COPING WITH AND ADJUSTMENT TO DISEASE

Morse and Johnson (1991) have proposed four phases in people's response to illness:

1. *Uncertainty*. Here, the person tries to understand the meaning of his/her symptoms, and it may indeed be some time before a definite diagnosis can be given.
2. *Disruption*. The person comes to understand that he/she has a significant illness, which may trigger a crisis, with extreme stress and dependence on health professionals and close family members.
3. *Striving for recovery*. The person attempts to gain some control over his/her life and the illness, typically by undergoing treatment.
4. *Restoration of wellbeing*. Here, the person achieves a new emotional equilibrium based on acceptance of the illness and its consequences.

As with stage models of response to bereavement (Kübler-Ross, 1969), it has been found that not all people move through these phases in a sequential manner and indeed some people will never reach acceptance, or may do so while still feeling significant disruption and distress.

Levels of anxiety and depression can be high in people with chronic illness, particularly when their situation worsens. For example, an Australian study found that 45 per cent of cancer patients who were, on average, three months post-surgery, experienced psychiatric disorders (Kissane et al., 2004). The most common problems included depression and anxiety disorders. While most studies have found that distress reduces over time, some individuals continue to experience high levels of psychological problems even several years after a cancer diagnosis, feeling anxious that the cancer will come back and upset by the bodily changes that are a legacy of their illness and its treatment. If the cancer does come back, these individuals now confront their own mortality, since cancer can rarely be cured at that stage. Depression rates are high at this stage and at the end of life (Bukberg, Penman, & Holland, 1984). Many other illnesses also place individuals at heightened risk of developing psychological disorders. For instance, one study found that depression is twice as likely in people living with diabetes as in the general population (Anderson, Friedland, Clouse, & Lustman, 2001). The most recent version of the *Diagnostic and Statistical Manual of Mental Disorders (DSM*-5) (American Psychiatric Association [APA], 2013) identifies a heterogeneous array of stress-response syndromes that occur after exposure to a distressing (traumatic or non-traumatic) event, such as the diagnosis of serious illness. More severe cases are classified as posttraumatic stress disorder.

Since people vary considerably in their response to illness, there has been much interest in identifying predictors of adjustment. Anderson (1993), for example, developed a model of adjustment to gynaecological cancer. She proposed that predisposing factors, such as age, socioeconomic status, number of dependent children, previous health status, social networks and concurrent stressors, influence how a person will initially respond to a new illness. The extent and severity of the disease and the potential for treatment to cure or diminish the impact of the disease will then further act to cause a low, moderate or high risk of psychological problems.

Other writers have emphasised the role of coping in determining response to illness. Lazarus and Folkman (1984) have been very active in this field and define coping as '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' (p. 141). They defined two styles of coping: (a) problem-focused coping in which the individual takes some action to solve the problem (such as undertaking exercise to reduce the risk of a repeat heart attack), and (b) emotion-focused coping in which the individual changes the way he/she thinks or acts in order to feel better about the situation (such as talking with friends to gain support, reframing a situation to see it in a positive light or undertaking distraction activities). Problem-focused coping is likely to be helpful in situations where something can be done (such as reducing the risk of disease), while emotion-focused coping will be more useful when the situation cannot be altered (such as if someone is dying of an incurable disease).

affect
Experience of feeling or emotion.

More recently, Folkman and Moskowitz (2000) have emphasised the role of positive **affect** and coping, noting that much of the coping literature has focused on negative outcomes, like distress. They note how positive affect