Eye of the Beholder: Perceived Stress, Coping Style, and Coping Effectiveness Among Discharged Psychiatric Patients

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ABSTRACT

Sources of perceived stress, coping style and coping efficacy were investigated among psychiatric patients being discharged to the community. The study's purpose was to (i) qualitatively characterize sources of perceived stress; (ii) identify preferred coping styles, and (iii) test the effectiveness of coping styles. Thematic coding of participants' narratives revealed that dominant stressors were family relationships, mental health symptoms, and employment issues. Consistent with previous findings among non-clinical samples, problem-focused coping styles were predictive of decreased perceived stress and increased perceived efficacy, whereas emotion-oriented coping styles were negatively associated with these outcomes. Contrary to hypotheses, avoidance coping styles was unrelated to outcomes.

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Many theoretical models of psychopathology, such as the stress-vulnerability model (Zubin and Spring, 1977) acknowledge the role of stress in the etiology and trajectory of mental disorders. Recently, the importance of patients’ own subjective appraisal of stress in connection to the experience and exacerbation of psychiatric illness has been emphasized (Koolhaas et al., 2011; Phillips, Francen, Edwards, and McMurray, 2007). Subjective appraisal of stress typically involves an evaluation of the personal significance of an event in relation to one's own well-being (Stuart, 2009). While it has been reported that levels of perceived stress tend to be higher among those with psychiatric illness compared to those without mental illness (Lavoie and Douglas, 2012), little is known about the sources of this perceived stress. An improved understanding of stressors as identified by the patient, particularly during difficult events such as psychiatric hospital discharge, would assist in better meeting the nursing needs of this population. Addressing this paucity of research is important given that many living with mental illness are believed to be especially sensitive to the negative effects of stress compared to those whose mental health is less compromised (Kessing, Agerbo, and Mortensen, 2004; Monroe and Hadjiyannakis, 2002).

When faced with circumstances perceived to be stressful, an individual typically mobilizes coping responses that serve to manage or minimize the demands of the situation (Lazarus and Folkman, 1984). According to Endler & Parker’s (1990) multidimensional interaction model of stress and coping, person variables (e.g., cognitive style, trait anxiety, emotionality) interact with situation variables (e.g., life events, hassles, pain) to induce subjective perceptions of threat. A threat appraisal, combined with perceived controllability of the situation, gives rise to changes in state levels of anxiety within an individual, which subsequently triggers specific physiological and behavioral reactions, including coping responses (Endler, 2009). Coping responses may, in turn, affect levels of anxiety, the perception of threat, or personal and situational variables.

Many stress theorists believe that individuals tend to approach and respond to a range of stressful situations using a consistent style (e.g., Endler, 2009). According to Endler & Parker (1999), coping styles can be categorized into three general types. Problem-focused coping is task-oriented and involves strategies aimed at taking action to modify the situation or generating alternative solutions. Emotion-focused coping is person-oriented and is directed at regulating emotions cued by the stressor; this style of coping may comprise affective responses such as outbursts or fantasizing reactions. Last, avoidance coping responses are either task-oriented (e.g., distracting oneself with another task) or person-oriented (e.g., social diversion, such as seeking out others), and are generally directed at distancing oneself from the stressful situation.

Assessing the effectiveness of various coping styles has traditionally been accomplished through examining stress reduction (Greenlass, 2002). Today, there are many ways to assess coping style effectiveness beyond psychological adaption, including perceived efficacy for managing problems well, and improved physical and mental health. Among non-clinical samples, those who adopt a problem-focused style have generally been found to adapt to stressful situations more successfully, experiencing greater psychological functioning (Higgins and Endler, 1995), perceived effectiveness (Ptacek, Smith, and Zanas, 1992), and improved health outcomes.
(Endler and Parker, 1994). In contrast, emotion-oriented and avoidance styles have typically been positively associated with maladaptive outcomes, such as psychological dysfunction (Higgins and Endler, 1995) and poorer health outcomes (Penley, Tomaka, and Wiebe, 2002). The “goodness of fit” hypothesis (Folkman, 1991, 1992) qualifies these broad findings by proposing that coping is more effective when there is a “match” between perceived control and coping responses. Specifically, problem-focused coping strategies are more effective in situations where a high level of control is perceived. Conversely, emotion-focused coping is more effective in situations that are perceived as unalterable.

COPING AND SERIOUS MENTAL ILLNESS

While some research has found that those with severe mental illness use the same range of coping strategies as the general population (Burton, Chaneb, and Meeks, 2007); other evidence suggests that those with major mental illness are impaired in their ability to acquire and employ useful coping strategies. Those with major mental illness tend to demonstrate diminished problem-solving abilities compared to healthy controls, opting to rely more heavily on emotion-oriented and avoidance coping (Horan, Ventura, Nuechterlein, Subotnik, Hwang, and Mintz, 2005; Horan et al., 2007; Phillips, Francey, Edwards, and McMurray, 2009). Exacerbation of psychiatric symptoms is related to using less task coping (Meyer, Phillips, Francey, Edwards, and McMurray, 2009). Exacerbation of psychiatric symptoms is related to using less task coping (Meyer, 2001), and more emotion-oriented coping responses (Strous, Ratner, Gibel, Ponizovsky, and Ritsner, 2005). Alternatively, the experience of less severe symptoms is related to using more problem-solving strategies (Boschi, Adams, Bromet, Lavelle, Everett, and Galambos, 2000). To date, coping style effectiveness as measured by perceived coping efficacy and stress has not been empirically tested among psychiatric samples.

PURPOSE OF THE STUDY

Insight into significant sources of perceived stress commonly reported by those living with mental illness is needed given the paucity of research concerning subjective stress among this population. Further, little is known about preferred coping responses reported by those with mental illness in comparison to those observed for the general population. Moreover, while the effectiveness of particular coping styles has been tested among non-clinical populations, these patterns have not been established among clinical psychiatric populations. To this end, a study was conducted to investigate the nature of perceived stress and coping styles among patients discharged from a psychiatric unit over a 6-month follow-up period. The aims of this study were to: (i) qualitatively characterize significant types of perceived sources of stress encountered by patients being discharged from psychiatric hospitalization; (ii) compare preferred coping styles of individuals living with mental illness to those reported by the general population, and (iii) test the effectiveness of these coping styles by examining their relation to concurrent levels of perceived coping efficacy and perceived stress.

While the first research question was exploratory in nature, the two remaining research questions were guided by a set of hypotheses. First, it was expected that participants would report less problem-focused coping, and more emotion-focused and avoidance coping compared to normative means reported for the general population. Second, it was hypothesized that the pattern of effectiveness of coping styles established among non-clinical samples would be similar among psychiatric samples. That is, problem-focused coping would be related to higher perceived coping efficacy and lower perceived stress. In contrast, emotion-focused and avoidance coping styles would be related to diminished perceived coping efficacy and elevated levels of perceived stress.

METHOD

Participants

A sample of 124 civil psychiatric adult patients admitted to a psychiatric unit of an urban hospital in British Columbia, Canada was used. At baseline, the sample was evenly split on gender (52.4% male), relatively young (\(M_{\text{age}} = 34.36, SD = 10.43\)), mostly Caucasian, single, and high school educated (\(M_{\text{education}} = 12.36 \text{ years}, SD = 2.18\)). The most common type of admission diagnosis among participants was a mood disorder. The average length of stay in hospital was 24.23 days (\(SD = 18.65\)). The mean number of previous hospitalizations for psychiatric health issues was 3.5 (SD = 9.28). The average length of illness based on age of first psychiatric hospitalization was 7.29 years (SD = 8.64). See Table 1 for supplementary sample demographics.

Procedure

This study represents a subcomponent of a larger study investigating risk factors for adverse safety outcomes (e.g., self-harm, violence) among civil psychiatric patients discharged to the community. The study was approved by university and regional health authority ethical review boards. To be eligible to participate, patients had to be at least 18 years of age; meet DSM IV-TR criteria for a major mental illness, speak English fluently; preparing for imminent hospital discharge; and willing and capable of providing informed consent to the study. Patients who met these criteria were identified

Table 1

<table>
<thead>
<tr>
<th>Characteristic</th>
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<tbody>
<tr>
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<tr>
<td>Involuntary</td>
<td>93</td>
<td>75.0</td>
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* Missing data for education = 11 cases. Full data (N = 124) was available for all other reported demographic variables.
† Multiple primary diagnoses were coded from the hospital file.
by hospital staff, who also queried patients about their willingness to be approached by the research team to take part in a study. Hospital staff informed the research team of potential participants who assented to being contacted. Research staff met individually with potential participants on the unit to review a description of the study, participant rights, and the consent form. Participants were asked to complete a brief multiple-choice questionnaire to assess sufficient comprehension of participation. Oral assent was also sought from the attending psychiatrist validating that the participant was capable of providing consent and would not experience undue distress from study participation. About 55% of those approached consented to participate.

Participants were interviewed at baseline just prior to release from hospital, as well as approximately every 4 weeks for 6 months in the community. In hospital, participants completed an interview and a series of self-report measures in a private setting with a research assistant to assess demographic information and mental health history, as well as repeated-measures variables such as psychiatric symptoms, perceived stress and coping, and safety outcomes. A hospital file review was conducted to verify information. Five follow-up interviews were conducted with the participant in the community to re-evaluate dynamic factors and outcome variables. Participants were thanked and given monetary compensation for their participation after each interview. To protect confidentiality, participants were assigned a unique study identification number so that identities were not tied to responses. All completed study materials were kept in secure storage. Digitized data used for computer analyses were password protected.

**Measures**

**Sources of Stress and Perceived Coping Efficacy**

The Perceived Coping Competence and Efficacy Assessment (PCCEA, Lavoie, 2010) was used to identify sources of perceived stress and coping efficacy. In part A of the assessment, respondents were asked to describe in their own words the most stressful event or situation that they encountered over the past 4 weeks. In part B, respondents answered eight questions about their perceived coping efficacy in responding to the described situation (e.g., I handled the situation well given the circumstances) by rating their agreement on a five-point Likert scale (1 = very much disagree, 5 = very much agree). A description of the development of this scale, and factor analysis for the PCCEA-B derived from a preliminary sample of discharged psychiatric patients supporting a single dimension of measurement can be found in Lavoie. Higher scores indicated greater perceived coping abilities. PCCEA-B scores were aggregated to generate a total score. The mean PCCEA-B score measured at baseline was 24.96 (SD = 7.68). Perceived coping efficacy did not differ between males and females \(t(89.26) = 0.981, P = ns\). The PCCEA-B had good internal reliability (\(\alpha = .863\)).

**Coping Style**

The 21-item Coping Inventory for Stressful Situations-Situation Specific Scale (CISS-SSC; Ender & Parker, 1999) was administered to assess the ways individuals react and cope with a specific situation. The instrument is composed of three seven-item subscales assessing three types of coping: task-oriented coping (e.g., analyze my problem before reacting); emotion-oriented coping (e.g., become very upset); and avoidance coping (e.g., visit a friend). Participants were asked to complete the CISS-SSC based on their reaction to the most stressful encountered over the past 4 weeks identified in PCCEA-Part A. Responses were scored on a five-point Likert scale (1 = not at all, 5 = very much). Higher scores on each of the subscales indicated greater use of the particular coping style. The CISS was constructed on both clinical and non-clinical samples and has demonstrated high reliability and validity (McWilliams, Cox, and Enns, 2003). At baseline, the mean score for the Task Scale was 22.21 (SD = 5.77), for the Emotion Scale was 22.43 (SD = 7.62), and was 17.96 (SD = 6.48) for the Avoidance Scale. There were no gender differences in engaging in task coping and avoidance coping; however, females demonstrated significantly greater reliance on emotion-oriented coping styles relative to males \(t(92) = 2.06, P < .05\). All CISS-SSC scales demonstrated adequate reliability (\(\alpha = .746–.868\)).

**Perceived Stress**

The PSS-10 (Cohen and Williamson, 1988) is a 10-item self-report instrument that measures the degree to which situations in one’s life are appraised as unpredictable, uncontrollable, and overwhelming. Participants indicated on a five-point Likert scale (0 = never, 4 = very often) how often they felt or thought a certain way during the past month (e.g., “How often have you felt you were on top of things?”). Higher scores indicated greater levels of perceived stress. The mean PSS-10 score measured at baseline was 22.38 (SD = 7.28). There were no gender differences in perceived stress \(t(107) = 1.64, P = ns\). The PSS-10 demonstrated high internal reliability (\(\alpha = .831\)).

**Data Analysis**

Qualitative thematic coding was conducted on respondent’s short narratives to identify appraised sources of significant stress. Respondents described the most stressful situation encountered over the past 4 weeks. Narratives from all baseline and follow-up interviews were examined for common themes across time. A total of 726 themes were coded from responses available for 113 participants. These descriptions were first independently categorized by the author to identify bucket codes that reflected dominant and recurrent themes in the data. The code list was given to a graduate-level secondary coder to re-categorize the themes. Consensus coding between both coders was then carried out on all qualitative data to enhance validity of the results. Subthemes within dominant themes were also identified.

Quantitative analyses were performed using SPSS Version 20.0 for Windows. A series of one-sample \(t\)-tests was conducted to compare coping style reliability in the present sample with normative general population means. To test coping style effectiveness, a series of multiple regression models was estimated to determine whether each of the three coping styles were predictive of concurrent levels of perceived coping efficacy and perceived stress. For the regression analyses, the three coping style variables were centered on their respective means in order to reduce multicollinearity. All three coping style variables were entered simultaneously into the regression models. Data screening revealed no outliers or influential cases. Tolerance and variance inflation factor values were acceptable indicating the absence of multicollinearity.

**RESULTS**

**Sources of Stress**

The first research question involved qualitative characterization of the most significant sources of stress encountered by psychiatric patients transitioning from the hospital to the community. Key themes are discussed in paraphrased form to protect the confidentiality of individual participants’ identities. The three most common themes across time were (i) family relationships, (ii) mental health symptoms, and (iii) employment issues. Themes representative of family relationships, emergent in 55.8% of cases, fell into three subthemes. Many participants, predominantly mothers, spoke about stress resulting from issues relating to care, custody and separation from children. Some related that stress stemmed from universal issues such as needing to secure daycare arrangements for children to facilitate working, as well as issues around management and discipline of children's behavior. Other participants discussed more formidable challenges such as dealing with the loss (or threatened
loss) of custody of their children or the stress of separation from children during hospitalization. A second subtheme connected to family relationships was stress related to conflict with family members, particularly with parents or siblings. Resentment of intrusive social control efforts by family members, often in terms of treatment compliance, or not meeting expected family obligations, was frequently reported. A third subtheme was stress related specifically to intimate partners. Many participants indicated that major stress was caused by conflict arising with current romantic partners. Respondents frequently indicated feelings of powerlessness during disagreements. Other participants' stress arose from dwelling on past relationships, often being accompanied by feelings of loss and isolation, or dealing with practical issues associated with terminated relationships such as sorting out custody and financial issues.

Themescentering around a second key category mental health symptoms, were present in 39.8% of cases. Four subthemes came to light. First, many participants identified the experience of negative affect as being the stressful component of dealing with symptoms, often because experiencing symptoms lead to anxiety, depression, feelings of isolation and lowered self-esteem. Indeed, many participants spoke of a sense of hopelessness tied to experiencing exacerbation of psychiatric symptoms. A second subtheme was the experience of fear, confusion, and feeling threatened as a result of encountering symptoms. Where some participants reported feeling frightened due to disturbing content of hallucinations or delusions, others expressed trepidation resulting from interaction with police services or impending hospitalization. Fear and uncertainty were also displayed in participants perceiving that hospital admission posed risks to holding onto their family, marriage, and job. A third subtheme was that symptoms were commonly perceived as stressful because they generated feelings of being “out of control” leaving the participant overwhelmed, or because symptoms, such as hearing voices, could not be controlled. A final subtheme of stress emanating from the experience of symptoms was that of disrupted functioning. Participants cited daily impairment of functioning as being considerably burdensome and hindering of their ability to live independently.

A final dominant theme that became apparent in 31.9% of cases was stress resulting from employment issues. Three subthemes related to work stress emerged. A common issue was apprehension to communicating with a supervisor about leaving or returning to work. Many participants were fearful of a lack understanding on the part of their manager or experiencing negative reactions or prejudice. Others were worried about losing their jobs in the context of high job satisfaction, or more commonly, dire financial need. General workload stress was a second evident subtheme. Numerous participants identified an overwhelming workload and a sense of being unable to catch up on work tasks as their most significant stressor. Relatedly, sleep and energy issues were commonly identified as significant stressors affecting job performance. A final subtheme that captured employment-based stress was attendant disrupted functioning and difficulty concentrating due to managing symptoms on the job. For example, many participants explained that significant stress came from the distraction of dealing with auditory voice hallucinations in the workplace.

Preferred Coping Style

The next set of analyses examined the types of coping styles preferred by participants as they prepared to transition into the community after psychiatric hospitalization. Mean use of each coping style was compared between the present sample and those previously reported for the general population to determine group-based coping style preferences during transition to the community, as well as the degree to which these coping styles were effective. The types of stressors most participants experienced during their hospitalization (and transition to the community) have important implications with respect to nursing education and patient planning. Three prevalent sources of stress identified across time were family relationships, mental health symptoms, and employment issues.

Family Relationships

Thematic coding suggested that the majority of participants disclosed family concerns as a prevailing stressor throughout their transition to the community. Most people who live with mental illness regularly interact with family members (Stuart, 2009). “Families are often the principle resource and the sole support available to individuals with mental illness...Because of the limited resources available to the hospital sector and the community, it is (families) who house, care, supervise and provide financial assistance...” (Kirby and Keon, 2004, p. 26). Despite this, families are often overlooked in terms of support or education about psychiatric illness (Family Mental

Coping Style and Its Relation to Perceived Coping Efficacy

The next set of analyses examined whether the types of coping styles used by participants were predictive of perceived coping efficacy. A multiple regression model was estimated to test the hypothesis that higher levels of task coping would be associated with perceived coping efficacy, and that higher levels of emotion and avoidance coping would be inversely related to perceived coping efficacy. Regression results indicated the overall model significantly predicted perceived coping efficacy \( R^2 = .395, \quad R^2_{adj} = .378, \quad F(3, 105) = 22.881, \quad P = .<.001, \quad \text{Cohen's} \quad f^2 = .653 \). A summary of the regression coefficients is presented in Table 2, and indicates that as hypothesized, higher perceived coping efficacy was predicted by greater reliance on task-focused coping and less use of emotion-focused coping. Avoidance coping was unrelated to perceived coping efficacy.

Coping Style and Its Relation to Perceived Stress

The last analysis explored the association between coping styles and concurrent levels of perceived stress. A multiple regression model was estimated to test the hypothesis that higher levels of task coping would be inversely associated with perceived stress, and that higher levels of emotion and avoidance coping would be positively related to perceived stress. Regression results indicated that the overall model significantly predicted concurrent perceived stress \( R^2 = .269, \quad R^2_{adj} = .248, \quad F(3, 102) = 12.54, \quad P = .<.001, \quad \text{Cohen's} \quad f^2 = .368 \). A summary of the regression coefficients is presented in Table 3, and indicates that as hypothesized, decreased concurrent perceived stress was predicted by higher task coping and lower emotion coping. Avoidance coping was not related to concurrent perceived stress.

DISCUSSION

This study investigated the key sources of perceived stress identified by individuals discharged from psychiatric hospitalization, coping styles preferences during transition to the community, as well as the degree to which these coping styles were effective. The types of stressors most participants experienced during their hospitalization (and transition to the community) have important implications with respect to nursing education and patient planning. Three prevalent sources of stress identified across time were family relationships, mental health symptoms, and employment issues.

Family Relationships

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Table 2

Coping Style Predicting Concurrent Perceived Coping Efficacy

<table>
<thead>
<tr>
<th>Coping style</th>
<th>B</th>
<th>SE</th>
<th>95% CI</th>
</tr>
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<tr>
<td>Constant</td>
<td>24.963</td>
<td>.580</td>
<td>[23.812, 26.114]</td>
</tr>
<tr>
<td>Task</td>
<td>0.677 ***</td>
<td>.105</td>
<td>[0.468, 0.886]</td>
</tr>
<tr>
<td>Emotion</td>
<td>-0.318 ***</td>
<td>.077</td>
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<tr>
<td>Avoidance</td>
<td>0.026</td>
<td>.093</td>
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</tr>
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</table>

Note. N = 108. SE = standard error for B. CI = confidence interval for B. *** P < .001.
Employment Issues
addressing perceived stress related to illness management. Directing
Subthemes identified commonplace stressful events unconnected to their mental health.
of illness on individual, social, and professional functioning; as well as
traverse challenges related to dealing with symptoms; consequences
management in this population, remarking that individuals must
be adapted among this population.

Preferred Coping Styles
Consistent with previous research in psychiatric samples (e.g.,
Horan et al., 2005; Horan et al., 2007; Phillips et al., 2009), the sample
used less problem-focused coping, and more emotion-oriented coping
compared to the general population. There were no between group
differences in the use of avoidance coping styles. Reduced use of
problem-oriented strategies among this population may be due to the
lack of available coping resources relative to others, such as decreased
social support (Hultman, Wieselgren, and Ohman, 1997). Another
explanation for the lower use of problem-solving coping styles is that
those with mental illness tend to perceive stressful life events as less
controllable relative to persons without mental illness (Pruessner,
Iyer, Faridi, Joobér, and Malla, 2011). Further research examining
perceived controllability in relation to coping style selection among
psychiatric populations is recommended.

Endler & Parker’s (1990) multidimensional interaction model
suggested that person variables affect stress and coping. Recent research
on the role of trait emotion-reactivity might be useful in explaining the
sample’s preference for emotion-focused coping. Many living with
schizophrenia are typified by heightened trait negative affectivity that
may amplify the intrapsychic effects of stressors. Those living with
psychotic disorders also display more intense emotions during personal
appraisals of stress compared to those without such a disorder (Pruessner et al., 2011). Thus, if those with major mental illness
experience magnified stress emotions, it follows that this group might
engage in elevated emotion-oriented coping to mitigate these feelings.

Coping Style Effectiveness
The present study examined the effectiveness of particular coping
styles. As hypothesized, problem-focused coping styles were associated
with heightened perceived coping efficacy and lowered concurrent
perceived stress levels. Both of the standardized effect sizes found
exceeded the conventional cutoff of Cohen’s $r^2 = 0.35$ for a large effect
size (Cohen, 1988) indicating that the ratio of the explained variance of
the outcome variables over the unexplained variance was high. Emotion-focused coping was predictive of diminished perceived coping
efficacy and heightened levels of concurrent perceived stress. Thus,
there is some consistency between coping styles that have been found
to be broadly effective among non-clinical populations as reported in
previous research with those styles that appear to be beneficial in
the present clinical sample. Those who rely on problem-focused strategies are often considered to adapt more successfully, likely owing to a
general orientation towards active problem resolution (Austenfeld and
Stanton, 2004; Moos, 2002). In contrast, emotion-focused coping is believed to be less adaptive due to the obstruction of negative emotion
management on rational decision-making (Austenfeld & Stanton).
Given these results, therapeutic interventions aimed at developing
enhanced problem-oriented coping skills to effectively manage change-
able stressors may be useful.

Contrary to hypotheses, use of avoidance coping styles during
transition to the community did not influence the effectiveness
outcomes in the present sample. Avoidance styles have been found
among non-clinical populations to be effective in mitigating stress in
the short term, particularly in situations in which the individual has
little control (Moos, 2002). However, avoidance styles have ultimately
been found to be detrimental in the long term. This null effect may be
due to the relation between coping and outcomes being examined at
the concurrent level, where there may not have been enough time for
the negative effects of avoidance to “catch up” with the participant.
Potential maladaptive effects of avoidance may be detectable after a
longer time period.

Implications
Generally, most adults living with mental illness have difficulty
adjusting to the community after psychiatric hospitalization. Present
findings assist in guiding where specific efforts might be placed by
identifying the key sources of stress that appear to be challenging to
patients transitioning to the community. Study results underscored a
relative tendency to use emotion-based coping strategies in this
sample (especially among females). Implications point to the
potential benefit of emphasizing problem-focused coping skills.
Psychosocial interventions to enhance coping ability and social
support can reduce symptom severity and improve overall level of
functioning (Pilling et al., 2002). Timing of access to coping skills
intervention is an important consideration in that patients are likely
to be unreceptive during challenging phases such as transition, but are
likely to be amenable to such intervention after stabilization.

Limitations
This study investigated perceived stress and coping styles
identified by predominantly involuntarily admitted patients dis-
charged from a psychiatric hospital setting with a mean hospital day
of 24 days. It is possible that patients discharged after a lengthier
hospitalization, or under voluntary circumstances, might identify

### Table 3
Coping Style Predicting Concurrent Perceived Stress

<table>
<thead>
<tr>
<th>Coping style</th>
<th>B</th>
<th>SE</th>
<th>95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Constant</td>
<td>22.558</td>
<td>6.16</td>
<td>[21.337, 23.779]</td>
</tr>
<tr>
<td>Task</td>
<td>0.300</td>
<td>.111</td>
<td>[−0.520, −0.081]</td>
</tr>
<tr>
<td>Emotion</td>
<td>0.393</td>
<td>.081</td>
<td>[0.231, 0.555]</td>
</tr>
<tr>
<td>Avoidance</td>
<td>−0.128</td>
<td>.098</td>
<td>[−0.324, 0.067]</td>
</tr>
</tbody>
</table>

**NOTE.** N = 108. SE = standard error for $B$. CI = confidence interval for $B$.

**P < .01.**

**P < .001.**
different stressors, perceive stress differently, or cope in different ways. The generalizability of the findings are limited to this original context. Moreover, the extent to which appraisals of coping efficacy correlate with true problem management was not assessed in this study, thus, it is difficult to determine with certainty whether perceptions translated into actual problem resolution. Due to the cross-sectional nature of the regression analysis, a causal link between the examined variables should not be asserted. Based on Endler & Parker’s (1990) multidirectional interaction model, there is a bidirectional relationship between coping and concurrent distress. While it is likely that coping style influenced concurrent perceived stress levels, these concurrent stress levels may have dictated, in part, the type of coping responses selected. Finally, while both regression models demonstrated large standardized effect sizes, other unmeasured variables may have accounted for variation in perceived coping efficacy and perceived stress, respectively.

Conclusions

Given that individuals interpret and are impacted by life events differently, considering subjective appraisal of potentially stressful situations is important to assisting patients with recovery. An enhanced understanding of patients’ own perceived sources of stress, particularly during difficult events such as community reintegration, has numerous applications in assisting with planning, support, and intervention efforts for patients. This research contributes to the literature by extending theories of coping to a particular situation in the mental health context, namely, preparing for transition to the community after hospitalization. It was found that coping style preferences among those being discharged from hospitalization are consistent with previous research. The effectiveness of particular coping styles appears to generally overlap between clinical and non-clinical samples. The present study provides evidence that reliance on emotion-focused coping among those living with mental illness is less gainful, and that problem-focused coping strategies may be more effective in navigating challenging events experienced during transition from psychiatric hospitalization.

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References