**Week 2**
**Monday 12th of October**
**Lecture 1**

**Coping**

**Session aims:**
By the end of this session, you should be able to demonstrate an understanding of:

- Factors that affect how individuals respond to a chronic illness
- How individuals adjust to chronic illness over time ( & individual differences in responses)
- Some social and environmental factors involved
- And be able to evaluate relevant theories, models and empirical research

Seminar 1: how we consider chronic illness across the lifespan

**Intro and definitions**

Developing a chronic condition places a number of demands on an individual and often on their family will touch on this as well. These demands can differ in condition as well as in other factors. There may be practical aspects, there may be emotion factors, cognitive, financial considerations and these can all vary depending on where these individuals are in life stage and socioeconomic factors and what the condition is.

But often, the person with the chronic condition is no longer invincible. The illness may take away any plans, hopes and dreams that they had, and it can introduce uncertainty.

Someone who is living with a chronic illness has to adapt and adjust and this is usually permanent.

When we are talking about a chronic condition, we are normally referring to something that does not have a cure (although that does snot refers to some types of cancer), and generally lasts six months.

Living with a chronic condition demands change does not normally only involve only the individual that has the disease.

Generally coping is viewed as situational rather than dispositional, and the meaning of this is that how an individual copes with one particular situation, might be very different to how they cope with another situation. It is not necessarily a personality trait so we don't necessarily think of people as good copers or bad copers, but more than someone may cope well in situation A but not so well in situation B.

Morse and Johnson (1991), proposed a generic model of emotional and coping response, so that is from the onset of symptoms to actually living with the chronic illness. And they proposed that: when individuals are facing illness they have to deal with uncertainty: trying to understand the meaning of the symptoms that they have, and also dealing with disruption: so they're experiencing a crisis which may be characterised by intense stress and a level of dependence (??).

What we see when people are addressing these issues is: striving, so they're attempting to gain control of their illness by means of active coping, so trying to do something. And also through restoration, so they propose that an individual achieves a new emotion- based on accepting the illness and its consequences → equilibrium.

When thinking about factors that can affect coping:

2 key ones

1. Illness related factors
2. Treatment-related factors

**Illness related factors**

- Individual's perception of 'threat' determines the difficulty in coping (Cohen & Lazarus, 1979)
- Some health problems are more difficult to deal with e.g.:
- Disfigurement - especially to face (Hagedoorn & Molleman, 2006)
- Self-efficacy in dealing with the responses of others
- Self-consciousness or stigma can lead to avoidance of others
- Changes in bodily function (Bekkers et al., 1995)
- E.g. seizures or having an ostomy

**Treatment-related factors**

People find that the treatment is actually worse than the illness it is supposed to be treating.

Treatment regimens can be difficult

Pain associated with the treatment rather than illness

Side effects - medication or treatments

Schedules that make everyday life changes e.g. giving up work

Schedules that mean changing lifestyles e.g. giving up smoking

Visible treatments – e.g. ointments with odours

Think about coping through a lifespan approach. Coping isnt static it does change through time.

**Definitions of coping & Adjustment**

- "Constantly changing cognitive and behavioural efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person" (Lazarus & Folkman, 1984, p.141) ---> this is about coping in general not coping with chronic illness.
    - Coping is not an outcome, we don't do things to get to a bad or good coping, it is a process where we do various tasks to get the good outcome or good quality of life.

- Adjustment often defined in terms of outcomes e.g. preserving functional status and low negative affect (Stanton et al., 2007)

- An essential "stabilizing factor that can help individuals maintain psychosocial adaptation during stressful periods" (Holahan et al., 1996; Moos & Moos, 1986) (in White et al., 2018 p.2)

**Stages and models**

**Stages of adjustment (Kubler-Ross, 1969; Shontz, 1975)**

Kubler-Ross' stages of grief; Denial. Anger. Bargaining. Depression. Acceptance.

Shontz: Initial reactions in 3 stages; shock, encounter, retreat → similar to denial but shouldnt last a long time.

Move away from stage-based to task-based approaches

Criticisms: Too prescriptive, rigid linearity, creating expectations of responses, categorises people

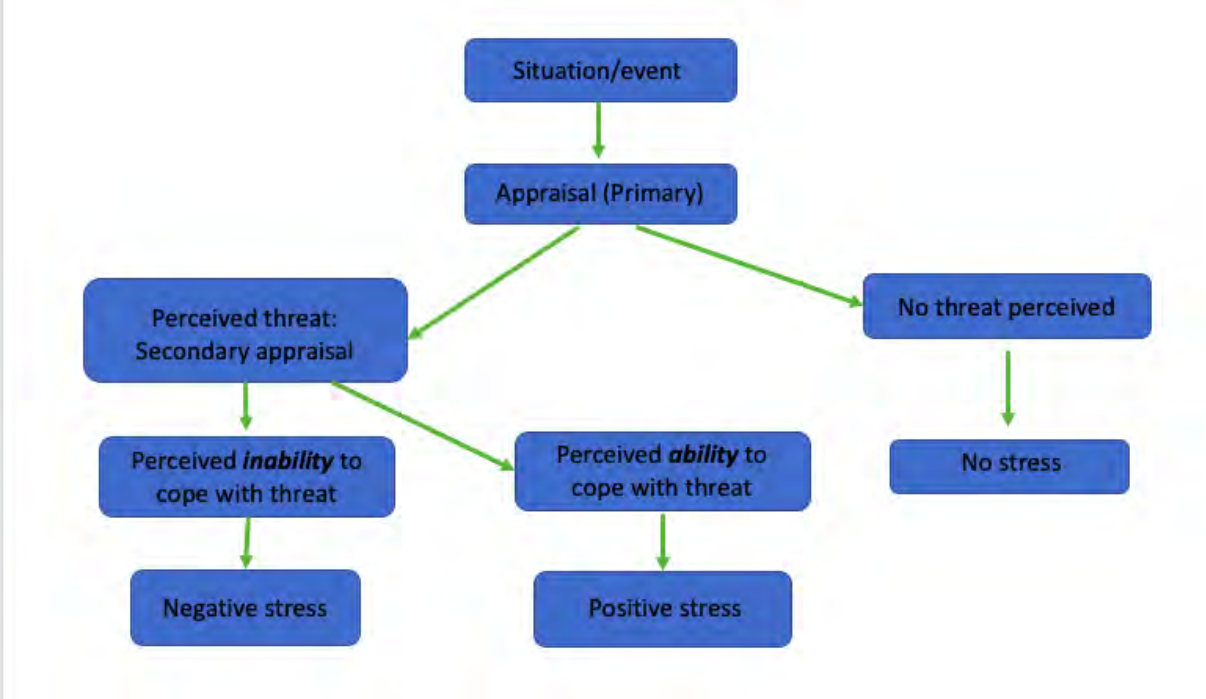
**But** can be a good starting point

Some people feel relieved after being diagnosed, it is like it is a relief, you're not imagining your symptoms

Not evyerone reachers the last stage, not everyone reaches acceptance or equilibrium.

Elements from different stages may cooccur

**Transactional Model of Coping (Lazarus & Folkman, 1984)**




Highly influential model because it changed the way people looked at coping. What theys ay is that coping is our attempt to change a stressor

This is a generic model, it is not about coping with a specific chrinicl illness or any illnesses whatsoever.

**They place cognitions in a central role and there is a relationship between cognition and emotions and coping, and this is dynamic and variable. So reflective changing situation.**

This was viewed as a novel model because unlike previous models, which saw coping as a reaction to emotion, this one has a reciprocal relationship between coping and emotion. Emotion can activate coping, coping can activate emotion.

These emotion and behaioural responses can kind of remain fluid until the situation is resolved.

### Crisis theory (Moos & Schaefer, 1984)

Specifically related to illness and they conceptualised physical illness as a crisis.

Physical illness as a crisis

Three processes:

Cognitive appraisal, adaptive tasks, coping skills

Self-regulation – individuals are motivated to re-establish a state of equilibrium and normality

Two new types of equilibrium:

Healthy adaptation: involves reality orientation, not being in a state of denial, adaptive tasks and constructive coping skills.

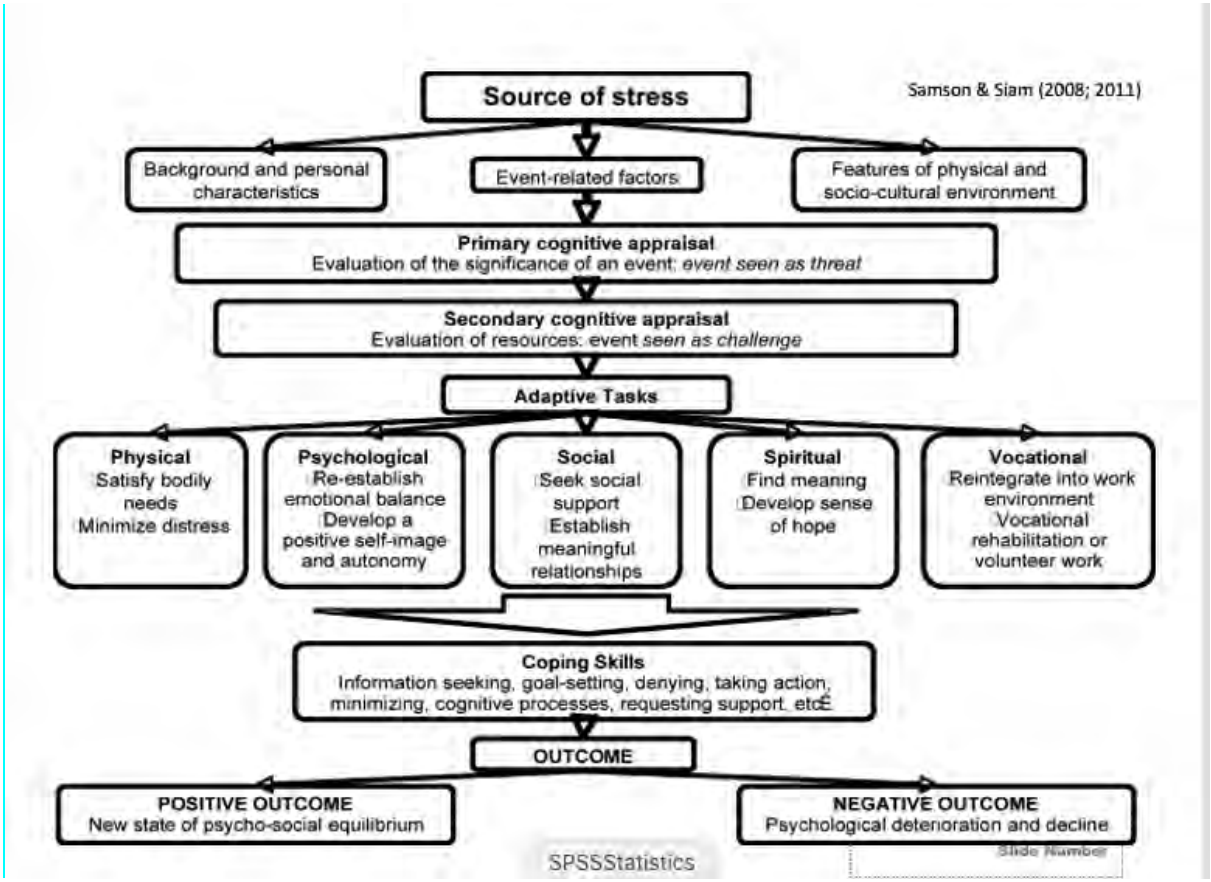
Maladaptive response: can result in deterioration

### Coping with a Chronic Illness (Moos & Holahan, 2007)

**Adaptive tasks: (related to health or general)**

- Managing symptoms
- Managing treatment
- Forming relationships with healthcare providers

- Managing emotions
- Maintaining a positive self-image
- Relating to family and friends
- Preparing for an uncertain future




**The comprehensive task based model of adaptation (Samson & Siam, 2008;2011)**

There are components that will look familiar in this already because it is based on other peoples work.

This is basically an effort to present a framework that combines tasks and issues with individual differences and flexibility.

The authors propose that this process of adaptation isnt neccesarily linear, so it si different from a stage based approach.

5 main components: personal history, cognitive evsluations of the illness, differet griups of adapting tasks, coping skills and final outcome.

Positive outcome is achieved when illness is seen less as an disruption and becomes acception and there is an idea of equilibrium.

**Working Model of Adjustment to Chronic Illness (Moss-Morris, 2013)**

Argues no consistent definition or way of measuring adjustment

Framework should link empirically defined stressors/ tasks to processes or specific coping strategies

Developed initially to understand adjustment to MS

Process of adjustment is to return to, or remain in, equilibrium

An adaptive task can be decision specific

**THRIVE (White et al.,2018)**

**T**herapeutic interventions

**H**abit & behavioural factors

**R**elational/social factors

**I**ndividual differences

**V**alues & beliefs

**E**motional factors

**Associated factors and critique**

**Avoidance strategies: things like denial, withdrawal and distancing.**

Benefits – Can help people to take things in gradually

Can also be maladaptive:

affects the ability to make decisions regarding treatments

affects the need to adjust lifestyles

affects adherence to medical regimes

Bose et al. (2016) – Avoidance coping dispositional

R/ship with emotional distress mediated by illness reps

They can be beneficial but they are not a good longterm strategy

**Positive appraisals**

•Role of optimism: A generalised and stable expectation that good rather than bad outcomes will occur in one's life

•e.g. Scheier & Carver (e.g. 1989, 1999); Carver et al. (2010); Carver & Scheier (2014); Rasmussen et al. (2009) – optimism & physical health

•Link to coping strategies (Scheier & Carver, 1992; Solberg et al., 2006) - COPE

•Unrealistic optimism - implications

Positive psychology interventions

E.g. Casellas-Grau et al. (2014) – breast ca: 5 groups of therapies

Post-traumatic growth (PTG)

Hefferon et al. (2009) – key themes: 'Reappraisal of life and priorities'; 'trauma = development of self'; 'existential re-evaluation'; 'new awareness of the body'

Zeligman et al. (2018) – gender differences & presence of meaning related to PTG

**Resilience and Vulnerability Factors**

**(in Helgeson & Zajdel, 2017)**

| Resilience | Vulnerability |
|---|---|
| Cognitive adaptation (e.g. Taylor, 1983) | Rumination |
| Personality | Poor social connections |
| Benefit-finding (also PTG) | Avoidance |
| Goals | Pessimistic-attribution style |

**Social support**

Social support increased emotional well-being in cancer pts (Boehmer et al., 2007)

Insulin-dependent diabetes – dismissive attachment style predicted poor adjustment & poor adherence to monitoring & injections (Turan et al., 2003)

Dyadic coping (e.g. Badr, 2004, Helgeson & Zajdel review, 2017; Badr & Aticelli, 2017) – **increasing interest**

**Critique of coping research**

**Frameworks** rather than specific theories or models

Lack of **clarity** re: coping as process or outcome (Schwarzer & Schwarzer, 1996)

**Timeframe** of measurement/ pro- or retrospective

Cognitive coping more likely to be **under-reported**, behavioural **over-reported** (Stone, 1988)

I**nconsistencies** in conceptualisation & measurement so cohesive picture of coping is difficult (Skinner, 2003)

**Measures**: retrospective, self-report, response formats, time period for assessing coping (Steed, 1998)

**Summary**

Often profound effects of a CI – importance of looking at adjustment

Importance of nature of CI

A number of models/frameworks proposed to explain adjustment

Mainly task-based

Range of definitions used

Issues around defining and measuring coping/ adjustment

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**Monday October 26th lecture 2**

Qualitative methods in the Psychology of chronic illness → ***Chronic fatigue syndrome***