Schemas in Transition: Towards an integrative cognitive model of adjustment and adjustment disorder

Abstract

This article synthesises research in adjustment disorder, health psychology, coping and trauma to offer a generic cognitive-behavioural theory of adjustment and coping. Disorders of adjustment result from difficulites in assimilation or accommodation of schemas in the light of new information. The greater the mismatch between one's current schematic world and the perceived change in the world, the greater the adjustment needed. Failure of schematic processing is evidenced by unresolved attempts at reappraisal, focused on: (a) the stressor, (b) options for coping, (c) its implications, and (d) the emotional and physiological reactions to the stressor. Coping behaviours can facilitate (e.g. effective problem solving, accessing support) or hinder (e.g. compulsive self soothing, avoidance) emotional processing. A new typology of coping is proposed with 3 foci of coping (problem-focus, emotion-focus, and context focus) within each of which there are 4 coping domains (acceptance, cognitive, behavioural and interpersonal). Implications for research and clinical practice discussed.

Cognitive behaviour therapy, stasis and change

One factor that has contributed to the considerable success of cognitive behaviour therapy over the last few decades has been its ability to generate disorder specific models that describe how maintenance processes maintain these disorders. Maintenance formulations of a range of conditions from

depression to psychosis (Beck et al 1979; Beck and Clark 1997; Garety et al 2001) allow therapists to identify and target these processes effectively. Most of these models also include developmental or stress-diathesis elements that explain the state shift from well-being to psychological disturbance in terms of the interaction between life events and underying cognitive structures or schemas (e.g. Beck 2008). The significance of life events may be most important early in the history of a condition such as depression but lessens with repeated episodes, possibly because it becomes progressively easier to activate negative schemas with each episode (Teasdale 2008). Most theoretical and empirical work has therefore focused on steady state factors which keep people trapped in particular affective or behavioural constellations, rather than the interaction between life events and schemas. The process of adjustment itself has received less attention until recently (Bachem and Maercker 2013, 2016), apart from in the areas of trauma and grief which are defined by the individual's reaction to specific stressors (e.g. Resick and Schnicke 1992). Cognitive models of adjustment disorder (AjD) have not been developed, despite its prevalence - in liaison psychiatry settings frequencies of AjD as high as 50% have been reported (American Psychiatric Association 2013). A generic model of adjustment may be helpful for a number of reasons:

1. To guide clinicians in applying CBT to people with a diagnosed adjustment disorder.
2. To help to understand the relationship between the different adult disorders associated with trauma and stress (in DSM V – Acute stress disorder, adjustment disorder, PTSD, and putative persistent complex bereavement

disorder; in ICD 11 -Acute stress reaction, adjustment disorder, PTSD, complex PTSD, and prolonged grief disorder).

3. To better understand and treat those depressive and anxiety disorders which contain a significant adjustment component. It has been suggested that the low levels of AjD in recent surveys (as low as 1% in primary care: Fernandez et al 2012) is a result of patients who would previously have been given the diagnosis now meeting criteria for major depressive disorder (Casey and Bailey 2011). Treating these patients with a protocol that does not fully acknowledge the impact of the particular life stress may have an effect on engagement and outcome.

This article builds on the foundational work of Lazarus and Folkman (Lazarus and Folkman 1984; Park and Folkman 1997) as well as contributions from many researchers in the fields of health psychology, coping and trauma research. It is an extension and generalization of the cognitive theory of adjustment to cancer developed by Moorey and Greer (Moorey & Greer, 2011).

Schematic processing in adversity

A serious adverse life event inevitably turns our world upside down and can challenge some of the deepest assumptions we hold about ourselves, the world and other people. In the face of illness, disability or loss, we may question our capacity to cope with whatever life throws at us: our sense of being in control of our world crumbles. Adversity may also challenge our self

worth: if, for instance, our worth is predicated on our physical appearance, a disfiguring injury may lead us to feel less valuable. Explicit hopes and plans for the future may need to be drastically revised, and implicit existential assumptions that we are invulnerable and immortal may also collapse: the world no longer seems predictable, fair or safe. Cognitive theorists have used the concept of a schema (*…a cognitive structure for screening, coding, and evaluating the stimuli that impinge on the organism…*Beck 1967, p. 283*)* to understand how traumatic events impinge upon our explicit and implicit belief systems. Piaget (1970) described learning as a process of *adaptation* to new information which is incorporated into existing belief systems (*assimilation*), or forces the existing beliefs to change (*accommodation).* Hollon and Garber (1988) were the first to recognise the relevance of this concept to cognitive therapy, and this was elaborated by Janoff-Bulman (1989) who proposed that a trauma, e.g. personal violence, threatens commonly beliefs: that the world is generally a good place (benevolence beliefs), that others can usually be trusted, and that the self is worthwhile (self-worth beliefs). In response to this trauma one might minimize the experience e.g. “It wasn’t really a rape” which *assimilates* the new information into the old belief system. Alternatively a person might *accommodate* their belief system to the new information, by acknowledging that generally people are well intentioned but some people can’t be trusted. A third way to react is to *overaccommodate*, shifting from a belief that “The world is safe”, “I am worthwhile” and “People are well meaning” to a belief that “The world is very dangerous “, “I am worthless” and, “No one can be trusted”. Resick and Schnicke (1992) further developed Janoff-Bulman’s model of post traumatic stress disorder. Neimeyer (2006 a, b;

Neimeyer et al 2010) applied Piaget's concept of adaptation to bereavement. The bereaved person must either *assimilate* the loss into pre-loss beliefs and self-stories by, for instance, "developing familiar religious explanations for the loss, assignment of responsibility… making downward comparisons' or *accommodate* the loss through 'reorganizing, deepening, or expanding their beliefs and self-narrative to embrace the reality of the loss" (Neimeyer et al 2010, p. 74). Neimeyer proposed that complicated grief reactions result from a failure in these "meaning- making processes", and the "fragmentation of a self- narrative that no longer makes sense in the present" (Neimeyer et al 2010, p. 74; Holland, Currier and Neimeyer 2006; Neimeyer et al. 2002). Adaptation to a major life event usually involves both assimilation and accommodation though it could be argued that, as Park and Folkman (1997, p. 120) observed, the stable nature of belief systems means that "people typically cope with event-belief mismatches through a process of assimilation, redefining or reappraising the situational meaning of the events rather than modifying their global meaning system." Shelley Taylor (Taylor and Armor 1996) cites evidence that we cope with adversity through maintaining *positive illusions* (i.e. self-aggrandizement, unrealistic optimism, and exaggerated perceptions of control) rather than changing our world view. Janoff-Bulman's just world theory and Taylor's cognitive adaptation theory epitomize the accommodation-assimilation dichotomy in accounts of schematic processing.

Either way, coming to terms with a negative life event necessitates a modification of schemas. This schematic processing is the cognitive component of an adjustment reaction and in most cases is accompanied by the activation of strong affect i.e. emotional processing. It has been argued

that effective cognitive processing needs to go hand in hand with emotional expression (Greenberg and Safran 1984, 1987; Lewis and Bucher 1992; Moorey and Greer 2011) and we can consider the adjustment process to be an example of *schemas in transition*. As we have seen, the conscious and automatic search after meaning in the face of a life change often involves a shift between various appraisals and their associated affect. In the early stages of an adjustment reaction there may be an *outcry* phase: an alarm reaction where the initial, basic level, undifferentiated processing of the threat leads to panic, fear and anger (Horowitz 1986, 2013). This is usually brief and is replaced by a cycling through various emotional states depending on the appraisal at any given time. When the self is seen as helpless, the world as uncontrollable and the future as hopeless, a sense of helplessness and hopelessness pervades, accompanied by depressed mood. When the focus is on the uncertainty of the outcome anxiety arises, while a focus on the unfairness of the situation leads to anger and rage. These states can be seen as a *trying on* of various schematic interpretations of the meaning of the adversity. Horowitz (1986, 2013) suggests that schema change is associated with shifts between undermodulated affect (intrusion phase), when the system is overwhelmed and overmodulated affect (denial phase) when the system shuts down in an effort at self-protection. Relatively little empirical evidence exists about the sequence of schema transition despite the continued popularity of stage models of adjustment (e.g. Bowlby 1961; Kubler-Ross 1969; Parkes 1972). Maciejewski et al (2007) found that in a sample of 233 bereaved people, contrary to the stage theory, acceptance was the commonest reaction, particularly where the death had been natural and

expected. This is consistent with a schema conceptualization – more processing is needed if the death is sudden, traumatic and unexpected. The strength of these reactions peaked in a sequence consistent with stage theory (disbelief, yearning, anger, depression, acceptance) within the first 6 months. Contrary to stage theory, different reactions co-existed at any given time, and yearning was present throughout the whole period. From a schema perspective, these phases are the result of the particular face of the prism of adjustment we are looking through at a given time. In both conscious and automatic attempts to make sense of the anomalous situation we move through various attributions, evaluations and predictions, sometimes attempting to fit the new information into our pre-existing world view, sometimes radically altering our view to make sense of what has happened. These may be better seen as *states* of grief or adjustment rather than pahses (Prigerson and Maciejewski 2008). Even within a phase there is often a cycling between different emotional states especially shortly after the trauma.

Factors influencing schematic processing

When considering the interaction between life events and belief systems, it may be helpful to separate beliefs about adversity and coping from core beliefs about the self, the world and other people (Adverse life event v Life context: Figure 1) (Williams 1997; Moorey and Greer 2011). In reactions to physical illness, for instance, past experiences of illness and its treatment in oneself or family members, modelling by carers of how to manage adversity etc. will all shape beliefs about the diagnosis, prognosis and degree to which

the illness can be successfully treated. In life threatening illness this has been termed a *survival schema* (Moorey and Greer 2011). Beliefs about adversity and the specific adverse event, and beliefs about the extent to which one can control or change the situation will influence the appraisal process. Negative beliefs that “cancer is incurable” will lead to assimilation of information into this schema i.e. positive news about prognosis will be minimized or discounted. The *self schema* on the other hand consists of global beliefs about the self, the world and other people (Figure 1). Moorey and Greer (2011, pp 181-184) present four ways in which life threatening illness can challenge belief systems, which are equally applicable to any major adverse life event. For most people, their positive beliefs about themselves and their ability to cope are challenged, through assimilation they remember the strengths and resources available to them, but they also accommodate some of their beliefs to the new information e.g. “That heart attack was a warning to me. I’m not indestructible. I’d better slow down.” On the other hand, if people have very rigid positive beliefs as described in Janoff-Bulman’s just world theory, these will be shattered. Overaccommodation leads them to completely shift to from positive to negative beliefs about danger, competence and control. A third group of people may have had major adversity in childhood and have developed core negative beliefs about themselves and the world. Their coping strategies are not well developed and so these negative beliefs are to the fore even before the major life event occurs. For these people the beliefs are confirmed: they already knew they were vulnerable, that others cannot be trusted and the world is a dangerous, unpredictable place. So they simply assimilate the adversity into their negative worldview.

In Moorey and Greer's fourth group, the adverse life event undermines coping beliefs and strategies and triggers negative core beliefs. Janoff-Bulman's model addresses the interaction between adversity and the individual's global world view, but says little about the intermediate beliefs and rules that often arise from self schemas. These may function as compensatory beliefs to prevent the activation of negative core beliefs. For instance, a high level administrator had secret fears that he was a failure and not good enough. His compensatory belief was "If I give 110% I will be worthwhile" and he lived by the rule "Everyone should work hard. If you don't contribute you're worthless." His compensatory strategy was to be a workaholic. He also coped with the stress of his work through heavy drinking. When he retired he was no longer able to contribute in the way he wanted and was also further disabled by cirrhosis of the liver. The consequence was that his core belief that he was worthless was activated and he became depressed.

Situational appraisal in adversity

Lazarus and Folkman's work laid the foundations for a transactional model of adaptation to stress, which still underpins most cognitive theory in this area. As with all cognitive models the appraisal of the stressor is the key mediating factor in determining the emotional and behavioural response. The interpretation of the meaning of the stressful situation is determined by an interaction between the situation and the underlying assumptions of the individual (Parks and Folkman 1997). Once a schema is activated this will determine the options for making sense of the life change and for choosing coping strategies. *Primary appraisal* refers to the initial judgment about the

“personal significance of a specific person-environment transaction” (Parks and Folkman 1997, p. 122). The question addressed is, “What is the nature of the threat? » and the emotional response will be determined by the evaluation of the situation. If the situation is a challenge, positive emotions arise, if it is seen as a significant threat in the future anxiety is generated, while an appraisal of the event as a harm, loss or defeat leads to depressed mood. *Secondary appraisal* asks the questions “What can I do about it?” This type of appraisal includes evaluations of the options for coping and expectations regarding outcomes (Bandura, 1982; Lazarus, 1991; Lazarus & Folkman, 1984). A key theme in secondary appraisal is the extent to which the person believes they can exert control over the situation. In the primary and secondary appraisals of the threat posed by life threatening illness, for instance, an interpretation of the diagnosis as a challenge with a positive prognosis and which the patient has the capacity to manage leads to a resourceful or *fighting spirit* (Moorey and Greer 2011). On the other hand, a perception that the diagnosis is a death sentence and belief that there is nothing one can do, leads to a helpless/hopeless adjustment style. These problem-focused primary and secondary appraisals of the immediate implication of the adverse life event are accompanied by more general appraisals of how it relates to the person’s life as a whole. “What does this mean for my family, work, friendships ? How does it impinge on my values, hopes and plans for the future?” (See Figure 2)

<u>The stress reaction and its appraisal</u>

Challenges to schemas result in emotional arousal and the bigger the challenge the greater the affective change. Emotional disturbance is therefore a natural part of the stress reaction. The nature of the adverse event may also evoke more evolution-based responses that are to some degree hard wired. In PTSD the level of anxiety induced at the time of the incident can lead to fragmented memories and intrusions. Although AD by definition is not a response to an immediate life threatening situation, sometimes the stressor may have evoked similar responses. For instance, a patient being told they have terminal cancer in an offhand manner can lead to intrusive memories of the face of the doctor giving the bad news. The predominant emotion in grief seems to be yearning ((Maciejewski et al 2007) which has a biological basis in attachment (Jacobs et al 1988 ; O'Connor et al 2008). Certain loss events, particularly interpersonal loss such as a partner leaving unexpectedly can evoke grief-like reactions in which yearning is a significant feature . Adjustment reactions will always include significant emotional arousal, but may also sometimes include PTSD-like components of intrusive imagery or grief-like components of yearning. The meaning of the presence of strong emotions, intrusive memories or yearning will have an effect on the adjustment process. There will be an ongoing appraisal of these emotional and stress reactions which may either help or obstruct the adjustment process. Beliefs like "Showing emotions is a sign of weakness" or "I should be over this now" can lead to emotional suppression and prevent emotional processing. Beliefs like "If I stop feeling angry about this accident the perpetrator will have won" or "I need to show people how I am really feeling" may contribute to continued rumination. If the attachment system is activated

as in grief or interpersonal loss like the end of a relationship, the feelings of yearning and memories of the lost loved one may either be resisted or clung to rather than accepted as part of the grieving process . In PTSD, where the trauma activated systems associated with immediate life-threat, the intrusions and flashbacks may be seen as signs that the world is *still* dangerous despite the objective threat having been removed, and these negative appraisals can lead to a persistence of PTSD symptoms (Ehlers and Clark 2000). So adjustment is not only an interaction between the stressful situation and the individual's appraisals of the meaning of the stressor, but also an ongoing process of appraisal and reappraisal of the stressor and the individual's reactions to that stressor. Figure 2 outlines the appraisals and stress responses in adjustment.

Coping responses that aid or hinder adjustment

Coping research is complex and continues to be hampered by failure to agree the best way to categorise coping responses, and to establish instruments that clearly distinguish between coping and adjustment (Folkman and Moskowitz 2004; Skinner et al 2003). Lazarus and Folkman (1984) proposed two types of coping: problem-focused and emotion-focused. Problem-focused coping directly addresses the stressor and takes steps to remove it or reduce its impact. Emotion-focused coping addresses and modulates reactions to the stressor, and may be particularly relevant when the stressor cannot be removed. Other researchers (e.g. Brown 1987) stressed the importance of approach v avoidance as a focus of coping. Holohan and Moos (1987)

created a 4 category typology that combined approach-avoidance with the distinction between cognitive (changing appraisals) and behavioural (changing the situation) coping. Yet others have included social support in the list (Carver 1989; Amirkhan 1990; Zautra et al 1996). As Moos and Schaeffer (1993) observed, there is considerable overlap between these typologies. A problem with some of these typologies is that they mix the focus of the coping response i.e. managing the stressor (problem-focus) and stress reaction (emotion-focus) with the method of coping (changing meaning, avoiding or accessing support). Because most typologies of coping focus on directly managing the stressor they underemphasize the importance of the life context in which the adverse reaction has taken place. Life goes on in the face of adversity: a mother with breast cancer still has to work and look after her children during the treatment; relationships still need to be nurtured and sustained alongside coping with illness. Attending to these does not always amount to avoidance. CBT for patients who are helpless and hopeless in the face of adversity makes significant use of building mastery activities that may have no link to the adverse life situation As the process of adjustment progresses the need to return to normal life becomes more salient, and necessitates a turning away from the stressor towards future life: the need for emotional processing decreases and acceptance increases (Maciejewski et al 2007). Indeed therapeutic work with PTSD and bereavement will include a focus of rebuilding one's life after the trauma or loss. This type of coping is neither problem-focused nor emotion-focused but could be seen as *context focused coping*. Context-focused coping covers all the ways in which we turn towards what is important to us in life – in the here and now or in the future –

and helps to sustain us as we also work to address the problem or face our emotional reactions. Context-focused coping is consistent with so-called *Third Wave* CBT approaches like Acceptance and Commitment Therapy and Behavioural Activation which emphasise the importance of actions that move people in the directions of their values rather than trying to fix emotional states (Hayes 2004; Martell et al 2001). Because coping is often defined as an individual's efforts to manage stress theories tend to emphasise change strategies over acceptance. While coping has traditionally been seen as a way to control a situation or our reaction to it, third wave approaches have highlighted the value of acceptance in situations where the stressor cannot be removed. This not only applies to situations that cannot be changed or ameliorated but also to many emotional states where attempts at emotional control simply ratchet up the emotion (Hayes 2004;,Segal, Williams and Teasdale 2013). Recognising the delicate balance between acceptance and change is one of the key features of the third wave therapy, Dialectical Behaviour Therapy (Linehan, 1993).

In the proposed new typology of coping there are three foci: *problem-focus*, where removal or mitigation of the problem is the goal; *emotion-focus*, where the stress reaction is the focus of attention; and *context-focus*, where attention is paid to maintaining everyday life and moving towards valued goals. Within each focus there are four types of coping strategy: acceptance based coping, cognitive or appraisal based coping, behavioural coping and interpersonal coping. In addressing an adverse life situation such as a diagnosis of a serious illness, we may accept the reality of the situation rather than trying to

deny it (problem-focused acceptance), we may realistically reappraise the situation e.g. taking an objective view of the prognosis (problem-focused cognitive coping), we may take action to deal with it e.g. gathering information and complying with treatment (problem-focused behavioural coping), and we may seek practical help e.g. asking a friend to give us a lift to a medical appointment (problem-focused interpersonal coping). If we focus on our emotional reaction we can accept the natural feelings of fear and sadness that arise (emotion-focused acceptance; N.B. this is similar to Stanton's concept of emotional-approach coping: Austenfeld and Stanton 2004), we can on a more cognitive level normalise these stress reactions (emotion-focused cognitive coping), we can engage in self-soothing to manage extreme emotions (emotion-focused behavioural coping), and we can accept emotional support and comfort from those close to us (emotion-focused interpersonal coping). If we focus on our life beyond the illness, we might accept and enjoy what we still have and can manage to do (context-focused acceptance), we can realistically appraise what is important to us (context-focused cognitive coping), we can move constructively towards goals that are important to us regardless of whether or not we have an illness (context-focused behavioural coping), and finally we can engage with the important people in our life (context-focused interpersonal coping). Each of these strategies can be unhelpful if they are overdeveloped or exaggerated e.g. focusing on everyday life to the exclusion of following medical advice, or as an attempt to escape painful feelings. If they are under-developed they may also cause problems e.g. giving up on day to day life, making no plans for the future because it seems hopeless, rejecting friends and family. Table 1 lists the ways in which

coping may be balanced, diminished or exaggerated in each of the 3 domains of problem-, emotion-, and context-focus. When the strategy is a balanced it can aid the adjustment process (Figure 3). Problem solving may actually eliminate the stress as when a job loss leads a person to retrain. But if this is exaggerated the problem solving may become compulsive as when a cancer patient spends 8 hours a day on the internet searching for new treatments. Emotional regulation strategies can help manage overwhelming feelings, but when these are used compulsively they may suppress the necessary emotional processing of an adverse event. Conversely, acceptance of some of the feelings and experiences in an adjustment reaction is essential, but some forms of acceptance may lead to fatalism. There is always a danger that these activities can become distractions: coping strategies in their exaggerated or diminished form may be forms of avoidance. The skill in negotiating the journey of adjustment is deciding where to focus coping at any given time: should the focus be on confronting and dealing with the stressor, allowing normal emotional reactions to unfold or getting on with important tasks that are unrelated to the stressor? When coping strategies are overdeveloped they become in effect safety behaviours. They may also be underdeveloped and so their absence when needed may also slow down the adjustment process: avoiding looking at information about an illness like multiple sclerosis may prevent you coming to terms with it, failing to accept the normality of grief experiences may lead to delayed grieving, refusing to allow others to help or support you may deprive you of important aides in your recovery. There is no separate approach-avoidance dimension in this typology, but it can be seen that a exaggerated focus on one of the three

areas implies an avoidance of the others. Thus too much emphasis on finding a cure for your illness avoids fear and loss; too much emphasis on getting on with everyday life avoids facing the reality of the illness.

Adjustment disorder

For a diagnosis of AD DSM V requires emotional or behavioural symptoms to have arisen within 3 months of the onset of an identifiable stressor. These symptoms should either cause “marked distress that is out of proportion to the severity or intensity of the stressor” or “significant impairment in social, occupational, or other important areas of functioning”. One factor increasing the subjectivity of this diagnosis is the need to take into account “the external context and the cultural factors that might influence symptom severity and presentation” (American Psychiatric Association 2013). ICD 11 similarly requires the presence of an identifiable stressor but the reaction must emerge within one month. It differs from DSM V in emphasizing preoccupation with the stressor or its consequences, as evidenced by “excessive worry, recurrent and distressing thoughts about the stressor, or constant rumination about its implications.” In both systems there is a similar criterion of impairment of personal, social or occupational functioning. The ICD 10 criteria for AD were much closer to DSM IV and V; the modifications in ICD 11 have been influenced by moves to redefine AD as a stress response syndrome (Maercker et al 2007; Strain and Friedman 2011; Maercker et al 2013). The proposed criteria included intrusive symptoms such as rumination, cognitive, emotional and behavioural avoidance, and failure to adapt. The current ICD 11 criteria (Table 2) for AjD include intrusions and failure to adapt but have

relegated symptoms of avoidance to “associated features” (Bachem et al 2016). In line with the proposed ICD 11 criteria for AjD the role of rumination and preoccupation as well as failure to adapt to the stressor, we can formulate the cognitive model of adjustment as follows :

Adjustment disorder arises when there is a failure to integrate new information about a stressful event or ongoing stressful situation into the person’s belief system, or to modify their beliefs as a result of the new information (Schematic processing). This is evidenced by a preoccupation with the stressor and unsuccessful attempts at reappraisal, focused on the stressor and its implications, or on the emotional and physiological reactions to the stressor (Maladaptive appraisals) as well as unhelpful attempts at coping such as compulsive problem solving or self soothing, or avoidance (Maladaptive coping).

This model has similarities to Bachem and Maercker’s recently developed cognitive behavioural model of AjD (Bachem and Maercker 2013, 2016) but conceptualizes adjustment in broader terms than a stress response syndrome and places greater emphasis on the role of schematic processing. Since most adjustment disorders will be expected to resolve within a relatively short time, clinical intervention may be relatively brief and should be aimed at facilitating the adjustment process, managing excessive symptomatology and identifying any factors which might lead on to the development of depressive or anxiety disorders. The first step is to allow the client to tell their story and to validate their experience. People with physical illness for instance may not have

recounted their experience in full before the consultation : inadequate time in a medical consultation or a wish not to burden relatives may have prevented them. Simply having the space to express their feelings and to create a coherent narrative may help them with schematic processing. During this assessment which may take one or two sessions the therapist will be able to identify appraisals that may be hindering the processing of the stressful situation. There may be unrealistic or unhelpful appraisals of the stressor itself or one's coping ability e.g. "This is going to kill me. I can't cope. " There may also be negative appraisals of the implications of the stressor e.g. "It's my fault." Finally there may be negative appraisals of the stress reaction e.g. "I shouldn't feel like this." Psychoeducation about the adjustment process and normalising the stress may be helpful, while verbal discussion can allow some cognitive restructuring of faulty appraisals. Identifying unhelpful attempts at coping and exploring other options will also be important and can help to prevent the development of safety behaviours. Focusing on avoidance, rumination, compulsive self-reliance or the presence of excessive reassurance seeking will be important. The clinician should ask the client life about their past history and the life context in which the adversity occurred. This allows for exploration of how the client's rules for living have interacted with the stressful situation. Contextualising the reaction may help to reduce a sense of being overwhelmed and confused by the experience. Finally client and therapist can negotiate the balance needed between supporting expression of emotions to facilitate emotional processing, and more problem-oriented interventions such as cognitive restructuring and modifying coping behaviours.

Implications for further research

The categorization of coping proposed in this paper is consistent with coping research but as yet untested. One prediction arising from the model is that people who are able to flexibly adapt their focus of coping to their circumstances will be better adjusted. For instance, being able to focus on preparing for an upcoming course of chemotherapy may require a problem focus, but at other times the flexibility to attend to family business may be needed, while on other occasions acknowledging feelings of fear may be appropriate. Similarly the idea that coping strategies may be over or underdeveloped implies that it is not the strategy itself but the context in which it is used, its function and the degree to which it is used that determines whether it is adaptive or maladaptive.

The model of adjustment also has implications for research into clinical practice. It suggests some ways in which a brief CBT intervention might be developed to treat AjD and also contains some ideas about how to formulate and treat patients with formal diagnoses of anxiety and depression who are experiencing co-existing adjustment difficulties.

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