Life continuously presents before us the circumstances that can affect our physical or psychological well being. Chronic illness conditions are particularly stressful because a chronic disease is an irreversible illness that one must live with for weeks to years. Not only the victim but many persons related to victims are likely to worry and become weary of the process of dealing with diagnosis, grieving, the loss of health or lifestyle, financial difficulties and worrying about the future. In the face of such losses the experience of fear, anger, depression, anxiety, and disorientation is normal. Chronic illness is an emotionally, as well as, physically depriving experience. It can do lasting harm by threatening a person’s sense of well being, competence and feelings of productivity (Dubey, 2003).

Life stresses, like a chronic disease may foster enhanced resilience because they provide an opportunity to learn new coping skills (Caspi, Bolger & Eckenrode, 1987). The coping process involves cognitions, emotions, and behaviour. Patients’ experience of chronic illness not only depends on the severity of illness but also the personal and social resources available. These psychosocial factors will moderate the perceived threat of a disease and facilitate or pose barriers to adaptation (Dubey, 2003).

Coping Researches in Chronic Illness

The central role of coping in the adaptation to chronic illness has been widely regarded yet the coping researches are far from describing a ‘magic bullet’ coping strategy that can instantly solve all the problems and restore emotional equilibrium (Aldwin & Revenson, 1987). Lazarus has emphasised that coping encompasses cognitive and behavioural efforts to reduce or eliminate stressful conditions and associated emotional distress (Lazarus & Folkman, 1984). Haan (1965) conceptualised coping behaviour as flexible, purposive, reality oriented and differentiated. Health and well being is being influenced by the interaction of biological, psychological and environmental factors. Coping researches in chronic diseases have taken into consideration, one of the three approaches, as:

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1. Health related variables (e.g., recovery or blood pressure) are directly affected by coping strategies.

2. Health or illness is indirectly affected by coping strategies.

3. The stress produced by specific illness is moderated or buffered by the coping strategies.

Coping researchers in chronic illnesses tried to investigate coping in terms of specific strategies which one uses to handle particular disease related constraints. Some researchers also studied coping in terms of personal style, which tend to be more stable across situations. According to these line of researches coping is viewed as having two major functions: (i) The management of and direct confrontation with the problem that is causing distress (problem focused coping); (ii) The regulation of emotions (emotion focused coping). Both forms of coping are used in most stressful encounters and that the relative proportion of each form varies according to how the crisis is appraised (Folkman & Lazarus, 1980). Coping as a trait or coping as a process is sometimes referred as an interindividual or dispositional and intraindividual or contextual approach. The interindividual approach describes the habitual ways of coping an individual use across different types of situations, whereas, the intraindividual approach to coping describes the basic coping behaviour an individual use in particular types of situation.

Possible psychophysiological and psychosocial routes by which coping can affect health and wellbeing were also investigated. The kind of coping strategies used by the person have both short-term and long-term consequences. Associated physiological responses will have long-term analogues on person’s overall morale, somatic health and illness and overall quality of social and work functioning. Coping strategies that help in the short run may be counterproductive in the long run. An individual can respond to a stressor in a wide variety of ways. So, the selection of problem focused or emotion focused or relationship focused coping strategies is dependent upon many factors. People who are flexible in their choice of coping show better adaptation than those who have more restricted or rigid coping repertoire. Transactional theory points that coping changes over time in response to changing objective demands and subjective appraisal of the person situation interaction. For example Denial is predictive of better medical outcome during acute hospitalization for coronary heart disease (Levenson, Mishra, Hamer & Hastillio, 1989). On the other hand denial may interfere with early detection and treatment of breast cancer. Following diagnosis, denial of one’s emotional reactions or the life threatening implications of the disease may have very different effects (Carver, et al., 1993). In the long run repressive coping may be associated with reduced adherence to medical requirement, prolonged pain and distress and less resistance to disease (Jamner, Schwarts & Leigh, 1988).

Penly, Tomaka and Wiebe (2002) in a meta analytic review reported that coping strategies of planful problem solving, positive reappraisal and Vitaliano’s problem focused coping were significantly correlated with positive overall health outcomes (i.e., physical and psychological outcomes), whereas, confrontative coping, distancing, self control, seeking social support, accepting responsibility, wishful thinking were negatively correlated with overall health outcomes. Approach oriented coping is positively related (Scheier, et al., 1989) and avoidance coping is negatively related with quality of life of patients recovering from cardiac surgery and for cancer patients escape avoidance is related with more emotional distress (Carver, et al., 1993).
Majority of the evidences suggest that more problem focused coping is related to better adjustment, whereas, avoidant coping and coping that focuses on the self (e.g., self blame) are related to poorer adjustment. These relations hold across different types of chronic illness and a variety of indicators of adjustment and well being (e.g., Dubey, 2003).

**Psychological Impact of Chronic Illness**

A patient’s experience of chronic illness will reflect its biology and developmental history but the degree to which it is a source of psychological stress will be dependent on the individual’s personal and social resources. These psychosocial factors moderate the perceived threat of a disease and facilitate or pose barriers to adaptation. Cassilith, et al., (1984) and others have reported that most of the out patients with diabetes, cancer, rheumatic diseases, renal and skin diseases do not report higher levels of stress and lower levels of well being throughout the history of their disease in comparison with similar healthy subjects, the exceptions being the initial and end stages. However, the disease and disability can generate a host of comorbid life stresses ranging from economic and social loss to sacrifice of life goals.

Confusion, anxiety, sorrow, grief, self blame are the typical reactions to the diagnosis of cancer which are also subject to changes over time (Couzjin, Ross & Winnubst, 1990). Acceptance of chronic illness can be accompanied by a fusion of the entire self with the disease, which generates depression, sense of hopelessness and despair.

Coping with asthma in general is different from coping with a specific attack (Maes & Scholosser, 1987) or coping with arthritis in general is different from coping with specific pain episode (Manne and Zautra, 1990) or coping with diabetes in daily life is different from the coping processes during a state of hypoglycemia (Pennings- van der Eerden & Visser, 1990). Besides the disease other important life events which contribute to the appraisal of disease related events, disease characteristics, treatment schedule, and demographic characteristics play role in coping with chronic illness.

**Coping Challenges by Chronic Illness**

Adjustment to chronic illness is determined by cognitive appraisal, coping strategies and coping resources available. Cognitive appraisal refers to the evaluative process that reflects the person’s subjective interpretation of an event (Lazarus & Folkman, 1984). Appraisal as studied in terms of threat, challenge and controllability has been found to be a strong predictor of adaptation to chronic illness (Pakenhann, 1999).

Coping resources are relatively stable characteristics. These resources are either internal or external. The cognitive appraisal of the situation and available coping resources made the ground for the development of coping strategies. External coping resources can be money, time, distance from professional help or the kind of social support or social network available on which the patient can rely upon. Social support and relationship within family have a positive (Dubey, 2003), as well as, negative impact on the adaptation to chronic illness. Dubey (2003) found that cohesive, less conflicting, more expressive, more caring and unconditionally supportive family environment predicted 13 percent variance in the use of active coping strategies in group of patients with cancer, diabetes and heart diseases. Along with this every member in the family tried to follow the rules set for
family and take his/her responsibility also make the patients feel less bothered about the organization in the family and this in turn helps him to concentrate more on to fight actively with complications of the disease. People who have more social contacts and networks rely more on active coping such as positive reinterpretation and seeking guidance and support and less on avoidance coping strategies especially on emotional ventilation (Moos, Brennan, Fondacaro & Moos, 1990). Rheumatoid arthritis patients (wives) with critical less supportive spouses (husbands), are more likely to use maladaptive coping behaviours such as wishful thinking, whereas, patients with supportive spouses reported more problem focused coping (Manne & Zautra, 1989) on the one hand, and on the other hand if the patient's wife's uses ineffective coping strategies such as self blame and wishful thinking were associated with poorer adjustment on the part of husband (Manne & Zautra, 1990). Individual with inadequate support were likely to become depressed as their disabilities related to diabetes increased (Littlefield, Rodin, Murray & Craven, 1990).

Social resources can bolster coping efforts by enhancing self efficacy, as well as, by providing information and guidance. Not only are the individuals coping strategies themselves often influenced by the social context but social environment modifies their effectiveness as well (Dubey, 2003). Internal resources comprised of the energy or physical strength a person possess, as well as, personality dispositions such as intelligence, trait anxiety, optimism, future orientation, autonomy, ego strength, hope, hardiness, perceived control, self esteem, self-efficacy etc. Studies have proposed that both personality and coping be involved directly or indirectly in the production and maintenance of various kinds of adjustments or maladjustments. Factors like, affiliation and approval motives, self-esteem, conformity, defensiveness (Lazarus, 1966), anxiety (Janis, 1974), self denigration and mastery (Pearlin & Schoolder, 1978) have potential effects on coping. Five factor Model of personality originally propounded by Tupes and Cristal (1961) and elaborated by several researchers (e.g., McCrae, 1992) suggested that five traits of neuroticism, extraversion, agreeableness, openness and consciousness represents the core components of personality and coping styles are related to these basic five factors of personality.

Smith, Pope, Rehdowalt and Poulten (1989) showed that trait anxiety was associated with relatively less use of problem focused coping and seeking social support and more use of wishful thinking and avoidance. Extraversion was a predictor of active coping among survivors of myocardial infarction (Martin, 1989). Optimism, the generalised expectation of favourable outcome seem to predict more active problem oriented ways of coping in surgical patients (Carver, Scheier & Pozo, 1992), and in chronically ill patients (Dubey, 2003). Agarwal and Pandey (1998) found that high future oriented chronically ill patients used more the coping strategies like, active coping, planning, positive reinterpretation, seeking social support for instrumental reasons. This future oriented outlook and positive coping strategies, in turn, enables the patient to find a meaningful life and satisfaction even in adverse circumstances (Dubey & Agarwal, 2004). Active coping efforts serve as mediating routes through which optimism relates to better psychological adjustment (Carver, et al., 1993) and overall wellbeing (Dubey, 2003).

The relationship between generalised belief about control and coping efforts has been studied in several ways. Having a sense of control was associated with better coping with stressful life events (Glass, McKnight & Valdimarsdottir, 1993). In a study on chronically ill patients by Dubey (2003)
perceived control emerged as best predictor of active coping strategies with 21 percent of variance and satisfaction with life with 26.1 percent variance (Dubey & Agarwal, 2004). Patients best adapt to chronic illness when they use active and vigilant coping strategies and this was done only when things seems controllable (Dubey, 1980). Coping researches conducted at this juncture of time consistently showed that patients’ who uses problem focused coping strategies have less difficulty in adjusting to chronic disease than the patients who use more avoidant emotion focused coping strategies. To cope with various diseases related stressors these findings are consistently.

Children’s Coping with Chronic Illness

In Indian context perhaps none of the statistical epidemiological estimate is available which show the prevalence rate of chronic diseases amongst children. However, most common chronic diseases in children are asthma, diabetes, leukemia, etc. Chronic illnesses during childhood have psychosocial costs-social isolation, adjustment problems, depressive symptoms, etc.

A chronic illness presents enormous coping challenges before the children and their caretakers. Vast individual differences exist in responses to chronic illness condition. Some children with chronic condition are well liked by their peers, excel in school and appear free from anxiety and depression, but other children are immature of their age, socially isolated and awkward and anxious or depressive. Children with neurological or sensory impairment appear particularly vulnerable to adjustment problems. Newacheck and Taylor (1992) found that most children in their study reported being bothered not at all, very little or some, by their conditions and have minimal limitations to their usual activities. Thompson (1985) emphasised maternal coping processes and adjustment to a greater extent. Tripathi and Agarwal (2003) found that Mother’s health attitude was significantly and positively correlated with academic behaviour, social relationship, future expectations and total efficacy of child. Those mothers’ who scored high on positive health beliefs had children who reported fewer psychological symptoms in spite of the fact that they were suffering from chronic illnesses. Thompson, et al., (1992) found that maternal anxiety was positively related to children’s internalising and externalising symptoms, after controlling disease severity, SES and the child’s age and gender.

In the studies on environmental influences on children’s coping with chronic illness the dimensions of family environment and family relationship have been assessed. Family cohesion, affection, flexibility and expressiveness in particular are associated with good psychological and physical adjustment and with active coping. Family conflict is associated with poor psychological and physical adjustment (Tripathi & Agarwal, 2003). This was also found in adults coping with chronic illness (Dubey, 2003). Kliewar, et al., (1994) suggested that parents’ influences their children’s threat appraisal and coping efforts through three processes—which then influences psychological adjusts. Parents coach their children to react emotionally and to use particular coping strategies when faced with problems, model their own emotional responses and coping efforts in response to stress and create a home environment that either invites open communication and cohesion or stifles them.

Coping processes refer to both how a child appraise or evaluates a situation and the efforts he or she uses to manage the associated affect or solve the problem. Pediatric researchers have often
developed their own coping measures, because measures used in adult coping researches were not valid, appropriate and meaningful for children with chronic illnesses. Band and Weisz (1990) found that coping was significantly related to medical adjustment for older children but not for younger children. Greater control coping (conceptually similar to problem focused coping) was associated with more favourable adjustment. Lewis and Kliewer (1996) with 39 sickle cell disease children demonstrated that active coping was negatively linked to self reported anxiety and health care utilization, while avoidant coping was positively related to anxiety. Ebata and Moos (1991) found that adolescents who use more approach coping such as positive reappraisal and problem solving and less avoidance coping.

We do not know much about whether the psychosocial impact of chronic disease is stable or varies depending on the developmental issues the child is facing in the life. Chronically ill children face the same developing tasks and challenges as healthy children do, like, expanding self understanding, learning more about how society works, developing intimate relationships with others, developing behavioural standards, managing behaviour, etc. Chronic illness may interfere with these developing tasks in multiple ways. Developing a healthy notion of self, good peer relationships and sense competence may be challenged by the constraint of living with a chronic disease, particularly if the child’s social interactions are limited. Chronic illnesses that result in decreased school attendance or limited participation in play or sports activities or that require adherence to medical routines or treatments that make the child seem different, all these presents coping challenges (Garrison & McQuiston, 1989).

**Interventions**

Chronic disease episodes will have a powerful impact on the individual and require complex revision of the self and its relation to the social context. The critical question is whether coping skills can be effectively taught? The coping researchers come to the conclusion that maladaptive coping behaviour may be causing and maintaining mental and physical illness. Teaching more adaptive coping strategies would be an effective intervention. Cognitive behavioural methods (e.g., cognitive restructuring), modifying the stress appraisal; process, use of multiple coping behaviour maybe a critical step in determining ensuing effective coping strategies. The cognitive behavioural method was found successful in modifying the ineffective coping strategies of cancer patients by Dubey (2004). In the study women cancer patients were tested for optimism, future orientation, perceived control and the use of coping strategies, along with perception of family environment by themselves and by their caregivers. Those who scored low on optimism, future orientation, and perceived control and were using more maladaptive coping strategies were intervened. A cognitive behavioural counseling schedule with 10 sessions was organised for these patients. The post test results indicated that after this intervention 65 percent started changing their secondary appraisal and tried to be optimistic more concreted on the brighter side of the events and looking forward for future and engages in task oriented behaviour. In the one month follow up they said that now they confront with the disease and do not let it go. The relationship between active coping and well being was found. Their caregivers also have the same confrontative, fighting attitude. So, cognitive behavioural method may have considerable effectiveness for altering faulty and dysfunctional behaviour.
Further research is needed in Indian setting to identify which coping strategy is most effective and adaptive in promoting positive outcomes and also how a coping strategy be used to relieve emotional distress and maintenance of well being. Particularly more intervention studies are needed as the prevalence rate of chronic diseases in India is rapid. A great number of diseases afflicting human being are psychosomatic in nature. Psychosomatic means rooted in our emotional, mental or perceptual and behavioural habits. So, coping can have an effect on three kinds of outcomes, i.e., psychological, social and physiological.

In Sankhyasukt coping orientation had been viewed as 'abhinivesa’, which means commencement of coping behaviour by arranging the behaviour in a proper response sequence. It is needed to understand this indigenous view of coping and develop some measuring tool based on this concept. Sometimes a coping score from a questionnaire gives an incomplete picture of the chronically ill person’s coping strategies. An in depth interview would be useful in obtaining a more clear picture. Additional research is needed to specify the processes by which social environmental factors influences the children’s physical and psychological well-being.

REFERENCES


