KNOWLEDGE AND CASES OF ADAPTIVE AND ACTIVE STRATEGIES AMONG PATIENTS IN OUR SOCIETY: EMPHASIZING ON THE THEORY OF STRESS AND COPING

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ABSTRACT

Coping strategies are essential in determining how individuals manage stress, illness, and psychological challenges. This study explores knowledge and cases of coping strategies among patients in our society, emphasizing the theory of stress and coping. Drawing insights from established theories of coping strategies, the research reveals that coping strategies do not only play an important role in the psychosocial adjustment of individuals with disabilities but also influence the health related quality of life of people with disorders. With the knowledge and awareness of coping strategies, it becomes a vital factor in improving the ability to deal successfully with situations by minimizing its impact on social and psychological functioning. The study concluded that the knowledge of coping strategies has been shown in this study to grant some measure of control over the psychological state of the patients. All coping strategies do not have the same effect on psychosocial well-being of patients. One of the recommendations made was that the various coping strategies should be taught in hospital-based health education seminars for patients.

Keyword: Coping Strategies, Patients and Society

Introduction

The knowledge of coping strategies can help one overcome the psychosocial trauma of stressful conditions. It has been observed that patients with relatively similar problems may

respond differently to their medical care and management. These differences could be as a result of their ability to cope with stressful conditions. According to the American Psychological Association (2018), coping strategies are an action, a series of actions, or a thought process used in meeting a stressful or unpleasant situation, or in modifying one's reaction to the situation. Additionally, Yu *et al.,* (2020) defined coping strategies as the specific efforts, both behavioural and psychological, that people employ to master, tolerate, reduce, or minimize stressful events.

According to Ali *et al.,* (2020), exposure to coping strategies education improved knowledge and behaviours in their subjects compared to their pre-education level. Moreover, the knowledge of coping strategies may also lead to an improvement in health related quality of life not only for patients but also for their families (Ryan *et al.,* 2013). Interestingly, coping strategies do not only play an important role in the psychosocial adjustment of individuals with disabilities but also influence the health related quality of life of people with disorders (Umucu and Lee, 2020). Together with the knowledge and awareness of coping strategies, it becomes a vital factor in improving the ability to deal successfully with situations by minimizing its impact on social and psychological functioning (Corn *et al.*, 2020).

Coping strategies, according to Weiten *et al.,* (2011), are those reactions or efforts made to master, reduce or tolerate the demands created by stress. According to the American Psychological Association (2018), coping strategies are an action, a series of actions, or a thought process used in meeting a stressful or unpleasant situation, or in modifying one's reaction to the situation. Additionally, Yu *et al.,* (2020) defined coping strategies as the specific efforts, both behavioural and psychological, that people employ to master, tolerate, reduce, or minimize stressful events. In order to better understand the range of coping efforts used by persons facing stressors, including for trauma and orthopaedic conditions, a number of authors over the years have tried to categorize

coping strategies. Some of the coping dimensions that have been explored are: Adaptive and Maladaptive (Mahmoud Alilou *et al*., 2022, Zeidner and Saklofske 2015), Active and Passive (Perez-Tejada *et al*., 2019), Emotion based (Perez, 2017), and Avoidance (Brands *et al.,* 2014, Stanisławski, 2022). Coping strategies can be applied to alleviate psychological impacts, emotional impacts and social impacts on traumatic and orthopaedic patients. The concept of coping strategies is expected to gain popularity in public circles and across our health care institutions. This study was designed to investigate the effect of the knowledge of coping strategies on psychosocial well-being of persons with musculoskeletal impairment in the National Orthopaedic Hospital in Igbobi, Lagos.

Theoretical Framework

Theory of Stress and Coping by Lazarus and Folkman (1984)

A major contribution to the contemporary understanding of coping is derived from the work of American psychologists, Richard Lazarus and Susan Folkman. The concept of the transactional model of stress and coping was first propounded by Richard Lazarus in 1966 in a book entitled "Psychological Stress and the Coping Process". In 1984, working in conjunction with Susan Folkman, he further elaborated this concept in a book entitled "Stress, Appraisal and Coping" (Lazarus and Folkman, 1984). According to the transactional model of stress and coping, stressful experiences are perceived as person-environment transactions. In these transactions, the person undergoes a four-stage assessment known as appraisal. When confronted with any possible stressful situation, the first stage is the primary appraisal of the event. In this stage, based on one's previous experience, knowledge about one's self, and knowledge about the event, the person internally determines whether he or she is in trouble. If the event is perceived to be threatening or has caused harm or loss in the past, then the stage of secondary appraisal occurs. If, on the other

hand, the event is judged to be irrelevant or poses no threat, then stress does not develop any further and no further coping is required.

The secondary appraisal determines how much control one has over the situation or the event. This understanding leads to the third stage where the individual ascertains what means of control are available to him or her. This stage is known as coping. Finally, the fourth stage is the stage of reappraisal, where the person determines whether the original event or situation has been effectively negated or not. The primary focus of conceptualization of coping by Lazarus and Folkman is on coping as an application of thought processes and behavioural efforts to combat demands that exceed a person's resources. The hallmarks of this conceptualization of coping are: (a) its focus on the "process" of coping as opposed to personality traits; (b) importance of specificity of specific stressful situations in inducing coping as opposed to a general physiological response; and (c) having no reference to the outcome (whether positive or negative) as opposed to the mastery concept that only emphasizes the positive aspects.

The hypothesized role of coping as a mediator of the effects of stress on psychological and social well-being of individuals provides a major impetus for the study of coping. The case for a relationship between coping and psychological outcomes is substantial, mainly because the coping process is initiated in response to a cognitive appraisal of a situation as stressful. When a situation is appraised as stressful, it is judged significant to the person involved, and is very capable of putting significant demand, or quickly exceeding the person’s ability to cope. The appraisal is made by a person with a particular psychosocial and biological heritage at a particular developmental stage in a particular setting, with particular personal, social, and material resources for coping, and with other demands competing for those resources. When those resources cannot match the demand placed on them, negative psychological outcomes are imminent.

In considering how the theory of stress and coping by Lazarus and Folkman (1984) relates to this study, effective coping to a stressful condition depends on how a person views the stressful event. A person with a past history of musculoskeletal injury will probably see a subsequent injury as minor, if he or she is able to use the affected part, and may cope without any form of treatment. However, if the subsequent injury resulted in pain, swelling and loss of function of the affected part, he or she will likely perceive it as serious and would seek for treatment. Also, a patient who has had surgery in the past, will most likely cope better when scheduled for another surgery. He will cope well with hospitalization and pain management.

Model of Psychological Well-Being by Ryff (1998)

The Psychological Well-Being Scale (Ryff, 1995; Ryff and Keyes, 1995; Compton, 2005) that operationalized Ryff's model gained recognition as a valid measure of positive mental health across different populations. The six dimensions in the model were used to obtain a holistic picture of well-being, with individuals doing a positive self-evaluation in relation to their present and past life, continued sense of personal growth and purpose in life, as well as their good relationships with others (Ryff and Keyes, 1995; Ryff and Singer, 2008). In her work, Ryff found that the well-being components had different outcomes at different periods in the human development process. For example, whilst high psychological well-being amongst young people emanated more from personal growth and was less based on environmental mastery, high levels of well-being amongst older individuals emanated more from autonomy and environmental mastery (Ryff, 1989b). She further found that, for younger people, psychological well-being was associated with pleasant activities, whilst older people associated well-being with positive relationships and work experiences (Ryff and Heidrech, 1997).

In her study on psychological well-being, Ryff (1989) argued that the meaning and measurement of well-being could not be understood within the traditional framework, which viewed health as the absence of illness, rather than as the presence of wellness. Based on this argument, Ryff (1989) aimed at developing an integrative view of well-being that took into account the role of positive functioning and mental health found in the work of life span theorists such as Erikson in 1969; the theory of psychosocial stages found in Rogers' 1961 depiction of the fully functioning individual; as well as Maslow's 1968 notion of self-actualization. It was this integrated view which led to Ryff's description of well-being as "an individual's striving for perfection, leading to the realisation of one's optimum potential". Ryff (1989) presented a model of psychological well-being entrenched within the eudaimonic tradition, and comprising six dimensions, namely self-acceptance, environmental mastery, personal growth, purpose in life, autonomy, and positive relations with others (Ryff, 1989a; Ryff, 1989b, Ryff, 1995; Gallagher *et al.,* 2009).

Self-acceptance refers to an ability to evaluate oneself, whilst accepting both the positive and negative aspects in one's abilities. Environmental mastery has to do with a sense of mastery and competence in making decisions conducive to meeting life goals; whilst personal growth is related to one's capacity for personal growth, self-knowledge, effectiveness and openness to new experiences. A purpose in life refers to one's sense of meaning, purpose and direction in life. Autonomy is characterized by independence and self-determination, coupled with abilities to resist societal pressures as well as self-regulation. Positive relations with others refer to an ability to create and sustain close relationships with others, a concern for the welfare of others and empathy and affection for others (Compton, 2005).

According to Ryff's 1989 model of psychological well-being, the six dimensions of well-being are guided and shaped by our socio-demographic characteristics such as age, gender, ethnicity and culture, as well as both positive and negative life experiences. In her study on positive ageing, Ryff identified constructs such as well-being, positive health and resilience as important building blocks for positive human development and mental health. This means that people cannot be studied in a vacuum, but within the context of their surrounding circumstances and experiences.

The experience of the researcher in clinical and nursing practice relates well to this theory in the present study. For instance, patients with high level of self-acceptance exhibit positive attitude towards their health conditions, resulting in good psychosocial well-being. Similarly, hospitalized patients with high levels of environmental mastery cope better with problems of hospitalization, such as change of environment, and this relates with psychosocial well-being. Also, patients with high levels of positive social relation will maintain good relationship with the health care team, their families and friends, and co-patients. This is an indication of a good psychosocial well-being.

Conceptual Review

Coping Strategies

Weiten *et al.,* (2011) referred to coping strategies as those reactions or efforts made to master, reduce or tolerate the demands created by stress. According to the American Psychological Association (2018), coping strategies are an action, a series of actions, or a thought process used in meeting a stressful or unpleasant situation, or in modifying one's reaction to the situation. Additionally, Yu *et al.,* (2020) defined coping strategies as the specific efforts, both behavioural and psychological, that people employ to master, tolerate, reduce, or minimize stressful events.. The extent to which a stressor affects an individual's physical, psychological and behavioural

outcomes is accounted for, in part, by one's coping resources and strategies. Coping skill is necessary for students' educational, professional and personal development. The ability and skill to manage imposed stresses effectively will lead to high levels of psychological well-being, while inability or skill deficits to manage it leads to lower levels of psychological well-being (Weiten *et al.*, 2011).

Frydenberg (2018) emphasized that coping does not occur in a vacuum. The social context of family, friends and community not only influences one's appraisals of situations, but also one's choice of coping strategies (Aldwin, 2011). The implication here is that the development of constructive coping strategies during childhood and adolescence determines how the individual would cope with adversities throughout the youth and adult years (Melato *et al*., 2017). A variety of other factors such as age, intellect, gender and parental/social support was found to influence coping styles amongst young people, while culture, race and nationality also emerged as prominent factors influencing coping processes (Breik and Zaza, 2019; Saleem *et al*., 2020; Ajibewa *et al*., 2021).

According to Liu *et al.*, 2023, support from family and friends serves an important function as a coping resource during adolescence. Any change in the social relationships with parents, siblings and peers during adolescence would have an impact on the extent to which those relationships will serve as sources for emotional support, even into adulthood. For individuals with brain injury, coping can be influenced by cognitive and interpersonal consequences of the head trauma. When accompanied by decreased perceived control, these individuals are more easily prone to use maladaptive coping styles, which can lead to a downhill spiraling into emotional instability (Murray, 2019; Roth and Hardin, 2019). For example, research has found that one of

the main contributing factors to the presence of enduring post-injury emotional complaints in this population is their use of maladaptive coping styles (Velikonja *et al.,* 2013).

The roles of Adaptive and Active coping strategies in well-being of patience

In order to better understand the range of coping efforts used by persons facing stressors, including for trauma and orthopaedic conditions, a number of authors over the years have tried to categorize coping strategies. Some of the coping dimensions that have been explored are: Adaptive and Maladaptive (Mahmoud Alilou *et al*., 2022, Zeidner and Saklofske 2015), Active and Passive (Perez-Tejada *et al*., 2019), Emotion based (Perez, 2017), and Avoidance (Brands *et al.*, 2014, Stanisławski, 2022). The number of dimensions seems bounded only by the imaginations of the various researchers involved.

The proliferation of categories, and the lack of consensus among theorists, has not stopped researchers and clinicians alike from declaring that certain types of coping are better than others. A general audience webpage article discussing problem focused versus emotion focused coping, for example, concludes that "In general problem focused coping is best, as it removes the stressor, and deals with the root cause of the problem, providing a long term solution". Similarly, several reviews have concluded that responding to traumatic pain with "passive" strategies has been associated with poor overall adjustment (Jensen *et al*., 2011). Similarly, Zeidner and Saklofske (2015) unequivocally referred to avoidance coping as "maladaptive," a stance that self-help websites and magazine articles are quick to agree with.

It is worth noting that there is a lot of overlap between coping strategies when they are employed by real people in real situations. The categorization of coping strategies is for the purpose of study and understanding – they are not used in exclusion of each other. In practical

terms, a person will employ a vast variety of coping strategies simultaneously when in stressful situations.

Adaptive Coping Strategies

The term adaptive coping strategy has been replaced by many other words and includes such words as active, problem-oriented, task-based, etc. Generally speaking, adaptive strategies help patients to reduce pain and stress, while promoting or improving function (Mahmoud Alilou *et al*., 2022). Adaptive coping strategy might involve problem solving, including collecting information and refocusing on the problem, or regulation of emotion by focusing attention on the emotional response aroused by the stressor). Maladaptive coping strategies are those that attempt to manage stress, but end up decreasing function despite temporary respite from certain symptoms. Several reviews have concluded that responding to traumatic pain with "passive" strategies has been associated with poor overall adjustment (Jensen *et al*., 2011). Similarly, Zeidner and Saklofske (2015) unequivocally referred to avoidance coping as "maladaptive," a stance that self-help websites and magazine articles are quick to agree with. The difference between adaptive and maladaptive coping strategies are not the strategies themselves, rather the outcomes they produce. Adaptive/Maladaptive are descriptors of the outcomes of applying said coping strategy with respect to the particular stressor involved. In other words, if the strategy manages stress while promoting optimal function in the user, it is in that sense an adaptive strategy. On the other hand, if the strategy manages stress symptoms but produces an overall decrease in function in the user, it is referred to as maladaptive. The proof of the particular cake is in the eating.

Active Coping Strategies

According to Grommisch *et al.* (2020), coping strategies reflect the repertoire of responses available to the individual and which can be successfully deployed in times of stress. Whereas

personality is relatively fixed, coping strategies can be taught explicitly or through modelling. The effect of coping strategies is usually classified as active or favourable, and passive or unfavourable (Prell *et al.,* 2021). Active coping strategies include securing social support, biofeedback, active distraction, problem solving, gathering information, prioritizing tasks, turning to religion, requesting and accepting help from family and friends. Active coping mechanisms usually involve an awareness of the stressor and conscious attempts to reduce stress. Active coping refers to cognitive and behavioural attempts to deal directly with problems and their effects (Prell *et al.,* 2021) as explained hereunder.

Cases of Coping Strategies

There are various cases in which coping strategies were brought into play, and were shown to help in maintaining and balancing psychosocial well-being, both generally, and specifically in the case of trauma and orthopaedic patients. The planned infrastructural landscape of Victoria Island, Lagos, Nigeria presents a case study of coping strategies. Victoria Island is categorized as a high-income location and is generally well planned and possesses adequate infrastructure, unlike most informal settlements in developing countries. Informal settlements tend to be situated in environmentally precarious locations where they are susceptible to frequent environmental disasters (Ajibade *et al.,* 2015), and their residents engage in the adoption of coping strategies to help mitigate the impact of disasters. The well-planned infrastructure in Victoria Island signifies anticipatory rather than reactive coping (Ajibade *et al.,* 2015). According to Boamah *et al.,* (2015), in Nigeria, individuals in lower income categories or in rural areas of the country adopt coping strategies. The difference in the findings is because higher income status in Nigeria probably confers on individuals the ability to acquire property in locations, which are less susceptible to the location hazards. Consequently, the extent of damage by location hazards surges in the aftermath

of disaster may not warrant the adoption of coping strategies (Ajibade *et al.,* 2015; Boamah, *et al.,* 2015; Boer *et al.,* 2015).

Boamah *et al.* (2015), in their paper on "Does Previous Experience of Floods Stimulate the Adoption of Coping Strategies, Evidence from Cross Sectional Surveys in Nigeria and Tanzania" examined the relationship between stressful life experiences on particular locations and the adoption of coping strategies among coastal dwellers in Tanzania and Nigeria. The stressful life experiences used in this study were the experience of floods and ocean surges within the past one year. Relationships between stressful life events and the adoption of relevant coping strategies have been explored by some authors (Boer *et al.,* 2015). In their study, the overall findings showed that individuals in both Tanzania and Nigeria who experienced stressful life events engaged in the adoption of coping strategies. Regardless of this, the findings also showed specific cross-country differentials in the predictors of adoption of flood-related coping strategies. This suggests that context-specific policies aimed at encouraging the adoption of coping strategies in vulnerable locations should be designed based on local needs and orientation (Boamah, *et al.,* 2015; Boer *et al.,* 2015).

Coping is influenced by the environment in which the professional is inserted, as well as the experiences of previous stressful situations. There are socio-demographic and functional influences regarding the coping strategy used; therefore, individual efforts linked to organizational conditions related to occupational stress and professional instrumentation on coping are necessary to understand and use them more effectively. High levels of occupational stress can be attributed to the sector of work and workloads. Different results of these experiences in the work environment are revealed, peculiar to each sector and region, but converge to the presence of occupational stress.

It is also inferred the need to adopt coping strategies and reflections on prevention of mental illness, knowing that stress consists of trigger and prolonged exposure threatens workers' health.

Conclusion

The knowledge of coping strategies has been shown in this study to grant some measure of control over the psychological state of the patients. All coping strategies do not have the same effect on psychosocial well-being of patients. It is also concluded from this study that the adaptive, active and emotion-based coping strategies, in that order, are more effective than the other strategies in fostering positive psychosocial well-being among patients.

Recommendation

1. The various coping strategies should be taught in hospital-based health education seminars for patients. The aim of such patients' education programmes will be to create the awareness of coping, and to establish in the minds of the patients the relationship between their psychosocial well-being and their ability to deploy coping strategies.
2. Patients should be taught to deploy their knowledge of coping strategies within the shortest time possible, after suffering musculoskeletal impairment, or after getting into hospital care for other reasons.
3. A single coping strategy should not be applied in isolation of other coping modalities because there is often a functional overlap by these modalities. Therefore, a patient obtains a most positive psychosocial well-being by a combination of different strategies.
4. Evidence from this study suggests that a combination of the adaptive, active and the emotion-based strategies may yield the most positive effect on the psychosocial well-being of the patients.

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