Published in final edited form as:

J Nerv Ment Dis. 2006 December ; 194(12): 917–924.

Coping With Psychosis: An Integrative Developmental Framework

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Abstract

One important way in which persons with severe mental illness, such as schizophrenia, can influence the recovery process is by coping with the profoundly negative effects of mental illness. Despite accumulating evidence on the active role of the person in his or her recovery, there remains much conceptual confusion regarding the nature and categorization of the concept of coping. The present article constructs a clinically useful framework of coping that describes parallel and consecutive types of coping processes by applying Schwarzer's proactive coping theory to severe mental illness. Four coping modes including reactive, anticipatory, preventive, and proactive are described, and the role of meaning making is elaborated on as an integrative framework. Future research can be directed at validating the presented model and investigating the relationship between these types of coping and other relevant dimensions such as symptoms, functioning, and recovery.

Keywords

Coping; severe mental illness; recovery

The last two decades have been characterized by major developments in the conceptualization of the course and outcome of severe mental illness (SMI), such as schizophrenia. Kraepelin's early definition of *dementia praecox*, which had associated schizophrenia with deterioration, helplessness, and pessimism, has been challenged by numerous studies that have shown that many with SMI achieve some meaningful degree of recovery (Harding et al., 1987) and moreover play an active role in their movement toward recovery across the course of their lives (Davidson et al., 2005; Roe, 2001; Strauss, 1992).

One way in which persons can influence their recovery process is the manner in which they cope with the potentially negative effects of SMI (Lysaker et al., 2004, 2005; Roe and Chopra, 2003; Roe et al., 2004; Yanos and Moos, 2006; Yanos, 2001). In addition to overwhelming symptoms (Hatfield, 1989), severe mental illness entails many other sources of stress which can impact on quality of life, including the experience and anticipation of widespread structural violence and social rejection (Angermeyer et al., 2004; Kelly, 2005), loss of social standing and self worth (Link et al., 2001; Wright et al., 2000), and poverty and vulnerability to criminal victimization and homelessness (Chernomas et al., 2000). Difficulties coping with any or all of these stressors linked with illness may also exacerbate symptoms. Thus, symptoms and the

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Supported in part by a grant from the National Institute of Mental Health (5K23MH066973-02) to Philip T. Yanos.

psychosocial stressors linked to SMI are thought to exacerbate one another in an interactive process, with difficulties managing stressors affecting and being affected by symptom severity (Yanos and Moos, 2006). In support of this view is empirical research showing that less adaptive coping predicts greater distress, symptom exacerbation, and reduced community tenure (e.g., Bak et al., 2003; Macdonald et al., 1998; Middleboe and Mortensen, 1997; Takai et al., 1990; Wiedl, 1992), while more adaptive coping has been linked with reduced positive symptom levels (Ritsner et al., 2003) and greater self-efficacy (Lysaker et al., 2001).

While the accumulating evidence on the active role of the person in his/her recovery has had a profound impact on our understanding, language, and interventions in relation to SMI, there remains much conceptual confusion on the nature and categorization of “coping.” For instance, what are the qualities of the types of coping which help persons adapt in the face of mental illness? Beyond the use of specific techniques to deal with a specific stressor, what are the properties of a type of coping that help persons to recover? Do the same types of coping apply to all the challenges posed by SMI (such as persistent symptoms, major relapses, social rejection, and disrupted identity), or do processes differ depending on the type of challenge posed by the SMI? Are there perhaps parallel or consecutive processes that relate to different kinds of concerns or even discrete stages along which persons change as they consider themselves as possible agents who can respond to solve difficulties?

In the current paper, we consider theoretical advances from the general behavioral sciences regarding coping in an effort to clarify some of the conceptual issues regarding coping with severe mental illness. While earlier conceptualizations of stress in the behavioral sciences focused on reaction to a stressor (Lazarus and Folkman, 1984), more recent examinations include concepts such as “proactive” and “anticipatory coping” (Aspinwall and Taylor, 1997; Hobfoll, 2001; Schwarzer and Taubert, 2002). Additional theoretical work has focused on appraisal, and the way it influences the degree to which different events are experienced as primarily stressful, or alternatively, as challenges or opportunities to practice or prove oneself, anticipate potential gains of mastery (Baltes, 1997), recourses (Hobfoll, 2001) or personal growth (Folkman, 1997; Roe and Chopra, 2003).

We build upon Schwarzer’s proactive coping theory (Schwarzer, 2000, 2001; Schwarzer and Taubert, 2002) from health psychology. This theory was chosen because of its potential applicability to coping with SMI, in the following ways. First, its emphasis on the time perspective distinguishes between reactive, anticipatory, preventive, and proactive coping. This perspective is consistent with recent conceptualization of coping with SMI as a nonlinear dynamic process in which types of coping are differentially used over time to address the numerous challenges posed by the illness and its aftermath (Roe et al., 2004). Second, the cognitive-transactional process is initiated and maintained by a person’s cognitive appraisal of present or potential stressors; this perspective is in accord with the view that how an individual responds to or copes with symptoms and other experiences related to SMI depends on the appraisal of both self and stressor (Roe, 2005; Yanos and Moos, 2006). In this sense, appraisal is conceptualized somewhat differently than in the past, when it referred principally to the appraisal of a stressor. Finally, while most of the existing literature on coping with SMI focuses primarily on negative events that have occurred, in line with recent coping theories we focus here on both negative events and *resilience*, which has been used to refer to personal growth after the experience of serious negative events (Schaefer and Moos, 2001). This view is concurrent with several recent studies and interventions in the area of SMI that emphasize goal-setting, resilience, and purposefulness (Davidson et al., 2005; Deegan, 2005; Mueser et al., 2002; Strauss, 1992).

By applying this model to SMI and elaborating on the process of meaning-making, we propose a framework that describes, along a continuum, parallel or consecutive nonlinear processes in

which persons with SMI cope and accordingly influence their recovery process. In the remainder of the paper we describe Schwarzer's concepts of reactive, anticipatory, preventive, and proactive coping and review research on coping with SMI relevant to each of these modes. To illustrate these better and make them more useful for practice, we present excerpts taken from 10 recorded and transcribed interviews conducted during 2004 with five persons diagnosed with SMI as part of an exploratory qualitative study of coping with SMI (the interviews were part of a pilot study that was approved by the Institutional Review Board's of Rutgers University and UMDNJ).

REACTIVE COPING

Historically, coping strategies emerged out of the literature on defense mechanisms that were understood as unconscious means of dealing with internal conflicts. Defense mechanisms were thought to alter one's perceptions of stressful events to reduce distress. Examples of such conceptualizations with respect to people with SMI include the Schreber case, in which Freud described how delusions may serve as a creative defense mechanism against internal states of terror, confusion, and psychotic breakdowns. Theoretical developments shifted from responding to stress generated by internal conflicts to what Schwarzer and Taubert (2002) call "reactive coping," which reflects an effort to deal with past or present stressful encounters and their consequences (Lazarus and Folkman, 1984). Reactive coping emphasizes the transactional processes, which include an exchange between the person and his or her environment, emphasizing two broad types of coping. The first is *emotion-focused*, which refers to efforts to deal with one's emotional response to a stressor (for example: trying to deal with the depressed mood one might experience after losing a job). The second is *problem-focused* coping, which is aimed at directly changing or managing a threatening or harmful stressor (for example: trying to find a new job to deal with job loss).

Both of these broadly defined types of coping can be identified in the literature of people with SMI coping with their illness and its consequences. Two potentially confusing conceptual issues should be addressed, however. First, there is the issue of symptoms: are they stressors, emotions, or both? Our perspective is that it depends on the type of symptom, and whether it is the primary stressor causing the person to be upset, or if it has arisen in response to another stressor. For example, if one is coping with a symptom such as a hallucination, then one will most likely be engaged in problem-focused coping; however, if one is coping with distressed mood that arises in response to experiencing hallucinations, then one is using emotion-focused coping. The distinction is that the hallucination itself is a symptom and a stressor but that the distressed mood is an emotional response to the symptom.

A further issue is the distinction between "emotion-focused/problem-focused" coping and categorizations such as "avoidant/approach." In a previous work by one of the authors, we have emphasized the distinction between "avoidant" and "problem-centered" coping strategies (Yanos et al., 2003). While "avoidant" coping has sometimes been regarded to be synonymous with emotion-focused coping, we feel that these types of categorizations are largely separate but related in that "avoidant" describes the way the person is coping (i.e., moving away from a stressor rather than toward it) while emotion-focused describes an aspect of stressor that is being coped with. From this perspective, emotion-focused coping responses could be categorized as either approach or avoidant.

There are many phenomena reported in the literature that describe processes of emotion-focused coping among people with SMI. An example of an emotion-focused coping strategy aimed primarily at relieving or regulating the emotional impact of a stressful situation is adjusting activity level. From our perspective, emotion-focused strategies involving adjustments of activity level can be either problem-centered or avoidant, depending on the

context of the problem (e.g., whether it is in response to an elevated/agitated or depressed mood; Yanos et al., 2003). Others have described how both increasing and decreasing activity level can be effective strategies depending on the situation. Breier and Strauss (1983) described how a number of their research participants reported that reducing their level of activity often led to a decrease in symptoms. This demonstrates both the effectiveness as well as the transactional process involved. Dittmann and Schuttler (1990) found inpatients with schizophrenia reported that withdrawal was the most effective strategy for coping with emotional disturbances resulting from psychotic experiences. In other contexts, however, social withdrawal (Falloon and Talbot, 1981), “emotional avoidance” (Gross, 1989), “tendency towards isolation” (Cohen and Berk, 1985), “tendency towards passivity,” and “spoiling oneself” (Carr, 1988) have been characterized as less adaptive responses to mood changes. Studies also note that increased social activity is often used as a way to facilitate coping (Mueser et al., 1997), improvement (Roe et al., 2004), and deal with depressed mood (Lee et al., 1993). In the interview excerpt below, an individual in his mid-30s diagnosed with major depression and a history of psychosis describes how he increased activity in an effort to cope with severe depression resulting from the death of a family member.

“It was dragging, uh, I was, you know . . . fatigued. Uh, in the bed, all morning. You know, sleeping off and on. Couldn’t bathe. Couldn’t brush my teeth. And, uh, and just being bored. It was . . . that’s what it was like. It was really . . . it was a mess.”

Interviewer: “So how did you deal with the situation?”

“Um, go out . . . go out. Get myself spirited. You know, try to get myself lifted up by being outside. You know, maybe, you know, maybe I can generate some energies and some high spirits and then come back in the house and get ready for tomorrow, then next day, hopefully I can come in the program.”

Problem-focused efforts aimed directly at changing or managing a threatening or harmful stressor include attempts to cope directly with symptoms (Yanos et al., 2001, 2003). Breier and Strauss (1983) examined self-control of psychotic symptoms among 20 hospitalized people with SMI and found that many described cognitive strategies to deal with symptoms. One such strategy noted was “self instruction,” which involves formulating statements to the self to help control psychotic behaviors. Similarly, other research has described ways of gaining cognitive and behavioral control over psychotic experience. This includes efforts to convince oneself that the psychotic experiences are not reality-based (Dittmann and Schuttler, 1990), accepting their occurrence without being “impressed” by them (Roe et al., 2004), and shifting attention away from unwanted thoughts and perceptions (Carr, 1988; Cohen and Berk, 1985). Mueser et al. (1997) conducted an exploratory study and reported a range of strategies the study participants used to cope with negative symptoms. These included increased activity (efforts to do things like getting out of the house, exercising or reading a book), and increased social involvement (spending time with others including family).

Others (Boschi et al., 2000; Farhall and Gehrke, 1997) also suggest that effective coping strategies involve this type of cognitive shift, and may include an intermediate stage of reality testing, as described, or the fluctuation between belief and disbelief (Stanton and David, 2000). Farhall and Gehrke (1997) suggest that active strategies of coping with hallucinations appear to be the most useful.

In our study, a man in his 40s diagnosed with schizophrenia described cognitive-based efforts to directly manage delusional ideas in the following manner.

“I started like thinking that the TV could see me and that the radio was talking to me and stuff . . . and so, basically, I just tried . . . to deal with it by like saying that to think logically

that no this can't be happening . . . this is not reality . . . and so I try to use logic to deal with it . . . so even though I was thinking about those things I tried to use logic and keep taking my medication hoping that this would like subside or decrease.”

A review of the literature indicates that there is reasonably good evidence that the use of problem-centered coping strategies to deal with symptoms and their emotional consequences is associated with better outcomes among people with SMI, although more research on this issues is needed (Yanos and Moos, 2006). Boschi et al. (2000) note that the employment of strategies to cope with psychotic symptoms may be most helpful in the early stages of the illness. Indeed, in more advanced stages of the illness, the relation between emotion-focused and problem-focused coping and symptom severity or outcomes such as quality of life has been found to be weak (Rudnick, 2001), and related strategies such as distraction may not be generally helpful (Crawford-Walker et al., 2005).

ANTICIPATORY COPING

Anticipatory coping (Schwarzer, 2001) differs from reactive coping with regard to the time perspective; that is, that the stressful event has not yet occurred, and thus the focus is on coping with something thought to be impending in the future. This type of coping is directed toward unknown upcoming risks that may cause harm or loss. This type of coping consists of the person coping by preparing for the perceived imminent threat. Thus, it involves managing known risks by using one's resources. The degree to which the actual methods of coping will differ from reactive coping, for instance, is determined primarily by coping with a stressor that is likely to occur in the near future rather than with a stressor that had already occurred.

A well-documented anticipatory coping strategy among people with SMI is taking steps to prevent relapse by early identification of warning signs. Arieti (1974) described how people with schizophrenia and related disorders developed ways to identify feelings and thoughts that preceded the experience of delusions and hallucinations. He maintained that this type of self-awareness helped them cope with preliminary symptoms of the illness and prevent relapse and to attempt to prevent further deterioration. In their retrospective study, Heinrichs et al. (1985) illustrated that over half of their study's participants were able to identify and assess the onset of a worsening in their condition and could then seek help before any more severe deterioration occurred. The discovery of a mechanism of early identification of prepsychotic signals was replicated in additional studies (Dittmann and Schuttler, 1990), and its importance was described in a first-person account by Leete (1989). A woman in her 50s diagnosed with schizoaffective disorder who was interviewed for our study described how she calls a Crisis Hotline when she perceives that a relapse might be impending.

“I depend on [calling the Crisis Hotline]. I'm trying to keep from going in [the acute hospital unit]. I don't want to go back there . . . usually when I call crisis and reach out for help and tell them how I am feeling they will either tell me to come to the emergency room or to get my medicine, take my medicine as prescribed, take me a cup of tea or drink a glass of milk and lie down for a while. If that doesn't work, get up and see if you can go around, be around somebody.”

The principles of monitoring warning signs have been used to develop relapse prevention programs (Herz et al., 2000; Lam et al., 2000; Perry et al., 1999; Scott et al., 2001) that teach a form of anticipatory coping skills in that they focus on helping people prepare for the possible but not yet occurring threat of relapse, and take steps directed to minimizing its negative effect. These programs usually include identifying events and situations that had triggered episodes in the past and making a conscious effort to build a routine that would help the person avoid such events and situations in the future. In addition, one can choose a support person whom

they would like to help him or her in case he or she felt that things were not going well, as well as generate a crisis plan to implement in case early warning signs are detected.

The relationship between anticipatory coping and a reduced likelihood of relapse has not been well-studied; however, positive findings for the impact of relapse prevention treatment suggest that learning to use anticipatory coping can reduce the likelihood of having a psychiatric hospitalization and associated consequences (Herz et al., 2000).

PREVENTIVE COPING

Preventive coping refers to the process by which a person builds up resources and resistance “just in case” possible stressors occur in the distant future (Schwarzer, 2001). Unlike reactive coping where the stressor has occurred, and anticipatory coping where there are more specific stressors within a shorter timeline which one is preparing for coping with, preventive coping reflects more general preparatory activities to cope with more unknown possible stressors within a more fluid timeline. Others (Aspinwall and Taylor, 1997) have referred to these types of strategies as *proactive coping*, but Schwarzer has drawn a distinction between preventive and proactive coping, which we follow in our adaptation of his model.

One example of preventive coping is developing “wellness management skills” (Copeland, 1997; Mueser et al., 2002). These are coping strategies that are used on a regular basis whether or not one is experiencing symptoms. The value and purpose of developing such strategies is that they can help reduce one’s vulnerability to future stress and improve resources for dealing more effectively with stressors that might occur. Typical wellness management strategies reported by people with SMI include routinely accessing social support, following a routine for taking medication, exercising, reducing substance use, and adopting a healthy and balanced lifestyle (Yanos, 2001). The man in his 40s diagnosed with schizophrenia who was interviewed for our study described his use of several preventive coping strategies as follows.

Interviewer: “I’d like to ask you about things you do on a regular basis to keep yourself going steady, preventing problems from starting, keep yourself stable.”

“Yeah . . . like getting up, coming to the program, attend my groups . . . um . . . picking up the milk for my mother . . . doing things for my mother . . . going to see my girlfriend . . . you know, having a nice conversation with her . . . keeping my temper . . . keeping my control . . . you know, just good things . . . talking positively . . . stuff like that . . . keep my self on a mental stable balance. But, I think everyone does that . . . even like people that don’t have mental illnesses . . . they have to keep themselves up so they don’t get depressed, because anybody can be mentally ill . . . so we all need that positive reinforcement.”

Another example of preventive coping that has not been previously characterized as such is initiating an advance directive, i.e., a statement of preferences for treatment in case of loss of capacity to make treatment decisions in the future. Such initiatives can be empowering, assuming control over treatment decisions, enhancing communications about treatment preferences, and facilitating their implementation before situations deteriorate to emergency status, which may also lead to reductions in involuntary psychiatric treatment. Such prospective decision-sharing initiatives assure maximum involvement in possible future interactions with the mental health system at times of crises (Swanson et al., 2000). Interestingly, and consistent with the proposed model’s emphasis on these types of coping often being parallel and overlapping, advance directive overlaps to some degree with anticipatory coping.

PROACTIVE COPING AND MEANING-MAKING

Coping has been traditionally defined as involving a response to a stressor. Clearly, by including anticipatory and preventive coping, we have taken a broader view of the coping construct. In addition, there are aspects of coping that go beyond responding to immediate or expected challenges. These include efforts to actively strive, seek new challenges, create new opportunities, and negotiate appraisals so that they will be less negative. This type of coping is characterized as “proactive coping” in Schwarzer’s model (Schwarzer and Taubert, 2002).

In our study, we found that participants sometimes discussed the single-minded pursuit of goals (which Schwarzer and Taubert [2002] call “tenacious goal striving”). For example, the female participant diagnosed with schizoaffective disorder in her late 50s discussed a determination to work. This participant had many physical health problems but was not deterred by these, and initiated the process of pursuing work.

“I want to walk like you one day. I’m willing to go to work like I am right now, and I feel that by me working, number one, it could give me my inner peace, it can give me a sense of belonging, it can give me extra finances . . . Ah, it can give me my independence. It can give me prestige. It is still not too late.

“I have to talk more extensively to my case manager, but, I brought the idea to her, that that was my goal. That is my goal. My steps, being referred to an outside agency for the mental handicapped and being referred to an outside agency, and uh, go through their one, two, three steps to prepare me for my job. If it means, where I have to go to school, I’m ready to do that. So, this is my prep.”

The participant subsequently completed a computer-training program and returned to work.

Another important aspect of proactive coping is positive reappraisal, in which the person is able to negotiate the appraisal of stressful life circumstances so that they are less negative or even positive. Studies have shown that there are sometimes positive consequences to experiencing adversity, indicating that people often do more than just cope with them (Affleck and Tennen, 1996; Folkman, 1997; Roe and Chopra 2003). In some respects, this process may be facilitated through the use of specific reactive coping strategies; however, in general, the use of specific strategies has been distinguished from the overall process (see, for example, Affleck and Tennen’s [1996] distinction between “benefit-reminding,” which they see as a coping strategy, and “benefit finding,” which is linked to a larger process). This process may involve a wide range of independently reported phenomena including examining and reflecting (Larsen, 2004), interpreting (Morrison et al., 2004), explaining, attributing (Birchwood et al., 2000), and integrating versus sealing over illness related experiences (McGlashan, 1987). From this perspective, coping is not limited to responding, but rather negotiating the appraisal and eventually influencing the perception, which frames the meaning of the experience of stress. Aside from shifts in appraisals, these processes may be beneficial as they may increase the person’s sense of control (Krabbendam et al., 2005), which has been found to be low among people with SMI (Horan et al., 2005), and which may contribute to changes in sense of self.

The emergence of these reports from diverse sources calls attention to the central role appraisal plays not only in perceiving an event as stressful but also in appraising one’s position in relation to it and ultimately no longer perceiving oneself as negated by the persistence of stressors. Put another way, this process of meaning-making does not involve a singular appraisal of an isolated event. Interpretations of stressful events involve evaluation of events in an interpersonal context that reflects on self experience. The stressful event is stressful *for* a person, and thus its appraisal necessarily involves, at least indirectly, an appraisal of the person as he or she experiences the stressor. An encounter with mental illness often awakens basic

and fundamental questions of identity, such as, “Who am I?” and, “Where is the ‘I’ who was previously there?” (Estroff, 1989). These questions mark the beginning of a journey that does not occur in a vacuum. Meaning-making processes are shaped through ongoing interactions with various social and institutional contexts (Larsen, 2004; Roe, 2001; Wagner and King, 2005), as well as by the person’s personal past history (Roe and Davidson, 2005).

This perspective is consistent with evolving phenomenological theories of SMI, which assert that an important element of these conditions often involves the experience of self as not attuned to or sufficiently connected to the world and others (Lysaker and Lysaker, 2001; 2002; 2004) and that moving toward recovery involves changes in the experience of self (Davidson and Strauss, 1992; Estroff, 1989). Roe and Ben-Yishai (1999), for example, applied principles developed for the analysis of fictional stories to qualitative interviews carried out with people with SMI. The five developmental categories that emerged from their analysis differed with regard to the role of the narrator in the life story, the manner in which the narrator separated her or his self from the disorder, and the relation of the narrator to the disorder. Ridgway (2001) similarly analyzed published first-person accounts of recovery and emphasized broad common themes, including moving from despair to hope, from withdrawal to engagement, from passive adjustment to active coping and reclaiming a positive sense of self, meaning, and purpose. These studies reflect that coping often involves simultaneous changes in appraisal of one’s self as well as the illness.

In an interview with an individual in his mid-30s dealing with persistent major depression, the person described his efforts to make sense of both progress and lack of progress in recovering from SMI by labeling the state of his life as “mediocre.” The transcript excerpted illustrates how he used this characterization in an effort to make sense of his experience.

“Mediocrity means to me that uh, I’m, I’m not . . . doing that bad. I’m doing bad on one end and I’m doing good on the other end. Uh, uh, I’m not . . . I’m not doing so good and I’m not doing so bad. Uh, what it also means to me, that I’m not . . . I’m still having symptoms, but I’m not severely sick where I’m just, where I just dropped out of the program or I’m in the hospital. So all those things mean to me, just, you know, hanging on. I’m still . . . you know people ask me, people will say I’m still hanging in there. That means mediocrity to me. Because you know, there is a lot . . . it’s still some, some, a lot of room for improvement. You know. And uh, and I also look at it as I have made some improvements, so there we going again with that word mediocrity coming into play. Because I’m not like where I used to be back then before I got into the program. I used to stay home all day, I used to be depressed all day, I was crying all day. My mind was so unstable I couldn’t even go outside or take a bath. I used to sit in the house for a whole week without putting my foot on the ground . . . the surface of the earth.”

For some individuals, achieving mastery in the process of constructing and negotiating meanings may be a major part of their recovery. In this type of coping, we suggest that persons have moved from reacting to actively making meaning of events and of seeing themselves as meaning-making beings. This process includes not only changes in appraisal of a stressor or seeing positive in the negative (Affleck and Tennen, 1996), but also experiencing and perceiving oneself differently in relation to the stressors and the sense of threat or suffering they generate. It includes a cognitive perception and emotional experience of a balance between life and self in which the unmanageable no longer negates the person as an actor/observer. This is not to imply that painful stressors are not often devastating, but rather that they can be perceived in a manner in which self-integrity is not compromised or overwhelmed. We argue here that in addition to personal strength, life often includes loss and pain, which need not to be avoided by cognitive distortions or exclusive emphasis on strengths. A great loss will always be a great loss, but the self experiencing that loss may be experienced differently. With some

of the other types of coping we describe here, a great loss might be experienced as bringing a person to the brink of destruction, when proactive coping is used most effectively, there is more acceptance, flexible reappraisal, and ultimately a self that can admit suffering and incorporate the human universal experience of pain and suffering into one's life.

DISCUSSION

The purpose of the present paper is to construct a clinically useful framework of coping that describes parallel and consecutive types of coping that relate to different kinds of concerns that arise along the continuum as people move toward recovery. To do so, we applied Schwarzer's proactive coping theory (Schwarzer, 2000, 2001; Schwarzer and Taubert, 2002) from health psychology and discussed the application of four types of coping—reactive, anticipatory, preventive, and proactive—to the area of coping with SMI. The distinction among these four types of coping may facilitate our understanding of reactive forms of coping, which constitute a large and important part of coping responses, as well other important types of coping that have been relatively neglected.

The idea that people might find benefit in adversity related to severe mental illness, which we discussed with regard to proactive coping, is also consistent with existential philosophical traditions stressing that participation in life entails suffering and that people do not necessarily strive for the absence of suffering as much as understanding it and finding meaning in it (Nietzsche, 1886/1966). This approach fits in well with shifts in conceptualization from earlier models that emphasized the importance of protecting people with SMI from threatening stress to more current models that emphasize the importance in seeking opportunities despite the inherent risk, possible disappointment, pain, and suffering. It also shifts our focus away from thinking about persons as passive observers of life who have a self that is somehow self-contained and exists outside of the world, and toward understanding human beings as meaning-making beings whose self exists intersubjectively, in interaction with others and the world in general. In particular, it seems possible that the continuum of coping types portrayed is related to the experience of self as an active agent that can understand, respond to, and eventually initiate contact with the world in the immediate interpersonal context. In reactive coping, persons observe the world and react, but have difficulty entering into the worlds of others, to alter their own construction of events, or to affect the flow of life events. In anticipatory coping, the self is again an observer of the world but now can at least prepare ahead of time so that when the stressful moment occurs, while there may be little to do spontaneously, there is something useful that has been rehearsed and that can be employed. In preventive coping, while the self again experiences itself as not able to affect the world in the manner of an active agent that can change the course of events, it can affect its own emotions and thoughts considerably and therefore exert control. Finally, in the phase we have referred to as proactive coping and meaning-making, the person can be attuned to the world and interact with it and with people out of a sense of meaningful identity and being in the world. It is in this phase that indeed, from a phenomenological position, one can be thought to have recovered, as in this state, the person is both actor and observer.

With validating evidence, the model presented here may have broad clinical implications for clinicians working with persons with SMI. For one, it emphasizes how clinicians may not want to think of themselves merely as teachers to passive subjects eager to learn specific behaviors or skills (Roe and Yanos, 2006). It may be that improved coping includes persons becoming able to understand themselves as participants in the world. They may need conditions to become increasingly able to be present in the moment and respond to the complexity of life situations from the state where they are. Thus, the clinician's role in facilitating coping would focus not mainly on psychoeducation or only illness management but also on facilitating the growth of self as a personal meaning maker. In coming to that point, this model may also serve as a broad

map providing a clinically useful integrative conceptualization of the type of coping strategies employed by persons with SMI. From this perspective, a future clinical goal might be to try to design stage-specific coping-enhancing interventions that best match the person's current stage of coping and help her move to the next stage. For instance, clinicians seeking to help persons in the reactive mode would initially facilitate their move toward anticipatory coping rather than to a more advanced meaning-making stance. Future research can be directed at validating the present model. In addition, investigating the relationship between stages of these types of coping and other relevant dimensions such as symptoms, functioning, and recovery is important.

Acknowledgements

The authors wish to thank Drs. Rudolf Moos and Abraham Rudnick for helpful comments on an earlier draft.

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