequences that affect both patients and their caregivers (Clarke & Critchley, 2016; Quintas et al., 2012). In fact, the latest report from the Global Burden of Disease Study (2025) ranks epilepsy among the 50 most common causes of death and disability worldwide. In addition, psychiatric comorbidities are frequent, mainly with anxiety and depression disorders (Gurgu et al., 2021; Lu et al., 2021). As a result, the quality of life of people with epilepsy is significantly affected (Tombini et al., 2021; Wolfzun et al., 2022).

Among the factors that influence psychosocial functioning and adaptation in people with epilepsy, psychological aspects such as negative perceptions of the disease, psychopathological symptoms, stigma, and family functioning are of particular relevance; while clinical factors, such as the severity and frequency of seizures, have a variable contribution to quality of life (Quintas et al., 2012; Rawlings et al., 2017; Tombini et al., 2021). In this context, personal resources are essential for mitigating the emotional and psychological impact associated with the diagnosis (Bakan & Inci, 2021; Tanywe et al., 2016). Among these, coping strategies, defined by Lazarus and Folkman (1984) as cognitive and behavioral efforts to manage external or internal demands assessed as exceeding personal resources, play a central role in this process. Although there are various theoretical classifications, a common distinction is made between efforts aimed at actively managing the stressor (problem-focused strategies, such as planning or problem solving), strategies aimed at coping with its emotional consequences (emotion-focused strategies, such as seeking emotional support or acceptance), and avoidance strategies (e.g., denial or substance use) (Folkman & Moskowitz, 2004; Lazarus & Folkman, 1984; Moos, 1977). In recent decades, religious coping has gained increasing attention as an additional dimension, due to its contribution to the assessment of stressful events and its association with physical and mental health outcomes (Folkman & Moskowitz, 2004). Reviews that include the study of coping in epilepsy point out that the type of strategies used contributes significantly to mental health indicators, quality of life, and attitudes toward treatment (Livneh et al., 2001; Tanywe et al., 2016). In particular, the use of less active strategies (such as worry, avoidance, or denial) is associated with poorer psychosocial functioning, while active coping seems to promote adaptation. However, these reviews also highlight the diversity of resources that patients employ in order to cope with the challenges of the disease. In turn, they suggest that various factors, such as illness perception, religiosity, family functioning, and clinical variables, contribute to the coping strategies adopted (Livneh et al., 2001; Tanywe et al., 2016). This highlights the importance of considering coping resources within a comprehensive approach to patients with epilepsy.

Although previous reviews exist, in recent years new advances have been made in understanding coping strategies and other psychosocial factors in people with epilepsy. Therefore, the main objective of this review is to identify the strategies used by adults with epilepsy to cope with their disease; it also aims to explore the relationships with psychological, clinical, and sociocultural variables. This update is expected to contribute to clinical practice by promoting more efficient care and a better understanding of people with epilepsy.

METHODS

PROCEDURE

A systematic review was conducted using the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guide (Page et al., 2021).

Studies that met the following criteria were included: a) participants over 18 years of age or with an average age over 18 years; diagnosed with epilepsy, drug-resistant epilepsy, or epileptic seizures; b) quantitative, randomized and non-randomized, cross-sectional and longitudinal studies published between 2014 and 2024, in English, Spanish, and Portuguese; c) in which coping strategies are a primary outcome measure.

Studies were excluded if they a) involved participants with comorbid chronic neurological diseases (e.g., dementia), non-epileptic paroxysmal events (e.g., psychogenic non-epileptic seizures), or paroxysmal events due to other medical causes (e.g., vasovagal syncope, stroke, sleep disorders); b) were single-case studies; c) were posters, conference abstracts, book chapters, notes, or letters to scientific journals.

For data collection, a search was conducted on October 31, 2024, in the PubMed, Cochrane Library, SciELO, Science Direct, and Lilacs databases. The search terms used were: ("epilepsy" OR "refractory epilepsy" OR "drug resistant epilepsy") AND ("coping strat-

egies" OR "coping"). Filters were applied for the year of publication and, when the database allowed, for language.

REGISTRATION AND PROTOCOL

The protocol for this systematic review was registered in the International Prospective Register of Systematic Reviews (PROSPERO), under code CRD42024628193.

DATA ANALYSIS

The results of the database search were uploaded to the *EndNote X9* reference manager. After removing duplicates, titles and abstracts were screened to assess the eligibility of the records. Records that did not meet the inclusion criteria were excluded, and those that did were read in full. In addition, the reference lists of the selected articles were reviewed to search for additional records. This process was carried out independently by two authors (LGM, MP), and in cases where discrepancies or conflicts arose, they were resolved by a third author (GPK).

The following data were extracted from each of the articles selected for inclusion: a) study characteristics: authors, year, country, and study design; b) sample characteristics: sample size, age, sex, educational level, occupation, marital status, psychiatric comorbidities; c) clinical characteristics: age of onset of seizures, duration of disease; d) results: coping strategies and associations with psychological, clinical, and sociodemographic variables. Two authors (LGM, MP) independently compiled and recorded the data in an Excel spreadsheet. The extracted data were then compared to assess discrepancies and ensure consistency in the information collected.

RISK OF BIAS ASSESSMENT

To assess the risk of bias in the included studies, the Critical Appraisal Checklist for cross-sectional studies from the Joanna Briggs Institute (Munn et al., 2014) was used – a reliable tool that has already been used in previous research on epilepsy (Andualem et al., 2024). The assessment tool consists of nine items that reviewers answer by selecting between: "yes," "no," "not reported," or "not applicable." For this study, the first eight items were used, excluding the ninth (referring to response rate management). This adaptation was made to ensure the relevance of the evaluation criteria without compromising the validity of the instrument, given that the excluded item could not be answered due to the methodological design of the included studies. Two reviewers independently assessed the quality of the studies, calculating overall scores per study based on the proportion of affirmative responses ("yes"). Accordingly, the quality of the studies was rated as: a) low (< 3 affirmative responses), b) medium (between 3 and 6), c) high (> 6).

A narrative synthesis of the results was performed. To report data on study and sample characteristics, weighted means and percentages were calculated.

RESULTS

STUDY SELECTION

The results of the search and study selection process are summarized in Figure 1. After conducting the search, 553 records were identified in the databases, and one record was included from another source. After removing duplicates, a total of 304 records were obtained. Following title and abstract screening, records that did not meet the inclusion criteria because they were not related to the objectives of this review were excluded; the 21 studies that did meet the criteria were read in full. Finally, data were extracted from 10 articles that met the inclusion criteria.

The general characteristics of the studies reported in this review are detailed in Table 1.

STUDY CHARACTERISTICS

Seven of the studies were correlational (70%), and three were descriptive. All studies were non-experimental, with a predominance of cross-sectional designs (90%); only one used a longitudinal design (Lin et al., 2018). Three articles that performed comparative analyses were identified. One of them compared patients with a healthy control group (Şenadım et al., 2021), while another also included a comparison group with patients with functional/dissociative seizures (Gargiulo et al., 2022). Finally, another compared participants with drug-resistant epilepsy (with and without psychiatric comorbidity) and participants with functional/dissociative seizures (Gargiulo et al., 2024).

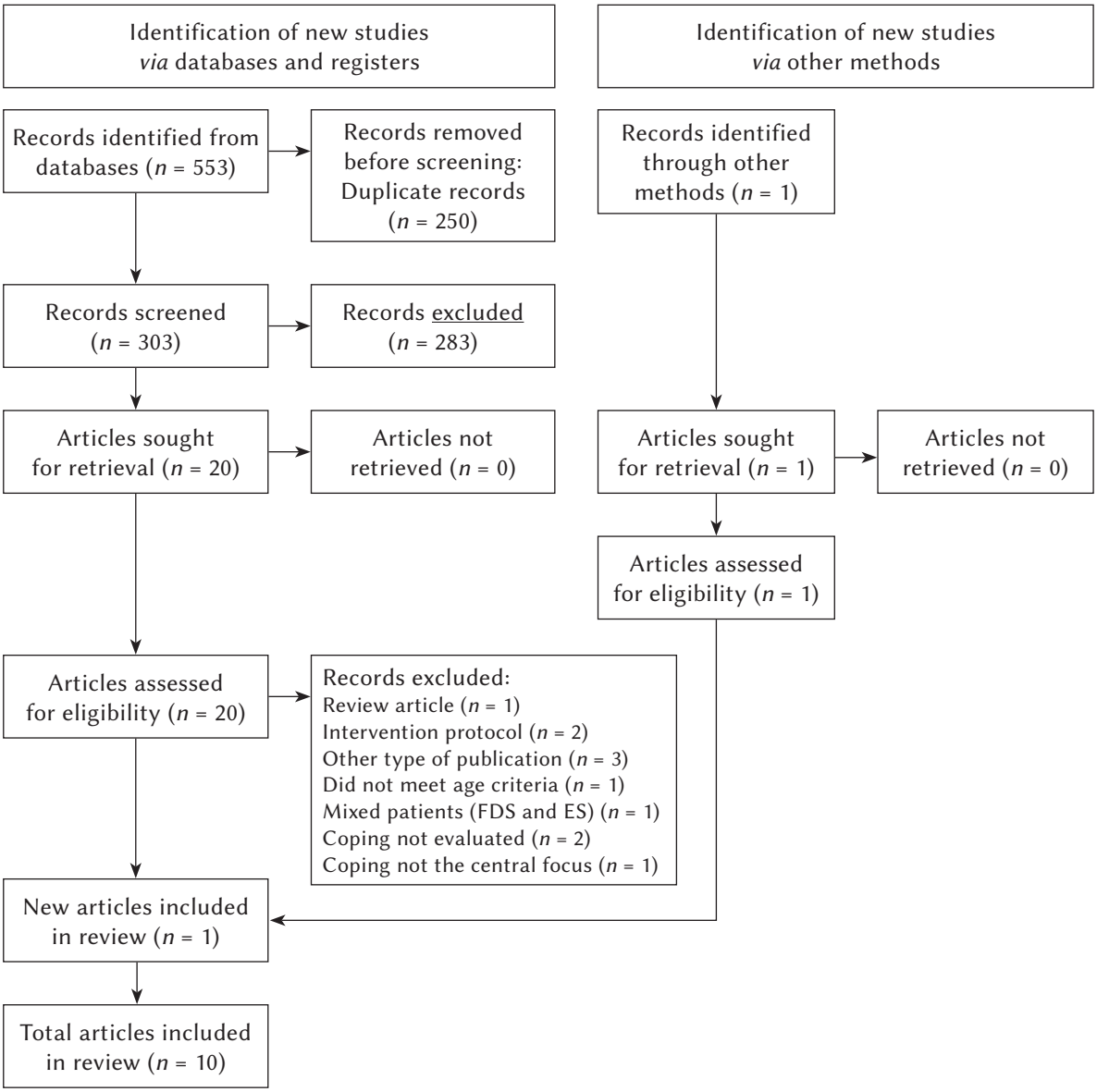
Most of the selected studies were conducted in the Middle East and Asia (70%), while the remaining 30% were conducted in the United States, the United Kingdom, and Argentina. Only two studies were conducted in a Spanish-speaking country (Argentina).

SAMPLE CHARACTERISTICS

A total of 1,835 people with epilepsy participated. The average ages of participants reported in the articles ranged from 21.6 to 36.1 years. The weighted mean age, considering sample sizes, was approx-

Figure 1

Flowchart of selection process



imately 32.9 years. In terms of gender, the majority of participants were women (58.1%). In fact, in 60% of the studies, women represented more than 60% of the sample (Batchelor & Taylor, 2021; Gargiulo et al., 2022; Gargiulo et al., 2024; Lee et al., 2019; Özcan & Çiftçi, 2024; Şenadım et al., 2021). The occupation of participants was reported in 50% of the studies, with the unemployment rate varying between 8.3% and 35.1% (Batchelor & Taylor, 2021; Hajisabbagh et al., 2019; Lee et al., 2019; Özcan & Çiftçi, 2024; Tu et al., 2022). The weighted mean unemployment rate, considering sample sizes, was approximately 25.3%. The marital status of participants was reported in 70% of the studies, with 61.5% of the participants being married (Batchelor & Taylor, 2021; Hajisabbagh et al., 2019; Lin et al., 2018; Özcan & Çiftçi, 2024; Şenadım et al., 2021; Tu et al., 2022).

Only 30% of studies reported analyzing psychiatric comorbidities in participants (Batchelor & Taylor, 2021; Gargiulo et al., 2022; Lee et al., 2019). Anxiety disorder and depressive disorder were the most frequently reported comorbidities. Regarding variables associated with the disease, 50% of the studies reported the age of onset of epilepsy, which ranged from 18.3 to 29.3 years (Batchelor & Taylor, 2021; Lee et al., 2019; Lin et al., 2018; Şenadım et al., 2021; Tu et al., 2022). The weighted mean age of onset of the disease, considering sample sizes, was approximately 24.3 years. In addition, 60% of the studies reported the duration of the disease, ranging from 6.8 to 20.7 years (Batchelor & Taylor, 2021; Hajisabbagh et al., 2019; Lee et al., 2019; Lin et al., 2018; Şenadım et al., 2021; Tu et al., 2022). The weighted mean duration was approximately 10.2 years.

Table 1

Main characteristics and results of the included studies

Author and publication year	Countries	Study design	Sample size	Mean age	Gender % women	Study quality	Coping measure	Findings
Batchelor & Taylor (2021)	United Kingdom	Correlational	144	21.6	21.6% women	Medium	B-COPE	Participants scored at a moderate level on problem-focused and avoidant strategies, and at a low level on emotion-focused strategies.
Gargiulo et al. (2024)	Argentina	Correlational with comparison groups	DREnc = 24 DREpc = 58 FDS = 26	DREnc = 29.6 DREpc = 30.6 FDS = 31.2	DREnc = 48% women DREpc = 71% women FDS = 85% women	Medium	CAE	The strategies most frequently used by the DREnc group were problem-focused strategies. The strategies most frequently used by the DREpc and FDS groups were emotion-focused strategies, specifically seeking social support, religiosity, negative self-focus, and hostility. The DREnc group used fewer avoidant and emotion-focused strategies than the DREpc and FDS groups.
Gargiulo et al. (2022)	Argentina	Correlational with comparison and control group	DRE = 60 FDS = 28 CG = 31	DRE = 30.8 FDS = 31.8 CG = 41.4	DRE = 61% women FDS = 85% women	Medium	CAE	Patients with DRE used more emotion-focused strategies (hostility) than the control group.
Hajisabbagh et al. (2019)	Iran	Descriptive	134	33.6	56% women	High	CISS	Emotion-focused strategies were the most frequently used, followed by problem-focused strategies. The least used were avoidant strategies.
Lee et al. (2019)	South Korea	Correlational	88	43	69.3% women	Medium	B-RCOPE	Positive religious coping was the most frequently used.
Lin et al. (2018)	Iran	Correlational	760	36.1	54.5% women	Medium	B-RCOPE	**
Ozcan & Çiftçi (2024)	Turkey	Descriptive	154	30.7	70.8% women	Medium	B-RCOPE	Both positive and negative religious coping scored high. Positive religious coping was more frequent among female participants, those with religious habits, housewives, married participants, and those with low income.

Table 1 continues

Table 1

Table 1 continued

Author and publication year	Countries	Study design	Sample size	Mean age	Gender % women	Study quality	Coping measure	Findings
Şenadım et al. (2021)	Turkey	Descriptive with control group	DRE = 120 CG = 40	DRE = 31.3 CG = 35.2	DRE = 60.8% women CG = 57.5% women	Medium	COPE	The control group used more avoidance strategies (substance use) compared to the epilepsy group. Women used more problem-focused and emotion-focused strategies, specifically instrumental social support, emotional social support, active coping, and acceptance. Participants with a history of febrile seizures used more avoidance strategies (denial) and emotion-focused strategies (emotional social support), as well as more problem-focused strategies (active coping). Participants on polytherapy used more avoidance strategies (venting of emotions) and more problem-focused strategies (suppression of competing activities). Single participants used more emotion-focused strategies (positive reinterpretation and growth).
Tu et al. (2022)	China	Correlational	135	27.3	50.4% women	Medium	SCSQ	**
Unalan et al. (2015)	Turkey	Correlational	182	32	57.7% women	Medium	COPE	Emotion-focused strategies were the most used, primarily positive religious coping, followed by positive reinterpretation and growth. The third most used was instrumental social support, a problem-focused strategy. Emotional venting was the most used avoidant strategy. Male participants used more problem-focused strategies (instrumental social support) and emotion-focused strategies (positive reinterpretation and growth). Participants with lower educational levels used fewer avoidant strategies (behavioral disengagement) and problem-focused strategies (restraint). Those with a traditional family structure used fewer avoidant and religious strategies compared to participants with a nuclear family structure. Participants who were housewives or in other occupations used more humor strategies, whereas workers, freelancers, and participants in other occupations used more restraint strategies.

Note. **No descriptive results reported; DREnc – drug-resistant epilepsy patients with no psychiatric comorbidity; DREpc – drug-resistant epilepsy patients with psychiatric comorbidity; FDS – functional dissociative seizures; CG – control group; B-COPE – Brief-Coping Orientation to Problems Experienced Inventory; CAE – Cuestionario de Afrontamiento del Estrés; CISS – Coping Inventory for Stressful Situations; B-RCOPE – Brief Religious Coping Scale; COPE – Coping Orientation to Problems Experienced Inventory; SCSQ – Simplified Coping Style Questionnaire.

STUDY RISK OF BIAS

Table 1 details the overall quality rating of each study. Of all the studies included, 10% scored as high quality, while the rest were of medium quality.

MAIN COPING OUTCOMES

The main results of coping strategies reported by the included studies and the assessment measures used for coping are detailed in Table 1.

In 80% of the studies, coping strategies were analyzed in relation to different variables. The results are presented below.

PSYCHIATRIC COMORBIDITIES

Forty percent of the included studies analyzed the relationship between coping strategies and psychopathological factors. Two studies found that higher levels of anxiety and depression are associated with greater use of avoidance strategies (Batchelor & Taylor, 2021; Gargiulo et al., 2022). Furthermore, in three studies, depressive symptoms negatively correlated with the use of problem-focused strategies (Batchelor & Taylor, 2021; Gargiulo et al., 2022; Unalan et al., 2015), in two of them, depressive symptoms were negatively associated with emotion-focused coping (Batchelor & Taylor, 2021; Unalan et al., 2015), and only one found a negative correlation with avoidance strategies (Unalan et al., 2015). One study found a positive correlation between suicidality and avoidant coping, whereas negative correlations were found with problem-focused and emotion-focused coping (Batchelor & Taylor, 2021). Moreover, in another study, negative religious coping was associated with more symptoms of anxiety and depression, but no statistically significant correlations were found with positive religious coping (Lee et al., 2019).

PSYCHOSOCIAL FACTORS

Fifty percent of the studies investigated the relationship between coping and psychosocial variables. Religiosity was analyzed by two studies (Lee et al., 2019; Lin et al., 2018). In the study by Lee et al. (2019), positive religious coping positively correlated with religiosity, but negative religious coping did not. Conversely, Lin et al. (2018) found no significant correlations between religiosity and positive religious coping but did find correlations with negative religious coping. Moreover, problem-focused coping positively correlated with emotional intelligence (Hajisabbagh et al., 2019), resilience (Gargiulo et al., 2022), quality of life (Tu et al., 2022), and illness perception, specifically with treatment control, illness understanding, and personal control dimensions. Furthermore, avoidant strategies negatively correlated with quality of life and with the same dimensions of illness perception (Tu et al., 2022). Emotion-focused strategies were negatively associated with emotional intelligence (Hajisabbagh et al., 2019), and a positive correlation was observed between emotional intelligence and the use of avoidance strategies (Hajisabbagh et al., 2019).

Another study found significant correlations between coping strategies and perceived social support (Unalan et al., 2015). Perception of social support from friends correlated positively with strategies such as positive reinterpretation and growth, venting of emotions, emotional and instrumental social support, active coping, acceptance, suppression of competing activities, and planning. Meanwhile, perceived social support scores from "someone special" were positively associated with multiple strategies, including positive reinterpretation and growth, venting of emotions, use of instrumental social support, active coping, self-control, use of emotional social support, acceptance, suppression of competing activities, and planning. In contrast, both forms of perceived support were negatively correlated with denial and humor strategies. The same study found positive correlations between the number of friends and the strategies of positive reinterpretation and growth, emotional venting, emotional and instrumental social support, acceptance, suppression of competing activities, and planning (Unalan et al., 2015).

SOCIODEMOGRAPHIC AND ILLNESS-RELATED FACTORS

Fifty percent of the studies analyzed the relationship between coping strategies and the clinical and sociodemographic variables of the participants. One of the studies found a positive correlation between religious coping strategies and the age of participants (Özcan & Çiftçi, 2024). Another study reported significant positive correlations between emotion-focused and avoidance strategies with age and illness duration, as well as between income level and the use of instrumental social support (Unalan et al., 2015). In this same study, seizure type was a predictor of problem-focused, emotion-focused, and avoidance strategies; family structure predicted the choice of avoidance and emotion-focused strategies; gender predicted problem-focused strategies; and educational level predicted avoidance strategies. Finally, two studies found no significant associations between coping and sex, age, educational level, occupation, type of epilepsy, seizure frequency, age of onset, or duration of illness (Hajisabbagh et al., 2019; Şenadım et al., 2021). On the other hand, one study found that

medication adherence was negatively correlated with negative religious coping and positively correlated with positive religious coping (Lin et al., 2018).

COPING AS A MEDIATOR OR PREDICTOR OF OTHER VARIABLES

In 50% of studies, coping was identified as a mediator or predictor of other variables. According to one study, avoidant coping strategies were independent predictors of anxiety, depression, and suicidality levels, explaining 33.9%, 33.8%, and 18.1% of their variance, respectively (Batchelor & Taylor, 2021). In another study, religious coping strategies, high scores on hostile coping, and negative self-focus were significant predictors of patients with drug-resistant epilepsy with psychiatric comorbidities, compared to those without comorbidities (Gargiulo et al., 2024). The study by Lee et al. (2019), in turn, found that negative religious coping and religiosity were predictors of depression levels.

Furthermore, in two studies, coping strategies mediated the relationship between different psychosocial and clinical variables (Lin et al., 2018; Tu et al., 2022). In one of them, negative religious coping, together with medication adherence, mediated the relationship between religiosity and quality of life. In addition, positive and negative religious coping, together with religiosity, explained between 48.5% and 48.9% of the variance in medication adherence. Specifically, negative religious coping was a significant mediator between religiosity and medication adherence (Lin et al., 2018). In another study, problem-focused coping strategies and avoidant coping were predictors of quality of life, explaining 7% of its variance; in addition, illness perception was found to directly influence coping strategies. Moreover, coping strategies mediated the relationship between illness perception and quality of life, explaining 20.5% of the total effect (Tu et al., 2022).

DISCUSSION

This review aimed to highlight the coping strategies used by adults living with epilepsy and explore their relationship with psychosocial and clinical aspects. Consistent with another review, the coping strategies most commonly used by people with epilepsy are emotion-focused strategies, followed by problem-focused strategies, and, to a lesser extent, avoidance strategies (Livneh et al., 2001). Those living with this condition are exposed to multiple adverse experiences such as discrimination, stigma, and financial challenges (Tanywe et al., 2016). Limitations affect areas such as employment, education, and everyday activities such as driving, cooking, or going out on their own (Rawlings et al., 2018; Sarudiansky et al., 2018). In this context, learning how to live with a chronic condition and trying to reappraise the situation from a growth perspective may represent fundamental strategies for promoting psychosocial adaptation in epilepsy. In fact, in people with multiple chronic diseases, as well as other physical and mental health conditions, emotional coping is more common than in the general population (Cheng et al., 2020; González Molina et al., 2023; Okanli et al., 2017). However, there seems to be no uniformity regarding the effectiveness of this dimension of coping across studies, as some consider it dysfunctional. This may be due to the theoretical classifications adopted by the studies and the fact that the evaluation of a strategy's usefulness depends on its suitability to the stressor, as well as on the results obtained from coping (Lazarus & Folkman, 1984).

In line with previous findings, this review found that psychological well-being is closely related to coping in epilepsy (Clarke & Critchley, 2016; Goldstein et al., 2005; Livneh et al., 2001). The use of avoidance strategies predicted the presence of more depressive and anxiety symptoms and higher levels of suicidality. The fact that avoidance coping has been associated with poorer mental health indicators is a general finding in the literature related to other health problems (Cullingham et al., 2019; Livneh, 2019). In addition, it has been found that people with mood disorders and anxiety disorders exhibit avoidant coping styles compared to people without disorders (Orzechowska et al., 2022). In people with epilepsy, the rates of psychiatric comorbidity are significantly higher than in the general population. Among these, mood disorders are the most common, followed by anxiety disorders and psychotic symptom disorders (Gurgu et al., 2021; Lu et al., 2021; Scott et al., 2017). In addition, the risk of suicidality is higher than in the general population, with a prevalence rate of completed suicide of 0.24%, according to the most recent review (Wang et al., 2023). Findings from this review are consistent with previous research in indicating that coping with the challenges of epilepsy through frequent use of avoidance strategies, rather than relying on more active strategies, is a risk factor for psychological well-being and psychosocial adjustment (Goldstein et al., 2005; Livneh et al., 2001; Oosterhuis, 1999).

Furthermore, the contribution of problem-focused and emotion-focused strategies to psychological well-being had mixed results. In some studies, they were associated with lower levels of suicidality, anxiety and depressive symptoms (Batchelor & Taylor, 2021; Gargiulo et al., 2022; Unalan et al., 2015). However, in people with drug-resistant epilepsy and psychiatric comorbidities, greater use of hostile, social support, religious, and negative self-focus strategies (i.e., emotion-focused coping) was observed com-

pared to those without comorbidities (Gargiulo et al., 2024). Similar findings were obtained in a review of people with multiple chronic diseases in which emotion-focused strategies were associated with better mental health outcomes on the one hand, and greater suicidality and physical dysfunction on the other (Cheng et al., 2020).

Furthermore, adopting a problem-solving approach has been associated with lower psychopathology in other studies on epilepsy (Krakow et al., 1999; Livneh et al., 2001). Patients with controlled seizures demonstrated greater problem-solving ability when coping with stress (Piazzini et al., 2007). By contrast, people with drug-resistant epilepsy experience high levels of stress, probably due to the uncontrollability of seizures, and a more severe and threatening perception of the disease (Gargiulo et al., 2022; Salter et al., 2017). Thus, patients with refractory epilepsy may choose different strategies to cope with the emotional consequences of stress, such as behaving aggressively, seeking refuge in their religious practices or loved ones, or feeling self-pity. However, in the long term, relying exclusively on these strategies can be detrimental to emotional well-being and quality of life, influencing the ability to address problems more effectively (Tombini et al., 2021). In turn, the fact that there are few longitudinal studies on coping with stress may limit understanding of the role of these strategies in mental and physical health outcomes.

In this review, the perception of social support was associated with greater use of problem-focused and emotion-focused strategies and less use of avoidance strategies. Specifically, these associations were observed for perceived support from friends and a "special someone." In addition, having more friends was associated with choosing problem-solving and emotional coping strategies. Previous studies have noted that patients with epilepsy receive emotional, physical, and financial support from family members, friends, religious communities, and patient associations (Deegbe et al., 2020; Hosseini et al., 2010; Tanywe et al., 2016). However, difficulties in communication and family functioning can negatively affect psychosocial functioning in young people with epilepsy and be associated with psychiatric symptoms in both caregivers and patients (Clarke & Critchley, 2016). In addition, caregiving demands can cause family members of people with epilepsy to feel overwhelmed and experience high levels of stress and apathy that negatively affect their relationship with the patient (Jabbarinejad et al., 2021; Karakis et al., 2014; Oliveira et al., 2022). In this way, partners or friends can become primary sources of support. Taken together, these forms of social support act as adaptive resources, promoting the use of practical strategies aimed at addressing material needs, such as seeking information about the disease or financial support for treatment, as well as emotional support to mitigate discrimination, stigma, and psychological distress associated with epilepsy.

In this review, avoidance strategies were negatively associated with quality of life, consistent with studies emphasizing the association of dysfunctional strategies with lower overall well-being (Goldstein et al., 2005; Westerhuis et al., 2011). It has already been documented that people with epilepsy have a significantly lower quality of life compared to the general population (Rawlings et al., 2017; Wolfzun et al., 2022), and that psychosocial variables play a key role in these outcomes, even after controlling for clinical variables such as seizure frequency and severity (Rawlings et al., 2017; Tombini et al., 2021; Westerhuis et al., 2011). In this regard, a negative coping style can interfere with self-management behaviors, emotional regulation, and attitude toward treatment, contributing to a more negative perspective of the disease. As a result of the interaction of these psychological factors, quality of life is negatively affected (Shallcross et al., 2015; Tu et al., 2022). Accordingly, the results of this study showed that both problem-focused and avoidance coping directly influenced quality of life, although they mainly played a mediating role among other relevant variables such as illness perception. Consequently, these findings reinforce the importance of coping as a potentially modifiable psychological factor associated with quality of life in epilepsy.

Consistent with previous studies, this review found an association between coping and illness perception (Goldstein et al., 2005; Hagger & Orbell, 2003; Kemp et al., 1999). Problem-focused strategies were associated with a greater perception of personal control, treatment control, and understanding of the disease. This suggests that people who perceive their disease as manageable tend to resort to more active strategies. The perception of having personal resources to cope with external demands and a greater sense of self-efficacy are associated with better social functioning, greater emotional well-being, and acceptance of epilepsy (Dewar et al., 2020; Hagger & Orbell, 2003; Livneh et al., 2001). In contrast, avoidance strategies were negatively associated with these same dimensions, indicating that the perception of higher severity of the disease leads to more dysfunctional management of stress and its associated consequences. In turn, coping had a mediating role between illness perception and quality of life. This finding has been noted in other studies, which highlight how illness representations shape health-seeking behaviors and stress management, influencing mental and physical health outcomes as well as treatment adherence (Dewar et al., 2020; Hagger & Orbell, 2003; Shallcross et al., 2015).

Regarding the contribution of clinical variables, the evidence remains inconsistent (Goldstein et al., 2005; Krakow et al., 1999; Piazzini et al., 2007), which was also reflected in this review. While two studies found no associations between clinical variables and

coping, two others did. Unalan et al. (2015) found that illness duration was associated with greater use of avoidance and emotion-focused strategies, while seizure type was a predictor of coping in general. In turn, Şenadım et al. (2021) found differences in coping in participants with a history of febrile seizures and polypharmacological treatment, specifically demonstrating greater use of avoidance strategies such as denial and venting of emotions, but also social support and problem-focused strategies. Similar results were found in other studies. Piazzini et al. (2007) found that patients with drug-resistant epilepsy used more avoidance, while patients with controlled epilepsy had a more active style. In contrast, Krakow et al. (1999) observed that, despite drug-resistant epilepsy, participants used problem-oriented strategies more frequently.

Taken together, these findings suggest that certain clinical characteristics, such as the severity and chronicity of seizures, or lack of response to treatment, can undermine perceptions of control and self-efficacy, resulting in greater psychological distress and promoting the use of avoidance or emotional strategies as a way of reducing the psychosocial impact of the disease. Even so, the simultaneous use of active strategies suggests that, even in the face of more severe symptoms, people with epilepsy also mobilize resources aimed at coping with difficulties or seeking support. This coexistence could be understood as an adaptive attempt to cope with the complexity of the condition, in which coping exhibits both a protective and compensatory function in managing distress. Therefore, future research could attempt to specify the contribution of clinical characteristics in the choice of resources for coping with the diagnosis.

In this review, emotional intelligence (EI), understood as the cognitive ability to perceive, understand, and regulate emotions in oneself and others (Cioca et al., 2024; Gargiulo et al., 2022), was associated with greater use of problem-focused coping and lower use of emotion-focused strategies, an aspect that has been documented in other studies (Cioca et al., 2024; Fteiha & Awwad, 2020; Moradi et al., 2011). Thus, higher EI seems to facilitate the ability to manage stress and emotional regulation, aspects that are particularly relevant in the context of chronic diseases (Moradi et al., 2011). In this regard, Pérez-Fernández et al. (2021) found that higher EI reduces distress related to chronic illnesses, promoting better self-management.

Several studies included in this review considered religious coping strategies as relevant factors. These are understood as religious beliefs and practices that help manage stress or adverse situations (Lin et al., 2018). Given that most studies evaluating religious coping included participants who profess religions such as Islam and Christianity, the results should be interpreted considering religious practices as a characteristic sociocultural factor. In these studies, coping took two forms: positive religious coping and negative religious coping. The former refers to trust in faith, and in a benevolent higher power that provides support, meaning, and comfort. In contrast, negative religious coping refers to the conception of God as distant and punitive, leading to a loss of hope for recovery (Lee et al., 2019; Lin et al., 2018; Özcan & Çiftçi, 2024).

The results of these studies showed that women, married people, those with low incomes, those with religious habits, older people, and, in particular, housewives had higher levels of positive religious coping. The latter is a factor possibly associated with the fact that their daily routines could allow more time to cultivate religious practices and focus more on them through religious communities (Özcan & Çiftçi, 2024). Complementary results were found in another study, in which younger people had higher scores for negative religious coping (Roger & Hatala, 2018). In turn, in a study on diabetes, people with lower incomes used more positive coping strategies (Amadi et al., 2016). However, these results contrast with other studies on epilepsy, in which no associations were observed between religious coping strategies and sociodemographic factors (Lee et al., 2019; Unalan et al., 2015). Therefore, further research is still needed to understand the relationship between social factors and religious coping. Also, it is important to consider culturally diverse populations with other religious practices to understand the influence of religious coping in other contexts.

Moreover, religious coping was also related to attitudes toward treatment. This review found that positive and negative religious coping, together with religiosity, explained a significant portion of the variability in treatment adherence. Specifically, Lin et al. (2018) found that negative religious coping was a significant mediator between religiosity and medication adherence, a finding consistent with other reviews on chronic illnesses (Freitas et al., 2015; Movahedizadeh et al., 2019). Beliefs about the origin of epilepsy can influence treatment decisions. In some cases, attributing supernatural causes (e.g., divine punishment or demonic powers) may lead people with epilepsy to seek help from traditional healers or religious institutions, which can delay the search for appropriate medical care and hinder the initiation or continuation of effective treatment (Sarudiansky et al., 2018; Tanywe et al., 2016). In addition, associations were found between this type of coping and higher levels of anxiety and depression symptoms (Lee et al., 2019). This suggests that the belief that there is little control over the disease, together with hopelessness about recovery, could favor the use of negative religious coping and greater emotional distress. In this regard, it was found that greater use of religious coping is associated with an external locus of control and higher levels of psychological distress (Livneh et al., 2001).

Religion and spirituality have also been described as sources of resilience in the face of adversity (Cal et al., 2015). In this sense, resilience, understood as the ability to adapt positively to adversity (Cal et al., 2015; Gargiulo et al., 2022) was an important factor in this review, being significantly associated with problem-focused coping strategies, an aspect widely noted in other studies on different chronic illnesses (Cal et al., 2015; Newton-John et al., 2014). These dimensions enhance the ability to cope with and adjust to stressful situations, strengthening the personal resources available to deal with the disease (Bravin et al., 2018). In fact, a study of patients with epilepsy points to resilience as a factor that can help them cope with the unpredictability of seizures and overcome associated adverse situations, such as social stigma (Tedrus et al., 2020).

Finally, the results of this review should be interpreted with some limitations considered. The restriction of publications to a limited period (2014-2024) represents a limitation in capturing the full scope of coping with epilepsy. However, this decision responds to the objective of providing an updated synthesis of the available evidence. Although the quality of the studies was classified as medium to high, another limitation relates to the participants in the samples, who mainly belong to specialized centers in epilepsy, patient communities, and subgroups with specific cultural characteristics. Consequently, the results may not be representative of the general population with epilepsy, which would limit their generalizability. Finally, almost all of the studies address coping from a cross-sectional approach; however, to fully understand the role of stress coping in the management and prognosis of chronic illnesses, more longitudinal studies are needed.

CONCLUSIONS

The reviewed evidence suggests that patients with epilepsy more frequently used emotion-focused coping and, to varying degrees, problem-focused strategies. These strategies were associated with more favorable outcomes in psychological well-being compared to avoidance strategies, which were associated with greater general distress, anxiety and depressive symptoms, and a more threatening illness perception. Moreover, religious coping was found to be a relevant factor, both for its cultural and personal dimensions and for its clinical implications, especially in relation to treatment adherence. In addition, differences in the use of coping strategies were identified based on sociodemographic, clinical, and psychosocial variables.

Overall, these findings highlight the role of coping strategies as a psychological factor of relevance for adaptation and self-efficacy in epilepsy. Future research should focus on developing psychosocial interventions that strengthen adaptive strategies while considering the cultural and spiritual context of patients. Routine assessment of coping in clinical practice may facilitate the development of more personalized and patient-centered interventions.

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