Coping with stress is a very popular subject and a central area of study within health psychology. A search of PsycInfo from 2007 to 2017 yielded 39,218 articles. This chapter provides an overview of classical theories and contemporary approaches to coping, how it changes across the lifespan, and how it relates to mental and physical health outcomes. We conclude with a brief examination of the efficacy of coping interventions and detail next steps for the field.

Most researchers still follow Lazarus and Folkman’s (1984) definition of coping, recently reiterated by Carver and Connor-Smith (2010, p. 684): Coping strategies are “efforts to prevent or diminish threat, harm, and loss, or to reduce associated distress.” How individuals cope with stress is the key to understanding resilience and the maintenance of mental and physical health in the face of trauma, chronic stress, and daily hassles.

Theories of Coping

To understand current approaches to coping, it is necessary to reprise classical theories. As with so many fields, old ideas sometimes arise like old wine in new bottles, so understanding the roots of coping theory is necessary to understand current issues in the field.

Classical Theories

Classical theories of coping fall into three categories: defense mechanisms, coping styles, and coping processes. Defense mechanisms are the unconscious strategies used to ward off the anxiety generated by conflict between the id and the superego (Freud, 1966). These include denial, projection, repression, displacement, and sublimation, and all distort reality to a greater or lesser extent (Vaillant, 1977). Cramer (2015) criticized self-report measures of defense mechanisms—if they are unconscious, how can individuals accurately report on their use? Given that most coping measures are retrospective, individuals may recognize processes that were formerly unconscious, but studies of defense mechanisms are becoming increasingly rare.

Theories of coping styles posit that there are consistent patterns in how individuals cope. From a learning theory perspective, Dollard and Miller (1950) proposed that coping consisted of approach or avoidance strategies. These have also been called blunting/monitoring (Miller, 1980) and sensitization/desensitization (Byrne, 1964), and are somewhat similar to Folkman and Lazarus’ (1980) typology of problem- and emotion-focused coping, described later. Although measures of approach/
avoidance generally have good psychometric properties (Endler & Parker, 1990), they are too simplistic to capture the range of human coping, as people typically use both approach and avoidance strategies (Stroebe & Schut, 2001).

Other coping style approaches focus on personality traits, such as anger repression (Butow et al., 2000) and rumination (Nolen-Hoeksema, 2000). However, there is very little evidence that people are consistent in their coping efforts across situations. In a daily diary study, Ptacek, Smith, Espe, and Raffety (1994) found little correlation between coping style measures and what individuals did on a daily basis, although averages of the emotion-focused coping measures across days were modestly correlated.

The coping process approach (Holahan & Moos, 1985; Lazarus & Folkman, 1984) defined coping as a flexible process that varied as a function of both situational demands and personal preferences and emphasized cognitive appraisal processes. Both personality and environmental characteristics influence stress appraisals that, in turn, shape coping efforts. Primary appraisals involve assessments of whether a situation involved a harm/loss, threat, challenge, or is benign. Secondary appraisals are judgments of the adequacy of coping resources to meet environmental demands, influencing the perceived stressfulness of the problem. Both primary and secondary appraisals shape coping responses. Individuals monitor the impact of their coping on both the situation and their negative affect, and modify both appraisals and coping strategies if current efforts are deemed ineffective. The hallmark of the coping process approach is to ask individuals to recall specific episodes and relate how they handled both the problem and the attendant negative emotions. Presumably, linking self-reported coping to a specific situation or stressor is more accurate than vague assertions of how one usually handles problems, which are influenced by self-presentation biases (Aldwin, 2007).

Initially, coping strategies were divided into a dichotomy of problem- and emotion-focused strategies; either type could be behavioral or cognitive (Folkman & Lazarus, 1980). Problem-focused strategies include making a plan of action, seeking advice, or refraining from action, whereas emotion-focused strategies seek to decrease emotional distress, and include avoidance and wishful thinking. Others sought to identify more specific types of strategies, such as seeking social support or cognitive reappraisal (Aldwin, Folkman, Schaefer, Coyne & Lazarus, 1980).

Coping process measures are psychometrically messy. There is only modest consistency of factor structures across studies, and hundreds of strategies have been identified (Skinner, Edge, Altman, & Sherwood, 2003). This is not surprising, for coping is flexible, and different situations may elicit different nuances in strategies or combinations of strategies. Carver, Scheier, and Weintraub (1989) addressed this problem by devising an instrument, the COPE, that can be used either as a process or style measure by changing the instructions, but psychometric problems persist with that measure and its short form, the Brief Cope (Carver, 1997).

Another problem with studying coping episodes is that better-adapted individuals may be able to avoid problems in the first place. Anticipatory and proactive coping processes may provide a particularly important window into adaptation (Aspinwall & Taylor, 1997). If individuals can anticipate a future problem and cope to mitigate it (such as studying for an exam), they can decrease the stressfulness of the event. Proactive coping are efforts to decrease the probability of the occurrence of the event, such as by attending to basic car maintenance to avoid breakdowns.

**Modern Coping Approaches**

**Problem-Focused Coping**

Modern coping approaches retain some of the features of earlier work, in particular, the stress and coping paradigm, but there is a greater emphasis on more nuanced forms of coping. Studies of
problem-focused coping often focus on its cognitive aspects. For example, Diehl, Willis, and Schaie (1995) studied everyday cognition. They argued that how well individuals can conceptualize the problem and consider alternatives may be key to effective coping. Of particular interest is the concept of **coping flexibility**, defined as the ability to evaluate ongoing coping efforts and change cognitive and affective sets (Stange, Alloy, & Fresco, 2017). Early attempts to assess coping flexibility examined only the number of strategies used, which were sometimes associated with depressive symptoms and suggested ineffective coping (Coyne, Aldwin, & Lazarus, 1981). More recent approaches assess the ability to substitute situationally more effective coping strategies if current attempts are unsuccessful (Kato, 2012).

Other cognitive approaches focus on the context of goals, reasoning that the goals that individuals have in a particular situation may affect the choice of coping strategies (Hoppmann, Coats, & Blanchard-Fields, 2008). Changing goals may be a coping **strategy**: *Accommodative* coping involves making changes to oneself, such as adjusting goals, to deal with intractable problems (Brandstätter, Rothermund, Kranz, & Kühn, 2010).

The strategy of cognitive restructuring has been refined to a greater focus on meaning-focused coping (Folkman, 2008) or meaning-making (Park, 2010). Changing meaning in stressful events has been associated with more positive outcomes, but not if the perceived meaning is negative, such as believing that God is punishing you (Pargament, Koenig, & Perez, 2000).

### Emotion-Focused Coping

There also has been a shift in approaches to emotion-focused coping. Earlier approaches often involved expression of negative emotions, avoidance, or the use of external substances to decrease distress. Stanton, Kirk, Cameron, and Danoff-Burg (2000) developed an emotional approach coping scale that consists of two factors: emotional processing and emotional expression. Emotional processing refers to understanding the source of the negative emotions and how they are impacting one’s life, while emotional expression involves the ability to express one’s feeling to others. Understanding the source and meaning of one’s emotions, and thoughtful expression of emotions (as opposed to just emotional expression) has been associated with better mental health (Stanton et al., 2000).

There is also a shift towards the construct of emotion regulation. There is still debate as to whether regulating emotions is a form of coping with stress, or whether coping is simply part of a broader construct of emotion regulation that occurs regardless of the presence or absence of a stressor (Folkman & Moskowitz, 2004). A meta-analysis (Compas et al., 2017) found massive similarity between both the conceptualization and measurement of specific types of emotion-focused coping and emotion regulation, with the primary difference being the precipitant: Coping measures focus on stressful situations, while emotion regulation may not have a stressful precipitant. There is surprisingly little overlap in these research fields, with only 1% of the more than 20,000 emotion regulation articles also examining coping.

Further, the emotion regulation field seems to be reprising arguments identified 30 years ago in the coping literature, such as whether regulation processes are conscious or unconscious, and if they occur in a similar fashion in controllable vs. non-controllable situations. The field of emotional regulation also faces similar problems in conceptualization and measurement that have plagued the study of coping (see Coyne, 1997). We concur with Compas et al. (2017) that the field of self-regulation should examine the coping literature, and that coping investigators could also benefit from a closer perusal of the self-regulation literature. Given Ptacek et al.’s (1994) work about the weakness of the correlation between coping styles measures and coping stresses, it would be instructive to examine the relationship between general emotion regulation and how individuals cope with problems in everyday life.
Religious Coping

There has also been an increased emphasis on religious coping. Pargament et al. (2000) identified five aspects of religious coping, including meaning, control, comfort/spirituality, intimacy/spirituality, and life transformation. A particularly interesting approach is a Buddhist measure of coping (Falb & Pargament, 2013) that includes items such as recognizing the impermanence of the stressful situation, seeking support from one’s religious community, practicing loving-kindness, and offering compassion to others.

Dyadic Coping

Seeking social support is an important component of coping measures, but many researchers now focus on the broader social context of coping (Berg, Sewell, Hughes, Wilson, & Brewer, 2016; Revenson & Lepore, 2012). In particular, there has been an upsurge in studies of dyadic coping (DeLongis & Zwicker, 2017; Kayser & Revenson, 2016). Dyadic coping conceptualizes the way couples (or dyads) cope with stress together by sharing appraisals of demands, supporting each other, and engaging in similar coping efforts as a team. It plays a beneficial role in marital satisfaction and health across adulthood (Revenson & DeLongis, 2011). In later life, however, dyadic coping may become very important and effective way to maintain relationship satisfaction (Landis, Peter-Wight, Martin, & Bodenmann, 2013), given decreases in individual resources.

Lifespan Perspectives on the Development of Coping

Childhood and Adolescence

Infants’ reactions to stress develop from relying primarily on reflexes to coordinated action schema such as thumb sucking for self-soothing (Skinner & Zimmer-Gembeck, 2009). As executive function and mobility increases, young children (ages 2 to 5) can utilize symbolic objects such as favorite animal toys for self-soothing (Aldwin, Yancura, & Boeninger, 2010). Their growing language ability allows them to express and communicate their emotions (Kopp, 2009).

In middle childhood, children encounter new types of stressors such as evaluations of physical or academic achievement. During this life phase, children’s problem- and emotional-focused coping increases dramatically, and they add cognitive strategies such as distraction, positive re-framing, and self-reassurance (Compas et al., 2017).

Adolescents use metacognitive coping strategies such as inhibitory control, planning, and anticipating consequences, and their problem-focused coping strategies become more sophisticated (Zimmer-Gembeck & Skinner, 2016). However, adolescence is also a time of the development of maladaptive coping strategies that involve risky health behaviors (smoking, drinking, and drug use) to relieve stress (Johnston, O’Malley, Bachman, Schulenberg, & Miech, 2016).

Adulthood

Young adults are more likely than older adults engage in risky behaviors such as eating, smoking and drinking alcohol (American Psychological Association, 2013), and substance use peaks in young adulthood (Johnston et al., 2016). They report conformity pressures from others as the main reasons for use of alcohol and marijuana (Patrick, Fairlie, & Lee, 2018). On the positive side, they learn which types of coping strategies are more effective to attain their goals in various situations, resulting in becoming more adept at dealing with life problems. For example, emotional awareness
and psychological endurance increase until early adulthood and remain stable until middle-age, but emotional regulation and anger management continue to increase until midlife (Hagler, Grych, Banyard, & Hamby, 2016).

Although late life is often considered to be a time of loss, including declines in health and deaths of spouses and friends, older adults show high levels of adaptive coping. For example, older adults showed greater use of acceptance in situations of moderate intensity compared to younger adults, and used fewer maladaptive coping strategies such as avoidance, self-criticism, and worry/ rumination in situations of high and moderate intensity (Schirda, Valentine, Aldao, & Prakash, 2016). While older adults are more vulnerable to physical stressors, such as extreme heat or cold, the literature is mixed concerning whether older adults are more vulnerable to psychosocial stressors, with laboratory studies suggesting heightened vulnerability, field studies suggesting lower vulnerability, and some studies showing no age differences (Aldwin, Yancura, & Boening, 2007).

The Strength and Vulnerability Integration model (Charles, 2010) argued that coping plays a large role in resilient aging. In particular, older adults may use more proactive coping to avoid problems or decrease their adverse impacts. This was empirically supported by a recent study, in which older adults used more proactive coping and had lower stress ratings than younger adults (Neubauer, Smyth, & Sliwinski, 2018).

Aldwin and Igarashi (2016) proposed a similar model, Coping, Appraisal and Resilience in Aging (CARA), but focused on stress appraisals as well as coping. The basic premise of this model is that older adults recognize their heightened vulnerability to stress in the face of declining physical and psychosocial resources, so they take steps to prevent the occurrence of stress or to minimize its impact through both appraisal and coping processes. The CARA model suggests that, on average, older adults are (1) less likely to perceive situations as “problems” and thus less likely to report stress occurrence; (2) appraise them as less stressful when they do occur; (3) cope more efficiently (e.g., decrease in effort); but (4) maintain levels of perceived coping efficacy. Coping efficacy is defined as self-reports of how well the individuals believe that they handled the problem. Preliminary support for this model found that coping effort in older adults decreased over 16 years, but coping efficacy remained stable (Aldwin, Choun, & Spiro, 2017).

There are individual differences in whether and how coping changes with age. Nonetheless, coping ability can improve with age, and may be one reason that older adults may report less stress and higher levels of life satisfaction.

**Coping and Culture**

Culture can affect nearly all aspects of the stress and coping process. The cultural context shapes the types of stressors that an individual is likely experience, how stressors are appraised, the choice of individual coping strategies, and the types of institutional mechanisms available to help individuals cope with stress (Aldwin, 2007). For example, ethnic minority groups are exposed to greater socio-economic stressors compared to non-Hispanic Whites (National Center for Health Statistics, 2017). Blacks may be particularly exposed to multiple types of discrimination stress in their daily lives (Merluzzi, Philip, Zhang, & Sullivan, 2015). Those who experience discrimination may be vulnerable to other types of stressors, such as chronic stress and daily hassles (Brondolo, Gallo, & Myers, 2009). Similarly, LGBT minorities who experience discrimination report higher rates of physical health problems than their non-stressed peers (Frost, Lehavot, & Meyer, 2015).

Studies on coping with discrimination showed that Blacks and Whites tend to use different coping strategies (Brondolo, Ver Halen, Pencille, Beatty, & Contrada, 2009). Although some studies find that Blacks are more likely to keep quiet about experiences of unfair treatment than are Whites (Krieger & Sidney, 1996), others have found that they are more likely to use confrontational coping strategies.
strategies (Plummer & Slane, 1996), increasing the risk for hypertension, but more so in Black men than in non-Hispanic Whites or Asians (Brondolo et al., 2005).

Bennett et al. (2013) argued that coping strategies often do not have the same protective effects in minorities as they do among Whites, and that culturally specific measures may be needed. James, Keenan, Strogatz, Browning, and Garrett (1992) hypothesized that Blacks under stress may simply try harder, a phenomenon he called “John Henryism” after a folk hero working on the railways in the 19th century who was purported to have won a contest with a steam-powered hammer, but died from massive heart failure. Jackson, Knight, and Rafferty (2010) argued that Blacks are more likely to use risky health behavior habits to cope with stress, protecting their mental health at cost to their physical health. Blacks are more likely to use emotion-focused coping and prayer (Knight, Silverstein, McCallum, & Fox, 2000), as do Latinas (Abraído-Lanza & Revenson, 1996). A meta-analysis of how Blacks cope with pain found that they were more likely to use spirituality and catastrophizing than Whites (Meints, Miller, & Hirsh, 2016).

Cross-national studies of coping often find more similarities than differences, however, and there may be complex interactions with type of stressor. For example, McCarty et al. (1999) found that Thai children were less likely to use confrontive coping than American children, but it varied by the type of stressor. Further, the same strategy may have different effects in different cultural contexts (Szabo et al., 2017). Thus, bicultural individuals may have different coping repertoires, depending upon the cultural context (LaFromboise, Coleman, & Gerton, 1995).

Coping and Health Outcomes

Coping and Mental Health

Understanding how coping is related to psychological outcomes (usually measured as psychological symptoms or distress) is complicated. For example, problem-focused coping is often positively correlated with mental health, whereas emotion-focused coping is (paradoxically) positively correlated with psychological symptoms (Penley, Tomaka, & Wiebe, 2002). Early measures of emotion-focused coping often used maladaptive strategies that were confounded with psychological symptoms, such as crying (Stanton, Danoff-Burg, Cameron, & Eli, 1994). As mentioned earlier, newer coping approaches focus on emotional processing, which puts more emphasis on understanding the source and meaning of one’s emotions, and on thoughtful expression of emotions (as opposed to just emotional expression). Both are associated with better mental health (Stanton et al., 2000). Thus, it is important to avoid confounding coping measures with assessment of distress outcomes. Causal directionality may also be a problem; individuals in psychological distress cope differently, and often less effectively, than those in better mental health (Coyne et al., 1981).

Further, the effects of coping strategies are often situation-specific. According to the goodness-of-fit model of coping (Lazarus & Folkman, 1984), the effectiveness of coping strategies depends on the controllability of the stressor. That is, emotion-focused coping is considered to be more appropriate for uncontrollable situations, whereas problem-focused coping is more effective in controllable situations. As Coyne and Racioppo (2000) pointed out, sometimes problem-focused coping temporarily will be useful in uncontrollable situations. For example, losing a loved one is an uncontrollable stressor; however, some facets of the problem, like planning the funeral or managing the estate, call for problem-focused coping. Nonetheless, there has been a great deal of controversy, as the goodness of fit hypothesis has been supported more strongly in studies using within-person designs, that is, comparing how individuals themselves differ when confronted with uncontrollable and uncontrollable situations, rather than between-person designs, which compare individuals (Park, Folkman, & Bostrom, 2001).
Coping

The relationship between use coping strategies and mental health can be affected by the severity of the stressor, as well as the reactions of other people (Stephens & Long, 2000). For example, the more stressful the situation, the more both coping and psychological symptoms are activated. Thus, it is important to control for the stressfulness of the situation to disentangle coping effort and coping efficacy. Vitaliano, DeWolfe, Maiuro, Russo, and Katon (1990) used coping ratios to address this situation (i.e., dividing the number of strategies used by the total number of strategies possible). Another approach is to separate coping efficacy from coping effort, and examine the interaction between the two (Aldwin & Revenson, 1987). Alternatively, Taylor, Davis, Yeung, Zautra, and Tennen (2017) suggested that coping efficacy could function as a mediator when examining outcomes such as pain over time.

Finally, much coping research has focused on the diminution of psychological symptoms instead of the maintenance of psychological well-being. Folkman and Moskowitz (2004) emphasized the co-occurrence of positive and negative emotions within a stressful situation. Zautra, Arewasikporn, and Davis (2010) defined resilience as the maintenance of positive affect within stressful situations. Indeed, the maintenance of positive emotions may have more effects on health than negative affect (Mroczek et al., 2013). Thus, more research is needed on whether (and how) different types of coping promote positive well-being in stressful situations.

Coping and Physical Health

Some of the same caveats concerning coping and mental health also apply to the relation of coping and physical health, especially in terms of causal directionality. More serious health problems may lead to greater coping effort, thus confounding effort with stress; covarying out the stressfulness of the problem may be necessary to uncover the true relationship between coping and outcomes (Aldwin, 2007). Longitudinal designs, especially within-person designs, may provide a more accurate picture of the relationship between coping and outcomes.

Between- vs. within-person analyses show even more complex relationships between coping and health. In a daily diary study of adolescents, between-person analyses (comparing changes across individuals) showed greater cortisol reactivity only among those who generally used less problem-focused coping. In the same study, however, within-person analyses (comparing how individuals varied from their own usual patterns) showed that individuals who used higher than usual levels of problem-focused coping also showed increased cortisol reactivity to stress (Sladek, Doane, Luecken, & Eisenberg, 2016). Clearly more research using complex statistical techniques is needed to untangle these relationships.

Reviewing the evidence for the relationship between coping and physical health outcomes, including cardiovascular, immune, and neuroendocrine outcomes, as well as disease progression, shows decidedly mixed results (Aldwin, Igarashi, Gilmer, & Levenson, 2018). In general, this review showed that avoidant coping has been associated with worse outcomes, whereas emotion processing and emotional expression have been associated with more positive outcomes, including biomarkers such as IL-6 and indications of disease progression. In contrast, problem-focused coping has been associated with better health outcomes.

A review by Olff, Langeland, and Gersons (2005) found a very complex relationship between cardiovascular and HPA arousal with stress appraisal and coping. Not only did the type of appraisal affect these responses, but coping did as well. Defensive responses were associated with greater cardiovascular (CV) arousal and cortisol level, while problem-focused coping was associated with lower CV arousal and cortisol. However, the effective use of defensive processes was associated with lower cortisol, but CV arousal levels were still high, leading to possible future problems with hypertension and heart disease.
Dyadic coping may also affect physical health outcomes. A good example is a daily diary study by Reed, O’Connor, Pace, Raison, and Butler (2017), who found that couples with low dyadic coping had greater inflammatory immune response to stress, as assessed by IL-6, while those with higher dyadic coping showed no immune reactivity.

These studies suggest a buffering model of coping—that coping plays a critical role as a moderator of the effects of stress on physiology, with some strategies protecting against the adverse effects of stress, but others enhancing them. Nonetheless, there is still a debate whether coping has direct, buffering, or indirect effects on physical health outcomes. For example, Yancura, Aldwin, Levenson, and Spiro (2006) found that the effects of coping were mediated through factors such as mastery, but often had direct effects. There may be additional modifiers of the ability of coping strategies to buffer stress. For example, breast cancer support groups had positive effects on physical health among women with low resources, but, for those with high levels of support, support groups actually had adverse effects (Helgeson, Cohen, Schulz, & Yasko, 2000). How coping “gets under the skin,” if it is not through buffering or changes in affective arousal, is a mystery that warrants further study.

Much of the effects of coping on immune reactivity has been conducted with people with HIV/AIDS. Ironson and Kremer (2011) provided a comprehensive review of these studies, largely focusing on CD4 cell counts, as well as AIDS progression and mortality. The results were extremely mixed, with some studies showing positive effects of problem-focused coping and adverse effects of avoidant coping showing negative effects, but others showed no effects or that avoidant coping showed lower CD4 decline. Finding meaning did result in less CD4 decline and lower mortality. In part, these mixed results reflect a lack of theory as to how and when coping might affect immune functioning. Finally, Ironson, Kremer, and Lucette (2016) found that spiritual coping predicted survival in HIV+ patients, independently of biomarkers.

Segerstrom (2007) provided an interesting model that addressed the energy requirements of maintaining immunity. The immune system requires a great deal of energy, and sometimes strategies which are more avoidant (e.g., require less energy) may be associated with positive outcomes, because they allow for better use of existing energy supplies for the immune system. In other instances, however, such as adherence to medical regimes, problem-focused coping may be more effective, especially when managing chronic illnesses.

Adjustment to illness. A major focus in the study of coping and physical health is on management of chronic illness, which often entails adherence to medical, dietary, and exercise regimes (see Chapter 13). Being able to cope with these demands is often crucial to slowing the progression of chronic illness. A meta-analysis by Hagger, Koch, Chatzisarantis, and Orbell (2017) demonstrated that coping mediated the relation between illness representations and illness outcomes such as disease state, physical, and social role functioning, as well as the psychological distress that often accompanies chronic illness. The effect of coping on illness outcomes is also sometimes mediated through its effect on negative affect and other aspects of well-being (Yancura & Aldwin, 2008).

Thus, the effects of coping on health outcomes are highly complex, showing direct, mediated, and moderation effects, as well as interactions with contextual factors. While we are closer to understanding the subtle nuances of when coping is effective (for what outcomes), or not, we still lack a comprehensive theory of coping to provide a framework for the effect of coping on health outcomes.

Coping Interventions

Coping interventions reflect a broad range of evidence-based psychological interventions, including stress management, health behavior interventions, cognitive behavior therapy (CBT), and other
forms of individual treatment. For example, CBT encourages individuals to reappraise their situations (e.g., changing from internal attributions to external ones), develop emotion-focused coping strategies (saying “no” to negative thoughts, or restricting them to particular time periods), and developing better problem-focused and interpersonal skills. These interventions also occur in a variety of domains, including chronic or life-threatening illness, stress, and trauma. A full review of all of these literatures is beyond the scope of this chapter, and we will focus primarily on coping interventions with chronic illness.

Antoni (2009) provided a comprehensive review of the cognitive behavior stress management (CBSM) interventions for HIV+/AIDS patients. Although some interventions focused on modifying sexual behaviors (e.g., wearing condoms) and medication adherence, the ones of particular interest for this chapter are those that examined whether modifying coping strategies has physiological impacts or modified the progression of HIV/AIDS. His review focused on interventions. Although it is fairly easy to demonstrate the effectiveness of CBSM on the negative affect associated with this disease (Harding, Liu, Catalan, & Sherr, 2011), it is harder to demonstrate physiological effects. However, interventions lasting at least 10 weeks showed significant effects on both neuroendocrine and immune factors, especially when the intervention was effective in decreasing emotional distress and increasing social support, suggesting that the effect of coping was mediated through these factors.

The early literature on coping interventions in cancer patients focused on reducing emotional distress and enhancing immune function. For example, a coping intervention with melanoma patients showed enhanced immunological function (Fawzy et al., 1990) and increased survival time (Fawzy et al., 1993). As cancer has become more of a chronic illness, the field has shifted to increasing quality of life in survivors, especially using dyadic interventions with partners. For example, a review by Brandão, Schulz, and Matos (2014) found that dyadic interventions were often effective in increasing quality of life and relationship quality, and decreasing psychological distress and physical symptoms associated with cancer. Similarly, a meta-analysis on coping interventions for diabetes management (Hood, Rohan, Peterson, & Drotar, 2010) found that those which targeted interactions with family members were often more effective in increasing metabolic control than those that focused only on individuals’ coping strategies. Another meta-analysis (Hartmann, Büzner, Wild, Eisler, & Herzog, 2010) confirmed that family-based coping interventions were effective than individual interventions in improving health for adults with a variety of chronic illnesses, including cardiovascular disease, stroke, cancer, and arthritis.

Thus, coping interventions can be effective in decreasing the psychological distress and improving quality of life, neuroendocrine and immune parameters, as well as disease progression. Family-based coping interventions may be more effective in some circumstances than individual-based interventions. Moskowitz (2009) reminds us that the maintenance of positive affect may also be important in coping with chronic disease.

**Summary**

The field of coping research has improved markedly over the past 50 years. We have more nuanced understanding of coping strategies, and a clearer idea both of how they develop and how they influence both mental and physical health. Coping interventions have also become more effective, as we come to understand the importance of individual differences in what works, as well as the importance of including families in the interventions. Coping measurement still leaves much to be desired, however, and much more research is needed to understanding the conceptual overlap and distinctions between coping and emotion regulation. Further, there is an urgent need for theoretical models to better address the complexities of how and when coping strategies may affect physical outcomes and the course of illness.
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