

## Living with chronic wounds: an exploration of adaptive and maladaptive coping strategies and their association with wellbeing



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This qualitative study explored the coping strategies used by individuals living with chronic wounds. Self-assessment of wellbeing was also sought. Semi-structured interviews were conducted to data saturation with seven individuals receiving 'in home' care for chronic wounds. Coping strategies were identified and categorised into 12 Families of Coping using framework analysis. Our sample demonstrated good levels of wellbeing. Participants overwhelmingly described the use of adaptive strategies which they recognised as helpful for coping with the challenges of living with chronic wounds. These strategies included seeking social and emotional support from others, solution-focused problem solving, finding new options to maintain health and wellbeing, distraction, and maintaining positive affect (humour and optimism). The authors recommend that wound-care practitioners promote these strategies to clients with the knowledge that they have been found to be helpful for coping with life with a chronic wound and are known to be related to better wellbeing.

**C**hronic wounds are a significant health problem, causing functional impairment and psychosocial difficulties for individuals (Upton and Upton, 2014). These difficulties include emotional distress, social isolation, body image issues and reduced mobility, all of which are known to impact on wellbeing (Hopman et al, 2014; Upton and Upton, 2015).

The relationship between wellbeing and the coping strategies used to deal with challenges associated with chronic illness is well established (Brunault et al, 2016; Lo Buono et al, 2017; Niihata et al, 2017). Few studies have focused specifically on the strategies used by individuals living with chronic wounds, although coping is acknowledged as an important psychological resource linked to wellbeing (Upton et al, 2016). Knowing which coping strategies are most effective, and which are associated with better wellbeing, could inform healthcare practice. For example, it has been suggested that an

individual who uses effective coping strategies may also find concordance with a prescribed management plan easier (Vermeiden et al, 2009). Thus, an individual's choice of coping strategies could directly impact on the wound healing process.

Approaches to categorising and describing coping vary across the literature. However, what is agreed, is that while coping involves adaption to a challenging situation, not all coping strategies are helpful or effective. For example, the psychological distress of living with a chronic wound could encourage increased alcohol consumption (Upton and Upton, 2015). Although this might provide short-term relief from symptoms such as pain, reliance on alcohol is unhelpful in the long-term, as it can inhibit wound healing processes, thereby prolonging the time living with a wound (Walburn et al, 2009).

In contrast, coping behaviours that focus on recovery — such as positively reappraising

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**Table 1. Families of Coping (Adapted from Skinner and Zimmer-Gembeck, 2016).**

	Coping family	Intended function	Examples of ways of coping
Adaptive strategies	Problem-solving	Adjust actions to be effective	Planning Taking control
	Information-seeking	Find additional contingencies	Reading Asking others
	Self-comforting	Protect available social resources	Emotional self-regulation Self-encouragement
	Support-seeking	Use available social resources	Seeking social contact/ emotional support Prayer
	Accommodation	Flexibly adjust preferences to options	Distraction Positive reappraisal and acceptance
	Negotiation	Find new options	Compromising Constructive resistance
Maladaptive strategies	Helplessness	Find limits of actions	Passivity Loss of control
	Escape	Escape noncontingent environments	Mental withdrawal Denial
	Delegation	Find limits of resources	Over-reliance on others Complaining/self-pity
	Social isolation	Withdraw from unsupportive contexts	Social and/or emotional withdrawal Avoiding others
	Submission	Give up preferences	Catastrophising/complaining Self-blame
	Opposition	Remove constraints	Blaming others Aggression/defiance

situations, or taking control — are more likely to be helpful. Behaviours leading to unhelpful outcomes are therefore maladaptive, while those leading to helpful outcomes are adaptive. Skinner and colleagues (Skinner, et al, 2003; Skinner and Zimmer-Gembeck, 2016) provide a comprehensive framework for understanding coping strategies. Grounded in a substantial meta-analysis, the framework categorises coping behaviours into 12 ‘families’, which can in turn be reduced to either adaptive or maladaptive strategies [Table 1].

Using this framework as a reference point, the authors explored the coping strategies used by people living with chronic wounds, their perceived usefulness, and their relationship to wellbeing.

## Method

### Design

A qualitative approach was chosen, as our intent was to explore the lived experience of individuals with chronic wounds. Semi-structured interviews were designed to capture participants’:

- Life satisfaction/wellbeing

- Experience of living with chronic wound(s) including challenges
- Coping strategies used in response to challenges and their perceived usefulness.

### Participants

Participants were recruited through the Australian Capital Territory (ACT) Health Community Care Program. Eligible participants were over 18 years of age, living with chronic wound(s) and receiving ‘in home’ wound-care through ACT Health. Individuals were excluded from the study if they were known to have cognitive impairment. Seven individuals were interviewed, which was the point at which data saturation occurred (no new themes emerging). Participants were aged from 67 to 92 years of age and had been living with their wounds for over a year (range: 18 months to 8 years). Six participants had leg or foot ulcers. One participant had a pressure injury. All participants reported having other chronic health conditions in addition to their wound(s).

Ethical approval was obtained from ACT Health Human Research Ethics Committee (Ethics number ETH.7.17.156).

### Procedure

Community nurses provided patients with information about the study. Individuals interested in participating were contacted by a member of the research team who discussed the study further and answered any questions. If individuals were happy to participate, interviews were arranged at a mutually convenient time in a place of their choosing (usually a home visit).

Interviews lasted from 60–90 minutes and were audio recorded with the permission of the participant.

### Data analysis

Audio data were transcribed verbatim, and analysed using Framework Analysis (King, 2012). Coping strategies were identified in each transcript, then categorised according to the Families of Coping framework (Skinner, et al, 2003; Skinner and Zimmer-Gembeck, 2016). Two researcher (MC,PU) undertook analysis independently, then compared their coping strategy groupings. Strong consistency in analysis was noted, with any discrepancies resolved through discussion and negotiation.

## Findings

### Wellbeing

All participants expressed satisfaction with their lives, with the majority reporting being satisfied

or very satisfied. Two participants only rated their general life satisfaction as 'okay'. Both were experiencing general health problems and severely impacted by their wounds. However, no-one described being dissatisfied with life. Rather they described their life in positive terms, using words such as fortunate, lucky, good and fulfilled.

## Adaptive coping strategies

### Problem solving

This coping strategy was common in our sample and was applied to either short-term practical challenges such as one-off appointments to a medical specialist, or more long-term wound-related problems including reduced mobility and physical functioning. Participants tended to be solution-focused, regularly re-evaluating their own capacity to overcome problems. Planning and taking control were important for this problem-solving. As one participant noted: "You look at ways of compensating ... I can adapt."

### Information seeking

No instances of information seeking were reported.

### Self-comforting

Using humour to manage the stresses of living with chronic wounds was a form of emotional self-regulation frequently described by participants. This humour took many forms, from reinterpreting wound-related experiences as amusing anecdotes, to poking fun at themselves and their wound. This approach was summed up by one participant as: "I have a lot of fun, and a lot of entertainment, you know, to keep me going."

Participants also described picking themselves up and just 'getting on with it'. All participants had felt discouraged, depressed or frustrated because of the impact the wound(s) had on their lives. Typically, they did not deny negative emotions, but they did not dwell on them either: "I just sort of have a good cry" Rather than feeling sorry for themselves for lost abilities, participants focused on what they could do: "[I don't] say that 'Oh, I can't do this, and I can't do that.' Because I could always find something to keep me occupied." Self-encouraging attitudes of 'I can get through this' were also evident.

### Support seeking

Seeking social contact and emotional support from others was a key strategy used by the

authors' sample. In particular, participants' families (partners, siblings, children and grandchildren) provided important support for both emotional and physical challenges: "There's always someone there who I can call on." As well as support provided by visits to or from family and friends, participants whose families did not live locally found other ways to keep in touch: "I regularly write letters to all the members of the family, the absent ones." Community nurses were also perceived as a major social support, particularly for individuals living alone. Participants appreciated the nurses social interactions, as well as their wound-care skills: "[the nurses provide] a social visit in many ways as well."

Finally, prayer and religious beliefs were also described as helpful coping mechanisms by some participants. One participant used prayer as an emotional comfort during challenging moments, while others were more focused on the social aspects of church attendance: "We have morning tea after the morning service on Sundays."

### Accommodation

Participants demonstrated a positive outlook in regard to their wound, and wider life experiences. For example, one participant noted they had a lot to be thankful for, while another said they considered themselves 'lucky'. Another form of accommodation, distraction was reported by most participants. Strategies ranged from simply thinking about other things, to listening to music, watching TV or engaging in other hobbies. Distraction was described as very helpful and often used to cope with physical pain, particularly when analgesics were not providing relief: "Thinking about other things works 100%"

### Negotiation

Finding new options was a helpful strategy for rehabilitation and staying active despite mobility restrictions. Walking was an important component of feeling 'normal' and demonstrated that individuals were finding new options to maintain participation in life. Physical activity was reported to promote a sense of wellness. Chosen options were often a compromise, being substantially different to participants' previous interests. For example, one participant, previously an active bush walker, could no longer walk long distances unaided. He had, therefore, taken up gardening, which had "given me that body exercise a bit. But that's it you know".

Participants had accepted their changed status and engaged in positive reappraisal of their situation: "Your expectations have gotta tone down." Multiple examples of perseverance and tenacity in the experience of living with wounds were also described, demonstrating constructive resistance to physical pain and reduced mobility: "You just grit your teeth and bear it ... but I'm determined not to give up."

### Maladaptive strategies

#### Helplessness

Participants did not see themselves as helpless, as they were confident in their ability to adapt and find solutions to problems. Helplessness was not used as a way to cope with living with wounds, although some participants voiced frustration and helplessness at not knowing the precise time of community nurse visits. It was clear they felt unable to control these activities and that this lack of control highlighted feelings of dependency.

#### Escape

Escaping by mental withdrawal or denial were not described by participants as current coping mechanisms. However, two participants reported previously using alcohol to overcome emotional difficulties and wound pain. Both participants felt that alcohol helped as an escape initially " ... because it helped not to think about it [the pain]."

#### Delegation

No coping strategies described by participants fitted into this category. Although participants sought out others for support, there was no evidence of over-dependency. Rather participants were proud of their ongoing independence and sought to keep social support on their own terms.

#### Social isolation

Participants did not report avoiding or withdrawing from interactions with others. On the contrary, they were keen to maintain relationships and engaged in social activities as often as they could. One participant described losing friends because their wound had reduced their mobility, but this was not an active choice: "A couple of people who I thought was quite close, I don't see anymore. Like, they'd be going for coffee somewhere or something and I couldn't go with them. I've just not got that flexibility."

#### Submission

One participant, whose wound was being treated palliatively, reported previously feeling hopeless about their situation. This acceptance

of the situation was one of passive submission and giving up.

#### Opposition

One participant described venting her frustration on her partner: "I'll be mad at him and he'll say 'I know you're not really angry at me, you're just frustrated with yourself'" Although this emotional venting did not change anything, it provided a useful outlet when emotions ran high, particularly as the participant's partner could recognise the situation, and would often diffuse it with humour, thus shifting the dyad to a more adaptive coping style.

#### Discussion

Participants reported a broad range of coping strategies, the majority of which were adaptive and perceived as helpful. The only maladaptive strategies reported had either occurred in the past and been rejected when found to be unhelpful (Escape and Submission) or were employed only occasionally and briefly (Opposition). As participants had been living with their wounds for a long time, it is likely that they have had the opportunity to explore different coping strategies and establish the ones that are most helpful. It is also probable that participants were displaying the positive psychological resources usually associated with better wellbeing (Upton et al, 2016), since all participants reported good wellbeing. Information seeking was the only adaptive strategy not reported by participants. Since participants had been living with wounds for so long, it is likely that they did not need further information about their condition or its treatment.

The most common strategy reported was also described as very helpful: seeking social contact and emotional support from others. Social support has previously been demonstrated to play an important role for wellbeing, particularly for people living with a chronic wound (Upton and Upton, 2015). There is also strong evidence that having access to social networks can improve physical wound healing as well as psychosocial wellbeing (Upton et al, 2015). It is of note that social and emotional support was realised through interactions with healthcare staff, as well as friends, family and the church.

Coping was also characterised by the use of strategies which maintained independence, personal control and decision making. Strategies were solution-focused and included overcoming changed physical functioning

through problem-solving or finding new options to maintain health and wellbeing. Purposeful distraction was also described as helpful by the majority of participants with most strategies linked to personal interests and relaxation. Participants were strengths-based, focusing on what they could do rather than what they could not. Strengths-based approaches appear to increase positive attitudes and self-efficacy in other healthcare settings (Yan et al, 2020) and could, therefore, play an important role in wound care.

Maintaining positive affect was also important. This ranged from using humour to manage stress, to upholding a hopeful outlook on life. This optimism was apparent when participants made favourable comparisons of their own situation with that of others. According to Social Comparison Theory, individuals often assess their own health status through comparison with that of others with the same health condition (Suls et al, 2002). Comparing the self to others with poorer health as our participants did, can result in either positive or negative beliefs about one's own health status, depending on whether the comparison is characterised by optimism or hopelessness. An optimistic person interprets the comparison as confirmation that their own health could be worse, while someone who feels hopeless will be certain that their own health will deteriorate. For our participants all social comparisons were downwards, but optimistic, making them helpful for wellbeing.

### Study limitations

As is typical for interview studies such as this one, we used an opt-in sampling approach that relied on gatekeepers (community nurses) as a first-line recruitment strategy. The limitations of this form of convenience sampling are well known, particularly the possibility of achieving a non-representative sample. This can result from a bias in the type of person prepared to participate in survey-type health research, with evidence suggesting that willing participants are typically white, educated, wealthy and more chronically ill than those who decline participation (Walter and Davis, 2016). These limitations are true to an extent for our sample, who were white and could be classified as 'more chronically ill' since each participant had at least one comorbidity and had been living with wounds for a number of years. They were however perhaps more representative of the chronic wound population in other ways, being over 60 years of age, and more likely to have a

leg or foot ulcer, two common features of the chronic wound population using community healthcare services (McClosker et al, 2019).

### Conclusion and recommendations

The authors identified a number of helpful coping strategies used by individuals living long-term with chronic wounds. Given the association of these strategies with good wellbeing, encouraging new wound-care clients to adopt these strategies should be implemented within evidence-informed, person-centred practice. While it is impossible to know how easy or difficult it may be to promote these behaviours in people who have been living with a wound for a long time, emphasising the credibility and relatedness of the information means the message is more likely to be heard and acted upon. Working within existing clinical relationships, practitioners are well placed to apply their knowledge of an individual's needs and capacity to provide tailored advice and support. Based on our findings we recommend practitioners:

- Promote the use of social support networks. If an individual has no family or friends living close by, encourage them to keep in touch with geographically distant relatives. Foster any opportunity to make social and emotional connections, including with others with chronic wounds (e.g. community clinics, 'leg club' models of care). Practitioners should also assume their role as a social and emotional support, particularly for individuals without significant others. This must be recognised as a legitimate aspect of holistic care, that can be achieved without overstepping professional boundaries:
- Encourage independence, maintenance of control and decision-making. Facilitate this through collaborating with the person in the treatment planning process, hearing and integrating their needs, wants, and values. Affording individuals this level of control improves treatment concordance together with wellbeing (Upton and Upton, 2015)
- Take a strengths-based, solution-focused approach to care. Focus on what the individual can do either alone or with support, rather than on their insufficiencies. Take the time to celebrate success, however small and encourage feeling of self-efficacy
- Maintain the individual's hope and optimism for a successful process and outcome but be honest and transparent about what that means. Each individual should focus on recovery or successful palliation

as appropriate

- Support individuals to find alternative methods of pain relief. While pain medication should always be a first-line treatment, individuals should have other techniques that they can employ as well. As described by the participants in this study, distraction and relaxation are facilitated by a range of behaviours; the key is that they are of sufficient value to the individual to be able to refocus attention.

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