Adaptation

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INTRODUCTION

Persons with chronic illness chart a life-course to successfully navigate the challenges that are inherent within themselves, their relationships, or the setting in which they find themselves. Throughout the course of their illness, individuals must rely on a healthcare system in which pharmaceuticals, machines, and a wide array of technology to manage and cure disease and injury have become the hallmarks of quality health care. Although the disease focus may be appropriate intermittently during the trajectory of a chronic illness to meet the physical demands of the individual, this perspective does not meet the social, psychological, and emotional needs of clients with chronic conditions. In other words, the disease focus of the healthcare system does not and cannot manage the illness experience of the client and family.

Early work by Visotsky, Hamburg, Goss, and Lebovits (1961) posed some initial questions regarding adaptation in their study of clients with polio. They asked their clients how it was possible to deal with this stressor, polio, and what coping behavior(s) could predict a favorable outcome (Stanton & Revenson, 2007). Nearly fifty years later, we are still asking the same questions. Although we have made progress in understanding certain components of adaptation, many questions remain answered.

The lens for viewing chronic illness is determined by numerous variables within the person as well as how the healthcare professional views the chronic condition. The elderly woman with arthritis who has been socialized to the primacy of medicine in the health care arena may rely solely on her physician prescribed pharmaceutical treatment of her joint pain and fatigue. On the other hand, a young man with Hepatitis C gathers information from a wide variety of sources regarding the treatment and management of his chronic condition and maintains control of his treatment plan.

Similarly, the adaptation mechanism of the elderly woman and the young man may be very different as well. Each individual brings to the illness their own uniqueness, whether it be personality traits, past experiences, culture, or values, to influence the adaptation process in their own way.

Defining Adaptation

The terms adjustment and adaptation are used interchangeably in the literature (Stanton & Revenson, 2007) and will be in this chapter as well. The term adaptation means that there is an
event, or something that is unusual or different that is perceived as a stressor to the individual that dictates a reaction, a change, or a behavior by the individual. Sharpe and Curran (2006) define adjustment as a response to a change in the environment that allows an organism to become more suitably adapted to that change (p. 1154).

An early description of adjustment (and a continuing one) is the absence of a diagnosed psychological disorder, psychological symptoms, or negative mood (Stanton, Revenson, & Tennen, 2007). Even in Visotsky’s study in 1961 with clients with polio, there was a movement to discount that definition. Yes, it may be a part of adjustment, but it is only one indicator of it.

Adjustment to illness has been operationalized as good quality of life, well-being, vitality, positive affect, life satisfaction, and global self-esteem (Sharpe & Curran, 2006). Conversely, Adjustment Disorder is defined as “the development of clinically significant emotional or behavioral symptoms in response to an identifiable stressor or stressor” (APA, 1997, p. 623).

There is little consistency in the literature in defining adaptation or adjustment. Each author/researcher defines adaptation or adjustment differently based on their own theoretical framework or outcome measurement.

This chapter provides a brief overview of adaptation in individuals with chronic illness. With entire books devoted to coping and adaptation, the depth in this chapter is limited. However, classic sources and models are included, along with interventions appropriate for individuals and families with chronic illness.

**IMPACT**

**Conceptualization of Adaptation**

Stanton and Revenson (2007) have identified five attributes of adjustment: (1) chronic illness necessitates adjustment in multiple life domains; (2) there are positive and negative indicators of adjustment; (3) adjustment is dynamic; (4) adjustment can be described only within the context of each unique individual; and (5) heterogeneity is the rule rather than the exception in adjustment. Each of these concepts are further described.

**Chronic Illness Necessitates Adjustment in Multiple Life Domains**

We know from caring for clients that adjustment is more than just physical, but includes adjustment that crosses interpersonal, cognitive, emotional, and behavioral domains. Adjustment is a holistic event in the client, with all domains being interrelated. Therefore, a change in one domain may affect adjustment in another domain (Stanton & Revenson, 2007; Stanton, Collins, & Sworowski, 2001; Stewart, Ross, & Hartley, 2004). Cognitive adaptation might involve a personal self-evaluation. Adaptation in the behavioral domain includes returning to work or resuming the role of the “breadwinner” of the family. Anxiety, in the emotional domain, may affect the ability to socialize, in the interpersonal domain, or influence blood pressure, in the physical domain. Emotional adaptation could be the absence of depression, and interpersonal adaptation may be the willingness to be “social” again. Again, each domain may affect the other.

**Adjustment Involves Both Positive and Negative Outcome Dimensions**

Typically we think of outcomes of chronic illness as being negative, as evidenced by distress, psychological dysfunction, relationships in disarray, and so forth. As stated previously, one definition of positive adjustment is the absence of a psychological disorder. However, there may be a positive side of chronic illness as well.

It’s not unusual to hear individuals with chronic illness say “having this disease has been the best thing that ever happened to me... it made me wake up to see what was important.” There may be positive aspects of chronic disease, but how this
occurs, we don’t know. Folkman, Moskowitz, Ozer, and Park (1997), in their study of HIV-positive and HIV-caregiving partners of men with AIDS, found that although study participants reported high levels of depressive symptoms, they also demonstrated positive morale and positive states of mind when compared with general population norms.

One possible way to describe these paradoxical findings is a concept titled response shift. Sprangers and Schwartz (2000) coined this phrase to describe a change in the meaning of one’s self-evaluation of a target construct as a result of (1) change in an individual’s internal standards of measurement, (2) change in the individual’s values, or (3) reconceptualization of the target construct (p. 12).

Although anecdotally we consider negative outcomes of chronic illness more common, research demonstrates that positive adjustment may more accurately represent the adjustment experience of most individuals with chronic disease (Stanton & Revenson, 2007). By focusing solely on psychopathology, a negative aspect of adjustment, one will have a limited understanding of adjustment.

Adjustment Is a Dynamic Process

Adjustment to chronic illness is neither linear nor lockstep (Stanton & Revenson, 2007, p. 568). As exacerbations occur, as in rheumatoid arthritis or multiple sclerosis, the cancer recurs, and the physical limitations of heart failure increase; each change requires a re-adjustment or re-adaptation. In addition, changes may not be limited to changes in one’s physical condition that affect adaptation, but changes in the rest of the individual’s life. Perhaps a spouse loses his/her job, a child is seriously injured, a parent is no longer able to care for themselves; all of these factors affect the adaptation of the client with chronic illness.

Adjustment Can Be Viewed Only from Within the Context of the Individual

There is variability in adaptation, and that is to be expected. From the context of the individual, the physical symptoms, the functional changes, and the uncertainty, may or may not be pertinent to that individual. Each stressor of the illness has a different relevance for each individual, and as a result will elicit a different reaction from each individual. The context of each individual is different, whether it be their age, gender, ethnicity, or social status. The 35-year-old married woman with three grade-school-aged children with newly diagnosed breast cancer has a different context than the 80-year-old woman whose family is raised. Although that is an extreme example, the variation that exists among individuals cannot be understated.
Models

As researchers, we have a broad goal to understand the process of adaptation, predict outcomes, and by having predictive ability, be able to modify interventions to meet the needs of our clients. A model that is able to perform all those activities is preferred for practice; however, a perfect model does not exist at this time. What follows are sample models from the literature.

Medical Model

The medical model provides a framework for the assumptions about the nature of health and illness. The client becomes a complex set of anatomic parts and interrelated systems. Anatomic, physiologic, and/or biochemical failures translate into etiologies of ill health, thus promoting a disease-oriented approach to care. This theoretical perspective of chronic illness is reflected in the language and actions of healthcare professionals who refer to "the diabetic in room 328," rather than to Mrs. Sanchez.

Pathophysiology, pharmacotherapy, and high technology are emphasized and become prominent in the diagnosis and intervention of all illness and disease, albeit acute or chronic. Antonovsky (1979) considered the medical model a dichotomous model. If pathology is present, then there is illness, and wellness or health is not possible. Explanatory assumptions and theories are used for determining the cause of symptoms, and uniformity of causality and treatment of disease is inferred.

The biomedical paradigm tends to medicalize all human conditions in which symptoms can be controlled and cured with biomedical strategies. This model reduces the individual to a disease and fails to recognize the human aspects and experiences of the individual who happens to have a chronic illness (Sakalys, 2000), and diminishes social and cultural explanation of disease (Mirowsky & Ross, 2002). Physical complaints and signs or symptoms of disease become the hallmarks of interaction and discourse within the healthcare arena.

The relationship between the healthcare professional and the client with chronic illness is one of objectivity, biological pathology, diagnosis, and signs and symptoms, all of which require medical interventions. Healthcare professionals tend to shield themselves from the human aspects of chronic illness, while their skill sets, techniques, and procedures become the focus of interaction with the client (Freeth, 2007). Power and expertise are held exclusively by the healthcare system, and the interactions between the healthcare professional and the client are directive and unbalanced. The individual with chronic illness becomes disempowered to engage in his/her own health care decisions and relies solely on the healthcare professional.

The medical model is insufficient in providing health care to individuals with chronic illness (Waisbond, 2007), and it fails to acknowledge the breadth and depth of the illness experience. This model does not acknowledge the person with the chronic condition, who holds knowledge and expertise about the factors that influence his/her physical symptoms of chronic disease, in other words, the expert patient. For example, at the end of the month, Mrs. Jones becomes anxious that she will not have enough money to purchase her prescriptions for her hypertension. Although she is able to financially manage, Mrs. Jones’ stress and worry exacerbate her hypertension. Mrs. Jones does not inform her physician that the probable cause of her elevated blood pressure is related to her stress. The physician responds to Mrs. Jones’ hypertension with a change of medication to manage her symptoms. The quantification of all signs and symptoms of disease fails to address the total illness experience of the individual. With increased attention to genetic research and gene technologies, the biomedical theories of disease will be continue to be reinforced, with less emphasis on the individual’s social context and experiences (Dixon-Woods, 2001).

Despite the limitations of the biomedical model for adaptation, its usefulness is apparent during the acute phase of chronic illness. Although
the focus of the biomedical model is limited to disease and organic dysfunction, this model is central for adaptation to chronic illness, particularly at the time of diagnosis when individuals and families are overwhelmed with a new diagnosis and sorting out the facts about the illness. In addition, during periods of illness exacerbations, the medical model helps to explain signs and symptoms and may provide a source of retreat and relief, depending on the stage of the chronic illness. There are times when individuals and families need current information about the chronic illness, signs and symptoms, the anticipated trajectory of the illness course, the array of treatment modalities, and traditional as well as alternative strategies. The biomedical model is the foundation for evidence based health care practice and provides the gold standard for treatment and intervention. As a consequence, the medical model provides measurable goals for treatment and client outcomes relative to morbidity and mortality.

Lazarus and Folkman Model

Although there are other stress and coping models, none are more well-known than the one developed by Richard Lazarus and Susan Folkman (1984). Their model, a cognitive-phenomenological theory of stress, views adaptation to chronic illness through adapting to stressors. It is a transactional model of stress and coping, meaning that antecedent variables, such as personality traits, past experiences, and disease and treatment variables, act via mediating variables, such as coping strategies, to produce outcomes, and, in this case, adaptation. Stressors are mediated by primary appraisal, which is the individual’s gauge of the significance and importance of the stressor. Primary appraisal is influenced by the background, experiences, culture, ethnicity, and personality of the individual, and is, therefore, characterized by stability across situations (Folkman, Lazarus, Gruen, & DeLongis, 1986).

The second step of the model is secondary appraisal of the situation. The individual asks the question, “what can I do about this situation,” and this leads to the coping strategies used to manage the stressor. Secondary appraisal is influenced by the physical and social environment and may be context specific (Stewart et al., 2004). To adapt involves applying the coping strategies that are most appropriate to the situation. Individuals use both problem-focused coping and emotion-focused coping. Originally it was presumed by Lazarus and Folkman that the goal was for all individuals to utilize problem-focused coping, and that emotion-focused coping yielded poor adaptation to the stressor, in this case the illness. However, work over the last 20 years has supported that there is a place for emotion-focused coping as well as problem-focused coping (Stewart et al.).

Engel’s Biopsychosocial Model

Clearly a model that could address both the biological and psychosocial aspects of chronic disease would be a preferred one for health care. Engel (1977) was perhaps one of the earliest authors of such a model. The main theme of the model is the influence of biologic, psychological, and social influences on the disease process. Engel’s model outlined three ways in which a psychosocial factor could influence a health outcome: direct, indirect, and moderating. A direct effect would be a belief or value of the client that would preclude him or her from a specific medical intervention. An indirect effect would be defined through a mediational process (Stewart et al., 2004). An example would be an individual’s current symptoms, for instance nausea and vomiting, decreasing their motivation to participate in a prescribed exercise regimen, and thereby decreasing physical functioning. A moderating effect alters the causal relationship between a psychosocial factor and a health outcome.

Livneh and Antonak Model

Livneh and Antonak (1997), working from previous models, proposed that variables that were associated with chronic illness could be organized into
four main categories: (1) disability-related (e.g., type of condition, terminal vs. nonterminal); (2) sociodemographic factors of the individual (e.g., gender, age, ethnicity); (3) individual differences or personality (e.g., coping strategies, locus of control, personal meaning of the condition); and (4) social and environmental factors (e.g., social support, stigma). The interactions of these classes of variables significantly affected adaptation.

Livneh and Antonak (1997) also saw the adaptation process as different from adaptation. They theorized that the process of adaptation was fluid and dynamic, whereas adaptation status was the end result or outcome of the process (Stewart et al., 2004).

**Moos and Holahan Model**

Stewart and colleagues (2004) suggest that an ideal model for adaptation should address four criteria: (1) the reciprocal influences of biological, psychological, social, and behavioral variables of the client and the disease process; (2) be sufficiently broad to apply to clients with a wide range of chronic illnesses and conditions; (3) be able to address the influences of culture, gender, ethnicity, and life stage of the client; and (4) be able to predict the level of client adaptation, which will then lead to appropriate interventions for the client.

Currently a search of the literature does not identify any “ideal” models that can meet the preceding criteria. Moos and Holahan (2007), however, have developed a simple model that provides a framework to view adaptation. Because of its ease of use and understanding, more detail will be provided on this model.

Moos and Holahan’s framework (Figure 4-1) is a way of conceptualizing coping, and integrating it into a broader model. According to the model, there are five sets of factors that are associated with the selection of appropriate coping skills and the resulting health-related outcomes; in this case, adaptation. The model includes three factors that influence cognitive appraisal: (1) personal resources (Panel I); (2) health-related factors (Panel II); and (3) the social and physical context (Panel III). Cognitive appraisal (Panel IV) then dictates what adaptive

**FIGURE 4-1**

Conceptual Model of the Determinants of Health-Related Outcomes of Chronic Illness and Disability.

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Although these studies looked at coping specifically, the relationship of coping with adaptation is uncertain. In addition, it is clear that little is known about the implications of culture and ethnicity in disease-related adaptation (Stanton et al., 2007).

The uniqueness of each individual influences how the chronic condition is appraised, what coping strategies are used, and how and if adaptation can be achieved. For instance, pessimists report higher levels of hostility and depression on the day before coronary artery bypass graft surgery than do optimists (Maes, Levanthal, & DeRidder, 1996). Clients who are optimists tend to cope in a more active, problem-oriented way, as opposed to pessimists who tend to use more avoidant or passive ways of coping. It is not clear how specifically these personality traits influence and affect coping. Carver, Scheier, and Weintraub (1989) have noted that the impact of personality characteristics on coping is modest, and that coping preferences exist independent of personality factors. Although coping preferences could be viewed as personality attributes, they may influence coping indirectly through their impact on appraisal (Maes et al., 1996).

Socioeconomic class affects health outcomes directly and through environmental mechanisms, including access to care and risky and protective health behaviors (Stanton et al., 2007). Although it can be conceptualized as a determinant of adaptation, the pattern is not unidirectional (p. 570). Chronic conditions often influence work patterns and work disability. Work-related disability and loss of a job can decrease an individual’s socioeconomic status.

Health-Related Factors
These factors include the type of onset and progression of the chronic condition, the location of symptoms, the prognosis, and the type of disability. Disease and treatment-related factors are often considered exogenous variables in adaptation (Stanton et al., 2001). A disease factor could be the
stigma that the individual (and or family) associates with the condition. Other disease factors could include a change in body image, declining mobility, extreme fatigue, and so forth. However, the existence and impact of disease factors may actually be influenced significantly by other determinants, such as ethnicity, socioeconomic status, and social support. Many studies do not reveal significant relationships of disease-related factors with adjustment (Stanton et al., 2001). For instance, disease stage of a chronic condition is related inconsistently to adjustment (van’t Spijker, Trijsburg, & Duivenvoorden, 1997).

Not only do the characteristics of the disease contribute, but also the treatment characteristics may contribute to the appraisal of the disease-related event. Surgery, monitoring of physical symptoms (e.g. blood glucose), diet, radiation, chemotherapy, and all of the side effects of treatment are important components in how the client appraises the situation.

Social and Physical Context

This context includes the relationships between the individuals with the chronic disease: their family members, caregivers, and social network. A supportive social context can enhance self-efficacy, transforming appraisal of a health condition as a challenge rather than a threat, and enhance reliance on approach coping (Rohrbaugh et al., 2004). When family members or friends do not convey interest, individuals with serious chronic conditions may avoid talking about their problem and be less likely to cope with the illness-related demands (Norton, Manne, Rubin, Hernandez, et al., 2005).

In general, social support is related to positive adaptation in several chronic diseases (Stanton et al., 2001). However, studies differ in how social support is conceptualized. Social support has been used as a coping strategy, a coping resource in the environment, and considered dependent on personality attributes and coping of the individual (Schreurs & deRidder, 1997). Clearly, interpersonal relationships can both aid and hinder adaptation to chronic illness. For women in particular, interpersonal relationships are vital components of women’s adjustment to major stressors (Revenson, 1994).

Cognitive Appraisal

Appraising the illness is the first step in deciding the adaptive tasks that need to be accomplished. This is also the step in the adaptation process where the illness is appraised as either a challenge or a threat. How the illness is appraised, whether it is controllable or threatening, determines appropriate adaptive tasks and subsequent coping strategies. Using Lazarus and Folkman’s model, primary appraisal of the “threat” or “event” includes the appraisal of harm or loss that has already occurred, or threatened harm or loss (Folkman & Greer, 2000), and includes an evaluation of its personal significance (Walker, Jackson, & Littlejohn, 2004). Secondary appraisal occurs when one assesses the situation’s controllability and compares to one’s available coping resources.

The individual who appraises their diagnosis of colon cancer as a death sentence will make very different decisions regarding treatment than another individual who sees hope. These two individual’s appraisals, coping and adjustment, will be very different.

Adaptive Tasks

The model of Moos and Holahan (2007) identified seven adaptive tasks. Three of the seven tasks are related to the health condition and its treatment, and the other four are more general and could apply to all life crises and transitions, not just chronic illness. The tasks include (1) managing symptoms, (2) managing treatment, (3) forming relationships with health care providers, (4) managing emotions, (5) maintaining a positive self-image, (6) relating to family members and friends, and (7) preparing for an uncertain future (Moos & Holahan, 2007, pp. 112–114).
Impact

CASE STUDY

During football practice in the summer before his senior year in high school, Jack, the star quarterback on the local high school team, collapsed on the field and was taken to the emergency room of the nearest hospital. Jack soon learned that his significant weight loss and increasing fatigue over the preceding year were caused by diabetes. There must be some mistake Jack kept telling himself; after all, only old people get this illness. “Why me”? Jack asked himself over and over. Jack had worked hard throughout high school, both in the classroom and on the football field to increase his chances of getting a full-ride scholarship to the university of his choice. He was acutely aware his parents were not financially able to send him to college, so Jack knew it was up to him; his athletic ability was his ticket out of his small, rural town. “What does this mean”? “I know I’ll never be able to play football again. That’s it, no college for me.” Jack was discharged home the next morning after the nurse had given him detailed instructions on how to manage his newly diagnosed diabetes. He became despondent and depressed, and he refused to acknowledge or discuss his concerns, questions, and fears with his parents, much less his friends. Jack didn’t want anyone to know that he was going to be sidelined and that his hopes and dreams for the future had been dashed by this illness called diabetes.

Discussion Questions

1. What is adaptation for Jack, and how can you as his nurse assist him in this process?
2. What information could you provide to both Jack and his parents to help him understand that he is not “sidelined” for life?
3. What are Jack’s personal resources, health-related factors, and social and physical factors that are contributing to his cognitive appraisal of the situation?

Coping

Moos and Holahan (2007) identify eight categories of coping skills: (1) logical analysis and the search for meaning, (2) positive reappraisal, (3) seeking guidance and support, (4) taking problem-solving action, (5) cognitive avoidance or denial, (6) acceptance and resignation, (7) seeking alternative rewards, and (8) emotional discharge.

Logical Analysis and the Search for Meaning. This set of skills may include drawing on past experiences, mentally rehearsing potential actions and positive self-talk that you’ve handled tough situations like this before. Likely the individual will need educational programs to learn about their condition, possible treatment, and consequences. With appropriate education and the facts, a logical analysis can then be accomplished.

Taylor’s cognitive adaptive theory (1983) suggests that the process of adjustment reflects a search for meaning in the experience, an endeavor for control of the situation, and an attempt to restore self-esteem. In Taylor’s study of breast cancer patients, clients needed to find meaning in their illness before moving on to adaptive tasks. Many individuals with chronic illness experience exacerbations, remissions, unpredictability of pain, and uncertainty, which means their adjustment is dynamic. As such, these individuals find themselves redefining the meaning that they have ascribed to the illness. Meaning is generated from one’s experience and is understood in terms of one’s responses to those experiences (Fife, 1995).
According to Janoff-Bulman and Frantz, (1997), finding meaning in chronic illness takes two forms. The first reflects an effort to determine if an event makes sense and often attributes causal factors to the event, and the second form of finding meaning reflects the value of the experience to the individual.

Pakenham (2007), using Taylor’s (1983) work as a basis, examined “sense making” in individuals living with multiple sclerosis (MS), and the relationship between sense making and positive and negative adjustment outcomes. With 408 persons with MS and 232 caregivers, six factors emerged from a factor analysis of the Sense Making Scale (SMS). They included redefined life purpose, acceptance, spiritual perspective, luck, changed values and priorities, and causal attribution. Results supported the hypothesis that the sense making dimensions that afforded a realistic sense of controllability and predictability or that preserved self-worth were related to better adjustment; whereas those dimensions that entailed viewing illness as fully random and uncontrollable, or that did not preserve self-worth were related to poorer adjustment (p. 386).

Positive Reappraisal. These are cognitive strategies by which the individual accepts the reality of the situation, but reframes it in a different light (Moos & Holahan, 2007, p. 115). Strategies might include positive self-talk, altering values and priorities, and focusing on something good emerging from the chronic illness.

Seeking Guidance and Support. This category of skills includes obtaining education about the health condition, and it may be used in connection with logical analysis. Related coping skills entail seeking emotional help and support from family, friends, and caregivers (Moos & Holahan, 2007).

Taking Problem-Solving Action. These skills involve taking action. Skills may involve learning how to control physical symptoms, planning their daily treatment regimen or minimizing the appearance of side effects of a treatment (Moos & Holahan, 2007).

Cognitive Avoidance or Denial. These strategies minimize the seriousness of a situation or perhaps even deny that it exists. These self-protective responses may temporarily assist an individual to “get through” a tough time and prevent feeling overwhelmed (Moos & Holahan, 2007).

Acceptance and Resignation. Acceptance may involve admitting to a health problem and being resigned to the changes it presents. If this is a terminal illness, the individual may be consciously accepting the inevitable (Moos & Holahan, 2007).

Seeking Alternative Rewards. Responses in this area redirect one’s energy and activities in other directions. Attempts are made to replace the losses that are associated with the illness (Moos & Holahan, 2007).

Emotional Discharge. This category includes the venting of emotions, perhaps crying or screaming out, or using jokes to help displace distress (Moos & Holahan, 2007).

Overview of Coping

Richard Lazarus’s 1966 book, Psychological Stress and Coping, was probably the initial scholarly work that expanded how coping was conceptualized. Since that time, the coping literature has increased significantly, with researchers undertaking studies to understand why some individuals fare better than others when encountering stress in their lives (Folkman & Moskowitz, 2004). Coping is a process that unfolds in the context of a situation or condition that is appraised as personally significant, and as taxing or exceeding the individual’s resources for coping (Lazarus & Folkman, 1984). The coping process is initiated in response to the individual’s appraisal that important goals have been harmed, lost, or threatened (Folkman & Moskowitz, 2004). What we have learned in the last 40 or more years
is that coping is a complex, multidimensional process that is sensitive both to the environment and its demands and resources, and to personality traits that influence the appraisal of stress, in this case chronic illness, and the resources for coping (Folkman & Moskowitz, 2004). Coping is not a stand-alone concept or phenomenon, but embedded in a complex, dynamic stress process that involves the person, the environment, and the relationship between them.

Lazarus and Folkman (1984) described problem-focused coping strategies and emotion-focused coping strategies. Problem-focused strategies were to alter person–environment relationships, and the purpose of emotion-focused strategies was to regulate internal states. Initially problem-focused strategies were seen as “better,” or could influence health outcomes in a more positive manner. However, since Lazarus and Folkman posited their original work, that view has changed. Emotion-focused coping strategies may specifically assist in developing and sustaining a sense of psychological well-being, despite unfavorable circumstances (Folkman & Greer, 2000).

Other theorists have used different terms to describe coping. In addition to problem-focused and emotion-focused coping, meaning-focused coping has been identified as a type of coping in which cognitive strategies are used to manage the meaning of the situation (Folkman & Moskowitz, 2004).

Shaw uses the terms passive coping, which includes avoidance, and active coping, which is nonavoidance coping (Shaw, 1999). This two-factor structure of coping is incorporated into the coping framework as an antecedent to the behavioral intention to cope as well as carrying out the coping behavior. It is likely that individuals may have a number of coping responses at their disposal, although each individual may have their own preferred styles based on their personality attributes (Shaw, 1999).

It is argued that there needs to be a better integration of the perspectives of coping and social support. Studies seem to focus on either social support or on coping, and not the integration of the two concepts (Schreurs & deRidder, 1997). Studying that relationship may be helpful in understanding adaptation to chronic illness.

Another issue in studying coping is that the coping strategy needs to be evaluated in the specific context in which it is used (Folkman & Moskowitz, 2004). Coping strategies are not inherently good or bad, but instead their effectiveness depends on the context in which they are used. Evaluation of the effectiveness of coping requires first, to have the appropriate outcomes selected, and second, attention must be paid to the fit between the coping and the situation (p. 754).

**Adaptation/Adjustment**

What do we know about adaptation? It is a complex construct (like coping), it is multidimensional, and it is a holistic concept. However, it is rarely measured holistically in studies. Consensus does exist regarding the centrality of an individual’s appraisal of their adjustment, it’s their adjustment and their perception, not the healthcare professional’s (Stanton et al., 2001).

We also understand that emotionally supportive relationships set the stage for positive adjustment, whereas criticism, social constraints, and social isolation impart risk (Stanton et al., 2007). Active approach-oriented coping strategies manage disease-related challenges and may bolster adjustment, whereas concerted efforts to avoid disease-related thoughts and feelings are predictors of distress (p. 578). Two basic conclusions come from the descriptive research literature: Most individuals appear to “adjust” well to chronic illness; and there is considerable variability in adjustment both across studies and across individuals within single studies (Stanton et al., 2001).

Maes and colleagues (1996) believe that definitions of adjustment are too simplistic, as many studies operationalize adjustment in terms of psychological outcomes and neglect the medical, cognitive, or social outcomes. Positive adjustment is
not merely the absence of pathology. Typical indicators of adjustment in research are both positive and negative affect and represent two very different dimensions. Therefore, using only depressive symptoms to indicate adjustment will yield only a partial picture of adjustment (Stanton et al., 2001). Maes and colleagues posit that although anxiety and depression are important markers of adjustment, perhaps assessment of everyday life behaviors and activities may be much more relevant (p. 243).

One variable that was studied in the 1970s with Kobasa’s work and into the early 1990s with Pollack, is the concept of hardiness. Brooks (2003) analyzed 125 articles published from 1966 to 2002 to determine the significance of hardiness in adaptation. This “personal resource,” within Moos and Holahan’s framework, demonstrated a significant relationship to psychological, psychosocial, and physiologic adaptation. Higher levels of hardiness had positive outcomes in clients with chronic illness (p. 11).

How coping is related specifically to adjustment has not been clearly described (Sharpe & Curran, p. 1154). Intellectually we believe that coping strategies do contribute to adaptation, and may be a mediator, but probably interact with other factors in contributing to adaptation (Stanton & Revenson, 2007).

Berg and Upchurch (2007) have advanced a model that speaks to dyadic coping and adjustment. Their development–contextual model of couples coping with chronic illness views chronic illness as affecting the adjustment of both the client and the spouse such that coping strategies enacted by the patient are related to those enacted by the spouse and vice versa.

**INTERVENTIONS**

The literature provides an abundance of descriptive studies measuring coping and/or adaptation, but few interventional studies exist. It appears that we can measure coping or adaptation, but that we are unable to conceptualize those results into interventions or ways in which we can help clients better cope with or adapt to chronic illness.

Stanton and Revenson (2007) suggest that we improve the interpersonal context of our clients by teaching them to develop and maintain social ties, recognize and accept others’ help and emotional encouragement, or change their appraisals of the support they are receiving. Psychosocial interventions are directed toward individual-level change and may include cognitive-behavioral interventions, educational, and interpersonal support components. Support groups may provide emotional support as well as an educational focus. The education is expected to strengthen one’s sense of control over the disease, reduce feelings of confusion, and enhance decision making (p. 221). The peer support provides emotional support and thus enhances self-esteem, minimizes aloneness, and may re-enforce coping strategies.

An earlier study that is still referred to frequently in the literature is that of Folkman and colleagues (1991) coping effectiveness training with HIV-positive men. This interventional study based on Lazarus and Folkman’s stress and coping theory was effective in increasing the quality of life in these men. The training included (1) appraisal training to disaggregate global stressors into specific coping tasks, (2) coping training to tailor application of strategies, and (3) social support training.

Nurses may be wise to capitalize on a client’s religious beliefs and partner with clergy to effect adaptation (Loeb, 2006). Programs related to health education and screening, support groups and physical activity that are based in a church may be helpful. Barg and Gullatte (2001) explain that church-based health programming can frame health information in a way that may better fit with a client’s view of life, that is, their relationship with God.

Pakenham’s study (2007), described earlier in this chapter, highlights the need for practitioners to facilitate clients’ cognitive processing of the implications and meaning of their illness.
Perhaps a blend of cognitive-restructuring strategies, client-centered approaches, and existential approaches may be helpful to the client and family.

Cognitive-Behavioral Strategies
Cognitive-behavioral strategies can be used to teach coping skills to clients with chronic illness (Folkman & Moskowitz, 2004). Sharpe and Curran (2007) have also encouraged the use of cognitive-behavioral treatments (CBTs), as the research literature is clear that CBT is effective in managing psychological distress associated with illness. Such programs include strategies with the aim of facilitating a realistic, but optimistic, attitude toward illness and/or facilitating more-adaptive coping strategies. Programs typically include education about the illness, goal setting and pacing, relaxation strategies and attention diversion skills, cognitive therapy, communication skills, and management of high-risk situations (such as exacerbations of the illness).

Emotional Intelligence
Emotional intelligence describes the ability to understand, perceive, use, and manage the emotions of self and others (McKenna, 2007). Emotional intelligence training includes six spheres of emotional competence: emotional openness/adaptation; the impact on and of others; self-esteem/identity; management of stress; communication skills/social functioning; and goal management and motivation. It is suggested that emotional self-management can affect the adjustment of individuals with chronic illness and this can be enabled by the use of emotional intelligence techniques by healthcare professionals (p. 551).

Self-Management Programs
Self-management programs based on enhancing self-efficacy are highly successful in reducing symptoms and encouraging behavior change in many chronic illnesses (Newman, 2006). Self-efficacy could be considered a personal context variable and thus may be a determinant in the appraisal of the illness, the coping strategies used by the individual, and the outcome (the physical, emotional, and social adaptation). Although self-efficacy is task- and situation-specific, programs that encourage that concept could influence adaptation.

Self-Help Groups
As common as self-help and self-support groups are for those with chronic illness, the research literature should be clearer as to their value. Unfortunately, that is not the case. Anecdotal articles exist, but there are few research-based articles. In addition, research commonly looks at such support groups for a short period—6, 10, 12, and 15 weeks—whereas a chronic illness can be present for 30, 40, or 50 years. Therefore, the outcome that we might see in such studies is greatly diminished as the studies demonstrate outcomes at one point in time.

Dibb and Yardley (2006) investigated the role that social comparison might play in adaptation using a self-help group as the context. Social comparison proposes that individuals with similar problems compare each other’s health status. Often this comparison occurs within self-help groups, which consist of individuals with similar circumstances. It has been suggested that downward comparison, where comparison is made with a person who is doing less well, will initiate positive affect as it increases self-esteem. Conversely, upward comparison with a person doing less well, may result in hope (p. 1603). Results of the study with 301 clients with Ménière’s disease demonstrated that positive social comparison was associated with better adjustment after controlling for other baseline variables, whereas negative social comparison was associated with worse adjustment over time.
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Positive Life Skills

In a sample of 187 HIV-infected women, a positive life skills workshop was effective in increasing antiretroviral adherence, improving mental well-being, and reducing stress (Bova, Burwick, & Quinones, 2008). The workshop consisted of 10 weekly sessions with 6 to 15 women in each group. Workshop facilitators shared a vision of a safe, positive, and respectful environment for women to learn and experience. Part of the workshop involved reframing negative meanings.

OUTCOMES

Stanton, Collins, and Sworowski (2001) in their summary of the literature suggest five conceptualizations of positive adjustment: (1) successful performance of various adaptive tasks that accompany chronic disease, (2) absence of a psychological disorder, (3) relatively low experience of negative affect and/or high experience of positive affect, (4) optimal behavioral/functional status, and (5) appraisals of satisfaction or well-being in various life domains (p. 388). Some of these are easily “measured.” For example, absence or presence of a psychological disorder could be ascertained with a degree of certainty. However, other conceptualizations cannot. An example is the appraisal of satisfaction. Does having an individual score high in life satisfaction or life well-being on a questionnaire accurately measure adjustment? How would optimal behavioral/functional status be measured? Furthermore, if we consider adjustment/adaptation as dynamic, could someone have positive adaptation today, but not tomorrow?

We have a long way to go in understanding, effecting, and measuring adaptation. With the increasing numbers of older adults and chronic disease, continuing research and study needs to be accomplished in this area.

EVIDENCE-BASED PRACTICE BOX

Loeb (2006) utilized a focus group to identify the coping strategies used by 28 community-dwelling African American older adults with multiple chronic conditions. Participants’ ages ranged from 55 to 89 with 69% being female. Focus group size ranged from 3 to 10 participants. Nine categories of coping strategies were identified and included: (1) dealing with it; (2) engaging in life; (3) exercising; (4) seeking information; (5) relying on God; (6) changing dietary patterns; (7) medicating; (8) self-monitoring; and (9) self-advocacy. Clients exhibited both emotion-focused and problem-focused coping. The “dealing with it” category included feeling fortunate to have lived a long life, reframing health problems as annoyances and maintaining a positive attitude. Problem-focused coping was evident in the “engaging in life” category. The health-related coping strategies, exercising, changing dietary patterns and medicating, involved action-based problem-focused coping. For the participants in this study, religion and relying on God were strong concepts. Loeb suggests that healthcare professionals capitalize on clients’ strong religious beliefs by partnering with clergy or churches to deliver health programs, screening programs, and support groups.

1. Why is adaptation to chronic illness important to the client and family with chronic illness?
2. Describe how different personal resources could affect adaptation.
3. Compare and contrast the key concepts of the models discussed in this chapter. What are the overlaps in these models? What are the missing elements in these models that would facilitate adaptation?
4. “Finding meaning” was a concept discussed in depth in this chapter. Why is this a necessary component of the adaptation process?
5. Apply the adaptation framework of Moos and Holahan to one of your clients with chronic illness. What fits and does not fit?
6. From your perspective, what is social support’s relationship to adaptation? What is your experience with the role of social support in the adaptation in your clients?
7. Develop a generic teaching plan that would address adaptation to chronic illness. What are key points that could then be individualized to clients?

REFERENCES

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References


