

Coping: conceptual and methodological issues

Nursing research has begun to explore the ways in which patients cope with the deleterious effects of physiological and psychological stressors, but the complexity of the construct of coping has been understated in such investigations. Clinical research in this area should reflect an appreciation of the multidimensionality of coping; the change that occurs in coping and its outcomes over time and across contexts; the salient variables that can affect the coping process, including stressor characteristics, environmental resources, and personal characteristics; and, the reciprocal nature of the relationship between coping and its adaptational outcomes.

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TWO INDIVIDUALS who are faced with the same stressful event or situation may have markedly different responses and outcomes. Although many factors enter into the resolution of stressful situations, the way in which an individual copes has been identified as an important factor mediating the relationship between a stressor and the individual's eventual adaptation. Lazarus and his colleagues¹⁻³ have defined coping as consisting of both cognitive and behavioral efforts aimed at mastering a stressful transaction. They also emphasize that coping efforts can be focused either toward dealing with the problem itself or managing the unpleasant emotions that are aroused because of the problem.

The construct of coping holds particular relevance for nursing. Within the profession, a major clinical focus has been assisting individuals to cope with the deleterious effects of physiological and psychological stressors. Because of an emphasis on pre-

vention, nursing has also been concerned with the period of time *before* the occurrence of the potential stressor and has promoted *anticipatory* coping efforts. Although clinical researchers have begun to investigate this important aspect of practice, the complexity of the construct of coping has been understated in such investigations.

MAJOR APPROACHES TO CONCEPTUALIZATION

As outlined by Folkman and Lazarus,⁴ the conceptualization of coping has been approached from three perspectives:

1. as a set of defensive or ego processes rather than a multidimensional construct;
2. as a personality trait rather than a process; and
3. as a special or unusual situation rather than a normative event.

In some theoretical frameworks, coping has been viewed as one of several ego processes⁵; in others, the definition of coping has been restricted even further to include only the classical defense mechanisms.⁶ However, evaluation of ego processes and defense mechanisms is difficult; this difficulty is reflected in the inadequate interrater reliabilities reported in such studies. For example, Haan⁷ reports interrater reliabilities of 0.45 to 0.65 in her studies of the development of ego processes. This approach has also tended to focus on tension reduction while ignoring the concomitant problem-solving function of coping. Many investigators now recognize the importance of assessing coping from a multidimensional perspective, examining cognitions and behaviors that are aimed at

problem solving as well as tension reduction.^{1,7,8-10} Nurse researchers who have been involved in the development of coping instruments have also adhered to this perspective.^{11,12}

Coping has also been treated as a personality trait or disposition rather than as a process. Traits that have been examined include sensitizing versus avoidance,¹³ monitoring versus blunting,¹⁴ and repression versus sensitization;¹⁵ all three of these traits refer to an individual's propensity to scan the environment for information regarding a stressful event. Investigators who adhere to this dispositional approach make the assumption that individuals are consistent in their responses to stressors across contexts. However, situational variables have been shown to contribute to differences in stress responses,^{9,16} and empirical evidence indicates that the trait approach to coping has had limited success in predicting an individual's behavior in actual situations.¹⁶⁻¹⁹

Folkman and Lazarus⁴ point out that this approach has two additional problems. First, since the traits that are measured are unidimensional, other aspects of coping are ignored. Second, since coping is conceptualized as consistent across situations and therefore static, changes in coping that occur over time are overlooked. Recent data support this common sense notion that there are differences in the way a person copes with a stressful transaction over time.²⁰ However, many of the coping studies reported in the nursing literature measure coping at only one point in time²¹⁻²⁵ and thus provide a restricted view of responses to stressful health-related situations.

Although some exceptions exist,²⁶ there

is also minimal emphasis on gathering information about the ways in which an individual copes *prior to* the occurrence of a potential stressor. With nursing's emphasis on prevention, this omission is particularly glaring since such data are critical to fostering anticipatory coping strategies that could reduce the impact of an impending stressor. Broadening the scope of coping measurements to include strategies used prior to a stressful event, during and immediately after an event, and later in the course of adaptation to a stressor would enrich understanding of the coping process and provide more meaningful data on which to base clinical interventions.

Coping has also been approached from the perspective of a special or unusual situation, and coping responses peculiar to that single situation have been described. An example of this is research describing the specific coping strategies used by a group of new adolescent mothers during their first month home from the hospital.²⁷

This approach is typically more comprehensive than some described here, in the sense that the assessments are not confined to defenses or traits alone. But such studies are limited because the results are often situation specific and, therefore, not generalizable to other contexts. However, given that there is no generally acceptable categorization of coping strategies and given the more clinically useful information obtained from such situation-specific assessments, this emphasis may be more appropriate to nursing research and practice than is the use of a normative approach. It has been operationalized in the work of Folkman and Lazarus⁴ and Pearlin and Schooler,¹⁰ both of which described coping responses to commonly

experienced life stressors. In both studies, findings indicated that a wide variety of coping strategies were used in response to stressors.

FACTORS AFFECTING COPING

Stressor characteristics

Little attention has been given to characterizing the nature of various stressors. Empirical evidence, however, does indicate that different types of stressors are associated with the use of different coping strategies.^{4,10,27,28} For example, Miller¹⁴ reviewed studies with results indicating that stressors having a high degree of

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invasiveness or intensity adversely affect the use of distraction as a coping response. Stressors have also been classified according to their duration^{29,30}; whether they are perceived as controllable or uncontrollable^{31,32}; and, whether they are psychosocial transitions, crises, or deficit situations.^{33,34}

Cohen's categorization may have particular relevance with respect to health-related stressors and, hence, nursing research. Four types of stressors are identified on the basis of duration:

1. acute conditions that are time limited, such as surgery;
2. chronic, intermittent stressors occur-

- ring once a day, every week, or only once a month;
- 3. chronic stress conditions such as being disabled; and
- 4. stress event sequences, in which one event initiates a series of other potentially stressful events extending over a period of time, such as adolescent parenthood.

However, there is a need for further refinements to this categorization, since other studies have highlighted the different impacts of various types of surgery (an acute stressor) on coping.^{35,36}

Environmental resources

An individual's access to various environmental resources affects the appraisal of a potential stressor and the type of coping efforts used.¹ For example, the lack of economic and educational resources may restrict access to effective coping responses.¹⁰ The effect of other sociocultural resources on coping also has been given growing attention in the literature.^{7,8,37,38}

An individual's social network and the supports it provides is a coping resource^{3,39-42} that is especially important to nursing research for two reasons. First, nurses provide different aspects of support to their patients, such as emotional support, cognitive assistance, and social reinforcement. Measuring the effects of such provisions on an individual's coping efforts may be one means of documenting the efficacy of these aspects of nursing care. Second, nursing is concerned with delivering family-centered care in many clinical situations. This includes mobilizing family support that the patient can draw on in coping with a stressful event. In practical situations, this

aspect of care is often overlooked because it consumes scarce clinical time. But if its impact on coping outcomes could be demonstrated, there would be tangible justification for implementing family-centered care in different settings.

Personal characteristics

A current emphasis of nursing research has been to examine the effects of enhancing a patient's ability to cope by providing preparatory information about an impending stressor. This approach is based on the notion of psychological preparation first introduced by Janis.⁴³ Based on work with surgical patients, Janis hypothesized that preparing an individual prior to a stressful situation would stimulate the "work of worrying"; that is, information about potentially disturbing perceptions may stimulate mental rehearsal, which can contribute to the development of effective reassuring cognitions and correct unwarranted anticipations or beliefs.

Although much of the research in this area supports the beneficial effects of this intervention, especially when preparatory information focuses on sensations the patient is likely to experience,^{35,44} results have sometimes been conflicting. These inconsistencies may result from an individual's preference for using certain coping strategies over others in particular situations.^{18,45,46} In studies designed to explore this interaction effect, subjects did better on postsurgical outcome measures when their preference for a particular type of coping was congruent with the type of preparatory information received.^{13,14} It is too early to make clinical recommendations based on such results, but nursing

research should certainly be actively involved in replicating such studies.

Other personal characteristics that may affect coping are the degree of fatalism and inflexibility³⁰; the sense of perceived or actual control over a situation^{17,23,47-52}; and problem-solving abilities.³³

CONSEQUENCES OF COPING

According to Lazarus,¹ the effects of coping can be measured on three different levels: physiological, psychological, and social. Salient information about a particular coping strategy may be lost if only one of these levels is assessed, since coping may result in positive outcomes on one level and negative outcomes on another. Consider, as a hypothetical example, an adolescent mother who has channeled her talents and emotional energy into developing a positive mother-infant relationship but has done so at the expense of her own continued psychosocial development in certain areas. Another example is the person who successfully denies the existence of harmful physical symptoms and achieves psychological comfort at the expense of exacerbating an underlying disease process.

Another issue to be considered is the time at which coping effectiveness should be measured. The issue of short-term versus long-term effectiveness has been considered in only a few studies.^{9,18} It is likely, however, that a particular strategy with satisfactory short-term results may have very different effects on a long-term basis. Since many of the coping studies in the nursing literature are cross-sectional designs and data are gathered either during or

just after the stressful event, the long-term effects of coping in these situations are unknown.

Finally, choosing *appropriate outcome measures* remains an issue that must be repeatedly evaluated, especially in health-related studies. For example, with the advent of diagnosis-related groups, it may no longer be appropriate to use length of hospital stay as a measure of outcome affected by coping, especially in patients with minor illness or minor surgery.

MEASUREMENT

In an extensive review of the various measures used to assess adaptive behavior including coping, Moos¹⁶ identified a broad array of measurement techniques including observations, interviews, family interactions, tape recordings, films, essays, sentence and story completions, and a variety of objective techniques. Based on this review, he recommended that various assessment techniques should be compared in studies and that particular attention should be given to the conditions in which it is advantageous to use one method rather than another.

Lazarus et al¹⁹ had difficulty assessing defensive coping mechanisms and questioned the relative usefulness of self-reports, observations, or a combination of both. And a similar measurement issue was raised by Pearlin and Schooler¹⁰ as a result of the ambiguities surrounding their assessments of concrete coping behaviors used to manage emotions. As Moos¹⁶ concluded, a combination of complementary techniques may be needed to gather comprehensive information about such a complex theoretical construct.

The appropriate design of coping studies is also a complex issue, but it is advantageous to the understanding of this process if repeated assessments of coping and its possible outcomes are explored in a longitudinal design. However, consideration of the nonrecursive nature of the coping process is important. Although coping is an independent variable affecting adaptation, it also may be a dependent variable influenced in turn by these same measures of adaptation.

This notion of ongoing feedback is essential to proper interpretation of data. In a study²⁵ examining the relationship between the use of postoperative coping strategies and surgery outcomes, the expected inverse relationship between coping behaviors and the development of symptoms was not found. Four of the six correlations were statistically significant, but the relationships were inverse to those predicted. Interpretation of these results was difficult because the associations between the use of coping behaviors and the symptoms of pain intensity and distress were conceptualized as static and unidirectional. However, if ongoing feedback between these factors is considered, coping can also be viewed as a dependent variable that therefore can reflect the immediate response to pain and distress. If measures of these variables had also been obtained at a later time, the expected inverse correlation may have been evident.

CLINICAL RESEARCH

Many of the early studies on coping were entirely descriptive, focusing on the contributions of various coping strategies

to psychological adjustment in different health-related situations.¹⁸ More recent descriptive research has outlined the coping strategies used by such groups as wives separated from their husbands^{41,54}; hemodialysis patients²¹; acutely ill patients seeking care at an emergency department²²; hypertensive patients²²; expectant adolescent fathers²⁶; and new adolescent mothers.²⁷ Current correlational studies have examined the relationships between the coping behaviors and functioning of parents²⁴; cognitive coping strategies and psychosocial adjustment in spinal-cord-injured patients⁵⁵; and denial or compliance to a medical regimen, as well as the chance of rehospitalization or death in patients with ischemic heart disease.⁵⁶

Clinical intervention studies of coping have had two major focuses: (1) the provision of preparatory information to enhance coping and (2) instruction and rehearsal in the use of specific cognitive^{52,57} or behavioral^{36,49} coping strategies. In some studies, both preparatory information and coping instructions have been included in the experimental conditions,⁵⁸⁻⁶⁰ but the separate effects have not been differentiated. However, in other studies,^{35,49,61} these two components have been separated to determine whether the use of either element alone or both in combination is more beneficial. It remains unclear as to the conditions under which either preparatory information, coping instruction, or both combined may be the preferred intervention strategy.

Although the overall results of intervention studies have generally indicated that either preparatory information or instruction in coping can have positive effects on

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clinical outcomes, conflicting results are found in the literature; this may be caused by an inadequate conceptualization of the coping process. Many variables that may interact with the experimental condition, such as the personal characteristics mentioned here, are often not assessed. In addition, investigators rarely consider factors such as environmental resources or differences in stressor characteristics, which could account for conflicting results. For example, many studies are concerned with surgery, but few investigators take into account that different types

of operative procedures vary in the degree of threat and the problems in adjustment that they present.

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Nursing research related to coping, whether it is descriptive, correlational, or experimental in design, must reflect an appreciation of the complexities of this construct. This involves a recognition of several factors including the multidimensionality of coping; the change that occurs in coping and its outcomes over time and across contexts; salient variables that can affect the coping process, such as stressor characteristics, environmental resources, and personal characteristics; and the reciprocal nature of the relationship between coping and its adaptational outcomes. Designing clinical research from this perspective can result in a richer understanding of the particular health-related problem, as well as the coping process itself.

REFERENCES

1. Lazarus RS: The stress and coping paradigm, in Bond LA, Rosen JC (eds): *Competence and Coping During Adulthood*. Hanover, New Hampshire, Univ. Press of England, 1980, pp 28-74.
2. Lazarus RS, Cohen JB, Folkman S, et al: Psychological stress and adaptation: Some unresolved issues, in Selye H (ed): *Selye's Guide to Stress Research*. New York, Van Nostrand Reinhold, 1980, pp 90-117.
3. Lazarus RS, Launier R: Stress-related transactions between person and environment, in Pervin L, Lewis M (eds): *Perspectives in International Psychology*. New York, Plenum Press, 1978, pp 287-327.
4. Folkman S, Lazarus RS: An analysis of coping in a middle-aged community sample. *J Health Soc Behav* 1980;21:219-239.
5. Haan N: *Coping and Defending: Processes of Self-Environmental Organization*. New York, Academic Press, 1977.
6. Wilson JF: Recovery from surgery and scores on the defense mechanisms inventory. *J Pers Assess* 1982;46:312-319.
7. Caplan G: Mastery of stress: Psychosocial aspects. *Am J Psychiatry* 1981;138:413-420.
8. Kaplan HB: Sociological theories, in Kutash IL, Schesinger LB (eds): *Handbook on Stress and Anxiety*. San Francisco, Jossey-Bass, 1980, pp 63-80.
9. McGrath JE: Major substantive issues: Time, setting, and the coping process, in McGrath JE (ed): *Social and Psychological Factors in Stress*. New York, Holt, Rinehart & Winston, 1970, pp 22-39.
10. Pearlin LI, Schooler C: The structure of coping. *J Health Soc Behav* 1978;19:2-21.
11. Hymovitch D: Development of the chronicity impact and coping instrument: Parent questionnaire. *Nurs Res* 1984;33:218-222.
12. Jalowiec A, Murphy SP, Powers MJ: Psychometric

- assessment of the Jalowiec coping scale. *Nurs Res* 1984;33:157-161.
13. Goldstein MJ: Individual differences in response to stress. *Am J Community Psychol* 1973;1:113-137.
14. Miller SM: When is a little information a dangerous thing? Coping with stressful events by monitoring versus blunting, in Levine S, Ursin H (eds): *Coping and Health*. New York, Plenum Press, 1980, pp 145-169.
15. Byrne D: The repression-sensitization scale: Rationale, reliability, and validity. *J Pers* 1961;29:334-349.
16. Moos RH: Psychological techniques in the assessment of adaptive behavior, in Coelho GV, Hamburg DA, Adams JE (eds): *Coping and Adaptation*. New York, Basic Books, 1974, pp 334-399.
17. Sandler IN, Lakey B: Locus of control as a stress moderator: The role of control perceptions and social support. *Am J Community Psychol* 1982;10:65-80.
18. Cohen F, Lazarus RS: Coping with the stresses of illness, in Stone G, Cohen F, Adler N (eds): *Health Psychology—A Handbook*. San Francisco, Jossey-Bass, 1979, pp 217-254.
19. Lazarus RS, Averill JR, Opton EM, Jr: The psychology of coping: Issues of research and assessment, in Coelho GV, Hamburg DA, Adams JE (eds): *Coping and Adaptation*. New York, Basic Books, 1974, pp 249-315.
20. Folkman S, Lazarus RS: If it changes it must be a process: A study of emotion and coping during three stages of a college examination. *J Pers Soc Psychol*, to be published.
21. Baldree KS, Murphy SP, Powers MJ: Stress identification and coping patterns in patients on hemodialysis. *Nurs Res* 1982;31:107-112.
22. Jalowiec A, Powers MJ: Stress and coping in hypertensive and emergency room patients. *Nurs Res* 1981;30:10-15.
23. LaMontagne LL: Children's locus of control beliefs vs predictors of preoperative coping behavior. *Nurs Res* 1984;33:76-79.
24. Ventura JN: Parent coping behaviors, parent functioning and infant temperament characteristics. *Nurs Res* 1982;31:269-273.
25. Ziemer MM: Effects of information on postsurgical coping. *Nurs Res* 1983;32:282-287.
26. Panzarine S, Elster AB: Coping in a group of expectant adolescent fathers: An exploratory study. *J Adolesc Health Care* 1983;4:117-120.
27. Panzarine S: Adolescent mothers: Perceived stressors, social supports and coping during the puerperium. *Dissertation Abstracts Int* 1984;44:2113B.
28. McCrae RR: Situational determinants of coping responses: Loss, threat, and challenge. *J Pers Soc Psychol* 1984;46:919-928.
29. Cohen F: Stress & bodily illness. *Psychiatr Clin North Am* 1981;4:269-286.
30. Wheaton B: Stress, personal coping resources, and psychiatric symptoms: An investigation of interactive models. *J Health Soc Behav* 1983;24:208-229.
31. Lowenthal MF, Chiriboga D: Social stress and adaptation: Toward a life course perspective, in Eisdorfer C, Lawton MP (eds): *The Psychology of Adult Development and Aging*. Washington, DC, American Psychological Association, 1973, pp 281-310.
32. Suls J, Mullen B: Life events, perceived control and illness: The role of uncertainty. *J Human Stress* 1981;7:30-34.
33. Parkes CM: Psycho-social transitions: A field for study. *Soc Sci Med* 1971;5:101-115.
34. Weiss RS: Transition states and other stressful situations: Their nature and programs for their management, in Caplan G, Killilea M (eds): *Support Systems and Mutual Help*. New York, Grune & Stratton, 1976, pp 213-232.
35. Johnson JE, Rice VH, Fuller SS, et al: Sensory information, instruction in a coping strategy, and recovery from surgery. *Res Nurs Health* 1978;1:4-17.
36. King IM, Tarsitano BJ: The effect of structured and unstructured pre-operative teaching: A replication. *Nurs Res* 1982;31:324-329.
37. Lee PDK, Newton N: Cultural aspects of coping. *Int J Soc Psychiatry* 1981;27:13-22.
38. Moos RH: Context and coping: Toward a unifying conceptual framework. *Am J Community Psychol* 1984;12:5-25.
39. Cohen F: Personality, stress, and the development of physical illness, in Stone GC, Cohen F, Adler NE (eds): *Health Psychology—A Handbook*. San Francisco, Jossey-Bass, 1979, pp 77-111.
40. Hirsch BJ: Coping and adaptation in high-risk populations: Toward an integrative model. *Schizophr Bull* 1981;7:164-172.
41. McCubbin HI: Integrating coping behavior in family stress theory. *J Marriage Fam* 1979;41:237-244.
42. Mechanic D: Illness behavior, social adaptation, and the management of illness. *J Nerv Ment Dis* 1977;165:79-87.
43. Janis IL: *Psychological Stress*. New York, Academic Press, 1953.
44. Hartfield MT, Cason CL, Cason GJ: Effects of information about a threatening procedure on patients' expectations and emotional distress. *Nurs Res* 1982;31:202-206.
45. Auerbach SM, Martelli MF, Mercuri LG: Anxiety, information, interpersonal impacts, and adjustment to a stressful health care situation. *J Pers Soc Psychol* 1983;44:1284-1296.
46. Wilson JF, Moore RW, Randolph S, et al: Behavioral

- preparation of patients for gastrointestinal endoscopy: Information, relaxation, and coping style. *J Human Stress* 1982;8:13-23.
47. Folkman S: Personal control and stress and coping processes: A theoretical analysis. *J Pers Soc Psychol* 1984;46:839-852.
 48. Gal R, Lazarus RS: The role of activity in anticipating and confronting stressful situations. *J Human Stress* 1975;1:4-20.
 49. Hill BJ: Sensory information, behavioral instructions and coping with sensory alteration surgery. *Nurs Res* 1982;31:17-21.
 50. McFarlane AH, Norman GR, Streiner DL, et al: A longitudinal study of the influence of the psychosocial environment on health status: A preliminary report. *J Health Soc Behav* 1980;21:124-133.
 51. Parkes KR: Locus of control, cognitive appraisal, and coping in stressful episodes. *J Pers Soc Psychol* 1984;46:655-668.
 52. Rodin J: Managing the stress of aging: The role of control and coping, in Levin S, Ursin H (eds): *Coping and Health*. New York, Plenum Press, 1980, pp 171-202.
 53. Rutter M: Stress, coping and development: Some issues and some questions. *J Child Psychol Psychiatry* 1981;22:323-356.
 54. McCubbin HI, Dahl BB, Lester GR, et al: Coping repertoires of families adapting to prolonged war-induced separations. *J Marriage Fam* 1976;38:461-472.
 55. Rosenstiel AK, Roth S: Relationship between cognitive activity and adjustment in four spinal-cord-injured individuals: A longitudinal investigation. *J Human Stress* 1981;7:35-43.
 56. Prince R, Frasure-Smith N, Rolicz-Woloszyk E: Life stress, denial and outcome in ischemic heart disease patients. *J Psychosom Res* 1982;26:23-32.
 57. Roskies E, Lazarus RS: Coping theory and the teaching of coping skills, in Davidson PD, Davidson SM (eds): *Behavioral Medicine: Changing Health Lifestyles*. New York, Brunner/Mazel, 1980.
 58. Visintainer MA, Wolfer JA: Psychological preparation for surgical pediatric patients: The effect on children's and parents' stress responses and adjustment. *Pediatrics* 1975;56:187-202.
 59. Wolfer JA, Visintainer MA: Pediatric surgical patients' and parents' stress responses and adjustment. *Nurs Res* 1975;24:244-255.
 60. Wolfer JA, Visintainer MA: Prehospital psychological preparation for tonsillectomy patients: Effects on children's and parents' adjustment. *Pediatrics* 1979;64:646-655.
 61. Langer EJ, Janis IL, Wolfer JA: Reduction of psychological stress in surgical patients. *J Exp Soc Psychol* 1975;11:155-165.