

In a previous study with community-dwelling people, the dual-process coping theory was applied to better understand determinants of distress after SCI.² The dual-process coping theory describes the way persons attempt to match goal-related coping with situations in which goals are blocked, for instance, due to loss of physical functioning or as part of aging.¹² This theory distinguishes 2 coping mechanisms: accommodative coping, which is reflected in flexible goal adjustment (FGA), and assimilative coping, which is reflected in tenacious goal pursuit (TGP). FGA entails adjusting personal preferences and goal orientations to given situational forces and constraints. This can involve either the devaluation or reevaluation of a particular goal, or the positive reappraisal of an emerging loss or limitation, as well as the consideration of alternative feasible goals. FGA should be considered as a neutralization rather than as an active solution of the problem.¹² The other coping mechanism, TGP, implies actively adjusting development and life circumstances to personal preferences, in other words maintaining goals. This can include activities such as acquiring relevant knowledge and skills, using compensatory means, or implementing basic lifestyle changes.^{13,14} Both FGA and TGP aim at eliminating discrepancies between actual life perspectives and salient concerns of personal development. From theoretical point of view, these scales are most often antagonistic, although they can synergistically complement each other in concrete episodes of coping. Problems such as bodily impairment, chronic illness, or bereavement generally pose multiple adaptive problems on different levels that often call for different coping mechanisms.¹³ Therefore, both scales may not be seen as the opposite ends of same dimension. If a discrepancy between the desired and factual situation appears, a person will usually employ TGP first, trying to actively reduce the gap. If there are no means to actively attain the desired aim, a person is most likely to adjust standards or priorities to the given circumstances.^{12,14} Thus, whereas TGP is prominent in aiming at improvement or maintenance of functioning, the reorientation effort of FGA becomes more beneficial in accepting permanent loss or constraint.¹²⁻¹⁴ There is, however, a large individual variation in the way people apply both mechanisms in their life.

Stemming from aging research, the concept of coping flexibility has been used in studies in people with a sudden onset of physical problems like amputation, SCI, and stroke in the last decade.^{2,15,16} The results are not unambiguous. In aging studies, a negative bivariate correlation was found between FGA and distress.¹⁷ In a cross-sectional study with community-dwelling people living with SCI, both FGA and TGP showed negative bivariate correlations with distress.² In that same study, FGA explained a significant percentage of the variance of distress in a regression analysis, after correction for demographic and SCI-related variables, social support, and task-oriented coping, whereas TGP did not.² Similar results were found in a study among people who sustained stroke. Only FGA, not TGP, measured at the end of their initial rehabilitation period was predictive for their quality of life (QoL) 1 year later.¹⁶ A different pattern was found in a study among people with a lower limb amputation in the initial rehabilitation phase. Although that study

showed a positive correlation between both FGA and TGP with physical and psychological QoL, TGP more strongly predicted higher scores on physical and psychological QoL 6 months postdischarge.¹⁵ FGA predicted higher environmental QoL 6 months postdischarge, whereas TGP did not.¹⁵ The differences in results in the presented studies might be caused due to differences in diagnostic groups or differences in time of measurement.

The objective of this study was to examine whether FGA and TGP, measured at admission to first SCI rehabilitation, were predictive of distress 1 year after discharge, controlling for baseline scores of sociodemographic and SCI-related variables. Based on most studies published to date, it was hypothesized that higher levels of FGA and TGP at admission would be related to less distress, and that FGA compared to TGP would explain more variance in both depression and anxiety, 1 year after discharge.

Methods

Participants

The cohort used for this study has been described in a previous study.¹⁸ In brief, people with SCI were included who were admitted for their first inpatient rehabilitation to the Sint Maartenskliniek, a specialized SCI rehabilitation clinic in the Netherlands, between March 2011 and April 2015. Excluded were people with cancer-related SCI with a short life expectancy, people who were not sufficiently able to read Dutch, or had severe psychiatric or cognitive problems, such as active psychosis, mental retardation, or severe traumatic brain injury that made it impossible to fill out the questionnaire reliably.

Procedure

The ward psychologist contacted the people with SCI in the first week of their admission and asked them to complete a set of psychological questionnaires for diagnostic purposes. During that same appointment, potential participants were informed about the purpose and contents of this study. All participants gave written informed consent. One year after discharge the same set of questionnaires was sent by postal mail to the home address, including a prepaid return envelope. If the participant was not able to write because of hand function problems, he/she was asked to complete the questionnaires with help of a partner or other trusted person. If no one was available, a clinical psychologist's assistant supported him/her. The local medical ethics committee approved the research protocol (reference number: 15-449/C). The participants received care as usual, which means all were invited for an intake with the ward psychologist in the first 2 weeks after admission. If treatment was indicated this was offered by the psychologist. Incidentally a psychiatrist was consulted for instance in case of antidepressant medication.

Measures

Demographics

Age, sex, living with a partner, educational level, and work were assessed at admission.

SCI characteristics

Etiology of the lesion was divided into traumatic and non-traumatic. Level and completeness of injury were determined

List of abbreviations:

FGA	flexible goal adjustment
HADS	Hospital Anxiety and Depression Scale
QoL	quality of life
SCI	spinal cord injury
TGP	tenacious goal pursuit
VAS	visual analog scale

Download English Version:

<https://daneshyari.com/en/article/11022118>

Download Persian Version:

<https://daneshyari.com/article/11022118>

[Daneshyari.com](https://daneshyari.com)