

**The measurement and meaning of coping in
psychiatric patients**

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I declare that this thesis is my own account of my research and contains as its main content work which has not previously been submitted for a degree at any tertiary education institution.

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ABSTRACT

In psychology and psychiatry there is a fundamental presumption that a categorical difference between “normal” and mentally ill people exists.

The primary research goal of this thesis was to explore the measurement and meaning of coping in a psychiatric population. The major research questions were: 1) Does the underlying assumption about “not coping” in those diagnosed with a mental illness do justice to the complexity of what coping might be for these people? and 2) Does it make sense to measure coping in a psychiatric population? Quantitative and qualitative approaches were employed to answer these questions.

Study A examined the psychometric adequacy of an existing coping scale, the Coping Scale for Adults Questionnaire (CSA; Frydenberg & Lewis, 1997) and its ability to discriminate between the coping strategies of a “normal” (n=369) and a psychiatric sample (n=110). Comparisons were made between the two groups across the 19 coping strategies, in terms of factor structure, gender and age. An additional comparison of coping strategies was made between a sub-sample of those diagnosed with schizophrenia and the “normative” sample.

Study B was a separate study between an age-and gender-matched sub-sample from a separate community sample in Western Australia matched to members of the psychiatric population.

Study C extended the examination of the CSA, with the inclusion of a sample of undergraduate university students (n=110). The CSA was found to have adequate psychometric properties and the ability to discriminate between the coping strategies of the psychiatric, community and university samples. However, it was identified that built into quantitative measurement of coping is a set of problematic assumptions about the coping strategies of those diagnosed with a mental illness that raised concerns about both the validity and sole reliance on quantitative measures in this area, prompting further qualitative studies.

The first part of the qualitative analyses comprised 25 male and 13 female inpatients of a psychiatric hospital who were interviewed about how they coped. The thematic analyses of psychiatric patients' descriptions of their coping revealed five key themes: patients reported that professional intervention reduced their ability to cope; they distrusted the mental health system and its professionals; coping mechanisms were misinterpreted; situational crises modulated coping; and, that sometimes coping was just "not coping."

The second qualitative part of the thesis comprised case studies from interviews, medical file information and patient demographics of 10 psychiatric inpatients. Psychiatric patients' narratives contained in the case files revealed commonalities in coping strategies and much more detailed descriptions of how they coped. Employing both the methodology of quantitative and qualitative approaches to coping offers an opportunity to construct a powerful and plausible argument about how people diagnosed with a mental illness cope. Overall, the findings from the studies revealed that the bedrock assumptions underpinning the current mental health system to understanding the meaning of coping in those

diagnosed with a mental illness did not reflect or do justice to their actual accounts of coping. A more respectful, nuanced understanding of the notion of coping by mental health professionals is suggested.

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CHAPTER 1

Overview

In psychology and psychiatry there is a fundamental presumption that a categorical difference between “normal” and mentally ill people exists (Boyle, 2002; Bracken & Thomas, 2005; Breggin, 1991; Double, 2006; Kinderman, Read, Moncrieff, & Bentall, 2013; Moncrieff, 2010; Klerman, 1978; Porter, 1987). For many years psychology and psychiatry have been labouring under serious misunderstandings about the meanings of “madness.” As will become apparent throughout this thesis, new frameworks are needed for patients to be understood less in terms of individual pathology and more in terms of their response to relative deprivation and social injustice, which erode the emotional, spiritual and intellectual resources essential to psychological wellbeing.

Indeed, traditional psychiatry is predicated on the idea that a defining feature of people diagnosed with a mental illness is that they have coping skills deficits, i.e., their coping strategies differ from the rest of the “normal” population, but this perspective has been directly researched by only a few. Taylor and Stanton (2007), in their review of coping, suggest that there is a “lack” of coping in those people diagnosed with mental illness, such as schizophrenia, anxiety disorders, and depression, which makes it difficult for them to manage challenges in daily living. Other researchers (e.g., Buchanan, 2007; Kraepelin, 1899; Tyler, 1995) categorize the coping efforts of patients as “symptoms” of a disorder, for example, avoidance in the diagnosis of schizophrenia, and, by doing so, diminish the meaning of the coping strategy for the person. Labelling patient symptoms as part of a diagnosis is connected to, and justified through, the theoretical

frameworks underlying the term “mental illness.” Summerfield (2012) highlights that diagnoses play a role in decontextualizing peoples’ lives. Labels, such as “depression,” switch the focus inward, whereas understanding the life story of a person provides a context in which the behaviour/s may be understood and provide meaning to those people. Throughout this thesis the terms “those diagnosed with a mental illness” and “those diagnosed with schizophrenia” and other diagnoses for that matter, will be used. However, it is acknowledged from the outset that both mental illness and schizophrenia are contested entities.

Furthermore, coping is not directly defined in psychiatry, rather, coping is understood to be what the person is *not* doing, which effectively is the psychopathology. Therefore, the primary aim of this thesis is to firstly investigate the meaning of how people diagnosed with a mental illness manage everyday problems. An additional aim is to investigate if it makes sense to measure their coping in ways currently defined. In so doing, this thesis explores both the measurement and meaning of coping in those diagnosed with a mental illness.

Given the pervasive influence of classification systems, such as the ICD-10 and the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV and DSM-V) (American Psychiatric Association, 1994; 2013), that are used throughout mental health departments to classify and define “mental disorders,” issues regarding diagnostic classification can not be overlooked. However, as Kinderman et al. (2013) contend, the psychiatric and psychological professions may be on the cusp of a major paradigm shift in the way psychiatric disorders are perceived. Specifically, the current DSM-V has received a wide range of criticism that has also highlighted scientific, philosophical, practical and humanitarian

weaknesses in the diagnostic approach to psychological well-being. This paradigm shift is long overdue, and researchers are only now beginning to move away from heavy reliance on diagnostic approaches, as diagnoses exclude and do not acknowledge the individual attempts that people make, as a result of their experiences, to manage their psychological wellbeing. The diagnostic approach to understanding meaning-making in patients' lives also prevents patients from understanding how they might use their own resources or coping mechanisms to address their difficulties.

In the chapters to follow, information with clinical relevance will be added where appropriate, as much of the inclination for this research came as a result of my work in high care psychiatric inpatient and outpatient facilities throughout Western Australia. To further explicate the reasoning behind this thesis and my role as researcher within it, I shall now describe my background. I am a Clinical Psychologist-(reg) with over 19 years experience, providing direct psychological intervention to children, adults and older adults in Western Australia. I have been employed in both the public and private sectors and currently run my own private practice.

Given my extensive work experience with minority populations, particularly in psychiatric settings, my research interest in the coping of those diagnosed with a mental illness came from exposure to the circumstances and the systemic issues with which patients were faced. Firstly, I recognised patients had survived circumstances few people would have coped with and that those patients' coping attempts were not fully acknowledged or understood by the current systems in place within mental health in Western Australia. Secondly, I

noted that within psychiatric hospitals in Western Australia there was no integration of patients back into the community. Patients went from being inpatients, to receiving relatively quick treatment (usually through heavy sedations and various medications), with little or no psychological input, and then were discharged back out into the community. Being discharged, usually back into abhorrent living circumstances, meant a high readmission rate for these patients, sometimes within the space of weeks.

Hence, I witnessed the “revolving door” first hand and the consequences of this, specifically, more medication, more unhelpful time away from the supports they did have, irregular living situations, and, for the most part, their problems remained unresolved. My eagerness was to understand in more detail how these people coped and what was going to aid them in this task. However, after quantitative and qualitative investigations I learnt a great deal more about what coping meant for these people in the psychiatric system, and, as with most PhD research, the thesis evolved into what I have submitted. I became aware that the models used by the professions of psychiatry and psychology, particularly within mental health settings, had profoundly disempowered, at best, and systemically, actively harmed, at worst, the most vulnerable.

When I commenced this research project, I was interested in how to measure coping and what coping meant for patients within a psychiatric context. My study was primarily exploratory and, while understanding some of the limits of regular coping questionnaires and checklists, an existing scale, the Coping Scale For Adults (CSA), presented an opportunity to measure the concept of coping within this population. This coping scale also had the advantage of clinical

utility, as suggested by its developers in Australia, Frydenberg and Lewis, (1997). While the scale appeared to be a psychometrically sound measure, as I discuss in this thesis, it had not been used with psychiatric samples. However, the CSA was chosen over other coping inventories on the basis of its sound psychometric properties, clear item structure and previous use in the Australian context. As will be described further in Chapters 2 and 4, a review of the CSA indicated that it provided a better alternative than other coping inventories, such as the WAYS of coping questionnaire (1988) for assessing the measurement of coping in a psychiatric sample (Frydenberg & Lewis 1997).

In order to investigate my research question authentically, a qualitative approach also needed to be adopted, whereby the patients were asked directly about their experiences of coping. Such an approach honoured the meaning of coping for these people. As a result, quantitative and qualitative approaches were used to investigate the meaning and measurement of coping in psychiatric patients, and to determine if firm evidence existed for the suggestion that those diagnosed with a mental illness have “coping skills deficits.” The studies revealed a set of findings which highlighted the different meaning of coping for these people, along with several systemic concerns relevant to the study of coping in psychiatric populations.

As a result of the methodological shift in the work reported, the thesis is presented in two parts. Each part orients to particular theoretical and methodological concerns. Part One of the thesis is concerned with the measurement of coping in those diagnosed with a mental illness by means of a

standardised questionnaire (CSA). It offers the first report of the evaluation and use in practice of the CSA in a psychiatric population.

Part Two, however, adopts a different stance. The process of conducting the work reported in the first part of the thesis raised difficult questions about the validity and authenticity of the enterprise of asking people diagnosed with a mental illness standardised questions about their “coping,” as an evaluation of how they manage difficult situations in their lives.

Looking at the two parts of the thesis in more detail, in Part One, the first two chapters set the context for the work conducted. Chapter 2 of the thesis reviews the history of mental illness and, particularly, research in the area of coping in relation to those diagnosed with a mental health disorder. In doing so, the general coping literature is reviewed, in full recognition that a more specific literature review of coping in those diagnosed with a mental illness would contain few research studies, which combine the whole spectrum of those diagnosed with a mental illness. Studies have mostly focused on the coping repertoires of individual diagnoses, e.g., those diagnosed with: schizophrenia, depression and anxiety. While there are indeed many excellent books written about the issues within mental health (e.g., Breggin; 1991; Newnes, Holmes, & Dunn, 1999) and later books documenting the life stories of patients and their experience of living with a mental health diagnosis (Hallam & Bender, 2011), as for documented research studies of patients’ accounts of coping within mental health systems, there are few.

Research into coping over the last 20 years has utilised mainly quantitative measurements, such as questionnaires and checklists and is discussed in detail in Chapter 3 in the Measurement of Coping.

The CSA scale used in this thesis to distinguish between “productive” and “non-productive” coping among three groups (a psychiatric sample, a university sample and a normative sample) is discussed in detail in Chapter 4.

Chapter 4 presents an overview of the CSA and the quantitative studies with the CSA. The findings of these quantitative investigations echoed sentiments of previous conclusions drawn from other researchers, in particular Oakland and Ostell (1996), who highlighted the contradictory and ineffective findings in the coping literature, which suggest that a particular coping strategy cannot be valued and labelled as effective or ineffective without reference to the context in which it is used. As can be seen in Chapter 4, the CSA as a measurement tool revealed that it is a very sound statistical instrument, for the purposes of measuring “productive” and “non-productive” coping. However, further research was required to reduce the gap between the theoretical importance and clinical usefulness of the coping concept in those diagnosed with a mental illness.

In Part Two of the thesis Chapter 5 is a qualitative study (published at the time of submission), which generated information from patients’ interviews about their coping. By means of thematic analyses, five themes emerged which provided a detailed account of how those diagnosed with a mental illness cope and of the meaning of coping for these people. Patients reported that professional intervention reduced their ability to cope; they distrusted the mental health system and its professionals; coping mechanisms were misinterpreted; situational crises

modulated coping; and, that sometimes coping was just “not coping.” The findings from this qualitative study revealed that if you talk to patients about the nature of their experience and the ways in which they deal with it, what you find is that the bedrock assumptions in which the mental health system operates do not do justice to these peoples’ experience.

Chapter 6, entitled “Meet the People,” provides a detailed description of patients’ narratives through the interviews, case notes and demographic information collected on each patient. The case studies revealed commonalities in coping (such as childhood trauma, poverty and learned helplessness, systemic issues) and more detailed descriptions on what coping means to psychiatric patients.

The final chapter, Chapter 7, of the thesis offers a summary of and conclusions drawn from the work conducted in the area of coping in those diagnosed with a mental illness, along with implications for future research and clinical practice.

Some chapters of this thesis have been submitted for publication during the process of writing-up, with one now published. In the journal article which is Chapter 5 of this study the reference to “we” is for the purposes of the journal article and not to the work carried out. For all such papers, I am first author, in recognition of my roles as primary researcher, analyst and author.

PART 1

CHAPTER 2

Introduction

“No excellent soul is exempt from a mixture of madness . . . ” ~ Aristotle

Preamble

The literature review will focus on coping in psychiatric patients and the reasons why the coping of this particular group has been singled out for special consideration in this current thesis. The basic layout of this chapter is as follows: Prior to discussing the literature on coping in psychiatric patients it is important to describe how the various terms relating to coping i.e., coping strategies, and coping styles, will be used throughout this thesis. There will be discussion of the coping construct differentiating between: a) coping as an action or way of thinking, without its functional consequences, and b) coping as a type of behaviour that implies success or failure (i.e., coping and not coping). The conceptual issues in the measurement of coping will then be discussed, followed by the general literature review directed at coping in psychiatric patients and how this differs from coping in the wider community. Finally, in order to comprehend how coping is understood within the mental health system, literature from the medically driven field of psychiatry that has its roots in the disease model of illness and pathology, is explored with specific attention given to the diagnostic framework around schizophrenia.

How the Concept of Coping will be Used Throughout This Thesis

The overall literature itself does not clearly define the various coping terms in every study and quite often coping is used interchangeably with coping

styles, coping resources and coping strategies. The definition of coping used in this thesis is one of the more commonly used psychological definitions of coping, namely, it views coping as a multidimensional concept as described by Lazarus and Folkman (1984). They defined coping as a construct, which constantly changes, comprising both cognitive and behavioural efforts to manage specific external and internal demands. These efforts are either appraised as taxing or exceeding the resources of the person. According to Lazarus and Folkman, in order to fully understand the coping process, one needs to understand three main features, namely: 1) what a person thinks and does, 2) what the person thinks or does as examined in a specific context, to get an understanding of what the person is coping with, and 3) the change in coping thoughts and acts as the stressful encounter unfolds. As the status of the person-environment changes, so does the coping process, and thus various coping strategies are used throughout the different stages of this process. Lazarus and Folkman (1984) suggest, “the way people cope heavily relies on the resources that are available to them and the constraints that inhibit use of these resources in the context of the specific encounter” (p. 158). A person is resourceful if they have many resources such as money, help, people, and relevant skills; to counter the demands placed upon them (Folkman & Lazarus, 1984).

Coping as a description of a type of action or thinking, without regard to its functional consequences is called a *coping strategy*, whereas a group of various coping strategies that are used preferentially over others is termed a *coping style*. A coping style includes a number of coping strategies known to the person using them to be effective or ineffective in a particular situation (Frydenberg & Lewis,

1997). Coping styles are thought to be made up of both personality traits and behaviours expressed as a result of a stressful encounter (Carver et al., 1989). In this way coping can be both active, e.g., dealing directly with the situation, or passive, e.g., avoiding or ignoring the situation (Fledderus, Bohlmeijer, & Pieterse, 2010). There are also the categories of problem-focused (planning, dealing directly with the situation) and emotion-focused (venting emotion, seeking the emotional support of others) coping strategies (Ward, Cichy, & Almeida, 2008). The term *coping repertoire* will be referred to in this thesis from time to time as the store of coping strategies and resources available to the person.

A review of the psychological literature from approximately 1967 indicated that psychological abstracts began to utilise a separate category for “coping” (Snyder, 1999). A recent (October 2013) literature search using ProQuest for journal articles with “coping” in the title revealed that interest in the subject of coping itself spans a vast area, with 29,024 references to coping in peer-reviewed scholarly publications. Indeed, interest in the subject of coping has grown dramatically, with coping receiving attention in educational systems (e.g., Ebata & Moos 1991; Frydenberg & Lewis, 1993; 1994; Lewis, Romi & Roache, 2011; Romi, Lewis & Roache, 2013), psychiatry (e.g., Cohen & Berk, 1985; Crossley, 1995; Koeing, 2009; Pierre, 2012; Rollins, Bond, Lysaker, McGrew, & Salyers, 2010) and psychology (e.g., Aldwin, 1994; Aldwin, & Park, 2004; Aranada, & Lincoln, 2011; Folkman, 2010; Holahan, Moos, Holahan, Cronkite, Randall, 2003; Holahan, Pahl, Cronkite, Holahan, North, & Moos, 2010; Lapidus, Shin, & Hutton, 2001; Lazarus, 1999; Lazarus & Folkman, 1984; Monat, Lazarus & Reevey, 2007; Ogden, 1996; Olsen, Trevino, Geske, & Vanderpool, 2012;

Perrez & Reicherts, 1992). Relatedly, in the area of mental health there has been a resurgence of research interest in the “psychology of the positive,” (e.g., Farhall, & Cotton, 2002; Provencher, & Keyes, 2011; Ritsner, Ben-Avi, Ponizovsky, Timinsky, Bistrov & Modai, 2003; Singh, Sharan, & Kulhara, 2002; Tobin, 2000), in contrast to historic perspectives, which were based on psychopathology.

It is generally accepted that there is no single coping mechanism so outstandingly effective that its possession alone insures a person’s ability to fend off stress or the difficulties one encounters throughout the lifespan. Frydenberg and Lewis (2002a) highlighted that the kinds of responses and resources people bring to bear in coping do make a difference to their emotional wellbeing. Nevertheless, research is yet to uncover an entire coping repertoire that might be effective for the general population, an impossible task given the very individual nature of coping, which will be discussed later in this chapter.

Throughout the psychological literature, coping has been used in many different contexts, such as coping with stress, coping after a traumatic incident, and coping with mental health symptoms. In addition, a myriad of ‘coping strategies’ have been prescribed to “work best” in these situations. For example, individuals with ‘good social support networks’ are believed to ‘cope better’ with stress and, indeed, the overall literature suggests that good social support systems act as a buffer against stress (Cohen, McGowan, Fooskas, & Rose, 1984; Cohen, Towbes, & Flocco, 1988; Cummins, 1988; Hobfoll, 1986; Ford & Procidano, 1990; Granovetter, 1982; Greenglass, 1993; Potasznik, & Nelson, 1984). For example, Greenglass (1993) suggested that social support provides a source of acceptance and intimacy, a source of guidance and provides services and resource

assistance. Of note here is that, historically, only a minority of researchers in the literature have recognized the usefulness of maladaptive strategies in helping to manage stressful encounters (Menninger, 1963; Snyder, 1999).

How people cope varies depending on the different kinds of stress to which they are exposed. For example, the loss of a loved one may be stressful, but may or may not be traumatic for the individual. There are many factors involved in grief, such as whether the death was sudden, the type of illness suffered and duration of the illness. There are also individual differences in personality traits and resources (McCrae, 1984), the cultural context (Greer, 2012), the person's well-being and their physical health (Lazarus, 2000), which will have a bearing on how an individual copes. These substantial differences in individual characteristics that exist in the participants involved in coping research make comparative analyses between studies difficult, as do the different methodologies, the contexts of the studies and the definitions of coping utilised by the researchers.

Researchers to date have recognised the role of coping in moderating the impact of stressful encounters. There is general agreement in the literature that long-term stress leads both to adverse mental health states, such as experiences of anxiety and depression, and also to physical illness, such as cardiovascular disease and type 2 diabetes (Kiecolt-Glaser, McGuire, Robles & Glaser, 2002; Taylor, Lerner, Sherman, & McDowell, 2003b). There is also a strong link between coping and physical and "mental health" (Aldwin & Park, 2004; Aldwin & Revenson, 1987; Antoni, Lehman Kilbourn, Boyers, & Culvers, 2001; Folkman, 2010; Hallam, 2007; Holahan et al., 2003; Aspinwall & Taylor, 1992; Holahan, North, & Moos, 2010).

A meta-analytical study of the association of coping to physical and psychological health outcomes in a non-clinical population was carried out by Penley, Tomaka and Wiebe (2002). The authors specifically examined a series of meta-analyses on non-clinical samples aged 18 and over, investigating the associations between coping strategies (specifically on the Ways of Coping Questionnaire; Ways of Coping Checklist; Ways of Coping Checklist- revised) and health-related outcomes. The results revealed that problem-focused coping was positively related to overall health outcomes and that confrontive coping, distancing, self-control, seeking social support, accepting responsibility, avoidance, and wishful thinking were negatively correlated with overall health outcomes. The type of health, i.e., physical vs psychological health, and situational characteristics, such as the type of stressor and perceived control and the duration of the stressor, moderated many of the overall associations.

In the literature there has been a long debate about the relative contribution of intraindividual and socioeconomic factors in the development of individuals' capacity to manage stress. As it is now, the weight of the evidence suggests that social factors do play a major role and their influence is seen in the degree of long-term stress that individuals have to cope with. However, this knowledge is seldom transferred into research practice within psychiatry or into psychiatric research. Research within psychiatry still mainly focuses on intraindividual factors, resulting in diagnoses, with the resulting treatment being mostly pharmaceutical intervention and psychological therapies for such "illnesses" (Kinderman, Read, Moncrieff, & Bentall, 2013; Layard, 2006). The

abilities that people have to manage or cope with these stressors are seldom acknowledged (Adler & Matthews, 1994; Wilkinson & Pickett, 2009).

Conceptual Issues in the Measurement of Coping

Conceptual issues in the measurement of coping are usually embedded in the type of methodological assumptions used. The different conceptualisations of coping impact on how the concept of coping is measured, providing very real issues for the measurement of coping. There are well-documented problems with the measurement of coping, with a plethora of research on coping scales and checklists (e.g., Coyne & Gottlieb, 1996; De Ridder, 1997; Endler & Parker, 1990). Existing coping scales differ in a number of important ways. Any particular instrument generally reflects how coping is defined, the theoretical assumptions employed and whether the coping that it is attempting to assess is in relation to a particular stressor or not. Generally, the instruments developed reflect the complex nature of the measurement of coping. The more popular coping scales used in psychiatry have been: The Ways of Coping Scale (WAYS-Revised), Folkman and Lazarus, 1988; The COPE Inventory, (COPE), Carver, Weintraub and Schier, 1989 and the Coping Response Inventory, Moos, (1992). These scales are situation specific scales designed to measure how individuals cope with a given situation (Folkman & Lazarus, 1985). However, coping is a multidimensional concept and covers many aspects of behaviour.

There is also controversy in the ways in which coping strategies have been assessed. Carver et al. (1989) make reference to this exact point, highlighting that most measures of coping strategies do not assess clear aspects, or include clear ideas about certain theoretical interests, though there may be good diversity in the

aspects that they measure (McCrae, 1982, 1984). Furthermore, some of the measures do not have a clear focus in their items that indicate what specific response a certain item is measuring. For example, some items may consist of words with different meanings to different people and as such the response means different things to different individuals. An item such as “I used alcohol to cope” may mean that a person used a controlled drinking approach of 1-2 glasses in a social environment which helped them relax, whereas others may interpret it as a tension reduction approach used regularly to cope by drinking a bottle of vodka while alone leading to a decline in their relationships. There is no clear way of measuring the full meaning of individual responses to items. In the Ways of Coping Questionnaire by Folkman & Lazarus (1984) some items have such ambiguity, e.g., item 6 states: “I did something which I didn’t think would work, but at least I was doing something” (p. 328). This item is most confusing for the respondent and again would elicit many different responses depending on its interpretation.

The variability in the measurement of coping and gaps in the research on coping make it difficult for direct comparisons between studies to be made (Endler & Parker, 1990; Felsten, 1998; Folkman & Moskowitz, 2004; Keyes, 2007; Ptacek, Smith & Dodge, 1994). Indeed, the methodological shortcomings of most coping scales reflect more basic underlying conceptual problems regarding the coping construct (DeRidder, 1997). For example, coping checklists encompass too narrow a conception of coping, resulting in incomplete and distorted measurement of coping (Coyne & Gottlieb, 1996).

A specific example of where the measurement of coping has failed can be seen in the study by Oxlad, Miller-Lewis and Wade (2004). Oxlad et al. investigated the validity of The Billings and Moos Coping Checklist (1981), one of the more popular coping checklists in mental health settings often used within such hospital settings to examine the strategies people use to cope with crisis. Oxlad et al. (2004) investigated the factor structure and psychometric properties of the Billings and Moos Coping Checklist. The Billings and Moos scale along with a number of other self-report questionnaires (Rosenberg's Self-Esteem Scale, Beck Hopelessness Scale, The Mental Health Subscore of the SF-36, The Life Orientation Test- Revised, The Depression Anxiety Stress Scales) was administered to 515 undergraduate university students and 119 patients awaiting elective coronary artery bypass graft surgery. Using both confirmatory and exploratory factor analyses the authors summarised and described the coping responses. The authors made two adjustments to the scale. Firstly, to improve its sensitivity, the scale response set was altered from the yes/no format to a 4-point Likert type scale. The second amendment was they changed the measure from situation-specific coping to dispositional coping. However, the major finding suggested that the Coping Checklist did not adequately fit the data. Specifically, the factor structure, internal consistency, test-retest reliability and validity of the Coping Checklist were "weak". The internal consistencies of the Billings and Moos scale for the groups were as follows: avoidance (0.44), active cognitive (0.72), and active behavioural (0.80). There was no data on test-retest reliability of the scale. The authors suggested that their amendments to the response set and also the focus from situation-specific to dispositional coping might account for

this poor fit. However, Schwarzer and Schwarzer (1996) claim scales such as the Billings and Moos Coping measure demonstrate unsatisfactory internal consistencies. Oxlad et al. (2004) also report that the Billings and Moos scale lacks information on its factor structure and psychometric properties.

Previously, Steed (1998) cautioned researchers that the use of factor analysis to identify the dimensionality of coping scales was fraught with problems. Lazarus and Folkman (1980, 1985, 1988) also reported that they found varying numbers of factors in their research, as items used for particular subscales changed from one study to another, and the sample used also varied. However, factor analyses have been used by many researchers to identify the dimensionality of coping scales (Ferguson, 2001; Frydenberg & Lewis, 1997, 2002a,b; Robbins & Tanck, 1978; Sawang, Oei, Goh, Mansoer, Markhum, & Ranawake, 2010), despite being critiqued heavily mainly due to the lack of transferability of results from one study to another. The findings from the Oxlad et al. study support this interpretation.

Steed (1998) acknowledges that choosing a scale for a specific study is difficult, given the number of coping measures from which to choose. Steed discusses the differences between specific and general measures of coping and has suggested the use of general measures is preferable, the advantage being that general measures allow the comparison of a number of coping strategies across various stressors. However, the reality is that neither a specific nor a general scale is likely to capture the whole coping repertoire and some coping strategies may be missed. Therefore, a combination of both qualitative and quantitative

measurement is likely to more effectively measure coping overall, than reliance on a single scale.

Coping as a Type of Behaviour that Implies Success or Failure.

Coping has also been referred to as a type of behaviour that implies success or failure i.e., not coping. For example, a person dealing effectively with something difficult could be seen to be '*coping*,' whereas a person not dealing effectively with something difficult may be seen to be '*not coping*.' This assumption of "coping well" or "coping badly" is particularly problematic when considered in the individual and functional context of the life of a psychiatric patient. One cannot assume that actions classified as of the coping type are necessarily examples of coping well or badly, as the patient's attempts at dealing with difficulty could be of functional value in the life of the patient. To recast, one cannot infer that a line exists between not coping and coping, it is impossible to produce a set of criteria or definitions that can be used objectively to discriminate between those who cope successfully and those who do not cope. Similarly, it is impossible to determine exactly when an experience reaches the point where it is considered significant and meets the criterion for "not coping." As a consequence, if the reliability and validity of the measurement of coping depends on the "threshold" of what constitutes coping and not coping these too are impossible to achieve.

Classification systems of coping that have been developed by researchers also tend to group various styles of coping into categories which reveal those that are more effective than others, therefore implying adaptive vs maladaptive functions of coping (Aranada, & Lincoln, 2011; Carver, Scheier, Weintraub, &

Jagdish, 1989; Frydenberg & Lewis, 1997, 2002a; Snyder, 1999). These classification systems do not bode well for assessing the functional consequences of coping of a psychiatric patient and do not acknowledge that *not coping* can have some value for psychiatric patients. For example, it is not uncommon for some psychiatric patients to feign illness for adaptive purposes. “Creative” types of coping that might be seen with psychiatric patients are not directly measurable with existing scales and checklist, but interpretable through closer examination and discussions with such patients. There is also literature supporting an existential/phenomenological view that so-called madness is coping (e.g., Bentall, 2003). Bentall believes:

. . . people who are experiencing psychological distress are rarely passive victims of their emotional turmoil; rather, *they usually make active attempts to cope with it* . . . some of these attempts may successfully ameliorate distress, *other coping strategies have the unfortunate effect of increasing the likelihood that the distress will persist* (p. 163).

This view in its strictest form, most certainly renders the use of coping scales redundant for psychiatric populations. However, research to date has shown that there are some commonalities in chosen coping strategies amongst psychiatric patients.

Folkman and Lazarus (1984) make reference to this very problem of being too definitive with the definition of coping and interpretation of coping and they state:

“Coping as a concept is typically equated with adaptational success, especially in the ego psychology models, wherein unsuccessful or less

successful efforts to deal with stress are called defense. This results in a confounding of coping and its outcome. If progress is to be made in understanding the relationship between coping and outcome, that is, what helps or hurts the person and in what ways, coping must be viewed as efforts to manage stressful demands regardless of outcome.

Accordingly, no strategy should be considered inherently better or worse than any other; judgements as to the adaptiveness of a strategy must be made contextually” (p. 140).

Folkman and Lazarus (1984) advise against categorizing coping efforts as maladaptive. Within psychiatry, viewing coping in this way is problematic, because the very functional behaviour, which carries people through situations, needs to be understood in order to verify and, perceive the significance of such behaviour. It is only through such understanding that one can be sympathetic and knowledgably treat psychiatric patients.

Theories of Coping and How Coping is Theoretically Understood

In historical terms, the concept of coping has only been studied as “coping” since the 1960’s (Snyder, 1999). Prior to this time the concept of coping was studied and understood under a variety of other names. The roots of coping in psychology and psychiatry can be traced back to Freud’s work on defense mechanisms (see A. Freud, 1968). Freud described coping as a defense mechanism that enables an individual to deal with unconscious and aggressive conflicts. Therefore, thoughts and feelings, which are troublesome to the conscious mind, are rendered unconscious. This concept of defense is still used today by many psychoanalysts, to describe the process by which the mind changes

the perception of stressful circumstances, which stem from internal processes (Snyder, 1999). While Freud interpreted defenses as protecting the ego against internal instinctual forces, Adler interpreted defenses as safeguards that serve to protect the self from external environmental threats (Ansbacher & Ansbacher, 1967).

Many different theoretical models of coping have been proposed in the last 30 years (e.g., Hobfoll's (1989) multi-axial model; Lazarus' (1966) transactional model). Hobfoll's (1989) model is based on the conservation of resources theory (COR), which predicts that loss is the principle ingredient in the stress process and it is the conservation of resources which influences the stress response. Hobfoll (2001) suggested that because resources are used to prevent resource loss, if there is enough loss this impacts on the individual's coping. Hobfoll stated, "This theory is seen as an alternative to appraisal-based stress theories because it relies more centrally on the objective and culturally construed nature of the environment in determining the stress process, rather than the individual's personal construal" (Hobfoll, 2001, p. 338). This point is now evident in many researchers' work in the area of mental health, as they claim that both sociocultural factors, as well as individual factors, form part of the self (Hallam, 2009; Summerfield, 2004, 2012a) and some have argued that therapeutic interventions have sometimes done little to "help" (Newnes, 2013). In relation to coping or not coping, Summerfield (2008) raised an interesting point, that is, how much or what kind of adversity can someone face and still be classified as "normal."

Coyne and Racioppo (2000) declared that coping research inadequately captures person-environment transactions and the coping process. However, Lazarus believed Coyne and Racioppo's review on coping is "greatly overdrawn" (Lazarus, 2000, p. 666). A review of the literature suggests that there is some truth in both views and, recently, more researchers have advocated for qualitative approaches to uncover the very individual nature of coping (Hasson-Ohayon, Roe & Kravetz, 2006; Robilotta, Cueto, & Yanos, 2010; Tischler, 2009).

In general, there are two key approaches, which characterize the psychological literature on coping. The first, the trait-based approach, has endeavoured to investigate the effect personality variables have on individual coping capacity (e.g., Carver & Connor-Smith, 2010; Coan, 1973; McCrae, 1984; McCrae & Costa, 1986; Taylor, Lerner, Sherman, & McDowell, 2003a). When coping is viewed as a trait, the assumption is that once in place, it operates as a stable behaviour. Therefore, research investigating trait-based coping has focused on how individuals cope in particular ways over their life course.

The second approach in the coping literature focuses on identifying the strategies people use to manage difficult situations and then measuring the outcomes of these strategies (e.g., Carver, Scheier, Weintraub & Jagdish, 1989; Endler & Parker, 1990; Frydenberg & Lewis, 1997; Moos, 1992; Moos, Holahan, & Beutler, 2003). This approach is sometimes referred to in the literature as the coping process. In line with this approach, coping is viewed as a vital feature of the emotion process and the emotional life. The relationship an individual has with their environment determines what coping mechanisms they use and the level of stress an individual experiences (Lazarus & Folkman, 1984). Through the

processes of primary and secondary appraisals the individual assesses a situation as threatening, and then determines whether or not they have the resource strategies to cope with that particular situation. Seen this way, relational meaning takes place, whereby the person's sense of the harms and benefits are weighed up in a particular person-environment relationship. Thus, the relational meaning influences the coping process.

The two central approaches to coping differ in terms of the extent to which they take into consideration contextual variables. Lazarus and colleagues have favoured approaches, which are strongly contextualist (e.g., Holahan & Moos, 1987; Lazarus & Folkman, 1984), whereas others (e.g., Bodenmann, Charvoz, Widmer & Bradbury, 2004) have concentrated on individual level variables. Most notably, trait approaches give value to personality characteristics (Carver & Connor-Smith, 2010; Coan, 1973; McCrae, 1984; McCrae & Costa, 1986) or individual and social resources (Holahan & Moos, 1987), such as optimism and social support (McColl, Hau & Skinner, 1995; Taylor & Stanton, 2007).

In both trait approaches and process approaches, coping is typically understood as the use of 'rational responses' to so-called 'objective problems'. This construal permits the division of coping into both adaptive or maladaptive coping, as well as the presence or absence of coping skills or deficits. In contrast to the deficit focus of much of the psychological literature (cf. Rose, 1989), more recently, some researchers (e.g., Iwanaga, Yokoyama, & Seiwa, 2004; Keyes, 2007; Yanos, 2001) have proposed that coping is better understood as a positive concept, and have focused on the use of adaptive strategies, such as building upon an individual's strengths.

As described, the different models of coping reported over the last 30 years have not necessarily advanced the area of coping research, in that there is no general agreement amongst researchers regarding one style of coping. Of special concern, the two major approaches have not culminated in a consistent conceptualization of the nature of coping for those diagnosed with a mental illness. Furthermore, the research carried out has utilised mostly standardised questionnaires, with very little use of qualitative research, and has had the tendency to categorise coping as adaptive or maladaptive (Skinner, Edge, Altman & Sherwood, 2003). The use of different methodologies, along with different theoretical orientations about “coping,” makes comparisons of coping research problematic. Throughout the overviews of coping, both old and new, one theoretical model, which does stand out and has “stood the test of time,” is the tried and tested model of Lazarus. In this model the coping process is the relationship between an individual and the environment and this relationship determines the level of stress and subsequent choice of coping strategy. This consequent relational meaning is a more fluid way of understanding and measuring quantitatively the concept of coping and seems to fit in the current area of adult mental health. This approach combined with qualitative measures has the potential to add to the understanding of what coping actually means for somebody who is diagnosed with a mental illness.

How Coping is Construed in Light of the Medical Model

It was made quite clear by various researchers (e.g., Boyle, 1990,1999, 2002, 2007; Breggin, 1991; Kinderman et al., 2013; Moncrieff, 2008), that the categorization of behaviours as “disorders” is neither reliable nor valid and such

categorisation has major implications for understanding coping in those diagnosed with a “mental disorder.” The notion of “threshold” also needs to be considered when accounting for distress, unusual experiences and how one copes. It is certainly known that within the mental health field one criterion for identifying an experience as “a mental health problem” is how unusual it is. But the question needs to be asked, what is that threshold? When does an experience become so unusual that it is considered significant and meets the criterion for a mental health problem? This question is important because research has shown that some so-called unusual experiences associated with distress are far more common than usually believed (see Wise, 2004 discourses on hearing voices).

Before discussing this research, it is also important to draw attention to the very fact that the ambiguity around the classification in thresholds for so-called mental disorders, highlights why it is hard to make comparisons within the literature as it stands on coping in a psychiatric population and how it differs from the wider community. As Cromby, Harper and Reavy (2013) point out:

“Many diagnostic criteria are formulated without any empirical investigation of base rates in the general population. This may explain why there is a frequent disparity between numbers of people seen by mental health services and numbers of people in community surveys who meet diagnostic criteria” (p. 10).

To illustrate this point, Van Os, Hanssen, Bijl and Ravelli (2000) reported that in a random sample of 7076 Dutch people, aged between 18-64 years (53.3% women), the prevalence of “true”, psychiatrist-rated clinical delusions and hallucinations, which met all the diagnostic criteria, was only 3.3%. However, the

prevalence for delusions and hallucinations that were not considered to be clinically relevant (i.e., not seeking help for the experience or bothered by the experience) was an additional 8.7%.

Coping with distress and the efforts of patients are rarely understood or acknowledged in light of the current medical framework. What is the focus of mental health professionals is what patients are “not” doing. Most of the time, diagnosis is seen as the end point, as opposed to the beginnings of understanding a patient’s behaviour in terms of the context of their life. The diagnosis also determines the kinds of treatments patients receive in a psychiatric hospital. Preconceived notions of diagnosis have implications for how health professionals may view their patients’ ability to cope, in terms of what patients can and can’t do. A diagnosis also creates psychological inflexibility for both the patient and treating health professional’s understanding of the true nature of patients’ coping. Understanding the meaning of coping for psychiatric patients is a necessary first step in recognising the sorts of things that must be taken into account in the treatment of those who are mentally ill. However, this first step has not been taken.

In the wider community coping can also be seen as part and parcel of everyday life. People are experiencing the effects of love, loss and also many health, social and material conditions evident in every day life. Just like other experiences are also influenced by biological or genetic capacities, meaning by our very nature as living organic human beings. So while coping is really not a separate aspect of experience, and is composed of many different things for different individuals, it can also not be known where it starts and ends. For this reason a completely reliable and valid way of categorising behaviour especially

through standardised psychological questionnaires, psychiatric practices and psychological practices as it stands, is not achievable. What is achievable in order to get a closer idea as to what ‘coping’ may be for those diagnosed with a mental illness could involve asking the patients directly if their ‘coping’ accomplished what they thought it would e.g., what the individual set out to do and if patients themselves thought they had achieved ‘coping’. Moreover, coping in psychiatric populations differs from coping in the wider community in that people diagnosed with “mental illness” often present to hospital with a number of often traumatic and distressing life events and situational crises. Therefore, we can assume this group of people are dealing with a different set of adversities with which the wider community has to “cope.”

A strict behavioural approach to coping e.g., a functional analysis, might also yield quite reliable and valid information. Taken into consideration would be what are thought of as the four main functions of behaviour: firstly, to get attention; secondly, to get tangible things; thirdly, to escape, delay or avoid; fourthly, simply because of the stimulation engaging in the behaviour provides. This approach closely examines the relationship between the individual and their environment and how the individual modifies their environment using their behaviour. Therefore, coping seen in this way would be the things an individual engages in to modify their environment in a way that makes their situation more bearable or comfortable in some way, i.e., the function of a particular coping behaviour is to modify the environment in a way that makes the individual’s circumstances better or more favourable. Another coping behaviour might modify the environment in a different but equally favourable way (e.g., feigning a

“mental illness” for adaptive purposes, such as saving government allowance money while in hospital). Therefore, behaviours are very individual in both psychiatric populations and the wider community and these behaviours, from the point of view of ‘coping,’ need to be seen in this way by the clinician and researcher.

Moral Treatment of Mental Illness: Past and Present

Providing a safe environment and a place to rest and recuperate with the aim focused on comfort and recovery for the mentally ill was posited by psychiatry’s grandfathers. It was at the end of the eighteenth century in both America and England that moral treatment reigned. It was approximately in 1792 that a man named William Tuke opened the York Retreat as an alternative to the York Asylum, which was known for the mistreatment of the people admitted (Boyle, 2002). Moral treatment argued against the treatment of the term “mental illness” in the same way as “medical disease” was treated, noting that emotional and mental illness required a different approach. Treatment centres were set up which focused on recovery and wellness. In moral treatment centres education, manual labour and physical exercise were the experience of the patient. Patients were in surroundings furnished well, with enough freedom to come and go, thereby maintaining their rights as citizens. This initial earlier, very gentle system was promotive of coping and encouraged coping and wellbeing with less focus on insanity. Not surprisingly, such centres lead to vast improvements in well-being and high discharge rates with full recovery (Shershow, 1978). The idea of the moral treatment movement was that it allowed individuals with difficulties to live a relatively normal life. Shershaw (1978) quotes Page (1900), an early advocate

of moral treatment, who claimed that common practices of the time were to “dig deeply” into the family and personal history of the patient. By doing this, valuable information was obtained to see if a possible link between the phenomena of mental illness in question and previous family difficulty or trauma could be established. In addition to this analysis, safeguards for the patient and those aiding in patient recovery were discussed, to guard against further occurrences of the behaviour.

According to Sherman, the dissolving of moral treatment occurred because its developers passed away and they were not replaced with likeminded individuals. This lack of followers, combined with a new psychiatry profession, along with a surge in immigrants into the eastern parts of America, saw an overburdening of the treatment houses and, as such, the deterioration of moral treatment centres began. The attentive care diminished and the new breed of psychiatrist, along with more focus on so-called “scientific” advances, brought a different focus to the term mental illness. Current mental health systems in Australia mirror this demise in treatment centres.

The influence of these so-called scientific advances, with no likely return to moral treatment, have resulted in the downward spiral of psychiatry. Even with the knowledge of the problems associated with these so called advances the problems are still occurring, despite these researchers best efforts to bring about change (Breggin, 1991, 2008; Moncrieff, 2008; Newnes, 1999, 2011; Summerfield, 2006; 2012a). Among the many problems identified are: labelling and diagnosis, medication as first line of treatment (and the routine use of electroconvulsive therapy (ECT); commonly used as a treatment option for so-

called drug-resistant depression and often for older people with depression; see Newnes, 2011), and ignoring the valuable contribution of individual factors. One of the major reasons postulated for the lack of substantial change within the area of mental health is that the focus has been, and still is, on the medical model. Today this approach still dominates, along with the heavy influence of the pharmaceutical industry, within psychiatry and in the subsequent development of a service industry around mental health (Bracken & Thomas, 2001, 2005; Bracken et al., 2012; Breggin, 1991, 2008; Moncrieff, 2008; Summerfield, 2012a).

Nevertheless, in 2005 Brackin and Thomas suggested that times were changing as real dialogues were starting to occur between those who experienced a so called mental illness and the society in which they lived. There is indeed now more collaboration between psychologists and psychiatrists in recognising the need for user involvement in the planning and development of services. However, the extent to which this collaboration has changed some of the inherent difficulties within the psychiatric system is unclear. There is a lot of referencing to this change, but the actual “doing” is not clearly reported on in the literature. Indeed, we might be on the verge of a paradigm shift (Kinderman et al., 2013), but based on current practices this shift has not yet occurred.

In 2013 the DSM-V was still published despite severe criticism by researchers and academics (Cosgrove, Krimsky & Vijayaraghavan, 2006). Example, Summerfield (2012c) claimed that he would challenge any psychiatrist, or anyone for that matter, if they could provide a scientific way of distinguishing between depression as a biomedical category and unhappiness – other than by reference to methodologies we have devised. Summerfield (2012c) goes on to

state that the current methodologies involve a clustering of symptoms by professionals and not nature, with the end result being a diagnosis, if enough “symptoms” are present. He claims: “It is “we” who cluster symptoms not nature and, if there are enough of the symptoms, we declare a mental disorder”(Summerfield, 2012c). The title of an article by Bentall (1992), “A proposal to classify happiness as a psychiatric disorder,” reflects just how faulty the current diagnostic paradigm truly is. As emphasised in a commentary by Rapley, “[But] real sciences do not decide on the existence and the nature of the phenomena they are dealing with via a show of hands with a vested interest and pharmaceutical sponsorship” (see Lane, 2012). Hence, the problem with diagnostic categories.

The Problematic Nature of Diagnoses Within Mental Health Systems: How Diagnosis Impacts on Coping Attempts

The World Health Organization (WHO) definition of mental health is: “A state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community” (World Health Organisation, 2011). This definition is rarely transferred over into mental health settings. Coping is not directly defined in psychiatry, rather, coping is understood to be what the person is not doing, which effectively is the psychopathology. Double (2002) provided a compelling commentary on the limits of psychiatric diagnosis. He wrote that a better way of understanding diagnosis could be through developing an understanding of the reasons behind a patient’s presentation, as opposed to viewing their presentation through a biomedical model. Double

warned against a sole reliance on an ‘underlying hypothetical disorder’ and an elimination of the meaning of patient’s distress, as this minimises the many social, familial and economic concerns of the individual, and objectifies patients so that they become “bodies requiring treatment.”

There is now a body of evidence accumulated in the research which supports the assertion that what has happened to people in their lives plays a major part in their resulting distress and behavioural problems (Bentall, 2003; Read, van Os, Morrison & Ross, 2005; Tew, 2005; Wilkinson & Pickett, (2009). Lucy Johnstone (1999, 2011) wrote about the traumatic lives of people diagnosed with mental illness. Johnstone (2011) believed that the key issues relating to psychosis would be better understood as individual reactions to trauma and abuse (sexual and physical abuse and neglect). Recent studies show clear evidence for physical and sexual abuse to be a major cause of what is labelled as schizophrenia (Larkin & Morrison, 2006; Larkin & Read, 2008; Morrison, Frame & Read, 2003; Read, 1997, 2005; Read & Bentall, 2012; Read, Morrison, & Ross, 2005). This finding within psychiatry is not unlike the finding Jeffrey Moussaieff Masson (1984) stumbled across while going through the archives of Freud’s letters. From these letters Masson wrote a book, “*The Assault on Truth: Freud’s Suppression of the Seduction Theory.*” In this book Masson provides the evidence, which revealed that Freud renounced the seduction theory (which was that emotional disturbances in adults, usually seen in women, stem from actual early traumatic experiences and the knowledge of which is repressed) in favour of the new theory, which was that female patients fantasize about early memories of rape and

seduction. This view formed the basis of psychoanalysis and Masson claims that it “poisoned” the profession hereon.

Bentall (2003) argues that the problem modern psychiatric services are faced with is not one of lack of personnel or resources but of the lack of “ideas.” Bentall argues that too much work has gone into the nature of mental illness under serious misunderstandings of what actually constitutes it. Not being able to cope is not, in itself, a sign of a mental illness, but individuals’ attempts to manage what is going on for them, or cope with what has happened to them and this is not directly assessed in initial interviews in psychiatric inpatient hospitals throughout Australia. Generally, the Diagnostic and Statistical Manual and the ICD-10 are the diagnostic tools of choice within most psychiatric hospitals across Australia. But, it must be acknowledged that the DSM-V definitions of “significant impairment,” “distress,” and “disability,” and the continuum of “normal,” are highly subjective, as such definitions rely upon the clinician’s interpretation of these categories.

Clinical judgement plays a critical role in the diagnostic process. However, even with appropriate training, clinicians will differ from one another. Utilisation of concepts, such as “significant impairment,” in psychiatry has led to many diagnostic formulations, which exclude the voice of the individual and, therefore, are of questionable reliability and validity (Kinderman et al., 2013; Kutchins & Kirk, 1989, 1997; Lane, 2012). What seems to be forgotten is that mental distress is on a spectrum of “normal” experience, and psychosocial factors, such as poverty, unemployment and trauma are, to date, the most strongly evidenced causal factors leading to the diagnosis of a mental illness (The British Psychological Society Response, 2011). There is strong evidence, which has

established a link between family relationships in childhood and common psychiatric disorders in later life (Keyes, et al., 2012; Read, 1997, 2005a; Read & Bentall, 2012; Weich, Patterson, Shaw, & Stewart-Brown, 2009).

One of the major problems with diagnosis is that clinicians and researchers often complain that patients do not fall neatly into standard diagnostic categories. Moreover, some patients often fall short of a symptom and, therefore, either do not meet the diagnostic requirements or have symptoms, which challenge definitional assumptions (Garety, 1985). Another issue with research including only those who fit neatly into diagnostic categories is that only this research gets published, which maintains the dominance of diagnostic categories (Harper, 1996). Boyle (1990, 1999) identified yet another issue with diagnoses which are the vested interests of “others” in this diagnostic process, the “others” being: the relatives of those diagnosed mentally ill, mental health professionals and the pharmaceutical industry. There are still many psychologists and psychiatrists who focus on the assessment of an individual’s ability to cope through classification systems. The role of diagnosis to date within mental health settings determines what treatments are provided with the aim of improving maladaptive/abnormal human behaviours. Relatively little attention is given to the person and their relationships to other people, groups, social institutions and society as a whole, and the very factors which may be maintaining or contributing to the issue of concern. Clinicians also need to be wary of imposing their views when formulating a diagnosis. As stated in the DSM-IV:

Clinicians assessing the symptoms of schizophrenia in socioeconomic or cultural situations that are different from their own must take cultural

differences into account. Ideas that may appear to be delusional in one culture (e.g., sorcery and witchcraft) may be commonly held in another” (American Psychiatric Association, 1994, p 281.)

This is especially true for the treatment of those rural aboriginal people diagnosed with schizophrenia. These people are also not immune from the effects of the western psychiatric model. A survey by Kowanko, Crespigny, Murray, Groenkjaer and Emden (2004), with 57% of the sample being from rural and remote regions, revealed the difficulties with medication management for aboriginals in rural settings. Not surprisingly, itinerant aboriginals had “particular difficulty storing their medications,” there was poor medication compliance, partly reported as being due to “the unwanted side effects of medications prescribed,” and transport issues to access medications. Also reported was a reluctance to access services related to experiences of or perceptions of racism and lack of confidentiality. Unfortunately to date, there are no known studies carried out on the meaning of coping for these people and the use of their specific cultural mechanisms for dealing with adversity.

Many researchers are aware of the construction of mental illness and the stigmatizing effects of diagnoses and labels on people, along with the associated negative consequences (Ben-Zeev, Young & Corrigan, 2010; Boyle, 1990, 2002; McHoul & Rapley, 2003b; Newnes, 2011; Summerfield, 2001b). Indeed, the unreliability of diagnoses and the continual inaction within the fields of psychology and psychiatry has caused many of their professionals to become quite critical of their own profession (Healy, 2012; McHoul & Rapley, 2003a; Newnes, 2004; Rapley, 2012; Summerfield, 2006, 2012a). For example,

Moncrieff (2008) states, “Even when they acknowledge that there is no evidence for a ‘chemical imbalance,’ many psychiatrists believe that the term is still justified and appropriate, thereby, demonstrating a deep underlying commitment to the idea” (p.11). Moncrieff also described that pharmaceutical companies employ a similar language in their advertising campaigns, likening depression to physical illness, such as arthritis or diabetes. An even louder version of this is echoed throughout the media, one of the most influential forces in the portrayal of public views on what constitutes a mental illness. As Rowe, Tilbury, Rapley, and O’Ferrall (2003) pointed out, this inherent belief, embedded by the profession and now the media, uses stigmatizing language to draw parallels between violence and crime and the mentally ill, which further negatively influences the general population’s understandings of what has become known as mental illness.

The issues with diagnosis within mental health are problematic on many levels. Boyle (1999) claimed that diagnosis does two things. Firstly, by attempting to classify those presenting with behavioural complaints in much the same way as those who present with physical complaints, psychiatry claims it is a branch of medicine. Secondly, psychiatry purports to have links with science, given the use of the diagnostic classification system, e.g., coding “like with like.” The veil of a science protects the discipline of psychiatry from questions about diagnostic reliability and disagreements regarding particular categories. The process of formulating a diagnosis does not take into consideration the very nature of understanding and responding to psychological distress and, thus, dismisses the experience of the patient (Newnes, 1999).

According to Moncrieff (2008), the claim that there are specific biochemical deviations in the brains of people with various psychiatric diagnoses is weak and inconsistent. However, the idea that “drugs cure a mental illness” is now embedded into the public consciousness, fundamentally changing the way we view ourselves and the nature of our experience (Rowe, 2007). Clinically this is evident in many presentations to General Practitioner (GP) clinics. For some people a form of coping is to consult their GP for a chat about their woes, and many leave with a script in hand, wondering then what is wrong with them. Unfortunately, with the widespread use of labels and categories, it is sometimes difficult to convince the psy-professions that people are usually “driven crazy by bad things that happen to them” (Read, Mosher & Bentall 2004, p. xvii).

Psychiatry, with its focus on mental illness, is essentially a medicine of the mind (Bracken & Thomas, 2005). As Bracken and Thomas claim the mind is not something tangible and, as a result, a medicine of the mind needs to be qualitatively different to a medicine focused on bodily tissues. Simple as this sounds, this important truth is far away from the discipline of psychiatry in 2013. Since its origins in the mid-nineteenth century, psychiatry has sought to model itself on a “medicine of the tissues,” and, by doing so, Bracken and Thomas (2005) believe it has not ignored such things as meanings, values, relationships, but it has rendered these as secondary concerns. Moreover, and somewhat unfortunately, the circular reasoning continues to exist in mental health settings and the community today.

An example of this circular reasoning is described clearly in an article by Smith (1978) who illustrated how patient “K” was diagnosed as mentally ill. The

article reports on how various agencies of social control worked through the institutionalised procedures for gathering information on an individual and then matched this information against the medical paradigms which provide “membership” of being “mentally ill”. As seen with many cases within psychiatry, much of what Smith counted as the informal work (e.g., the individual’s ideas of what was happening for them, and then the family and friends’ ideas) was already done before even entering into the official process (e.g., the mental health inpatient setting). Smith highlighted that these informal accounts can also be described as social organisation, which precedes the production of the actual interview within a psychiatric setting and can impact on individuals. Smith suggested that it is reasonable to assume that people do react in ways, which seem odd to others when they are going through the mental health process and, hence, such behaviours should not be classified as a symptom of a disorder. Moncrieff (2010) reported that this classification process presents serious concerns, because, once a psychiatric diagnosis is applied, it is a cue to implement actions of “care” presented in the guise of “treatment,” which largely constitutes “behavioural control.” It is this process which causes the relevant social circumstances and individual suffering to be bypassed, unexamined and unchallenged (Rapley, Moncrieff & Dillon, 2011).

Coping in Those Diagnosed With a Mental Illness

This section will begin with a review of the literature on coping in psychiatric patients and how this differs from the wider community. A series of research findings will be reported on which will help to cast light on this contrast. Coping has rarely been measured from a general perspective; more often it has

been measured in response to specific situations and or stressors, e.g., coping with grief, coping with trauma. When assessing ones coping strategies research has often made gender comparisons of which particular coping strategies are used by one sex or the other. The research conflicts with some research supporting gender differences and others arguing that there are no difference. How an individual copes in general is important to consider, given the many individual factors that come into play during the coping process.

Gender and Age Differences in Coping

While there is an abundance of research highlighting gender differences in coping amongst people from the wider community, there is little known about gender differences in coping mechanisms specifically for those people diagnosed with a mental illness. In summary, the literature on coping suggests that women seek social support and use emotion-focused coping to a greater extent than men (Felsten, 1998; Porter, Marco, Schwartz, Neale, Shiffman, & Stone 2000; Ptacek et al., 1994; Stroebe, 2001). But there is little research evidence that psychiatric samples show any different gender patterns in coping from those seen in the wider community.

There has been little research into coping strategies and age differences within psychiatric samples. However, possible reasons why coping in psychiatric patients is likely to be a function of age, can be explained through a behavioural paradigm. Most patients diagnosed with a mental illness and frequent hospital admissions over time develop strategies and ways of coping both with their symptoms and the system itself (as will be discussed a little later in this thesis under coping with the mental health system). Psychiatric patients along with the

wider community also deal with the developmental milestones of life and the stressors of daily living (Agar-Jacomb & Read, 2009; Aldwin and Revenson, 1987; Barnett & Lapsley, 2006). However, psychiatric patients are more likely to incur more stressors such as unemployment, poor housing and unhealthy social and familial relationships than people living in the wider community which may or may not contribute to distress (Barnett & Lapsley, 2006). In Bentall's (2003) book *Madness Explained: Psychosis and Human Nature* the main aim of his book was to highlight as he quotes: ". . . the vanishingly small difference between the 'us' who are sane and then 'them' who are not" (p. xiv).

It is also important to consider that the experience of a hospital admission in itself may be something difficult that the patient has to deal with (depending on the type of admission involuntary or voluntary, diagnosis given medications they need to comply with). As well as coping with a hospital admission, the following scenario would be common: the patient might be coping with a relationship that just ended, all the friends they have lost, and the job they are struggling to keep, along with the money problems that have resulted. They might possibly be coping with the unmet expectation of "getting their life back together," when their life has disintegrated. Any new adaptive behaviour that they were using is not likely to maintain, since they do not have a life to embed it within and such behaviour is not able to be reinforced. For many patients, losing social support and the isolation that may accompany a long admission would be added stressors requiring coping.

It is commonly referenced in the psychological literature that people diagnosed with a mental illness, such as depression, schizophrenia or anxiety, lack

adequate ‘coping’ for managing the challenges of daily living, which at times causes these individuals psychological distress (Piccinelli & Wilkinson, 2000; Taylor & Stanton, 2007). In addition, there are now a few studies that have recognised the need to investigate coping specifically among persons diagnosed with mental illness (Keyes, 2007; Tischler, 2009; Yanos, 2001). However, an extensive search of past literature indicates that there has been little research into evaluating coping strategies in people diagnosed with a mental illness. This historical lack of research on coping in people diagnosed with a mental illness contrasts with other research, into stress and coping in those caring for an adult diagnosed with a mental illness (e.g., Mackay & Pakenham, 2012), that has found that coping resources emerged as the most consistent predictor of adjustment. Nevertheless, the paucity of research on coping in those diagnosed with a mental illness is consistent with the historical tone in the fields of psychology and psychiatry, whereby maladjustment has received more attention in the literature than positive functioning.

Before beginning with the research evaluating coping strategies in those diagnosed with a mental illness, and within the general community, it needs to be highlighted that coping studies conducted in the general community usually compare differences between men and women in their ‘coping’ response to a particular crisis or trauma or grief, whereas coping research in those diagnosed with a mental illness has focused on their use of “maladaptive coping styles.” Some limited attempts at research evaluating coping strategies of those diagnosed with a mental illness can be seen in the area of adults coping with childhood sexual abuse (e.g., Walsh, Fortier & Dilillo, 2010). However, Williams (1999)

claimed that histories of abuse are seldom heard within mental health services and not from the lack of women wanting to share their stories. It seems many women have spent a considerable number of years in and out of mental health services without being provided with a safe environment to talk about their experiences or with someone who could offer support. This state of affairs continues to occur despite research efforts, such as Weich et al. (2009), that have indicated that trauma in childhood due to family is reflected in mental health problems later in life. In their systematic review of studies between 1970-2008, Weich et al. found that abusive relationships predicted depression, anxiety and PTSD (Post Traumatic Stress Disorder). Such findings justify the much earlier position of Page (1900, cited in Shershaw, 1978), who advocated for the moral treatment approach, which seems more suitable to these presentations than what psychiatry has to offer to date.

Other coping research has looked at particular coping strategies, such as leisure, which help relieve the symptoms of a “diagnosis of mental illness”, such as depression (e.g., Nimrod, Douglas & Berdychevsky, 2012); and at the types of major and chronic stressors that people diagnosed with a severe mental illness experience which influence coping (Robilotta, et al., 2010). Nimrod et al. (2012) based their investigation on data from 25 online depression “communities” through the Internet. Their study identified four loose themes, these being: leisure activities thought to be very beneficial in coping with depression; unhealthy uses of leisure (e.g., avoidance, doing nothing); difficulty participating in healthy forms of leisure; and that various strategies (e.g., taking one step at a time, time management) helped with constraints on the use of leisure to improve ones health.

These findings must be interpreted cautiously due to non-random sampling. There was an inherent bias in this study towards focusing on those who were more inclined to use the Internet and on a group that was more willing to share their thoughts online.

There are also studies on coping that have focused on what types of coping styles are most beneficial for people diagnosed with mental health issues, such as the study on self enhancement by Taylor et al. (2003a). Ninety-two participants (45 men and 47 women) participated in the study that investigated just what constituted self-enhancement. The researchers used multiple measures of self-enhancement, such as personality assessments (e.g. Eysenck Personality Inventory; Spielberger State-Trait Anxiety Inventory), interviews (the authors listed the areas of discussion but did not state the actual questions they asked the participants), friend ratings (friends were nominated by the participant to provide information), peer judge ratings of mental health (two people were recruited by the authors and provided with instructions on how to evaluate the criteria for mental health), and clinician ratings (made by one clinician who was “psychoanalytically oriented,” asked to use the Emotions Memory Test (EMT)) and then rated his judgements of the participants on a 3 point scale (1 not very confident to 3 very confident)).

While the overall results of Taylor et al. (2003a) were supportive of a linear relationship between self-enhancement and psychological adjustment, with a cluster of coping resources, including optimism, mastery, self-esteem, and social support, related to multiple indicators of mental health, the results again should be interpreted with caution. Taylor et al. (2003a) implied that there was a qualitative

element to their study, however, the word “qualitative” was only used in one paragraph of the method under the clinician’s ratings of participants. In referring to the clinician who carried out the ratings, the authors stated:

“He was then asked to attend to qualitative factors such as how the self was represented, how the interpersonal world was represented, the affective tone of the material, whether the memories were narratively coherent or contained inner contradictions (suggesting omissions and distortions)” (p. 169).

It seems with this study that a myriad of research variables were thrown together and that the study was not well thought out. There are procedures, outlined by Shenton (2004) and Harper (2013), to ensure trustworthiness in qualitative research projects, such as credibility, transferability, dependability, and confirmability that were not apparent in Taylor et al.’s study.

Coping Research in Those Diagnosed with Schizophrenia

Those studies which have been carried out which review coping within the sample of those diagnosed with a mental illness have largely focused on schizophrenia and how coping in this sample differs to coping within the wider community. In assessing research into coping in those diagnosed with the specific diagnosis of schizophrenia, the findings suggest that “productive” coping is reflective of the number of social supports, as those diagnosed with schizophrenia are more isolated and are reported to have “less sophisticated” coping mechanisms (Cohen & Berk, 1985; Falloon & Talbot, 1981; Lysaker, Bryson, Marks, Greig & Bell, 2004). Some research has reported on patients’ coping with being diagnosed with schizophrenia (Rollins et al., 2010); and other research has

found that those diagnosed with schizophrenia experience difficulties in coping with major and minor stresses (Carr, 1988).

In another study into coping in those diagnosed with schizophrenia, Rudnik (2001) investigated the impact of coping on the relation between symptoms and quality of life in those diagnosed with schizophrenia. The author postulated that the relation between severity of symptoms and level of quality of life in those diagnosed with schizophrenia is not strong. The study set out to investigate whether coping strategies help to regulate the symptoms experienced and quality of life of the patient. Fifty-eight adult outpatients diagnosed with schizophrenia, who were recruited from a community mental health centre participated in the study. The patients completed the Positive and Negative Syndrome Scale (PANSS), the Ways of Coping Checklist, and the Wisconsin Quality of Life Index. While negative symptoms reported by outpatients diagnosed with schizophrenia were inversely related to activities of daily living, the positive symptoms patients experienced were directly related to distress. The overall results confirmed that coping, either problem-focused or emotion-focused, did not moderate the relation between symptoms and quality of life, with the author advocating for further research into coping in those diagnosed with schizophrenia.

Subsequently, Rudnik and Martins (2009) re-analysed data from the Rudnik (2001) study. Their findings suggested that problem-focused coping was not more effective than emotion-focused coping in many circumstances for those diagnosed with schizophrenia and that assumptions that applied to the broader general population, specifically that problem-focused coping is better than

emotion-focused coping, may not apply to this population. The authors also found that factors linked to emotion-focused coping, such as the concept of “hope,” may be more helpful in many circumstances for individuals who are diagnosed with schizophrenia. This last point is useful for researchers investigating the well-being and coping of those diagnosed with schizophrenia and, in particular, their choice of coping mechanisms, because evaluations usually entail what these patients are *not* doing, rather than what they *are* doing.

On a positive note there were two earlier studies that looked at coping and subjective experience that showed just how capable those diagnosed with schizophrenia were; however, these findings did not transfer into further research. One of the earliest studies by Cohen and Berk (1985) looked at the techniques those diagnosed with schizophrenia had developed to cope with their “symptoms.” The researchers noted that “there was an absence of any systematic accounting of these techniques in the professional literature” (p 407). An observation that is still current almost three decades later. Cohen and Berk found that the methods that people diagnosed with schizophrenia use can be an important adjunct to therapy and postulated that techniques successfully utilised by patients could be incorporated into psycho educational programs to treat patients and their families.

In their study in Brooklyn 84 outpatients (52%men, mean age 43.3years) met the diagnostic DSM-III classification of “schizophrenia” with exclusion criteria (not acutely disorganised, agitated, paranoid). Ninety three per cent had a previous hospital admission and all patients were taking prescribed neuroleptic medications as well as being involved in-group or individual therapy. The patients

participated in a 30-minute open-ended interview that asked how they dealt with each of the 29 symptoms on a psychiatric symptom questionnaire derived from Herz's list of 29 pre-morbid symptoms commonly reported with those patients diagnosed with schizophrenia.

One of the progressive factors of this study was that the main aim was targeted at getting the patients to explain those methods which worked best for them and that were developed by the patients themselves, although also included were techniques they had learnt from professional intervention. Of the 1501 responses recorded, there was an average of 17.9 methods per patient, with *fighting back* the coping mechanism most frequently reported, indicating that those diagnosed with schizophrenia often employed active strategies to subdue their symptoms. However, the second most frequent method was “does nothing – accepts,” suggesting that many learnt to live with their symptoms and treatment regimes. The results also suggested that “medical strategies” were commonly used for anxiety and the symptoms usually associated with schizophrenia. The authors noted that prayer was used almost exclusively as a coping mechanism for the “symptoms” commonly associated with the diagnosis of schizophrenia. Coping responses were also noted to vary depending on demographic, social and psychological functioning. Employment as a coping strategy allowed those diagnosed with schizophrenia to use the coping strategy “fight back” more often than those who were unemployed. While there were differences noted between males and females in this study, these differences did not reach statistical significance. There were also no age differences in responses, suggesting similar patterns of coping responses across age in those diagnosed with schizophrenia.

The overall conclusions of this study suggested that those diagnosed with schizophrenia develop a variety of coping mechanisms to deal with different types of symptoms.

What studies like these show, and what is quite commonplace within mental health settings when the more “severe diagnoses” are applied, is that there are two very polar opposite “coping” responses to the “illness” of what is termed “schizophrenia”. However, the studies demonstrating significant functional coping in those diagnosed with schizophrenia are rare. The diagnosis of schizophrenia is one of the most highly psychologically inflexible diagnoses, because of the treatment regime this diagnosis dictates. There are the restrictions to the individual of medication compliance, and the well-known side effects these medications carry which patients have to manage. There is also the stigma attached to the label of schizophrenia, which affects how these people are perceived by others. It is not surprising that some people do nothing, give in, give up, which is also seen as treatment compliant, and others “fight back.”

One study from 22 years ago is also worth discussion, because of the findings of the study and how they were reported at the time, which highlights the degree of subjective clinical judgment that is often involved in such cases. Cutting and Dunne (1989) developed a “standardized assessment” to elicit the subjective experiences of patients with the “major psychiatric illnesses of schizophrenia” and depression over three stages. The first stage, an open-ended interview, covered nine areas of psychological functioning and was conducted with three groups of patients diagnosed with schizophrenia (acute, remitted and chronic) and one group of depressed patients. On the basis of their replies, a

structured interview was given to the patients on two separate occasions, approximately six months apart, to test inter-rater reliability. The findings indicated that for some patients their accounts did not vary much within this time period, thereby supporting inter-rater reliability of the interview instrument. The authors state “Perceptual dysfunction appears to be the most invariant feature of the early stage of schizophrenia, but a qualitative disturbance of thinking also occurs” (Cutting & Dunne, 1989, p. 217). These findings were not elaborated upon and “qualitative disturbance” was not defined, which makes a replication of this study difficult. The authors also downplay positive aspects of their findings, as they state they were “surprised” at the number of subjects with “good memory” and the “clarity” of their reports detailing their first psychotic breakdown, which occurred many years after the event. This study demonstrates the assumptions held by the researchers that are not unlike some of those held by health professionals today, and the stigma associated with the diagnosis of schizophrenia.

An earlier study by Carr (1988) investigated the techniques for “coping with schizophrenia.” Carr developed a questionnaire to assess how non-hospitalised patients diagnosed with schizophrenia coped with various symptoms of their illness. The questionnaire was not a standardised questionnaire, and, therefore, was of questionable reliability and validity. The author wrote “all patients were administered a questionnaire, the items of which were derived from the few empirical studies cited above and anecdotal reports of clinicians and patients” (Carr, 1988, p. 342). Carr reported that “about 350” individual coping techniques were identified and these ranged from behaviour change, socialisation, cognitive control and the use of medical care, as well as behaviours which were

likely to have been identified by others as symptomatic of the illness. The results were not expanded upon and, obviously, these findings must be interpreted cautiously, because the study lacked reliability, due to the type of questionnaire developed and the approximations of results provided. A qualitative note is that the coping strategies that Carr described people diagnosed with schizophrenia used, all seem very sensible and logical ways to manage what is considered by some to be a serious illness. Had the instrument been reliable and valid, replication by other researchers could have possibly been useful in clinical settings.

In essence, the research on coping in those diagnosed with schizophrenia is limited and unreliable. The focus of this research is reflective of the diagnostic approaches to the treatment of the illness, with studies investigating more medication noncompliance rather than the underlying features of what has happened to patients in the past, the meaning of their experience of the illness labelled “schizophrenia” and the various coping mechanisms they already have in place (Lysaker et al., 2005; Rollins et al., 2010). These points will be drawn upon further within this literature review.

The Medical Model and Concepts of “Mental Illness”

Many of the misunderstandings of patient coping by health professionals begin with the ways in which ‘coping’ and so-called ‘normal’ aspects of behaviour are defined. The idea of normality originated from the mid-17th century, from a Latin base, *norma* ‘carpenter’s square’ (Oxford Dictionary). The definition of normality in English is, “the condition of being normal; the state of being usual, typical, or expected” (Oxford Dictionary). People have been

describing this concept juxtaposed with “madness,” which is defined as: “the state of having a serious mental illness” (“Madness,” n.d.), for some time. Bracken and Thomas (2005) argue psychiatry itself had its origins during the European Enlightenment and in the modernist culture that emerged. They believe two major themes “preoccupied the thinkers of the Enlightenment period,” (p. 6). The first was the quest for truth by means of human reason, as opposed to religious revelation. This was a change from previous styles of thinking. Scientific investigation was commended and became the idealized tool for the “revelation of truth.” The second was the exploration of the many aspects of what it was to be a person, the idea of human rights, and exploration of what made up an individual (e.g., personalities) and out of which evolved the need for a “mental” science. Thus, psychiatry was born and its focus was on reason and order.

Bracken and Thomas (2005) believe the enlightenment gave rise to a generation that attempted to clear the ‘unreasonable’ elements. Unreasonable people, such as those deemed “insane,” were confined in institutions. Porter (1987) believes that attitudes to and treatment of those deemed “mad” also resulted from a political shift in thinking during this time. This thinking took form in the rise of “exclusion” and “labelling” people as “delinquent” or having “dangerous” traits. Furthermore, the emergence of institutions was, as many believe (Bracken & Thomas, 2005; Porter, 1987, Read, 2004c), more an act of social exclusion, than one of a medical venture. Seen in this way, any behaviour could be reconstructed into a symptom of mental illness simply by “expert” decree (Read, 2004a,b).

It was during this time researchers in the field of psychiatry set out to discover the universal laws underlying human behaviour and its causal factors. In relation to “madness” and “distress,” however, psychiatry continued to replace spiritual, moral, political and individuals’ understandings of madness within the framework of psychopathology and brain dysfunction (Read, 2004a). The very important aspects of the social contexts of peoples’ lives and the attempts people make to alleviate the distress from their lives were excluded from consideration. A possible reason for this was provided by Szasz (1971), who claimed that the principle problem in psychiatry is the threat of the feared violence of the “madman,” and the actual counter-violence of society and the psychiatrist against him. Szasz reported that this resulted in “dehumanisation oppression, and persecution of the citizen branded mentally ill” (p. xvii).

It was not until the late nineteenth century that the concept of mental illness was defined by etiology by the fathers of modern psychiatry, Emil Kraepelin and Eugene Bleuer (see Klerman, 1978). Kraepelin was significant in psychiatry as one of the first to approach mental illness in terms of causation and etiology using the principles of modern scientific medicine. Although “schizophrenia” was not Kraepelin’s term, he and several other European psychiatrists combined clinical observations of what they each considered to be schizophrenia. Klerman (1978) clearly indicated that within current psychiatry there is a split between mad and normal. The Kraepelinian approach towards mental health placed its emphasis on categorizing diseases.

While most of the debate in the literature concerns the nature and theory of disease, implicit in these debates are very practical decisions, such as who will be

considered sick, who will be treated within the medical system and under what financial umbrella (Bracken & Thomas, 2005; Klerman, 1978; Read 2004b; Summerfield, 2006).

How the Medical Model Impacts those Diagnosed with “Mental Illness”

The “medical model” has become a phrase that polarises professions and as such the term mental illness is a contested entity. It is for this reason, along with the fact that it is often used to justify many of psychiatry’s practices, that the medical model is often criticized both within medicine and by other professions. Klerman (1978) pointed out that “the concept of illness is not arbitrary but reflects areas of shared consensus, embodying truths arrived at by rules of evidence” (p. 107). However, there are the conformists to the medical model and the antagonists against –the antipsychiatrists and critical psychiatry movement. Closely following are social psychologists, in particular Rosenhan (1973) who is critical of the normal/abnormal divide, as what is viewed as normal in one culture may be seen quite differently in another, highlighting that the notions of normality and abnormality may not be quite as accurate as they are claimed to be. Rosenhan believes the medical model serves to rationalise and control behaviour that is “different” or “odd.”

In 2007 an Australian National Survey of Mental Health and Wellbeing, focusing on the 12-month and lifetime prevalence of mental disorders in the Australian population, revealed the following. For anxiety, affective and substance use disorder, the survey estimated that “almost half (45.5%) of Australians aged 16-85 (7.3 million people) experienced a mental disorder over their lifetime. Each year, 1 in 5 Australians (20%) in the 16-85 age range or 3.2

million Australians, are estimated to experience symptoms of a mental disorder.” The “low prevalence” group, including psychotic illness, eating disorders and severe personality disorder, were followed-up through The National Survey of Psychotic Illness. Results showed that an estimated 64,000 people in Australia aged 18-64 have a psychotic illness and are in contact with public specialised mental health services each year. This equates to 4.5 cases per 1000 population. This survey found that schizophrenia accounted for almost half (47%) of the diagnoses, and people diagnosed with a psychotic illness also experienced poor physical health outcomes, such as heart or circulatory conditions (26.8%) and diabetes (20.5%). The prevalence of diabetes was more than 3 times the rate seen in the general population (Australian Government, Australian Institute of Health and Welfare, n.d).

Not surprisingly, the literature indicates that medical interventions dominate the treatment of those diagnosed with a mental illness, with drug treatment being used as the first line of intervention, neglecting other avenues of treatment (Breggin, 1991, 2008; Hansen, McHoul, & Rapley, 2003a; Moncrieff, 2008). Moncrieff (2008) refers to the “new drugs” as a “panacea” introduced around the 1950’s and 1960’s when the beginning of drug-centered treatment took over in psychiatry. Labelling of people as “mentally ill,” according to Klerman (1978), serves to do a number of things:

. . . reinforces his deviant role within the community, legitimizes his isolation from the rest of society, and contributes to the stripping from him of his dignity, civil rights, and personal autonomy. Viewed in this context, psychoactive drugs are a further extension of medical model labelling.

They reinforce the symbolic power of the psychiatrists by giving them chemical control, which leads to the further dehumanization of the individual, so-called “patient” (p.109).

Labelling thereby separating people into “mad” and “bad” was considered a major humanitarian gain in psychiatry (Bracken & Thomas, 2005; Klerman, 1978). This separation has been imprinted onto the psyche of many and, in particular, a large portion of the psyche of psychiatry and psychology, despite the weight of evidence contrary to the idea of madness. There has been little consideration given to cultural variations in behaviour and what is considered to be normal within a particular tribe or society. Therefore, this apparent “humanitarian gain” has resulted in dire consequences for people who are being diagnosed and treated for a “mental illness”. The recent release of the DSM-V has codified even more diagnostic categories, while also loosening the thresholds of some existing categories, allowing many more behaviours to be diagnosable.

One example of the recent change in the DSM-V is the inclusion of a category labelled Somatic Symptom Disorders, which some have argued has no adequate justification to be classified as a “mental disorder” at all (Frances & Chapman, 2013; Sykes, 2012) and is more the result of “problems in living” (this reference originally created by Szasz, 1960), such as housing or economic problems. With the new classification system now in place, it is more likely that everyday behaviours may be subjected to judgements on a continuum of the ever lop-sided continuum of normal-abnormal. Sentiments of Porter (1987) in his summation of the history of madness come to mind, when reflecting on the

current DSM-V. Porter writes: “Is it possible to be odd, to be strange, in ways that still make sense?” (p. 5).

The unhindered progress of psychiatry means that most parts of being human need not be experienced without some form of readily accessible psychological or psychiatric help (Bracken et al., 2013; Summerfield, 2004; Summerfield & Veale, 2008). The concept of the person within the mental health system has changed from one of coping to now one of vulnerability, which, in part, is due to the professionals within mental health projecting the meaning of not coping onto others (Pupavac, 2001). This has further reinforced the power dynamic between the doctor and patient. Few patients question medicine itself, with most patients putting their trust in and following advice from doctors, psychiatrists and psychologists and, thus, psychiatry remains undisputed.

The role of clinical psychology as an accomplice to the profession of psychiatry within the area of mental health, should not be overlooked. Psychology with its many sub disciplines (e.g., social psychology, developmental psychology, educational psychology, cognitive psychology, humanistic psychology, and neuropsychology) was never originally intended to “treat” madness or “disorder,” but rather was partly developed out of the need for classification systems. There were of course, those psychologists who were swept up in the birth of the psychoanalytical movement. However clinical psychology has since flourished, with its classification systems within mental health, and has put its diagnostic, assessment and measurement tools (e.g., intelligence tests, personality tests) to use. These results can and do provide many of the bases of some diagnoses provided to individuals today.

Hansen, McHoul and Rapley (2003) go a step further in identifying the problems with diagnosis in their book, *Beyond Help*. They state that in all of the publications they collected and reviewed, psychological distress was represented as “illness” with biological origins and associated diagnostic categories’ “symptoms.” They state:

mental illness was presented as an entity that individuals can have and know, at the same time as being distinct from persons as such, in the same way that the human immunodeficiency virus (HIV) may sensibly be separated from the actual person who it infects. The mind is reduced to being identical with the brain which, as a bodily organ like any other, may become “diseased” (p. 149).

Hansen et al. (2003) continue to argue that the psy-disciplines fail to reliably identify any underlying processes for these diagnostic groups, yet continue to use language, which conveys that these matters are scientifically known. To illustrate this, here is an excerpt from an online pamphlet in Australia titled “What is schizophrenia?”

. . . certain biochemical substances in the brain are believed to be involved in schizophrenia, especially a neurotransmitter called dopamine. One likely cause of this chemical imbalance is the person’s genetic predisposition to the illness. Complications during pregnancy or birth that cause structural damage to the brain may also be involved” (“What is Schizophrenia,” n.d.).

The terms “one likely cause” are vague constructions, which specify nothing, while giving the impression that a chemical imbalance is a known truth of those

diagnosed with schizophrenia. These unsubstantiated claims are in circulation throughout most hospitals in Western Australia and the implications of such for society is that they will continue to perpetuate this false belief that the diagnosis of a mental illness are akin to “diseases.”

There are now mental health service-user groups in Australia: Australian National Association for Mental Health (ANAMH); Australian Psychiatric Disability Coalition (APDC); GROW Australia; National ARAFMI; SANE Australia, Hearing Voices Network (HVN) and Consumers of Mental Health Western Australia (CoMHWA). The Hearing Voices Network (which is part of the Richmond Fellowship) provides a framework and environment, which facilitates the recovery of people who experience hearing voices. The network educates both sufferers and society about the “meaning” of hearing voices, which is a real experience and not uncommon. The motto of HVN is that the voice hearer is asked questions about “what has happened to you,” as opposed to “what is wrong with you.” Another service-user group, called Survivors Speak Out, is one of the largest groups of British mental health service users. All of these groups allow people to access resources and help people to be “heard.” Chamberlin (1994) refers to the “Mental Patients’ Bill of Rights,” which she helped draw up as her work in the Mental Patients’ Liberation Project in New York City. This Bill of Rights was drawn up to provide a voice to many people who had negative experiences with mental health services and who were rightly so very angry over their mistreatment. The basic premise of these rights were: treat humans as human beings; treat with decency and respect with rights like any other citizen; citizens have the right to not be treated like a criminal and not to be

locked up against their will; citizens have the right to retain their own personal property and the right to bring a grievance to any person who has mistreated them (Chamberlin, 1994).

Chamberlin stated that the Bill of Rights became legal and emphasised this point about her efforts: “Does this sound like it was written by people unable to tell what is happening to them or able only to articulate “pitiful” requests for cigarettes or spare change?” (p. 286). The success of support groups depends upon a number of factors and, as Crossley and Crossley (2001) pointed out, “the formulation of “voice” remains dependent on existing schemas of habitus which may shape it in various ways. Simultaneously, however, it depends on the existence of audiences and relations of symbolic power which allow it to be heard” (p. 1488). However, overall, mental health consumer and support groups are effective in that they allow people to share their personal experiences, bonding in the commonality of issues which develops empathy towards one another, as fears and discomfort are shared along with stories of victory.

Over 42 years ago Szasz (1971) raised questions about psychiatry’s practices being ill conceived within the field of diagnosing mental illness and concluded that psychiatry’s practices were particularly destructive to personal and political dignity. Today, the concept of mental illness as a myth seems to be grasped by more professionals within the area of psychology and psychiatry. However as Newnes (2011) in his article, *Toxic Psychology*, highlighted:

Despite the profession-generated myth that clinical psychologists are determinedly anti-psychiatric, many not only ape medical colleagues in the

use of diagnosis or so-called treatment but are also silent when it comes to opposing medically defined illness and aid (p. 225).

Newnes goes on to highlight that there are many critics of psychiatry, many of whom are psychiatrists themselves (e.g., Breggin, Healy, Laing).

In the United Kingdom there is a strong movement, called the critical psychiatry movement, which is now well established and influential in the area of psychiatry. The critical psychiatry movement could be viewed as a positive reframe of the anti-psychiatry movement. The messages of the movement are clear and quite uncompromising, as Hallam and Bender (2011) put it, “. . . the message of these critical voices (now sometimes called the anti-psychiatry movement) was blunt: madness is a product of a mad family or a mad society” (p. 17). The critical psychiatry movement aims to bring psychiatry back to a more controlled, authentic discipline.

In a parallel movement, Thomas, Bracken, and Timini (2012) claim that evidence-based medicine has brought major benefits in somatic medicine, but the benefits are “less clear” within psychiatry. The authors advocate for framing mental health problems outside of a technical idiom and including both culture and meaning within mental health practice. One of the original arguments for including cultural contexts dates back to Kleinman (1977) who contended that psychiatric theory excluded cultural variables. Given that the individual is also interpretable within a wider social system of relationships, and their own dynamic behavioural repertoires, it makes sense that in order to fully understand the person, we must also understand these various contexts (Hallam, 2009).

Those Diagnosed with Schizophrenia, Coping Efforts and Treatment

Modules to Date.

This next section will review those diagnosed with schizophrenia their coping efforts and the historical background of the development of schizophrenia and mental illness.

Studies into those diagnosed with schizophrenia are varied and have ranged from the belief that the “symptoms” of (those diagnosed with schizophrenia), were the result of a vitamin deficiency (Hoffer, 1973), which improved with an increase in multivitamins; or that it was a dopamine disorder, which saw the emergence of neuroleptic drugs (Insel, 2010), but eventually, the evidence mounted against these drugs and the dopamine hypothesis itself (Healy, 2002; Insel, 2010). Then, in 2002, the possibility of a neurodegenerative disease was raised (Hyman, 2002), but later Hyman, (2008) abandoned this idea due to the findings that there were no simple genomic disorders in psychiatry. As it stands now, the most prevalent model within research suggests rethinking schizophrenia as a neurodevelopmental disorder, with psychosis as a late preventable stage (Insel, 2010). While theoretically this is how the term “schizophrenia” is understood within the research literature, schizophrenia remains contested within the research and theoretical, literature in psychology and psychiatry (e.g., Breggin, 1991; Boyle, 1990, 2002, 2007; Hallam & Bender, 2011; Laing, 1960; Larkin & Read, 2008; Moncrieff, 2013a,b; Read 2004a,b,c; 2005b; Read et al., 2006). As Hallam and Bender (2011) state: “After 50 years of

research, a theory to account for the symptoms of ‘schizophrenia’ has yet to emerge and may never do so if the concept itself is faulty” (p.224).

It seems the diagnosis of schizophrenia came about within the discipline psychiatry with its classification systems, which classified “symptoms” into disorders, which suggest an underlying “disease” (Hallam & Bender, 2011). This practice mimics much of mainstream medicine and poses that those diagnosed with schizophrenia be treated in much the same way as a physical disease, such as diabetes, might be treated within medicine. Indeed, the diagnosis of schizophrenia is viewed as being on the “severe” spectrum of “mental illness”, therefore implying a posed risk to “self” and “others,” and this big label carries with it some rather heavy duty medication regimes.

So firstly, it must be questioned why the label “schizophrenia” is still being used alongside its prescribed treatment regimes, even though it is heavily contested. Moncrieff (2013b) acknowledges that even within mainstream psychiatry “. . . that the label is applied to people with a variety of different problems” (p. 13). But the label “schizophrenia” is rarely challenged within many inpatient psychiatric facilities and the diagnosis along with the medication regimes are used routinely, while patient coping attempts are overlooked. Secondly, as Hallam and Bender (2011) also note, because the “cause” of “schizophrenia” remains unknown, the likely assumption is that its origin is somehow genetic and, therefore, no therapeutic work is offered to such patients. What is known about those diagnosed with schizophrenia is that around 25 per cent of all those diagnosed with schizophrenia recover entirely and remain

recovered for good (Shean, 2010). Therefore, for some diagnosed with schizophrenia, the entire experience resolves.

There is substantial evidence suggesting that environmental causes such as childhood trauma and family have a significant impact on those diagnosed with schizophrenia and there are evidence-based practices for suitable treatment of such causes (Shean, 2009, 2010). Moreover, with the inconclusive findings about the symptoms of a diagnosis of schizophrenia, it is unhelpful to cast an impression that this diagnostic criteria is at all credible, and at the minimum, those presenting with symptoms that fall into this “so-called diagnostic category” should be provided with the same care and available therapeutic treatments as others. Unfortunately, to date, the appropriate care and therapeutic treatment are often lacking and medication is the first port of call, and may be all that is offered to most patients to help them “cope.” As Moncrieff (2013a) claims, people have been using psychoactive substances since the beginning of time to stop pain and suffering. It has only been in the last few decades that people have been “persuaded” that taking psychiatric medications is a “remedy for an underlying disease” (Moncrieff, 2013a, p. 19).

Within inpatient psychiatric populations, medication compliance is a constant tension, particularly in relation to those diagnosed with schizophrenia. But even beyond this diagnostic category, medication compliance has become the major driving force in many inpatient psychiatric facilities in Western Australia in terms of patient management, while the expressions of patients’ attempts at coping with their “illness” go unnoticed or are seen as combative. Perusal of any inpatient medical file (or outpatient for that matter), especially of a patient

diagnosed with schizophrenia, reveals daily records of noted “medication compliance.”

Compliance with medications also weighs heavily on patients’ minds, as seen in Hallam and Bender’s (2011) description of the patient David. David’s awareness of and frustrations with the side-effects of the chlorpromazine he is required to take whilst an inpatient. Patients are constantly weighing up the pros and cons of taking their medications. The pros usually being: to please doctors, possibility of an early discharge and the thinking that if they could only take the medication “long enough” and “consistently,” (over several months is the specified date on the depart fact information sheet for patients (see “Sane Australia: Antipsychotic Medication,” 2010), they may realise the “true benefits” of the medication in the “hope” that medication may eventually cure them “one day.” On the other side of the dilemma is “weighing up” the “cons,” which consist of mainly the well-documented side effects of taking antipsychotic medication. This decision is a constant challenge for patients diagnosed with schizophrenia and is problematic when there are known alternative evidence-based treatments such as counselling and CBT (see Shean, 2009, 2010).

Another additional problem here is that in Australia, if the patient happens to be sectioned under the Western Australia Mental Health Act (1996), they become “involuntary” and lose all of their decision making when it comes to treating their illness. They are required by law to take their medications, which has further implications as to whether or not they will be discharged from the inpatient psychiatric facility, because “usually medication compliance helps.” Sometimes patients are monitored by a community nursing team, which changes

from time to time and involves being administered depot medications during home visits. Although with most depot injections now, patients are required to attend the hospital or clinic for the injection to ensure “medication compliance.” The administration of depot medication as a form of medication compliance is not for this literature review, although it is important to document, as it involves the powers of the authorities and the complete loss of control patients have over their treatment regime and access to alternative mainstream treatments.

In Western Australia an involuntary status is hard to shift and requires third and fourth opinions of psychiatrists. The process can be quite a lengthy and traumatic one for a patient, who is usually already suffering a great deal. The psychiatrist is often faced with the responsibility of making a decision, which involves assessing the “risk” factors for both the “patient” and “society.” This is never a straight forward process and an unfortunate position for a psychiatrist to be in, with many negative ramifications of wrong decisions (see Brown, 2012). The fallout from such occurrences, according to Rose (1996), is really of psychiatry’s own doing. Rose claims psychiatry saw itself as a “know how” of conduct of the 19th century and, as such, was “intrinsically bound to changing the ways in which human beings have tried to govern themselves”(p. 3). Psychiatry developed systems and judgements about conduct and techniques for acting upon behaviour to “improve” human behaviour. In addition to psychiatrists are the many allied professionals or psy-professionals, as they are sometimes referred to (see Newnes, 2013), such as clinical psychologists, social workers, nurses, occupational therapists, general practitioners and so on, who also act as advisors of mental health and who can also act to maintain the status quo (Newnes, 2013).

Rose (1996) argues that the development of the psy-complex has greatly broadened the range of available mechanisms and sites for the social regulation of disorder. Rose states that this had led to the profession being “caught up within a culture of blame, in which almost any unfortunate event becomes a ‘tragedy’ which could have been avoided and for which some authority is to be held culpable”(p.4). This then places political expectations upon the professionals working in the mental health field and has all sorts of implications, for instance, the need to work within a model of risk assessment and to judge patients accordingly.

A literature search in the area of psychiatry reflected that many studies strongly advocate for medication compliance by those diagnosed with schizophrenia, with most of these studies purporting that medication “noncompliance” is a severe problem, causes a “relapse of symptoms” (see Rettenbacher et al., 1999) and needs to be addressed (Fenton, Blyer, & Heinsen, 1997; Gardiner & Hill, 1994; Rettenbacher et al., 1999). Some studies often report recruiting relatives to “ensure medication compliance” (see Rettenbacher et al., 2004). However, what is absent in these studies is the patients’ experience regarding the many reasons they chose not to take their medication. One such reason for non-compliance recognised in the literature is the side-effects of typical anti-psychotics (such as obesity, cardiovascular disease, type II diabetes, decreased life expectancy, blurred vision, dry mouth, trembling, constipation, brain damage, and tardive dyskinesia (loss of control over movements of the mouth, tongue and sometimes other parts of the body), which have been clearly documented by researchers and clinicians and are a serious threat to patient well-

being (Breggin, 1991, 2008; Healy, 2013; Moncrieff, 2008, 2013a,b; Ozbilen, & Adams, 2012; Reynolds & Kirk, 2010; Tschoner, 2007).

One of the main arguments for the use of antipsychotic medication has been that they reduce the “symptoms” of psychoses, such as paranoia, confused thinking, delusions, and hallucinations. On many patient fact sheets (see: “Sane Australia: Antipsychotic Medication,” 2010), taking an antipsychotic is seen as quite a simple process, comparable to people who take medications for asthma, diabetes, and high blood pressure. But research has shown that antipsychotics do not usually improve the quality of life for patients in most cases, and the side effects of the drugs can be a source of distress. Puscher et al. (2006) investigated adherence to medication and quality of life in people diagnosed with schizophrenia. The authors used a multicentre randomized control trial with over 409 subjects. They found no direct relation between medication adherence and quality of life. Their conclusions suggest, rather than focus on medication adherence researchers, clinicians should be focusing more on symptomatic impairment, global functioning and medication side effects. Existing medical research over the last decade has little to show in the way of “miracle cures” or solutions to some of the many side-effects antipsychotic medications carry.

Almost completely overlooked are the causal factors behind “symptoms” to psychoses in those diagnosed with schizophrenia, which Johnstone (1999, 2011) and Read (1997) refer to as the trauma (sexual abuse and physical abuse, and deprivation/neglect). Johnstone (2011) argues that those presenting with “symptoms” of schizophrenia should be offered the same sorts of psychological therapies, which are afforded to others, who do not present with similar symptoms.

Again, the researchers have also neglected to include the meaning behind the experience of the “illness” many of these people are managing with daily. Fortunately, there are professionals out there in the medical field (Breggin, Healy, Moncrieff) who are revealing the truths about medications and their side effects, and these people are gathering quite a momentum. Moncrieff (2013a) highlights a disturbing fact in that antipsychotics, which were once reserved for only the more severe cases, are now prescribed to treat minor ailments, such as sleep disturbance and depression. Moncrieff refers to the increased dispensing of antipsychotic medication as “the newest opium of the people” (p. 21).

Boyle (2002) notes that the need for schizophrenia to exist is important in psychiatry, because it drives medication regimes. Boyle believes this is due to the never-ending quest to find a cure for this “complex disorder,” while in the meantime, acknowledging that “its signs and symptoms may change.” Boyle states that it is evident within the framework in which schizophrenia is understood that there is still a reluctance to consider that the medical profession is pathologising psychotic behaviours and experiences and not seeing them as relational. Despite the fact that psychotic behaviours and experiences appear in social and interpersonal contexts, and “that their form and content are given meaning by those contexts” (p.316). It is not surprising that the relational meaning of behaviour is bypassed in mental health settings, given that the first line of treatment for those who are diagnosed with schizophrenia is medication. According to Boyle (2002), the application of medication to reduce symptoms began simply because nobody knew how to produce a cure.

Hallam and Bender (2011) describe a vivid example of how these scenarios play out in their book, *David's Box: The journals and letters of a young man diagnosed as schizophrenic, 1960-1971*. They discuss the harrowing details of David's life and family history, in particular the loss of David's mother who committed suicide, which nobody talked about in David's family. David was provided with neuroleptic medication as treatment, despite the fact that family therapy was very much in use in the 1960's and acknowledged the links between unhealthy family dynamics of persons diagnosed with schizophrenia. Undoubtedly, the continued pathologising of psychotic behaviours in the absence of relational meaning is preposterous, given the amount of alternatives and theory that exist in relation to the treatment of those diagnosed with schizophrenia.

The mental health field has created many sophisticated treatment strategies with a base of clinical knowledge which have inadvertently neglected to take into account the personal resources and meaningful strategies used by people diagnosed with mental illness to sustain coping ability and strength (Tepper, Rogers, Coleman & Maloney, 2001).

Literature Review in Those Diagnosed with a Mental Illness

This section will review those studies carried out on coping in those diagnosed with a mental illness and, in parts, will specifically focus on those diagnosed with schizophrenia as this sample has been the focus of many research articles on coping. While comparisons will generally try to be made with how coping in psychiatric patients differs from coping in the wider community, it needs to be mentioned that the two samples are dealing with a very different set of life circumstances. Most inpatients and community psychiatric patients, just by

being diagnosed with a so-called mental illness, face a set of challenges and adversities that they need to manage and navigate – e.g., schizophrenia and the stigma, medication regimes and side-effects. Therefore, a comparative analysis is near impossible, because, these are not situations generally people living in the community are facing on a daily basis.

Religion as a Coping Mechanism

This section will highlight where my position on religious coping differs to a number of theorists and researchers in that they do not consider the functional utility of religious coping for those diagnosed with a “mental illness.” As discussed several times throughout this thesis, coping within those diagnosed with a mental illness focuses heavily upon what the person is *not* doing rather than *what they are* doing. The types of coping often reported in the literature are more a descriptive portrayal of the coping response (e.g., particular coping strategies) rather than an evaluation of the functional utility of the type of coping an individual uses. By functional utility of coping, I mean its ability to adequately provide for its intended purpose – e.g., does the particular coping do and achieve what the individual intended it to? There are already a myriad of descriptive “coping strategies” that researchers have identified. However, as described earlier, unless an individual’s overall coping is understood within their context, the entirety of an individual’s coping may be bypassed.

Sullivan (1993) carried out a large qualitative study, which investigated religious types of coping. He investigated the relationship between spirituality and those diagnosed with a “severe mental illness” with 40 participants who were consumers of mental health services. Sullivan found that half of the psychiatric

outpatients perceived their spiritual beliefs and practices as crucial to their psychiatric improvement. The author reported that spirituality served as an effective buffer against negative life events, was a source of social support for some and provided a sense of meaning and coherence to their lives. Therefore, religious coping provided both a coping strategy for an individual and an additional functional utility.

Therefore, if religious coping features within the coping repertoire of an individual, it could well serve as both a coping strategy such as praying to God, and attending church, and have a functional utility. That is, it could be seen as a way of problem solving, or the incorporation of the congregation as a source of social support akin to a surrogate family. As Sullivan (1993) suggests:

“... the role of spirituality as a framework can help people understand various life events such as death and provide meaning in one’s life” (p. 128).

Seen in this way, religious coping provides an interpretive framework for the individual to make sense of their existence, and this, in itself, is a way of coping. To elaborate on this point further, Sullivan suggests that when religion/spirituality is seen as a “coping process,” it can potentially lift individuals of their burdens in that a higher power is employed for guidance and assistance in times of need. Sullivan claims that in his study coping strategies such as “prayer” were a crucial part of the patients lives, which by its utilisation offered functional utility, as seen in the excerpt below:

“I can pray and ask the Lord to get rid of the voices and to help me relax”
(p. 129).

Therefore, an individual's spiritual/religious life might be a very important variable to consider in coping with day-to-day activities and might determine what helps an individual.

Gettis (1987) in his article, *The Jesus Delusion: A Theoretical and Phenomenological Look*, reviewed the writings of Karen Horney and Alfred Adler, which emphasised that the Jesus delusion was more than just "craziness." Gettis suggests that so-called delusions offer *solutions* to an individual's problems and can provide relief from negative emotions and engender feelings of positive emotions, such as joy and importance. But, it is not always the case that religious beliefs are seen as helpful within a psychiatric framework. More often than not, they can be misinterpreted as symptoms of the so-called disorder of schizophrenia, as opposed to a series of behaviours with functional value.

Many researchers and theorists have conflicting views about the role religion serves in those diagnosed with mental illness. Some even go as far as to suggest that religion "detracts" and "worsens" those patients who become preoccupied with religious thoughts. While some research has provided evidence for religion as a positive coping strategy for some people diagnosed with a mental illness, many patients' attempts at using religious coping are still misdiagnosed as "symptoms of a disorder." This is particularly evident for people diagnosed with schizophrenia. Szasz (1974) wrote on this state of mental health: "If you talk to God, you are praying, If God talks to you, you have schizophrenia. If the dead talk to you, you're a spiritualist; If God talks to you, you are a schizophrenic" (p.113). Within the area of mental health the images and thoughts and the role of spirituality are seldom viewed positively or seen as being seen of

importance (Sullivan, 1993). Sullivan states that this can be due to the very individualized nature in which people describe their faith and practice. This perspective then implies very different functional utility for people, but this view is seldom considered within psychiatric frameworks.

The roots of the intertwined nature of religion and “madness” revert back to the identification and prosecution of witches in the 1400s (see Karaemer and Sprenger’s account cited in Read, 2004. p. 13). The manual, *Malleus Maleficarum* (1486), was used to achieve this purpose, and the questions it contained, and subsequent information gathered, over time became known as “truths,” and its effects were long lasting, not unlike diagnostic manuals today. I refer to this briefly to re-iterate a necessary and related point, also made by Moncrieff (2008), namely that, if there are no equally powerful groups to challenge so-called “truths,” then false knowledge eventually becomes established as real knowledge.

Another account, illustrated by Yap (1960), refers to the term “Possession Syndrome” in the mix of generating an accurate diagnosis of a presenting issue. Yap carried out an analysis of 66 Hong Kong Chinese in-patients who were all “showing symptoms of possession in varying degree” (p.114). Interestingly, and reflective of the time, the characteristics predisposing to “possession” were being female, being divorced and female, being widowed and female or being a concubine, along with being illiterate and from low occupational background and low social status. Yap detailed that many of the cases of “possession syndrome” were people suffering from “pseudo-psychotic hysteria,” symptoms that were the result of real environmental difficulties, different cultural backgrounds, and the

belief or absence of belief in possession, and other sources of evil. What is interesting about this older study is that although it investigates the “phenomena of possession” and puts a diagnostic angle to the presenting complaints, Yap took into consideration the many variables (behaviour, contextual cultural), which influenced the phenomena of “possession”. He reported on the outcomes of the study explicitly so they reflected behaviour and cultural context, something that is missing in much of the mental health literature to date.

McAll (1971) also acknowledged the role of spirituality and makes mention of case studies which detailed accounts of people becoming “freed” from their apparent “madness” through exorcism or religious beliefs. Unfortunately, today in the area of mental health, if you are not coping and happen to be admitted to a psychiatric facility and you speak of the Bible and God in ways which others may term “religiose,” you may be viewed as displaying a symptom of schizophrenia.

Most of the studies investigating religious coping in those diagnosed with a mental illness are of samples comprising mainly those with diagnoses of schizophrenia. However, individuals diagnosed with schizophrenia, major depression, have been found to use more religious forms of coping over other forms of coping and this has been mainly attributable to their overall loss of hope. Over the past few decades an increasing number of research studies have explored the relationship between the role of religion, spirituality and mental health.

The use of religion as a way of coping is not a “new” phenomenon, as documented above. Recent research has demonstrated that religious belief can be an adaptive coping mechanism for people diagnosed with mental illness (Ano &

Vasconcelles, 2004; Bergin, Masters, & Richards, 1987; Crossley, 1995; Koeing, 2009; Pargament, Koeing, Tarakeshwar, & Hahn, 2004; Ruchita, Parmanand, Dandeeep, Kumar, Malhotra & Tyagi, 2011; Phillips & Stein, 2007; Smolak, Gearing, Alonzo, Baldwin, Harmon, & McHugh, 2013; Sullivan 1993). A few studies highlighting the literature on the use of religion as a coping strategy are discussed below.

Certainly, there are supporters of the position that religion contributes to schizophrenia, such as Borrás et al. (2007). They examined how religious beliefs and practices impacted medication compliance and illness representations in those diagnosed with chronic schizophrenia. In a sample of 103 stabilized, diagnosed chronic schizophrenia patients (87 men, 13 women, and 3 unknown gender), several religious groups were represented: 58% were Christians, 2% Jewish, 4% Muslim, 14% Buddhist, 14% belonged to “minority religious movements,” and 19% had no religious affiliation. The authors reported that two thirds of their sample considered spirituality as an important part of their everyday life, although the patients who reported religious representations of patient illness were “less compliant” to medication adherence. Borrás et al. discussed these findings as “problematic,” in the context of adherence to medication treatment regimes. This was mainly because the use of religion and spirituality shaped patient attitudes, they believed, in an “unfavourable” way towards the use of medication. However, the very efforts patients used to manage their difficulties were ignored. A more worrying conclusion made in the Borrás et al. study was their recommendation that clinicians develop a “shared representation of illness” to increase medication compliance.

Tepper et al. (2001) carried out a study to examine the prevalence of religious coping among people diagnosed with “persistent mental illness” and to gain a preliminary understanding of the relationship between religious coping, symptom severity and overall functioning. A total of 406 individuals diagnosed with a mental illness, who were patients at 1 of 13 mental health facilities in Los Angeles, completed a survey consisting of the Religious Coping Index, the Symptom Checklist 90-R (SCL-90), the Global Assessment of Functioning (GAF) and a 48-item demographic questionnaire. The results revealed that more than 80 per cent of the participants used religious beliefs or activities to cope with daily difficulties or frustrations, highlighting, yet again, that religion is a well-utilised strategy for people diagnosed with a mental illness.

Ruchita et al. (2011) measured spirituality/religiousness and its relation to coping skills in patients with diagnoses of “residual schizophrenia”. The study was a cross sectional design with 103 patients who were assessed on the positive and negative syndrome scale (PANSS) and the Ways of Coping Questionnaire, to gauge their repertoire of coping skills, and then on the WHO Quality of Life-Spirituality, Religiousness and Personal Belief Scale (WHOQOL-SRPB) to assess religiousness and spirituality. The results showed positive reappraisal as a coping strategy had significant positive correlation with all facets of WHOQOL-SRPB. Positive re-appraisal was a dimension described by the authors as giving positive meaning to a situation by focusing on one’s personal growth experience. The results indicated that a spiritual, religious or personal belief system is associated with active and adaptive coping skills in people diagnosed with “residual schizophrenia.”

Finally, Curlin, et al. (2006) reported on a study in which they interviewed 49 health care providers from 6 faith-based and 4 secular community health centres to explore the way their own religious beliefs transferred over to the community members from minority patient populations. The results revealed that having an understanding of religious content helped the staff relate better to patients and understand patient behaviours. Such positive associations between religious understanding and relations with patients lend support to Lamba and Ellison's (2012) emphasised that psychiatrists must take the findings that religion can have positive mental health effects seriously.

Coping in Psychiatric Patients

Overall, as detailed above, there has been very little research detailing the complexities of what coping may be for those diagnosed with a mental illness. Certainly, given the many problems with diagnostic formulations, many of the existing research findings are questionable. This next section to follow will review the literature which helps to shed light on studies which are mostly qualitative in nature and also help to highlight the ways in which coping research has failed to address the overall experience of what coping may be for individuals diagnosed with a mental illness. The two areas, which will be highlighted here, are: "*coping with mental health services*" as much as "*coping with distress/unusual experiences.*"

To date, there have been relatively few qualitative studies on coping in those diagnosed with a mental illness, despite the fact qualitative data can reveal more information about context, meaning and the coping process (Tischler, 2009).

Utilising qualitative forms of investigations enables the “humanity” in coping to emerge and helps researchers grasp the various individual factors associated with coping, as this information is lost in the categorization of coping as adaptive or maladaptive. To generate more meaningful research, Tischler suggested the use of qualitative methodologies in marginalised populations. The approaches commonly used in qualitative research in those diagnosed with a mental illness have ranged from assessing certain outcomes and interventions of programs (e.g., Barnett & Lapsley, 2006; Hasson-Ohayon et al., 2006), to patient views and satisfaction with mental health services (e.g., Goodwin, Holmes, Newnes & Waltho, 1999; Turner & Newnes, 1993). Others have conducted qualitative investigations into the types of major life and chronic stressors that people with severe mental health issues face (e.g., Robilotta et al., 2010). However none have actively addressed using a qualitative approach to what the experience of coping might be for those diagnosed with a mental illness.

Coping with Distress and Unusual Experiences

It seems fitting to begin this section with an excerpt from a man who really summed up what exactly “the origins of unhappiness” might be as he offered a more appropriate answer to the understanding of “distress.” David Smail (1993) in the introduction to his book *The Origins of Unhappiness- A New Understanding of Personal Distress*, Smail outlines why there really are no simple solutions and encourages:

“Instead of looking inward to detect and eradicate within ourselves the products of ‘psychopathology’, we need to direct our gaze out into the world to identify the sources of our pain and unhappiness” (p.1).

Smail (1993) believes the current systems focus too much on “symptoms of illness”, “faulty cognitions,” instead of investigating what could be wrong with a social world which gives rise to these forms of suffering. He explains that individuals may from time to time conduct themselves “pathologically,” however, at their outset they remain “innocent victims of *social* pathology rather than harbourers of some kind of psychological abnormality” (p.1).

As Moncrieff, Dillon and Rapley (2011) state “Madness, misery and distress are experiences that – as far as we can tell – human beings have always faced” (p. 256). However, over the last 200 years coping with distress and/or unusual experiences is now a mutual shared experience with medical expert specialists knowing best. This is, of course, much worse for those people who are diagnosed with a mental illness, as opposed to the wider community, because with an involuntary admission to hospital, an individual forfeits their right to moderate or cope with the behaviour in a way they choose to and often a way which is helpful to them. Having so-called expert opinion make judgement on what is deemed “normal” has impacts on the understanding of self. This notion of “normal” is also heavily intertwined with expert opinions weighing up the *risks* as *potential danger* that needs to be managed (by means of medications or therapy) all in the name of social security (Rose, 1996). This is to say that currently it is perceived by many that distress and unusual experiences are best understood within a “specialist body of knowledge” (Moncrieff et al., 2011, p. 257). As discussed earlier, the notion of “threshold” sparks debates on what actually constitutes an unusual experience or what levels of distress are clinicians using to gauge how one is coping. A case in point is psychosis. Psychotic symptoms in

clinical samples have been shown to occur on a continuum (Straus, 1969). Straus formed this conclusion after collecting data from interviewing “119 acute psychiatric patients” for the World Health Organization International Pilot Study of Schizophrenia. He states “. . . evidence relative to the rating of delusions and hallucinations describes continua of experiences, not discrete phenomena.” (p. 581). Straus (1969) further argued:

“conceptualizing hallucinations and delusions as points on continua rather than as discontinuous entities also allows for more accurate evaluation of the vicissitudes of these symptoms in a given patient over a period of time” (p. 581).

This focus, however, has not been the case in psychology and psychiatry, being heavily influenced by individualistic accounts of paranoia and other forms of distress (Cromby & Harper, 2009). But as Cromby et al. (2013) note: “. . .we use ‘distress’ as a generic term to refer to all the phenomena and experiences that are sometimes called ‘psychopathology’ or ‘mental illness’”(p. 9). This way of conceptualising distress is problematic because it overlooks the role of the environment, social context of the individual and again brings the focus back onto the individual, and something within them that may cause this distress. In psychiatric settings this can sometimes have the adverse effect of interpreting individual’s talk of distress/unusual experiences as nothing more than “symptoms of an illness” (Cromby et al., 2013). Much of the actual experience of the individual is neglected and overlooked, rather than being a process where attention could be drawn to noticing the links between peoples distress and the circumstances of their situations. These approaches have impacted on how an

individual's coping is understood within both the psychiatric framework and, to a large degree, also in the wider community. A better way to understand distress would be to look at patterns of activity and experience, which are helpful or not helpful to the individual in the individual's social and cultural context. Finally, it is not just the actual experiences and accounts, but the *meaning* they have for the individual. As Smail (1993) suggests, this level of understanding lifts any "abnormality" connotation and helps an individual to understand his or her own experience as valid.

As discussed previously, a diagnosis of schizophrenia, or depression for that matter, is really quite an unreliable description of people's problems and experiences. Understanding each person in terms of the unique influences on their development and, especially, their relationships with other people provides further insight into how people might deal with difficulties in their lives. Researchers (e.g., Bracken & Thomas 2005; Double, 2006; Kinderman et al., 2013; Moncrieff, 2008; Summerfield, 2005; 2012a) have also emphasised the importance of recognising meaning in order to understand psychiatric disturbance and to aid recovery. Kinderman et al. (2013) suggested that focusing on and trying to understand peoples' "problems in living" (Szasz, 1960) in the same way as bodily diseases excludes the individual "meaning" in peoples' responses and experiences. This focus on bodily disease prevents people from developing the insight into how they might apply their own coping resources to dealing with their difficulties.

An example of a study that detailed patient accounts of their problems was a study by Estroff, Lachicotte, Illingworth and Johnston (1991). They carried out a qualitative, longitudinal investigation of 169 people diagnosed with severe

persistent mental illness from two large psychiatric hospitals. The sample (53% female) was relatively young, with the mean age being 28, and 80% of the sample falling within the 18-35 year age bracket. The researchers aimed to describe how and why some of these individuals became formally designated as disabled (i.e., became recipients of disability income), while others did not. They hypothesised that an individual's self labelling and ideas about illness might influence their willingness to occupy a sick role and, thus, contribute to different outcomes over time. Their findings reflected that patients' understandings of their problems, more than a formal psychiatric diagnosis, have a strong influence on their views of themselves. In addition, the authors concluded that self-labelling was influenced by many factors that were mainly contextual, experiential and sociocultural in nature. This study represents a strong example of a way to research how one copes.

The value of qualitative investigation into those diagnosed with a mental illness is further emphasised in the work by Harper (1996; 2013). Harper (1996) took a deconstructive approach to previous qualitative investigations of those diagnosed with schizophrenia and highlighted how the phenomena of paranoia came about. Paranoia is often seen as an associated symptom of the diagnosis of schizophrenia, personality disorder and delusional disorder in the DSM-IV. Harper discussed how, even though his belief in paranoia was suspended, this did not reflect that he did not believe in the reality of emotional suffering. Certainly within mental health settings, there is an assumption that if you deviate away from traditional medical protocols, then you will possibly "miss" vital information. Harper pointed out that "distress is always mediated through concepts which are

historically and culturally contingent” (p.425). Therefore, it is not surprising that other researchers have concluded that the approach of diagnosing delusions is not particularly reliable or valid (Bell, Halligan, & Ellis, 2003, 2006).

Harper (1996) also discussed reification of form over meaningless content and that the classification systems of the DSM-IV paid little attention to the “content” of the phenomena and more attention to their “form,” transforming behaviour into “symptoms.” According to Harper, this transformation frequently occurs within mental health inpatient facilities. As a consequence, patients’ interview content, that is, what is talked about in the course of a diagnostic interview, becomes rearranged into a belief, which, in turn, may be converted, if it meets certain diagnostic criteria, into a ‘delusion.’ As such, Harper advocated that discursive approaches are one way of overcoming some of the problems within this area of mental health, because such approaches are non-individualistic. Such approaches look at the discourse used, by whom, what interests are involved and the positioning of the individual within these interests. In focusing on what is actually said (the discourse) and on the possible functions of what is said, and not making the focus entirely about the individual, a discursive model bridges the pathological/normal divide. This approach then puts certain texts, like that of paranoia, in a forum that is culturally available to many, rather than only to a minority of so-called “abnormal” individuals. This type of approach is one solution to the current problems facing mental health systems within western societies.

An example of bridging the pathological/normal divide is a study carried out by Wise (2004) on CBT, psychosis and attributions of irrationality. Wise

claimed that contemporary psychiatry and psychology view voice-hearing as a symptom of psychotic illness. This view is thought to be maintained and perpetuated by the collusion of professionals who pay attention to the lived reality of the voice-hearers' experience. When Wise analysed the transcripts of voice-hearers, it was found that these individuals presented as "rational people" and were "rational conversationalists." Through the transcripts, a degree of "privilege" can be seen, which is locally afforded to a professional version of one of the participant's voice-hearing experiences. Wise suggested that, through a close analysis of actual therapy talk, diagnosed 'schizophrenic' patients might be seriously underestimated by their professional 'helpers,' both in their ability to interact socially and in their cognitive capacities.

A recent study by Ziolkowska (2011) investigated the discursive representation of mental health problems during the first psychiatric interview. The author aimed to analyse patients' and doctors' discursive representations of mental health problems during this first interview. Sixteen psychiatric interviews were recorded over a 12-month period within three psychiatric hospitals in Poland. Each interview was the first encounter between the doctor and patient and was recorded by a separate doctor. The interviews were transcribed and the analysis of the representations of mental health problems was conducted on the part of the interview where the main complaint and the history of the present illness were discussed. The results demonstrated that the doctors constructed illness manifestations mainly in terms of existence and possession, e.g., the existence of medical symptoms and personality traits, whereas patients constructed illness manifestations in terms of action, as dynamic and contextualised processes.

Ziolkowska reported “Doctors’ static picture of illness manifestations eliminates the possibility of exploring the complicated relationship between patients’ and their problems” (p. 123). This finding supports Boyle (2002) assertion that too often the patients’ experience is seen through a diagnostic medical paradigm, as opposed to being seen in the contexts in which they occur.

Coping With Mental Health Services

It is of no surprise that dissatisfaction with mental health services that has arisen over the years. Hudson (1999) states:

“The late 1950s and the 60’s saw a strong civil and human rights movement emerging and growing in many countries and the movement was appalled at the often inhumane and corrupt psychiatric services. In the 60’s and 70’s inmates of the psychiatric hospitals emerged from their incarceration with horrific individual testimonies of the conditions, the barbaric treatments, the brutality...” (p. 136).

As discussed previously there are now the service user movement, which has brought about patient advocacy groups and it is now common practice to have patients’ councils. While overall there have been some major shake-ups and positive shifts within mental health systems, there are also other sets of circumstances relating to mental health services that patients have to “cope with,” such as long waiting times, a number of medical appointments, the negative attitudes sometimes displayed towards those who are diagnosed with a personality disorder (Cromly et al., 2013) and the stigma of attending such services. Along with these, some patients feel that their treatments are not working, e.g., medication and its adverse effects, which they also have to *cope with*.

Within mental health systems there are people who receive treatment from psychiatrists or clinical psychologists who, indeed, do not want this. Either their behaviour is distressing for *others* around them or their behaviour breaks the law in some way, leading them to receive treatment they otherwise did not want. Not always is there malice behind the identification of distress by others. Some are attempts to keep the person safe from themselves and/or others. Nevertheless, once an individual becomes part of the mental health system, they do lose a certain degree of power and autonomy, which produces another set of problems. To follow are a set of studies and their important findings which look at patient's views of mental health services.

A good representation of the views of inpatient service users is presented by Goodwin et al. (1999) who examined the views of 110 patients in adult inpatient psychiatric services in a large rural county in England. Over a 4-year period, semi-structured interviews reflected 13 themes detailing the prominent issues for inpatient service users. These themes reflected that the hospital environment had an influence on patients' psychological well being and that both the formal and informal methods of the hospital system employed to control patients made patients feel powerless. The patients also reported that hospital policies had an impact on their well-being, with patients reporting that they appreciated being able to do basic things which were not usually permitted, such as taking a phone call in the nurses' office. One theme reflected the patients' appreciation of staff that took the time to talk and listen to their concerns, although the patients preferred more formal forms of talking, as in counselling. Basic codes of conduct, such as respect, caring, and sympathy, were reported to

help patients' sense of well-being. Many negative themes reported by patients centred around: feeling imprisoned within the hospital; a lack of information regarding their own treatment by helping professions, including their medication; a lack of informed consent; a lack of information about the effects of medication; and lack of practical help.

The findings suggested that service users' dissatisfaction outweighed the favourable components of their experience and their overall satisfaction with the institution. Goodwin et al. (1999) raised a concern which is relevant today within psychiatric hospitals in Western Australia, namely that, the intentions which create policies for psychiatric facilities are rarely the practice experienced by psychiatric patients. On the basis of these findings, the researchers advocated for more humane and caring practices within psychiatric institutions. However, they acknowledged that even with the best intentions of procedures and practices, this was still perceived by some service users as "coercive."

The strengths of the Goodwin et al. (1999) study lay in the more humane nature in which the research questions were based and the methodology used. One of the advantages of this study was that the authors controlled for bias, which arises if interviews are carried out by people directly involved in patient care and treatment. The interviewers were trainee clinical psychologists and psychology undergraduate students. The confidential treatment of patient information in the study was also very important, as often patients can shy away from answering difficult questions, if they believe that information will go back to their psychiatrist or treating team. Importantly, the methodology of qualitative interview in this study afforded the patients flexibility in their responses.

While it is no surprise that patients were disenchanted with psychiatric services, other issues raised by Goodwin et al. (1999) over 13 years ago are still relevant, namely, the “slow-turning wheels” of the health service, concerns about privacy, and lack of information in relation to medication. Goodwin et al. reported that the patients in their study were not informed about the full effects of their medication and not provided with an understanding of their rights within such systems, a finding which is alarming. Many years later, things are still the same within most mental health facilities in Western Australia, despite best research efforts highlighting the issues patients have raised.

What may seem to be progress, such as informing patients about the various medications they are to be placed on, including side effects of medications, some of which increase the tendency to suicide (see Busch et al., 2010, Creaney, Murray & Healy, 1991; Healy & Aldred, 2005), may not really be progress. Currently, most patients can recite verbatim the names of the medications they are on and the side effects they suffer. This, in part, is due to two main reasons, firstly, the ease of accessible information via the internet and through service-user groups, and secondly, the increase in knowledge along with the “medicalization” of their language around what constitutes a mental illness. For example, what is astounding within current dialogues of some patients (a point raised later in the case studies) is the language employed by patients, which is learnt through being a long-time psychiatric inpatient.

Many patients can recite verbatim the names of prescription medications, although few have “real knowledge” about the effects of such medications or reasons as to “why” they are taking them. They have only their personal

experiences of side-effects, which vary from person to person. The questions must be asked: Is having more knowledge about medications progress? Is this change? Or are we just producing better informed, more aware service users, with exactly the same problems and “enabling” sickness roles and “illness” models, much the same way we were 40 years ago?

An example of a qualitative investigation into both patients’ experiences of mental distress and their experiences of mental health services was carried out in New Zealand by Barnett and Lapsley (2006). Forty young adults, between the ages of 18-29, were administered an interview schedule developed by the researchers. Although the report claimed to cover the broader spectrum of mental health, it focused primarily only on the phenomena of psychosis, in particular, “first episode psychosis” and recovery groups associated with this particular diagnosis.

Although consistent with discursive interpretations of those diagnosed with a mental illness, Barnett and Lapsley (2006) noted “a problem” in their recruiting process, in that some service users who were diagnosed with “non-psychosis” diagnoses reported seeing themselves as just experiencing an array of personal and social difficulties, rather than “suffering a mental illness.” The authors acknowledged that it would have been better not to use the term “mental illness,” as this imposed a conceptual framework over young adults’ mental health experiences. This is a good point and is interesting in that it provides some insight into how these people saw themselves and their difficulties and how they were reluctant to categorize these difficulties on an abnormal spectrum.

Barnett and Lapsley (2006) used a combination of a thematic analysis and the NVivo qualitative data analysis software, a technical aid for conducting qualitative analysis, to identify themes in the study. The patient narratives demonstrated a range of childhood and teenage experiences of adversity and trauma that occurred prior to the development of the mental health problems. These narratives also reflected key themes under this broad category, such as: lack of a safe family atmosphere, feeling unsafe at an emotional level, parents with drug and alcohol issues, loss and abandonment issues, school and peer difficulties, and use of drugs and alcohol to cope with problems.

Another area relating to mental decline and subsequent help-seeking and mental health crises also emerged. The key themes here were: a sustained build up of emotion from childhood; traumatic stressful life events compounding the earlier experiences; and a series of significant life events in close succession. The crises leading to an inpatient admission was another area identified that reflected the following key themes: negative experiences of the inpatient environment; describing nursing staff in acute units; associating with other service users in the unit; safety for women, sexual harassment and sexual abuse in acute units; treatments with a focus on medication and the absence of talking therapies; the need to be somewhere; leaving hospital and returning. In summary, Barnett and Lapsley reported that the participants had developed narrative relationships with mental health services that were ostensibly designed to help them on the road to recovery. This first inpatient experience gave an initial flavour, often a “sour one,” to their subsequent understanding of services, their understanding of what it meant to have a mental illness and their role as service users.

Barnett and Lapsley (2006) also examined the ways in which the participants experienced, tried to make sense of and found their way around mental health services. The researchers described that around 25% of participants reported merely surviving day-to-day following their experiences with mental health services, around 50% reported moving forward, taking concrete steps, but many were suffering the residual effects of the disruption that the experience with mental health services had caused in their lives. Finally, 25% reported living well in the presence or absence of a diagnosed mental illness. This study also revealed two strikingly important aspects of mental health services and recovery, namely, the voice of the consumer and the significant impact of mental health services on the service user. The notable conclusions from the study were that, firstly, some patients chose to identify with problems in living, rather than as having a diagnosable mental illness, and, secondly, that the contact with a service was not pleasant, because the disruption was felt for some time after their contact.

What is evident throughout the qualitative studies reviewed is that there are similar themes in all the qualitative research conclusions. Specifically, “problems in living” as noted by Szasz (1960) as being the causal factor patients report as contributing largely to their difficulties, and that patients usually prefer to identify with “problems in living” rather than a diagnosis of mental illness; the admission to a mental health facility was traumatic in nature and there were long lasting emotional reverberations of an admission, and fear around medication and its ineffectiveness.

Beyond initial first contact there is another issue which plagues the mental health services for those people who have had prolonged contact with services.

This is the development of “psychiatric patienthood,” which is the experience of being a patient, which can take on an identity of its own. Psychiatric patients who have had a number of hospital admissions and received numerous amounts of medications can sometimes become fixated in ‘psychiatric patienthood.’

Summerfield (2001a), in his article *The Man who had 42 Psychiatrists – and Rising- a Memorable Patient*, discussed the difficulty of shifting paradigms for patients who were very embedded in ‘psychiatric patienthood.’ He described a case study and the difficulty associated with trying to help a client move away from psychiatric patienthood to coping as “an ordinary citizen,” concluding that, for most long term service users, this paradigm shift is difficult. Even while trialling the new paradigm for a while, it seems psychiatric patienthood is a well-conditioned phenomena, with most patients eventually returning to “psychiatric patienthood.”

The Meaning of Coping in Psychiatric Patients

While these qualitative studies have highlighted the difficulties which face those diagnosed with a mental illness, there has been little direct research on how these people “cope” and the meaning of coping for them. Boyle (2011) suggested that it is important to consider the impact of peoples’ life experiences and their unique environments, which are a known major cause of emotional distress. According to Boyle, psychology and psychiatry must give credence to “context” in the role of peoples’ lives. Individual factors also need to be taken into consideration, as people differ in how much pain they are prepared to feel and, subsequently, what requires their coping efforts.

Regrettably very little progress has been made in these areas to date. In the context of drug taking, in particular taking an antidepressant medication, Rowe (2003) made a valid point and one that is familiar in many clinical presentations:

There is no pill which can change the memories of an unhappy childhood into memories of a happy one; or turn an unhappy marriage into a happy one; or fill the person who takes the drugs with a permanent, unshakable self-confidence. . . . make the person you love love you; or create a secure peaceful world; or banish death (p. 223).

Rowe further explained that a reduction in awareness, such as taking an antidepressant medication can provide time and space from the issue/s at hand, however, such action will not solve the actual problem. Only the person in their complete state of awareness, and with their insights, can cope with and solve their difficulties.

The systemic infrastructure surrounding the term mental illness in the guise of “help,” e.g., the forever expanding world of psychiatric and psychological therapies (Pierre, 2012), places more emphasis on vulnerability and less on the strengths of an individual, and, in this way, can be harmful to personal coping attempts. While this is not the case for all patients, there are individuals becoming more reliant upon such services and possibly for the wrong reasons. There has been a significant increase in the number of people diagnosed with depression, however, it is unknown exactly how many of these people are actually depressed. Within Western Australian psychiatric systems, mainstream ‘psychology thinking’ is, in some cases, as ‘medical model’ as mainstream psychiatric thinking. Both, in practice, see the mind as if it were an organ, which

can reveal itself through a technical intervention. Boyle (2011) in her review on psychiatry and psychology believes that both disciplines are responsible in converting distress and problem behaviour to ‘symptoms’ and ‘disorders’ and she believes that this is one of the purest avoidance strategies within psychiatry. Boyle does not exempt psychology from this process either and holds psychology accountable for its great many ‘intra-psychic’ approaches, which usually characterise people using mental health services with ‘abnormalities’.

There are certain individuals who have endured considerable distress, for which the utilisation of Cognitive Behavioural Therapy (CBT) would be insufficient to assist the patients’ concerns in its entirety. Aspects of the CBT approach, in particular its “change your thinking” approach, implies at a level that by changing thoughts, a myriad of problems in one’s life may be overcome (Elderman, 2013). This approach, to a certain extent, may render the most distressed patient powerless in their own process and often, when therapy fails to assist, from clinical experience, it can also leave patients disheartened and with thoughts of “failure.” There are aspects of CBT that are useful, such as reframing ones thoughts and situations in order to help understand triggers for various feelings, and the behavioural aspects of engagement in more pleasant activities. Although CBT as a stock standard inpatient therapeutic tool alone, again focuses on the individual and not so much on the context of individuals. The reality is that for many people who have suffered childhood trauma, or people from war torn countries seeking refuge, CBT approaches alone in some cases will not offer suffice explanations, as such people have endured a journey that alters mind, body and spirit.

Boyle (2011) believes the CBT approach fails in its persistence to focus on the present, particularly in the framework of “triggers” which bring about the negative experience for a person. This lack of emphasis on the “past,” and the historical context of presenting problems, does not fully acknowledge distress.

The psychologising of everyday problems into major mental health problems is not promotive of coping. For example, in Australia, accessing “psychological help” has never been easier through the “Better Access” schemes, whereby people can receive discounted psychological intervention via their general practitioner. Through a Mental Health Care Plan, for up to 10 government-subsidised psychological sessions per calendar year (originally up to 18 per calendar year, but in 2013 was cut to 10), people can enjoy a myriad of cognitive behavioural interventions to help them overcome many “*disorders.*” Australia is not alone in providing such access. In the United Kingdom there was the Layard (2006) initiative to increase access to psychological therapy, because anxiety and depression are now seen as the major causes of misery in the United Kingdom today, without there being any real investigation into the real causes of misery for people.

Summary

In summary, I will now bring clarity and state what can and cannot be inferred from the literature as it exists. This thesis aims to shed light and knowledge to the area of “coping” in those diagnosed with a mental illness. This area to date has been under researched within psychology and psychiatry.

Firstly, in relation to coping theory, it is well recognised in the many research studies evaluated for this PhD that Lazarus’s theory (1966, 1999) is the

so-called grandfather of the coping literature and his position is still current in the coping literature. His position still considers that coping thoughts and actions under stress must be measured separately from their outcomes, in order to examine independently their adaptiveness or “maladaptiveness” for the individual. This is the same position the current thesis holds. This PhD considers the context of coping, which sits comfortably within Lazarus’s theory, in that whether a coping process is good or bad, adaptively speaking, depends on the particular person, the specific type of encounter in the short or long run, and the outcome modality being studied, for example moral, social functioning or somatic health. This thesis aims to demonstrate that there may be no universally good or bad coping process, though some might more often be better or worse than others. Measuring coping attempts as a success or failure is problematic within psychology and psychiatry and does little for individual improvement in functioning. Measuring an individual’s failures may inadvertently convert patient distress or “unusual experiences” into “symptoms of a disorder” rather than as behaviours occurring as a reaction to living circumstances, relationships, etc. Therefore, the environment plays a large role and coping is best seen within its context, as opposed to occurring within the individual.

The way coping has been researched and understood in the past has been problematic in the area of mental health, and is not fully understood and realised within the professions of psychology and psychiatry, with current research yet to enable researchers to move forward in understanding psychiatric patients’ accounts of what coping means to them. There is only one known study by Cohen and Berk (1985), which attempted to look beyond the current medical paradigm in

terms of exploring the methods patients employ to control distress. When research is evaluated from both community and psychiatric samples, it appears that the research in the community samples has focused on the differences in coping strategies, in particular with university populations. By contrast, coping literature in psychiatric populations has focused on what those people diagnosed with a mental illness are *not* doing. In particular, those diagnosed with schizophrenia have dominated this research section, yet there is ambiguity in research findings (see Cohen & Berk, 1985). Religion as a type of coping strategy has been mostly overlooked and portrayed rather negatively in many mainstream psychiatric settings and the literature. It is proposed in this thesis, that the incorporation of religion as a coping strategy may be effective for psychiatric patients, and, indeed the wider community, because it provides an interpretative framework for a person to make sense of their existence, and this, in itself is a way of coping.

“Coping” as it stands within psychiatry and psychology, in terms of those diagnosed with a “mental illness,” is a set of “symptoms” of an “illness” and involves “treatment.” This approach is not helpful or, in fact, even useful, if the context of the presenting problem is not acknowledged and understood. As detailed previously in this chapter, this view of coping within a psychiatric population is heavily connected to the medicalization of everyday problems and the large role the “medical model” plays within psychiatry. Individuals are “seen” within this “medical framework” and, thus, symptoms are seen as occurring “within the individual” with much focus on the “abnormal,” without reflection into the social environmental and familial contexts. The “hardest hit,” so to speak, are those who end up with “big” diagnoses, such as “schizophrenia” and

“psychoses,” because they are treated predominantly within a medical framework. This approach bypasses the meaning of coping for an individual, which ultimately invalidates their entire experience. There is little attention within the literature on coping regarding how psychiatric patients cope with unusual or distressing experiences and also how they cope with being a patient within the mental health services of Western Australia. These points need serious re-examination, because the meaning of the coping experience as it stands, both theoretically and practically, does not do justice to the complexity of what coping might be for psychiatric patients. A truer understanding of the many meanings and themes around coping, therefore, needs to be explored.

In the research evaluated it is difficult to get a single view or approach to the meaning and measurement of coping in a psychiatric population. What we can infer from the literature reviewed thus far is that the term ‘coping’ has been used in many different ways and it does not lend itself well to drawing comparisons from study to study. However, this deficit also has been seen in the nature of coping research, primarily due to the inconsistent use of the term “coping,” and the ways in which the dimensionality of coping has been measured and analysed.

There is an extensive amount of research within psychiatric populations devoted to “those diagnosed with schizophrenia” of which all studies are, by definition, fundamentally flawed, given that as others have concluded, all psychiatric diagnoses are moral judgements (*pace Szasz*). Many of the ‘coping strategies’ per se have been construed rather negatively in those diagnosed with schizophrenia without any thought given to the functional utility of these

strategies in the context of their environments. One can not infer a coping strategy is 'maladaptive' or 'unproductive' without reference to the environment in which it is used and the outcome for the individual.

To date there is no clear data on what constitutes coping in a psychiatric population or a clear set of functional 'coping strategies.' This is possibly due to the problems of coping being a multi-referential lay construct. Boyle (2002) viewed the label schizophrenia in the same way and cautions about the problems associated with using lay concepts in the way in which they were not intended. Coping is one of these, especially as the familiarity of this word means that it can mean different things to different people. However, for the researcher, it may, as Boyle (2002) states, "blunt our critical faculties" (p. 8), when it comes to assessing the construct.

While possibly not as problematic for understanding coping in the wider community, it is within the area of mental health that, clinically, many patients' attempts at coping are going unnoticed and, instead, coping efforts are being misinterpreted or ignored. The verdict from inpatient mental health service users of hospitalised therapeutic assistance is not at all complimentary. The evidence has established that psychiatric patients find the healthcare system less than supportive of their 'coping' efforts. Moreover, there is considerable evidence of the stigmatizing effects of being a "psychiatric" patient in the first place. In searching for a way forward we need to relinquish the diagnosis and labelling associated with "poor coping." A more sensible approach might be to ask people about the sorts of things they find difficult to manage in their lives, and then,

based on this information, work backwards to understand the “meaning” and then provide, *if necessary*, the required “help.”

Throughout this chapter, an attempt has been made to convey the concept of coping as multifaceted. Moreover, the emphasis has been that in order to fully understand what the concept of coping means for those diagnosed with a mental health disorder, coping within these contexts around the term “mental illness” needs to be understood. The concept of “coping” or “not coping” has been understood by various people to mean different things, as evidenced by the way religious coping is viewed in those diagnosed with schizophrenia. What is clear across the literature on coping is that the understandings of what coping means to the profession are dependent upon the prevailing ethos of the times. Other influencing factors are vested in the bias of the profession as it is shaped by culture, politics and economics (Smail, 1993). What is also evident throughout all the historical literature is that if information is relayed over and over for a period of time, regardless of its reliability and validity, it forms a “truth,” and these truths get woven into the fabric of society and form part of the way we live, unless severely disputed. As Summerfield (2004) noted, the Western version of the self has gone from one of resilience and strength to one of vulnerability and requiring help.

It would seem that the assumptions that psychiatry and psychology make about “coping” do not do justice to the complexity of what coping might be. In the literature there are those who heavily contest the use of a diagnostic paradigm and heavily contest diagnoses, especially schizophrenia. The actual daily experience of being a patient is largely absent from mainstream psychology and

psychiatry. The central question I put forward in this thesis is whether it makes sense to measure coping, and, if so, whether it can be measured in a way that adds meaning to coping for these patients. What we have seen so far that is built into the current measurement of coping is a set of very difficult and very problematic assumptions about “mad” people and their lives. These assumptions beg the questions: Are there more constructive ways to think about coping in those diagnosed with a mental illness? And how can we better understand the social and cultural factors contributing to the concept of coping? Can we find ways of helping that do not implicitly accept medicalised explanations of the reasons contributing to poor coping in those diagnosed with a mental illness?

Investigations into the meaning and measurement of coping for those diagnosed with a mental illness have, to date, not asked individuals genuinely how they are coping and what coping means for them. Questions such as, “What things do you find the most difficult to deal with in your life? Are there any particular situations that you find difficult to manage? What sorts of things do you do to manage difficult situations? When do you use the (various) approaches you have described and which works best? And when do the other approaches work best?” As Boyle (2002, 2011) strongly urges, “Stop with the avoidance strategies,” i.e., ignoring context and converting distress into symptoms of “disorders,” and start to ask people genuinely how they are coping and what coping means for them. This clarion call has provided the impetus for the current thesis.

CHAPTER 3

The Measurement of Coping

Preamble

There are many issues to consider when measuring the concept of coping, as discussed in the previous chapter. For example, how coping is defined determines what type of coping is measured, e.g. a coping strategy vs a coping style. The measurement scale is also of importance, because a scale with a number of response options is likely to capture a range of coping, as opposed to forced-choice response sets whereby coping strategies could be missed. Coping can also be measured in relation to a specific event versus coping with a situation in general. In summary, the literature details various studies that have used very different coping scales and methodologies, which make statistical comparisons difficult. However this could also reflect the very difficult nature of measuring a concept like “coping.”

This chapter aims to address some of the issues in the measurement of coping and the way coping has been measured (breadth, dimensionality, variability and generality of coping measures), what constitutes good validity, along with a review of the major coping scales currently used presently within psychology and psychiatry.

Important Issues in the Measurement of Coping

The measurement of the concept of coping mirrors the theory of coping, and, thus, two major approaches have led the way. Steed (1998) in *A Critique of Coping Scales* (1998) refers to two major debates in the assessment of coping. The first is whether coping should be conceptualised as a trait-like personality

characteristic or as state-like response to a specific stressor. The second is over the use of general scales, as opposed to situation-specific scales, to measure the construct of coping.

Both approaches carry with them assumptions about the different ways coping is thought to occur, with the trait approaches towards coping tending to assess coping traits and trait styles rather than processes. Lazarus and Folkman (1984) define coping traits as: "...properties of persons that dispose them to react in certain ways" (p. 139). For example, researchers who have measured coping from a trait perspective have used measures such as the NEO-Five Factor Inventory (FFI) to assess personality related to health outcomes. As discussed at length in Chapter 2, the problems with intra individual approaches is that they do not taken context into consideration. As the literature currently stands, the most extensively used measure of coping (e.g., WAYS) is based upon Lazarus' theory of stress and coping.

Researchers in the coping field urge those measuring coping to consider issues such as stability, generality and dimensionality (Schwarzer & Schwarzer, 1996). Stability refers to the consistency of an individual's coping behaviour over time. Generality refers to assessing whether people apply the same strategy when they face different situations. Dimensionality refers to the way coping strategies are grouped on the basis of purpose, meaning or functional value, for example, the way coping has sometimes been referred to as either problem-focused or emotion-focused (Billings & Moos, 1984; Folkman & Lazarus, 1980). The dimensionality of coping has been acknowledged by several authors (Lazarus & Folkman, 1984, Lazarus, 1966, 1999, 2000. Lazarus (1966) discusses the multidimensional nature

of the coping concept and concludes that there are many aspects to measuring one's coping behaviour, which underestimate the complexity and variability of coping efforts. Steed (1998) also acknowledges the difficulties with creating discrete categories for coping and the disagreement occurring within the literature over the optimal number of categories.

Steed (1998) also recognises that choosing a scale for a specific study is difficult and the researcher is faced with a number of coping measures from which to choose and whether to choose specific or general measures of coping. Specific scales are designed for specific types of stressful situations, such as trauma, marriage, parenting, finance (Pearlin & Schooler, 1978), and are less likely to be applicable to a variety of situations. For this reason the use of general measures is preferable. The advantages of general measures are that they allow the comparison of a number of coping strategies across various stressors. However, the reality is that neither a specific nor a general scale is likely to capture the whole coping repertoire and some coping strategies may be missed. Currently, researchers (e.g., Frydenberg & Lewis, 1994; 1997; Schwarzer & Schwarzer, 1996) widely concur that individuals may generalise their coping strategies across situations to a certain degree and possibly reapply these strategies at a later occasion. However, individual differences play a large role when generalising coping responses.

The variability in the measurement of coping and gaps in the research on coping make it difficult for direct comparisons between studies to be made (Endler & Parker, 1990; Felsten, 1998; Folkman & Moskowitz, 2004; Keyes, 2007; Ptacek, Smith & Dodge, 1994). Indeed, the methodological shortcomings of

most coping scales reflect more basic underlying conceptual problems regarding the coping construct (De Ridder, 1997). For example, coping checklists encompass too narrow a conception of coping, resulting in incomplete and distorted measurement of coping (Coyne & Gottlieb, 1996). Therefore, a combination of both qualitative and quantitative measurement is likely to more effectively measure coping overall, than reliance on a single scale.

“Good validity” of a Coping Scale

A coping scale is valid if it measures what it is intended to measure in the specific study. Given that self-report measures have been used widely in the measurement of coping, the extent to which such measures predict actual coping behaviour has been investigated. Research has shown that there is a moderate to high probability that coping style scores accurately relate to the use of behavioural strategies in response to both physical and psychological stressors (Miller, 1987; Steed, 1998). But, existing coping measures differ in a number of important ways. Any particular instrument generally reflects how coping is defined, the theoretical assumptions employed and whether the coping that it is attempting to assess is in relation to a particular stressor or not. Generally, the instruments developed reflect the complex nature of the measurement of coping and the validity of a scale is study specific and therefore, must be considered each time the particular coping scale is chosen for a new study. This ensures “good validity” of a coping scale.

An Overview of Coping Scales

Designing coping scales to measure every element of the coping repertoire, which is multidimensional, multi-layered and individual is a difficult task. Despite

this, there has been a surge in new coping instruments, reaching almost saturation point. This thesis used the definition of coping as a process and, therefore, only scales that also were based on this definition will be reviewed in this chapter.

Choosing a scale to measure coping can be difficult and researchers face many problems with this decision. Steed (1998) recommended choosing scales that minimise some of the problems commonly encountered with coping scales. Specifically, Steed suggested that items should be evaluated for content confound, and possess equal numbers of cognitive and behavioural items, consider the possibility of ceiling effects, use more than one response format and that researchers should define the coping period when writing instructions for respondents. As discussed, when conceptualising coping as either problem-focussed or emotion-focussed, it is important to take into account that less threatening stressors may reduce emotional distress and, similarly, when emotional arousal is managed well, the individual's resulting efforts at problem solving will be smoother. Steed (1998) suggests that a particular coping strategy may carry out further functions, that is, it may serve to fulfil varying functions for other individuals in the same situation, or varying functions for the same individual over time. In effect, Steed suggests that it is the individual involved who determines the functional nature of coping and inevitably, this poses a challenge for the measurement of coping based solely on quantitative scales.

As with most concepts such as "quality of life," "stress," and "coping," a number of instruments have been designed to measure them. In the last 20 years there has been a profusion of scales developed to measure coping. More recently (2010-2013), there has been a surge in coping inventories designed to measure

specific aspects of coping in those diagnosed with schizophrenia. An example of one such scale is the Heidelberg Coping Scale for Delusions, designed to measure individuals coping with a symptom under the label of schizophrenia. Just to demonstrate how awry this has all become, two tables below will demonstrate the entirety of coping instruments in the literature to date. The list, is of course, not all-inclusive, however this review has concentrated on the major coping scales used in the area of mental health. Cohen (see Monat & Lazarus, 1991, p. 231) provided a historical table, which allows the reader to see which measures were developed and used prior to 1991. These measures are presented in Table 3.1.

Table 3.1

Coping Scales From 1959 to 1986 Adapted from Cohen (1991; cited in Monat & Lazarus, 1991).

Scale	Reference
Coping-Avoidance Sentence Completion Test	Goldstein (1959)
Rorschach Index of Repressive Style (RIRS)	Gardner et al.(1959); Levine and Speivack, (1964)
Repression Sensitisation Scale	Byrne (1961)
Modified Repression-Sensitization Scale	Epstein and Fenz (1967)
Defense Mechanism Inventory	Gleser and Ihilevich (1969)
Cohen Avoidance-Vigilance Interview	Cohen and Lazarus (1973)
Denial Scale	Hackett and Cassem (1974)
Coping-Defense Measure	Joffe and Naditch (1977)
Repression Style Index	Weinberger, Schwartz, and Davidson (1979)
Ways of Coping Questionnaire (WAYS)	Folkman and Lazarus (1980)
Coping Measure	Billings and Moos (1984)
Coping Flexibility	Kemeny (1985)
Assessment of Coping Modes	Cohen et al. (1986)

A summary review of the literature over the last two decades revealed the following additional coping scales, shown in Table 3.2.

Table 3.2

Coping Scales From 1986 to 2013

Scale	Reference
The COPE Inventory (COPE)	Carver, Weintraub, and Scheier (1989)
Multidimensional Coping Inventory (MCI)	Endler and Parker (1990)
Religious Coping Activities Scale (RCAS)	Pargament (1991)
The Adolescent Coping Scale (ACS)	Frydenberg and Lewis (1993)
Coping Styles Questionnaire (CSQ)	Roger, Jarvis and Najarian (1993)
Ways of Religious Coping Scale (WORCS)	Boudreaux, Catz, Ryan, Amarai-Melendez, and Brantley (1995)
Coping Scale for Adults (CSA)	Frydenberg and Lewis (1997)
Religious Coping Scale (RCOPE)	Pargament, Koeing, and Perez (2000)
Coping With Surgical Stress Scale (COSS)	Walter (2000)
Depression Coping Self-Efficacy Scale (DCSES)	Perraud (2000)
Brief Resiliency Coping Scale (BRCS)	Sinclair and Wallston (2004)
Coping Attitudes Scale (CAS)	DeJong and Overholser (2007)
Paediatric Cancer Coping Scale (PCCS)	Wu, Chin, Chen, Lai, and Tseng (2010)
Adolescent Religious Coping Scale	Bjorck, Braese, Tadie, and Gililland (2010)
Youth Coping in Traumatic Times (YCITT)	Paasivirta et al. (2010)
Perceived Ability to Cope With Trauma (PACT)	Bonanno, Pat-Horenczyk, and Noll (2011)
Mindful Coping Scale (MCS)	Tharaldsen and Bru (2011)
Heidelberg Coping Scale for Delusions	Ruckl et al. (2012)
Problem-Focused Style of Coping Scale (PF- SOC)	Chang, Lan, Lin, and Heppner (2012)
Meaning Focused Coping Questionnaire (MFCQ)	Gan, Guo, and Tong (2013)
Student Coping Scale	Boujut (2013)

The above coping scales in Table 3.2 reflect the recent contributions to the measurement of coping in the literature, for example, The Meaning Focused Coping Questionnaire (MFCQ). A review of the MFCQ's factor analytical results suggests that the scale measures a dimension that the authors consider to be coping but is, in fact, different from coping, that is, the way an individual evaluates a situation and reconciles their beliefs and goals in relation to that stressful situation. This scale appears to be measuring something other than coping, as constructed by theories of coping within the current psychological literature (Folkman & Lazarus, 1984; Lazarus, 1966).

In addition to the psychological and psychiatric scales, a number of other scales with low psychometrically measured reliability, have been devised to measure coping over the last two decades, particularly in the area of nursing such as: Depression Coping Self-Efficacy Scale (DCSES), (Perraud, 2000; Carpinello, Knight, Markowitz, & Pease, 2000); and the Brief Resilient Coping Scale (BRCS), (Sinclair & Wallston, 2004). These scales appear to have good face validity. However, on further examination, they are fraught with confounds. For example, the DCSES, which reports to assess depression, coping and self-efficacy levels, relates them to levels of depressive symptoms and global functioning, during and after treatment. Perraud (2000) developed the DCSES, to measure the coping self-efficacy of depressed psychiatric patients. The author states that item development “. . . arose from an extensive review of the literature and a survey of nurse experts for identification of coping actions for depressed patients.” (Perraud, 2000, p. 276). This approach to item development is concerning, as members of only one allied health profession, i.e., nurses, were surveyed for their input into

identification of “coping actions.” Another concerning factor is the potential procedural confounds associated with the use of a variety of procedures to elicit patient responses, including administering the scales by interview. While the authors suggested that their analyses supported the use of the DCSES to measure coping self-efficacy of depressed psychiatric patients, there is insufficient evidence in their paper and subsequent to this paper to support its reliability and validity.

Coping Scales and Their Literature Review

The more extensively used measures of coping are based upon Lazarus’ theory of stress and coping which has enabled coping scale development to be guided by theory, as opposed to measuring random coping strategies someone thought “may” have been useful, e.g. see above criticisms of the DCSES. The more popular coping scales used in health setting and mental health settings have been: The Ways of Coping Scale (WAYS-Revised), Folkman and Lazarus, 1988; The COPE Inventory, (COPE), Carver, Weintraub and Scheier, 1989 and the Coping Response Inventory, Moos, (1992).

The COPE Inventory (COPE), by Carver, Weintraub and Scheier (1989) is a measure of coping designed to assess “ineffective” and “effective” coping. It has been used in many health-related settings. It was developed based upon both Lazarus and Folkman’s (1984) stress and coping model and also partly from the researcher’s own model of behavioural self-regulation. The full COPE is a 60-item instrument with 4 items per scale. This scale has been reported to be problematic in inpatient settings because of the time taken to complete it and, therefore, much development has gone into briefer versions of this scale. Carver et

al. (1997) reported that the “impatience” noted by patient respondents to the full COPE scale prompted the scale developers to reduce the scale to 3-items per scale (Carver et al, 1993), and then to its current 2-item, 14 scales questionnaire. The data reported on the 2-item scale is from a sample of community residents who were participating in a study on response to the natural disaster Hurricane Andrew. This sample consisted of 168 participants (66% female, 40% non Hispanic whites, 34% African Americans, 17% Hispanics and 5% Asian) who were recruited from the community that had been seriously affected by the hurricane, therefore, a convenience sample as opposed to a random sample. This sample did have the added advantage of being a non-student sample under a great deal of stress. The Brief COPE was administered to this sample on 3 occasions (first, between 3-6 month’s, second, after 6 months, and third, 1 year later). The Brief COPE scale proved to be somewhat reliable and, despite having only 2 items per scale, items reportedly met or exceeded the 0.50 regarded as minimally acceptable for item reliability. An exploratory factor analysis with an oblique rotation to permit correlations among the factors was carried on the small sample of 168 participants; it yielded nine factors with eigenvalues greater than 1.0, which together accounted for 72.4% of the variance in responding. The four a priori scales formed factors: Substance Use, Religion, Humour and Behavioural Disengagement. The use of emotional support and use of instrumental support formed a single factor. The authors note that this scale in this form is a good tool to be used mostly with coping in naturally occurring settings with time demands.

The Coping Response Inventory (CRI) by Moos (1992) has two main conceptual approaches to classify coping responses. The first approach is the

focus of coping, which is the person's orientation and activity in response to a stressor. The second approach is the method of coping that the person employs, e.g., cognitive or behavioural efforts. Both of these approaches combined make up the CRI. The CRI organises coping into eight dimensions. The first four dimensions measure approach coping and the second four measure avoidance coping. The first two indices in each domain reflect cognitive coping efforts; the second two indices in each domain reflect behavioural coping efforts. Each of the eight dimensions consists of six items and respondents select a stressor to focus on and rate their reliance on each of the 48 coping items on a 4-point scale from "fairly often" to "not at all." The CRI has been used in investigating coping behaviours of problem drinkers (Moos, Brennan, Fondacaro, & Moos, 1990). Outcomes of the CRI are most useful for a specific type of situation and where coping with that particular individual life stressor is measured and focused on. Moos (1995) describes the framework of the CRI as a dialectical view of change necessary for human development, taking the view that life crises are confrontations that can challenge an individual and provide an opportunity for growth. Holahan and Moos (1990) demonstrated that indeed some individuals show an increase in personal and social resources, possibly due to positive feedback from effective coping with stressors. Given the different theoretical orientation of this scale and its applications to more individual specific stressors, it is more suited to a longitudinal study design in that repeated administrations may yield richer data. For these reasons, it was not used as a measure of coping in this thesis.

The WAYS of Coping Questionnaire (WAYS, Folkman & Lazarus, 1988) is a popular and widely used measure and can be administered via self-report and also by an interviewer (e.g., De Ridder, 1997; Parker, Endler, & Bagby, 1993). This scale reflects Folkman and Lazarus' transactional theory of stress and coping and is meant to be used in relation to a person's particular, specific stressful encounter. The person then reports all coping efforts in relation to this encounter and these are then categorized into either emotion-focused or problem-focused efforts. The WAYS can be purchased on Mindgarden.com and the website details its application and uses:

The WAYS can help counselors work with clients to develop practical coping skills by evaluating their process, their strengths and weaknesses, and providing models of alternative coping mechanisms. The WAYS is excellent for research on coping . . . (see "WAYS:Mindgarden.com." n.d.).

The interpretations of coping in this way, is that especially in mental health clinical settings, people's weaknesses are more prone to be converted into diagnoses. Therefore, an individual's "coping" is reflected by "the scale" and experts' interpretation thereof. The measurement of coping in this way is problematic in it involves categorising coping efforts as adaptive and maladaptive. As discussed earlier, this view of "not coping" and judgements on coping efforts, especially in the area of mental health, is troublesome in that it allows for misinterpretation of an individuals attempts to manage difficulties in their life. As Lazarus and Folkman (1984) state, "all other sources of data have most of the same drawbacks as self-report regarding the validity of inferences about psychological process" (p. 322).

Parker, Endler, and Bagby (1993) sought to evaluate the replicability of the Ways of Coping Questionnaire (WAYS) by using confirmatory factor analysis with a large sample of subjects coping with a homogeneous stressor. The authors claim that the population (a college sample) and the stressor (preparing for an upcoming exam) were identical to those selected by Folkman and Lazarus (1985) for their study. Two separate studies were conducted. The first study involved 530 college students who completed the WAYS before a mid term exam. Six different theoretical models, corresponding to the various dimensions of coping as assessed by the WAYS, were tested for goodness of fit again using confirmatory factor analysis. The authors reported that none of these coping models were good representations of the data, with the oblique versions representing a better fit than the orthogonal versions. The parameter estimates for the relationships among the factors for the six-factor 42-item model were quite high across the models (from 0.27 to 0.86, with a mean of 0.56) and for the eight-factor 42-item model (0.08 to 0.86, with a mean of 0.50). The eight-factor 52-item model parameter estimates ranged from 0.12 to 0.84 with a mean of 0.58). All provided “weak evidence” for the multidimensionality of coping processes. The authors contended that, based on these results, their findings suggested that the relationship among the various factors on the WAYS is a problematic feature of the scale. They argued that the parameter estimates in several cases were “unacceptably high,” contradicting the theoretical assumptions underlying coping dimensions proposed by Folkman and Lazarus (1984). For example in the 42-item eight-factor model, problem-focused coping was related to an emotion-focused coping dimension (emphasising the positive coping strategy).

A second study by Parker et al. (1993) aimed to derive a replicable set of coping dimensions, using a series of exploratory factor analyses with the data collected in study one. A 4-factor model was derived and then tested for goodness-of-fit with a separate sample of 392 college students who were also embarking on exams. This 4-factor model proved to also misrepresent the data. The parameter estimates for the relationship among factors for the oblique 4-factor model offered some empirical evidence for the multidimensionality of coping responses assessed by the 38 critical items (estimates were low to moderate, 0.14 to 0.64, with a mean of 0.35). These findings suggest little empirical support for the WAYS models proposed by Folkman and Lazarus (1985, 1988). The authors suggest that “. . . the failure of the WAYS factor structure to be replicated in samples confronting a homogeneous stressor should be of considerable concern to researchers in the coping area” (Parker et al., 1993). This study draws attention to two main issues again, firstly the use of factor analyses to identify the dimensionality of coping scales, an approach that has been heavily criticised (Folkman & Lazarus, 1980, 1985, 1988; Steed, 1998). Secondly, while the authors made every attempt to replicate the exact study, the samples were different and responded differently. While Parker et al. (1993) raise some concerns about the construct validity of the WAYS, these results, when interpreted within the broader literature on the measurement of coping, can be understood.

A reliability generalization study on the WAYS by Rexrode, Peterson and O’Toole (2008) also reported negatively on the WAYS. Their study found that the range of reliability coefficients reported across studies was wide. Rexrode et al.

(2008) reported that “only 61% of the WAYS articles used in this study attributed reliability to the scores rather than the actual instrument, and another 39% of the studies did not report reliability” (p. 270-271). These results emphasise the need for researchers to report the reliability of the WAYS subscale scores more accurately in their samples.

The scale chosen for this thesis was the Coping Scale for Adults (CSA). There were three main justifications for choosing the CSA as the measurement instrument over other coping scales in this study. The first was how the CSA developers, Frydenberg and Lewis (1997), based their conceptualisation of coping, and thus the CSA itself, around Lazarus and his colleague’s cognitive-phenomenological theory. In particular, coping was conceptualised as an adaptive function, where the individual and the environment are engaged in an interactive process. Secondly the CSA was chosen over Lazarus’s scales due to its development in an Australian context, thereby, providing an opportunity to measure coping with people of similar cultural orientation. Given that studies investigating personality variables have revealed that there are some culture specific coping constructs, the CSA was preferable to other measures (Terracciano & McCrae, 2006). The third reason for choosing the CSA over the Ways of Coping Checklist was that the scale was well constructed using a 5-level Likert scale to assess how each coping strategy was used, whereas the Ways of Coping scale used a more constrained 4-point scale. And finally, the CSA has an item titled “not cope” and has a section titled “list any other things you do to cope with your concern/s,” which from a clinical perspective allows reflection of the individualised strategies people use to manage difficult situations.

Conclusions and Recommendations

This chapter addressed some of the issues in the measurement of coping and the way coping has been measured (breadth, dimensionality, variability and generality of coping measures), what constitutes good validity, along with a review of the coping scales currently used within psychology and psychiatry. Folkman and Lazarus (1980) recognition that more appropriate measures of coping were needed, because measures devised to assess coping on a normal population were inadequate or inappropriate has seen a plethora of new coping inventories. Although some of these suffer the same difficulties that Folkman and Lazarus themselves found, that being, that the difficulty lies with transferring stress and coping theory into interventions, which is problematic because measurement depends on how coping is understood. Indeed, Coyne and Gottlieb (1996) stated that, typically, the application and interpretation of checklists are not faithful to a transactional model of stress and coping; statistical controls can not eliminate the effects of key person and situation variables on coping and no consistent interpretation can be assigned to coping scale scores. Coyne and Racioppo (2000), in their review on the coping literature, suggest that a moratorium on studies incorporating checklists be imposed, because conventional checklist methodology has been uncritically accepted as a standard and serves to discourage the development of alternative methodologies. Moreover, Lazarus (2000) himself also highlighted the need for prospective designs emphasizing individual differences that are compatible with a holistic outlook. The overall consensus on the way coping has been measured depends on the way coping is defined and whether coping is seen as a process or a trait of a person.

As seen in this chapter, there are a myriad of coping inventories making comparative studies difficult. The most popular coping scale, the WAYS by Folkman and Lazarus (1988) that is used substantially throughout the literature, also has various versions, making comparisons difficult. In summary, what we learn from the measurement of coping is that the way coping is conceptualised relies on the way coping is defined, i.e., a trait or a process, and whether or not one is measuring a coping strategy in relation to a specific event or coping in general. This section helped to generate a guide for choosing the appropriate coping scale based on what is known about coping to date. Stability, generality and dimensionality are considerations the researcher needs to take into account when measuring coping. These considerations enable the researcher to choose an appropriate scale, for the appropriate population, to help measure what the researcher has in mind. In essence, a coping scale is valid if it measures what it is intended to measure in the specific study. The next chapter will review the CSA and how effective it is at measuring coping strategies of a psychiatric population, with comparative analyses undertaken with samples of university students and the general public.

CHAPTER 4

The Coping Scale for Adults (CSA) and Quantitative Studies A, B and C.

Preamble

This chapter introduces the Coping Scale for Adults (CSA) by Erica Frydenberg and Ramon Lewis (1997), a coping scale originally developed on a community sample in Australia. Given the psychometric shortcomings of some of the more prominent scales, such as the WAYS (Folkman & Lazarus, 1988), as described in the previous chapter, a review of the CSA indicated that it provided a better alternative for assessing the measurement of coping in a psychiatric sample.

This first part of the chapter comprises an overview of the CSA scale, followed by three studies in which the CSA scale was used.

Introduction

According to Frydenberg and Lewis (1997) the conceptualisation of coping which underlies the CSA by Frydenberg and Lewis (1997) was derived from Lazarus and colleagues cognitive-phenomenological theory of coping as an adaptive function, whereby there is an interactive process between the individual and their environment. Frydenberg and Lewis (1997), longstanding researchers in the area of coping in Australia, developed the CSA to assist in clinical areas and research contexts. The CSA is a self-report inventory for adult populations, 18 years of age and over. The CSA comprises 74 items, including 70 structured items that assess the 18 coping strategies, 3 items that comprise an optional “Not Cope” scale, and the final item, an open-ended response question, asking the respondent to indicate any coping behaviours they use. The respondent rates the 73 items

using a 5 point Likert-scale (1-doesn't apply or don't do it, 2- used very little, 3 – used sometimes, 4-used often and 5-used a great deal).

The scaled response format on this questionnaire has advantages in that it provides a range of response options, in comparison to traditional checklists which have yes/no categories (Tabachnick & Fidell, 1989). The CSA has two forms: the general form, which assesses an individual's choice of coping strategy in general; and the specific form, which assesses an individual's behaviour in relation to a specific situation. The specific form of the CSA can be used whereby either the individual nominates the concern or the administrator nominates the concern. Frydenberg and Lewis (1994) considered that an individual's choice of coping strategies was usually consistent, regardless of the nature of concern, and thereby advocated the use of a general scale. The authors also believed that there will be times when people's general style of coping, as it applies to all their concerns, will be of greater interest than the way in which their general style is modified to cope with a particular concern. Indeed, Steed (1998) has also emphasised that there are advantages in using a "general" scale, in that it allows comparison of strategy use across various stressors, or even the various stages of a single stressor. The CSA also has short forms of both the specific form and the general form, with each short form comprising 20 items.

Much of the preliminary material of the CSA came from the Adolescent Coping Scale (ACS) which was developed to assess the coping strategies of young people (Frydenberg & Lewis, 1993). The CSA builds upon the earlier work on the ACS. The close links between the CSA and the ACS, according to Frydenberg and Lewis (1997), ensure items in the CSA are lucid, and are not

reliant on reading or comprehension skills beyond primary school age. Not all the items of the ACS were included in the CSA and items were modified to suit an adult population, e.g., ACS: Attend school regularly, CSA: Put effort into my work. In the development phase of the CSA, Frydenberg and Lewis (1997) carried out a factor analysis on the items to determine suitability of the Adolescent Coping Scale (ACS) with an adult population. An oblique factor analysis (principal components with Oblimin rotation) was used, because it was assumed that the scales would not be entirely orthogonal, since it can be hypothesised that while coping contains a number of distinct strategies, such strategies are likely to have some overlap. The results revealed suitability of the ACS scales for use with an adult population. Along with this, the authors added a few additional scales to try to capture the entire adult coping repertoire. The four scales were: Thinking about the problem, Humour, Protect sense of self, and Plan and prioritise.

The structured nature of the CSA allows for coping behaviours which might not have spontaneously come to mind with less structured approaches. There is also room for individuals to write down other ways that they may cope, which suggests the CSA scale does not preclude other coping strategies that may arise for an individual. Given low attention and concentration spans have been reported to often be present in those diagnosed with a mental illness (Medalia & Revheim, 2002), the CSA was thought to be a good measuring tool to use within the psychiatric setting of the current thesis, because of the structured nature of the questionnaire and its readable, behaviourally-defined items.

In essence, the CSA captures all of the coping strategies identified in the ACS. As a clinical therapeutic tool the CSA is used to primarily help people to

identify and maximise their use of productive strategies and minimise the use of dysfunctional strategies. According to Frydenberg and Lewis (1997), the CSA helps respondents not only to identify their various coping strategies, but also facilitates the development of further coping strategies. In their subsequent writings, Frydenberg and Lewis (2002a) stated that removing non-productive coping, the focus of much mainstream mental health, does not necessarily promote productive coping. They claimed, therefore, that it is the combination of both an increase in productive coping strategies and a reduction in non-productive coping strategies that enhanced an individual's overall coping.

The 19 CSA coping strategies, as described in the CSA Manual (Frydenberg & Lewis, 1997, p.10-11), are:

1. **Seek Social Support** is represented by items which indicate an inclination to share the problem with others and enlist support in its management, e.g. *Talk to other people to help me sort it out.*
2. **Focus on Solving the Problem** is a strategy, which comprises reflecting on the problem, planning solutions, and tackling the problem systematically, e.g. *Work at solving the problem to the best of my ability.*
3. **Work Hard** is a scale describing commitment, ambition and industry, e.g. *Keep up with work as required.*
4. **Worry** is characterised by items, which indicate a concern about the future in general terms or, more specifically, concern with happiness in the future, e.g. *Worry about what is happening.*
5. **Improve Relationships** is about improving ones relationship with others, engaging in a particular intimate relationship, e.g. *Spend more time with husband/wife/boy/girlfriend.*

6. **Wishful Thinking** is characterised by items, which are based on hope and anticipation of a positive outcome, e.g. *Hope that the problem will sort itself out.*
7. **Tension Reduction** is characterised by items, which reflect an attempt to make oneself feel better by releasing tension, e.g. *Release pressure by taking alcohol or cigarettes.*
8. **Social Action** is about letting others know what is of concern and enlisting support by writing petitions or organising an activity such as a meeting or a rally, e.g. *Join with people who have the same concern.*
9. **Ignore the Problem** is characterised by items which reflect a conscious blocking out of the problem, e.g. *Put the problem out of my mind.*
10. **Self-Blame** indicates that individuals are critical of themselves for being responsible for the concern or worry, e.g. *Blame myself.*
11. **Keep to Self** is characterised by items which reflect the individuals withdrawal from others and a desire to keep others from knowing about concerns, e.g. *Keep my feelings to myself.*
12. **Seek Spiritual Support** is characterised by items which reflect prayer and belief in the assistance of a spiritual leader or God, e.g. *Pray for help and guidance so that everything will be all right.*
13. **Focus on the Positive** is represented by items, which indicate a positive and cheerful outlook on the current situation. This includes seeing the bright side of circumstances and seeing oneself as fortunate, e.g. *Look on the bright side of things and think of all that is good.*
14. **Seek Professional Help** denotes the use of a professional adviser, such as a teacher or counsellor, e.g. *Discuss the problem with qualified people.*
15. **Seek Relaxing Diversions** is about general relaxation. It is characterised by items, which describe leisure activities such as reading and listening to music e.g.

Find a way to relax, for example, listening to music, read a book, play a musical instrument, watch television.

16. **Physical Recreation** is characterised by items, which relate to playing sport and keeping fit, e.g. *Keep fit and healthy.*
17. **Protect Self** comprises items which indicate attempts to support ones self-concept by constructive self talk and looking after ones appearance, e.g. *Work on my self image.*
18. **Humour** is about being funny as a diversion, e.g. *Create a humorous diversion.*
19. In addition to the 18 coping strategies there is an optional scale called **Not Cope**, which is characterised by, items reflecting an inability to cope and the occurrence of psychosomatic illness, e.g. *I get sick, for example, headache, stomach ache.*

In the development of the CSA Frydenberg and Lewis (1997) had noted limitations in Lazarus and Folkman's theory. When the 19 coping scales were explored further with factor analysis, the possibility emerged of combining coping strategies into styles. As a result, four distinct coping styles emerged; these styles, including their respective coping strategies, were:

1. *Dealing with the problem directly.* Focus on solving the problem, work hard, improve relationships, seek relaxing diversions, physical recreation, protect self, humour.
2. *Optimism.* Focus on the positive, seek relaxing diversions, seek spiritual support, wishful thinking.
3. *Sharing.* Seek social support, social action, seek professional help.
4. *Nonproductive coping strategies.* Worry, wishful thinking, tension reduction; ignore the problem, self-blame, keep to self, not cope. (Frydenberg & Lewis, 1997, p.36).

Grouping coping strategies into styles follows a trait approach to coping, which generally tends to classify people in order to make predictions on how they will cope with various stressful encounters (Lazarus & Folkman, 1984), instead of a process approach to coping.

The rationale for choosing the CSA as the measuring tool in this study lay in its diverse measurement of coping strategies along with the clinical applications of the scale. After reviewing other coping scales, the CSA appeared to be the most comprehensive instrument of its kind and the first to be developed in an Australian context. It also provides an opportunity for the separate measurement of a comprehensive range of coping strategies that have been confounded in previous research, allowing a more valid measurement of coping strategies than is currently available. The CSA has many features which do set it apart as a valuable instrument for research and clinical purposes and, given the sample under investigation was a psychiatric population, this was of importance.

Most of the time coping has been categorized by past researchers as either adaptive or maladaptive and, now, by Frydenberg and Lewis (1997) as “productive” (such as problem solving strategies, seeking social support, focusing on work) and as “non-productive” (avoidance, keeping to oneself). Romi, Lewis and Roache, (2013) reported that much of the non-productive coping label has originated in research linking the use of coping strategies, such as withdrawal and avoidance, to mental health problems in children and adolescents, but this has yet to be investigated in adult populations.

One of the downsides of using the CSA is that there are few published studies that have used the scale by researchers other than Erica Frydenberg and

Ramon Lewis, its developers. Erica Frydenberg has stated that she is aware that people were using the scale clinically in educational and health settings (Personal Communication, 22nd July 2013). However, she was not aware of people actively using the scale for research purposes and publishing the results. All but one of the studies I will be reporting on below are by Frydenberg and Lewis.

Reliability and Validity of the Coping Scale for Adults (CSA)

Given that one of the main aims of the current research was to measure the coping strategies of a psychiatric population, the question needed to be raised “Will the CSA adequately measure the coping strategies of a psychiatric population?”.

Reliability

Frydenberg and Lewis (1997) spent a considerable amount of time on the item reliability of the CSA scale. The authors did a test-retest on items to see if they met reliability to involve subscale inclusion. The subscales comprised of an adequate number of relatively equal items, around 4 items per subscale. All items were responded to by more than 88 per cent of the respondents within one point of measurement on the two testing occasions, thereby satisfying the criteria for response stability.

To ascertain the extent to which responses to the 73 (excluding Not Cope) items of the CSA remained stable over time, 25 respondents in the original study were administered the questionnaire on a second occasion, approximately 14 days after the first administration. The test-retest correlations (Pearson product moment) were then computed for the individual items. For an item to be considered reliable, its correlation co-efficient had to be 0.58 or higher ($p < 0.001$).

If the test-retest correlation was less than 0.58, an additional criterion had to be satisfied, namely that at least 80% of the responses had to be within one point of measurement on the two occasions. The reason for this was that an item's response may be poorly correlated on two occasions due to a restricted range of response rather than due to an instability of responses (see Frydenberg & Lewis, 1997, p.25). Only 10 of the items failed to register statistically significant correlations, however, all were responded to by more than 88 percent of respondents within one point of measurement on the two testing occasions, thereby satisfying the criterion of *response stability*, as discussed in Chapter 3. From a review of the scale development data, the Cronbach alpha co-efficients of internal consistency (alpha) [range 0.69-0.92] and test-retest stability co-efficients [0.33-0.94] showed that all the scales had response distributions covering almost the entire full range of possible raw scores. Furthermore, the response to items within the scales had sufficient internal consistency in all cases to justify the separate use of these scales (Frydenberg & Lewis, 1997). The developers reported that "the 18 coping strategies revealed high test-retest reliability co-efficients apart from 2 with moderate and one with low. These being co-efficients for *Focus on Solving the Problem*, *Social Action* and *Work Hard* scales.

The authors concluded that the 18 scales of the CSA (excluding the Not Cope scale) were very reliable and compared favourably in this regard with published coping scales, such as those of Folkman and Lazarus (1988) and Moos (1993) (See discussion on Billings and Moo's scale in Chapter 3).

Validity

Frydenberg and Lewis (1997) contend that the CSA allowed for a more valid measurement of coping strategies than previous scales and they reported that “Adults enjoyed completing the questionnaire, as it provided a stimulus for thinking about behaviour” (p. 12). Frydenberg and Lewis (1997) stated that the questionnaire also has good *content validity* in that as a measure of coping the CSA represents a wide range of coping strategies. The authors identified consistent patterns across studies carried out using the CSA that linked more positive outcomes and less negative ones to the “productive strategies” listed in the CSA. The authors also reported on the *construct validity* of the CSA, noting that it was helpful in uncovering significant relationships between a number of undesired outcomes, such as low self esteem, feeling overwhelmed, stress and coping strategies that have been considered non-productive. These findings were consistent with their previous work (Frydenberg & Lewis, 1997) that reported that maladaptive coping styles and negative outcomes are stronger than those between productive coping styles and productive outcomes.

Published Studies Using the Coping Scale for Adults

As indicated previously, the CSA has not been independently assessed for its psychometric properties. To date there are no reported studies of the CSA measuring coping in a psychiatric population. Indeed, there are few published studies using the CSA, but those of note will be reported on below.

The CSA has been used to investigate teachers’ coping with the stress of classroom discipline. For example, Lewis, Romi, and Roache (2011) investigated 515 teachers from Australia and identified the unproductive coping styles which lead to a greater tendency for teachers to become sick. The CSA has

also been used to investigate the relationship between workplace contexts and how people cope with their concerns (Frydenberg & Lewis, 2002b). The findings from this study indicated that managers, irrespective of age and gender, were more likely to respond by utilising problem solving or applying themselves and were less likely to use non-productive strategies, such as *worry*, *letting off steam* and *wishful thinking*.

More recent uses of the CSA have been by Romi et al. (2013) who investigated 772 teachers' coping strategies and classroom management techniques across Australia, China and Israel. The findings across the three different cultures were confounded, partly due to the different cultural notions of coping and different understandings and meanings of the various cultural coping constructs. The authors highlighted this in the Israeli teachers' notions of worrying: "In Israel, the use of *Worry* relates to what might be characterized as under-assertion (hinting, but not punishment) and aggression" (Romi, Lewis & Roache, 2013, p.224). This study highlighted the role of cultural differences between the nations of teachers. What is seen as a coping strategy in Australia is not universally applicable across other nations, a finding that has implications for the use of such coping scales with different nationalities.

Frydenberg and Lewis (2002a) in their article reviewed six unpublished studies (Evert, 1996; Goble, 1995; Jones, 1997; Lyneham, 1997; McDonald, 1996; Spanjer, 1999), that are predominantly masters dissertations, all which have used the CSA. In their review the studies were examined for their utility and validity. Frydenberg and Lewis concluded that the findings appeared to provide support for the view that the link between maladaptive styles and negative

outcomes is stronger than the link between productive styles and productive outcomes. They suggested that while the therapeutic enhancement of productive coping strategies may be seen as the way forward, removing or minimising the dysfunctional (non productive) coping mechanisms “does not necessarily promote the good” (p. 15). The authors advocate for “tackling” both sets (productive and non productive) strategies to build up peoples’ coping resources and to help them develop resilience (Frydenberg & Lewis, 2002a). They raise a good point here and one that could transfer over well to mental health settings. Undoubtedly, the combination of increasing productive coping and reducing non-helpful coping strategies is a potentially useful approach within clinical settings. However, it is implausible that questionnaire results alone would facilitate this, and, more likely, the success would come if used alongside a detailed clinical formulation, incorporating the many contextual factors impacting on patient coping.

One study of the CSA that is independent of the Frydenberg and Lewis research group was carried out by McGreal, Evans and Burrows (1997). The authors utilised the specific form of the CSA in a pilot study to assess gender differences in coping strategy use following loss of a child through miscarriage or stillbirth. The results suggested differences between men and women in chosen coping strategies. Women were more likely than men to use *worry*, *tension reduction*, *wishful thinking*, and *spiritual support*. Men were more likely than women to use *ignore the problem*. However, these results need to be interpreted with caution due to the small sample size (N=52, 37 females and 17 males), the wide variety of age cohorts, uncontrolled variables, such as knowledge of whether the subject’s experience was of the first or second miscarriage or stillbirth, and

acknowledgement of the differences in loss at early stages of the pregnancy vs. later stages, e.g., giving birth.

Conclusions

The CSA, based on Lazarus's theory of stress and coping, has been used extensively in Australia and has clear items combined with a Likert rating scale. The scale has been found to have good reliability and validity when used within adult groups. As a *measurement tool* the CSA provides information that only *describes* what people use or, more precisely, what coping strategies people say they use, rather than whether these strategies are functionally useful. The CSA was thought to be a good choice to use with a clinical sample to assess whether it has any clinical utility for the measurement of coping.

Comparative Group – College students

When reviewing the coping literature, the majority of studies have focused on the benefits of positive coping amongst college and university students (e.g., Brown, 1994; Epstein, & Katz, 1992; Folkman, & Lazarus, 1985; Lawrence, Ashford & Dent, 2006; McCarthy, Lambert & Moller, 2006; Shankland, Genolini, Franca, Guelfi, & Ionescu, 2010).

Epstein and Katz (1992) found that a productive workload in everyday life was found to be positively associated with coping ability and unrelated to stress. Lawrence, Ashford and Dent (2006) carried out a study to investigate coping strategies adopted by men and women who were first-year students in higher education. The York Self-Esteem Inventory (YSEI), the Emotional Control Questionnaire (ECQ) and the Coping Styles Questionnaire (CSQ) were used to measure men's and women's' coping. One hundred and sixty (N=58 female,

N=102 male) first-year sport sciences undergraduate students completed the questionnaires with one of the authors present at the end of their academic year. The results indicated that men reported coping strategies, such as “bottling up,” and tended to detach themselves from situations, in contrast to the women, who were more likely to use emotion-focused coping.

Folkman and Lazarus (1985) examined emotion and coping of college students (N=108, gender distinctions not specified), measuring the coping process at three stages of a mid-term examination, which were: an anticipation stage, the waiting period and waiting for their results after their exams. They found that different forms of coping were evident during the waiting and anticipatory stages of an exam. Problem-focused coping strategies and emphasizing the positive were present before an exam and distancing more prominent after the exam. The authors reported that despite the normatively shared emotional reactions at each stage, individual differences were evident at each stage of the examination period.

Overall, the studies of coping in university students have also focused on particular subgroups of university students. For example, Williams, Arnold, and Mills (2005) investigated how veterinary students coped with stress. However, most studies have used within-groups procedures and not done comparative studies (Felsten, 1998; Porter, Marco, Schwartz, Neale; Shiffman & Stone, 2000). In general, some studies into the coping mechanisms of university students have found that men tend to use avoidance and detach themselves (e.g., Lawrence, Ashford & Dent, 2006), however, others (e.g., Felsten, 1998; Porter, Marco, Schwartz, Neale, Shiffman, & Stone, 2000) have found no differences in coping strategies in men and women.

Study A: The Psychometric Adequacy of the Coping Scale for Adults (CSA)—An Examination With a Psychiatric Sample

Preamble

The central research aim of this thesis was to investigate the meaning and measurement of coping in a psychiatric population. An extensive review of the measurement research on coping concluded that an entire coping repertoire of “coping” for psychiatric patients has yet to be captured by current psychometric scales. However, the literature examined to date also suggests that those diagnosed with a mental illness lack adequate coping resources for managing the challenges of daily living (Piccinelli & Wilkinson, 2000; Taylor & Stanton, 2007).

Introduction

Study A examines the psychometric adequacy of an existing coping scale, The Coping Scale for Adults (CSA; Frydenberg & Lewis, 1997), and, in particular, its ability to measure the coping strategies of a psychiatric sample (n=110).

Comparisons are made across the 19 coping strategies, in terms of factor structure, gender and age. The objective is to evaluate the CSA’s ability, as measured by its 19 subscales, to discriminate a psychiatric sample’s coping strategies when viewed against information from the normative sample of the CSA. The study is a cross-sectional design, comparing the similarities and differences in coping strategies of both groups. Given “not coping” is of particular interest in those diagnosed with a mental illness, in the analyses special consideration is given to the “not cope” scale on the CSA.

The CSA scale is made up of 18 coping strategies, which are “productive and non-productive,” plus one “not coping” strategy. Previous research has

suggested that those diagnosed with a psychiatric illness use more maladaptive than adaptive coping strategies and the current study set out to test this assumption (Aldwin & Revenson, 1987; Fledderus, Bohlmeijer & Pieterse, 2010; Frydenberg & Lewis, 2002a). It should be noted that, as discussed in Chapter 2, “not coping” may be a functional coping strategy, not maladaptive but adaptive, and entirely appropriate, depending on the patient’s circumstance.

Hypotheses

The first hypothesis was based on the oft-stated claim in the literature (e.g., Aranada, & Lincoln, 2011; Carver, Scheier, Weintraub, & Jagdish, 1989; Frydenberg & Lewis, 1997, 2002a; Skinner, Edge, Altman & Sherwood, 2003; Snyder, 1999) that psychiatric samples use more maladaptive coping strategies. Therefore, it is proposed:

Hypothesis 1. The psychiatric sample will endorse more non-productive coping strategies, as measured by the CSA, than the normative sample.

There is also abundant research (e.g., Ano & Vasconcelles, 2004; Bergin, Masters, & Richards, 1987; Crossley, 1995; Koeing, 2009; Pargament, Koeing, Tarakeshwar, & Hahn, 2004; Ruchita, Parmanand, Dandeeep, Kumar, Malhotra & Tyagi, 2011; Phillips & Stein, 2007; Smolak, Gearing, Alonzo, Baldwin, Harmon, & McHugh, 2013; Sullivan 1993), that religion is used as a coping strategy.

Therefore, it is proposed:

Hypothesis 2a. That the psychiatric sample will be more likely than the normative sample to endorse *seek spiritual support* as a coping mechanism.

Some research has focused on those diagnosed with schizophrenia and their use of religion as a coping mechanism (Ano & Vasconcelles, 2004; Bergin,

Masters, & Richards, 1987; Crossley, 1995; Koeing, 2009; Pargament, Koeing, Tarakeshwar, & Hahn, 2004; Ruchita, Parmanand, Danddeep, Kumar, Malhotra & Tyagi, 2011; Phillips & Stein, 2007; Smolak, Gearing, Alonzo, Baldwin, Harmon, & McHugh, 2013; Sullivan 1993). Therefore, it is proposed:

Hypothesis 2b. That those diagnosed with schizophrenia will be more likely than the normative sample to endorse *seek spiritual support* as a coping mechanism.

The third and fourth hypotheses culminated in investigating if gender differences existed in the types of coping strategy used, because, to date, some research has supported this view and suggested evidence for this (e.g., Felsten, 1998; Labouvie-Vief, Hakim-Larson & Hobart, 1987; Littlewood, Cramer, Hoekstra, & Humphrey, 1991; Matud, 2004; Melendez, Mayordomo, Sancho, & Tomas, 2012; McGreal, Evans & Burrows, 1997; Porter, Marco, Schwartz, Neale, Shiffman, & Stone 2000; Ptacek et al., 1994; Stroebe, 2001). There are also a few studies that suggest evidence for gender differences in coping strategies (e.g., Frydenberg and Lewis (1997) also found significant gender differences, as reported both in adolescent samples and adult samples, in studies using the 19 CSA subscales (Frydenberg & Lewis, 1993,1994,1997, 2000, 2002a, 2002b). Nevertheless, Lazarus (1999) contends that women and men cope similarly. But, there is also a suggestion in the literature that men use more avoidance coping: (e.g., e.g., Lawrence, Ashford & Dent, 2006) and women use more emotion focused coping e.g., Felsten, 1998; Porter, Marco, Schwartz, Neale, Shiffman, & Stone 2000; Ptacek et al., 1994; Stroebe, 2001). Given these claims in the literature, it is proposed:

Hypothesis 3. Men will endorse avoidance coping strategies more than women, as measured by the CSA.

Hypothesis 4. That women will endorse more social support and emotion-focused coping than men, as measured by the CSA.

An additional comparison of coping strategies will be made between a subsample of those diagnosed with schizophrenia and the “normative” sample.

Given the vast amount of research on the “lack” of coping in those diagnosed with schizophrenia (e.g., Buchanan, 2007; Kraepelin, 1899; Tyler, 1995), it is predicted that:

Hypothesis 5. Those diagnosed with schizophrenia will endorse non-productive coping strategies more than the normative sample, as measured by the CSA.

Method.

Materials. All samples completed the General Form of the Coping Scale for Adults Questionnaire (CSA).

Participants

Psychiatric sample. This sample consisted of 110 adults, men (N=55) and women (N=55), between the ages of 18-75 years (\bar{x} age, 33.54, SD =10.01). The median age was 31 years. Participants were psychiatric inpatients, from a psychiatric hospital in Western Australia who participated voluntarily in the study. All patients had a choice to participate in the study or to decline the offer to participate, with 100% volunteering to participate. Participants were selected against specific inclusion and exclusion criteria. The inclusion criteria were: their first language was English, that they had at least 10 years of education, and that

they could read and write. The exclusion criteria were: no known organic deficits or memory deficits, e.g., Alzheimer’s disease or dementia. Table 4.1 shows the characteristics of the sample according to gender and primary diagnosis, as reported in the patients’ medical files and confirmed by their doctor.

Table 4.1

Psychiatric Sample Classified by Gender and Diagnosis

	Schizophrenia	Depression	Bipolar	Personality disorder	Not otherwise specified	Total
Male	30	12	7	2	4	55
Female	20	10	16	7	2	55
Total	50	22	23	9	6	110

A greater number of patients were diagnosed with schizophrenia and bipolar disorder in this study, which is consistent with previous research sample characteristics on individuals diagnosed with a mental illness (Bourdon, Rae, Narrow, Manderscheid, & Regier, 1994). The finding in this study that the psychiatric sample consisted of more men than women with the diagnosis of depression is not in line with current research (Kessing, 2005; Page, 1999).

Normative sample. The normative sample was the original sample from the CSA study (Frydenberg & Lewis, 1997) that consisted of 369 adults, with an age range of 17-75 years. One hundred and sixty four males and 205 females were included. A representative sampling of gender was reported by the authors, but there was a biased distribution of occupational status favouring the upper end of the occupational continuum (Frydenberg & Lewis, 1997). The sample consisted of 133 Australian middle managers from a private sector organisation in the retail

industry and 236 non-managers from the Australian community. Frydenberg and Lewis (2002b) reported that the managerial respondents were randomly sent out a questionnaire, accompanied by a short memo requesting their participation. The respondents completed the questionnaire within their work environment, with the remaining respondents surveyed in a range of settings, including supermarket malls and doctors' waiting rooms at various times of the day. Participation in the study was voluntary.

Procedure: Psychiatric sample. The current study took place in a large psychiatric hospital in Western Australia with an inpatient facility. The setting for the completion of questionnaires was the dining room of the ward. All ethical guidelines were adhered to and ethics approval was obtained for the study from the ethics committee of both the university and the psychiatric hospital over a period of 12 months. I, as researcher, recruited participants through psychiatrists' and medical officers' patient lists throughout the four wards of the hospital. These medical professionals were not involved in the selection or interview process and only provided information on patients and their diagnosis prior to patient selection. I individually approached patients with information about the study requesting their consent to participate, subject to screening. Once consent was obtained to access their medical files, information was screened against the inclusion and exclusion criteria and their diagnosis collected. All participants met the inclusion criteria and for these patients their medical file was used only to access information about their diagnosis. I made an appointment with the patient to complete the questionnaire, at a time convenient for the patient, and escorted each participant to the dining room on the ward of the psychiatric hospital outside of

meal times. Patients were given the Coping Scale for Adults questionnaire (CSA), the general form, and a pencil. Subjects did not provide their names or any other identifying information, only their date of birth and gender. The General questionnaire has a short description of how to complete the questionnaire which is written on the front of the questionnaire. The test instructions were:

People have a number of concerns or worries, such as work, studies, family, friends, the world and the like. Below is a list of ways in which people cope with a wide variety of concerns or problems. Please indicate the things you do to deal with your concerns or worries by marking the appropriate number. Work down the page and mark 1, 2, 3, 4 or 5 as you come to each statement. There are no right or wrong answers. Do not spend too much time on any one statement but give the answer which best describes how you feel.

For example if you sometimes cope with your concern by "Talk to others to see what they would do if they had that problem" you would mark 3 as shown below:

	Doesn't apply or don't do it	Used very little	Used some-times	Used often	Used a great deal
1. Talk to others to see what they would do if they had the problem.	1	2	█	4	5

Please note that within the scale there are 3 items, designed primarily for clinical purposes, that indicate difficulty with coping. If you don't wish to complete these items you may omit them. The relevant items (highlighted within an asterisk) are 9, 28 and 63.

Each patient was asked if they had any questions and each patient fully understood what was required.

Scoring. Each questionnaire was hand-scored and entered into the overall data set for the study. The questionnaire has a computerized software program for scoring, however, this was not available to the researcher at the time of this study. It should be noted that participants answered all of the questions on the questionnaire. Lewis, Romi and Roache (2011) also attained a 100% response rate from their participants, further evidence that the CSA is a straight-forward, easy to administer and answer questionnaire.

Results. The results of the study follow.

Diagnostic categories of psychiatric patients. Preliminary analyses were carried out to investigate whether there were gender differences across diagnoses. Given the low frequencies in the diagnostic categories when broken down by gender, the personality disorder (PD) and not otherwise specified (NOS) categories were grouped together as “other.” Chi square test for independence (see Appendix A) indicated no significant association between gender and diagnosis ($\chi^2(3) = 6.304, p=0.10$). The strength of the association Cramer’s v was 0.24, which suggests a slight agreement between gender and diagnosis.

Preliminary analyses of subscale data. A preliminary analysis of the data split by gender across all 19 subscales was conducted using box plots and histograms. The majority of histograms and boxplots across gender were symmetric. However, on the social action subscale, both men ($z=2.21, p=0.02$) and women ($z=2.74, p=0.01$) exhibited significant skewness (see Appendix A for relevant sample statistics). The skewness did not appear to be caused by one or

two extreme outliers, but rather by a spread of scores that tapered off towards the upper end of score totals. Therefore, no data transformation for this subscale was considered necessary.

Logistic regression: Prediction of gender based on age and diagnosis.

In order to examine possible gender differences in the psychiatric sample logistic regression analysis was used with age and diagnosis as predictors. With the gender variable being dichotomous logistic regression was favoured here over an alternative MANOVA type design, in order to avoid the parametric assumption of multivariate normality that a MANOVA type design requires. A logistic regression was used as it carries no parametric or homogeneity of variance assumptions. Table 4.2 displays the results of the logistic regression model, predicting gender based on age and diagnosis for the psychiatric sample. The overall model was not significant ($p = .12$) with the final correct classification rate being 61.8%. Specifically, 42 of 55 (76.4%) of the male sample were correctly classified (true negatives), while 26 of 55 (47.3%) of the female sample were correctly classified (true positives). None of the four individual predictors was significant (Table 4.2).

Table 4.2

Prediction of Gender Based on Age and Diagnosis: Psychiatric Sample Only

Variable	<i>B</i>	<i>SE</i>	Wald	<i>df</i>	<i>p</i> Value	Exp(<i>B</i>)
Age	-0.02	0.02	0.81	1	.37	0.98
Schizophrenic	-0.80	0.60	1.76	1	.18	0.45
Depressive	-0.65	0.68	0.89	1	.35	0.52
Bipolar	0.44	0.70	0.39	1	.53	1.55
Constant	1.06	0.90	1.39	1	.24	2.88

Note. $n = 110$. Gender classification: 0 = male, 1 = female. Full model: $\chi^2(4, n = 110) = 7.24$, $p = .12$. Base classification rate = 50.0%. Final classification rate = 61.8%.

Correlations. In order to further examine and distinguish the 18 scales of the CSA, the magnitudes of the scale intercorrelations were considered. In summary the scales appear sufficiently distinct to warrant their separate use. For the psychiatric sample an examination of correlations between subscales completed by the men and by the women showed a large number of significant correlations, ranging from low to high magnitude. Overall, female correlations were greater than male correlations (see correlational matrix Appendix A for exact values). Considering the magnitude of the male subscale correlations, 31 percent had correlations greater in magnitude than 0.4, 16 percent were greater than 0.5, and 2 percent were greater than 0.6, with the maximum correlation being 0.64 between the *improve relationships* subscale and *social support* subscale. By comparison, 39 percent of the female subscale correlations were greater in magnitude than 0.4, 28 percent were greater than 0.5 and 16 were greater than 0.6, with the maximum correlation being 0.79 between *protect self* and *focus on the positive* subscales.

Factor analysis. For comparative purposes the data analytic procedures described by Frydenberg and Lewis (1997) in the CSA manual were replicated. The first

step in establishing the usefulness of the CSA in capturing psychiatric patients' coping strategies was to determine the extent to which the items in the questionnaire satisfactorily assessed the related (but distinct) strategies of coping they were designed to measure; the second step was to compare those strategies used to those measured in a "normal" community sample. Unfortunately the whole normative data set of the original CSA set was not available for use, and this was the reason subscale scores were factored instead of individualised items. Following the procedure outlined in the CSA manual, a factor analysis using a principal axis factoring method of factor extraction, followed by an oblique rotation using the oblimin method, was performed on the whole psychiatric sample, in order to maximise the sample size for the analysis. The oblique procedure was used since it was assumed (see also Frydenberg & Lewis, 1997), that the 19 scales would not be entirely orthogonal or independent. Using the criterion of extracting factors with eigenvalues greater than 1 resulted in 4 factors being extracted, which accounted for 54.5% of the variance. Factor 1 accounted for 31.40% of the variance, factor 2 accounted for 14.87% of the variance, factor 3 accounted for 4.85% of the variance and factor 4 accounted for 3.35% of the variance (see Table 4.3). Visual inspection of the scree plot (see Appendix B) indicated that even a 3-factor solution might be appropriate for the psychiatric sample, without an unwarranted loss of information, compared to a 4-factor solution; however, the 4-factor model was considered the better fit. Using the 4 extracted factors, an oblique rotation using the oblimin method revealed the pattern matrix shown in Table 4.3.

Table 4.3

Psychiatric Sample: Pattern Matrix of 18 Coping Scales Plus Not Cope

Coping strategy	Factor			
	1	2	3	4
Social support	.60			
Focus on solving the problem			.40	-.40
Work hard	.52			
Worry		.61		-.44
Improve relationships	.69			
Wishful thinking		.43		
Tension reduction	.43	.43		
Social action	.43			-.42
Ignore the problem		.68		
Self-blame		.72		
Keep to self		.81		
Seek spiritual support			.63	
Focus on the positive	.68		.36	
Seek professional help				-.64
Seek relaxing diversions	.35			-.50
Physical recreation			.64	
Protect self	.40		.39	
Humour	.70			
Not cope		.48		
Percentage of variance	31.40	14.87	4.85	3.35

Table 4.4

Normative Sample: Pattern Matrix of the 18 Coping Scales Plus Not Cope

Coping strategy	Factor			
	1. Dealing with the Problem	2. Not Cope	3. Optimism	4. Sharing problems
Social support				.66
Focus on solving the problem	.78			
Work hard	.74			
Worry		.83		
Improve relationships	.39			
Wishful thinking		.57	.50	
Tension reduction		.73		
Social action				.57
Ignore the problem		.60		
Self-blame		.78		
Keep to self		.39		-.70
Seek spiritual support			.68	
Focus on the positive			.76	
Seek professional help				.56
Seek relaxing diversions	.40		.46	
Physical recreation	.50			
Protect self	.60			
Humour	.35			
Not cope		.76		
Percentage of variance	23.3	15.2	9.1	7.2

Note. From “Coping Scale for Adults: Administrator’s Manual,” by E. Frydenberg and R. Lewis, ACER: Melbourne, Australia, 1997, p. 37. Copyright 1997 by Erica Frydenberg and Ramon Lewis. Reprinted with permission.

When interpreting results of a factor analysis, sample size is a component to consider but not the sole focus, as Guadagnoli and Velicer (1988) found that if

a factor has 4 or more loadings greater than 0.6, then it is reliable regardless of sample size. For the psychiatric sample, on the whole the loadings were quite reasonable, and certainly this was the case for 2 of the factors (factor 1 and factor 2). The 110 sample size falls in the lower end of the acceptable size for factor analysis (Field, 2013; Guadagnoli & Velicer, 1988). However, as detailed above, the factor analysis was carried out as a replication of the original CSA analyses of Frydenberg and Lewis (1997) and the data was used for comparative purposes.

When compared with the results presented in Table 4.4 from the CSA manual, the current study's factor analysis highlighted the following differences between the psychiatric sample and the normative sample. Examination of the psychiatric data found positive loadings on Factor 1 of the following subscales: *social support, work hard and achieve, improve relationships, tension reduction, social action, focus on the positive, seek relaxing diversions, protect self and humour*. Frydenberg and Lewis (1997) describe Factor 1 on the CSA as “**Dealing with the Problem,**” which encompasses working hard and solving the problem while maintaining a social dimension, characterised by relaxing and indulging in humorous diversions and physical recreation, as well as attempting to improve the significant relationships in one's life. The original CSA Factor 1 and the psychiatric factor analyses differed, as the psychiatric sample's version of “**Dealing with the Problem**” included **extra** coping strategies such as: *tension reduction, seek social support, social action and focus on the positive*.

Examination of the psychiatric sample data also found positive loadings on Factor 2 of the following subscales: *worry, wishful thinking, tension reduction, ignore the problem, self blame and keep to self and not cope*. Factor 2 of

Frydenberg and Lewis (1997) was labelled “**Not Cope**” on the original CSA and comprised a list of strategies associated with “not coping.” The psychiatric sample had the same subscales, although the loadings were different to the normative group of the CSA on this factor.

Examination of the psychiatric sample’s data found positive loadings on Factor 3 “**Optimism**” of the following subscales: *focus on solving the problem, seek spiritual support, focus on the positive, physical recreation and protect self*. Factor 3 on the original CSA consisted of *wishful thinking, seek spiritual support, focus on the positive and seek relaxing diversions* and is different to this extracted factor from the psychiatric group, as it was inclusive of coping strategies such as *physical recreation and protection of self* and not *relaxing diversions*.

Examination of the psychiatric data found negative loadings on Factor 4 “**Strategies which Focus on Sharing problems**” of the following subscales: *focus on solving the problem, worry, social action, seek professional help and seek relaxing diversions*. Hence, the factor extracted here from the psychiatric sample is dissimilar from that obtained from the normative group and can not be classed as a “sharing problems” factor, rather it is a combination of “productive” and so-called “non-productive” coping strategies.

The four factors from the psychiatric sample were generally weakly correlated with one another, with the highest being -0.43, between factor 1 and factor 4, as seen in Table 4.5.

Table 4.5

Factor Correlation Matrix of the Psychiatric Sample

Factor	1.	2.	3.	4.
1.	1.000	0.35	.322	-.431
2.	.035	1.000	-.053	-.110
3.	.322	-.053	1.000	-.238
4.	-.431	-.110	-.238	1.000

Univariate two-sample unequal variance t-tests comparing coping

strategies. Unequal variance two sample t-tests were carried out on the psychiatric and normative samples to examine possible mean differences on each of the 19 subscales. This approach was adopted to avoid possible unwarranted homogeneity of variance violations between the two groups. In all cases, samples were large enough to be robust to violations of the assumption of sampling from normally distributed populations. The overall alpha level was capped at 0.05 across all 19 tests, and using a Bonferroni adjustment meant that each t-test and ANOVA was evaluated for significance at an alpha level of 0.0026.

Table 4.6

Two-Sample Unequal Variance t-Tests Between Coping Strategies of the Psychiatric Sample and the Normative Sample

Strategy	Psychiatric sample (N = 110)		Normative sample (N = 369)		p Value	t	df
	\bar{x}	SD	\bar{x}	SD			
Social support	12.40	3.97	12.65	3.12	0.545	-0.61	151.31
Focus on solving the problem	23.65	6.95	25.59	4.61	0.007	-2.75	138.76
Work hard	10.14	3.62	12.01	3.19	0.001 *	-4.88	162.72
Worry	13.5	4.01	11.26	3.26	0.001 *	5.53	154.41
Improve relationships	11.53	4.08	12.07	4.18	0.227	-1.21	182.59
Wishful thinking	12.79	3.96	10.07	3.84	0.001*	6.37	174.61
Tension reduction	11.08	3.67	8.69	3.19	0.001*	6.17	162.2
Social action	9.84	4.06	7.23	2.93	0.001*	6.27	144.44
Ignore the problem	8.51	2.71	6.51	2.43	0.001*	6.95	164.71
Self-blame	12.04	3.81	11.36	3.17	0.090	1.70	156.65
Keep to self	12.34	3.57	11.43	3.61	0.020	2.34	180.61
Seek spiritual support	9.01	4.11	5.49	2.44	0.001*	8.54	132.67
Focus on the positive	12.63	4.16	12.75	3.30	0.782	-0.28	152.14
Seek professional help	12.50	4.43	7.95	3.52	0.001*	9.88	152.29
Seek relaxing diversions	13.10	3.88	14.45	3.62	0.001*	-3.25	169.53
Physical recreation	8.35	3.20	8.24	3.09	0.750	0.319	174.03
Protect self	11.80	3.84	12.14	3.52	0.407	-0.83	167.34
Humour	8.63	3.41	7.87	2.94	0.036	2.11	160.33
Not cope	8.22	2.99	6.71	2.66	0.001*	4.76	163.8

Note. Adapted from Frydenberg and Lewis (2002b, p. 647).

*Significant at $p = .0026$.

As can be seen in Table 4.6, the psychiatric sample was significantly more likely to use ‘*not coping*’ than the normative sample. The psychiatric sample was also significantly more likely than the normative sample to engage in : *ignore, worry, wishful thinking tension reduction, social action, seek spiritual support and seek professional help*. They were less likely to *work hard and achieve, and relax*.

Age and Gender Analyses

The literature, and indeed Frydenberg and Lewis (1997), pay particular attention to age and gender differences in coping strategies. While these analyses are not particularly necessary in a psychiatric sample, it was thought, nevertheless, important to carry them out to be consistent with previous research and to also allow for further comparisons between the psychiatric and normative samples.

There will also be comparative analyses between women in the psychiatric sample and women in the normal sample and men in the psychiatric sample and men in the normal sample.

Within gender differences in coping strategies between psychiatric and normative samples. For further analysis, both the psychiatric and normative samples were split by gender and the above analyses repeated.

Univariate analyses: Psychiatric sample. Separate univariate one-way ANOVAS were conducted to look at mean differences in subscale scores across age quartiles in the psychiatric sample split by gender (see electronic Appendix for analyses). The homogeneity of variance assumption, as measured by Levene's test, was satisfied for all subscales for both genders using a 0.01 level of significance for each test, with the exception of the *social acceptance* subscale for females ($p=0.002$). However, as ANOVA is robust to assumption violations, no further action was taken in regards to this assumption violation. Only the *protect self* subscale was found to have significant mean difference across age quartiles for men ($F_{3,51}=7.8, p=0.01$). Post hoc t-tests using a Bonferroni adjustment revealed a significant mean difference between the 17-33 year age group and the 44 -75 year age group ($p=0.01$), with the younger age group having a higher mean ($\bar{x}=16$), than the older year age group ($\bar{x}= 9.93$). For women, no significant mean differences across age quartiles were found for any of the subscales.

An investigation of the proportion of people in each age quartile across the normative and psychiatric groups, using a chi square analysis, revealed no significant differences between proportions in each quartile across the two groups ($\chi^2(3)=6.25, p=0.1$), as can be seen in Table 4.7.

Table 4.7

Classification of the Numbers and Proportions in Each Age Quartile Across the Two Groups

Sample group	Age quartile				Total
	17–26	27–33	34–43	44–75	
Normative					
Count	94	111	80	81	366
Expected count	85.3	111.5	86.9	82.3	366.0
% Within sample group	25.7	30.3	21.9	22.1	100.0
Psychiatric					
Count	17	34	33	26	110
Expected count	25.7	33.5	26.1	24.7	110.0
% Within sample group	15.5	30.9	30.0	23.6	100.0
Total					
Count	111	145	113	107	476
Expected count	111.0	145.0	113.0	107.0	476.0
% Within sample group	23.3	30.5	23.7	22.5	100.0

Univariate analyses: Gender differences in coping strategies—

psychiatric sample. Unequal variance two sample t-tests were carried out in the psychiatric sample to see if there were gender differences in coping strategies.

Both samples were large enough to fulfil the assumption of sampling from normally distributed populations. Due to conducting a large number of t-tests using data from low to moderately correlated subscales, each test was evaluated for significance at an alpha level of 0.01. Univariate t-tests showed no significant differences between males and females on any of the 19 subscales.

Logistic regression: Prediction of gender based on age and coping scale

scores. Table 4.8 displays the results of the logistic regression model predicting gender based on age and the 19 coping scale scores for the psychiatric sample. The overall model was significant ($p = .003$) with the final correct classification rate being 74.5%. Specifically, 42 of 55 (76.4%) of the male sample were correctly classified (true negatives) while 40 of 55 (72.7%) of the female sample were correctly classified (true positives). Five of the 20 predictors were significant. Specifically, female inpatients were more likely to: (a) be younger ($B = -0.07, p = .01$); (b) have lower *social action* scores ($B = -0.30, p = .006$); (c) have lower *keep to self* scores ($B = -0.22, p = .05$); (d) have higher *focus on the positive* scores ($B = 0.44, p = .001$); and (e) have lower *protect self* scores ($B = -0.32, p = .003$), as seen in Table 4.8.

Table 4.8

Prediction of Gender Based on Age and Coping Scale Scores: Psychiatric Sample Only

Variable	<i>B</i>	<i>SE</i>	Wald	<i>df</i>	<i>p</i> Value	Exp(<i>B</i>)
Age	-0.07	0.03	6.19	1	.01	0.93
Social support	0.06	0.11	0.29	1	.59	1.06
Focus on solving the problem	0.02	0.07	0.09	1	.76	1.02
Work hard	-0.07	0.10	0.44	1	.51	0.94
Worry	0.12	0.09	1.74	1	.19	1.12
Improve relationships	0.01	0.10	0.00	1	.95	1.01
Wishful thinking	-0.04	0.09	0.27	1	.61	0.96
Tension reduction	-0.10	0.08	1.41	1	.24	0.91
Social action	-0.30	0.11	7.42	1	.006	0.74
Ignore the problem	0.00	0.12	0.00	1	1.00	1.00
Self-blame	-0.10	0.09	1.28	1	.26	0.90
Keep to self	-0.22	0.11	3.95	1	.05	0.81
Seek spiritual support	-0.04	0.08	0.31	1	.58	0.96
Focus on the positive	0.44	0.13	11.85	1	.001	1.56
Seek professional help	0.10	0.08	1.45	1	.23	1.10
Seek relaxing diversions	-0.08	0.10	0.64	1	.42	0.93
Physical recreation	0.02	0.13	0.04	1	.85	1.02
Protect self	-0.32	0.11	8.63	1	.003	0.72
Humour	-0.12	0.10	1.68	1	.19	0.88
Not cope	0.12	0.10	1.53	1	.22	1.13
Constant	7.13	2.39	8.94	1	.003	1,254.62

Note. *n* = 110. Gender classification: 0 = male, 1 = female. Full model: χ^2 (20, *n* = 110) =

41.38, *p* = .003. Base classification rate = 50.0%. Final classification rate = 74.5%.

Age quartiles. For comparative purposes, age quartiles were defined, according to Frydenberg and Lewis, (2002b) as: 17-26, 27-33, 34-43 and 44-75 years. The statistical approach used across analyses involved a large number of tests involving subscales that required a need for more stringent tests, a possible mitigating factor of large samples. The overall alpha level was capped at 0.05 across all 19 tests, and using a Bonferroni adjustment meant that each t-test and ANOVA was evaluated for significance at an alpha level of 0.0026.

Table 4.9

Differences in Coping Strategies Between Adults From a Normative Sample and a Psychiatric Sample Split by Gender

Strategy	Men's normative (<i>N</i> = 164)		Men's psychiatric (<i>N</i> = 55)		<i>p</i> Value	Women's normative (<i>N</i> = 205)		Women's psychiatric (<i>N</i> = 55)		<i>p</i> Value
	\bar{x}	<i>SD</i>	\bar{x}	<i>SD</i>		\bar{x}	<i>SD</i>	\bar{x}	<i>SD</i>	
Social support	12	2.8	12.21	3.59	0.694	13.2	3.2	12.58	4.34	0.326
Focus on solving the problem	25.8	4.4	23.76	5.91	0.021	25.4	4.8	23.54	7.09	0.030
Work hard	12	2.4	10.63	3.67	0.007*	12	2.5	9.63	3.82	0.001*
Worry	10.09	3.8	13.94	3.69	0.001*	11.5	3.9	13.05	4.29	0.012
Improve relationships	12	3.4	11.87	4.16	0.712	12.1	3.6	11.18	4.02	0.128
Wishful thinking	9.8	3.3	13.52	3.62	0.001*	10.3	3.8	12.05	4.18	0.006
Tension reduction	7.8	3.0	11.60	3.85	0.001*	9.4	3.4	10.56	3.44	0.029
Social action	7.3	3.1	10.49	3.86	0.001*	7.1	2.7	9.2	4.20	0.001*
Ignore the problem	6.4	2.0	8.76	2.73	0.001*	6.6	2.6	8.27	2.69	0.001*
Self-blame	11.	3.7	12.63	3.86	0.011	11.6	3.6	11.43	3.70	0.775
Keep to self	1	3.4	13.03	2.89	0.030	11	3.05	11.63	4.05	0.288
Seek spiritual support	4.9	3.0	8.98	4.33	0.001*	6	3.4	9.05	3.94	0.001*

Table 4.9 (continued)

Strategy	Men's psychiatric		Men's normative		<i>p</i> Value	Women's psychiatric		Women's normative		<i>p</i> Value
	(N = 164)		(N = 55)			(N = 205)		(N = 55)		
	\bar{x}	<i>SD</i>	\bar{x}	<i>SD</i>		\bar{x}	<i>SD</i>	\bar{x}	<i>SD</i>	
Focus on the positive	12.6	3	12.49	3.87	0.848	12.8	3.3	12.76	4.46	0.951
Seek professional help	8.2	4.2	12.61	4.61	0.001*	7.8	4.2	12.38	4.28	0.001*
Seek relaxing diversions	14.3	3.2	13.49	3.76	0.156	14.6	3.1	12.71	4.01	0.002*
Physical recreation	8.5	3.1	8.61	3.15	0.810	8	3.3	8.09	3.27	0.857
Protect self	11.6	3	12.61	3.45	0.054	12.6	3.0	11	4.07	0.008
Humour	8.4	2.9	9.00	3.43	0.247	7.4	2.9	8.27	3.38	0.085
Not cope	9.2	3.4	8.25	2.91	0.047	9.6	3.0	8.2	3.09	0.004

*Significant at $p = .0026$.

As can be seen from Table 4.9, there were significant mean differences between men in the normative and psychiatric samples on the following coping strategies: *worry, wishful thinking, tension reduction, social action, ignore the problem, seek spiritual support and seek professional help*. For all these coping strategies the psychiatric sample had higher scores. For women in the normative and psychiatric samples there were significant mean differences on the following coping strategies: *work hard and achieve, wishful thinking, social action, ignore the problem, seek spiritual, support, seek professional help, protect self and not coping*. Mean scores from the normative sample were significantly higher on *work hard and achieve*, whereas they were higher in the psychiatric sample for: *social action, ignore the problem, seek spiritual support, and seek professional help*.

Comparison of coping strategies of the age quartiles of normative and psychiatric samples. Unequal variance two sample t-tests were carried out within each of the age quartiles on the psychiatric and normative samples to examine possible mean differences on each of the 19 subscales (see Table 4.10). The findings presented below take into consideration that the psychiatric sample had relatively smaller sample size than the normative sample in each of the 4 age quartiles.

Table 4.10

Two-Sample Unequal Variance t-Tests Between The Normative and Psychiatric Samples' Coping Strategies on Each Subscale Within Each Quartile

Strategy	Normative		Psychiatric		<i>p</i> Value
	\bar{x}	<i>SD</i>	\bar{x}	<i>SD</i>	
17–26 ^a					
Seek Social support	13.8	2.9	13.47	4.09	0.754
Focus on solving the problem	26	4.4	26.7	6.91	0.691
Work hard	12.1	2.2	11.35	3.77	0.001*
Worry	12.4	3.9	15.89	4.73	0.030
Improve relationships	12.5	3.4	13.11	3.74	0.537
Wishful thinking	10.9	3.7	13.35	3.97	0.028
Tension reduction	10.4	3.6	11.70	4.61	0.283
Social action	7.2	2.9	11.64	3.46	0.001*
Ignore the problem	6.9	2.5	8.52	3.66	0.096
Self-blame	12.2	3.6	11.17	3.80	0.311
Keep to self	11.5	3.6	12.11	3.82	0.547
Seek spiritual support	5.6	3.1	10.82	3.81	0.006

Table 4.10 (continued)

Strategy	Normative		Psychiatric		<i>p</i> Value
	\bar{x}	<i>SD</i>	\bar{x}	<i>SD</i>	
Focus on the positive	12.5	2.9	13.47	5.08	0.454
Seek professional help	7.3	4.1	12.76	5.17	0.001*
Seek relaxing diversions	15.6	2.9	13.05	4.02	0.022
Physical recreation	8.7	3.3	10.23	3.70	0.126
Protect self	13.0	2.7	13.70	4.92	0.575
Humour	8.7	2.8	9.29	3.94	0.561
Not cope	7.6	2.8	8.82	3.19	0.155
27–33 ^b					
Seek Social support	12.9	2.7	13.17	4.12	0.721
Focus on solving the problem	25.4	4.1	23.70	6.65	0.166
Work hard	12.0	2.4	10.17	3.93	0.014
Worry	11.5	3.9	14.24	3.94	0.02
Improve relationships	12.2	3.4	12.35	4.38	0.855
Wishful thinking	9.9	3.6	12.82	3.52	0.001*

Table 4.10 (continued)

Strategy	Normative		Psychiatric		<i>p</i> Value
	\bar{x}	<i>SD</i>	\bar{x}	<i>SD</i>	
Tension reduction	8.8	3.3	11.38	3.64	0.001*
Social action	7.7	2.7	10.61	4.68	0.001*
Ignore the problem	6.6	2.5	8.52	2.66	0.001*
Self-blame	11.4	3.8	12.58	4.32	0.158
Keep to self	11.1	3.4	12.20	3.74	0.132
Seek spiritual support	5.1	3.0	9.41	4.18	0.001*
Focus on the positive	12.5	3.1	12.94	3.94	0.553
Seek professional help	7.6	3.7	12.26	4.19	0.001*
Seek relaxing diversions	14.3	3.0	13.58	3.93	0.330
Physical recreation	8.9	3.4	8.47	3.40	0.521
Protect self	12.2	2.9	12.35	4.02	0.841
Humour	8.1	2.9	9.26	3.91	0.116
Not cope	6.8	2.7	7.73	2.56	0.072

Table 4.10 (continued)

Strategy	Normative		Psychiatric		<i>p</i> Value
	\bar{x}	<i>SD</i>	\bar{x}	<i>SD</i>	
34–43 ^c					
Seek Social support	12.0	2.5	12.03	3.73	0.966
Focus on solving the problem	26	4.3	22.51	6.34	0.06
Work hard	12.3	2.3	9.6	3.32	0.001*
Worry	10.8	3.5	13.44	4.01	0.003*
Improve relationships	11.9	3.3	10.84	3.28	0.124
Wishful thinking	9.4	3.2	13.21	4.11	0.001*
Tension reduction	7.9	2.6	11.42	3.58	0.001*
Social action	7.1	2.9	9.12	3.94	0.010
Ignore the problem	6.2	2.2	8.42	2.38	0.001*
Self-blame	10.9	3.4	11.93	3.57	0.163
Keep to self	11.8	3.5	12.09	3.46	0.688
Seek spiritual support	5.2	2.9	7.84	3.92	0.001

Focus on the positive	12.5	2.8	12.30	4.05	0.797
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Table 4.10 (continued)

Strategy	Normative		Psychiatric		<i>p</i> Value
	\bar{x}	<i>SD</i>	\bar{x}	<i>SD</i>	
Seek professional help	7.9	4.3	13.06	4.68	0.001*
Seek relaxing diversions	13.5	3.2	12.63	3.68	0.241
Physical recreation	7.7	2.9	7.75	2.54	0.928
Protect self	11.8	3.2	11.21	3.30	0.387
Humour	7.4	2.7	8.27	2.54	0.109
Not cope	6.4	2.3	8.06	2.90	0.005
44–75 ^d					
Seek Social support	11.6	3.8	11.15	3.78	0.601
Focus on solving the problem	25.1	5.7	23.03	5.75	0.117
Work hard	11.6	2.9	9.96	3.49	0.037
Worry	10.1	3.8	13.94	3.78	0.001*
Improve relationships	11.7	3.9	10.26	4.46	0.148
Wishful thinking	10.1	4.0	11.84	4.36	0.079

Tension reduction 7.5 2.7 9.84 3.02 0.001*

Table 4.10 (continued)

Strategy	Normative		Psychiatric		<i>p</i> Value
	\bar{x}	<i>SD</i>	\bar{x}	<i>SD</i>	
Social action	6.9	3.2	8.57	3.20	0.026
Ignore the problem	6.4	2.4	8.61	2.61	0.001*
Self-blame	10.9	3.5	12.0	3.50	0.170
Keep to self	11.6	3.6	12.96	3.47	0.092
Seek spiritual support	6.4	4.0	8.80	4.20	0.014
Focus on the positive	13.7	3.6	12.07	4.06	0.750
Seek professional help	9.5	4.8	11.92	4.05	0.015
Seek relaxing diversions	14.3	3.5	13.07	4.15	0.181
Physical recreation	7.3	2.8	7.73	3.03	0.525
Protect self	11.5	3.5	10.61	2.95	0.208
Humour	7.1	3.1	7.84	3.26	0.314
Not cope	5.8	2.6	8.69	3.48	0.001*

^aNormative, *n* = 94; psychiatric, *n* = 17. ^bNormative, *n* = 111; psychiatric, *n* = 34. ^cNormative, *n* = 80; psychiatric, *n* = 33. ^dNormative, *n* = 81; psychiatric, *n* = 26.

*Significant at *p* = .0026.

In the 17-26 year age quartile, significant mean differences were found on subscales: *work hard and achieve*, *social action*, *seek spiritual support* and *seek professional help*. The psychiatric sample used more *social action*, *seek spiritual support* and *seek professional help* than the normative sample, whereas the normative sample used more *work hard and achieve* coping strategies. In the 27-33 year age quartile, significant mean differences were found on subscales: *wishful thinking*, *tension reduction*, *social action*, *ignore the problem*, *seek spiritual support* and *seek professional help*. In all cases, the psychiatric sample means were larger than those of the normative sample. In the 34-43 year age quartile, significant mean differences were found on subscales: *work hard and achieve*, *wishful thinking*, *tension reduction*, *ignore the problem*, *seek spiritual support*, and *seek professional help*. In all cases the psychiatric sample means were higher than the normative sample, with the exception of *work hard and achieve*. In the 44-75 year age quartile significant mean differences were found on subscales: *worry*, *tension reduction*, *ignore the problem*, and *not coping*. The psychiatric means were higher than the normative sample on all these coping strategies.

Differences in coping strategies between the normative sample and the schizophrenic subsample. An analysis was conducted to compare the normative sample to a subsample of those only diagnosed with schizophrenia. Unequal variance two sample t- tests were carried out on the subsample and normative samples to examine possible mean differences on each of the 19 subscales. This approach was adopted to avoid possible unwarranted homogeneity of variance violations between the two groups. In all cases, samples were large enough to be

robust to violations of the assumption of sampling from normally distributed populations.

Table 4.11

Unequal Variance Two-Sample t-Tests on Coping Strategies Between a Normative Sample and People Diagnosed with Schizophrenia

Strategy	Normative, $N =$ 369		Schizophrenics, $N =$ 50		p Value
	\bar{x}	SD	\bar{x}	SD	
Social support	12.65	3.12	12.46	3.78	0.735
Focus on solving the problem	25.59	4.61	23.92	6.91	0.103
Work hard	12.01	3.19	10.02	3.49	0.001*
Worry	11.26	3.26	13.42	3.65	0.001*
Improve relationships	12.07	4.18	11.74	4.11	0.597
Wishful thinking	10.07	3.84	12.64	3.43	0.001*
Tension reduction	8.69	3.19	10.68	3.70	0.001*
Social action	7.23	2.93	9.70	4.15	0.001*
Ignore the problem	6.51	2.43	8.62	2.26	0.001*
Self-blame	11.36	3.17	11.08	3.70	0.612
Keep to self	11.43	3.61	12.62	3.46	0.026
Seek spiritual support	5.49	2.44	9.44	3.56	0.001*
Focus on the positive	12.75	3.30	13.40	4.16	0.293
Seek professional help	7.95	3.52	12.76	4.34	0.001*
Seek relaxing diversions	14.45	3.62	14	3.77	0.429
Physical recreation	8.24	3.09	8.66	3.39	0.409
Protect self	12.14	3.52	12.42	3.94	0.635
Humour	7.87	2.94	8.82	3.46	0.069
Not cope	6.71	2.66	7.90	2.88	0.007

Note. Data for normative sample from Frydenberg and Lewis (2002b, Table 2).

* $p = .0026$.

As can be seen in Table 4.11, the unequal variance two-sample t-tests revealed significant mean differences between subjects diagnosed with schizophrenia and the normative sample. Significant mean differences were found on the following variables: *work hard and achieve*, *worry*, *wishful thinking*, *social action*, *ignore the problem*, *seek spiritual support* and *seek professional help*. Those patients diagnosed with schizophrenia had higher mean scores on all these subscales except for the coping strategy *work hard and achieve*. The normative sample was more likely to *work hard and achieve* than those diagnosed with schizophrenia. This pattern was different to how the psychiatric group as a whole compared to the normative group, the difference being that those patients diagnosed with schizophrenia sought more *relaxing diversions* than the psychiatric group as a whole. There was no difference between those diagnosed with schizophrenia and the normative sample on endorsing the coping strategy *seek relaxing diversions*.

Discussion. This study evaluated how well the CSA measured coping strategies in people diagnosed with a mental illness. Specifically, it compared how this group differed from the normative sample used in the original validation of the CSA scale.

Factor analysis results. The results of the factor analysis demonstrated that coping in psychiatric patients, while more suited to the four factor model, might even be described in terms of a three-factor solution without any unwarranted loss of information, compared to the original, four-factor solution. The three-factor model being: (a) dealing with the problem, (b) not coping, or (c)

optimism. This model omits the fourth factor of the original model, which was characterised by sharing coping strategies, i.e., *sharing problems, seeking professional help, social action and seek social support*. The 3-factor structure would also be a more parsimonious model for inpatients at a psychiatric hospital, as such individuals often do not have the resources, such as social support, to fall back on and are either already engaged with professional help or do not wish for professional help.

Not coping and non-productive coping strategies. All comparative analyses highlighted a number of significant differences in the way the psychiatric sample coped with general concerns, when compared to the normative sample. On this basis, the CSA appeared to discriminate between the psychiatric and normative populations.

Hypothesis 1: The first hypothesis was supported in that the psychiatric sample endorsed the not coping subscale and non-productive coping strategies more on the CSA questionnaire, than the normative sample. The finding that the psychiatric sample was more likely to endorse *not coping* and less likely to endorse productive strategies than the normative sample was not unexpected, given that the psychiatric sample were inpatients in a psychiatric hospital and this finding is consistent with other research (Frydenberg, & Lewis, 2002b; Wisniewski & Frydenberg, 1995). For example, the *work hard and achieve* coping strategy was not likely to be endorsed by the psychiatric patients, because as inpatients most were unemployed and hospitalised. The different coping strategies endorsed by the two groups suggest each group may adapt a particular coping strategy depending on the demands placed upon them by virtue of

differing environments, a finding which is certainly in keeping with research on coping in those diagnosed with a mental illness (Steed, 1998). This finding also concurs with Holahan and Moos (1987) who found that active coping strategies were associated with more personal and contextual resources, whereas avoidance coping was associated with fewer such resources. The results are also consistent with prior work in the psychological literature on the link between coping and personal and environmental resources (Billings & Moos, 1981; Pearlin & Schooler, 1978; Tepper, Rogers, Coleman & Maloney, 2001).

The coping strategy *work hard and achieve* is considered an effective coping strategy amongst the vast majority of those in the coping field and also falls into categories such as problem solving and problem focused, that are seen as adaptive coping strategies (Endler & Parker, 1990; Lazarus & Folkman, 1980). The normative sample in this study were more likely than the psychiatric sample to use the *work hard and achieve* coping strategy. The literature suggests that the majority of people use work as a coping strategy and are more likely to put more of their efforts into work when faced with difficult situations (Stanley, 1983). For the psychiatric sample in this study who were hospitalised, this was not an option. For many of these people in such dire circumstances, when faced with adversity, they also have few options other than to “not cope,” as they have few social supports, and often abhorrent family and living conditions. Newnes (2014) argues that social factors are still minimised by health professionals. Instead, there is the continued implementation of boundaries of what meets “normal” and, in effect, this boundary setting also highlights what is “abnormal,” which is anything that does not fit into the parameters defined as “normal.”

The psychiatric sample was more likely than the normative sample to engage in, what Frydenberg and Lewis (1997) term, “non-productive” coping strategies. Contrary to previous research (Aldwin & Revenson, 1987; Fledderus, Bohlmeijer & Pieterse, 2010), the psychiatric patients in this study were more inclined to use a mixture of non-productive strategies with more productive, adaptive coping strategies, such as optimistic and shared coping strategies. The psychiatric sample also used social resources, a finding consistent with Holahan and Moos (1987). There was a difference between the psychiatric and normative sample on *not coping*, with the psychiatric sample endorsing more items on this subscale compared to the normative sample. This subscale contained coping strategies such as: *worry*, *keep to self* and *wishful thinking*, seen by Frydenberg & Lewis (1997) as “non-productive” coping strategies. However, such coping strategies may be useful to individuals in times of stress. As reported above, while the psychiatric sample may have endorsed more so-called “non-productive” coping strategies, they used a mixture of productive coping alongside *not coping*. Such an approach may be useful for these patients, given the multiple vicissitudes they are “dealing with”. Categorising such attempts as “non-productive” when the context is unknown may be passing a judgment on the way a person manages difficulties in their life. This is where the CSA does little to represent individual variation in coping strategies.

An interesting finding in this comparative study was that the hospital admission did not seem to have prevented some types of problem-solving, or active coping attempts. This finding is especially noteworthy, considering some inpatients were involuntarily admitted to the facility.

Religious and spiritual coping mechanisms.

Hypothesis 2a. Hypothesis 2a that the psychiatric sample will be more likely than the normative sample to endorse *seek spiritual support*, was also supported by the current study and these results are consistent with many other research studies (Ano & Vasconcelles, 2004; Bergin, Masters, & Richards, 1987; Crossley, 1995; Koeing, 2009; Pargament, Koeing, Tarakeshwar, & Hahn, 2004; Ruchita, Parmanand, Dandeeep, Kumar, Malhotra & Tyagi, 2011; Phillips & Stein, 2007; Smolak, et al., 2013; Tepper, Rogers, Coleman & Maloney, 2001).

Hypothesis 2b. Hypothesis 2b that those diagnosed with schizophrenia will be more likely than the normative sample to use the coping strategy *seek spiritual support* was supported by the research findings. Those diagnosed with schizophrenia did use an optimistic coping strategy *seek spiritual support*, which has been reported in the literature (Ruchita et al., 2011; Smolak, et al., 2013; Tepper et al., 2001). Again, as found with the overall psychiatric sample, those diagnosed with schizophrenia used a mixture of “productive” and “unproductive” coping strategies.

Gender differences.

Hypothesis 3. The third hypothesis that men will endorse avoidance coping strategies more than women, as measured by the CSA, was not supported by univariate analyses.

Hypothesis 4. The fourth hypothesis that women will endorse more social support and emotion-focused coping than men as measured by the CSA was also not supported. Investigations into gender differences revealed no significant

differences between men and women in the types of coping strategies they used, a finding consistent with Folkman and Lazarus (1980).

While there were no gender differences as reflected in the univariate analyses, multivariate analyses revealed that gender could be accurately predicted by the following subscales, *social action*, *keep to self*, *focus on the positive* and *protect self*, as a set. Multivariate analyses revealed that women in the psychiatric sample were more likely to have lower *protect self* and *social action* subscale scores, be younger and have higher focus on the positive scores. Overall, the literature has revealed that women are more likely than men to use strategies that involved verbal expressions to others, to seek emotional support, ruminate about problems, and use positive self talk, (Felsten, 1998; Pearlin & Schooler, 1978; Tamres, Janicki & Helgeson, 2002).

Another interesting finding in the study was that men in the psychiatric sample used some of what are considered to be more stereotypical coping mechanisms of women, such as: *worry*, *wishful thinking*, *tension reduction*, *social action*, *ignore the problem*, *seek spiritual support* and *seek professional help*, more than men from the normative sample. This finding is in contrast to general research in how men cope.

There were no significant differences in problem-focused strategies, indicating that men from the psychiatric group fared similarly to the normative group. The age cohort of 17-33 year old men revealed coping mechanisms, such as protecting themselves, more than any other cohort, and more than females. This finding is consistent with previous research (Porter & Stone, 1995; Ptacek et al., 1994). Contrary to findings from Frydenberg and Lewis, (2002b), this study

found that gender and age did impact, to a certain extent, on responses given by the psychiatric population.

Gender differences in coping strategies were investigated using two different approaches (univariate and multivariate statistical analyses). It was no surprise that some variables were significant on their own, but not significant in the presence of others, and some insignificant on their own, but significant in the presence of others. Interestingly, what this means for this study is that women in the psychiatric sample were more likely to be younger than men; have lower *social action* scores; have lower *keep to self* scores; have higher *focus on the positive* scores; and have lower *protect self* scores.

Analyses conducted to investigate whether there was a relationship between diagnosis and gender, revealed that there were no significant differences, a finding consistent with Narrow et al. (2007) and Kinderman et al., (2013) who acknowledge the general unreliability of psychiatric diagnoses per se. The unreliability of psychiatric diagnoses is a point other researchers have raised (e.g., Aboraya, 2007; Jacobs, 2009). Review of diagnoses and discussions with ward psychiatrists revealed patients had received an array of diagnoses and, therefore, for the purposes of this study, the most recent diagnosis was used. The multiplicity of diagnoses and the limited conclusions which could be drawn raise an important consideration for future researchers who wish to use diagnosis in analyses.

Coping strategies of those diagnosed with schizophrenia. When the psychiatric sample was refined to those diagnosed with schizophrenia and compared to the normative sample, the results revealed significant differences on

the following subscales: *work hard and achieve*, *worry*, *wishful thinking*, *social action*, *ignore the problem*, *seek spiritual support* and *seek professional help*.

Those people diagnosed with schizophrenia had higher mean scores than the normative sample on all subscales except for the subscale *work hard and achieve*.

Hypothesis 5, that the normative sample would be more likely to use the *work hard and achieve* coping strategy than those diagnosed with schizophrenia from the psychiatric sample, was supported by the results of this study. The schizophrenic subsample, in keeping with previous research findings, utilised *worry*, *ignoring the problem*, *seek spiritual support* and *seek professional help* significantly more so than the normative sample. These results are in keeping with research on people diagnosed with schizophrenia.

Strengths and limitations of Study A. The strengths of this study lie with the instrument, as the CSA was easy to administer, had good psychometric reliability, and patients reported that they enjoyed completing the questionnaire, as it prompted them to think about their many coping strategies. Some remarked that it reminded them of certain coping strategies they had not used in a while and could possibly use again. Given some of the patients who completed the questionnaire may have had low attention and concentration spans at the time, from a clinical perspective this feedback is helpful in understanding that patients did not find completing the questionnaire too challenging. Therefore, the CSA demonstrated good clinical utility within a psychiatric hospital. The CSA also provided a range of coping strategies which were easily identifiable and the Likert style of response options made for a reliable and valid way to measure patients' *coping strategies*.

Where limitations arise with the CSA are in its use as a measurement tool of coping per se for psychiatric inpatients. This scale alone only reflected the coping strategies which patients endorsed they might use or were more likely to use than other coping strategies, in general. The very nature of the scale's categorisation of coping attempts as "productive" and "non productive" again enforced a categorization on an individual's attempts to manage situations.

Conclusion and recommendations. In this study the CSA successfully discriminated between the psychiatric and normative samples' coping strategies. In particular, the findings suggest that the CSA might be a useful tool for measuring the coping strategies of individuals diagnosed with a mental illness, with caution applied. But, it must also be remembered that there are many problems associated with transferring such information from coping questionnaires over into a summary of patient overall coping and the meaning of coping for this population, as also suggested by Aldwin and Revenson (1987) in their longitudinal study. Aldwin and Revenson found that coping inventories negatively correlated with perceptions of efficacy, which suggested, in their study, that they may have overlooked the positive coping strategies of people. What people report on a questionnaire is only a particular coping strategy, not their overall coping per se. A score for the use of a particular coping strategy might be useful in an individual capacity, but clustering groups of scores for people and comparing them does nothing to add to the meaning of the coping experience.

A possible way around the limitations of the CSA as a questionnaire listing items patients only endorse, would be to use the CSA as an adjunct clinical tool as part of case formulation, but only in an individual clinical capacity. Such

inventories could be used as a way of enhancing a coping repertoire, but not as a coping diagnostic tool per se. As a teaching resource or a way to help identify patients' strengths and coping styles, with caution applied, it has its merits.

However, more appropriately, carefully formulated approaches that bring together a variety of sources of information, plus personalized contact, interviews and discussions of how patients manage their difficulties, in general, would yield a richer and a more personalised account of patients coping. I would certainly caution against the sole use of the CSA questionnaire as a research instrument for those diagnosed with a mental illness, because it might promote "assessment of" and "judgment of" coping by mental health professions, resulting in the categorization of patient coping attempts.

**Study B: Matched Study: A Comparative Analysis Between a
Community and a Psychiatric Sample Matched on Age and Gender.**

The purpose of the Study

A matched study was carried out between the psychiatric group and a separate adult community group in Western Australia to investigate differences in coping strategies between the two groups after matching for age and sex. This study was a comparative study of coping strategies between a psychiatric inpatient sample and a “normal” community sample that were matched on age and gender. The study was a matched pairs design, to investigate differences in coping strategies between the two groups after matching for age and sex. Participants were matched on these two variables as previous studies had found evidence for age and gender differences in coping strategies. For example, Frydenberg and Lewis (1997) had found significant gender and age differences in coping strategies in both adolescent and adult samples using the CSA as a measurement tool (Frydenberg & Lewis, 1993, 1994, 1997, 2000, 2002a, 2002b). These findings are also consistent with previous research on gender and age differences (Labouvie-Vief, Hakim-Larson & Hobart, 1987; Littlewood, Cramer, Hoekstra, & Humphrey, 1991; Matud, 2004; Melendez, Mayordomo, Sancho, & Tomas, 2012; McGreal, Evans & Burrows, 1997). The psychiatric sample matched with a community sample for age and sex, will use more unproductive coping strategies as measured by the CSA.

Therefore, it is hypothesised:

Hypothesis 1. When matched for age and sex, those diagnosed with a mental illness would use more unproductive strategies than the community sample.

Design

The study was a matched pairs design, to investigate differences in coping strategies between the two groups after matching for age and sex.

Method

Participants

Psychiatric sample. The original psychiatric sample, as described in Study A of this chapter, was also used for this study. They were matched by year of birth and gender against the set of ten male and ten female community participants. In brief, this group of psychiatric patients consisted of inpatients, 18-75 years old (\bar{x} =33.54, SD=10.01), with a variety of diagnoses (see Study A, Table 4.1).

Matched Community Participants. Twenty male (N=10) (\bar{x} age, 35.9, SD =11.46) and female (N=10) (\bar{x} age, 35.2, SD =9.23) adults, between the ages of 18-60, from the Western Australian community, were matched by year of birth and gender against the set of psychiatric inpatients described in Study A (see Study A for participant information). Recruiting of the matched sample took place over a six-month period. A list of the year of birth required was posted on my supervisor's office door at the university and employees (not students) at the university completed a questionnaire if they matched the required age and gender. People were also recruited from doctor's surgeries in local neighbourhoods using the same process. Questionnaires were completed by the participant in their own environment as per questionnaire instructions on the front of the CSA and returned via the reply-paid envelope to my supervisor's university address.

Measures

The matched sample completed the General Form of the Coping Scale for Adults Questionnaire (CSA). The questionnaire takes on average 10 minutes. The

community participants completed the questionnaires in their home environment as per the CSA test instructions on the CSA questionnaire (see Study A test instructions)

Procedure

The procedure for the psychiatric sample was as described in Study A.

Results

In order to see whether the 20 pairs matched by age and gender were suitable for analysis by a paired t-test, difference scores were computed for each subscale and examined by the use of QQ plots to check for any evidence of the difference scores possibly being sampled from non-normal distributions (as the paired t-test assumes that the difference scores were sampled from a normally distributed population). For all 19 subscales, the QQ plots did not indicate that the difference scores might have come from non-normally distributions. As a result of this, the data were analysed by the use of paired t-tests. Due to conducting a large number of tests using data from correlated subscales, each test was evaluated for significance at a Bonferroni adjusted alpha level of 0.0026 (see Appendix B).

No significant mean differences between the two samples were found on the 19 subscales. As a check of the robustness of the above analysis, Wilcoxon Signed Ranked tests, which avoid the assumption of the difference score populations being normally distributed, were conducted on each subscale. The results of these analyses were in total agreement with the above paired t-tests, and showed no significant differences (see Appendix B).

Discussion: There was no support for the first hypothesis that aimed to explore whether a matched-pairs analyses, matched for age and sex, would reveal differences in coping strategies between the psychiatric group and a community sample. These findings are also not consistent with findings from Study A. A possible reason for the lack of significant differences between the groups could have been due to the matching variables of gender and year of birth being ineffective in terms of controlling the variability in the participants. Another possible reason could have been the small sample size that may have resulted in the analyses having a lack of power to find significant differences between the two groups (Siegel & Castellan, 1988).

A finding that needs to be acknowledged from Study A that may have influenced the matched study was that there was a biased distribution of occupational status favouring the upper end of the occupational continuum (Frydenberg & Lewis, 1997). In Study A the normative sample comprised 133 Australian middle managers from a private sector organisation in the retail industry and 236 non-managers from the Australian community. Therefore, it could be considered that the comparative group in Study A was not a “true” representation of a normative community sample, as it favoured higher occupational status. Consequently, this smaller matched study with the findings of no difference just might reflect more of the true meaning of the little difference in the choice of coping strategies between so-called normative and psychiatric samples.

Study C: How Do Those Diagnosed With a Mental Illness Cope When Compared to University Students? A Comparative Analysis of Coping Using the Coping Scale for Adults (CSA)

The current study extended the investigation of the CSA (Frydenberg & Lewis, 1997) with the incorporation of a sample of undergraduate university students (N=110). The objective of this study was to compare coping strategies of those diagnosed with a mental illness to university students. The study was a cross-sectional design of the similarities and differences in coping strategies of psychiatric inpatients and university students, as measured by the CSA. Factor structure, gender and age differences across the 19 coping strategies were compared.

Method.

Participants

Undergraduate university students. The participants were 110 students (\bar{x} =30.34, SD=9.0), male (N=55) and female (N= 55), aged between 18-60 years, who were enrolled in undergraduate psychology units. Students volunteered and were randomly selected from a number of tutorial groups in first and second year psychology.

Psychiatric sample. The original psychiatric sample, as described in Study A of this chapter, was also used for this study. In brief, this group consisted of inpatients, 18-75 years old (\bar{x} =33.54, SD=10.01), with a variety of diagnoses (see Study A, Table 4.1).

Descriptions of Coping strategy endorsed across the university and psychiatric groups within each age quartile. For comparative

purposes age quartiles were defined as previously in Study A, namely 17-26, 27-33, 34-43 and 44-75 years. Unequal variance two-sample t-tests were carried out within each of the age quartiles on the university and psychiatric samples to examine possible differences in coping strategy use across each of the 19 subscales (see Table 4.13). With the exception of the psychiatric sample 17-26 age quartile and the university samples 27-33, 34-43 and 44-75 age quartiles, all other samples were large enough to be suitable for general parametric techniques. It should be noted, however, that the last age quartile, 44-75 years, does not consist of any university males, and is, therefore, a comparison with only university females of that age.

Table 4.12

Age Quartile Cross-Tabulation for the Psychiatric and University Samples

Sample group	Age quartile				Total
	17–26	27–33	34–43	44–75	
Psychiatric					
Count	17	34	33	26	110
Expected count	35.5	28.0	27.5	19.0	110.0
% Within sample group	15.5	30.9	30.0	23.6	100.0
University					
Count	54	22	22	12	110
Expected count	35.5	28.0	27.5	19.0	110.0
% Within sample group	49.1	20.0	20.0	10.9	100.0
Total					
Count	71	56	55	38	220
Expected count	71.0	56.0	55.0	38.0	220.0
% Within sample group	32.3	25.5	25.0	17.3	100.0

Procedure. Students were administered the General form of the CSA in their tutorial group. The standardised test instructions were used and the examiner was present in the room while students completed the questionnaire. Recruiting took place over a 6 month period. Data collected for the psychiatric sample was as described in Study A.

Results.

Comparative analyses of university and psychiatric samples. Several analyses were carried out to examine possible differences between the university and psychiatric samples. To investigate possible age differences between the university and psychiatric samples, a two-way ANOVA (age by group and

gender) revealed a significant interaction between gender and group ($F_{3,216} = 10.99$, $p = 0.000$). To examine this interaction effect more closely, separate unequal variance t-tests were carried out. Within the male subgroup there was a significant difference in age between the university and psychiatric groups ($t_{75} = 5.9$, $p = 0.000$), with the psychiatric males being older ($\bar{x} = 37.05$, $SD = 11.52$) than the university males ($\bar{x} = 26.98$, $SD = 5.25$).

Within the female subgroup there was no significant difference in age between the two samples ($t_{104} = 0.93$, $p = 0.35$). Within the psychiatric group there was no significant age difference between genders ($t_{100} = 0.83$, $p = 0.409$). Within the university group there was a significant age difference between genders ($t_{79} = -4.23$, $p = 0.000$), with males ($\bar{x} = 26.98$, $SD = 5.25$) on average being younger than females ($\bar{x} = 33.70$, $SD = 10.57$).

Data from the university sample were analysed similarly to Study A. A preliminary analysis of the data split by gender across all 19 subscales was conducted using box plots and histograms. The majority of histograms and boxplots were reasonably symmetrical (see Appendix B). For males *social action* ($z = 2.42$, $p = 0.01$), *seek spiritual support* ($z = 3.55$, $p = 0.00$); *seek professional help* ($z = 2.85$, $p = 0.00$) exhibited significant skewness. For females *work* ($z = -2.51$, $p = 0.01$), *tension reduction* ($z = 3.16$, $p = 0.00$), *social acceptance* ($z = 4.46$, $p = 0.00$), *seek spiritual support* ($z = 2.73$, $p = 0.01$), and *seek professional help* ($z = 2.25$, $p = 0.02$) exhibited significant skewness (see Appendix B for relevant sample statistics). The skewness did not appear to be caused by one or two extreme outliers, but instead appeared to be the result of a spread of scores that tapered off

towards the upper end of score totals. No data transformation was considered necessary.

Preliminary analysis. Unequal variance two sample t-tests were carried out on the university sample to examine age differences across gender. Both samples were large enough to avoid the assumption of sampling from normally distributed populations. There was evidence of a significant mean difference on the age variable across gender ($t_{79}=4.23$, $p=0.00$), with females being older ($\bar{x}=33.7$; $SD=10.57$) than males ($\bar{x}=27.0$; $SD=5.24$). As a result of this finding, age was included as a co-variate in any multivariate analyses that follow.

Age quartiles, university and psychiatric samples. An investigation of the proportion of people in each age quartile across the university and psychiatric groups, using a chi-square analysis, revealed significant differences between proportions in each quartile across the two groups ($\chi^2(3) = 29.21$, $p = 0.00$), as can be seen in Table 4.12. In the 27-33 age quartile and the 34-43 age quartile there were more psychiatric subjects than university subjects. The university sample had more than expected numbers in the 17-26 age quartile and less than expected in the 45-75 age quartile.

Table 4.13

Two-Sample Unequal Variance t-Tests Between the University and Psychiatric Samples' Coping Strategies on Each Subscale Within Each Quartile

Strategy	University		Psychiatric		<i>p</i> Value
	\bar{x}	<i>SD</i>	\bar{x}	<i>SD</i>	
17–26 ^a					
Seek Social support	14.22	3.5	13.47	4.09	0.502
Focus on solving the problem	25.22	4.59	26.7	6.91	0.416
Work hard and achieve	10.99	2.50	11.35	3.77	0.716
Worry	10.96	3.56	15.89	4.73	0.038
Improve relationships	10.85	3.09	13.11	3.74	0.033
Wishful thinking	11.42	2.94	13.35	3.97	0.078
Tension reduction	9.90	3.30	11.70	4.61	0.15
Social action	7.05	2.46	11.64	3.46	0.001*
Ignore the problem	7.25	2.22	8.52	3.66	0.191
Self-blame	11.01	3.86	11.17	3.80	0.883
Keep to self	10.00	3.71	12.11	3.82	0.055

Table 4.13 (continued)

Strategy	University		Psychiatric		<i>p</i> Value
	\bar{x}	<i>SD</i>	\bar{x}	<i>SD</i>	
Seek spiritual support	6.03	3.72	10.82	3.81	0.001*
Focus on the positive	12.89	3.34	13.47	5.08	0.662
Seek professional help	6.81	3.44	12.76	5.17	0.001*
Seek relaxing diversions	15.09	2.57	13.05	4.02	0.064
Physical recreation	8.51	3.04	10.23	3.70	0.096
Protect self	11.51	3.35	13.70	4.92	0.102
Humour	8.78	3.11	9.29	3.94	0.627
Not cope	7.12	2.94	8.82	3.19	0.063
27–33 ^b					
Seek Social support	12.09	3.89	13.17	4.12	0.324
Focus on solving the problem	25.59	3.47	23.70	6.65	0.172
Work hard and achieve	10.95	2.08	10.17	3.93	0.339
Worry	10.36	3.44	14.24	3.94	0.005

Table 4.13 (continued)

Strategy	University		Psychiatric		<i>p</i> Value
	\bar{x}	<i>SD</i>	\bar{x}	<i>SD</i>	
Improve relationships	10.86	3.28	12.35	4.38	0.153
Wishful thinking	10.73	2.69	12.82	3.52	0.015
Tension reduction	9.63	3.30	11.38	3.64	0.07
Social action	6.90	2.34	10.61	4.68	0.001*
Ignore the problem	7.04	1.40	8.52	2.66	0.009
Self-blame	10.59	4.17	12.58	4.32	0.091
Keep to self	10.90	2.69	12.20	3.74	0.138
Seek spiritual support	5.45	3.63	9.41	4.18	0.001*
Focus on the positive	12.04	1.73	12.94	3.94	0.250
Seek professional help	8.72	3.45	12.26	4.19	0.001*
Seek relaxing diversions	15.09	2.54	13.58	3.93	0.088
Physical recreation	7.63	2.79	8.47	3.40	0.321
Protect self	12.31	2.64	12.35	4.02	0.969

Table 4.13 (continued)

Strategy	University		Psychiatric		<i>p</i> Value
	\bar{x}	<i>SD</i>	\bar{x}	<i>SD</i>	
Humour	8.77	2.50	9.26	3.91	0.568
Not cope	6.71	2.16	7.73	2.56	0.115
34–43 ^c					
Seek Social support	11.63	3.87	12.03	3.73	0.709
Focus on solving the problem	27.18	3.06	22.51	6.34	0.001*
Work hard and achieve	11.44	1.67	9.6	3.32	0.009
Worry	11.13	3.76	13.44	4.01	0.047
Improve relationships	10.31	3.69	10.84	3.28	0.589
Wishful thinking	11.41	3.08	13.21	4.11	0.069
Tension reduction	9.45	2.55	11.42	3.58	0.021
Social action	8.72	3.28	9.12	3.94	0.689
Ignore the problem	7.59	2.21	8.42	2.38	0.192
Self-blame	11.18	4.59	11.93	3.57	0.518

Table 4.13 (continued)

Strategy	University		Psychiatric		<i>p</i> Value
	\bar{x}	<i>SD</i>	\bar{x}	<i>SD</i>	
Keep to self	10.04	3.97	12.09	3.46	0.056
Seek spiritual support	6.09	3.10	7.84	3.92	0.070
Focus on the positive	12.68	3.24	12.30	4.05	0.703
Seek professional help	8.95	3.48	13.06	4.68	0.001*
Seek relaxing diversions	14.45	2.82	12.63	3.68	0.044
Physical recreation	8.54	2.85	7.75	2.54	0.301
Protect self	12.31	2.86	11.21	3.30	0.194
Humour	9.00	3.43	8.27	2.54	0.401
Not cope	6.63	2.42	8.06	2.90	0.054
44–75 ^d					
Seek Social Support	15.58	3.11	11.15	3.78	0.001*
Focus on solving the problem	29.08	3.02	23.03	5.75	0.001*
Work hard and achieve	12.1	0.94	9.96	3.49	0.005

Table 4.13 (continued)

Strategy	University		Psychiatric		<i>p</i> Value
	\bar{x}	<i>SD</i>	\bar{x}	<i>SD</i>	
Worry	10.75	2.99	13.94	3.78	0.010
Improve relationships	11.25	2.49	10.26	4.46	0.392
Wishful thinking	10.17	3.54	11.84	4.36	0.218
Tension reduction	9.25	2.99	9.84	3.02	0.575
Social action	8.58	4.54	8.57	3.20	0.997
Ignore the problem	6.25	2.56	8.61	2.61	0.015
Self-blame	12.58	3.17	12.0	3.50	0.615
Keep to self	8.67	2.87	12.96	3.47	0.001*
Seek spiritual support	7.50	3.63	8.80	4.20	0.336
Focus on the positive	12.25	2.73	12.07	4.06	0.878
Seek professional help	12.66	4.73	11.92	4.05	0.644
Seek relaxing diversions	14.5	2.93	13.07	4.15	0.236
Physical recreation	6.75	2.73	7.73	3.03	0.331

Table 4.13 (continued)

Strategy	University		Psychiatric		<i>p</i> Value
	\bar{x}	<i>SD</i>	\bar{x}	<i>SD</i>	
Protect self	12.58	2.84	10.61	2.95	0.063
Humour	9.00	3.19	7.84	3.26	0.315
Not cope	6.67	3.60	8.69	3.48	0.119

^aUniversity, *n* = 54; psychiatric, *n* = 17. ^bUniversity, *n* = 22; psychiatric, *n* = 34. ^cUniversity, *n* = 22; psychiatric, *n* = 33. ^dUniversity, *n* = 12; psychiatric, *n* = 26.

*Significant at *p* = .0026.

Due to conducting a large number of t-tests using data from correlated subscales, the overall alpha level was capped at 0.05 across all 19 tests. Thus, using a Bonferroni adjustment meant that each test was evaluated for significance at an alpha level of 0.0026.

In the 17-26 age quartile, significant differences were found *for social action, seek spiritual support and seek professional help*, with the psychiatric sample using these coping strategies more than the university sample.

In the 27-33 age quartile, significant differences appeared on the subscales: *social action, seek spiritual support and seek professional help*. In all cases, the psychiatric sample means were larger, indicating that they used these coping strategies more often than the university sample.

In the 34-43 age quartile, significant differences were found with *seek professional help*, and *focus on solving the problem*. The university sample reported that they used more *focus on solving the problem* than the psychiatric sample and the psychiatric sample reported that they used *seek professional help* coping strategy more than the university students.

In the 44-75 age quartile, significant differences were found on coping strategies *seek social support, focus on solving the problem, and keep to self*. The university reported that they *focus on solving the problem* and used *seek social support* coping strategies more than the psychiatric sample. The psychiatric sample used coping strategy *keep to self* more than the university students in this age quartile.

ANOVA. Separate univariate one-way ANOVAS were conducted to look at mean differences across age quartiles in the university sample split by gender (see electronic Appendix for analyses). It should be noted that for males there

was no 44-75 age quartile, as there were no males older than 43 in the university sample. The homogeneity of variance assumption was assessed with the Levene's test prior to conducting each separate ANOVA and was satisfied for all subscales. Only the *seek social support* subscale was found to be significantly different across age quartiles for males ($F_{2,52}=9.44, p=0.00$). Post hoc t-tests revealed no significant mean differences between the 17-26 age quartile and both the 27-33 ($p=0.006$) and 34-43 ($p=0.003$) age quartiles. The mean score (13.91) for the 17-26 age quartile was significantly different to the mean score (9.7) for 27-33 age quartile and the mean score (9.4) for the 34-43 age quartile. There was no significant mean difference between the 27-33 and the 34-43 age quartiles.

For females, significant mean differences across age quartiles were found for *focus on solving the problem* ($F_{3,51}=8.49, p=0.000$) and *seek professional help* ($F_{3,51}=5.76, p=0.002$). For *focus on solving the problem* post hoc t-tests using a Bonferroni adjustment error rate of 0.0026 revealed significant differences between the 17-26 age quartile (mean= 23.68) and both the 34-43 (mean=28.25) and 44-74 (mean=29.08) age quartiles. There were no other significant mean differences between any other age quartile groups on this subscale. For *seek professional help* the 17-26 (mean=7.42) age quartile was significantly different to the 44-75 (mean=12.67) age quartile. There were no other significant mean differences between any other age quartile groups on this subscale.

Correlations. The correlations between the 18 scales of the CSA were examined and their magnitudes were considered for the total student sample. Of the 153 correlations between pairs of scales, 9 percent had correlations greater in magnitude than 0.4, 4 percent were greater than 0.5, and no correlations were greater than 0.6. These correlations were similar to those reported for the

normative sample (Frydenberg & Lewis, 1997), with the exception of a maximum correlation of 0.73 between *self blame* and *worry* in the normative sample.

The magnitudes of the scale correlations were considered separately for male and female students. For males, of the correlations between pairs of scales, 13 percent had correlations greater than 0.4, 5 percent were greater than 0.5, and 2 percent were greater than 0.6, with the maximum correlation being 0.78 between *self blame* and *worry* coping strategies. For females, 11 percent had correlations greater in magnitude than 0.4, 4 percent were greater than 0.5 and 1 percent were greater than 0.6, with the maximum correlation being 0.66 between *work hard and achieve* and *problem focused coping strategies*. In essence, the correlation patterns were similar for males and females (see Appendix B for exact values). As noted previously in Study A, the CSA manual did not provide separate between-scales correlations for males and females.

Factor analysis. In order to compare the underlying factor structure of the CSA in relation to the university sample, a principal axis factor analysis was performed. Following the procedure outlined in the CSA manual, this method of factor extraction, followed by an oblique rotation using the oblimin method, was performed on the whole university sample, in order to maximise the sample size for the analysis. Using the criteria of extracting factors that have eigenvalues greater than 1 resulted in 6 factors being extracted which accounted for 50.95% of the total percentage of variance available for extraction. Factor 1 accounted for 18.81% of the variance, factor 2 accounted for 11.50% of the variance, factor 3 accounted for 7.17% of the variance, factor 4 accounted for 5.41% of the

variance, factor 5 accounted for 4.86% of the variance and factor 6 accounted for 3.20% of the variance.

The scree plot (see Appendix B) indicated that even a 6-factor solution might be applicable, without an unwarranted loss of information, compared to a 4-factor solution of the original CSA. Using the 6 extracted factors, an oblique rotation using the oblimin method revealed the factor pattern matrix, shown in Table 4.14.

The pattern matrix in Table 4.14 is different from that of the normative sample (see Table 4.4) both in terms of the number of extracted factors and variable loadings. These differences could be due to a number of reasons. Firstly, the samples came from different populations and the sample sizes were significantly different across the two samples. The university was also a significantly younger sample than the psychiatric group.

The correlations between the 6 extracted factors were low and mainly negative, as seen in Table 4.14.

Examination of the data suggested that factor 1 significant loadings, consisting of *worrying, wishful thinking, tension reduction, self blame* and *not cope*, could represent a “non-productive coping” dimension, similar to factor 2 in the normative sample (**non-productive coping**).

Factor 2 loadings, consisting of *focus on solving the problem, seek relaxing diversions, protect the self* and *humour*, could be seen as “dealing with the problem,” similar to factor 1 with the normative sample (**dealing with the problem**).

Table 4.14

Pattern Matrix of the 18 Coping Scales Plus Not Cope Scale for the University Sample

Strategy	Factor					
	1	2	3	4	5	6
Social support			-.545			
Focus on solving the problem		.662				
Work hard					.503	
Worry	.863					
Improve relationships						
Wishful thinking	.507					
Tension reduction	.621					
Social action				.459		-.423
Ignore the problem						
Self-blame	.769					
Keep to self			.835			
Seek spiritual support					-.733	
Focus on the positive						-.718
Seek professional help				.550		
Seek relaxing diversions		.480				
Physical recreation						-.573
Protect self		.641				
Humour		.603				
Not cope	.750					
Percentage of variance	18.81	11.50	7.17	5.41	4.86	3.20

Table 4.15

Factor Correlation Matrix of the University Sample

Factor	1	2	3	4	5	6
1	1.000	-.066	.084	-.075	-.268	.007
2	-.066	1.000	-.237	.004	.025	-.326
3	.084	-.237	1.000	-.076	-.010	-.051
4	-.075	.004	-.076	1.000	.018	-.030
5	-.268	.025	-.010	.018	1.000	.101
6	.007	-.326	-.051	-.030	.101	1.000

Factor 3 loadings, consisting of *social support* and *keep to self*, was the reverse of the normative samples factor 4 (**sharing the problems**), as the university sample had a negative loading for *social support* and a positive loading on the *keep to the self* subscale. Hence, the third factor extracted for the university sample was more likely to represent “keep to self.”

Factor 4 loadings, consisting of *social action* and *seek professional help* reflected a pro-active degree of coping, similar to the normative sample’s factor 4, (**sharing the problem**).

Factor 5 had a positive loading on *work hard and achieve* and a negative loading on *seek spiritual support*, which was not in keeping with their loadings in the normative sample, “**dealing with the problem**” (factor 1) and “**optimism**” (factor 3), respectively. The factor extracted here was more a practical strategy for dealing with problems in general.

Factor 6 consisted of negative loadings on *focus on the positive*, *social action* and *physical recreation*. In the normative sample these items loaded on separate factors as seen in the normative sample “**optimism**,” “**sharing the**

problem,” and **“dealing with the problem,”** respectively. The factor extracted here was more consistent with a withdrawal coping strategy.

Gender

Univariate analyses: The coping strategies used by university students.

Unequal variance two sample t-tests were carried out on the university sample to see if the coping strategies used by males differed from those used by females. Both samples were large enough to avoid the assumption of sampling from normally distributed populations. Examination of univariate t-tests showed only one significant difference between males and females on the *seek social support* subscale, with females utilising this coping strategy more than males (refer to Table 4.16).

Logistic regression: Gender by subscales and age as the predictor. Table 4.17 displays the results of the logistic regression model predicting gender based on age and the 19 coping scale scores for the university sample. The overall model was significant ($p = .001$) with the final correct classification rate being 83.6%. Specifically, 49 of 55 (89.1%) of the male sample were correctly classified (true negatives) while 43 of 55 (78.2%) of the female sample were correctly classified (true positives). Nine of the 20 predictors were significant. Specifically, female students were more likely to: (a) be older ($B = 0.29, p = .001$); (b) have higher *seek social support* scores ($B = 0.38, p = .003$); (c) have higher *improve relationships* scores ($B = 0.33, p = .02$); (d) have higher *tension reduction* scores ($B = 0.42, p = .01$); (e) have lower *social action* scores ($B = -0.36, p = .03$); (f) have lower *ignore the problem* scores ($B = -0.55, p = .03$); (g) have lower *self-blame* scores ($B = -0.51, p = .01$); (h) have higher *keep to self* scores ($B = 0.40, p = .008$); and (i) have lower *humour* scores ($B = -0.40, p = .008$) (Table 4.17).

Table 4.16

Gender Differences in Coping Strategies Used by an Adult University Sample

Strategy	Male (<i>N</i> = 55)		Female (<i>N</i> = 55)		<i>p</i> Value
	\bar{x}	<i>SD</i>	\bar{x}	<i>SD</i>	
Social support	12.32	4.11	14.52	3.17	0.002*
Focus on solving the problem	26.03	4.30	26.18	3.96	0.854
Work hard	11.01	2.50	11.30	1.76	0.612
Worry	10.25	3.85	11.45	2.99	0.071
Improve relationships	10.16	3.45	11.41	2.75	0.038
Wishful thinking	11.12	3.00	11.16	2.97	0.949
Tension reduction	9.09	3.12	10.29	2.99	0.042
Social action	7.67	2.79	7.38	3.14	0.609
Ignore the problem	7.58	2.06	6.76	2.13	0.043
Self-blame	10.52	4.44	11.74	3.42	0.111
Keep to self	10.36	3.86	9.72	3.11	0.344
Seek spiritual support	5.90	3.59	6.27	3.58	0.596
Focus on the positive	13.14	3.05	12.07	2.84	0.059
Seek professional help	7.54	3.81	8.98	4.08	0.059
Seek relaxing diversions	15.05	2.79	14.74	2.49	0.542
Physical recreation	8.74	3.07	7.56	2.72	0.035
Protect self	12.05	3.47	11.85	2.63	0.073
Humour	9.52	3.02	8.16	2.92	0.018
Not cope	6.38	2.46	7.41	2.95	0.05

*Significant at .0026.

Table 4.17

Prediction of Gender Based on Age and Coping Scale Scores: University Sample Only

Variable	<i>B</i>	<i>SE</i>	Wald	<i>df</i>	<i>p</i> Value	Exp (<i>B</i>)
Age	0.29	0.07	15.11	1	.001	1.33
Social support	0.38	0.13	8.53	1	.003	1.47
Focus on solving the problem	-0.18	0.13	1.94	1	.16	0.84
Work hard	0.27	0.21	1.63	1	.20	1.31
Worry	0.32	0.19	2.79	1	.10	1.38
Improve relationships	0.33	0.14	5.87	1	.02	1.39
Wishful thinking	-0.05	0.15	0.13	1	.72	0.95
Tension reduction	0.42	0.16	6.64	1	.01	1.52
Social action	-0.36	0.16	4.72	1	.03	0.70
Ignore the problem	-0.55	0.25	4.98	1	.03	0.57
Self-blame	-0.51	0.20	6.36	1	.01	0.60
Keep to self	0.40	0.15	7.01	1	.008	1.49
Seek spiritual support	0.07	0.10	0.46	1	.50	1.07
Focus on the positive	0.01	0.16	0.01	1	.93	1.01
Seek professional help	0.11	0.11	1.02	1	.31	1.12
Seek relaxing diversions	-0.17	0.16	1.15	1	.28	0.84
Physical recreation	-0.22	0.13	2.78	1	.10	0.80
Protect self	-0.06	0.13	0.23	1	.63	0.94
Humour	-0.40	0.15	7.08	1	.008	0.67
Not cope	0.28	0.20	1.94	1	.16	1.33
Constant	-8.83	4.47	3.91	1	.05	0.00

Note. $n = 110$. Gender classification: 0 = male, 1 = female. Full model: $\chi^2(20, n = 110) = 76.15$, $p = .001$. Base classification rate = 50.0%. Final classification rate = 83.6%.

Comparison of Psychiatric and University Samples.

Subscale univariate analyses. Unequal variance two-sample t-tests were carried out on the university and psychiatric samples to examine possible coping

strategy use for each of the 19 subscales. As can be seen in Table 4.18, the psychiatric sample was more likely to use *not coping* than the university sample. The psychiatric sample was also more likely than the university sample to engage in *ignore, worry, wishful thinking, social action, keep to self, seek spiritual support, seek professional help* and *not cope*. They were less likely than the university sample to *focus on solving the problem, and relax*.

Table 4.18
Two-Sample Unequal Variance *t*-Tests Between the Psychiatric Sample and the University Sample

Strategy	Psychiatric (<i>N</i> = 110)		University (<i>N</i> = 110)		<i>p</i> Value	<i>t</i>	<i>df</i>
	\bar{x}	<i>SD</i>	\bar{x}	<i>SD</i>			
Social support	12.40	3.97	13.43	3.81	0.051	-1.96	217.632
Focus on solving the problem	23.65	6.95	26.10	4.11	0.002*	-3.18	176.930
Work hard	10.14	3.62	11.20	2.16	0.009	-2.64	177.884
Worry	13.5	4.01	10.85	3.49	0.001*	5.23	213.926
Improve relationships	11.53	4.08	10.79	3.17	0.134	1.50	205.451
Wishful thinking	12.79	3.96	11.14	2.97	0.001*	3.50	202.151
Tension reduction	11.08	3.67	9.69	3.10	0.003	3.03	212.071
Social action	9.84	4.06	7.52	2.96	0.001*	4.84	199.384
Ignore the problem	8.51	2.71	7.17	2.12	0.001*	4.08	206.060
Self-blame	12.04	3.81	11.13	3.99	0.085	1.73	217.537
Keep to self	12.34	3.57	10.04	3.50	0.001*	4.82	217.914
Seek spiritual support	9.01	4.11	6.09	3.57	0.001*	5.63	213.813
Focus on the positive	12.63	4.16	12.60	2.98	0.951	0.06	197.550
Seek professional help	12.50	4.43	8.26	3.99	0.001*	7.46	215.657
Seek relaxing diversions	13.10	3.88	14.90	2.64	0.001*	-4.02	192.112
Physical recreation	8.35	3.20	8.15	2.94	0.630	0.48	216.453
Protect self	11.80	3.84	11.95	3.06	0.749	-0.32	207.652
Humour	8.63	3.41	8.84	3.04	0.630	-0.48	215.186
Not cope	8.22	2.99	6.89	2.75	0.001*	3.43	216.491

*Significant at *p* = .0026.

Multivariate analysis: Logistic regression. In order to replicate the *t*-test analyses conducted incorporating any potential correlations between subscales, a multivariate logistic regression was undertaken. Table 4.19 displays the results of the logistic regression model predicting group based on age and the 19 coping subscale scores. The overall model was significant ($p = .001$) with the final correct classification rate being 89.5%. Specifically, 98 of 110 (89.1%) of the psychiatric sample were correctly classified (true negatives) while 99 of 110 (90.0%) of the university sample were correctly classified (true positives). Ten of the 20 predictors were significant. Specifically, as seen in Table 4.19, university students were more likely to: (a) be younger ($B = -0.07, p = .004$); (b) have higher *focus on solving the problem* scores ($B = 0.23, p = .001$); (c) have lower *worry* scores ($B = -0.32, p = .001$); (d) have lower *tension reduction* scores ($B = -0.23, p = .01$); (e) have lower *social action* scores ($B = -0.17, p = .05$); (f) have higher *self-blame* scores ($B = 0.43, p = .001$); (g) have lower *keep to self* scores ($B = -0.17, p = .04$); (h) have lower *seek spiritual support* scores ($B = -0.25, p = .001$); (i) have lower *seek professional help* scores ($B = -0.27, p = .001$); and (j) have higher *seek relaxing diversions* scores ($B = 0.22, p = .02$).

Table 4.19

Prediction of Group Based on Age and Coping Scale Scores

Variable	<i>B</i>	<i>SE</i>	Wald	<i>df</i>	<i>p</i> Value	Exp(<i>B</i>)
Age	-0.07	0.02	8.08	1	.004	0.93
Social support	0.10	0.09	1.34	1	.25	1.10
Focus on solving the problem	0.23	0.07	10.16	1	.001	1.25
Work hard	-0.03	0.09	0.09	1	.77	0.97
Worry	-0.32	0.10	11.13	1	.001	0.73
Improve relationships	-0.11	0.09	1.59	1	.21	0.89
Wishful thinking	-0.15	0.09	2.70	1	.10	0.86
Tension reduction	-0.23	0.09	6.44	1	.01	0.79
Social action	-0.17	0.08	3.86	1	.05	0.85
Ignore the problem	0.01	0.10	0.01	1	.91	1.01
Self-blame	0.43	0.11	16.35	1	.001	1.54
Keep to self	-0.17	0.08	4.22	1	.04	0.85
Seek spiritual support	-0.25	0.07	13.25	1	.001	0.78
Focus on the positive	-0.04	0.10	0.20	1	.66	0.96
Seek professional help	-0.27	0.08	12.79	1	.001	0.76
Seek relaxing diversions	0.22	0.10	5.25	1	.02	1.25
Physical recreation	0.13	0.09	2.09	1	.15	1.14
Protect self	0.07	0.10	0.51	1	.47	1.07
Humour	0.08	0.08	0.96	1	.33	1.08
Not cope	0.08	0.11	0.48	1	.49	1.08
Constant	2.22	1.83	1.48	1	.22	9.25

Note. *N* = 220. Group classification: 0 = psychiatric, 1 = university. Full model: $\chi^2(20, N = 220)$

= 164.82, *p* = .001. Base classification rate = 50.0%. Final classification rate = 89.5%.

Discussion. The purpose of this study was an exploratory comparative analysis, to investigate the coping strategies adopted by university students and, specifically, it addressed how this group endorsed coping strategies compared with the psychiatric sample. In line with previous research, the university sample exhibited several differences. Firstly, as a comparative sample they were much younger than the referent group a common demographic characteristic in research with college or university samples (e.g., Geisner, Neighbors & Larimer, 2006; Main et al., 2011).

Within the university the one significant gender difference, that being for *seek social support*, with women engaging in this coping strategy significantly more often than men, was not unexpected. With the exception of this subscale, these results suggest that both men and women cope similarly, a finding consistent with current research. For example, Lawrence, Ashford, and Dent (2006) investigated differences in the coping strategies adopted by male and female first year students in a higher education environment and the extent to which such strategies had an impact on self-esteem and attainment. They found gender differences in terms of engagement in coping strategies and academic attainment. Specifically, women “attained” at a significantly higher level than men, while they found men detached themselves from the emotions of a situation and used strategies such as emotional inhibition, or as they stated, ‘bottling up’ of emotions more than women.

In considering coping strategies in combination, multivariate analyses interestingly revealed that women in the university sample were more likely to be older than men and have higher *seek social support; improve relationship; tension reduction, keep to self* scores; and lower *social action, ignore the*

problem, self blame and humour scores than their male counterparts on the CSA. This finding is consistent with Folkman and Lazarus' (1985) examination of emotion and coping of college students at various intervals of the university semester. University students are known to utilise a variety of coping mechanisms relating to the time period within the semester.

A number of significant differences were noted in the way the university sample coped with general concerns when compared to the psychiatric sample. When compared with the normative sample, the university sample utilised less productive coping mechanisms than the normative sample, a finding consistent with poor coping of university students (Brown, 1994; Epstein, & Katz, 1992; Folkman, & Lazarus, 1985; McCarthy, Lambert & Moller, 2006; Lawrence, Ashford & Dent, 2006; Shankland, Genolini, Franca, Guelfi, & Ionescu, 2010).

Although the psychiatric sample was more likely to use *not coping* than the university sample and engage in the following coping strategies more so than the university sample: *ignore, worry, wishful thinking, tension reduction, social action, keep to self, seek spiritual support, seek professional help* and *not cope*, they were less likely than the university sample to use *focus on solving the problem, work hard and achieve*, and *seek relaxing diversions*.

Finally, factor analyses revealed a 6-factor structure in the university sample suggesting that university students use a slightly different combination of coping methods compared to the psychiatric sample and normative sample. The six categories being: non-productive coping, dealing with the problem, sharing the problem, pro-active independent degree of coping; practical strategy for dealing with problems in general and a withdrawal coping strategy. The results may reflect the different demands placed upon university students within the

university environment, as Folkman and Lazarus' (1985) study noted students use different coping mechanisms at the different stages of a university semester, depending on the stresses of the time.

This study carries with it some limitations and the results are limited in their generalizability because of the relatively small sample sizes in some sub-analyses. Confirmatory factor analyses were not carried out for two reasons. Firstly, the sample sizes were not large enough to sub-divide into a sample for confirmatory analysis and, secondly, this study replicated all of the analyses carried out by Frydenberg and Lewis (1997). Frydenberg and Lewis used a principal components with Oblimin rotation factor analysis to establish the usefulness of the CSA, in determining the extent to which the items on the questionnaire satisfactorily assessed the related (but distinct) strategies of coping they were designed to measure. Because of the overall nature of the present study in assessing the usefulness of the CSA, Frydenberg and Lewis's (1997) approach was adopted for the current analyses.

While there are some differences between the university sample and psychiatric sample in the pattern of their results, the majority of the findings are consistent with research on coping within university populations. In general, university students have been found to use more withdrawn, avoidant coping strategies.

General Discussion

Overall, the application of quantitative methodology to measure coping in those diagnosed with a mental illness was useful in identifying the coping strategies described on the CSA that psychiatric patients endorsed as being of importance to them. While researchers have found that the use of social support increases well-being in psychiatric populations, this study did not support this (Cohen, McGowan, Fooskas & Rose, 1984; Cohen, Towbes & Flocco, 1988; Cummins, 1988; Hobfoll, 1986; Ford & Procidano, 1990; Granovetter, 1982; Greenglass, 1993; Potasznik & Nelson, 1984). When patients were asked to comment on the use of social support as a coping strategy, they reported using social support as a coping strategy, but not significantly more than the normative or university samples. Overall, it was found that psychiatric patients do report using what Frydenberg and Lewis (1997) report as “non-productive” coping mechanisms. When compared to the broader literature, these results suggest that the psychiatric sample was more likely than so-called “normative” samples, to use passive coping strategies rather than active coping strategies (Carver, Scheier, Weintraub & Jagdish, 1989; Fledderus, Bohlmeijer & Pieterse, 2010).

Dividing coping into productive and non-productive is not helpful in understanding the meaning of coping for patients and may misrepresent patients' attempts to cope with their difficulties. Questions such as: At what point does *worry* become unproductive? What defines *not coping*? And at what point does *wishful thinking*, and *keeping to oneself* become unproductive? Different coping strategies can serve many things for different individuals. Pearlin and Schooler (1978) also mention the notion of an individual's coping resources referring to not what people do, but to what is available to them in developing their coping

repertoires, which may not be easily measured by a scale. Therefore, coping strategies, such as seeking social support, may not be available to individuals who have had little or no social supports, which is sometimes the case with many people diagnosed with a “psychiatric illness”. Granovetter (1982) further elaborates on the role of social support and claims that people of no relation to the person, for example, the person at the news agency, the person at the corner shop or the service station attendant or any person who is seen frequently, can provide the role of social support as effectively and, in some cases, even more so than a family member, close relative or friend.

However, the psychiatric group’s choice of coping strategies should not be underestimated, as they used a broader array of strategies than the normative and university groups, as measured by the number of strategies they endorsed more frequently. This finding is at odds with the bulk of past research that suggests that psychiatric patients “don’t cope.” As discussed in Chapter 2, coping is usually understood in psychiatry to be what a person is “not” doing, rather than what they “do” to manage their difficulties, and the concept of the person within the mental health system is one of vulnerability and not coping (Pupavac, 2001). The assertion commonly referenced in the psychological literature that people diagnosed with a mental illness, such as depression, schizophrenia and anxiety, lack adequate coping resources for managing the challenges of daily living, which at times causes psychological distress (Piccinelli & Wilkinson, 2000; Taylor & Stanton, 2007), was not supported by this quantitative study. What this quantitative study reflected was that patients do use an array of coping strategies (both productive and non-productive) and were quite willing to report on exactly the types of coping strategies they used.

The CSA was found to be a useful tool for measuring the coping strategies of individuals diagnosed with a mental illness, in that it assesses a variety of coping strategies via the 19 separate scales, which is in keeping with the complex and multidimensional nature of coping. When evaluating the CSA as a measuring tool, the results from comparative analyses indicated that the CSA offers a measure of external validation and of clinical utility. The psychiatric sample endorsed various types of coping strategies, thereby suggesting that the CSA provided a set of coping strategies they in some way may have related to. The CSA also discriminated between the types of coping strategies endorsed by all three samples. However, as a measurement scale, in itself it does not advance our understanding of the reasons why it discriminates. The instrument itself uses a Likert rating scale which provides a good range for responses and, therefore, good potential for variability. The CSA items are unambiguous and, as stated in the administrators' manual, were behaviourally and cognitively defined, so respondents could easily understand the questions (Frydenberg & Lewis, 1997). A clinical qualitative note was that psychiatric patients reported that they "enjoyed" completing the questionnaire and some patients provided written statements at the end of the questionnaire which were not formally analysed. However, some comments reflect that patients considered the questionnaire was helpful, as it acted as a reminder of what coping strategies they already used and also reminded them of others that they had used in the past (remembering through prompting of the coping strategy on the questionnaire).

The quantitative measurement of coping revealed the many coping strategies that those diagnosed with a mental illness use to cope in general. However, what this measurement did not reflect was the very individualized

nature of coping and, in particular, individual factors. Lazarus (2000) advocated for mixed methodological approaches to coping research, as current approaches focus too narrowly on the presumed goal of reduction of psychological distress and ignore the likelihood that people approach difficult situations with multiple goals. Many quantitative measures run the risk of over simplifying constructs such as “coping” and may mask the underlying meaning and contributions to one’s coping. Boyle (2011) argues that standardised assessments in the area of mental health which categorise coping (i.e., non-productive and productive coping), run the risk of converting experience to “symptoms” or disorders, without ever mentioning the role of context and life experience. This categorisation overlooks important factors in the causation of patient “distress” or, as researched in this study, “coping.” Boyle argues that the approaches of quantitative measurement, such as correlating scales comparing groups, relies too heavily on the persons’ “inner world.”

While the many coping strategies psychiatric patients use was revealed, and was compared to other samples, what was missed was the essentially rational, local and individual nature of coping in psychiatric patients’ lives. Summerfield (2011) argues that:

. . . valid research methods must reflect the ‘nature of reality’ for participants and a standard questionnaire used across heterogeneous societies cannot do this (p. 239).

In the area of mental health, coping questionnaires do not reflect what Summerfield refers to as ‘the nature of reality’ for patients. The difficult and problematic nature of taking standardised questionnaire results to be indicative of a person’s “reality,” was also highlighted in a study by Shedler, Mayman and

Manis (1993). Shedler et al (1993) found that people who denied psychological distress on self-report measures and who also appeared to look healthy on the basis of these standard mental health scales, in actual fact, were not psychologically healthy. They named this concept, “illusory mental health,” and they report that it has physical costs and may be a risk factor for medical illness. They found that clinical judges were far better in distinguishing genuine from illusory mental health, whereas so-called “objective” mental health scales were not. The authors call into question the standardised methods that researchers are using and advocate for more meaningful mental health research. As Lazarus (2000) explains, the questionnaire format is advantageous in that it permits the study of large samples and the quantification of the coping process. However, as Folkman and Moskowitz (2004) make clear, the main source of data is included in in-depth interviews and observations.

From another perspective, Coyne and Racioppo (2000) have criticized the failure of stress and coping research to be useful in clinical practice, and Lazarus (2000) reports that many researchers “hope” that research findings will have practical value, however, few rarely do. Tennen, Affleck, Armeli and Carney (2000) report that a daily process approach to coping, tracking mood and coping as close to their real time occurrence as possible, offers unique insights. However, such an approach is demanding, both on researchers and the participants. Tennen et al. provide an example of an alternative choice of data collection in the form of a pain diary and how a pain diary may yield a different picture of the pain experience than would a summary from a clinical office visit.

While there are those who believe more scientific approaches are needed in the classification of what constitutes a mental illness (e.g., Titmarsh &

Goodyer, 2011), there are others who believe that collaboratively working with patients identifying individualized contributing factors, and how these may influence the person's presentation, in addition to recognising their personal strengths, may allow a deeper understanding of the patient and, hence, a more personalized treatment approach (e.g., Macneil, Hasty, Conus & Berk, 2012). In addition, Folkman and Moskowitz (2004) also advocate for more longitudinal studies to reflect more detail of the true nature of coping for individuals across the lifespan.

To bridge the gap between research and its transfer to clinical practice, the use of qualitative procedures might be advantageous for future investigations of coping in the area of mental health. From the findings of this quantitative study, it is recommended that quantitative methods are used in researching the coping strategies of those diagnosed with a mental illness, although this author would caution against a sole reliance on a quantitative approach. Relying on only one measurement approach to coping may not do justice to the overall experience of what coping strategies are useful for people diagnosed with a mental illness, and what coping might mean for these people.

Summary and Conclusions

What this study has demonstrated is that the exclusive use of quantitative approaches will only generate information to a set of pre-determined coping strategies, as outlined on a questionnaire. Therefore, a single quantitative measure of coping is not useful in identifying coping from a multidimensional perspective. A side matter to the sole use of quantitative measures is that from a clinical standpoint, as Hallam (2013) points out, there may be a failure to engage in individual case formulation due to the reliance on quantitative research

methods, and this reliance also dictates future outcomes and the language employed, e.g., “disorder.” This is the point at which qualitative measures have an added advantage, as Summerfield (2008) advocates the use of more qualitative measurement within mental health to “promote more grass roots ownership of the terms of reference of mental health and enable a robust and relevant knowledge base to emerge” (p. 993).

Overall, the quantitative measurement of coping via the CSA was helpful in identifying the particular coping strategies these patients used. However, categorising their attempts as “productive” or “non-productive” implied some strategies were superior to others and ignored the fact that these patients were dealing with a set of difficult life circumstances unlike those faced by most people. Applying labels of “productive coping” and “unproductive coping” is reliant on a reductive and circular logic and understanding; categorising coping this way misses the essentially rational, local and individual nature of what might count as coping, in the context of psychiatric patients’ lives. Social factors and contextual factors have a major influence on both the degree of long-term stress that individuals have to cope with and also the abilities that people have to manage or cope with these stressors, and are more suitable to qualitative measurement.

PREFACE TO PART 2

Part 1 of this thesis has shown that, with the exercise of caution, quantitative approaches to coping might have their place in applied research within psychology. However, there are acknowledged major conceptual and methodological issues with the sole use of such measures in the measurement of coping (De Ridder, 1997; Oakland & Ostell, 1996; Schwarzer, & Schwarzer, 1996).

In particular, as seen in the previous chapter, the CSA, a standardized rating scale, was unable to account for personal characteristics, history, context and circumstances, which determine which incidents people report as being stressful. In essence, such quantitative measures result in ignoring both past coping efforts, which have influenced the perception of the stressful episode encountered, and the range of coping responses employed. A more detailed analysis revealed that these summary statistics masked very real difficulties.

Part 1 to set out to explore what role there was for the quantification of coping or a coping process, given coping can mean very different things for different people. As discussed in Chapter 2, coping is referred to in three versions throughout this thesis: coping as the overall concept of the action, coping strategies or mechanisms as the things people do to cope, and coping styles, as combinations of coping strategies that people use as a way of coping.

The quantification of “coping” per se is problematic as coping and categorization of a “non-productive coping” give rise to the interpretation by some that the individual is not coping at all. This approach invites notions such as “poor coping” and “pathology” and explores the weaknesses of people. Snyder (1999) believes that “...the movement toward a positive adaptive view

about people is still evolving, and that there still are many negative, pathological assumptive networks being applied to the understanding of the coping process” (p. 331). This is not to say that coping strategies as listed via a questionnaire are not useful, although the current research suggest caution against the sole use of such measures in a psychiatric population to measure coping. As the reader will come to understand from the findings in this thesis, coping and coping processes are best understood in an individual formulated context.

In order to fully understand the coping process, an individual’s fundamental assumptions which guide them through their world, the world in which they live and the people and events that shape their experience (whether these are benevolent or malevolent) need to be considered. The quantification of coping strategies is unlikely to capture all of these assumptions, along with the meaningfulness of their world and how they ‘make sense’ of it, as well as their notions of “self.”

Given the problematic nature of the measurement of coping solely by questionnaire, there are many reasons why one would caution against their sole use of quantitative measures as highlighted by Boyle, (2011) and Summerfield, (2008). In the quantitative measurement of psychiatric patients’ coping, described in the previous chapter, the problem of “causation” arose. No causation could be inferred from participants responses, because the results could demonstrate only how certain variables correlated with each other or what pre-defined coping strategies were preferred over others. CSA scores indicated the types of coping mechanisms respondents used. While these responses could be compared across the other groups (university sample, normative sample and a matched community sample) measured with the same instrument, again this

revealed little about the meaning of coping for psychiatric inpatients. These quantitative results also posed a phenomenological question for this study. Even though the psychiatric patients engaged in a variety of coping strategies, as measured by the CSA; did their responses reflect the true meaning of coping for them? In an attempt to move closer to the meaning of coping for the individual, additional information is needed. One might ask clinically pertinent questions of the individual about the significance and importance of their various coping strategies. In this way the clinician tries to determine definitions of what coping might be for the individual, given the ever changing, individual nature of coping. Therefore, there are two possible components to the measurement of coping. The first, the measurement of coping strategies through quantitative means, and then, narrative approaches which allow a more authentic account of what coping is for an individual. Therefore, coping can be established in two very different ways.

In Part 2 of this thesis, I clearly follow a post-modern, constructivist theoretical orientation to understanding the meaning and measurement of coping and this is reflected in the type of methodology chosen. The design of this study was exploratory in nature and centered around a phenomenological investigation. The nature and the purpose of the design was to unearth as much as possible about psychiatric patients coping without having any preconceived notions about what one might expect a patient's coping ability to be and the difficulties they experience. Through a semi structured interview and detailed case formulations much more was discovered about how patients' cope and this information, to a certain extent, challenged mainstream definitions of coping.

To follow is the article that is currently in print in the journal: *Qualitative Health Research*. Following on from this is Chapter 6 called *Meet the People*,

which is a series of cases studies of 10 selected inpatients.

What follows in the next chapter is a qualitative investigation of the reports of the meaning of coping by the 38 psychiatric inpatients themselves. This study is currently *in print* in the journal, qualitative health research, and is formatted with respect to their publication conventions. This study contains 2 other authors who were my supervisors of this PhD project, I am first author in recognition of my roles as primary researcher, analyst and author. With regard to the data analysis, transcription and reading and re-reading the texts, and coding the data, I transcribed the data and read and re read the data under supervision from both Dr Suzanne Dziurawiec and Professor Mark Rapley who was highly qualified in qualitative research and methodology.

Chapter 6, called Meet the People, presents a series of case studies of 10 selected inpatients part of the larger sample of inpatients who were interviewed for the qualitative study. The thesis concludes with an overall discussion in Chapter 7.

PART 2

CHAPTER 5

Part 2. Study 3. The meaning of coping for psychiatric patients

Part 2. This chapter has been published in the journal: *Qualitative Health Research*. The following chapter represents this manuscript.

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Abstract

Contemporary psychiatric theory holds that a precipitant of major mental illness is the inability of some vulnerable individuals to cope with the difficulties of everyday life. Such mentally ill people are characterized as having deficient, dysfunctional, or absent coping skills. Recently, researchers have exerted considerable effort to distinguish between productive and non-productive coping. In this article, we argue that not only are such conceptualizations reliant on reductive, circular logic but they also miss the essentially rational, local, and individual nature of coping in psychiatric patients' lives. We used semistructured interviews and thematic analyses of psychiatric patients' descriptions of their coping. Patients reported that professional intervention reduced their ability to cope, that they distrusted the mental health system and its professionals, that coping mechanisms were misinterpreted, that situational crises modulated coping, and that sometimes coping was just "not coping." We argue for a more respectful, nuanced understanding among mental health professionals of coping.

It appears that a consensus in the literature has coalesced around the proposition that long-term stress leads both to adverse mental health states, such as anxiety and depression, and to physical illness, such as cardiovascular disease and type 2 diabetes (Kiecolt-Glaser, McGuire, Robles, & Glaser, 2002). Although debate has raged about the relative contributions of intraindividual and socioeconomic factors in the development of individuals' capacities to manage stress, the weight of the evidence suggests that social factors play a major role. This influence is seen in both the degree of long-term stress with which individuals have to cope and in the abilities people have to manage, or cope with, these stressors, with concomitant inequalities in both physical and mental health outcomes (Adler & Matthews, 1994; Wilkinson & Pickett, 2009).

In psychology and psychiatry, the roots of coping research can be traced, arguably, back to Freud's work on defense mechanisms (see Freud, 1968) and Adler's reformulation of defenses as safeguards that serve to protect the self from external environmental threats (Ansbacher & Ansbacher, 1967). Although researchers have proposed many different theoretical models of coping in the last 30 years (e.g., Hobfoll's, 1989, multi-axial model; Lazarus's, 1966, transactional model), the field is plagued by the fact that coping has been understood, researched, and studied in different ways (Skinner, Edge, Altman, & Sherwood, 2003). To date, this diversity in approaches has not resulted in a coherent conceptualization regarding the nature of coping for those diagnosed with a mental illness.

Broadly speaking, two major approaches characterize the psychological literature on coping. The first, trait-based approach, has examined the effect

personality variables have on individual coping capacity (e.g., Coan, 1973; McCrae, 1984; McCrae & Costa, 1986). Treatment of coping as a trait assumes that, once coping is in place, it presumably operates as a stable behavior. Therefore, the individual will cope in particular ways over his or her life course. The second approach has concentrated on identifying and measuring the strategies people use to manage problematic situations (e.g., Carver, Scheier, & Weintraub, 1989; Endler & Parker, 1990; Frydenberg & Lewis, 1997; Moos, 1992). Consistent with this approach, coping is viewed as an essential aspect of the emotional process and emotional life. It is the relationship between an individual and the environment that determines the level of stress the individual experiences and what coping mechanisms he or she utilizes (Lazarus & Folkman, 1984). Through a process of primary appraisal, the individual assesses a situation as threatening, and then, through a secondary appraisal, the individual determines whether he or she has the resource strategies to cope. In this view (e.g., Lazarus, 1999), emotions are always a response to *relational meaning*: the person's sense of the harms and benefits in a particular person–environment relationship. This relational meaning determines the coping process.

The major approaches to coping vary in terms of the degree to which they take into consideration contextual variables. Some approaches are strongly contextualist (e.g., Holahan & Moos, 1987; Lazarus & Folkman, 1984), whereas others (e.g., Bodenmann, Charvoz, Widmer, & Bradbury, 2004) focus on individual-level variables. In particular, trait approaches give weight to personality characteristics (Coan, 1973; McCrae, 1984; McCrae & Costa, 1986) or individual and social resources (Holahan & Moos, 1987) such as optimism and social support (McColl, Hau, & Skinner, 1995; Taylor & Stanton, 2007).

Under both approaches, however, coping is typically construed as the deployment of rational responses to objective problems. This view permits, ipso facto, the demarcation of adaptive and maladaptive coping and the presence or absence of coping skills or deficits. In contrast to the deficit focus of much of the psychological literature (cf. Rose, 1989), more recently, some researchers (e.g., Iwanaga, Yokoyama, & Seiwa, 2004; Keyes, 2007) have proposed that coping is better understood as a positive concept and have focused on the use of adaptive strategies, building on an individual's strengths. It should also be noted that, historically, a minority position in the literature has recognized that maladaptive strategies can also be useful, if they help to manage stressors successfully (Menninger, 1963; Snyder, 1999).

Although the literature acknowledges major conceptual and methodological issues within the research and measurement of coping (e.g., Coyne & Gottlieb, 1996; De Ridder, 1997), currently the most popular method for measuring coping is quantitative, and the most common approaches are those derived from the work of Lazarus and colleagues (e.g., Lazarus & Folkman, 1984). In keeping with established critiques of mainstream social science methods (cf. Garfinkel, 1967; Schütz, 1962), Coyne and Gottlieb (1996) argued that coping theory and the associated checklist methodology obscure, where they do not minimize, important individual differences in how people manage stressful events. Thus, coping appears to be a more uniformly reflective, planned, and goal-oriented activity than it may actually be. In particular, standardized rating scales, such as the Ways of Coping Questionnaire (WAYS; Folkman & Lazarus, 1988) or the Coping Response Inventory (Moos, 1992), are unable to accommodate the fact that personal characteristics, history, and circumstances

determine which incidents people report as being stressful. In addition, previous coping efforts influence the perception of novel stressful episodes an individual encounters, and the range of coping responses the individual employs may reflect how these episodes fit into the rest of the individual's current circumstances and history.

Consistent with these criticisms, Oakland and Ostell (1996) also noted that the efficacy of coping actions and the adequacy of external resources are two pivotal variables in the coping process, both of which are commonly overlooked in quantitative checklists. Moreover, an associated difficulty with the psychometric measurement of coping is that rating scales tend to treat coping strategies as definable capacities (similar to, perhaps, short-term memory), of which persons may have greater or lesser amounts. As a consequence, by their cross-sectional nature, scales such as the Coping Scales for Adults (CSA; Frydenberg & Lewis, 1997) and the WAYS (Folkman & Lazarus, 1988), even when they claim to attempt to characterize coping as a process, fall back on intraindividual thoughts and actions and components of coping rather than conceiving of coping as an ongoing interactional process. For example, the WAYS identifies a set of eight distinct coping factors that, although eschewing the explicitly pejorative characterization of some strategies as nonproductive, and recognizing the importance of personal meaning, the seeking of support, and spiritual or religious dimensions to coping, still arguably conveys that some factors (or ways of coping) are superior to others.

With respect to coping in psychiatric populations, currently, dominant understandings of *mental disorder*, often referred to as *biopsychosocial* or *diathesis/vulnerability-stress* models (Read, Mosher, & Bentall, 2004), suggest

that such disorders arise from the difficulty some (biologically vulnerable) individuals have in dealing with adversity. For these individuals, adverse life circumstances precipitate the onset of a putative biological (most commonly, it is suggested, neurochemical and/or genetic) disease process (Moncrieff, 2008; Taylor & Stanton, 2007). That is to say, those who are diagnosed as mentally ill are, it is claimed (and for a bewildering range of possible theoretical reasons), unable to cope with the “vicissitudes of life” (Summerfield, 2004, p. 233). That there is an inherently circular form of, essentially, folk reasoning at work here has not, it seems, obstructed the rise to near-total theoretical hegemony of this so-called model in contemporary psychiatry and (clinical) psychology (Boyle, 2011; Bracken & Thomas, 2005; Hansen, McHoul, & Rapley, 2003; Smith, 1978; Summerfield, 2006, 2008).

Smith (1978) clearly described an example of this circular reasoning, illustrating how patient “K” was diagnosed as mentally ill. The article reported on the gathering of information from various sources, the interpretations of others, and elements of K’s behavior, with the final judgment that K is mentally ill. In essence, how do we know that K is mentally ill? We know this because she cannot cope effectively with the challenges of everyday living. Why can she not cope effectively with the challenges of everyday living? We know this because she is mentally ill. This presents serious concerns, because, as Moncrieff (2010) suggested, once a psychiatric diagnosis is applied, it signals a need for various care actions and behavioral controls, which are presented as treatments. In the process, the patient is often overlooked, and, as Rapley, Moncrieff, and Dillon (2011) pointed out, “the social circumstances that cause or contribute to [the patient’s] suffering often go unexamined and unchallenged” (pp. 4–5).

When patients' coping was measured psychometrically by the CSA, their coping strategies differed from those of other samples such as community and university samples (Ryan & Dziurawiec, 2013). The patients were more likely to respond by using what Frydenberg and Lewis (1997) described as nonproductive coping strategies such as ignoring problems, worrying, keeping to oneself, seeking spiritual support, and seeking professional help. They were less likely to engage in productive strategies such as focusing on solving the problem, working hard and achieving, or relaxing to deal with problems—what are, in effect, characteristics of the highly Westernized, gendered, and culture-bound version of the self-contained, rugged individualist. In essence, then, scales such as the CSA valorize a stereotypically masculine set of ways of dealing with problems in living (what, according to Barry, 1997, might be termed the “Marlboro man” approach—created via an extensive, 45-year-long advertising campaign, the image involved a rugged cowboy character with only a cigarette, to conjure up a masculine image for filtered cigarettes). Such scales explicitly denigrate as nonproductive, a priori, ways of handling stressful life events that are more passive or that draw on interpersonal resources.

Quite aside from the concerns raised in the literature that the field of coping research is disappointing and has stagnated (Sommerfield & McCrae, 2000), and the many, as yet unresolved, methodological issues in quantitative coping research (De Ridder, 1997), serious questions remain in the conceptual domain. How sensible is it to categorize peoples' attempts at coping? Can coping be sensibly described, a priori, as productive or unproductive? At what point does an attempt to cope become unproductive? Are broad categorizations of coping as productive or unproductive based on an empirical knowledge base, or are they,

as they may appear, more like moral judgments than scientific evaluations? Indeed, can any particular coping strategy sensibly be labeled as effective or ineffective, productive or nonproductive, or even adaptive or maladaptive without reference to the context in which it is used? By what criteria are we to judge that some forms of coping are pathological or are symptoms of mental illness? A closer look at psychiatric inpatients' attempts to cope was needed. Furthermore, assumptions about symptomatology, pathology, and disorder needed to be suspended.

Method

We conducted a phenomenological investigation of the experience of coping as told by psychiatric inpatients. The study was part of a larger doctoral-study investigation, into coping in a psychiatric population. Via semistructured interviews and thematic analyses, we aimed to understand better what psychiatric patients find particularly challenging, how they cope with these challenges, and how these understandings of their coping call into question mainstream definitions of coping. The justification for this type of design was that it permitted us to capture more of the patients' experience of coping, without any preconceived notions of what their coping abilities might be. In conducting this study, we gathered information about the various strategies patients use and do not use. We followed strategies for ensuring trustworthiness in qualitative research, such as credibility, transferability, dependability, and confirmability, as Shenton (2004) outlined. One great advantage of the methodology we used was that patients reported enjoying the experience of the interview, and therefore, as much as possible, we are confident that this article presents a true picture of the phenomenon of what coping means to patients.

Procedure

We conducted this study in a large, inpatient-only psychiatric hospital in Western Australia. The hospital offered no addiction, rehabilitation, or other specialty services. The setting for the interviews was a separate room in the research department of the hospital. The study adhered to all ethical guidelines, and we obtained approval for the study from the ethics committees of both the university and the psychiatric hospital. The first author approached psychiatrists and medical officers from throughout the hospital to request their patient lists. These medical professionals were not involved in the selection or interview process. Data collection took place over a period of 12 months.

We recruited participants throughout all wards of the hospital, with the exception of the long-stay ward, which contained many patients with severe neurocognitive deficits. The first author individually approached patients with information about the study and requested their consent to participate, subject to screening. Once a patient gave both verbal and signed consent to access his or her medical files, we screened relevant information against the inclusion and exclusion criteria. All patients met the inclusion criteria, which were that the patient spoke English as his or her first language and that he or she had completed at least 10 years of education. Exclusion criteria included deteriorating organic conditions and significant memory impairment (e.g., Alzheimer's disease or dementia). The first author made an appointment for an interview at a time convenient for each patient and, on the day of the interview, met the patient on the ward and escorted him or her to the interview room. At the conclusion of the interview, the first author escorted each participant back to the ward.

Participants

Thirty-eight patients, 25 men and 13 women, aged between 18 and 60 years, participated in the study. This sample size is around the mean number of subjects generally found in interview studies reported in the qualitative literature (Mason, 2010). Of the men, 16 had a diagnosis of schizophrenia, three of depression, five of bipolar disorder, and one of personality disorder. Among the women, six had a diagnosis of schizophrenia, two of depression, three of bipolar disorder, and two of personality disorder. We found in the review of the patients' medical files that they had been given many diagnoses—sometimes up to three or four different diagnoses over a period of 2 years—and multiple medications. The most recent long-standing diagnosis was the one used for this study. Patients had varying amounts of contact with inpatient mental health services, with the number of inpatient admissions ranging from between 1 and 5 (18 patients) to more than 25 (1 patient). In terms of their psychiatric histories, fewer than half of patients had received counseling or psychological intervention for their problems (10/38), all were currently in receipt of psychotropic medication, and the majority reported a history of illicit drug use (26/38) and, in some cases, multiple suicide attempts (28/38). In 16 cases, a family history of mental illness was reported.

Interview

The first author, who is an experienced psychologist, carried out the semistructured interviews, which provided an opportunity for patients to talk in more detail about their difficult life experiences and their methods for coping with these experiences. Each patient completed an interview that took approximately 35 minutes. Interviews were brief to allow for low attention and concentration spans, which have been reported in the research to often be

concomitant with various mental illnesses (Medalia & Revheim, 2002). The interviewer developed good rapport with all patients and informed them that there were no right or wrong answers to the questions, asked them to be honest in their responses, and made them aware that, at any stage, they could leave the interview or exit the research study. The interviewer provided patients with her contact details (e-mail address and telephone numbers) in case they wanted to discuss their own interviews or read and/or comment on their transcripts. Only two patients wanted to listen to their responses immediately after the interview, primarily to make sure that the researcher had recorded everything, but partly out of curiosity. Neither patient requested any edits to their recordings. Moreover, no patient left the study or later requested that his or her information be retracted.

Interview questions were as follows: What things do you find the most difficult to deal with in your life? Are there any particular situations that you find difficult to manage? (all of the patients identified at least one situation, and the interviewer noted all situations). What sorts of things do you do to manage difficult situations? (interviewer listed the patient's particular situations). When do you use the (various) approaches you have described? Which works best? When do the other approaches work best?

The first author audio-recorded and transcribed interviews verbatim. A professional secretary working in a mental health hospital, and with experience in transcription of doctors' audio recordings, also transcribed the interviews. A 100 percent agreement rate regarding content was achieved, with only minor variations in pauses and punctuation.

Analytic Procedure: Thematic Analysis

We adopted a phenomenological approach for the analysis of the interviews and used an inductive thematic analytical procedure, described by Hayes (1997) and elaborated by Braun and Clarke (2006). This approach allowed for a richer interpretation of the data and the capacity to assess underlying themes. We adopted strategies for ensuring the trustworthiness of the data, in accordance with Guba's constructs (see Shenton, 2004). The first author read and reread, noting initial ideas, and the second author, who had extensive experience in qualitative research, provided supervision of the process. The first author carefully scrutinized the interviews to identify meaningful units of text relevant to the questions posed about coping and then generated the initial codes, grouping units of text on the same issue together into analytical categories and giving provisional definitions. The same unit of text could be included in more than one category. Finally, after the first author completed the process of reviewing, defining, and naming the themes, the second author carried out a validity check. Both authors systematically reviewed the data to ensure that an exhaustive set of data supported each theme.

Results

We identified 12 categories organized into five superordinate themes. There was equal distribution of responses across all but one of the five themes. The five key themes were as follows: (a) a coping strategy was not a symptom of mental disorder; (b) coping was hindered by distrust in the mental health system and its professionals; (c) coping is related to meaningfulness, that is, being able to comprehend, manage, and attribute meaning to oneself and the world; (d) situational crises modulated coping strategies; and (e) "not coping" is a way of managing difficult situations. In the analysis that follows, we expand on the

themes arising from this analysis. As such, what we offer is a necessarily selective discussion of pertinent instances of the themes we identified.

Theme 1: A Coping Strategy Was Not a Symptom of Mental Disorder

Patients recounted a number of ways of managing difficulties in their lives. On the face of it, these coping strategies are describable as unproductive forms of coping or, more strongly, could be construed as symptomatic of the mental disorders with which patients have been diagnosed. Hence, the provision of fanciful narratives about managing difficulties might be readily redescribed as representing a departure from conventional reality testing and avoidance of, or retreating from, problems. For example, the use of drugs and alcohol might be construed as the type of socially avoidant and/or maladaptive behavior conceptualized as a secondary symptom of those diagnosed with schizophrenia (American Psychiatric Association, 2013). We note that such interpretations are predicated on an a priori assumption of patienthood, a perspective that conditions explanation. Here we suggest that, if we suspend judgment and examine patients' accounts in their own terms, some rather different understandings of their accounts become possible. That is to say, there is a choice to be made about the meaning that is attributed to the reports patients make about their experiences.

In the following extract, a patient describes the techniques he used to handle the experience of hearing voices:

Interviewer (I): Does this happen before, before you have a relapse?

Patient (P): No, I just feel a bit sick and it gets worse and worse. I just lay up in my bedroom and wait for it to pass.

I: So you just feel a bit sick.

P: Not physically sick.

I: Can you explain that situation to me?

P: Well, I hear voices and I get disoriented. Disoriented or orientated, what is it?

I: Disoriented. Oriented means you are aware of your time and place.

P: That's what I thought.

I: When you say you get disoriented, do you mean you don't know where you are?

P: Yes. I don't know what day it is, I don't know what week it is. I know where I am, but I just lock myself away in my bedroom until it's passed.

I: Does that work? Have you used this in the past to help manage that?

P: Yeah.

I: How long do you lock yourself away?

P: Until it's over, four hours, five hours.

I: Can you tell me about that?

P: If I get very bad, I take PRN, which is a very strong dose of droperidol, which helps a bit but gives me a lot of side effects. That's another reason for locking myself away.

I: So you don't just lock yourself away, you take PRN before you do that?

P: Yes.

The patient's way of managing his distressing experience by locking himself away for 4 or 5 hours is presented as a tried-and-tested coping mechanism. This type of behavior could be describable as avoidant or

unproductive coping and is potentially categorizable as a variety of the social withdrawal (or asociality) considered to be a symptom of serious mental illness under prevailing nosologies (American Psychiatric Association, 2013).

Alternatively, it is understandable as a perfectly sensible and efficacious way of dealing with feeling sick and disoriented. We note that his description of his way of dealing with voices is, semantically and prosodically, matter of fact and businesslike: there is no sense of floridity or reality distortion in his description.

A similar interpretation is applicable to the following exchange, in which another patient fluently describes the strategies she uses to manage both her mental health difficulties and associated illicit drug use:

I: So what sorts of things do you do to manage these situations?

P: Just taking every day as it comes. Just prove to myself that I can stay off the drugs and keep clean. Remember my time in [the psychiatric hospital] without them. My sadness, my rehabilitation, my detox.

Medication that I've found to substitute those drugs. The stages like I said for the butterfly. From the caterpillar to the egg, from the egg to the caterpillar and now the egg to the butterfly and now I'm reaching out and I'm going to fly off and spread my wings. That's my strategy for how I'm going to handle this.

I: Can you just tell me a little bit about that?

P: I'm the egg. I felt like I was in a stocking trying to get out, like in theater arts where you see people reaching out and struggling and trying to get out of that stocking. That's how I felt before I went through detox. Now I feel I've broken out of that and I'm going to change into a butterfly. I don't live on anxieties anymore. I used to at one stage of my

life but that's when I was depressed and lonely but now I have to just go with the flow.

I: Which strategy do you use now and works the best?

P: The butterfly strategy.

I: Do the others work?

P: That's the only one that I can see clearly that means something to me.

The patient clearly articulates three ways of dealing with her difficulties. These are her own, self-developed coping mechanisms. It is of note that three of the approaches identified are analogous to established psychotherapeutic interventions: first, what might be otherwise described as cognitive coping strategies, that is, "taking every day as it comes," "proving to myself that I can stay off the drugs and keep clean," "remembering" successful withdrawal; second, using medication appropriately; and third, employing an approach akin to narrative therapy, providing a metaphorical restorying of her recovery. In an account reminiscent of Laing's (1960) description of a study of a chronic schizophrenic called "Ghost of the Weed Garden" in his book *The Divided Self: An Existential Study in Insanity and Madness*, the patient uses the extended metaphor of metamorphosis to help the interviewer understand her experience.

McCabe, Heath, Burns, and Priebe (2002) suggested that the standard psychiatric injunction not to engage with the detailed concerns and content of psychotic patients' talk is, indeed, routine practice. Assertions such as "I'm going to change into a butterfly" are, in everyday psychiatric practice, less likely to be taken metaphorically and more likely to be viewed as delusional. As with the avoidance strategies described by the first extract, however, the account this

patient offers is clear and insightful. To characterize either of these patients' ways of coping as other than effective, for them, is to misconstrue their experiences.

Theme 2: Coping Was Hindered by Distrust in the Approach of the Mental Health System and Its Professionals

Across all patients' accounts, the ability to cope with their difficulties was strongly related to levels of distrust in the mental health system and the professionals working in it. This theme revealed barriers to patient coping and cast doubt on what is considered by mainstream psychiatry and psychology to facilitate coping. In all interviews, patients described hospital stays, particularly after involuntary admission, and psychiatrists, with their systemic reliance on physical treatments, with medication as a first line of treatment and the routine use of electroconvulsive therapy (ECT; commonly used as a treatment option for so-called drug-resistant depression and often for older people with depression; see Newnes, 2011), as unhelpful and not supportive of their own coping.

Indeed, a number of informants suggested that their interaction with mental health services decreased their sense that they were able to cope with their difficulties, instead promoting a sense of learned helplessness. As described previously in a patient's extract under Theme 1, the medication prescribed to assist him to cope with his mental health problems had effects that produced additional difficulties with which he then had to cope. Although, for this patient, the strong dose of droperidol "helps a bit," the side effects it induces, paradoxically, augment his perception that he needs to use avoidance as a strategy to manage his problems. Here, then, we can see the unintended iatrogenic consequences of psychiatric intervention: nonproductive coping

strategies being fostered by interventions intended to ameliorate the difficulties warranting the intervention in the first place.

Similarly, another patient's experience illustrates the way in which, although he describes his psychiatric medication regime as helpful, he is reduced to the nonproductive strategy of wishful thinking, simply "hoping I'll get better," in the face of professional ignorance about ways to help him cope with his impotence:

I: What things do you find the most difficult to deal with in your life?

P: Impotence.

I: What situations do you find difficult to manage?

P: Mundane day-to-day activities.

I: What are you doing to manage your impotence?

P: I can't manage it. It's beyond the pale.

I: Do you take much medication at the moment?

P: Heaps of things. I'm on olanzapine, that's an antipsychotic. I'm on sertraline, that's an antidepressant. I'm on clonazepam and diazepam, they're both tranquilizers, for antianxiety. I'm on anti-gastric reflux. Occasionally I'm on Epidrin, which is antimigraine. I'm on procyclidine, which is antiakathisia. I think that's the lot but there may be something else.

I: Have you tried to do anything else?

P: I've tried to masturbate myself . . . It makes me feel low self-esteem.

I: Have you talked about it in your men's groups?

P: I've told my psychiatrists here. They didn't know how to deal with it but said they are going to ring around to see if there are any specialists who could help me. I've got no further than that.

The finding here that patients need to cope with side effects of their medication, in addition to the difficulties for which the medication is prescribed, is consistent with Jablensky et al.'s (1999) finding that 63.2% of respondents to their Australian national mental health survey described specific side effects of medication and believed that these side effects impaired their daily lives. Researchers in a subsequent study in 2010 established that three-quarters of participants (77.4%) complained of medication side effects and that three-fifths (61%) suffered impairment in their daily lives as a result of these medication side effects (Morgan et al., 2012).

For some of the patients, if professional help in the form of medication was seen as limited, more assertive interventions were seen as being positively countertherapeutic. In the following extract, another patient describes situations he finds difficult to manage:

I: Are there any difficult situations you find difficult to manage?

P: In particular, being locked in Admissions East and people are being dragged in kicking and screaming, throwing themselves against walls, or shitting themselves at nighttime. Having to explain myself over and over again. Being accountable for every minute of every day. I don't pry into other people's lives. I'm just constantly repeating myself.

In addition to unpleasant physical surroundings, deprivation of liberty, and the distressing experience of witnessing "people . . . being dragged in

kicking and screaming,” the patient’s account draws attention to another feature found repeatedly in the interviews, namely, the difficulties patients had in their interactions with mental health professionals. Whereas for this patient, the issue was having to explain himself over and over again, being accountable for every minute of every day, and constantly repeating himself, many other respondents reported not trusting health professionals, not trusting professional advice, and not being heard by their treating psychiatrists. Another patient reported that she felt her psychiatrist thought she was lying and, since her hospital admission, she had found out that things she had spoken about confidentially with her psychiatrist had not remained confidential. She reported, “I’m having second thoughts about psychiatrists now, only because I always thought a psychiatrist was like a doctor, confidential, but I was told it’s not, it’s not like a [general practitioner] being a psychiatrist.”

The lack of congruence between individuals’ understandings of themselves and mental health professionals’ diagnostic perceptions of the individuals was a topic that the patients frequently raised. When asked what the most difficult things to deal with were, another patient reported that she could cope with most problems but not with being called crazy. As she said, “I’m not crazy, they put me down crazy, but I’m not crazy.” As such, when discussing what strategies helped them with coping, patients reported that, because many mental health professionals saw them unidimensionally, medication did not always help, and ECT did not make them “better.” Paradoxically, some patients were rendered helpless by the mental health system. Patients repeatedly reported how disheartening they found the experience of putting their faith and trust in the

mental health system and in professionals, only to be given a label and left with a so-called cure (medication or ECT) that did not work.

In addition, a number of patients suggested that they had let important people down, or “failed” them, by being admitted to the hospital. Indeed, for several of the women interviewed, being involuntarily separated from family and children was not perceived as an aid to recovery. Rather, as one patient mentioned, it was looking forward to leaving the hospital that gave him hope and enabled him to cope with the additional trauma of compulsory hospitalization. As he said, “I know I’m not a danger to myself and others. I just want to get on with my life. A normal life. Everyone’s wondering where the hell I am, lecturers, cricket planning, being locked in here is compounding the problem.” Another patient’s estimation of her situation seemed to sum up this dilemma clearly: “I know I have to help myself, the tablets aren’t going to do it, the ECT isn’t going to do it. I don’t know if I’m strong enough to do it either.”

The interview responses as a whole suggest, for these patients at least, that their repeated exposure to the mental health system has decreased their confidence in their coping skills and increased a sense of helplessness. Patients repeatedly offered accounts of “putting up with hospital,” “going along with [treatment],” and “doing nothing” while hospitalized. They also described using (what the coping literature characterizes as nonproductive) coping strategies, such as wishful thinking, hope, and passivity, to help them endure their situations.

Theme 3: Coping Is Being Able to Comprehend, Manage, and Find Meaning in Self and the World

Across all interviews, patients described coping as enhanced or, conversely, as compromised by a small number of common factors. Patients indicated that

when they experienced the world as predictable, understandable, and structured, they felt that they had adequate personal resources to meet the demands placed on them by circumstances, that they and their lives made a contribution to others (that they were worthwhile), that they had their difficulties heard and construed as “normal,” that they experienced self-esteem, and that their coping abilities were enhanced. Conversely, when their experience of the world ran contrary to this (and, as we have seen, many patients’ experiences of mental health services consisted of precisely this), they reported that their capacity to cope was severely attenuated.

Patients’ experiences of mental health services were largely experiences of being passive and, not infrequently, unwilling recipients of treatment. In response to the question, “What do you find most difficult to deal with in life?” one patient reported,

Probably having a psychiatric illness. At times I find that hard to deal with. Just I don’t know if you’d call it embarrassing just having that label, saying the words *schizophrenia* and *psychosis* is a bit heavy for people to fathom or understand. Some people understand it better than others and I find that quite difficult . . . Sometimes you have your good days and your bad days, and when you have your bad days sometimes you want to be in total isolation away from people and they sometimes don’t understand that you just want to be alone and you don’t want to offend them or be offensive toward them.

Patients described wanting to be able to comprehend, manage, and find meaningfulness in their experiences and the world around them, just as everyone

always tries to make sense of his or her predicaments. As Rowe (2003) described this quest for meaning, “we give our world meaning and we act in accordance with that meaning” (p. 174). One of the difficulties facing patients was the understanding of their illness by spouses and/or family members. In keeping with these concerns, many patients claimed that they would be careful about with whom they discussed their illnesses and that, most of the time, they omitted details, making it easier to understand, in an effort not to burden their spouses, families, and friends. As one patient explained, “trying to cope with the label and illness . . . it is about sort of easing into it with people, not telling them the full scope and complexity of the illness.” But when queried about what most helped them cope with their difficulties, patients also reported that talking to people whom they trusted or whom they felt could shed some objective light on their situation was helpful. This process added meaningfulness to their situation and sense of themselves. As this patient observed, “for me, relaxing or speaking to a close friend. Having a chat to someone who can shed some light onto a few problems you’re having at the time. That works best.”

In addition to seeking support from friends and family, a number of patients described a range of strategies they used to add meaning and achievement to their lives as a way of coping with mental health difficulties. In the following extract, a patient describes his own, active strategies for dealing with his suicidal thoughts:

I: If I were to ask you what strategy you use that works the best, what would you say?

P: Now that we’re sitting here talking, I realize how strong the poetry is, because it also enables me to think wow I’ve written five pages, I feel

good. I've done something. So on top of everything else it's an accomplishment. So I'd probably say that stands quite high up on the list. In my bedroom it would be different. It depends what I'm coping with. Suicidal thoughts or something like that is very difficult to come out of. Then I have to have layer upon layer, I have to have a bath, have the essential oils, I have to do some meditation, I have to pray.

We are struck by both the very mundane nature of the strategies identified by the patients in these interviews—seeking support from understanding friends, attempting to secure objective advice, adopting self-care strategies such as meditation and relaxation techniques—and also the very real difficulties that being identified as mentally ill caused for patients in adopting these coping strategies. Also of note, we suggest, is the very articulate and insightful way in which patients were able to describe both the coping mechanisms they found helpful and the barriers to their use that diagnosis posed.

Theme 4: Situational Crises Modulated Coping Strategies

Across all interviews, patients reported that their usual coping styles were affected by situational crises, leading to an increase in the need for coping strategies and adaptation of strategies and, for some, admission to hospital. The deployment of certain coping strategies and the need for coping depended on the seriousness of the circumstances. Patients adapted their coping strategies depending on the severity of their life events. Of note here is that most of the patients interviewed described abhorrent life circumstances with which few people would have coped. As Newnes (2014) emphasized, the material context of peoples' lives needs to be recognized:

Talking treatments are *bound* to kill a little of the spirit, *despite* the best intentions of patient and psychologist; talk is neither going to change the context of the patient's life nor—necessarily lead to the patient gaining the power essential to change, a fairly dispiriting outcome (p.18).

One patient described having to “adapt” her coping style for many years after her partner went to prison, and, at the same time, she was embroiled in legal proceedings against her parents. Her partner was her major source of support over the years, to help her cope with the anxiety with which she had been left from being repeatedly sexually and physically abused by both her parents for 28 years of her life. When asked what she found difficult to deal with in her life, she described the following:

P: Loss of my children. My partner being in prison I guess, it's hard when he's not around. Legal proceedings. The list goes on.

I: What sorts of things do you do to manage these difficult situations?

P: I have very little coping mechanisms, I don't cope well. I don't have any stress triggers, like I don't have any signs that I'm under stress and when I do erupt it's usually a self-mutilation of some sort or it's suicidal attempts but there's no sort of sign in between. It's either I feel really fine or I feel suicidal and there's nothing in between.

I: Which strategy works best for you?

P: Accepting it. When I accept it, I basically let go of the situation, I believe it's out of my hands and I just let it go. I'm not in a secure, stable position to fight for any rights and until I'm home based and settled I've got nothing to stand on to fight with so I have to accept it and let it lie for

now but I don't think I'll leave it at that forever. That's just a temporary measure to cope so that I can cope with life.

This patient's voluntary hospital admission occurred after she began self-mutilation. She then reports accepting her situation, and this helped her cope. Bridgett and Polak (2003) reported that a crisis leading to a hospital admission is defined as when a patient has exhausted his or her coping resources and support from others. For the majority of patients interviewed, a suicide attempt had preceded an admission to the hospital. Many patients reported serious life events (both past and present) that had led to an increase in the utilization of coping strategies, thoughts of suicidality, and a subsequent hospital admission.

Patient emergency admissions were usually preceded by a situational crisis, such as relationship breakdown and loss of contact with family, significant other, children, and loved ones. Other patients spoke of situations in which insidious trauma that dominated their lives had become intolerable. They described engaging in a variety of behaviors, ranging from dangerous to sabotaging, to cope with situational crises. Patients described "serious" situations, outside of, by their definition, normal experiences, that they saw as requiring drastic measures. One patient reported that he jumped in front of a train as an attempt to cope with a relationship breakdown: "I just got sick of relationships breaking down. You build things up and they just keep falling down. It's like why should I try? If you try you get hurt, so why bother?" Bridgett and Polak (2003) have highlighted that a hospital admission, once seen as a necessary resource for dealing with a situation in which alternative resources have been exhausted, now carries, at least for some, the side effect of being taken from the social context and medicalized.

Theme 5: “Not Coping” as a Way of Coping

Dillon (2011) outlined ways in which dissociation, consequent on severely traumatizing life experiences, may function as a self-protection (or coping) strategy. In the interviews discussed in this article, many patients similarly reported dealing with their distressing experiences simply by accepting the fact that not coping with them was, in and of itself, an effective strategy for dealing with overwhelming circumstances. That is to say, some patients actively and consciously rejected the societal expectations of rugged individualism, which is the essence of normal in the academic coping literature. In essence, we see the embrace of not coping as a coping mechanism.

Patients reported various strategies that would be categorized as unproductive coping mechanisms by instruments such as the CSA. As the interviews show, some patients would engage, for example, in binge drinking to manage a crisis, and then return to their regular routines. Some patients reported a powerful sense of guilt, having been told by mental health workers that this type of strategy was inappropriate, which then necessitated additional emotional and psychological resourcefulness to cope with the guilt induced by such professional advice. The variety of supports reported most frequently to help get through difficult situations were religion, alcohol, and prescription and illicit drugs, which Malow, West, Williams, and Sutker (1989) argued to all be means of self-medicating. Indeed, patients displayed acute insight into the fact that their inappropriate use of alcohol or drugs was a strategy to cope with particular situations at particular points in time. As one patient put it,

I've been doing a lot of drugs. Chases the demons away. Puts you into a different state of mind so that you're not thinking about why you're

taking the drugs, you're just enjoying the drugs you're taking. You're just escaping the reason not the cause . . . that's my way of coping, shut the world out.

Another patient described how "not coping" actually helps her "cope." Her response to the question, "What helps you to cope?" illustrates this clearly: My husband. . . . Now I can say, "I feel like shit" and go back to bed or say, "I want to go home" and we'll go. I know that if I'm in bed the kids will have a cooked meal for them. He's allowing me to have a breakdown and learn to cope and to not cope when I can't cope.

Conclusion

To our knowledge, this study is the first to reveal the personal accounts of the many ways in which psychiatric patients cope with the difficulties with which they are faced. Among some patients, a style of coping was evident that is reflective of stable coping strategies (McCrae & Costa, 1986). The majority of patients used a combination of coping mechanisms, which is more in keeping with Lazarus's (1966) theory of coping. Patients' accounts of coping reflected the relational meaning between themselves and their environments, which affected the levels of stress they experienced and their subsequent coping processes (Lazarus & Folkman, 1984). In some instances, their accounts illuminated the barriers to their coping, which calls into question what mainstream psychiatry and psychology consider as facilitative of coping. We identified five themes that cohere around the problems inherent in the definitions of coping imposed by others in their environment. These definitional impositions

negatively affect patients' experiences of self and their views of their own coping strategies.

Underlying many patients' reports of difficulty in coping with their problems was a sense of confusion over the issue of their personal agency consequent on diagnosis, multiple problems induced by a systemic reliance on physical treatments in mental health services, and the diminution by professional helpers of their personal resources for coping with distress. Feelings of worthlessness and decreased self-esteem engendered by contact, often involuntary, with mental health services were associated with poorer coping responses. Patients consistently reported being frustrated by not being heard by service providers and that their experiences with services did not add meaning to their lives.

Summerfield (2004) argued that underpinning the construct of mental health is the concept of the person, which contains questions such as, What can someone be faced with and still be normal? What is acceptable behavior in a time of crisis? The idea of the person in current Western society now focuses not on resilience but on vulnerability, which leads to a "blurring between unpleasant but everyday mental states and those suggesting a clinical syndrome" (Summerfield & Veale, 2008, p. 327). This notion of pathologizing normal, everyday behavior, for example, marital problems or bereavement, requiring mental health professional intervention has severe consequences on how the individual views his or her own coping, "even when the person concerned has lived a competent life to date and has never demonstrated vulnerability to mental disturbance" (Summerfield, 2004, p. 233). There are also cultural implications with too narrow a view of what constitutes coping for those with mental health

issues. What is seen as culturally appropriate in one group may be viewed as vastly different in another. This echoes Summerfield's (2008) argument that the globalization of mental health is fraught with issues and sets out "to instruct, regulate, and modernize, presenting as definitive the contemporary Western way of being a person" (p. 992).

As we explored the meaning of coping with psychiatric inpatients, the difficulties they face, and how they "do" coping, one feature emerged repeatedly: professional intervention in the form of diagnosis, as opposed to understanding patients as people experiencing "problems in living," reduced informants' ability to cope. Relatedly, patients repeatedly provided accounts of experiences in which professionals misinterpreted coping strategies as symptoms of illness, rather than as the best attempts the patients could muster to manage their difficulties. What was important for patients was to find someone who could be trusted, who could help them to make sense of what they were experiencing without judgment. This, however, was a service that was not provided, or facilitated, by the mental health system in which the patients were enmeshed. This outcome resulted in the patients' lack of trust in mental health services and in the professionals working in them, which in turn led to additional difficulties in coping. Most of the patients interviewed saw themselves as members of the community dealing with everyday life events such as love, loss, and relationship breakdown. This sometimes led to successful coping, meaning, on occasion, not coping—a strategy that patients were able to clearly articulate.

Bentall (1992) elegantly demonstrated that the criteria psychiatry employs to define some forms of conduct as pathological are, and can only be, moral ones. Similarly, what does or does not count as helpful, healthy, or

appropriate means of dealing with problems, that is, coping strategies, cannot but be a matter of local and individual, rather than universal, definition. As such, we suggest, not only is the global notion of inadequate coping in and of itself a totalizing moral judgment but also the notion that ways of coping, which attract the opprobrium of psychiatry, are in some meaningful sense “symptomatic” of a “mental disorder” is inherently tautologous and, hence, meaningless. Even were this not the case, it is our contention that the ways of managing often traumatic life circumstances, described by the patients in this study, are not only essentially comprehensible but also often creative and courageous. To describe such ways of coping as “nonproductive,” or as “symptoms” of “mental disorder,” is, we suggest (with due respect to Sarbin & Mancuso, 1984), not to arrive at a medical diagnosis but rather to pass pejorative moral judgment.

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References

- Adler, N., & Matthews, K. (1994). Health psychology: Why do some people get sick and some stay well? *Annual Review of Psychology, 45*, 229–259.
doi:10.1146/annurev.ps.45.020194.001305
- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: Author.
- Ansbacher, H. L., & Ansbacher, R. R. (1967). *The individual psychology of Alfred Adler*. New York: Harper & Row.
- Barry, A. M. (1997). *Visual intelligence: Perception, image and manipulation in visual communications*. Albany: State University of New York Press.
- Bentall, R. P. (1992). A proposal to classify happiness as a psychiatric disorder. *Journal of Medical Ethics, 18*, 94–98. doi:10.1136/jme.18.2.94
- Bodenmann, G., Charvoz, L., Widmer, K., & Bradbury, T. (2004). Differences in individual and dyadic coping among low and high depressed, partially remitted, and non-depressed persons. *Journal of Psychopathology and Behavioral Assessment, 26*, 75–85.
doi:10.1023/B:JOBA.0000013655.45146.47
- Boyle, M. (2011). Making the world go away and how psychology and psychiatry benefit. In M. Rapley, J. Moncrieff, & J. Dillon (Eds.), *De-medicalizing misery: Psychiatry, psychology, and the human condition* (pp. 27–43). Basingstoke, England: Palgrave Macmillan.
- Bracken, P., & Thomas, P. (2005). *Postpsychiatry: Mental health in a postmodern world*. Oxford: Oxford University Press.
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*, 77–101.

doi:10.1191/1478088706qp063oa

Bridgett, C., & Polak, P. (2003). Social systems intervention and crisis resolution.

Part 1: Assessment. *Advances in Psychiatric Treatment*, 9, 424–431.

doi:10.1192/apt.9.6.424

Carver, C. S., Scheier, M. F., & Weintraub, J. K. (1989). Assessing coping

strategies: A theoretically based approach. *Journal of Personality and*

Social Psychology, 56, 267–283. doi:10.1037/0022-3514.56.2.267

Coan, R. (1973). Personality variables associated with cigarette smoking.

Journal of Personality and Social Psychology, 26, 86–104.

doi:10.1037/h0034213

Coyne, J. C., & Gottlieb, B. H. (1996). The mismeasurement of coping by

checklist. *Journal of Personality*, 64, 959–991. doi:10.1111/j.1467-

6494.1996.tb00950.x

De Ridder, D. (1997). What is wrong with coping assessment? A review of

conceptual and methodological issues. *Psychology & Health*, 12, 417–

431. doi:10.1080/08870449708406717

Dillon, J. (2011). The personal *is* the political. In M. Rapley, J. Moncrieff, & J.

Dillon (Eds.), *De-medicalizing misery: Psychiatry, psychology, and the*

human condition (pp. 141–157). Basingstoke, England: Palgrave

Macmillan.

Endler, N. S., & Parker, J. D. A. (1990). Multidimensional assessment of coping:

A critical evaluation. *Journal of Personality & Social Psychology*, 58,

844–854. doi:10.1037/0022-3514.58.5.844

Folkman, S., & Lazarus, R. S. (1988). *Manual for the Ways of Coping*

Questionnaire. Palo Alto, CA: Consulting Psychologists Press.

- Freud, A. (1968). *The ego and the mechanisms of defence* (Rev. ed.). London: Hogarth Press for the Institute of Psycho-analysis.
- Frydenberg, E., & Lewis, R. (1997). *Coping Scale for Adults: Administrator's manual*. Melbourne: Australian Council for Educational Research Press.
- Garfinkel, H. (1967). *Studies in ethnomethodology*. Englewood Cliffs, NJ: Prentice Hall.
- Hansen, S., McHoul, A., & Rapley, M. (2003). *Beyond help: A consumers' guide to psychology*. Ross-on-Wye, England: PCCS Books.
- Hayes, N. (1997). *Doing qualitative analysis in psychology*. East Sussex, England: Psychology Press.
- Hobfoll, S. E. (1989). Conservation of resources: A new attempt at conceptualizing stress. *American Psychologist*, *44*, 513–524.
doi:10.1037/0003-066X.44.3.513
- Holahan, C. J., & Moos, R. H. (1987). Personal and contextual determinants of coping strategies. *Journal of Personality and Social Psychology*, *52*, 946–955. doi:10.1037/0022-3514.52.5.946
- Iwanaga, M., Yokoyama, H., & Seiwa, H. (2004). Coping availability and stress reduction for optimistic and pessimistic individuals. *Personality and Individual Differences*, *36*, 11–22. doi:10.1016/S0191-8869(03)00047-3
- Jablensky, A., McGrath, J., Herrman, H., Castle, D., Gureje, O., Morgan, V., & Korten, A. (1999). *National survey of mental health and wellbeing. Report 4. People living with psychotic illness: An Australian study 1997–98*. Canberra: Commonwealth of Australia.

- Keyes, C. L. M. (2007). Promoting and protecting mental health as flourishing: A complementary strategy for improving national mental health. *American Psychologist, 62*, 95–108. doi:10.1037/0003-066X.62.2.95
- Kiecolt-Glaser, J. K., McGuire, L., Robles, T. F., & Glaser, R. (2002). Emotions, morbidity, and mortality: New perspectives from psychoneuroimmunology. *Annual Review of Psychology, 53*, 83–107. doi:10.1146/annurev.psych.53.100901.135217
- Laing, D. D. (1960). *The divided self: An existential study in sanity and madness*. London: Penguin Group.
- Lazarus, R. S. (1966). *Psychological stress and the coping process*. New York: McGraw-Hill.
- Lazarus, R. S. (1999). *Stress and emotion: A new synthesis*. New York: Springer.
- Lazarus, R. S., & Folkman, S. (1984). *Stress, appraisal, and coping*. New York: Springer.
- Malow, R. M., West, J. A., Williams, J. L., & Sutker, P. B. (1989). Personality disorders classification and symptoms in cocaine and opioid addicts. *Journal of Consulting and Clinical Psychology, 57*, 765–767. doi:10.1037/0022-006X.57.6.765
- Mason, M. (2010). Sample size and saturation in PhD studies using qualitative interviews. *Qualitative Social Research, 11*, 1–19. Retrieved from <http://www.qualitative-research.net/index.php/fqs/article/view/1428>
- McCabe, R., Heath, C., Burns, T., & Priebe, S. (2002). Engagement of patients with psychosis in the consultation: Conversation analytic study. *British Medical Journal, 325*, 1148–1151. doi:10.1136/bmj.325.7373.1148

- McColl, M. A., Hau, L., & Skinner, H. (1995). Structural relationships between social support and coping. *Social Science Medicine*, *41*, 395–407.
doi:10.1016/0277-9536(94)00338-T
- McCrae, R. R. (1984). Situational determinants of coping responses: Loss, threat, and challenge. *Journal of Personality and Social Psychology*, *46*, 919–928. doi:10.1037/0022-3514.46.4.919
- McCrae, R. R., & Costa, R. T. (1986). Personality, coping, and coping effectiveness in an adult sample. *Journal of Personality*, *54*, 385–405.
doi:10.1111/j.1467-6494.1986.tb00401.x
- Medalia, A., & Revheim, N. (2002). *Dealing with cognitive dysfunction associated with psychiatric disabilities: A handbook for family and friends of individuals with psychiatric disorders*. New York: State Office of Mental Health. Retrieved from
<http://www.omh.state.ny.us/omhweb/resources>
- Menninger, K. (1963). *The vital balance: The life process in mental health and illness*. New York: Viking Press.
- Moncrieff, J. (2008). *The myth of the chemical cure: A critique of psychiatric drug treatment*. London: Palgrave Macmillan.
- Moncrieff, J. (2010). Psychiatric diagnosis as a political device. *Social Theory & Health*, *8*, 370–382. doi:10.1057/sth.2009.11
- Moos, R. (1992). *Coping Response Inventory manual*. Palo Alto, CA: Department of Veterans Affairs and Stanford University Medical Centers, Center for Health Care and Evaluation.
- Morgan, V. A., Waterreus, A., Jablensky, A., Mackinnon, A., McGrath, J. J., Carr, V., . . . Saw, S. (2012). *People living with psychotic illness 2010:*

Australian and New Zealand Journal of Psychiatry, 46, 735–752.

doi:10.1177/0004867412449877

- Newnes, C. (2011). Toxic psychology. In M. Rapley, J. Moncrieff, & J. Dillon (Eds.), *De-medicalizing misery: Psychiatry, psychology and the human condition* (pp. 211–225). Basingstoke, England: Palgrave Macmillan.
- Newnes, C. (2014). *Clinical psychology: A critical examination*. Ross-on-Wye, England: PCCS Books.
- Oakland, S., & Ostell, A. (1996). Measuring coping: A review and critique. *Human Relations*, 49, 133–155. doi:10.1177/001872679604900201
- Rapley, M., Moncrieff, J., & Dillon, J. (2011). Carving nature at its joints? DSM and the medicalization of everyday life. In M. Rapley, J. Moncrieff, & J. Dillon (Eds.), *De-medicalizing misery: Psychiatry, psychology and the human condition* (pp. 1–9). Basingstoke, England: Palgrave Macmillan.
- Read, J., Mosher, L. R., & Bentall, R. P. (2004). *Models of madness: Psychological social and biological approaches to schizophrenia*. London: Routledge.
- Rose, N. (1989). *Governing the soul: The shaping of the private self*. London: Routledge.
- Rowe, D. (2003). *Depression: The way out of your prison* (3rd ed.). New York: Brunner-Routledge.
- Ryan, J., & Dziurawiec, S. (2013). *Productive and non-productive coping in psychiatric patients*. Unpublished manuscript.
- Sarbin, T. R., & Mancuso, J. C. (1984). *Schizophrenia: Medical diagnosis or moral verdict?* New York: Pergamon Press.

- Schütz, A. L. (1962). *Collected papers, Vol. I: The problem of social reality*. The Hague, Netherlands: Martinus Nijhoff.
- Shenton, A. K. (2004). Strategies for ensuring trustworthiness in qualitative research projects. *Education for Information, 22*, 63–75. Retrieved from <http://iospress.metapress.com/index/3ccttm2g59cklapx.pdf>
- Skinner, E. A., Edge, K., Altman, J., & Sherwood, H. (2003). Searching for the structure of coping: A review and critique of category systems for classifying ways of coping. *Psychological Bulletin, 129*, 216–269. doi:10.1037/0033-2909.129.2.216
- Smith, D. (1978). “K is mentally ill”: The anatomy of a factual account. *Sociology, 12*, 23–53. doi:10.1177/003803857801200103
- Snyder, C. R. (1999). *Coping: The psychology of what works*. New York: Oxford University Press.
- Somerfield, M. R., & McCrae, R. R. (2000). Stress and coping research: Methodological challenges, theoretical advances, and clinical applications. *American Psychologist, 55*, 620–625. doi:10.1037/0003-066X.55.6.620
- Summerfield, D. (2004). Cross cultural perspectives on the medicalisation of human suffering. In G. Rosen (Ed.), *Post-traumatic stress disorder: Issues and controversies* (pp. 233–245). London: John Wiley.
- Summerfield, D. (2006). Depression: Epidemic or pseudoepidemic? *Journal of the Royal Society of Medicine, 99*, 161–162. doi:10.1258/jrsm.99.3.161
- Summerfield, D. (2008). How scientifically valid is the knowledge base of global mental health. *British Medical Journal, 336*, 992–994. doi:10.1136/bmj.39513.441030.AD

- Summerfield, D., & Veale, D. (2008). Proposals for massive expansion of psychological therapies would be counterproductive across society. *The British Journal of Psychiatry*, *192*, 326–330.
doi:10.1192/bjp.bp.107.046961.
- Taylor, S. E., & Stanton, A. L. (2007). Coping resources, coping processes, and mental health. *Annual Review of Clinical Psychology*, *3*, 377–401.
doi:10.1146/annurev.clinpsy.3.022806.091520
- Wilkinson, R., & Pickett, K. (2009). *The spirit level: Why more equal societies almost always do better*. London: Allen Lane.

CHAPTER 6

Meet the People: A Selection of Case Studies

“I know I have to help myself, the tablets aren’t going to do it, the ECT isn’t going to do it. I don’t know if I’m strong enough to do it either”

—Louise

Preamble

This chapter examined, through a narrative synthesis of a set of case studies, the commonalities amongst patients that impact on their coping. The same 38 inpatients used in Chapter 5 were used in this chapter of case studies, although only 10 cases were selected for in-depth analysis. This chapter expands on the thematic analysis carried out in Chapter 5 and takes more of an individualistic case formulation approach to the understanding of the nature of coping, including the patients’ psychiatric, social, environmental and family contexts. The circumstances and meanings of coping are reflected through patients’ interviews and information accessed from their medical files. Information from patient medical files is not the focus of these case studies and is used only throughout to provide contextual, qualitative information of the patients interviewed for this study. The qualitative information gathered, combined with patient interviews of their coping, proved helpful in identifying more about the meaning of coping for these patients.

Introduction

There is evidence now accruing for the use of more individualistic approaches to the measurement of coping (Davies, Thomas, Leudar, 1999; Hallam, 2013; Lazarus, 2000). Indeed, individualistic approaches to the investigation of coping are significant in the area of mental health, as they allow

a more detailed analysis of the contextual variables impacting on patients' coping. While compilations of case studies alone present limited contributions to the development of scientific knowledge, as part of a larger study they can provide interesting and noteworthy insights (Peterson, 2004).

As detailed in the previous literature reviews, (see Chapters 4 & 5), the ways in which coping has been researched and understood in the past have been problematic for the area of mental health and have not enabled researchers to move forward in understanding psychiatric patients' accounts of coping. These approaches have meant that patients' attempts at coping have either gone unnoticed, or been viewed by others as "unhelpful," and overall coping behaviours and strengths minimized. As noted previously, there are many criticisms of the sole use of quantitative psychometric measurements of coping. When solely quantitative measurement is used, what is reflected is a problem of causation. For example, statistical relationships may be revealed in the data, but quantitative measurement of coping through standardised questionnaires does not measure "process." This is a methodological problem and the point at which the coping literature falters.

Coping by its very nature is an interactional entity and depends very much on how an individual interacts with their circumstances, which makes measuring the concept of coping in itself difficult. Psychologists need to acknowledge the difficulties in measurement and in defining coping and report accordingly. As seen in Chapter 4, coping can be measured in terms of what an individual uses in times of need (e.g., coping strategies) but, when unpicked further (e.g., through narrative and qualitative lines of investigations), much more is revealed about the coping experience for the individual. As Rowe (2007)

stated, “all individuals try to make sense of their predicament. They are driven by a quest for *meaning*” (p. 174). So too, people diagnosed with a “mental illness” are trying to make sense of their experience, and dismissing their coping attempts as unproductive coping or “madness,” is characteristic of only a few cultures, including Australia, America and Britain. Because individuals and their coping mechanisms can not be classified easily, the inclusion of personal narratives alongside quantitative measures can reveal a much deeper description and understanding of patients’ coping. One of the advantages of narrative approaches to coping is the restorying of the many attempts those diagnosed with a mental illness make at managing difficulties in their lives, much of which is unseen in quantitative approaches (Combs & Freedman, 2012; Freedman & Combs, 1996; Hallam, 2013; Morgan, 2001, 2002; Morgan, Brosi & Brosi, 2011).

Personal narratives as a therapeutic technique have been used successfully in the treatment of persons diagnosed with various “mental illness” (Combs & Freedman, 2012; Davies et al., 1999; Ensink, 1993; Morgan, Brosi & Brosi, 2011). In this chapter the patients’ own accounts of their experience of managing difficulties (coping) were the main focus and these are reflected through semi-structured interviews. With these, along with medical file notes, I attempt to explicate the relationship between coping attempts and mental illness, as we know it.

This chapter is unique in that it brings together not only the content of the semi-structured interviews that detail description of patients’ narratives, but also information reviewed from patients’ medical files, such as psychiatrists’ letters, psychiatrists’ intake and discharge summaries, ward round meeting discussions of patients and allied health (e.g., social workers, psychologist and

occupational therapists) input into patient care. The combined accounts provide vital information about patient coping. This approach was seen as necessary because contemporary psychology and psychiatry offer scientific “truths” about coping which themselves offer hypothetical realities, which are amenable to analysis. Hallam (2013) states:

. . . scientific constructs differ from any of the socially constructed realities of “mental illness.” The concept of mental illness is not a scientific concept; the idea of being mentally ill constitutes reality, and, if taken to be something “real,” a person may look to science to explain it” (p. 106).

In constructing the individual case formulations my position in parts is shared with critical discourse analysis and qualitative analytical approaches in that I suspend, where I can, a prevailing mainstream knowledge (e.g., clinical psychological, psychiatric) and following Foucault scholarship, illuminate psychiatric inpatient truths as contingent upon social cultural contexts, presented by the inpatients themselves, and contextual information, as indicated in their files. My formulation highlights that patients do not bring an interiorised irrationality with them into the therapeutic space, but rather examines how the contemporary truth of the irrationality of patients is brought off in, by, and through their “therapeutic” interactions with professionals. That is to say here that, while at one level primarily investigating one’s coping the co-construction of what is ‘madness’ by therapists and patients takes precedence, rather than starting from the *a priori* position that, for example, certain forms of talk index a pre-existing form of insanity referred to as ‘schizophrenia.’ Within this presentation of case studies, there will be, at times, a critical analysis of the psy-

professions in terms of their impact on patients' coping per se. This perspective begins from a position of "critical psychology" and "survivor" literatures (Sweeney et al., 2009), which suggest that mainstream psychiatric assumptions about those diagnosed with a mental health issue entail pathologizing generalisations about complex issues which are, in practice, shaped by and produced in the interaction of psychiatrists, allied health professionals and patients. By employing qualitative methods, an understanding of the experiences of patients' coping in terms of personal and interpersonal meaning was explored, and provided a platform to view patients' coping attempts as individualised ways of managing situations. These approaches also circumvented categorising patient coping attempts as non-productive or productive, or as in the extreme cases within psychiatry, as inherently meaningless symptoms of an individualized "mental illness."

The end result is a set of case formulations which reflect a real set of experiences which revealed commonalities in the context of coping.

The Present Study

Patient demographics were collected for the 38 patients (see Appendix C for the complete list). For each of the patients interviewed, the following information was gathered: gender, date of birth, diagnosis, number of admissions, number of suicide attempts, family history of mental illness, psychiatric medication, counselling offered, engagement in counselling, and illicit drug use. A late inclusion of descriptive information was whether the patient was still alive after the interviews, as it was disturbing yet poignant to find that 4 of the patients from this study had died. This study used interview content of 10 patients who were selected on the basis of their most current diagnosis to represent a mixture

of the diagnoses from the same 38 inpatients in the qualitative study, who completed the semi-structured interview (see Chapter 5 for methodology). Patient demographics for the patients included in the present study are listed below in Table 6.1.

Table 6.1

Descriptive Information Regarding Patients

Patient	Year of birth	Diagnosis	Admissions	Suicide attempt	Family history of illness	Psychiatric medication	Counseling offered	Engage counseling	Drug use
Tanya	1974	Depression	3	0	No	Yes	Yes	No	Yes
Ben	1970	Bipolar	26	26	Yes	Yes	Yes	No	Yes
Anna	1971	Borderline Personality Disorder	11	11	No	Yes	Yes	Yes	Yes
Jim	1972	Bipolar	3	0	No	Yes	Yes	No	Yes
Rose	1972	Schizophrenia	3	0	Yes	Yes	Yes	No	Yes
Mark	1977	Depression	2	2	Yes	Yes	No	No	No
Tara	1968	Schizophrenia	9	1	No	Yes	No	No	No
Mel	1962	Bipolar disorder	5	5	No	Yes	No	No	No
Phil	1968	Schizophrenia	15	11	Yes	Yes	Yes	Yes	Yes
James	1957	Schizophrenia	53	12	No	Yes	No	No	Yes

The word “coping” was not used in the semi-structured interview questions due to the preconceived notions people often have about coping. Instead, patients were asked, “What things do you find the most difficult to deal with in your life?” and “What sorts of things do you do to manage difficult situations?” followed by “When do various approaches get used?” And “Which works best?” and “When do various approaches work best?” The word coping did appear from time to time through patients’ descriptions and during the process of the interview. A less sophisticated vocabulary was utilised in the semi-structured interviews, in order to relate to the patients. For example, no difficult words or complicated sentences were used and I would try, where possible, to use patient examples of their coping attempts to move deeper into their story. The open ended, reflective lines of interviewing allowed the interview to unearth as much as possible about the patient’s coping efforts. These were not therapy sessions, of course, but when combined with background information collection from the patient’s medical file, bits and pieces of the patient’s life and contexts emerged.

Information was taken from patients’ interviews and will be used as excerpts in this study to illustrate each individual’s experience of coping as a psychiatric patient. Medical file records contain relevant background information. The information reviewed for case studies included: diagnosis (if multiple admissions, all admissions were reviewed), medication prescribed, contact with health professionals, community services, and other qualitative information. Only non-identifying qualitative information was used throughout the case studies.

Files were reviewed after the patient interviews. Files were perused on more than one occasion to gather a more detailed description of patients' lives and their social and cultural contexts. Patients agreed to the use of the release of all confidential information and agreed for it to be used as part of the PhD or any publication arising out of the PhD. The hospital requested a special formatted consent form to be completed by patients' to authorize access to their medical files for research purposes.

It should be noted that the research interview and transparency of this study was of a high standard: patients could leave the study whenever they wished. Even after completing their interview, patients could request for their interview to be deleted, and, if anything was recorded they felt did not reflect their position, they could also request to delete that part. The interview content revealed honest, real and frank disclosure, some of an extremely private nature; yet these patients wanted to convey their story. As previously mentioned, only two patients did want to listen to their responses immediately after the interview, which they did, primarily it seemed to make sure that the researcher had "recorded everything."

Qualitative information relevant to this study from patient medical files, such as admissions and medication, is referred to from time to time in this study to reflect information relevant to patient coping. Pseudonyms have been used to protect the identity of the patient and information gathered during this study. Where there has been a break in the transcript to omit a lengthy transcript, this will be indicated by ellipses (i.e. . . .). Excerpts from the transcripts appear throughout this chapter.

Meet the People: 10 Case Studies

Mel. Mel was a 40-year-old mother who reported a long history of being treated for bipolar affective disorder. Mel reported a very unhappy childhood and that her parents had an extremely volatile relationship. She reported that she suffered a neglectful, abusive childhood, both of which has been found to relate to later onset of psychiatric problems (Keyes, et al., 2012; Read, 1997, 2005a; Read & Bentall, 2012; Weich, Patterson, Shaw, & Stewart-Brown, 2009). Mel reported that she trained to be a school teacher. While she taught for some years, she stopped teaching after becoming “unwell.” Mel married at the age of 23, had 3 children, and reported that she was “happily married,” for a period of time. Mel reported that she found her marriage deteriorated, and her husband on unemployment benefits difficult to deal with. Mel’s 9-year history of bipolar affective disorder and was treated with antidepressants, antipsychotics, benzodiazepines, and eventually ECT.

Of her five admissions to this particular inpatient hospital, she was usually admitted for suicidal attempts or extreme suicidal ideation. Mel was also treated with ECT over a 25-year span for recurrent episodes of depression. She reported that she self-harmed on several occasions. Her admissions to hospital centred around feeling as though she was not able to cope with everyday life, and perseveration, with respect to her memory loss. She reported at times she stopped taking her sodium valproate as she put on too much weight while on this medication and also admitted that she became quite drowsy while on this medication.

In most of Mel’s admission’s notes, psychological follow-up was highly recommended, although there was no documentation on file to suggest this was carried out in hospital or in the community, apart from a single cognitive

assessment, which indicated memory impairment. Mel reported poor memory for 20 or so years and reported that she felt depressed because she could not “remember any happy times in her life.” Mel reported “there is nothing that anyone can do to help me get my memory back,” and that she had no energy or motivation to do anything. She reported that she experienced problems in her daily living activities e.g., washing and dressing herself. A behavioural observation noted in her medical file was that she experienced these difficulties because she had forgotten how to do simple tasks. In her interview Mel describes her memory problems as a significant barrier to her “feeling better” and reported regularly having to “cope” with her memory difficulties.

During the interview for this study Mel described her memory problems as being the most difficult thing to manage. She reported that she found it hard to retain information. She also found it hard being away from her children when she was admitted to hospital for her suicidal ideation. Mel was from the country so she only had telephone contact and no visits from family members. Mel described the following:

Interviewer (I): What things do you find the most difficult to deal with in your life

Patient (P): What I find most difficult to deal with is my memory problem. That’s the most difficult one. The fact that I don’t retain information, that’s the main problem in my life and the fact that I’m not with my children that’s the second most difficult thing to deal with.

I: Are there any particular situations that you find difficult to manage?

P: I can’t think of any. I’ve been in hospital now for a long time so I’m not put into situations to have to handle situations. I don’t really have to

handle anything. Everything's done for you. So you're not really faced with anything.

I: What sorts of things do you do to manage those difficult situations?

P: To manage not being with my children. I've taken to ringing them up once a week. I ring them up weekly and I have written letters.

It was well documented that Mel found it difficult being away from her children and that this had a profound negative impact on her overall coping. It is not clear whether or not efforts were made to reunite Mel with her children, although she spent long periods in hospital away from her family.

During her last admission, which was approximately six months after her interview for this research study, she was commenced on anti-depressant medication, and had another course of ECT treatment, after a second opinion from another psychiatrist, despite her memory concerns. Her mood and affect had reportedly improved significantly, however she again expressed concern that her memory was very poor during the admission which was making her feel more "depressed." At this point Mel was assessed by a psychologist for memory difficulties and it was found that her "cognitive performance was weaker than her educational history implied." Given these findings her treating psychiatrist ordered a battery of scans to investigate a possible organic cause for her presentation. She was treated with further ECT, which was thought to improve her affect. Sadly, Mel succeeded in one of her suicide attempts and took an overdose of prescribed medications as discovered in the write up of her case study. Certainly Mel's poor memory, depression and missing her children impacted on her overall coping. Mel's case presents a dilemma many treating professionals are faced with within mental health systems and that is the concern

of the patient's safety. In the most serious concerns for "safety" confinement is sometimes the only possible solution, as determined by the Western Australia Mental Health Act of 1996, however it was also the confinement with which Mel found impacted on her "coping" as reported in her interview for this study.

Rose. Rose was an Aboriginal woman with three children, who was in a defacto relationship. Rose was from a family of four and reported a "happy childhood," although her sister was given a diagnosis of schizophrenia when she was 18 years of age. Rose lived in the Northern Territory region of Australia and she was first referred to a country psychiatric clinic. Her first admission indicated that Rose was delusional, paranoid and was unable to look after herself and her children and they were placed in the care of family services. Rose was reportedly paranoid that her neighbours were against her and her partner and claimed that her neighbours rape her when her defacto is not around. Rose had reportedly used marijuana, alcohol, heroin and amphetamines in the past. Rose reported that she had infrequent contact with her children.

Rose's mood reportedly improved while she was abstinent in hospital. Her illicit substance use was thought to have contributed to her admission. In Rose's second admission two years later, her presentation to hospital was similar, an admission for increasing paranoia and delusions although this time Rose reported that her husband was involved in her mistreatment. Precipitants to this admission were: polysubstance abuse, recent bone infection, daily marijuana use 2-4 cones per day and speed - intravenous 4 or more times per week. At the end of this admission, file notes suggested that she was "coping" and that her delusions were "unfounded." Rose also requested drug counselling for drug

misuse. Her discharge summary indicated that the diagnosis of schizophrenia appeared less likely and was more likely to be drug induced psychosis.

Rose's third admission two years later indicated that she had relapsed into drug misuse, this time with both amphetamines and cannabis. On this admission she requested change of treating professional. It was thought that she developed a "delusional system" regarding the medical profession. Her discharge diagnosis as documented was: cannabis abuse, psychotic relapse, paranoid schizophrenia (schizoaffective). Rose was commenced on a compulsory antipsychotic medication regime. The basis for the diagnosis change from drug-induced psychoses, as indicated in her previous two admissions, to psychotic relapse, paranoid schizophrenia (schizoaffective) is not clear. In both of Rose's previous admissions it was reported that her alcohol and drug use had caused her paranoia and delusions, which resolved after abstaining from alcohol and drugs while in hospital. It was clear in her interview and she reported that she was annoyed and extremely upset that her children had been taken away from her and this was the most difficult thing to deal with as seen in the below excerpt:

I: What things do you find the most difficult to deal with in your life?

P: Getting my children back. Because it's going to take time.

To "cope" with the loss of her children, Rose used many creative coping strategies, one which was described previously in Chapter 5, involved a metaphor of a caterpillar breaking out from an egg to a butterfly, to deal with this anguish. She elaborated as follows:

I: When did these various approaches get used?

P: They used to get used because I fell out of society and I just stopped.

I: Which strategy do you use now that works the best?

P: The butterfly strategy

I: Do the others work.

P: That's the only one that I can see clearly that means something to me.

I: Is there anything else that you do or think about that helps?

P: Just that

That one line where Rose indicates that's the only effective strategy that means something to her is in effect a coping strategy which is both helpful and provides meaning to Rose. What Rose clearly demonstrates here is the ability to see beyond her situation and describe where she is at from a psychological perspective using a metaphor. She uses this strategy in order to describe her meaning and this is a particularly useful cultural story telling, a metaphorical strategy Aboriginal women have used for many years, especially in their "dreamtime." Dreamtime is also used to refer to an Aboriginal person's set of beliefs or spirituality. Therefore, this technique could be understood in the Western framework as a religious coping mechanism.

When investigating coping within Aboriginal cultures, it is also important to note that the role of the woman in child rearing is seen as vital. In Aboriginal culture the woman's role is the major influence in the socialization of the young, more so than the man's. Therefore, if children are left with the men, they suffer further neglect and miss the teachings the women provide for them. A limited number of studies have highlighted the additional problem that incarceration causes for Aboriginal women and their children.

In Baldry's (2009) focus group that explored the experiences and needs of 17 Aboriginal women post-prison, the number one finding was: "The overwhelming theme in the women's interviews was the importance of their

children in their lives” (Baldry, 2009, p.14). These women expressed their concern for needing their children in their lives, which is central to their cultural values as primary caregivers. They reported having had little to no contact with their children while in prison, and that it was not uncommon for their children to be made wards of the state once they were imprisoned, without any consultation with them as mothers. Alcohol and drug use were significant barriers to gaining and maintaining the custody of their children.

This case study supports Baldry’s claims and also shows the issues around Rose’s “poor coping.” Indeed, Aboriginal women and children within Aboriginal communities throughout Australia are subjected to some horrific forms of abuse which are well recognized and could have been at the root of Rose’s problems. (Bhandari, 2006; Holland, Dudgeon & Milroy, 2013). Holland et al. (2013) draw support for their position from a conclusion drawn by a prominent Aboriginal professor of psychiatry Helen Milroy:

The impact of trauma on Aboriginal and Torres Strait Islander children and their families is a major undetected, underestimated and misunderstood determinant of mental health conditions in the Aboriginal and Torres Strait Islander adult population (p. 15).

What is very clear from Rose’s admissions is that her delusions and paranoia eventually resulted in the diagnosis of schizophrenia after her third admission. Before this time her diagnoses were linked to her repeated drug and alcohol misuse. As reported in her interview, she found it difficult to be without her children, was aware of her drug and alcohol misuse, and had informed people of the mistreatment she had experienced in the form of rape in her hometown.

Yet these issues were not explored further with her in the admissions to hospital and she was commenced on compulsory medication regimes.

Jim. Jim was a 30-year-old man born in Australia who reported an unpleasant family history including sexual abuse by a family member. All of Jim's hospital admissions identify the history of sexual abuse as the main presenting problem of the patient. Jim reported throughout his interview that he experienced flashbacks of the past sexual abuse and feelings of guilt on a daily basis. His first admission to the hospital was documented as a "self presentation." He was diagnosed with bipolar affective disorder and was managed on the acute care unit and commenced on flupenthixol depot. On his second admission, Jim was admitted as a voluntary patient and was managed on anti-depressants, and a course of ECT. He was reported to initially respond and then his mood would deteriorate and further ECT treatments were given. At the end of the course of the ECT treatment, he was discharged into the community where he was referred to a psychiatrist for psychotherapy.

Jim's third admission was seven years later. On this occasion he was described as "paranoid" and "not making sense" when the police had arrested him. He had been using marijuana heavily on the day and was caught lighting a fire. He was admitted as a voluntary patient, although was managed on a locked ward, due to his "delusions and lack of insight." His management was on-going at the time this case history was written. Jim's belief that he was a healer, was "a problem," in his interviews. He reported in his interview that he had sessions with the psychologists in the hospital for past issues of sexual abuse. Regarding Jim's interview, the relevant excerpts are as follows:

I: What things do you find the most difficult to deal with in your life.

P: My own sexual abuse. Relationships and what's going on in the environment.

I: What sorts of things do you do to manage difficult situations?

P: I normally go out the bush and meditate and put my feet in the running brook or something but for six weeks I haven't been able to do that because I was required in Perth for various appointments with politicians and stuff so I wasn't able to fall back on what I normally do to alleviate the pressure of difficult situations.

I: Is there anything else that you do to manage difficult situations?

P: Meditate. Just go back to nature to your roots. I'm very much a Christian but I'm also very much a pagan an earth person.

I: Any other things you do that help?

P: Make up beautiful, relaxing herbal brews. I'm a bit of a cook. I practice Kadachism which is the black fella method of helping ones people. Things like that I find helps me improve the situation.

I: In relation to the issues that you identified what do you do to cope with your past history of sexual abuse.

P: When I'm with a group of friends I can be reasonably open and frank about it which makes it an awful lot easier. They're my new friends though. Not my old friends. I've been to many counseling sessions and I find that anyone who charges \$110 just to walk in the door, although I know they have to make a living I don't think you build up a relationship for that rate when you're not very well to achieve an end. It takes five or six weeks to get to know each other.

While Jim has engaged in psychological intervention, he brings up the economics of it all. To find \$110 when he is on unemployment benefits is extremely difficult. Moreover, he is correct in that a therapeutic relationship does take some time to build up. In his interview he also detailed finding it difficult to manage “worrying.” He reported that he was also worried about being on medication, and that he suffered many side effects from the medication. Jim’s interview reflected that he believed the trauma of being sexually abused and relationship issues were the most difficult things he has had to deal with in his life. He described using helpful coping strategies, such as meditation and his Christian faith, to deal with the trauma he had experienced in his past. In his interview Jim described that he had had difficulties with relationships and, in particular, impulse control with sex and that he had had sexual intercourse with many women. He described the problem, as he saw it, and had used abstinence.

James. James was a 57-year-old man who reported family difficulties and that his family had caused him great sadness for many years. His affairs were managed by the public trust. During this current admission when he was interviewed, he was being treated with an increased dose of his antipsychotic medication. James had over 53 admissions to the one-inpatient psychiatric hospital. The first was in 1988 when the diagnosis given was “schizophrenic episode.” His admissions ranged from involuntary to voluntary, with a series of unconventional admissions, which ranged from “special admissions” to “social admissions.” It is unclear whether he was reviewed during these unconventional admissions, as such admissions seemed to occur when James self presented to hospital due to situational crises or self neglect. He was typically commenced on his usual medication regimes of antipsychotic medication.

For James, the following reasons for admission to hospital included: not coping, increasing paranoia, lack of insight, delusional beliefs and thought disorder. These terms were never expanded upon or behaviourally described, just the words are used. Therefore, it is unclear why James was paranoid or thought-disordered or how he lacked insight which led to his admission to hospital. James reported that he used marijuana to cope. In his interview James reported that he visited a psychiatrist in his late teens to “get help,” because as he described, he thought psychiatrists “helped people.” At the time, he described himself as having an alcohol problem and that he “felt depressed”. When asked if there were any particular situations that he finds difficult to manage, James said:

P: Not really. I don't like being on psychiatric medication. I've been on it for 23 years and I get fed up with it you know. I mean why can't I have tablets. They stick a needle in my bum every two weeks because the doctors don't trust me to take the medication. All these chemicals going up to my brain might shorten my life expectancy. I'm concerned about it and the doctors don't tell me anything about the medication. They don't care. They just see me and throw me out of the office (laughs) Not quite but some of the doctors don't like me. They're too strict.

I: Can you tell me how you manage the psychiatric medication, having it every two weeks, how do you deal with that?

P: Not very good. I'm in here because I was avoiding the nurses coming to inject me. Like I said with these injections I could get tardive dyskinesia. The doctors don't give a shit about me, they couldn't care less. What do they care they get their fucking fifteen hundred dollars a week, what do they care about me, nothing. They don't care about me, it's just a

job. They get their money and the nurses get their five or six hundred dollars, no one cares. I can't do anything about it Jacqui, they make me have the needle. They make it compulsory that I have the needle. I don't think it's fair because when I was (patients age) I took myself off to a psychiatrist, I wasn't brought in by police, I didn't commit a crime, I went to a bloody doctor because I was depressed. I was drinking too much because I was depressed and I thought a psychiatrist was someone you could talk to. Next thing I know I had shock treatment and I was stabbed in the arse with a modocate injection. It was bloody horrible, I felt worse. It stuffed me up. I'd like to know what my life would be if I'd never ever gone to a psychiatrist. I could have stopped drinking and figured the whole thing out for myself. I wasn't having auditory hallucinations, I wasn't hearing voices, I wasn't crazy. No one's crazy in my family. No one's got a history of being in an institution or psychiatric disability or illness. I think some of the patients come here because someone died in the family and they're stuck on medications for the rest of their lives. Doctors don't care, they're just drumming up business to keep people in the hospital so they can get their way. I don't think the doctors really care much.

I: So that must be quite difficult to deal with

P: When I first saw a psychiatrist he molested me when I was (age of patient). He was homosexual. I don't care I got over that but I was quite scared at the time. I was only a kid. When I first went to (the name of Hospital) I was (age of patient) and I saw a doctor and he said "I can't see anything wrong with you but I'll get you to see another doctor". . . . I'm

not homosexual. He knew I was frightened. What I can remember is that for a long time I was frightened, I wasn't very happy and I thought I could talk to him and he'd give me some sort of therapy or something. Actually he started touching me on the hands and I said "what are you doing that for" and next thing he's kissing me and his hand goes down my jeans and next thing he's sitting on the floor. . . So the whole thing disgusted me, well it didn't disgust me but I was frightened you know that it would happen again.

I: Have you ever told any one about this?

P: I've told a few doctors about this but they can't do anything about it I suppose. I don't care. That's history, I don't worry. He didn't hurt me physically, there was no violence or anything like that. I can't prove it. Even if I could, I wouldn't punish him. He was nice to me after that, he took me to the beach and he didn't touch me again afterwards. He invited me to his house for dinner and we used to go fishing at . . .

After this interview I discussed with the patient the nature of the information and if he wanted to pursue it further. He declined and informed me "there was no point" and that he had reported the incident to the police and relevant authorities many times and many years ago. He reported that given it had happened some time ago he did not see the point in rehashing it, and there was a sense of protection for the abuser. He reported that he wanted his interview information to be released as it may help other people in similar situations. The patients' subsequent drinking, seeking "help" and receiving ECT and being abused was this patients experience of mental health services. Despite these emotional traumas and retraumatising James reported that he manages by staying clear of

places that prompt his drinking or drug use, e.g., hotels, certain friends. He also reported that he uses “blocking” to block anxious thoughts, a well-known Cognitive Behavioural Therapy (CBT) technique. He concludes that he “cherishes most days” stating that he is “lucky to have got this far.”

James’ admissions are many and his medication regime has varied from self-administration to depot medication (where he would either be visited by community nurses or attended outpatient appointments for depot medication). Admissions were plenty and indicated an increased level of dependency on the psychiatric system. From the history of his 53 admissions there was no documentation or mention of psychological intervention. What is evident in this case study, apart from the detrimental effects of being abused by the profession he initially went to for “help,” is that after 53 admissions the likelihood of James having a collaborative approach to his treatment is virtually nil, as confirmed by the depot medications he is “required” to have when discharged out into the community or else he faces an involuntary admission. James has lost all negotiating and involvement within his treatment which would and has had a profound affect on his coping.

The first thing that he said in the opening line of his interview was that he found “worrying about death” difficult to deal with at that exact point in time. He reported the many frustrations of his power being taken away from him and was able to articulate and converse well, as evidenced by this long transcript. What would have been the outcomes for James had he had some involvement in his treatment? These cycles of coercion around medication compliance can exacerbate patient’s symptoms particularly the “symptoms” of paranoia and mistrust, such that a hospitalisation may become a traumatic experience for these

people. Interestingly, when these “symptoms” are treated this way, with first line of treatment being medication, problems are not addressed and are usually more likely to occur.

While reporting these things as being difficult to manage, James also reported that after a number of admissions he had witnessed a lot at this psychiatric hospital. When asked how he was managing and if he was complying with medication regimes, James reported:

. . . I’ve been coming to this hospital off and on for 23 years and do you know I’ve counted 17 of my friends from this hospital who’ve hung themselves, gassed themselves with hoses from exhausts. They’ve either jumped off flats or jumped in front of trains, I can’t take it. This hospital is supposed to help people and there’s some people I recognize from 20 years ago who are three times worse than when they first came here.

There is a sense in James’ reports that he is angry about the lack of progress of his friends mental health, and, given his own negative experiences with mental health services, this at times is too much for him. As he states “I can’t take it.”

Tanya. Tanya was a 28-year-old woman, who lived with her boyfriend and his parents and also had admissions to psychiatric facilities in the eastern states of Australia. Her admissions stated that she had a long history of bipolar disorder. She was initially admitted to the hospital on a Form 3 - an Involuntary Transportation Order under the Western Australian Mental Health Act 1996 and soon after re-admitted as an involuntary patient. Tanya reported that her friends complained about her and made reports to authorities about her behaviour. She reported that she finds “medication compliance” difficult and also uses cannabis and alcohol.

Tanya was immediately commenced on an anti-psychotic medication on her first admission to hospital and reported no psychological intervention.

Tanya's second admission occurred two months later. In this admission Tanya was admitted for using marijuana heavily and was bingeing on alcohol over the weekends and was commenced on another anti-psychotic medication. When asked about the sorts of things she found difficult to manage, Tanya reported:

I: Are there any particular situations you find difficult to manage?

P: I'm really weak towards men, in terms of they can play me so easily. I can get trapped because I need to be loved by my father. Female friendships I find extremely difficult because I've been hurt so many times, I don't trust them.

Tanya's friends and family were involved in Tanya's admission to the psychiatric facility and she was "upset" with this. In her interview Tanya described her lack of trust towards men and her friends. Given this, she described very sensible, creative coping mechanisms, consisting of creative writing, religion, yoga to cope with her situation and she had even designed what psychologists would call a desensitisation program, which helped her to get out into the community:

I: What sort of things do you do to manage these difficult situations?

P: Well I suppose I create my own reality where I don't have to go to work, I can study and concentrate on things that I find important to human civilisation. One of my biggest things is that I'm not here for me I'm here to evolve as a human being for the whole of us. When I say 'we' I'm talking about the human race. I study eastern philosophy and theology and religions and yoga. I study music privately . . . I write about

what I see in the world that upsets me. I write about the good I see in the world. I write about my own feelings. I write poetry. That's a major outlet, it keeps me alive.

I: When do these various approaches get used?

P: Well poetry for instance is a coping mechanism that I invented to re-enter society. I was so panic stricken that going out with my notebook I could go to a café, I could order a coffee, I could open my book and I can write. And that way I feel like I'm doing something. I suppose for an unemployed person, a long-time unemployed person, you think that everybody knows you're unemployed, and you think I'm not allowed to be sitting here drinking this coffee. I mean you don't think you're allowed to be doing anything when you're unemployed. So that's given me a job that I feel if I'm doing something, if somebody looks at me. I'm also not that aware of those looking at me. So that's a huge coping mechanism for me and it's creative.

I: If I were to ask you what strategy you use that works the best, what would you say?

P: Now that we're sitting here talking I realise how strong the poetry is, because it also enables me to think wow I've written 5 pages, I feel good. I've done something. So on top of everything else it's an accomplishment. So I'd probably say that stands quite high up on the list. In my bedroom it would be different. It depends what I'm coping with. Suicidal thoughts or something like that is very difficult to come out of. Then I have to have layer upon layer, I have to have a bath, have the essential oils, I have to do some meditation, I have to pray. Or even to deal with thoughts when I

plug into mass consciousness and think, wow I have no money, wow I have nowhere to live, wow I supposedly need these things. And that does overwhelm me from time to time. I see people driving round in nice cars and nice clothes, I still see those things in life but I don't need them. I draw on all my resources when I need them.

I: Is there anything else you can tell me about that you do or think about that helps?

P: Yoga . . . would have to be a Godsend. I would never have stopped yoga in general because I would never have stopped trying to kill myself without yoga, as an exercise as a philosophy but the yoga niga is a 30-minute relaxation compared to a 10-minute type. So that's a very deep sleep whilst you're wide-awake. That would have to be the most important thing. I don't do it enough.

While a lengthy excerpt, it details the very sensible, logical, and practical ways Tanya “coped” with difficulties from prayer to yoga. Towards the end of her admission file, Tanya was offered psychological counselling and did accept. There was no mention as to whether she was referred to an outpatient community clinic for follow-up.

Ben. Ben was a 30-year-old man and reported many family difficulties and that he was sexually abused as a child. He reported that he uses a combination of prescribed medications and illicit substances to “cope.” Ben's admissions to hospital indicated that since the age of 18 he acquired disproportionately large number of diagnostic labels in psychiatry, such as: bipolar disorder, schizophrenia, schizoaffective disorder, depression, personality disorder NOS (not otherwise specified), generalised anxiety disorder and

paranoid schizophrenia. Along with numerous admissions, he had had unsuccessful placements in the community.

He described feeling depressed and reported mood swings. He reported that he feels that “everyone is blaming me for being in hospital” and feels anger towards people and therefore to “cope” tends to avoid people. He reported that he has lost much confidence to socialise and as a result he has low self-esteem, feels unable to sustain or form friendships and has no close friends or family. Ben had 26 admissions to the inpatient hospital and he was on a disability pension and an administrator managed his financial affairs. His itinerant lifestyle and unstable accommodation, were reported to have made it difficult to ensure adequate community mental health follow-up. On occasion that, Ben reported he would “get admitted” to acquire enough money to “get ahead” in some of his debts. As Hallam and Bender (2011) point out being disabled by a diagnosis of mental illness and thus having to claim benefits on this criteria must be both demoralizing and demotivating for people. The reality is that many of these patients’ pensions barely cover rent and food, and patients often find themselves itinerant and looking for accommodation. In some psychiatric hospitals in Western Australia, patients are known to admit themselves for a week to buy time in which they can save up money, highlighting a very real economic problem that these patients have.

Ben’s medical history revealed that he was on a number of medications, ranging from anti-depressant medication to anti-psychotic medication and doses of benzodiazepine, used pro re nata (PRN as needed or as the situation arises), to “little or nothing.” His diagnoses varied from emotionally unstable personality disorder to borderline type. His multiple diagnoses led to second psychiatric

opinions and one of which recommended psychological counselling for all issues, for substance abuse, recent bereavement (mother dying), self-esteem and confidence, and for social skills to facilitate a positive personality style. It is unclear if he was referred to a psychologist, as medical file notes showed no psychological input or that he received such treatment. When asked about the types of situations he finds difficult to deal with, Ben described finding social situations particularly difficult. He reported in his interview:

Some days I just want to bury my head in the sand, I just want to disappear especially if the focus is on me. I manage this by trying to be in a good mood which actually helps.

Ben described that avoiding some social situations was actually helpful for alleviating anxiety symptoms. His interview suggested that he had learnt to use humour to avoid feeling uncomfortable in social situations. Both avoidance and humour were very useful coping mechanisms to help him cope with situations with which he was faced.

Anna. Anna was a 30-year-old woman diagnosed with borderline personality disorder (BPD), borderline intelligence and polysubstance misuse. Anna reported a difficult family history, and that she was sexually abused by both of her biological parents.

Anna reported that she left home when she was 18 years of age, married and had two children. Her husband was in jail at the time of this interview and Anna reported that he also had a diagnosis of schizophrenia. She reported an emotionally and physically abusive relationship with her husband. Anna reported that her biological mother fostered Annas children, and this was due to the claims that she was using drugs use and unable to care for her children. Anna

reported that she had commenced legal proceedings to prosecute her parents and that the legal proceedings had been extremely stressful for her and she was finding them difficult to cope with. Anna reported that she found it difficult to abstain from drug use in difficult times as she usually uses drugs to help her cope. Her substance misuse consisted of marijuana, amphetamines, benzodiazepines, IV heroin, alcohol binges, and heavy tobacco use. Most admissions involved a medication regime of slowly reducing benzodiazepines. She was also on a methadone program for heroin withdrawal.

Clark (2006) discusses the role of moral judgment in borderline personality disorder diagnosis and claims it is a complex diagnosis for the most part because it “involves the *essence* of being a particular person in society” (p. 184). This diagnosis has received a lot of attention in the research literature particularly because it is open to other forms of bias and moral judgment mainly due to the types of behaviour requiring classification. A closer look at the DSM-V classification of BPD states:

A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity, beginning by early adulthood and present in a variety of contexts, as indicated by . . . (p. 663).

The five categories involve issues of abandonment, a pattern of unstable and intense interpersonal relationships, identity disturbance, self-damaging impulsivity in two areas, recurrent suicidal behaviour, feelings of emptiness, inappropriate or intense anger, and dissociation and or stress-related paranoia (American Psychiatric Association, 2013). Clark (2006) argues that part of any clinical training is learning to keep personal and moral judgments from clouding

clinical judgment. However, this does not always occur and as such patients who fall into this diagnostic category may be subjected to moral judgment.

Anna had 11 admissions to the one psychiatric hospital over a 2-year period and most of these admissions to hospital were the result of a crisis. She had been on various medication regimes from antipsychotic medications, antidepressants and benzodiazepine medication. She had a series of sessions of cognitive behaviour therapy (CBT) while in hospital to help her to try and make the associated links between irrational beliefs and her behaviour, which she reportedly had difficulty doing. It is unclear as to whether she engaged in further psychological treatment or why a CBT approach was chosen, given her accompanying diagnosis of borderline intelligence. What was clear was that Anna did not maintain follow-up with community services on discharge on that occasion. Anna reported in her interview that she can make alterations to her lifestyle and at times has done so, however acknowledges that her drug and alcohol dependence do at times have a negative impact on her well-being. She reported that she found it extremely hard not having her children and that she missed her children. Her complex family history and intermittent contact with her mother (as at times she would contact her mother just to talk to her children) caused her to relive parts of her traumatic childhood.

Anna's treatment consisted mainly of medical interventions. In most of her admissions she was prescribed high doses of anti-psychotics.

I saw Anna in her 11th admission and she reported that she was not coping without her children and partner's support. In her interview Anna responded as follows:

I: What things you find the most difficult to deal with in your life?

P: Just getting back into a regular routine. Routine, like a structured life. It's been so unstructured for like 4 years and I find to restructure, very hard. Just the general stuff, like housing issues, work issues, because I've only ever raised a family and been a wife, and now I don't have any responsibilities and no structure I find it hard to get back into the normal life structure again.

These comments demonstrated that Anna was aware that her children added meaning to her life and structure. Naturally, she was feeling somewhat lost without this in her life:

I: What sorts of things do you do to manage these difficult situations?

P: I have very little coping mechanisms, I don't cope well. I don't have any stress triggers, like I don't have any signs that I'm under stress and when I do erupt it's usually a self-mutilation of some sort or it's suicidal attempts but there's no sort of sign in between. It's either I feel really fine or I feel suicidal and there's nothing in between.

I: Can you tell me when you do that and what is that in response to?

P: A build up of it all. I don't usually notice that it's there because it's usually blocked out.

I: With the loss of your children how do manage that, what do you do to manage that?

P: Oh I beat myself up about it every day. I put myself through hell and back every day but now I've learned I can't change it so the only thing I can do so that I can deal with it is to just accept it. Otherwise I'm just going to continue fighting with myself and I'm going to be playing World War 3 with myself and beating myself up with self-mutilation keep

continuing unless I just accept the situation for what it is, even though I'm not happy with it. Just like let it go for my own peace of mind so I can just settle, otherwise I'm going to keep on going like this forever. It's easier to walk away rather than keep fighting.

Anna reported that she is aware that when it “gets all too much” she engages in self mutilation as she had “little coping mechanisms” when it came to managing her thoughts of not being with her children. With the additional dynamics of the custody arrangements with her children in the care of her own mother and father who sexually abused her, this would be distressing for any mother. She reported that she does manage or cope in the conventional sense and demonstrated that she does not notice any warning signs and this is when she engages in self-mutilation or suicide attempts. Anna reported using unconventional but very common coping strategies, with psychiatric patients who have “given up”: accepting things as they were, walking away and stop the fighting. These techniques helped her and she clearly stated that this was a “temporary measure to cope,” to give her some space so that she can “cope with life.” Outwardly, these were seemingly useful coping strategies for Anna.

From a clinical perspective it is unclear why a CBT approach was taken, given Anna's' diagnoses of borderline intelligence, BPD and polysubstance use. Given these factors, it is not surprising that Anna had difficulty with the CBT approach. This case illustrates how evidence-based practices sometimes do not transfer over into clinical practice. Moreover, what this case study reveals is a set of assumptions and procedures imposed upon a vulnerable individual which did not help them at all with their “coping.” Typical mainstream CBT protocols (e.g., Fenn & Byrne, 2013) will not work for some specific populations, such as the

verbally impaired, because language and intelligence are intertwined like bricks are to houses. A longer term therapeutic approach focusing on the historical and contextual factors and being reunited with her children would have been more likely to help Anna “cope,” as evidenced by her interview.

Phil. Phil was a man in his mid 30’s with a long history of reported chronic paranoid schizophrenia and cannabis abuse. Phil had over 15 admissions and serious and multiple suicide attempts over 10 years. One suicide attempt had left him with long term physical injuries, which also led to a long admission in the long-stay section in the psychiatric hospital. There was no indication of any psychological intervention while in hospital and only various medication regimes were listed as the sole treatments (predominantly antipsychotics and benzodiazepines). He reported that he used marijuana misuse and alcohol, but not on a regular basis and reported the odd binge drinking on a weekend. His financial affairs were managed by the public trust.

Phil reported a difficult relationship with his mother, and escalations would often occur during his hospital leave, which would cause a “worsening of his mental state.” His marijuana use resulted in a number of failed housing placements. Phil reported that he found it difficult to abstain from using marijuana as many of his friends also used the drug. In the current admission when he was interviewed for this study, he had an injury to his foot which had limited his ability to engage in activities, and he was finding this difficult. In his interview he reported:

I: What things do you find the most difficult to deal with in your life?

P: Not being able to work

I: What sorts of things do you do to manage not being able to work?

P: Not much. Consciously now I'm trying to make sure I do the right thing as much as I can which is making sure my rubbish goes in the bin, keeping my room tidy and working towards going back to work. When the plaster comes off my foot I hope I can get some gardening up at

I: So you're keeping a routine. Does that help?

P: Yes

I: Any other strategies you use?

P: I don't know. I just try and relax and get myself through the time, until my foot's better and I can go back to work. Nothing much else I can do.

I: What other things do you find difficult to deal with in your life?

P: My psychosis and schizophrenia.

I: What do you do to manage those situations?

P: Well I've just recently spoken to a lady who's going to give me some drug counselling. I try as best as I can stay away from drugs. I've only had one cone in 5 weeks. That was 2 weeks ago and it's been hard to cope with because I haven't lined up a counsellor but that's happening from today, my doctor's ringing her up. Hopefully once a week I can see her and work out exactly what the drugs been doing to me and whether it is as bad as what people say and whether it's the effects will feel after being off it for 4 months. Whether I'll come back to normal or not. I used to have a really good lifestyle like you Jacqui. Working, socialising.

Here Phil compares his life to others. He reflects on what it means to live a "normal" life and participate in community living. The interview reflects his despair at being back in hospital, as this was his first admission after four years

of living in the community. He had been offered drug counselling and he was eager to attend. His interview continued as follows:

I: You think the counselling will be good?

P: Well if she can tune me in about the effects of the drugs and how to stay away from them.

I: What sorts of things are you doing now?

I: I don't like the hostel I'm in. They make you feel very low and they wake you up at 7.00 am in the morning. Just depresses you, it's really hard. I believe I'll come through it eventually one way or another. I don't have my family there much besides mum. I really hope and dream that one day in the next 3 months I can go back to work, even if I'm getting \$2 an hour. I wouldn't work for under \$5 but if I can earn \$5 or more an hour, I'll work a bit harder. If I'm working, all this paranoia will go out of my brain and I'll start mixing back into normal living. If you sit around too much my brain begins to ferment and stew over things and worry and all this. If I meet a close friend and we talk about old surf stories and how we go surfing, it gives me hope. I believe mental illness is just a cause and effect thing. From my actions, or their actions, what you've done in the past, what your coping skills are like.

Phil demonstrated that occupying his time would prevent a build up of negative thoughts and help him to recover and enter into a more "normal" lifestyle, e.g., working. He acknowledges "sitting around" is not helping him. During this admission he was provided with psychological intervention in the form of individual counselling while in hospital on a long stay admission. Phil reported that he enjoyed this and it helped to talk through all the reasons for his anger. Six

months after the interview, while writing up this case study, Phil had been discharged and was living in the community. This case study is a good example of when a person is seen as a whole person, i.e., the polysubstance issues were treated, he was listened to and received longer term intervention. Phil was able to live in the community, as opposed to the multiple admissions (15) earlier in his life. The fact that he was living independently in the community is evidence that he had mostly dealt with “issues of paranoia.”

Mark. Mark was a 23-year-old, married man with one child who lived with his parents. He reported an unhappy childhood. Mark reported that his parents were abused as children and that their parents were both heavy drinkers. Mark married a lady after a brief courtship and reported being unhappy in this relationship, although stayed when his wife became pregnant. Marks first admission to hospital was the result of an impulsive overdose in the context of interfamilial conflict. He took a mix of his own medication and a family members antidepressant medication.

Mark reported a “miserable” childhood where he was bullied and had attempted suicide on many occasions. He reported that was admitted to hospital as his mother requested that he be “committed.” He was diagnosed with multiple personality disorder, and many of the types of “personalities” which formed the basis of this diagnosis, Mark described in his interview for this study. Mark reported experiencing the characters as internal voices that speak to him directly in the second person. He struggled to control these voices and believed they were inserted into his head and were not under his control. He also described that when suppressing a character “my eyes and nose bleed and sometimes I fall to the ground.”

In both of his admissions he was diagnosed as having a personality disorder with bizarre ideation and gender identification issues. Prodromal schizophrenia was considered, however, there was no clear evidence of any psychotic phenomena during the course of the admission and neurological investigations indicated no abnormalities, so therefore this diagnosis was not advanced. Being “in character” was not diagnosable and did not meet the DSM-IV criteria.

In the interview with Mark, themes of wanting to be accepted emerged. He reported, “using characters” to cope:

I: I’d just like to ask you about some of the things you find difficult to deal with in your life

P: Probably the main thing is wanting to be accepted by other people. Not just family but everyone that I meet or associate with.

I: Are there any particular situations that you find difficult to manage?

P: Well pretty much all situations I’ve used characters for the past 15 years, personality type characters to compensate for loss of confidence when I’m talking with certain people. Family not so much because they know what you’re like but you still feel you’re obligated, not impress them, but be in good order.

I: Are there any other things you find difficult to deal with in your life?

P: Probably limited experience. Mainly because of religion background. I do feel that I’ve been boxed in from a lot of world experiences. For example when I was married, I’m separated now, but on my wedding night I had no idea what to do. That’s probably a big example of how naïve my thinking is. I wasn’t allowed to go to sex ed, I just wasn’t

allowed to, I had to go to the library and things like that. It was a bit embarrassing at first but I find that with everything that I do, education being limited because I left school at 17 in Year 9 I use my characters to compensate for . . .

I: So it's possibly due to your religious upbringing that you feel quite alienated from the world around you? Tell me more about that.

P: Well it's not that my parents rammed religion down my throat on my own, it's just that I knew nothing else. Probably if I'd come into it later I would have known bits and pieces but even my parents were pretty naïve at that kind of stuff. I feel, well I can do a lot of things because I'm able to get around it with some small degree of difficulty. I can compensate by pretending or using different characters.

Mark described finding most things in life difficult due to his strict religious parents and his religious upbringing. He described that he was never allowed to go to sex education classes at school, and had to go to the library. Therefore when he married he had little knowledge of what was expected from him. In the interview he described his characters and his religious upbringing, which make him feel alienated from society. Mark provided a sensible interpretation of his upbringing and clearly demonstrated coping mechanisms to manage these difficult situations:

I: What sorts of things do you do to manage these sorts of situations?

P: Characters. For instance I like talking to people, it doesn't bother me and I mean people call me a born salesman because when I was doing advertising before I got into the hotel industry I could just walk into a room and work it, it's easy. . . I was using characters for instance

Chandler from Friends. He's got good humour, I can do that. "*Could I have been any more late for work*" I can find a lot of confidence from that. Even at night time now when I go home, every night I've got a four-hour tape of Friends that just plays even when I'm sleeping through the night. I can't sleep, I just have a laugh, and it doesn't matter how many times I've seen the tape I just enjoy it. It's not just that I've got other characters. I don't find myself terribly attractive and so I compensate by clothes and trying to imitate looks, like brooding looks, like Angel from Buffy the Vampire Slayer. I relate to his character, a tortured soul so to speak, you know. Very much.

I: Can I ask you, are you a character at the moment or are you Mark?

P: Well this is the thing. Because I've done characters for so many years since I was about 8, it's only just recently in the last 6 to 8 months that I'm getting pieces of my own personality back. I forgot. Because I used to be able with certain people, peer groups or whatever, I could at the same time be different characters because that's how that person wanted me to be. So I can't keep it up, I couldn't falter . . .

I: Do you find that that this helps you?

P: It distracts me.

I: Is this how you manage your situations?

P: Most of the time but it's becoming harder and harder.

I: Which one works best

P: I think it's a combination of all of them because it's a part of what I've done for so many years, it's my comfort zone, you know. When I used to get a beating at school I wouldn't tell my mother. I'd make a story up or

something, I fell over that's why I've got a black eye or bruised ribs or whatever. I'd distract myself with thinking that at 4 o'clock one of my favourite shows would be on TV and that would be it. Everything would just go away and that's how it is even today. I don't just watch anything, I watch something that relates to me which I find essentially how I'd like to be or I can relate to . . .

I: Is there anything else that you think about that helps?

P: I'm never comfortable with myself and that's why now I try to drop everything and not use my characters so much. Every now and then I try to sneak back in. I think is this working and I have self doubt about my own abilities, that's why I plan when I leave hospital to pursue my education. Get back on track. Get my Year 10 curriculum. Go to college. I feel that by doing that I'll be able to re-live my lost education opportunities.

What this large extract demonstrated was Mark's knowledge of the use of various behaviours which made him feel comfortable in situations he may not have otherwise felt comfortable in. He claimed he knew nothing better when growing up and that his experiences were extremely limited. He also demonstrated creative construction of various guards or defences to manage difficulties in his life, such as humour and pretending to be someone else. He described his limitations and the areas he wanted to improve in. Mark used creative coping mechanisms, which provided meaning and strengthened his sense of self.

Tara. Tara was an Aboriginal lady in her late 30's who reported that she had been raped several times. She was diagnosed with chronic paranoid

schizophrenia and had 9 admissions to inpatient psychiatric facilities. Her treatment consisted solely of medication. There was no evidence of her involvement in any psychological intervention, occupational therapy or that she was linked in with any community supports.

She had experienced several side effects (agitation and stiffness) and as a result her depot intervals for her compulsory medication regime reduced from fortnightly to three-weekly to help with the side effects of the medications. Her admissions were precipitated by not sleeping for consecutive days. She developed side effects (akathisia) on Olanzapine (an anti-psychotic agent) and this was stopped on her request. When asked about difficulties she had to manage, Tara reported that while she found medication unhelpful, she recently changed her mind, as her doctors had informed her that they had found “the right” medication. Tara had been in hospital for 3 weeks before this interview:

I: What things do you find the most difficult to deal with in your life?

P: Up until this admission I found medication the most difficult to deal with . . . I’ve been on medication for 11 years and they’ve finally found the right one. I’ve only been on this one for a couple of weeks or just on a month I’ve been on it. It takes about six weeks to be really good so my psychiatrist tells me . . . I’m still a very strong believer in Mother Nature and the power of positive thinking.

Here Tara described a history of “medication taking,” which is quite typical of individuals who have had numerous admissions to psychiatric hospitals.

However, what is evident are the years of trial and error, of trying to find the miracle cure for patients which Taras’ case demonstrates well.

I: What sorts of things do you do to manage difficult situations?

P: One of the things I'll have to deal with is going regularly to the clinic, that will be different. I can't deny that, it will be a thing that I will have to come to terms with. For 11 years I haven't been going to a clinic.

Here is an example of Tara's foresight, as she is aware that regular attendance for medication compliance at her clinic is going to be a commitment and something she is possibly going to find difficult to manage. In the next excerpt Tara identified that her medication side effects have posed problems in the past and the unwarranted side effects of the medication impacted her university studies:

I: Are there certain situations in general you find difficult?

P: My studies. I'm going to be studying full time and I see that as a potential difficulty because it's new to me. I think I'll find that extremely difficult at first. I found studying before too difficult because I had too many side effects from the medications.

I: What sorts of things did you do to manage that difficult situation?

P: Gee, well I used to stop taking the medication basically.

I: Did that help?

P: Yeah, because it's the best sort of life off the medication but it's very, very difficult, it's extremely difficult and very hard to ... you've got to have a lot of perseverance, a lot of energy to stay positive. If it wasn't for my Christian belief, I would have given up long ago. That's the only thing that keeps me going. My mother said I might find the right drug, and I did. Nobody can really take the place of your family and your friends ever, you know. The most difficult thing I had to face up to was coming to terms with the fact the medication works for me. It was a bit of a shock.

This excerpt revealed four important factors: First, her “hope” and influence from her mother of “finding the right drug” second, her “shock” that medication might work for her, after 11 years of problems with medications and their side effects; third, she highlighted the role of her supportive family and friends, although file notes stated that she wasn’t particularly happy with the friends who were behind her admission to hospital; and fourth, the role of her belief system and the use of religion to help her manage difficulties, which is often reported by patients (Ano & Vasconcelles, 2004; Bergin, Masters, & Richards, 1987; Crossley, 1995; Koeing, 2009; Pargament, Koeing, Tarakeshwar, & Hahn, 2004; Ruchita, Parmanand, Dandeeep, Kumar, Malhotra & Tyagi, 2011; Phillips & Stein, 2007; Smolak, Gearing, Alonzo, Baldwin, Harmon, & McHugh, 2013). Even though her file notes indicated Tara’s religious beliefs and that she attended religious services, this coping strategy was not drawn upon further or utilized throughout her admission/s, despite the hospital having access to an on-campus chapel and chaplain:

I: So how did your Christian belief help you?

P: Oh immensely. I wouldn’t be sitting here talking to you now, because if you ... it’s hard to put into words to be honest. I’ve got a very, very strong faith in my religion but I don’t go around shoving it down people’s throats. But it teaches me how to live and I can honestly say that I wouldn’t be sitting here if it wasn’t for my Christian belief. It’s helped me in so many ways.

Tara has a confused stance on whether her medication is helping, despite her belief that it “may just work this time.” But she clearly attributes her Christianity and religious beliefs to her improvement. Tara’s response to the next interview

question is also rather confusing and sounds more like she is ambivalent about how the medication will work for her and is relying on a “doctor knows best” assumption. As she says, medication still “limits” her life:

I: Did stop taking medication work?

P: Um. It did, but my life was very limited, whereas being on medication my life is limited again, but they’ll be a lot more things that I’ll be able to do in different ways that I couldn’t do before. I’m no longer scared of medication like I was before. I used to have injections and this drug and that drug. I just hope they just keep me on this one drug and don’t take me off it. So now I’m looking forward to getting married, finding a nice guy and having kids, not straight away but later on and doing some study and getting into Uni and eventually have a full time job and then get married and have a baby which is my goal down the track.

This excerpt demonstrates that Tara is implicitly aware of Harper’s (1999) “rationality trap,” and the difficulty and unpredictability of the position she is in. She is almost proving herself and attempting, as best she can, to be seen as “normal.” Medication has failed 11 times, she is an involuntary patient and is now on an order for medication compliance. Tara described a process of being trialled on various medications in order to “stabilise” and this was a scary experience for her. Her ultimate goal was to regain a functional life and engage in activities most people do, such as entering a relationship, studying and employment. It seems most of her life has been “on hold” for some time. Galasinski and Opalinski (2012) found in their qualitative study on psychiatrists’ views of patient insight that it was possessing and accepting psychiatric knowledge which constituted having insight and the unquestioning acceptance

and trust in whatever treatment the doctor deems fit to administer. The authors concluded that medicalization of mental illness appeared to be the preferred mode of patient narrative for psychiatrists. Tara's case highlights this very point.

Tara's case revealed a common problem within mental health settings, "the revolving door." Tara stopped taking her medications because they were "limiting," and the process of readmission occurs again. She is trialled on various medications in the hope for "the right one," as she claims, and when you ask Tara what helps her cope, she states religion. Yet, there is a chapel at the hospital, which is not utilized in any of her admissions. This system reinforced the cycle of behaviour and at each admission nothing was done differently. If a different approach had been taken, the door may have stopped revolving.

Discussion

The overall aim of this set of case studies was to unpack the complex issues perceived by patients in relation to how they cope. The case studies revealed a set of life circumstances, shared experiences that these people went through as psychiatric inpatients and in their lives in general. When investigating what these people shared in common, their narratives reflect very difficult life experiences which most people would be hard pressed to deal with. What these case studies demonstrate are clear accounts that these patients, most of the time, were clearly oriented to time and place, but were deemed to be "out of touch with reality" within the current system in which they were placed, or volunteered to go to, in some cases. Some patients were held against their will, with little choice, and commenced on a myriad of medications, many of which carried multiple side-effects which patients then had to "cope" with. Sharing noisy

wards with other “crazy” people, and poor sleep while in hospital contributed to feeling unsettled within the hospital and added to feelings of displacement.

The patients reported very sensibly how they managed and coped. Coping was not ineffectual or maladaptive, especially in comparison to what they were dealing with. In relation to diagnosis, patients who were classified with the same diagnosis were not “the same” and, therefore, as implied by the current diagnostic paradigm, did not “suffer the same disease.” Also, of note, was that the identification of “insanity, madness, and mental illness” in some cases was first made by the individuals themselves, their family members, social workers, or general practitioners, before the patient even reached a psychiatrist. In these case studies, as Moncrieff (2010) noted previously, diagnosis was a cue for the implementation of both social and behavioural control of patients’ “problematic behaviour,” for either themselves or for others around them, and such control is not provided for by other social systems.

The cases clearly highlighted the extreme emotional experiences many of these patients endured, and presented narratives that could often explain their behaviours. Attributing their explanations as symptomatic of a mental illness for these cases was unreasonable. The cases also demonstrated that most suffered abuse of some kind, and mostly sexual abuse. As such, Johnstone (2011) states, there are well-known responses to abuse. Not being able to cope with the abuse again is not a sign of a mental illness. Other commonalities shared by the 10 cases revealed: lower socioeconomic status; unstable accommodation; drug and alcohol use; family conflict; little to no formal psychological intervention/treatment; lower levels of education and, in some cases, lower levels of intelligence, as assessed by standardised psychological intelligence tests.

These issues combined resulted in repeated admissions for some patients, thereby demonstrating the limited positive benefits of an admission to hospital. There were no file records reporting that the patients improved, got better or were “well” after their admissions, only notes stating “mild improvement” at best. Admission length depended on the nature of the diagnosis, with most patients being discharged after 2 weeks, with no formal treatment plan while in the community, which usually resulted in readmissions for these patients, supporting the “revolving door theory” of mental health settings.

Hallam and Bender (2011), when describing the journal letters about how poorly treated a schizophrenic man was from 1960-1971, emphasise that there are more therapeutic and available psychological methods which have been developed for managing such kinds of problems. However, a number of these case studies never received any form of psychological treatment. Out of 38 cases only 5 engaged with psychology in their admission and medication was always the first line of treatment.

What was also revealed throughout the case studies was a degree of professional privilege. Nevertheless, the patients interviewed in this study were quite aware of their need for therapeutic treatment outcomes, despite the fact that their medicated treatment regime was often trite and banal. An excerpt from one of the 38 patients sums up the divide between patients and the psy-professions; When asked how he managed this difficulty he encountered, he responded with:

I try to be as true to myself as possible. If I say I’m depressed, psychiatrists want to give me an antidepressant, when what I really want if I say I’m depressed is for them to say ‘why are you depressed? Let’s

examine why, where does it come from, what is its cause, what is its cure?’ See what I mean, see the difference.

This very point runs through all the case studies and is evidence of the lack of a collaborative approach to patient treatment. Diagnosis was the beginning and end to understanding patient problems and dictated patient treatment regimes.

Given patients’ life circumstances and the degree of coping and understanding these patients employed, it does not make sense to retain the criterion “difficulty in managing” or “inability to cope” as an indicator of “madness.” As such, an ascription of mental illness to these patients’ accounts is unwarranted. I justify for this assertion by drawing upon elements from the substantial literature on the negative effects of labelling on the individual. It has been argued that concepts of “pathology” or “abnormality” within psychology and psychiatry are used to view ‘distress’ as occurring in the individual and what has ‘gone wrong’ with them either psychologically or biologically. For example, Smail (1993) pointed out that the utilisation of pathology by psychology and psychiatry suggests “that there something is ‘wrong’ with the person in distress which has to be put ‘right’”(p.19), and ignores the various contexts in which the distress is occurring. This pathologising prevents a level of critical analysis from extending beyond the individual to the nature of society itself and also gives way to more categorising, isolating and treating these so-called “mental faults.”

Another well-known advocate against concepts of “pathology” the psychiatrist R.D. Laing, who demonstrated that the problems in the lives of people diagnosed with “schizophrenia” were indeed due to “problems of living,” such as problems with their families, relationships, financial concerns and in questions about the meaning of life (Laing, 1960). Laing became critical of

psychiatry because he believed that it tended to individualize, and subsequently pathologize, what were in fact problems of living. Individualising behaviours and putting the onus back on to the person allowed psychiatry to act as an agent of social control. Laing's ground breaking book sparked a number of moral and political critiques of psychiatry. Laing himself saw "madness" as a patient's journey, at times distressing, although full of meaning, rather than an illness within the individual.

More than half a century later, Boyle (2011) wrote that this notion of converting experience to symptoms of disorders is problematic in several ways. Firstly, it allows a lot of research to be carried out using "intra psychic attributes" (p.29), without a mention of the context in which the behaviours occur. Secondly, Boyle warned that focusing on the individual's inner world, a narrow approach, gives way to "diagnoses" and "disorder," providing the basis for researching psychopathology. Boyle (2011) states:

"...If we are ever to de-medicalize misery, then both the impact of people's environments and their life experiences, as major causes of emotional distress, *and* the social significance of these connections will have to be made more prominent" (p. 27).

There are other reasons why concepts of pathology, diagnosis and mental illness should be discarded (see also Chapter 2 on the stigma associated with being given a "diagnosis"). Patients interviewed in this study found that the label of a "psychiatric disorder" did little to empower them or increase their well being. More often than not such labelling led to further suffering as a result of being diagnosed with "pathology" leading to reports of shame, low self esteem, social isolation and alienation by family and peers.

The use of psychiatric diagnoses are on the rise and their consequences are far reaching, despite very little evidence for their existence as distinct entities (Boyle, 2002, 2011; Rapley, 2012). Hallam (2013) also states:

“There is very little evidence for discrete biomedical causes of the common psychological problems: “psychological disorders” bear only a minor resemblance to medical disorders” (p. 9).

Justifications for abolishing all concepts of diagnoses in psychiatry and psychology have been raised well before this thesis. However, such action seems more needed now than ever, with an increasing number of diagnoses being put forward, and the cited unreliability of diagnoses (Aboraya, 2007; Boyle, 1990, 1999, 2002, 2007; Jacobs, 2009; Kinderman et al, 2013). It is time for another serious rethink about the use of the terms “pathology” and “psychopathology” when referring to peoples’ presenting problems.

Although while I advocate along with others for diagnoses in psychiatry and psychology to be abolished, I also concur with a noteworthy point raised by Hallam (2013). He states that one should not ignore the existence of patterns of an individual’s complaint. Indeed, patterns are useful to gather an understanding of an individual’s distress. However, when grouped into “disorders” or “diagnoses” and given a uniformity by the nature of “criteria,” they then give rise to a supposed commonality which leads to the design of particular treatments for such “disorders.” This may not be as problematic for very distinctive complaints such as anxiety and panic, for which there are proven psychological techniques including cognitive behavioural therapy, hypnosis and relaxation techniques, that can be helpful in reducing symptoms. There are also many extremely short-term sedative medical treatments, such as the use of benzodiazepines to provide

instant relief of the disturbing and often physiological symptoms, e.g., heart racing, sweating, fear of losing control. Anxiety and panic, without the word “disorder,” are therefore not problematic entities, in so far as the treatment regime is not as stringent and long lasting and, therefore, ‘help’ from professionals is usually short-term, depending on symptom etiology. However, the criteria proposed to meet the diagnosis of schizophrenia is extremely problematic, in so far as the criteria themselves are ambiguous. Often patients do not meet all the criteria which leads into splitting off diagnostic formulations, such as “Not otherwise specified,” or schizo-affective disorder, and medication is usually the first treatment option for such a diagnosis. Patients have been “shoe horned” into diagnostic categories which they do not meet, although this is now, of course, less problematic since the release of the DSM-5 which has more diagnostic categories with some looser criteria. In any case, as Hallam (2013) states “labelling a pattern as a disorder does not amount to an explanation for it” (p.10).

The conclusions that can be drawn from these 10 case studies is that most of the patients did not respond particularly well to medication regimes as the sole treatment. Patients were not restored to societal functioning after any of their admissions or treatments regarding their so called “pathology,” hence, the high readmission rate for some patients. The results of this study, along with research on the unreliability of diagnosis, stigmatizing effects of labelling, and the negative impact of pathologizing behaviour, provide some supporting evidence for advocating for the abandonment of all concepts of pathology.

As far as could be inferred from a detailed examination of the patients medical files, medication was used as the first line of treatment for all of the 10

patients in this study. Psychological intervention was only recommended in a single file note in Ben's case and was not followed up. It was suggested that Ben receive psychological input for his "grief issues" relating to his mother's death, alongside some of his "other psychological issues," such as low self-esteem, but he was offered no such input and was commenced on a medication regime.

Cultural context was also ignored in the case of Rose, who was not unlike many indigenous Australians incarcerated in both psychiatric and prison systems here in Australia. Little attention is given to the cultural needs of indigenous Australians within these systems and they continue to be managed within a westernized framework of mental health. Such management often results in deteriorating mental health and poor outcomes for these people.

For the 10 cases reviewed here, it seems these patients "coped" considerably well, given this type of "help," that did not significantly change, add to or make better their circumstances in any significant way. Patient "symptoms" became comprehensible and provided a set of meaningful ways of managing some very difficult experiences in their lives. This conclusion is supported by an earlier single case study on dialogical engagement with voices by Davies, Thomas and Leuder (1999), who found evidence of the ways in which patient experiences can be unearthed and properties explicated in the context of patient narrative. Narratives draw on people's accounts and experiences and offer an opportunity to construct a powerful and plausible argument about how people end up where they are and how they cope and change over time. Unfortunately this kind of narrative model was not used in patient management in the psychiatric setting. Instead, what emerged and led the way was characteristic of

a distinctly Westernized, gendered, and culture-bound version of the self, which neglected more meaningful ways of interpreting patient coping.

The case studies provide sensible accounts and reflect the complexities of individual's lives and the fact that some people are hard pushed to "cope" with their life. To say that this is symptomatic of a mental illness is not supported by the evidence from these patients' accounts. This is not to say such people are not difficult or may not be a menace to society. However, applying diagnostic criteria with one-fit treatment regimes does not seem to work. The interviews reflect sensible, creative and useful ways of managing difficulties, and even patient "not coping" was not sufficient enough to qualify them as diagnosable and "mad." There was a sense of patients really wanting and needing to be heard and wanting "us" to take note of what they were telling us.

It must be reiterated that diagnosis was not a reliable reflection of patient circumstance or coping abilities, as most of these patients had been given more than one diagnosis over the course of their life. Patients acquired at least four different diagnoses over their lives as patients within the psychiatric facility. This was usually but not always the case for patients with more than 3 presentations to a psychiatric facility within Australia. While the latest diagnosis was used in the case studies, medication regimes often reflected the paths of previous treatment regimes and, again, were dictated by a diagnostic approach. In particular, one diagnosis, "schizophrenia," revealed a one-way street treatment regime of medication. Johnstone (2011) reports that this particular diagnosis-medication pathway has been highlighted in the research and she emphasises that 'psychotic' patients should be offered the same range of psychological therapies as any other clients with a history of abuse; however, they are not.

In these case studies it was evident that there was not a single discussion about “cause.” Qualitative information gathered from medical files revealed no file notes, no psychiatric reports, and no psychiatric opinion, which detailed asking any questions such as “What caused this? What happened to you?” Obviously this point is slightly biased by the form of data collection used in this study and these questions cannot be answered retrospectively; however, from files reviewed, patient formulation did not focus on cause. What seemed to be the case was that the diagnostic framework took precedence, which then determined the treatment regime. This scenario occurs all too frequently within psychiatry, where “psychological disorder” has resulted in prescribed treatment manuals which translate each disorder into therapeutic procedures. This pathway is problematic on many levels because the sole reliance on following a set of treatment steps based upon a diagnosis may miss or override essential information on patients, information that might help them.

It is now well known that therapist expertise plays a role in whether treatment is successful. Hallam (2013) contends that there are many therapeutic approaches applicable to the individual case, “without having to view a client’s putative disorder as determining what is offered” (p. 47). As Hallam points out, descriptions are not “formulations.” He maintains that while researchers have made an effort to understand the processes causing “disorders,” their preconceptions of what constitutes a disorder hamper and influence. Hallam asserts that the diagnosis needs to be a starting point to understand behaviour and determinants, rather than an end point.

Both Johnstone (2011) and Read (2007, 2005, 2008) have argued that distress is often a reflection in the majority of cases of abuse (physical and

sexual) and in the response to the abuse. Furthermore, Weich, Patterson, Shaw and Stewart-Brown (2009) argue that “prospective long-term cohort studies over periods ranging from 10 to 37 years support the view that parental abuse (physical and sexual abuse, and neglect) in childhood is inextricably linked with common psychiatric disorders later in life” (p. 397). In essence, however, this link is not deterministic, not being able to cope with the aftermath of abuse is not a sign of mental illness.

We have a choice as health professionals to deal with patient reports of trauma in a different way. What these case studies demonstrate is the unique, creative use of personalised coping strategies that were good for as long as they lasted and as long as they were needed. However, more importantly, they reflect the many obstacles and, in particular, the “trauma” which leads to an array of upheavals and stressors in patient’s lives, which would test anybody’s coping repertoire. What is astounding is that the psychiatric system *added* to the burden experienced by these patients and worsened their so-called “symptoms.” In the very extreme cases, some patients reported being exposed to many more stressors (including rape and abuse), to a myriad of medications, and ECT, which did not increase coping and, in fact, produced aversive symptoms, e.g., considerable memory loss, which lead to increased helplessness. For a system that purports to “help” people with all the advances in medication, psychiatric training and psychological input, these accounts leave one questioning the impact this particular mental health system was having on these people.

The patients within this psychiatric facility were inpatients already on medication regimes, many of whom required sedation on a daily basis. In the one case when psychological therapy was offered to a woman diagnosed with

borderline personality disorder, cognitive behavioural therapy (CBT) was the model used. The use of CBT within a high care psychiatric facility over individualistic approaches is questionable and illuminates yet another obstacle which stands in the way of what is the best intervention which enables patient progress and helps them to “cope.” As indicated previously, CBT protocols (e.g., Fenn & Byrne, 2013) will not work so well for specific populations, such as the verbally impaired, because language and intelligence are required for CBT to be comprehended and effective. Perspective taking is also a function of language as the ability for “you” to reflect on “you” is a function of language (mainly pronouns). Given this, the conceptualisations CBT often use are unworkable with people with underdeveloped language ability and with poor attention and concentration spans. Individualised formulated treatment approaches are more suitable for those people presenting in crisis situations with multiple stressors.

The requirements of the CBT approach, e.g., the homework tasks; high attention and concentration spans to grasp tasks and to make the links between thoughts, feelings and behaviours, are going to be difficult for somebody who has to line up and be administered their medication daily by a nurse. More supportive forms of therapy are better suited to acute psychiatric care facilities, because patients, when admitted, are usually traumatised and/or withdrawing from drugs and alcohol, and have lowered attention and concentration spans.

Inpatient psychiatric settings require professionals with particular skill sets and skill levels. Hallam (2013) acknowledges that therapist skills are often the result of many years of accumulated knowledge and experience in the field. Ideally, “a practitioner has to combine nomothetic knowledge that relates to a theory of therapeutic change with an intimate knowledge of cultural norms and

social practices” (Hallam, 2013, p. 42). Hallam further explains that therapists should take into considerations their knowledge and expertise before choice of strategy is applied. And, finally, evaluation of outcomes can be done both formally (e.g., via a reliable and valid assessment) or informally through the patients’ descriptions/outcome (e.g., the person no longer reports anxiety). Patient file notes in the current study did not reflect that any such approaches were taken for those who were offered or who received psychological input.

While some clinicians and researchers suggest that diagnosis often facilitates patients’ and their families’ meaning-making of what is being experienced, and that this nurtures adaptive coping, this study suggests the opposite. A review of the medical files of the many patients interviewed revealed that they had many diagnoses, from schizophrenia to bipolar disorder to major depressive disorder to personality disorder, and had been medicated accordingly. Many had been given three or four different diagnoses over a period of two years and multiple medications. This process of diagnosis was very confusing for many of the patients and left them with feelings the opposite of nurturing or adaptive meaning-making. The labelling process and diagnosis did not facilitate patients’ coping and, in fact, did the complete opposite for some, as they themselves reported. Of particular note was that some patients found the diagnosis to be “unhelpful” and reported this many times. In addition, at this inpatient facility, families were not directly involved with patient care, despite patients reporting, more often than not that families were, in fact, the cause of the distress experienced by the patients. Diagnosis triggered a standardized medication treatment regime that failed to take into consideration social and cultural context, personal circumstances of the patient, and failed to incorporate

reliable formulations as to the root causes of patient behaviour. This approach did not consider what patients themselves deemed as effective coping strategies.

According to Read, Haslam, Sayce and Davies (2006), people diagnosed with schizophrenia are the target of some of the worst prejudgement and discrimination. The problem is pervasive and is seen often in harmful attitudes among some mental health staff. In their review, Read et al. state that attitudes do not seem to have improved over the 50 years they have been conducting and reviewing studies and that source evidence suggests that attitudes are deteriorating. This study is further evidence of this fact. Indeed, diagnostic labelling simultaneously increases the perceived seriousness of the person's difficulties, lowers evaluations of the person's social skills and produces more pessimistic views about recovery. It also leads to social distance and rejection. Martin, Pescosolido and Tuch (2000) found that labelling schizophrenia as a mental illness created a social stigma and increased people's desire to keep at a distance from people diagnosed with schizophrenia.

The commonalities shared amongst the 10 case studies are not new to the literature, as such. For example, we are aware of the impact of negative family relationships in childhood increasing the likelihood of psychiatric disorders in later life (Keyes, et al., 2012; Read, 1997, 2005a; Read & Bentall, 2012; Weich, et al., 2009). The literature has also established that psychiatric patients find the healthcare system less than supportive of their "coping" efforts (Goodwin et al., 1999) and we have considerable evidence of the stigmatizing effects of being a "psychiatric" patient in the first place. What is newer information is the extent to which this population found that the limiting definitions of "coping" by others in their environment affected their experience of "self" and their views of their

strengths and their coping. The complexities of the individual require complex, contextualised treatment regimes and not off-the-rack, blanket responses to a “diagnosed” condition. The latter, all- too-commonly applied blanket responses can entrench individuals as patients by eroding their ability to apply the coping mechanisms that they advocate and accept as useful in restoring their own functional lives.

CHAPTER 7

Discussion and Final Conclusions

Preamble

In this chapter the salient implications and key findings of this series of studies are summarised, in an effort to demonstrate from a clinical perspective how coping should be researched and understood by mental health professionals in the future. The overall purpose of this research was to understand what psychiatric patients find particularly challenging, how they cope with these challenges, and what were the most helpful ways to measure this. The major research questions were: Does the prevailing assumption about “not coping” in those diagnosed with a mental illness do justice to the complexity of what coping might be for these people? Does it make sense to measure coping in a psychiatric population? The assertion that is commonly referenced in the psychological

literature that people diagnosed with a mental illness, such as depression, schizophrenia and anxiety, lack adequate coping resources for managing the challenges of daily living, which at times causes psychological distress (Piccinelli & Wilkinson, 2000; Taylor & Stanton, 2007), was not fully supported by this qualitative and quantitative study. The findings of this series of studies that addressed these questions, as described below, were then used to challenge mainstream definitions of coping.

Relational Meaning: Meaning-Making as Integral to Coping

People try to make sense of their lives and experiences everyday, and will adapt to the circumstances in which they find themselves. Lazarus and Folkman (1984) state: “Humans are meaning-oriented, meaning-building creatures who are constantly evaluating everything that happens...” (p. 276-277). The process of making sense of your world and adding meaning to it is very individual in nature. People also differ in their sensitivity and vulnerability to certain types of events/situations and in interpretations of and reactions to those events/situations (Lazarus & Folkman, 1984). Nevertheless, people who present to psychiatric inpatient facilities in Western Australia are considered to have dysfunctional coping repertoires, as judged implicitly by the current psychiatric paradigm in place and those psychologists and psychiatrists working within these frameworks. The findings of this thesis clearly refute this assumption and further add that such an assumption does not do justice to the complexity of who these people are and what they have experienced. The findings in this thesis support the importance of meaning-making and relational support as being integral to understanding coping in those people diagnosed with a mental illness.

Lazarus and Folkman (1984) believe that understanding the cognitive appraisal process is essential to understanding stress and coping. Individuals will vary in their sensitivities to and reactions towards particular situations and it is the process of the interplay between both environmental and individual factors which defines coping. Thus, the relationship an individual has with their environment determines to a large degree what coping mechanisms they will use and the level of stress they will experience (Lazarus & Folkman, 1984). Patients in this study reported using both primary and secondary appraisal processes to assess coping for various situations that arose in their lives. They reported clear accounts of adopting certain coping strategies in these situations. It was evident that relational meaning took place, whereby the patient weighed up the pros and cons of situations before they employed a particular coping strategy. Thus, in this way the relational meaning influenced the coping process. In some instances, patients reported that they were equipped with the coping resources to manage these difficulties. However, when they were not, they reported relying on the mental health system, which, in effect, was a form of coping. Extenuating life circumstances and/or problems in living usually precipitated this.

Lazarus's coping theory provided a foundation for understanding the coping process for the patients in this study and, furthermore, it can be used to assist professionals in mental health settings in understanding patient coping. In addition, focussed attempts towards developing supportive and enabling models of practice are needed which replace the current "caring" and "service providing" ones. As discussed later in this chapter, patients in this study reported that the mental health system did little to promote adaptation and coping and, in fact, worsened their distress, which called for additional coping.

The Inadequacy of Quantitative Approaches to Coping

While quantitative methods may be useful for the measurement of coping per se, in the general community, in this study a quantitative approach was less sensitive to the experience and meaning of coping for patients. The CSA as a measurement of coping strategies provided a set of useable results. However, the CSA could not pick up what the qualitative investigations revealed, i.e., that patients had suffered severe trauma and were continuing to suffer within the psychiatric institution to which they had come to be “cared for.” Instead, CSA results produced a set of coping strategies which were then categorised into two groups, mainly productive and unproductive coping, which did little to honour the true coping experience for this group of people, and, furthermore, ran the risk of overlooking aspects of important variables related to their coping experience.

Via a qualitative approach and planned semi-structured interviews, additional information was revealed about the meaning of coping for psychiatric patients. The impact of contextual variables, diagnoses, childhood trauma and neglect lay bare the very real nature of patient experience and how this impacted on their coping. These findings highlighted the real importance of recognising meaning in order to understand “psychiatric disturbance,” and to aid in the patients’ recovery. The CSA missed the very individual nature of coping and out of such results further questions arose, such as: “What do these scores mean? What value do they add to the coping experience of a psychiatric inpatient?” The very fact that in semi-structured interviews inpatients revealed more about “coping” and reported that they coped in a multitude of ways is evidence of the value of qualitative approaches. This study again highlighted the problem other authors have identified with coping research: that the coping process cannot be

measured with quantitative methods alone. As Boyle (2011) points out, scales which are designed to measure ‘deficits,’ i.e., “unproductive coping” as seen in the CSA, neglect the context and life experience of the individual.

This thesis has also demonstrated through its findings that coping is a complex, multi-dimensional construct. Just as individuals are complex, coping varies from situation to situation and its development and use depend upon many different social and cultural contexts, all of which complicates the measurement of it. The unveiling of the meaning of coping for those diagnosed with mental illnesses revealed the many layers contributing to patient “coping.” What has become apparent during the investigative process of coping is that psychiatric inpatients demonstrated clear understandings of the reasons for their coping or not coping and detailed very sensible ways of coming to terms with a set of circumstances many people would be hard pushed to face. However, some of the current systems in place within Western Australia deem these people in such institutions to be “out of touch with reality.”

Measurement of Coping

In Chapter 3 of this thesis I reviewed the area of quantitative measurement of coping. There are a plethora of new coping scales coming out, in particular those measuring religious coping. This study would argue that this influx is not warranted and needs to be curtailed, because coping as a construct is complex and multi-layered and needs to be inclusive of the many variables involved in this process. The second major study, which looked at the measurement of coping in a psychiatric population, found that the sole use of quantitative measures did not reflect the true meaning of coping for this

population and, detrimentally, missed vital details contributing to the understanding of coping. As Lazarus and Folkman (1984) state:

Definitions of coping must include *efforts* to manage stressful demands, regardless of outcome. This means that no one strategy is considered inherently better than any other (p.134).

While the Frydenberg and Lewis (1997) Coping Scale for Adults (CSA) based its items on Lazarus's theory, the process of the categorization of the scale items into productive and non-productive coping goes against Lazarus's theory, in some respects.

Another useful point made by Folkman and Lazarus (1980) on the measurement of coping was the recognition that more appropriate measures of coping were needed, because measures devised to assess coping on a normal population have been inadequate or inappropriate. They acknowledged that the difficulty lies with transferring stress and coping theory into interventions, which can be problematic, because measurement depends on how coping is understood. This author would concur. Possible approaches to safeguard the understanding of coping for psychiatric inpatients and to prevent their coping from being misrepresented were discussed in this thesis. This thesis also advanced the argument, that, similarly, it is the act of measurement which constructs an object referred to as "coping," but that in so doing the quantitative measurement jeopardises an adequate understanding of the very nature of coping for the people it seeks to calibrate.

A closer examination of both quantitative and qualitative findings revealed information that did not truly reflect what patients were really saying about themselves. Some patients reported high scores on productive coping

mechanisms, yet they considered their overall coping mechanisms as far from being able to “cope.” Patients demonstrated that such “unproductive coping strategies” were extremely useful for them. For example, avoidance was sometimes misinterpreted as a symptom of their disorder, rather than a very productive coping mechanism to deal with the very unpleasant side effects of medications. Sleeping off the side effects of medication was instead a productive strategy rather than avoidance. These findings are in direct contrast to the conclusions of Lysaker et al. (2004) who found that persons diagnosed with schizophrenia cope with stress in a relatively “avoidant and ineffectual manner.” I would argue such descriptions are unjustified and are highly judgemental. A high score on the CSA’s non-productive coping, which included: *worry, keep to self, self-blame, wishful thinking, ignore the problem* and *not cope*, could be negatively viewed but this would misrepresent the actual coping experience of psychiatric patients.

The patients interviewed in this study who were diagnosed with schizophrenia, namely, Rose, Ben, Phil, James and Tara, coped in various creative ways to manage the difficulties they faced. Some coping strategies were unique to the individual and creative and some were more well-known mainstream coping strategies which have been well recognised in the literature, e.g., religious coping, avoidance, alcohol and substance use, social support, listening to music. Here then, by definition, is a sample of people who supposedly cannot “cope,” but when they were asked about the kinds of things they found difficult to manage in their lives, what was revealed was that these people could cope in a multitude of ways. Furthermore, these people reported real sets of unimaginable life circumstances, such as sexual abuse, violent rape,

extreme neglect and poverty, and they responded to these traumas with some very adaptive, creative coping.

What is missing from a very practical standpoint within mental health settings and needs to be taken into consideration here is that these people solved their problems in the best ways they could, with what they had at the time. For example, Rose was an Aboriginal woman coping with physical abuse, rape, her own drug addiction and her children being taken out of her care (which she had no control over). Tara reported trying to engage in university studies, but the side effects from her antipsychotic medications (which are well documented) interfered with her ability to pursue her studies and reduced her coping. Quantitative measurement of coping neglects contextual, cultural and the many individualistic layers of what coping means to a person and their sense of self.

As argued in Chapter 5, considering the coping strategies of those diagnosed with mental health illness as productive and non-productive is more reliant on reductive and circular logic. Understanding coping in this way misses the essentially rational, local and individual nature of what might count as “coping” in the context of psychiatric inpatients’ lives. This point has major implications for mental health settings in relation to how patients are assessed and the type of treatment they are offered.

The coping efforts described, both quantitatively and qualitatively, reflect firstly, how a questionnaire suggested psychiatric inpatients were managing their “coping efforts,” and secondly, how inpatients perceived their coping through their own accounts. This raised an important phenomenological question, as reflected by these patients’ high scores on some aspects of their coping, yet, when interviewed, patients reported many factors, both within and outside of

their control, that impacted on their coping. The five themes identified in Chapter 5 highlight the very real nature and underpinnings of patients' coping efforts, e.g., poor trust of health professionals, medication side-effects, feeling misunderstood, that contributed to their need to engage in more coping efforts and affected their overall sense of coping.

Therefore, a sole reliance upon quantitative measures of coping would miss the entirety of what coping means for psychiatric patients. If there is to be an authentic account of coping for these people, which reflects the "whole person," then this needs to be researched qualitatively. A combination of quantitative and qualitative measures may be useful, but only clinically on an individual basis, because quantitative measures alone do not reveal the true meanings of coping. By taking more of an individualistic approach, therapists can begin to assist in helping psychiatric patients to help themselves recover and build upon their strengths.

Given what we already know from the concerns raised in the literature that the field of coping research is 'disappointing' and has 'stagnated' (Somerfield & McCrae, 2000), and the many, unresolved, methodological issues in quantitative coping research (De Ridder, 1997), we now know that it is not sensible to categorise people's attempts at "coping" as unproductive. Such broad categorisations of coping as "productive" or "unproductive" are based on a supposedly definitive, westernised empirical knowledge base and are more moral judgments than scientific evaluations.

As detailed in Chapter 2, qualitative research in the area of coping is not as vast as the quantitative research, however it provides a useful alternative to understanding peoples' distress and coping. A number of authors recommend

the use of qualitative methodologies to enhance our understanding of coping behaviours (Braun & Clarke, 2006; Iwasaki, Mactavish & Mackay, 2005; Moos & Holahan, 2003). The advantage of qualitative research is that it involves an in-depth understanding of human behaviour and the reasons that govern human behaviour. Unlike quantitative research, qualitative research relies on reasons behind various aspects of behaviour. The “why” and “how,” as compared to the “what” “where” and “when” of quantitative approaches. Smaller samples rather than large random samples are usually utilised. Qualitative research categorises data into patterns, themes, or categories as the basis for organising and reporting results. The use of qualitative methodologies in psychology and psychiatry is a notable breakthrough in research, as for many years both disciplines have used many “statistical” and “quantifiable” research approaches that suggest a highly transferable science. Within mental health, this has often meant that this highly transferable science, in the form of labelling and diagnosing, takes precedent over “helping” individuals, a point that will be expanded on further in this discussion.

Importance of Social and Cultural Context

Parts of the findings from qualitative studies in this thesis echo what the literature has established; namely, that psychiatric patients find the healthcare system less than supportive, and there is considerable evidence of the stigmatizing effects of being a "psychiatric" patient in the first place. However, this thesis provided new information regarding the extent to which these psychiatric inpatients found the limiting definitions of "coping" by others in their environment affected their experience of 'self' and their views of their

strengths. This finding suggests that pejorative moral judgment continues to be at play within psychiatric settings.

Being diagnosed as having a mental illness affected patients' belief of self and what they believed that they could and could not do and, therefore, did not aid in their recovery. First line treatments of medication regimes within psychiatric hospitals overlooked the very nature of the reason why patients were referred in the first place. As seen in Chapter 2, many medications prescribed within psychiatry carry very serious side-effects and sometimes black box label warnings, e.g., anti-depressant medications which may increase suicidal ideation. The findings of this thesis revealed that many patients suffering from sexual abuse were, therefore, already "coping" with a significant level of trauma, and to be treated with medication regimes having serious psychological side-effects by a so-called "care" facility is a failure of "care."

Certainly on a national level, the Mental Health Council of Australia (MHCA) is aware of the crisis in mental health care, as evidenced by this reporting in 2005 which detailed:

... after 12 years of mental health reform in Australia, any person seeking mental health care runs the serious risk that his or her basic needs will be ignored, trivialised or neglected. ...In the short-term, the system as it currently operates may result in a failure to provide basic medical and psychological health care, inappropriate use of short-term seclusion, confinement or over-reliance on sedating medications. Longer-term, the impact may include deteriorating mental health and wellbeing, suicide, higher rates of homelessness, prolonged unemployment, incarceration or increased financial burden and poverty...For many people, ongoing

financial and personal support from family and friends is the only real safeguard against these outcomes (MHCA, 2005, p.14-15).

A similar picture was reflected in the experiences of the people from this study who were having difficulty “coping,” had come from impoverished backgrounds, unsupportive and abusive family environments and who went to a system to ask for “help.” However, the mental health system fails to recognise that “perceived mental health problems may be a normal reaction to harsh living conditions” (Summerfield, 2008, p.993). Certainly, the findings from the current study would support such a suggestion.

National work groups, such as the National Mental Health Commission, have been established to help report on and add awareness to these very issues within the mental health system. However, up until 2012 in Western Australia there has been very little reporting from these work groups.

A very recent finding, particularly relevant to this thesis, is a concerning statistic reported by a working group from the National Mental Health Commission. Holland, Dudgeon and Milroy (2013) found that, at present, within the Australian mental health system the rates of suicide and hospitalisation for mental health conditions among indigenous Australians are double those of other Australians. Cultural context continues to be ignored in most mental health institutions within Australia, despite the number of indigenous Australians presenting to such facilities.

Indeed, indigenous Australians are treated within a standard western framework, which pays little to no attention to their belief systems of ways of being. But, as Vicary and Andrews (2000) point out, a white psychologist offering a service to an Aboriginal community has to work in a very different

way than they would within a white community, and also has to have a fairly comprehensive understanding of the Aboriginal culture and belief system. Practicing clinicians already know that reframing patient problems in terms of their life circumstances and social contexts, past and present, goes a long way in helping the understanding of the issue of concern and bringing about change in a positive way for that person.

Indeed, this study has revealed that any particular coping strategy can sensibly be labelled as ‘effective’ or ‘ineffective,’ ‘productive’ or ‘non-productive,’ or even ‘adaptive’ or ‘maladaptive’ without reference to the context in which it is used. But, it is only when context is considered that coping can be understood.

Diagnosis and its Impact on Patient Coping

As discussed at length in the literature review in Chapter 2, psychiatric diagnoses are problematic on several levels. The findings from this study suggest that cataloguing human distress in much the same ways as other “proper sciences” such as chemistry . . . ” (see Rapley, 2012, p.81, for expanded discussion) is unwarranted and unhelpful. Furthermore, a confounding variable in this study, as reported in patient medical files, were the many DSM-III and DSM-IV diagnoses patients acquired as a result of attendance at a mental health facility. Some patients acquired at least four different diagnoses during their time within the psychiatric facility, adding further doubt over the use of diagnoses within mental health facilities and supporting the argument for the lack of reliability and validity of DSM diagnoses. What the findings certainly revealed is that a formal psychiatric diagnosis did little to help patients’ understanding of their problems.

There are those clinicians who believe that diagnosis often facilitates patients' and their families' meaning-making of what is being experienced, and this nurtures adaptive coping. This study provides evidence that the direct opposite can occur and did occur, particularly within this high care facility psychiatric hospital. Also, of particular note here, was that, at this inpatient facility, families were not directly involved with patient care and, more often than not, patients reported that their families were the cause of the distress experienced by the patient themselves. The labelling left some patients with the opposite feelings of nurturing and adaptive meaning-making and definitely did not help them cope, as they themselves reported.

This study supported the notion that applying a diagnosis reduced coping, for some of the patients interviewed. However, as most clinicians would concur, many times in clinical work, as was evident in this study, labelling and diagnosing does not foster patients' coping and, in fact, can do the complete opposite. Diagnosing creates an inflexibility which is the antithesis of human evolutionary development and adaptation. Patients reflected this very fact in their interviews. Some "became the diagnosis" and others had rather given up hope of making change which was reflected in their not coping. Thus, putting a diagnosis on a person, which by definition is inflexible, does little to promote adaptation and coping.

Review of medical file notes for the 38 patients interviewed revealed that none were reported to have been followed up after their discharge from hospital and their progress was unknown. This lack of follow-up was particularly concerning, given that some patients were only in hospital for one week and commenced on medications which carried significant side-effects. Adding to this

concern was the fact that over half of the patients in this study had “no fixed address” and some were labelled itinerant; therefore, for some, this may have meant being discharged back into homelessness. What was revealed was that the psychiatric facility had no ongoing contact with the patient and their treatment, for example, their medication regime, or their progress. Therefore, if their “psychiatric condition” improved, either “spontaneously” or through no contact with mental health services for a period of time, the variables and context in which this occurred were unknown.

If patients mental state deteriorated, as evidenced in this study, most patients were usually re-admitted to a psychiatric facility on this basis. There was no procedure in place to track vital changes in patient mental health and, furthermore, it appeared to be not even considered. In my clinical experience of working in such environments for over 17 years and the knowledge base I have regarding such situations, typically if context was considered at all, it was only considered during weekly ward round meetings within inpatient psychiatric facilities, which were attended by the psychiatrist, a medical officer, a social worker, a clinical psychologist and a nurse. In general, much time would be spent in these meetings discussing the reasons for admission, by which time, many patients had already been commenced on medication regimes. Therefore, while I note in this thesis that context did not appear to be considered, it may have been considered verbally in these weekly meetings but not documented on the patients’ file. Nevertheless, the actions reflected through admissions and patients’ interviews in this study suggest that context was not the focus of consideration, nor did or that knowledge of such contexts transfer over into the understanding of patients’ presenting problems.

Boyle (2011) believes that this “persistent avoidance of context” (p. 43) is a problem within the professions of psychology and psychiatry. By ignoring context, an individual’s distress is completely overlooked within the contingencies of the environment and its influences, the result being a reclassification of distress to occurring “within” an individual. Although as seen in this study, the life circumstances and experiences reported by these patients were experiences most people considered on the “normal” spectrum would be hard pushed to deal with. It seems that if you cope with harsh circumstances, then you are not technically “diagnosable,” however, if you don’t “cope,” you might very likely fall into a diagnostic framework. The DSM framework ignores context and converts distress into “problem behaviour,” or “symptoms” and “disorders,” occurring “within” the individual, as written under the definition of mental disorder in the manual. When referring to mental disorder the DSM IV states:

Whatever its original cause, it must currently be considered a manifestation of a behavioural, psychological, or biological dysfunction in the individual (American Psychiatric Association, 1994, p. xxi-xxii).

The DSM-V definition of mental disorder has become more obscure:

. . . clinically significant disturbance in an individual’s cognition, emotion regulation, or behaviour that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. . . .

(American Psychiatric Association, 2013, p.20).

The focus is still on “within” the individual and neglects context.

Mainstream psychology and psychiatry have been influenced by these assumptions, which decontextualize an individual’s life, and frame behaviours in

terms of cognitions and emotions, which have links to the mind and brain (Boyle, 2011). These assumptions are particularly problematic and open to a great deal of misinterpretation by clinicians, resulting in differing opinions regarding diagnosis and medication regimes.

As seen in the current study, a review of patient medical files indicated that what was considered at the time of the patient's admission, and often repeatedly on some admissions, was medication noncompliance, frequently recorded as "a reason for an admission," especially with diagnoses such as schizophrenia or bipolar disorder. What was most unfortunate though, was that some of these same patients were able to demonstrate, quite clearly in their interviews, the circumstances leading up to their admission and the difficulties they faced, e.g., poor housing, no accommodation, poverty, abusive relationships, drug and alcohol problems, rape, trauma; however, rarely was this information documented as, a reason for their presenting concern upon admission to the hospital.

As described in Chapter 6, psychological intervention was rarely provided to the patient and the only form of "help" which was clearly documented was medication regimes and ECT. I am not advocating here that psychological approaches would have been better for those patients, just merely stating that this was the process (for a detailed argument on why some current psychological approaches e.g., CBT are no better Boyle, 2011, p. 32-33). It appeared that the diagnostic approach at the hospital bypassed patients' attempts at coping and did not help them with their current life situations. When the meaning of coping was explored with psychiatric inpatients, the difficulties they faced, and how they "did" coping, one feature emerged repeatedly: professional

intervention in the form of diagnosis, as opposed to understanding patients as people experiencing “problems in living,” (Szasz, 1960), reduced informants’ ability to cope. Some research (Ziolkowska, 2011) has already confirmed that doctors’ interpretations of illness do indeed eliminate the possibility of exploring the complex relationships between patients and their problems, thereby providing more evidence to reject the prevailing framework.

I would argue, along with Kinderman et al. (2013) and other concerned psychologists and psychiatrists, that the mental health community needs to embrace a paradigm shift with respect to the impact of diagnosis. A paradigm shift along the lines of Kinderman, et al., who advocate that “dropping the language of disorder within mental health” would be a good starting point. This shift is crucial for future development of new ways of understanding the reality of the lived experience of being a psychiatric inpatient, and for a more sophisticated theoretical approach by the research community towards coping behaviour and interpretations of coping amongst psychiatric inpatients. The horrendous situations impacting upon an individual do not warrant labels such as “mad,” or “mental illness,” or a diagnosis, e.g. schizophrenia. Undeniably some people suffer distress and are in need of help; however, there is no evidence that these experiences are best understood as “illnesses” with biological causes or that these patients have overall coping deficits.

A more fitting approach to understanding patient behaviours is suggested by Hallam (2013). When formulating the reasons behind much problematic behaviour, he states, “that normal psychological processes, in combination with events that are not necessarily out of the ordinary, can conspire together to produce problems of all kinds” (p. 44). Unfortunately, the psychiatric

classification systems in practice endorse limited views of causality which have serious implications within mental health settings, such as subscribing to medication regimes as the first line of treatment. These practices are not new. For example, Mosher (2004) describes how over the last four decades at least psychopharmacological treatments have taken the place of a psycho-social model treatment of schizophrenia. Indeed, the recursive nature of current mental health are reflected in the sentiments of Laing (1960):

The behaviour of the patient is to some extent a function of the behaviour of the psychiatrist in the same behavioural field. The standard psychiatric patient is a function of the standard psychiatrist, and of the standard mental hospital (p.28).

An example of an alternative approach which minimized the use of medications is seen in the project of Soteria House in California which was established in the 1971 to treat those diagnosed with schizophrenia. Neuroleptic medications were not used for at least the first 6 weeks upon a patient's admission to Soteria (for a full review, see Mosher Hendrix & Fort, 2005). Soteria house was more about understanding the individual as a whole person. Mosher (2004) states its model:

“focused on finding shared meaning and understanding of the subjective experience of ‘schizophrenia’ (‘personal or developmental crisis’ was the operant term), including the experience of others involved in the interactional process” (p. 350-351).

This facility resembled the earlier moral treatments to mental illness and its results were impressive. The Soteria Project also collected data (see Mosher 2004, for a review) and overall patients who were admitted to the facility had

partially recovered within 6-8 weeks. At a follow-up 6 weeks after admission, 76% of the people had not received antipsychotic medications. At a 2 year follow-up, 43% used no antipsychotic medications and were functioning well in society with fewer admissions (Mosher, 2004). This demonstrated that by understanding context and meaning, treating individuals with decency and respect, and creating an environment conducive to that healing, actually had a positive impact on patients' functioning.

Where to From Here?

In reference to survivors of the psychiatric system, Dorothy Rowe (2007), in her book *Beyond Fear*, uses a famous axiom "the more things change the more they remain the same" (p.152). This still appears to be the situation within mental health systems throughout Australia, and this study is evidence of this. The patients in this study reported discrimination by friends, family and the mental health system that added to patients' problems and clearly obliterated their attempts at coping. The treatments available within these systems are unlikely to help patients recover and rarely consider patient attempts at coping. This study demonstrated that this psychiatric facility served to decrease the self-esteem of most of the patients interviewed even further by the treatments it imposed on the patients. The procedures and practices of the service served to decrease any chance some of these patients had of returning to normal societal functioning. If we know anything about coping per se, it is that it is the ability to adapt, and what the patients in this study have shown is an incredible adaptation to sometimes the most horrific circumstances and unhelpful forms of treatment.

Future directions in mental health in terms of provisions for the treatment of those diagnosed with a mental health illness have been mapped out for some

time and are underway, as seen in both Britain and Australia. There are some who believe, like Lord Layard of the English House of Lords, that more psychologists and cognitive behavioural therapy through the NHS (United Kingdom National Health System), which is akin to the Medicare Mental Health Care Plan Scheme in Australia, will lead to more positive mental health in the general community and, thus, more “coping”. However, there are those who disagree with this proposition (e.g., Harper, 1996; Rowe, 2003, 2007; Summerfield, 2008, 2006, 2012a) and believe that such approaches create a version of the self as one of vulnerability and not resilience. Moreover, these approaches are also seen to take away individual freedoms and the power of the people to make a difference in their own lives.

Harper (2012) suggests that the assumption that the source of people’s unhappiness “lies inside people’s heads”(p.2), and in how they see the world is problematic, because it is followed by the assumption that changing a person’s thinking is the solution, which still puts the onus back on to the individual to make their life “better.” He believes that approaches such as these ignore social and cultural contexts, including whether these people have supportive relationships, a reasonable income, etc. Harper states:

Unfortunately, we have a tendency to attribute a person’s behaviour to individual factors such as intelligence or moral strength, rather than their social context such as poverty or child abuse. This is such a common research finding that psychologists have a term for it: the fundamental attribution error (Harper, 1996, p. 2).

The inequality in peoples’ lives was reflected in patients’ interviews and case histories in this thesis and suggests that addressing social context, poverty

and child abuse would go a lot further to increasing the general “coping” and overall happiness of these patients and others than current treatments. David Smail (1993) agrees that a person’s ‘psychology’ consists of the meaning systems through which their experience of the environment is understood, interpreted, and represented. In general, the goal of any such treatment intervention should be to help a client manage in the context of a life that is bound together by their individual set of values and circumstances.

A full review of all the practical and theoretical concerns and debates of the future of mental health is beyond the scope of this thesis (see Boyle, 2011 for more detailed exposition). However, a few important points raised by Boyle are relevant to this thesis. One point Boyle raises is that if there is to be any advances towards an approach inclusive of context, then the language used by both psychology and psychiatry needs to be reconsidered. Boyle notes that medicalised terms, inclusive of the term mental health, convey the impression of “. . . a lack of intelligibility and suggesting a pathological or deficient individual” (p. 41). Boyle is quite candid about where the problems lie and how to begin fixing them, “. . . without exposure – by which I mean that prominence is given to context and life experience at every possible opportunity in practice, theory and research – nothing will change” (p. 40). The current diagnostic paradigms within psychiatry and psychology, as they stand, ignore context and serve to undermine the distress an individual experiences.

In line with the recommendations of Boyle (2011), Davies et al. (1999) and Hallam (2013), a way forward should focus more on an individualistic approach inclusive of context. In this way professionals can work with personal accounts of patients’ lives, and within each person’s explanatory framework to

help strengthen patient coping repertoires. Rowe (2007) asserts that peoples' problems are often resolved, if they are listened to and treated with respect. Summerfield (2004, 2005, 2008) also believes people need to cope and develop strategies "in their own way," as opposed to strategies being imposed on them. This approach makes sense, because coming to terms with a traumatic experience appears to be linked to thinking about oneself in relation to others, and this relational thinking would be the common cultural social context which surrounds and means something for the individual.

Conclusion

Overall, the findings from the studies in this thesis revealed that the bedrock assumptions of psychology's and psychiatry's approaches to coping, in those diagnosed with a mental illness, do not do justice to their actual accounts of coping. Firstly, the diagnostic approach and medical treatment of distress and mental health issues were identified as problematic and a recommendation was put forward for a more respectful, nuanced understanding of the notion of coping by mental health professionals. Clinicians within mental health settings need to pay more attention not only to the content of patient's lives, but also to re-establishing that background sense of coherence, purpose and meaning for the individual. The findings of this study challenge stereotypical interpretations of coping, and are long overdue, as is the portrayal of psychiatric inpatients' coping as helpful to them, regardless of 'expert' judgments thereof. In so doing, this thesis calls for practitioner and academic reconsideration of how coping is conceptualized, as a matter of urgency.

How then are we as mental health practitioners to refrain from making formalised judgements about psychiatric inpatients' coping? Perhaps, most

reliably, we can accept the uncertainty of the mental condition of people, and that every coping strategy used may be good for as long as it lasts; we can refrain from formalised measurement of the qualitative phenomena “coping” with patients and, finally, we can seal the lid on the quantitative coping box. To describe such ways of coping by psychiatric inpatients, as were found in the current research, as “non-productive,” or as “symptoms” of “mental disorder” is, as suggested previously in this thesis (pace Sarbin and Mancuso, 1984), not to arrive at a medical diagnosis, but rather to pass pejorative moral judgment. As Smail (1993) claims it is individuals’ worlds and not their ‘psychology’ which causes them distress. Therefore, to respond to the distress and trauma of psychiatric inpatients with further, frequently life-long, traumatisation in the guise of “help” needs to be urgently reconsidered.

REFERENCES

- Adler, N., & Matthews, K. (1994). Health psychology: Why do some people get sick and some stay well? *Annual Review of Psychology, 45*, 229-259.
doi:10.1146/annurev.ps.45.020194.001305
- Aboraya, A. (2007). The reliability of psychiatric diagnoses: Point: Our psychiatric diagnoses are still unreliable. *Psychiatry, 4*, 22-25. Retrieved from: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2922387/>
- Agar-Jacomb, K., & Read, J. (2009). Mental health crisis services: What do service users need when in crisis? *Journal of Mental Health, 18*, 99-110.
- Aldwin, C. M. (1994). *Stress, coping and development: An integrative perspective*. New York: The Guilford Press.
- Aldwin, C. M., & Park, C. L. (2004). Coping and physical health outcomes: An overview. *Psychology and Health, 19*, 277-281.
doi:10.1080/0887044042000193514
- Aldwin, C. M., & Revenson, T. A. (1987). Does coping help? A re-examination of the relation between coping and mental health. *Journal of Personality and Social Psychology, 53*, 337-348. doi:10.1037/0022-3514.53.2.337
- American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders*. (4th ed.). Washington, DC: Author.
- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: Author.
- Ano, G. G., & Vasconcelles, E. B. (2004). Religious coping and psychological adjustment to stress: A meta-analysis. *Journal of Clinical Psychology, 61*, 461- 480. doi:10.1002/jclp.20049

- Ansbacher, H. L., & Ansbacher, R. R. (1967). *The individual psychology of Alfred Adler*. New York: Harper & Row.
- Antoni, M. H, Lehman J., M, Kilbourn, K., M., Boyers, A., E., & Culvers J. L. (2001). Cognitive behavioural stress management intervention decreases the prevalence of depression and enhances benefit finding among women under treatment for early stage breast cancer. *Health Psychology, 20*, 20-32. doi:10.1037/0278-6133.20.1.20
- Aranada, M. P., & Lincoln, K. D. (2011). Financial strain, negative interaction, coping styles, and mental health among low-income latinos. *Race and Social Problems, 3*, 280-297. doi:10.1007/s12552-011-9060-4.
- Aspinwall, L. G., & Taylor, S. E. (1992). Modelling cognitive adaption: a longitudinal investigation of the impact of individual differences and coping on college adjustment and performance. *Journal of Personality and Social Psychology, 63*, 989-1003.
- Australian Government, Australian Institute of Health and Welfare, n.d. *Background to mental health services in Australia*. Retrieved from: <http://mhsa.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=386547056>
- 55
- Baldry, E. (2009). Home Safely: Aboriginal women post prison and their children. *Indigenous Law Bulletin, 7*, 14-17. ISSN: 1328-5475
- Barnett, H., & Lapsley, H. (2006). *Journeys of despair, journeys of hope: Young adults talk about severe mental distress, mental health services and recovery*. Wellington: Mental Health Commission.
- Bell, V., Halligan, P. W., & Ellis, H. D. (2003). Beliefs about delusions. *The Psychologist, 16*, 418-423.

- Bell, V., Halligan, P. W., & Ellis, H. D. (2006). Diagnosing delusions: A review of inter-rater reliability. *Schizophrenia Research, 86*(1-3), 76-79.
- Bellman, S., Forster, N., Still, L., & Cooper, C. L. (2003). Gender differences in the use of social support as a moderator of occupational stress. *Stress and Health, 19*, 45-58. doi:10.1002/smi.954
- Bentall, R. (1992). A proposal to classify happiness as a psychiatric disorder. *Journal of Medical Ethics, 18*, 94-98.
- Bentall, R. B. (2003). *Madness explained: Psychosis and human nature*. London, UK: Penguin Books.
- Ben-Zeev, D., Young, M. A., & Corrigan, P. W. (2010). DSM-V and the stigma of mental illness. *Journal of Mental Health, 19*, 318-327. doi:10.3109/09638237.2010.492484
- Bergin, A. E., Masters, K. S., & Richards, P. S. (1987). Religiousness and mental health reconsidered: A study of an intrinsically religious sample. *Journal of Counselling Psychology, 35*, 197-204
- Buchanan, R. W. (2007). Persistent negative symptoms in schizophrenia: An overview. *Schizophrenia Bulletin, 33*, 1013-1022. doi:10.1093/schbul/sbl057
- Bhandari, N. (2006). Australia: Gov't blamed for abuse of Aboriginal women, children. *Global Information Network*.
<http://www.ipsnews.net/2006/05/australia-ignoring-abuse-of-aboriginal-women-children/>
- Billings, A. G., & Moos, R. H. (1981). The role of coping resources in attenuating the stress of life events. *Journal of Behavioral Medicine, 4*, 139-157. doi:

- Bjorck, J. P., Braese, R.W., Tadie, J. T., & Gililand, D. D. (2010). The Adolescent Religious Coping Scale: Development, Validation, and Cross-Validation. *Journal of Child and Family Studies, 19*, 343-359. doi:10.1007/s10826-009-9305-7
- Bodenmann, G., Charvoz, L., Widmer, K., & Bradbury, T. (2004). Differences in individual and dyadic coping among low and high depressed, partially remitted, and nondepressed persons. *Journal of Psychopathology and Behavioural Assessment, 26*, 75-85. doi:10.1023/B:JOBA.0000013655.45146.47
- Bonanno, G. A., Pat-Horenczyk, R., & Noll, J. (2011). Coping flexibility and trauma: The Perceived Ability to Cope with Trauma (PACT) Scale. *Psychological Trauma: Theory, Research, Practice and Policy*. Advance online publication. doi: 10.1037/a0020921
- Borden, W., & Berlin, S. (1990). Gender, coping and psychological well-being in spouses of older adults with chronic dementia. *American Journal of Orthopsychiatry, 60*, 603-610. doi:10.1037/h0079209
- Borras, L., Mohr, S., Brandt, P. Y., Gillieron, C., Eytan, A., & Huguelet, P. (2007). Religious beliefs in schizophrenia: Their relevance for adherence to treatment. *Schizophrenia Bulletin, 33*, 1238-1246. doi:10.1093/schbul/sbl070
- Boudreaux, E., Catz, S., Ryan, L., Amarai-Melendez, M., & Brantley, P. J. (1995). The Ways of Religious Coping Scale: Reliability validity, and scale development. *Assessment, 2*, 233-244. doi:10.1177/1073191195002003004

- Bourdon, K. H., Rae, D. S., Narrow, W. E., Manderscheid, R. W., & Regier, D. A. (1994). *National prevalence and treatment of mental and addictive disorders*. In R. W. Manderscheid and M.A. Sonnenschein (Eds.) *Mental Health, United States, 1994* (DHHS Publication No. SMA 94-3000, pp. 22-51). Washington, DC: U.S. Government Printing Office.
- Boyle, M. (1990). Is schizophrenia what it was? A re-analysis of Kraepelin's and Bleuler's population. *Journal of the History of the Behavioural Sciences*, 26, 323-333. doi:10.1002/1520-6696(199010)26:4<323::AID-JHBS2300260402>3.0.CO;2-M
- Boyle, M. (1999). Diagnosis. In C. Newnes, G. Holmes & C. Dunn (Eds.), *This is madness; A critical look at psychiatry and the future of mental health services* (pp.75-90). Ross-on-Wye, UK: PCCS BOOKS.
- Boyle, M. (2002). *Schizophrenia: A scientific delusion? (second edition)*. London: Routledge.
- Boyle, M. (2007). The problem with diagnosis. *The Psychologist*, 20, 290-292.
- Boyle, M. (2011). Making the world go away and how psychology and psychiatry benefit. In M. Rapley, J. Moncrieff & J. Dillon (Eds.), *De-medicalizing misery: Psychiatry, psychology and the human condition* (pp. 27-43). Basingstoke, UK: Palgrave MacMillan.
- Bracken, P., Thomas, P., Timimi, S., Asen, E., Behr, G., Beuster, C. . . . Yeomans, D. (2012). Psychiatry beyond the current paradigm. *The British Journal of Psychiatry*, 201, 430-434.
doi:10.1192/bjp.bp.112.109447
- Bracken, P. (2001). Postpsychiatry: A new direction for mental health. *British Medical Journal*, 322, 724-727.

- Bracken, P., & Thomas, P. (2005). *Postpsychiatry: Mental health in a postmodern world*. Oxford, UK: Oxford University Press.
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*, 77-101.
doi:10.1191/1478088706qp063oa
- Breggin, P. (1991). *Toxic psychiatry: Drugs and electroconvulsive therapy: The truth and the better alternatives*. NY: St Martin's Press.
- Breggin, P. R. (2008). *Medication madness: A psychiatrist exposes the dangers of mood-altering medications*. NY: St Martin's Press.
- Brown, A. L. (2012). Report released after Fremantle Hospital suicide spate. Retrieved from <http://www.watoday.com.au/wa-news/report-released-after-fremantle-hospital-suicide-spate-20120703-21fa5.html>
- Brown, S. (1994). Factor Structure of a brief version of the Ways Of Coping Questionnaire (WOC): A study with veterinary medicine students. *Measurement & Evaluation in Counseling and Development, 27*, 308-315.
- Busch, S. H., Frank, R., Leslie, L., Martin, A., Rosenheck, R.A., Martin, E. G., & Barry, C. I. (2010). Antidepressants and suicide risk: How did specific information in FDA safety warnings affect treatment patterns? *Psychiatric Services, 61(1)*, 1-6.
- Carpinello, S. E., Knight, E. L., Markowitz, F. E., & Pease, E. A. (2000). The development of the mental health confidence scale: A measure of self-efficacy in individuals diagnosed with mental disorders. *Psychiatric Rehabilitation Journal, 23*, 236-243.

- Carr, V. (1988). Patients' techniques for coping with schizophrenia: An exploratory study. *British Journal of Medical Psychology*, *61*, 339-352. doi:10.1111/j.2044-8341.1988.tb02796.x
- Carver, C. S. (1997). You want to measure coping but your protocol's too long: Consider the Brief COPE. *International Journal of Behavioral Medicine*, *4*, 92-100. doi:10.1207/s15327558ijbm0401_6
- Carver, C. S., & Connor-Smith, J. (2010). Personality and coping. *Annual Review of Psychology*, *61*, 679-704. doi:10.1146/annurev.psych.093008.100352
- Carver, C. S., & Scheier, M. F. (1994). Situational coping and coping dispositions in a stressful transaction. *Journal of Personality and Social Psychology*, *66*, 184-195. doi:10.1037/0022-3514.66.1.184
- Carver, C. S., Scheier, M. F., Weintraub, J., K., & Jagdish, K. (1989). Assessing coping strategies: A theoretically based approach. *Journal of Personality and Social Psychology*, *56*, 267-283. doi:10.1037/0022-3514.56.2.267
- Chamberlin, J. (1994). II. A psychiatric survivor speaks out. *Feminism & Psychology*, *4*, 284-287. doi:10.1177/0959353594042008
- Chang, Y., Lan, Y. L., Lin, H. Y., & Heppner, P. P. (2012). Psychometric analyses of the Problem-Focused Style of Coping (PF-SOC) Scale with Taiwanese samples. *Journal of Psychoeducational Assessment*, *30*, 171-180. doi:10.1177/0734282911410410
- Clark, L. A. (2006). The role of moral judgment in personality disorder diagnosis. *Journal of Personality Disorders*, *20*, 184-185. doi:10.1521/pedi.2006.20.2.184

- Coan, R. (1973). Personality variables associated with cigarette smoking. *Journal of Personality and Social Psychology, 26*, 86-104.
doi:10.1037/h0034213
- Cohen, C. J., & Berk, C. A. (1985). Personal coping styles of schizophrenic outpatients. *Hospital and Community Psychiatry, 36*, 407-410.
- Cohen, L. H., McGowan, J., Fooskas, S., & Rose, S. (1984). Positive life events and social support and the relationship between life stress and psychological disorder. *American Journal of Community Psychology, 12*, 567-587.
- Cohen, L. H., Towbes, L. C., & Flocco, R. (1988). Effects of induced mood on self-reported life events and perceived and received social support. *Journal of Personality and Social Psychology, 55*, 669-674.
- Combs, G. & Freedman, J. (2012). Narrative, poststructuralism, and social justice: Current practices in narrative therapy. *The Counseling Psychologist, 40*, 1033-1060. doi:10.1177/0011000012460662
- Cosgrove, L., Krimsky, S., & Vijayaraghavan, M. (2006). Financial ties between the DSM-IV panel members and the pharmaceutical industry. *Psychotherapy and Psychosomatics, 75*, 154-160.
- Coyne, J. C., & Gottlieb, B. H. (1996). The mismeasurement of coping by checklist. *Journal of Personality, 64*, 959-991. doi:10.1111/j.1467-6494.1996.tb00950.x
- Coyne, J. C., & Racioppo, M. W. (2000). Never the twain shall meet? Closing the gap between coping research and clinical intervention research. *American Psychologist, 55*, 655-664. doi: 10.1037//0003-066X.55.6.655

- Cramer, P. (2000). Defence mechanisms in psychology today: Further processes for adaptation. *American Psychologist*, *55*, 637-646. doi:10.1037/0003-066X.55.6.637
- Creaney, W., Murray, I., & Healy, D. (1991). Antidepressant induced suicidal ideation. *Human Psychopharmacology*, *6*, 329-332.
doi:10.1002/hup.470060411
- Cromby, J., & Harper, D. (2009). Paranoia: A social account. *Theory Psychology*, *19*, 335-361. doi:10.1177/0959354309104158
- Crossley, D. (1995). Religious experience within mental illness: Opening the door on research. *British Journal of Psychiatry*, *166*, 284-286.
doi:10.1192/bjp.166.3.284
- Crossley, M. L., & Crossley, N. (2001). 'Patient' voices, social movements and the habitus; how psychiatric survivors 'speak out'. *Social Science & Medicine*, *10*, 1477-1489. doi:10.1016/S0277-9536(00)00257-4
- Cummins, R. C. (1988). Perceptions of social support, receipt of supportive behaviours and locus of control as moderators of the effects of chronic stress. *American Journal of Community Psychology*, *16*, 685-700.
- Curlin, F. A., Serrano, K. D., Baker, M. G., Carricaburu, S. L., Smucker, D. R., & Chin, M. H. (2006). Following the call: How providers make sense of their decisions to work in faith-based and secular urban community health centers. *Journal of Health Care for the Poor and Underserved*, *17*, 944-957. doi:10.1370/afm.677
- Cutting, J., & Dunne, F. (1989). Subjective experience of schizophrenia. *Schizophrenia Bulletin*, *15*, 217-231. doi:10.1093/schbul/15.2.217

- Davies, P., Thomas, P., & Leudar, I. (1999). *Dialogical engagement with voices: A single case study*. *British Journal of Medical Psychology*, *72*, 179-187.
- DeJong, T. M., & Overholser, J. C. (2007). Coping Attitudes Scale: Psychometric properties of a measure of positive attitudes in depression. *Cognitive Therapy & Research*, *31*, 39-50. doi:10.1007/s10608-006-9059-0
- De Ridder, D. (1997). What is wrong with coping assessment? A review of conceptual and methodological issues. *Psychology and Health*, *12*, 417-431. doi:10.1080/08870449708406717
- De Ridder, D., & Schreurs, K. (2001). Developing interventions for chronically ill patients: Is coping a helpful concept? *Clinical Psychology Review*, *21*, 205-240. doi: 10.1016/S0272-7358(99)00046-X
- Dexter, G., Larkin, M., & Newnes, C. (2011). A qualitative exploration of child clinical psychologists' understanding of user involvement. *Clinical Child Psychology and Psychiatry*, *17*, 246-265. doi: 10.1177/1359104511400970
- Double, D. B. (2002). The limits of psychiatry. *British Medical Journal*, *324*, 900-904. doi:http://dx.doi.org/10.1136/bmj.324.7352.1523
- Double, D. B. (2006). Historical perspectives on anti-psychiatry. In D. B. Double, (Ed.), *Critical psychiatry: The limits of madness*. (pp.19-40). Basingstoke, UK: Palgrave Macmillan.
- Ebata, A. T., & Moos, T. (1991). Coping and adjustment in distressed and healthy adolescents. *Journal of Applied and Developmental Psychology*, *12*, 33-54.
- Elderman, S. (2013). *Change your thinking. Third edition*. Australia: ABC Books.

- Elklit, A. (1996). Coping Styles questionnaire: a contribution to the validation of a scale for measuring coping strategies. *Personality and Individual Differences, 21*, 809-812. doi:10.1016/0191-8869(96)00123-7
- Endler, N. S., Kantor, L., & Parker, J. D. A. (1994). State-trait coping, state-trait anxiety and academic performance. *Personality and Individual Differences, 16*, 663-670. doi:10.1016/0191-8869(94)90208-9
- Endler, N. S., & Parker, J. D. A. (1990). Multidimensional assessment of coping: A critical evaluation. *Journal of Personality & Social Psychology, 58*, 844-854. doi:10.1037/0022-3514.58.5.844
- Endler, N. S., & Parker, J. D. A. (1994). Assessment of multidimensional coping: Task, emotion and avoidance strategies. *Psychological Assessment, 6*, 50-60. doi: 10.1037/1040-3590.6.1.50
- Ensink, B. (1993). Trauma: A study of child abuse and hallucinations. In M. Romme & S. Escher (Eds.), *Accepting voices* (pp. 165-171). London: MIND Publications.
- Epstein, S., & Katz, L. (1992). Coping, ability, stress, productive load, and symptoms. *Journal of Personality and Social Psychology, 62*, 813-825. doi:10.1037/0022-3514.62.5.813
- Estroff, S.E., Lachicotte, W.S., Illingworth, L.C., & Johnston, A. (1991). Everybody's got a little mental illness: Accounts of illness and self among people with severe, persistent mental illness. *Medical Anthropology Quarterly, 5*, 331-369.
- Falloon, I. R. H., & Talbot, T. (1981). Persistent auditory hallucinations: Coping mechanisms and implications for management. *Psychological Medicine, 11*, 329-339.

- Farhall, J., & Cotton, S. (2002). Implementing psychological treatment for symptoms of psychosis in an area mental health service: The response of patients, therapists and managers. *Journal of Mental Health, 11*, 511-522. doi:10.1080/09638230020023868
- Field, A. (2013). *Discovering statistics using IBM SPSS statistics*. London: SAGE publications Ltd.
- Felsten, G. (1998). Gender and coping: Use of distinct strategies and associations with stress and depression. *Anxiety Stress and Coping, 11*, 289-309. doi:10.1080/10615809808248316
- Fenn, K., & Byrne, M. (2013). The key principles of cognitive behavioural therapy. *InnovAiT, 6*, 579-585. doi:10.1177/1755738012471029
- Fenton, W. S., Blyer, C. R., & Heinssen, R. K. (1997). Determinants of medication compliance in schizophrenia: Empirical and clinical findings. *Schizophrenia Bulletin, 23*, 637-651.
- Ferguson, E. (2001). Personality and coping traits: A joint factor analysis. *British Journal of Health Psychology, 6*, 311-325. doi:10.1348/135910701169232
- Fledderus, M., Bohlmeijer, E. T., & Pieterse, M. E. (2010). Does experiential avoidance mediate the effects of maladaptive coping styles on psychopathology and mental health? *Behavior Modification, 34*, 503-519. doi:10.1177/0145445510378379
- Folkman, S. (2010). Stress, coping, and hope. *Psycho-Oncology, 19*, 901-908. doi:10.1002/pon.1836
- Folkman, S., & Lazarus, R. S. (1980). An analysis of coping in a middle-aged community sample. *Journal of Health and Social Behaviour, 21*, 219-239.

- Folkman, S., & Lazarus, R. S. (1985). If it changes it must be a process: Study of emotion and coping during three stages of a college examination. *Journal of Personality and Social Psychology*, *48*, 150-170. doi:10.1037/0022-3514.48.1.150
- Folkman, S., Lazarus, R. S., Pimley, S., & Novacek, J. (1987). Age differences in stress and coping processes. *Psychology and Aging*, *2*, 171-184. doi:10.1037/0882-7974.2.2.171
- Folkman, S., & Lazarus, R. S. (1984). *Stress, appraisal, and coping*. New York: Springer Publishing Company.
- Folkman, S., & Lazarus, R. S. (1988). *Manual for the Ways of Coping Questionnaire*. Palo Alto, CA: Consulting Psychologist Press.
- Folkman, S., & Lazarus, R. S. (1988). Coping as a mediator of emotion. *Journal of Personality and Social Psychology*, *54*, 466-475. doi:10.1037/0022-3514.54.3.466
- Folkman, S., & Moskowitz, T. (2004). Coping: pitfalls and promise. *Annual Reviews of Psychology*, *55*, 745-774. doi:10.1146/annurev.psych.55.090902.141456
- Ford, G. G., & Procidano, M. E. (1990). The relationship of self-actualisation to social support, life stress and adjustment. *Social Behaviour and Personality*, *18*, 41-51.
- Foucault, M. (1967). *Madness and civilization: A history of insanity in the age of reason*. London: Routledge.
- Frances, A., & Chapman, S. (2013). DSM-5 somatic symptom disorder mislabels medical illness as mental disorder. *Australian and New Zealand Journal of Psychiatry*, *47*, 483-484. doi:10.1177/0004867413484525

- Freedman, J., & Combs, G. (1996). *Narrative therapy: The social construction of preferred realities*. New York: W. W. Norton.
- Freud, A. (1968). *The ego and the mechanisms of defence* (Rev.ed). London: Hogarth Press [for] the Institute of Psycho-Analysis.
- Frydenberg, E., & Lewis, R. (1993). *Manual: The Adolescent Coping Scale*. Melbourne, Australia: Australian Council for Educational Research (ACER) Press.
- Frydenberg, E., & Lewis, R. (1994). Coping with different concerns: Consistency and variation in coping strategies used by adolescents. *Australian Psychologist*, 29, 45-48. doi:10.1080/00050069408257320
- Frydenberg, E., & Lewis, R. (1997). *Coping Scale for Adults: Administrator's manual*. Melbourne, Australia: The Australian Council for Educational Research (ACER) Press.
- Frydenberg, E., & Lewis, R. (2000). *The coping scale for adults: Construct validity and what the instrument tells us*. Paper presented at the Annual Meeting of the American Educational Research Association Conference, New Orleans April 2000.
- Frydenberg, E., & Lewis, R. (2002a). The Coping Scale for Adults: Correlates of productive and non-productive coping. *The Australian Educational and Developmental Psychologist*, 1, 5-17.
- Frydenberg, E., & Lewis, R. (2002b). Do managers cope productively?: A comparison between Australian middle level managers and adults in the general community. *Journal of Managerial Psychology*, 17, 640-654. doi:10.1108/02683940210450466

- Galasinski, D., & Opalinski, K. (2012). Psychiatric accounts of insight. *Qualitative Health Research, 22*, 1460-1467.
doi:10.1177/1049732312450283
- Gan, Y., Guo, M., & Tong, J. (2013). Scale development of Meaning-Focused Coping. *Journal of Loss and Trauma, 18*, 10-26.
doi:10.1080/15325024.2012.678780
- Gardiner, J., & Hill, O. W. (1994). Compliance with depot medication and readmission to hospital of patients with schizophrenia. *Psychiatric Bulletin, 18*, 660-661. doi:10.1192/pb.18.11.660
- Gardiner, M., & Tiggemann, M. (1999). Gender differences in leadership style, job stress and mental health in male-and female-dominated industries. *Journal of Occupational and Organizational Psychology, 72*, 301-315.
doi:10.1348/096317999166699
- Garety, P. (1985). Delusions: Problems in definition and measurement. *British Journal of Medical Psychology, 58*, 25-34.
- Geisner, I. M., Neighbors, C., & Larimer, M. E. (2006). A randomized trial of a brief, mailed intervention for symptoms of depression. *Journal of Counselling and Clinical Psychology, 74*, 393-399. doi:10.1037/0022-006X.74.2.393
- Gettis, A. (1987). The Jesus delusion: A theoretical and phenomenological look. *Journal of Religion and Health, 26*, 131-136. ISSN 0022-4197, 07/1987
- Goldstein, J. M., & Lewine, R. R. (2000). Overview of sex differences in schizophrenia: Where have we been and where do we go from here? In D. Castle, J. McGrath & J. Kulkarni (Eds.), *Women and Schizophrenia* (pp.111-143). Cambridge: Cambridge University Press.

- Goodwin, I., Holmes, G., Newnes, C., & Waltho, D. (1999). A qualitative analysis of the views of in-patient mental health service users. *Journal of Mental Health, 8*, 43-54.
- Gorman, D., Brough, M., & Ramirez, E. (2003). How young people from culturally and linguistically diverse backgrounds experience mental health: Some insights for mental health nurses. *International Journal of Mental Health Nursing, 12*, 194-202. doi:10.1046/j.1440-0979.2003.00289.x
- Granovetter, M. (1982). The strength of weak ties: A network theory revisited. In P.V Marsden & N. Lin (Eds.), *Social structure and network analysis*. Beverly Hills: Sage.
- Greenglass, E. (1993). The contribution of social support to coping strategies. *Applied Psychology: An International Review, 42*, 323-340.
- Greer, T. M. (2012). Coping strategies as moderators of the relation between individual race-related stress and mental health symptoms for African American women. *Psychology of Women Quarterly, 35*, 215-226.
- Guadagnoli, E., & Velicer, W. F. (1988). Relation of sample size to the stability of component patterns. *Psychological Bulletin, 103*, 265-275.
- Hallam, R. S. (2007). Coping, conversation tactics and marital interaction in persons with acquired profound hearing loss (APHL): Correlates of distress. *Audiological Medicine, 103*-111.
doi:10.1080/16513860701223060
- Hallam, R. S. (2009). *Virtual selves, real persons*. Cambridge, UK: Cambridge University Press.

- Hallam, R. S. (2013). *Individual case formulation: Practical resources for the mental health professional*. Academic Press: London.
- Hallam, R., & Bender, M. (2011). *David's box: The journals and letters of a young man diagnosed as schizophrenic, 1960-1971*. London, UK: Polpresa Press.
- Hansen, S., McHoul, A., & Rapley, M. (2003). *Beyond help: A consumers' guide to psychology*. United Kingdom: PCCS Books Llangarron Ross-on-Wye Herefordshire.
- Harper, D. J. (1996). Deconstructing 'paranoia': Towards a discursive understanding of apparently unwarranted suspicion. *Theory Psychology*, 6, 423-448.
- Harper, D. J. (1999). *Deconstructing Paranoia: An analysis of the discourses associated with the concept of paranoid delusion*. PhD thesis, Manchester Metropolitan University.
- Harper, D. (2013). Reflections on qualitative research in clinical psychology training. *Journal of Critical Psychology, Counselling and Psychotherapy*, 13, 42-46.
- Harper, D. (2012). The sad truth about the action for happiness movement, *Society, The Guardian*, 2-5. Retrieved from:
<http://www.theguardian.com/society/2012/feb/21/sad-truth-action-for-happiness-movement>
- Hasson-Ohayon, I., Roe, D., & Kravetz, S. (2006). A qualitative approach to the evaluation of psychosocial interventions for persons with severe mental illness. *Psychological Services*, 3, 262-273. doi:10.1037/1541-1559.3.4.262

- Healy, D. (2002). *The creation of psychopharmacology*. USA: Harvard University Press.
- Healy, D., & Aldred, G. (2005). Antidepressant drug use & the risk of suicide. *International Review of Psychiatry, 17*, 163-172.
doi:10.1080/09540260500071624
- Healy, D. (2013). *Pharmageddon*. Berkeley, CA: University of California Press.
- Hobfoll, S. E. (1986). *Stress, social support and women*. NY: Hemisphere Publishing Corporation.
- Hobfoll, S. E. (1989). Conservation of resources: A new attempt at conceptualising stress. *American Psychologist, 44*, 513-524.
doi:10.1037/0003-066X.44.3.513
- Hobfoll, S. E. (2001). The influence of culture, community, and the nested-self in the stress process: Advancing conservation of resources theory. *Applied Psychology: An International Review, 50*, 337-421.
doi:10.1111/1464-0597.00062
- Hoffer, A. (1973). A neurological form of schizophrenia. *Canadian Medical Association, 108*, 186-194.
- Holahan, C. J., & Moos, R. H. (1987). Personal and contextual determinants of coping strategies. *Journal of Personality and Social Psychology, 52*, 946-955. doi:10.1037/0022-3514.52.5.946
- Holahan, C. J., & Moos, R. H. (1990). Life stressors, resistance factors, and improved psychological functioning: An extension of the stress-resistance paradigm. *Journal of Personality and Social Psychology, 58*, 909-917.

- Holahan, C. J., Moos, R. H., Holahan, C. K., Cronkite, R. C., & Randall, P. K. (2003). Drinking to cope and alcohol use and abuse in unipolar depression: A 10-year model. *Journal of Abnormal Psychology, 112*, 159-165. doi:10.1037/0021-843X.112.1.159
- Holahan, C. J., Pahl, S. A., Cronkite, R. C., Holahan, C. K., North, R. J. & Moos, R. H. (2010). Depression and vulnerability to incident physical illness across 10 years. *Journal of Affective Disorders, 123*, 222-229. doi:10.1016/j.jad.2009.10.006
- Holland, C., Dudgeon, P., & Milroy, H. (2013). The mental health and social and emotional wellbeing of Aboriginal and Torres Strait Islander Peoples, families and communities- supplementary paper to: *A contributing Life: the 2012 National Report Card of Mental Health and Suicide Prevention, for the National Mental health Commission, March (2013) updated May 2013*. Retrieved from: [http://www.mentalhealthcommission.gov.au/media/56367/27%20May%202013%20FINAL%20SUPPLEMENTARY%20PAPER%20\(2\).pdf](http://www.mentalhealthcommission.gov.au/media/56367/27%20May%202013%20FINAL%20SUPPLEMENTARY%20PAPER%20(2).pdf)
- House, J. S., Umberson, D., & Landis, K.R. (1988). Structures and processes of social support. *Annual Review of Sociology, 14*, 293-318.
- Hoven, C.W., Duarte, C.S., Lucas, C.P., Wu, P., Mandell, D.J., Goodwin, R.D., Cohen, M., Balaban, V., Woodruff, B.A., Bin, F., Musa, G.J., Mei, L., Cantor, P.A., Aber, J.L., Cohen, P., Susser, E., (2005). Psychopathology among New York City public school children six months after September 11. *Archives of General Psychiatry 62*, 545–552.
- Hudson, M. (1999). Psychiatric hospitals and patients' councils. In C. Newnes, G. Holmes & C. Dunn (Eds.), *This is madness; A critical look at psychiatry*

and the future of mental health services (pp.135-147). Ross-on-Wye, UK:
PCCS Books.

Hwang, K. K. (1977). The patterns of coping strategies in a Chinese society.
Acta Psychologica Taiwanica, *19*, 61-73.

Hyman, S. E. (2002). Neuroscience, genetics, and the future of psychiatric
diagnosis. *Psychopathology*, *35*, 139-144. doi:10.1159/000065134

Hyman, S. E. (2008). *A glimmer of light for neuropsychiatric disorder*. *Nature*,
455, 890-893. doi:10.1038/nature07454

Insel, T. (2010). Rethinking schizophrenia. *Nature*, *468*, 187-193.
doi:10.1038/nature09552

Iwanaga, M., Yokoyama, H., & Seiwa, H. (2004). Coping availability and stress
reduction for optimistic and pessimistic individuals. *Personality and
Individual Differences*, *36*, 11-22. doi:10.1016/S0191-8869(03)00047-3.

Iwasaki, Y., MacTavish, J., & MacKay, K. (2005). Building on strengths and
resilience: Leisure as a stress survival strategy. *British Journal of
Guidance and Counselling*, *33*, 81-100.
doi:10.1080/03069880412331335894

Jablensky, A., McGrath, J., Herrman, H., Castle, D., Gureje, O., Morgan, V., &
Korten, A. (1999). *National survey of mental health and wellbeing.
Report 4. People living with psychotic illness: An Australian study 1997-
98*. Canberra, ACT: Commonwealth of Australia.

Jacobs, D. H. (2009). Is a correct psychiatric diagnosis possible? Major
depressive disorder as a case in point. *Ethical Human Psychology and
Psychiatry*, *11*, 83-96. doi: 10.1891/1559-4343.11.2.83

- Johnstone, L. (1999). Do families cause “schizophrenia”? Revisiting a taboo subject. In C. Newnes, G. Holmes & C. Dunn (Eds.), *This is madness; A critical look at psychiatry and the future of mental health services* (pp.119-134). Ross-on-Wye, UK: PCCS Books.
- Johnstone, L. (2011). Can traumatic events traumatize people? Trauma, madness and “psychosis”. In M. Rapley, J. Moncrieff & J. Dillon (Eds.), *De-medicalizing misery: Psychiatry, psychology and the human condition* (pp. 99-109). Basingstoke: Palgrave MacMillan.
- Joiner, T. E., Brown, J. S., Perez, M. Sethuraman, G., & Sallee, F. R. (2005). The illusion of mental health: In the mind of which beholder? *Journal of Personality Assessment, 85*, 92-97.
- Jones, S., & Hayward, P. (2004). *Coping with schizophrenia: A guide for patients, families and caregivers*. Oxford UK: Oneworld.
- Kanfer, F., & Saslow, G. (1965). Behavioral analysis: An alternative to diagnostic classification. *Archives of General Psychiatry, 12*, 529-538.
doi:10.1001/archpsyc.1965.01720360001001
- Kashdan, T. B., Barrios, V., Forsyth, J. P., & Steger, M. F. (2006). Experiential avoidance as generalised psychological vulnerability: Comparisons with coping and emotion regulation strategies. *Behaviour Research and Therapy, 44*, 1301-1320. doi:10.1016/j.brat.2005.10.003
- Kennedy, N., Boydell, J., Kalidindi, S., Fearon, P., Jones, P., Van Os, J., & Murray, R.M. (2005). Gender differences in incidence and age at onset of mania and bipolar disorder over a 35-year period in Camberwell, England. *American Journal of Psychiatry, 162*, 257-262.
doi:10.1176/appi.ajp.162.2.257

- Kessing, L.V. (2005). Gender differences in patients presenting with a single depressive episode according to ICD-10. *Social Psychiatry and Psychiatric Epidemiology*, 40, 197-201.
- Kessler, R. C. (2006). The epidemiology of depression among women. In C. L. M. Keyes, & S. H. Goodman (Eds.), *Women and Depression: A handbook for the social, behavioural and biomedical sciences* (pp. 22-37). Cambridge: Cambridge University Press.
- Keyes, C. L. M. (2007). Promoting and protecting mental health as flourishing: A complimentary strategy for improving national mental health. *American Psychologist*, 62, 95-108. doi:10.1037/0003-066X.62.2.95
- Keyes, K. M., Eaton, N. R., Krueger, R. F., McLaughlin, K. A., Wall, M. M., Grant, B. F., & Hasin, D. S. (2012). Childhood maltreatment and the structure of common psychiatric disorders. *The British Journal of Psychiatry*, 200, 107-115. doi:10.1192/bjp.bp.111.093062
- Kiecolt-Glaser, J. K., McGuire, L., Robles, T. F., & Glaser, R. (2002). Emotions, morbidity, and mortality: New perspectives from psychoneuroimmunology. *Annual Review of Psychology*, 53, 83-107. doi:10.1146/annurev.psych.53.100901.135217
- Kinderman, P. (2009). Understanding and addressing psychological and social problems: the mediating psychological processes model. *International Journal of Social Psychiatry*, 55, 464-470. doi:10.1177/0020764008097757
- Kinderman, P., Read, J., Moncrieff, J., & Bentall, R.P. (2013). Drop the language of disorder. *Evidence Based Mental Health*, 16, 2-3. doi:10.1136/eb-2012-100987.

- Kleinman, A. (1977). Depression, somatisation and the new 'cross-cultural psychiatry'. *Social Science and Medicine*, 11, 3-10.
- Klerman, G. L. (1978). The evolution of a scientific nosology. In J.C. Shershow, (Ed.), *Schizophrenia: Science and practice*. (99-121). London, UK: Harvard University Press.
- Kline, P. (1993). *The handbook of psychological testing*. London: Routledge.
- Koeing, H. G. (2009). Research on religion, spirituality and mental health: A review. *Canadian Journal of Psychiatry*, 54, 283-291.
- Kowanko, I., De Crespigny, C., Murray, H., Groenkjaer, M., & Emden, C. (2004). Better medication management for Aboriginal people with mental health disorder: a survey of providers. *Australian Journal of Rural Health*, 12, 253-257. doi:10.1111/j.1440-1854.2004.00625.x
- Kraepelin, E. (1899). *Psychiatrie: ein Lehrbuch für Studierende und Ärzte* (6th edn). Leipzig: Barth Verlag. Reprinted (1990) as *Psychiatry: a textbook for students and physicians* (ed. J.M. Quen; trans. H. Metoiu & S. Ayed). Canton, MA: Science History Publications.
- Kutchins, H., & Kirk, S. A. (1989). DSM-III-R: The conflict over new psychiatric diagnoses. *Health and Social Work*, 14, 91-101.
- Kutchins, H., & Kirk, S. A. (Eds.) (1997). *Making us crazy: DSM- The psychiatric bible and the creation of mental disorder*. London: Constable and Company Limited.
- Labouvie-Vief, G., Hakim-Larson, J., & Hobart, C. J. (1987). Age, ego level and the life span development of coping and defense processes. *Psychology and Aging*, 2, 286-293.
- Laing, D. D. (1960). *The divided self: An existential study in sanity and madness*.

London: Penguin Group.

- Lamba, G., & Ellison, J. M. (2012). Religion/spirituality and depression. *The American Journal of Psychiatry*, *169*, 433.
doi:10.1176/lappi.2012.12010006
- Lane, C. (2012). DSM-5 is diagnosed, with a stinging rebuke to the APA. *Psychology Today*.
- Lapidus, L. B., Shin, S., & Hutton, E.M. (2001). An evaluation of a six-week intervention designed to facilitate coping with psychological stress. *Journal of Clinical Psychology*, *57*, 1381-1401. doi:10.1002/jclp.1104
- Larkin, W., & Morrison, A. P. (2006). *Trauma and psychosis: New directions for theory and therapy*. London: Routledge.
- Larkin, W., & Read, J. (2008). Childhood trauma and psychosis: Evidence, pathways, and implications. *Journal of Postgraduate medicine*, *54*, 287-293.
- Lawrence, J., Ashford, K., & Dent, P. (2006). Gender differences in coping strategies of undergraduate students and their impact on self-esteem and attainment. *Active Learning in Higher Education*, *7*, 273-281.
doi:10.1177/1469787406069058
- Lawrence, R. E., & Curlin, F. A. (2009). Autonomy, religion and clinical decisions: Findings from a national physician survey. *Journal of Medical Ethics*, *35*, 214-218. doi:10.1136/jme.2008.027565
- Layard, R. (2006) The case for psychological treatment centres. *British Medical Journal*, *332*, 1030-32.
- Lazarus, R. S. (1966). *Psychological stress and the coping process*. New York: McGraw-Hill.

- Lazarus, R. S. (1999). *Stress and emotion: A new synthesis*. New York: Springer Publishing Company.
- Lazarus, R. S. (2000). Toward better research on stress and coping. *The American Psychologist*, *55*, 665-673. doi:10.1037/0003-066X.55.6.665
- Lazarus, R. S., & Folkman, S. (1984). *Stress, appraisal, and coping*. New York: Springer Publishing Company.
- Lazarus, R. S., & Launier, R. (1978). Stress-related transactions between person and environment. In A. Pervin & M. Lewis (Eds.), *Perspectives in International Psychology*, (pp. 287-327). New York: Plenum.
- Lewis, R., Romi, S., & Roache, J. (2011). Coping styles as mediators of teachers' classroom management techniques. *Research in Education*, *85*, 53-68.
- Littlewood, J. L., Cramer, D., Hoekstra, J., & Humphrey, G. B. (1991). Gender differences in parental coping following their child's death. *British Journal of Guidance and Counselling*, *19*, 139-148.
- Littlewood, R. (1990). From categories to contexts: A decade of the "new cross-cultural psychiatry". *British Journal of Psychiatry*, *156*, 308-327.
- Lysaker, P. H., Bryson, G. J., Marks, K., Greig, T. C., & Bell, M. D. (2004). Coping style in schizophrenia: Associations with neurocognitive deficits and personality. *Schizophrenia Bulletin*, *30*, 113-145.
- Lysaker, P.H., Davis, L.W., Lightfoot, J., Hunter, N., & Stasburger, A. (2005). Association of neurocognition, anxiety, positive and negative symptoms with coping preference in schizophrenia spectrum disorder. *Schizophrenia Research*, *80*, 163-171. doi:10.1016/j.schres.2005.07.005

- Madness. (n.d.). In Oxford Dictionary (British and World English). Retrieved from:<http://www.oxforddictionaries.com/definition/english/madness?q=madness>
- Mackay, C., & Pakenham, K. L. (2012). A stress and coping model of adjustment to caring for an adult with mental illness. *Normative Mental Health Journal, 48*, 450-462. doi:10.1007/s10597-011-9435-4
- Macneil, C. A., Hasty, M., Conus, P., & Berk, M. (2012). Is diagnosis enough to guide interventions in mental health? Using case formulation in clinical practice. *BCM Medicine, 10*, 111. doi:10.1186/1741-7015-10-111
- Main, A., Zhou, Q., Ma, Y., Luecken, L. J., & Liu, X. (2011). Relations of SARS-related stressors and coping to Chinese college students' psychological adjustment during the Beijing SARS epidemic. *Journal of Counselling Psychology, 58*, 410-423. doi:10.1037/a0023632
- Martin, J. K., Pescosolido, B. A., & Tuch, S. A. (2000). Of fear and loathing: The role of 'disturbing behavior' labels, and causal attributions in shaping public attitudes toward people with mental illness. *Journal of Health and Social Behavior, 41*, 208-223.
- Masson, J. M. (1988). *Against therapy*. Monroe, ME: Common Courage Press.
- Matud, M. P. (2004). Gender differences in stress and coping styles. *Personality and Individual Differences, 37*, 1401-1415. doi:10.1016/j.paid.2004.01.010
- McAll, R. K. (1971). Demonosis or the possession syndrome. *International Journal of Social Psychiatry, 17*, 150-158.
- McCarthy, C. J., Lambert, R. G., & Moller, N. P. (2006). Preventive resources and emotion regulation expectancies as mediators between attachment

- and college students' stress outcomes. *International Journal of Stress Management*, *13*, 1-22. doi: 10.1037/1072-5245.13.1.1
- McCull, M. A., Hau, L., & Skinner, H. (1995). Structural relationships between social support and coping. *Social Science Medicine*, *41*, 395-407. doi:10.1016/0277-9536(94)00338-T
- McCrae, R. R. (1984). Situational determinants of coping responses: Loss, threat, and challenge. *Journal of Personality and Social Psychology*, *46*, 919-928. doi:10.1037/0022-3514.46.4.919
- McCrae, R. R., & Costa, R. T. (1986). Personality, coping, and coping effectiveness in an adult sample. *Journal of Personality*, *54*, 385-405.
- McGrath, J., Sukanta, S., Welham, J., El-Saadi, O., MacCauley, C., & Chant, D. (2004). A systematic review of the incidence of schizophrenia: the distribution rates and the influence of sex, urbanicity, migrant status and methodology. *BMC Medicine*, *2*, 1-22. doi:10.1186/1741-7015-2-13
- McGreal, D., Evans, B. J., & Burrows, G. D. (1997). Gender differences in coping following loss of a child through miscarriage or stillbirth: A pilot study. *Stress Medicine*, *13*, 159-165. doi:10.1002/(SICI)1099-1700(199707)13:3<159::AID-SMI734>3.0.CO;2-5
- McHoul, A., & Rapley, M. (2003a). What can psychological terms actually do? (Or if Sigmund calls, tell him it didn't work). *Journal of Pragmatics*, *35*, 507-522. doi:10.1016/S0378-2166(02)00103-0
- McHoul, A., & Rapley, M. (2003b). Call me mad, but... *Meanjin*, *62*, 214-224.
- Melendez, J. C., Mayordomo, T., Sancho, P., & Tomas, J. M. (2012). Coping strategies: Gender differences and development throughout life span. *The*

Spanish Journal of Psychology, 15, 1089-1098.

doi:10.5209/rev_SJOP.2012.v15.n3.39399

Menninger, K. (1963). *The vital balance: The life process in mental health and illness*. New York: The Viking Press.

Mental Health Council of Australia (MHCOA) n.d, Retrieved from:

<http://www.mhca.org.au/>

Mental Health Council of Australia (MHCOA). (2005) *Not for Service:*

Experiences of injustice and despair in mental health care in Australia,

Retrieved from:

<http://www.mhca.org.au/index.php/component/search/?searchword=Not%20for%20service:%20exp&searchphrase=all>

Meyer, B. (2001). Coping with severe mental illness: Relations of the Brief

COPE with symptoms, functioning, and well-being. *Journal of*

Psychopathology & Behavioral Assessment. 23, 265-277.

doi:10.1023/A:1012731520781

Miller, S. M. (1987). Monitoring and blunting: Validation of a questionnaire to assess styles of information seeking under threat. *Journal of Personality and Social Psychology*, 52, 345-353.

Monat, A., & Lazarus, R. S. (1991). *Stress and Coping: an anthology*. New York: Columbia University Press.

Monat, A., Lazarus, R. S., & Reevey, G. M. (Eds.). (2007). *The Praeger handbook on stress and coping* (Vol.1). Westport CT: Praeger Publishers.

Moncrieff, J. (2008). *The myth of the chemical cure: A critique of psychiatric drug treatment*. London: Palgrave Macmillan.

- Moncrieff, J. (2010). Psychiatric diagnosis as a political device. *Social Theory & Health, 8*, 370–382. doi:10.1057/sth.2009.11
- Moncrieff, J. (2013a). Miracle cures for modern day woes: The rise of prescription drug use and psychiatric diagnoses. *Journal of Critical Psychology, Counselling and Psychotherapy, 13*, 18-22.
- Moncrieff, J. (2013b). *The bitterest pills: The troubling story of antipsychotic drugs*. London: Palgrave Macmillan.
- Moos, R. (1992). *Coping Response Inventory manual*. Palo Alto, CA: Department of Veterans Affairs and Stanford University Medical Centers, Center for Health Care and Evaluation.
- Moos, R. H., (1995). Development and applications of new measures of life stressors, social resources, and coping responses. *European Journal of Psychological Assessment, 11*, 1-13
- Moos, R., Brennan, P., Fondacaro, M., & Moos, B. (1990). Approach and avoidance coping responses among older and nonproblem drinkers. *Psychology and Aging, 5*, 31-40.
- Moos, R., & Holahan, C. J. (2003). Dispositional and contextual perspectives on coping: Toward an integrated framework. *Journal of Clinical Psychology, 59*, 1387-1401.
- Moos, R., Holahan, C. L., & Beutler, L. E. (Eds.). (2003). Special issue on coping. *Journal of Clinical Psychology, 59*, 1257-1403.
- Morgan, A. (2000). *What is narrative therapy? An easy to read introduction*. Adelaide: Dulwich Centre Publications.

- Morgan, A. (2002). Beginning to use a narrative approach in therapy. *International Journal of Narrative Therapy and Community Work*, 2002, 85-90.
- Morgan, M. L., Brosi, W. A., & Brosi, M. W. (2011). Restorying older adults' narratives about self and substance abuse. *The American Journal of Family Therapy*. 39, 444-455. doi:1080/01926187.2011.560784
- Morrison, A. P., Frame, L., & Larkin, W. (2003). Relationships between trauma and psychosis: A review and integration. *The British Journal of Clinical Psychology*, 42, 331-353. doi:10.1348/014466503322528892
- Mosher, L. (2004). Non-hospital, non-drug intervention with first episode psychosis. In J. Read, L. Mosher & R. Bentall (Eds.), *Models of Madness: psychological, social and biological approaches to schizophrenia* (pp. 349-364). London: Routledge.
- Mosher, L., Hendrix, V., & Fort, D. (2005). *Soteria: Through madness to deliverance*. Philadelphia PA: Xlibris Corporation.
- Narrow, W. E., First, M. B., Sirovatka, M. S., & Regier, M. D. (2007). *Age and gender considerations in psychiatric diagnosis: A research agenda for DSM-V*. Washington, DC: American Psychiatric Pub.
- National Mental Health Commission, (2012). Retrieved from:
<http://www.mentalhealthcommission.gov.au/>
- Newnes, C. (1999). Histories of psychiatry. In C. Newnes, G. Holmes & C. Dunn (Eds.), *This is madness: A critical look at psychiatry and the future of mental health services* (pp. 7-28). Ross-on-Wye, UK: PCCS BOOKS.
- Newnes, C. (2004). Psychology and psychotherapy's potential for countering the medicalization of everything. *Journal of Humanistic Psychology*, 44,

358-376. doi:10.1177/0022167804266180

- Newnes, C. (2011). Toxic psychology. In M. Rapley, J. Moncrieff & J. Dillon (Eds.), *De-medicalizing misery: Psychiatry, psychology and the human condition* (pp. 211-225). Basingstoke, UK: Palgrave MacMillan.
- Newnes, C. (2014). *Clinical psychology: A critical examination*. Ross-on-Wye, UK: PCCS Books.
- Newnes, C., Holmes, G., & Dunn, C. (1999). *This is madness: A critical look at psychiatry and the future of mental health services*. Ross on Wye, UK: PCCS Books.
- Nimrod, G., Douglas, A. K., & Berdychevsky, L. (2012). Leisure in coping with depression. *Journal of Leisure Research, 44*, 419-449.
- Nolen-Hoeksema, S. (1991). Responses to depression and their effects on the duration of depressed mood. *Journal of Abnormal Psychology, 100*, 569-582. doi:10.1037//0021-843X.109.3.504
- Oakland, S., & Ostell, A. (1996). Measuring coping: a review and critique. *Human Relations, 49*, 133-155. doi:10.1177/001872679604900201
- Ogden, J. (1996). *Health psychology: A textbook*. Philadelphia: Open University Press.
- Olsen, M. M., Trevino, D. B., Geske, J. A., & Vanderpool, H. (2012). Religious coping and mental health outcomes: An exploratory study of socioeconomically disadvantaged patients. *The Journal of Science and Healing, 8*, 172-176. doi:10.1016/j.explore.2012.02.005
- Oxlad, M., Miller-Lewis, L., & Wade, T. D. (2004). The measurement of coping responses: Validity of the Billings and Moos Coping Checklist. *Journal*

of Psychosomatic Research, 57, 477-484.

doi:10.1016/j.jpsychores.2004.02.018

Ozbilen, M., & Adams, C. E. (2012). P-1107-Anticholinergic side effects of antipsychotic medications. *Abstracts of the 20th European Congress of Psychiatry*, 27, 1. doi:10.1016/S0924-9338(12)75274-4

Paasivirta, M. E., Duarte, C. S., Wu, P., Bin, F., Goodman, R. F., Brown, E. J., Andrews, H. F., & Hoven, C. W. (2010). Factor structure of the Youth Coping In traumatic Times (YCITT) scale. *Psychiatry Research*, 179, 357-362. doi:10.1016/j.psychres.2009.03.018

Page, S. (1999). Two studies of gender and reporting differences with the Beck Depression Inventory. *Current Research in Social Psychology*, 4, 146-159.

Pargament, K. I. (2002). The bitter and the sweet: An evaluation of the costs and benefits of religiousness. *Psychological Inquiry*, 13, 168-181.

Pargament, K. I., Koenig, H. G., & Perez, L. M. (2000). The many methods of religious coping: Development and initial validation of the RCOPE. *Journal of Clinical Psychology*, 56, 519-543. doi:10.1002/(SICI)1097-4679(200004)56:4<519::AID-JCLP6>33.0.CO;2-1

Pargament, K. I., Koenig, H. G., Tarakeshwar, N., & Hahn, J. (2004). Religious coping methods as predictors of psychological, physical, and spiritual outcomes among medically ill elderly patients: A two year longitudinal study. *Journal of Health Psychology*, 9, 713-730.

- Pargament, K. I., Smith, B. W., Koenig, H. G., & Perez, L. (1998). Patterns of positive and negative religious coping with major life stressors. *Journal for the Scientific Study of Religion*, 37, 710-724.
- Parker, J. E., Endler, N. S., & Bagby, R. M. (1993). If it changes, it might be unstable: Examining the factor structure of the Ways of Coping Questionnaire. *Psychological Assessment*, 5, 361-368. doi:10.1037/1040-3590.5.3.361
- Pearlin, L. I. (1991). The studying of coping: An overview of problems and directions. In J. Eckenrode (Eds.), *The social context of coping* (pp. 267-276). New York: Plenum Press.
- Pearlin, L. I., & Schooler, K. (1978). The structure of coping. *Journal of Health and Social Behaviour*, 19, 2-22.
- Penley, J. A., Tomaka, J., & Wiebe, J. S. (2002). The association of coping to physical and psychological health outcomes: A meta-analytic review. *Journal of Behavioural Medicine*, 25, 551-603. doi:10.1023/A:1020641400589
- Perraud, S. (2000). Development of the Depression Coping Self-Efficacy Scale (DCSES). *Archives of Psychiatric Nursing*, 14(6), 276-284.
- Perrez, M., & Reicherts, M. (1992). *Stress, coping and health: A situation-behaviour approach, theory, methods and applications*. Toronto: Hogrefe & Huber Publishers.
- Peterson, D. R. (2004). Science, scientism and professional responsibility. *Clinical Psychology: Science & Practice*, 11, 196-210.
- Phillips, R. E., & Stein, C. H. (2007). God's will, God's punishment, or God's limitations? Religious coping strategies reported by young adults living

with serious mental illness. *Journal of Clinical Psychology*, 63, 529-540.

doi:10.1002/jclp.20364

Piccinelli, M., & Wilkinson, G. (2000). Gender differences in depression.

Critical review. *The British Journal of Psychiatry*, 177, 486-492.

doi:10.1192/bjp.177.6.486

Pierre, J. M. (2012). Mental illness and mental health: Is the glass half empty or

half full. *Canadian Journal of Psychiatry*, 57, 651-658.

Plancherel, B., Bolognini, M., & Halfon, O. (1998). Coping strategies in early

and mid adolescence: Differences according to age and gender in a

normative sample. *European Psychologist*, 3, 192-201.

doi:10.1027/1016-9040.3.3.192

Porter, L. S., Marco, C. A., Schwartz, J. E., Neale, J. M., Shiffman, S., & Stone,

A. A. (2000). Gender differences in coping: A comparison of trait and

momentary assessments. *Journal of Social and Clinical Psychology*, 19,

480-498. doi:10.1521/jscp.2000.19.4.480

Porter, L. S., & Stone, A. A. (1995). Are there really gender differences in

coping? A reconsideration of previous data and results from a daily study.

Journal of Social and Clinical Psychology, 14, 184-202.

Porter, R. (1987). *A social history of madness: Stories of the insane*. London,

UK: Weidenfeld & Nicolson.

Potasznik, H., & Nelson, G. (1984). Stress and social support: The burden

experienced by the family of a mentally ill person. *American Journal of*

Community Psychology, 12, 589-607.

ProQuest. <http://search.proquest.com>

- Provencher, H. L., & Keyes, C. L. M. (2011). Complete mental health recovery: Bridging mental illness with positive mental health. *Journal of Public Mental Health, 10*, 57-69. doi:10.1108/17465721111134556
- Ptacek, J. T., Smith, R. T., & Dodge, K. L. (1994). Gender differences in coping with stress: When stressor and appraisals do not differ. *Personality and Social Psychology Bulletin, 20*, 421-430. doi: 10.1177/0146167294204009
- Pupavac, V. (2001). Therapeutic governance: Psychosocial intervention and trauma risk management. *Disasters, 25*, 358-372.
- Puscher, B., Born, A., Giebler, A., Helm, H., Leese, M., Bindman, J., . . . Becker, T. (2006). Adherence to medication and quality of life in people with schizophrenia. *The Journal of Nervous and Mental Disease, 194*, 746-752.
- Rapley, M. (1995). Black swans: conversation analysis of interviews with people with learning disabilities. *Clinical Psychology Forum, 84*, 17-23.
- Rapley, M. (2012). W(h)ither DSM? *Maturitas, 73*, 81-82. doi:10.1016/j.maturitas.2012.06.003
- Rapley, M., & McHoul, A. (2004). Paying Attention. *Meanjin, 63*, 60-67.
- Rapley, M., McHoul, A., & Hansen, S. (2003). I want, therefore I am: A tribute to David Smail. *Clinical Psychology, 24*, 13-19.
- Rapley, M., Moncrieff, J., & Dillon, J. (2011). Carving nature at its joints? DSM and the medicalization of everyday life. In M. Rapley, J. Moncrieff & J. Dillon (Eds.), *De-medicalizing misery: Psychiatry, psychology and the human condition* (pp.1-9). Basingstoke, UK: Palgrave MacMillan.

- Rapp, C. A., & Goscha, R. J. (2006) *The strengths model: Case management with people with psychiatric disabilities*. Oxford: Oxford University Press.
- Ravindran, A. V., Matheson, K., Griffiths, J., Merali, Z., & Anisman, H. (2002). Stress, coping, uplifts, and quality of life in subtypes of depression: A conceptual frame and emerging data. *Journal of Affective Disorders*, 71, 121-130. doi:10.1016/s0165-0327(01)00389-5
- Read, J. (1997). Child abuse and psychosis: A literature review and implications for professional practice. *Professional Psychology: Research and Practice*, 28, 448-456. doi:10.1037/0735-7028.28.5.448
- Read, J. (2004a). The invention of 'schizophrenia'. In J. Read, L. R. Moshier & R. P. Bentall (Eds.), *Models of madness. Psychological, social and biological approaches to schizophrenia* (pp. 21-34). NY: Routledge.
- Read, J. (2004b). Does 'schizophrenia' exist? Reliability and validity. In J. Read, L. R. Moshier & R. P. Bentall (Eds.), *Models of madness. Psychological, social and biological approaches to schizophrenia* (pp. 43-56). NY: Routledge.
- Read, J. (2004c). A history of madness. In J. Read, L. R. Moshier & R. P. Bentall (Eds.), *Models of madness. Psychological, social and biological approaches to schizophrenia* (pp. 9-20). NY: Routledge.
- Read, J. (2005a). What makes people crazy. *Mental Health Today*, 32-34.
- Read, J. (2005b). The bio-bio-bio model of madness. *Psychologist*, 18, 596-597.
- Read, J., & Bentall, R. P. (2012). Negative childhood experiences and mental health: Theoretical, clinical and primary prevention implications. *The*

British Journal of Psychiatry, 200, 89-91.

doi:10.1192/bjp.bp.111.096727

Read, J., Haslam, N., Sayce, L., & Davies, E., (2006). Prejudice and schizophrenia: A review of the 'mental illness is an illness like any other' approach. *Acta Psychiatrica Scandinavia*, 114, 303-318.

doi:10.1111/j.1600-0447.2006.00824.x

Read, J., Moshier, L. R., & Bentall, R. P. (2004). *Models of madness: Psychological, social and biological approaches to schizophrenia*. NY: Routledge.

Read, J., van Os, J., Morrison, A. P., & Ross, C. A. (2005). Childhood trauma, psychosis and schizophrenia: A literature review with theoretical and clinical implications. *Acta Psychiatrica Scandinavia*, 112, 330-350. doi:

10.1111/j.1600-0447.2005.00634

Rettenbacher, M. A., Hummer, M., Eder, U., Hofer, A., Kemmler, G., Kurzthaler, E., . . . Fleischhacker, W. W. (1999). Attitudes towards illness, antipsychotic medication and compliance in outpatients with schizophrenia. *European Neuropsychopharmacology*, 9, 287.

doi:10.1016/S0924-977X(99)80343-5

Rettenbacher, M. A., Hofer, A., Eder, U., Hummer, M., Kemmler, G., Weiss, E., & Fleischhacker, W. W. (2004). Compliance in schizophrenia: psychopathology, side effects, and patients' attitudes toward the illness and medication. *The Journal of Clinical Psychiatry*, 65, 1211-1218. doi:

Reynolds, G. P., & Kirk, S. L. (2010). Metabolic side effects of antipsychotic drug treatment- pharmacological mechanisms. *Pharmacology & Therapeutics*, 125, 169-179. doi:10.1016/j.pharmthera.2009.10.010

- Rexrode, K. R., Peterson, S., & O'Toole, S. (2008). The Ways of Coping Scale: A reliability generalization study. *Educational and Psychological Measurement, 68*, 262-280. doi:10.1177/0013164407310128
- Ritsner, M., Ben-Avi, I., Ponizovsky, A., Timinsky, I., Bistrov, E., & Modai, I (2003). Quality of life and coping with schizophrenia symptoms. *Quality Of Life Research, 12*, 1-9. doi:10.1023/A:1022049111822
- Robbins, P. R., & Tanck, R. H. (1978). A factor analysis of coping behaviors. *Journal of Clinical Psychology, 34*, 379-380. doi:10.1002/1097-4679(197804)34:2<379::AID-JCLP2270340223>3.0.CO;2-W
- Robilotta, S., Cueto, E., & Yanos, P. T. (2010). An examination of stress and coping among adults diagnosed with severe mental illness. *The Israel Journal of Psychiatry and Related Science, 47*, 222-231.
- Roger, D., Jarvis, G., & Najarian, B. (1993). Detachment and coping: The construction and validation of a new scale for measuring coping strategies. *Personality and Individual Differences, 15*, 619-626. doi:10.1016/0191-8869(93)90003-L
- Roger, D., & Najarian, B. (1989). 'The construction and validation of a new scale for measuring emotion control', *Personality and Individual Differences, 10*, 845-853. doi: 10.1177/1469787406069058
- Rollins, A. L., Bond, G. R., Lysaker, P. H., McGrew, J. H., & Salyers, M. P. (2010). Coping with positive and negative symptoms of schizophrenia. *American Journal of Psychiatric Rehabilitation, 13*, 208-223. doi:10.1080/15487768.2010.501297

- Romi, S., Lewis, R., & Roache, J. (2013). Classroom management and teachers' coping strategies: Inside classrooms in Australia, China and Israel. *Prospects, 43*, 215-231. doi:10.1007/s11125-013-9271-0
- Rose, A. J., & Rudolph, K. D. (2006). A review of sex differences in peer relationship processes: Potential trade-offs for the emotional and behavioural development of girls and boys. *Psychological Bulletin, 132*, 98-131. doi: 10.1037/0033-2909.132.1.98
- Rose, N. (1989). *Governing the soul: The shaping of the private self*. London: Routledge.
- Rose, N. (1996). Psychiatry as a political science: Advanced liberalism and the administration of risk. *History of the Human Sciences, 9*(2), 1-22. doi:10.1177/095269519600900201
- Rose, N. (2013). What is mental illness today? Five hard questions. (Psychiatry Video file). Retrieved from: <http://www.youtube.com/watch?v=KxI6DmbEKQg>
- [Rosenhan, D. L. \(1973\). On being sane in insane places. *Science, 179*, 250-258](#)
- Rowe, D. (2003). *Depression: The way out of your prison* (3rd ed.). New York: Brunner-Routledge.
- Rowe, D. (2007). *Beyond fear. Fully updated 20th Anniversary Edition*. London: Harper Perennial.
- Rowe, R., Tilbury, F., Rapley, M., & O'Ferrall, I. (2003). 'About a year before the breakdown I was having symptoms': Sadness, pathology and the Australia newspaper media. *Sociology of Health & Illness, 25*, 680-696.
- Ruchita, S. Parmanand, K. Dandeep, G. Kumar, S. Malhotra, R., & Tyagi, S. (2011). Relationship between spirituality/religiousness and coping in

- patients with residual schizophrenia. *Quality of Life Research*, 20, 1053-1060. doi:10.1007/s11136-010-9839-6
- Ruckl, S., Buche, L., Gentner, N. C., Heyne, J., Von Bock, A., Barthel, A., Vedder, H., Burgy, M., & Kronmuller, K. T. (2012). Heidelberg Coping Scales for Delusions: Psychometric evaluation of an expert rating instrument. *Psychopathology*, 45, 244-251. doi:10.1159/000330583
- Rudnik, A. (2001). The impact of coping on the relation between symptoms and quality of life in schizophrenia. *Psychiatry*, 64, 304-308. doi:10.1521/psyc.64.4.304.18599
- Rudnik, A., & Martins, J. (2009). Coping and schizophrenia. *Archives of Psychiatric Nursing*, 23(1), 11-15. doi:10.1016/j.apnu.2008.02.009
- SANE Australia. (2010). Antipsychotic medication: factsheet 2010. Retrieved from: http://www.sane.org/images/stories/information/factsheets/1007_info_10_antipsychotic.pdf
- Sarbin, T. R., & Mancuso, J. C. (1984). *Schizophrenia: Medical diagnosis or moral verdict?* New York: Pergamon Press.
- Sawang, S., Oei, T.P.S, Goh, Y. W, Mansoer, W., Markhum, E., & Ranawake, D. (2010). Confirmatory factor analysis of the Way of Coping Checklist-Revised (WCCL-R) in the Asian Context. *Applied Psychology: An International Review*, 59, 202-219. doi:10.1111/j.1464-0597.2009.00378.x
- Schwarzer, R., & Schwarzer, C. (1996). A critical survey of coping instruments, In M. Zeidner & N. S. (eds.) *Handbook of coping* (pp.107-132). New York: Wiley.

- Seltzer, M. M. Greenberg, J.S., & Krauss, M. W. (1995). A comparison of coping strategies of aging mothers of adults with mental illness or mental retardation. *Psychology and Aging, 10*, 64-75. doi:10.1037/0882-7974.10.1.64
- Shankland, R., Genolini, C., Franca, L. R., Guelfi, J. D., & Ionescu, S. (2010). Student adjustment to higher education: the role of alternative educational pathways in coping with the demands of student life. *Higher Education, 59*, 353-366. doi:10.1007/s10734-009-9252-7
- Shean, G. D. (2009). Evidence-based psychosocial practices and recovery from schizophrenia. *Psychiatry, 72*, 307-320.
- Shean, G. D. (2010). *Recovery from schizophrenia: Etiological models and evidence-based treatments*. Available at: www.hindawi.com/books.html
- Shedler, J., Mayman, M., & Manis, M. (1993). The illusion of mental health. *American Psychologist, 48*, 1117-1131.
- Shenton, A. K. (2004). Strategies for ensuring trustworthiness in qualitative research projects. *Education for Information, 22*, 63–75. Retrieved from <http://iospress.metapress.com/index/3ccttm2g59cklapx.pdf>
- Shershow, J. C. (1978). Approaches to understanding schizophrenia. In J.C. Shershow, (Ed.), *Schizophrenia: Science and practice*. (99-121). London, UK: Harvard University Press.
- Siegel, S., & Castellan, N. J. (1988). *Nonparametric statistics for the behavioural sciences (2nd edition)*. New York NY: McGraw-Hill.
- Sinclair, V. G., & Wallston, K. A. (2004). The development and psychometric evaluation of the Brief Resilient Coping Scale. *Assessment, 11*, 94-101. doi:10.1177/1073191103258144

- Singh, G., Sharan, P., & Kulhara, P. (2002). Coping with hallucinations in schizophrenia: A correlational study. *Hong Kong Journal of Psychiatry, 12*, 5-11.
- Skinner, E. A., Edge, K., Altman, J., & Sherwood, H. (2003). Searching for the structure of coping: a review and critique of category systems for classifying ways of coping. *Psychological Bulletin, 129*, 216-269. doi:10.1037/0033-2909.129.2.216
- Smail, D. (1993). *The origins of unhappiness: A new understanding of personal distress*. London: Harper Collins Publishers.
- Smith, D. (1978). "K is mentally ill": The anatomy of a factual account. *Sociology, 12*, 23–53. doi:10.1177/003803857801200103
- Smolak, A., Gearing, D., Alonzo, S., Baldwin, S., Harmon, S. & McHugh, K. (2013). Social support and religion: Mental health service use and treatment of schizophrenia. *Community Mental Health Journal, 49*, 444-450.
- Snyder, C. R. (1999). *Coping: The psychology of what works*. NY: Oxford University Press.
- Somerfield, M. R., & McCrae, R. R. (2000). Stress and coping research: methodological challenges, theoretical advances and clinical applications. *American Psychologist, 55*, 620-625. doi:10.1037/0003-066X.55.6.620
- Stanley, C. (1983). The normal psychology of the aging male: Sex differences in coping and perceptions of life events: Discussion. *Journal of Geriatric Psychiatry, 16*, 211-222.
- Steed, L. G. (1998). A critique of coping scales. *Australian Psychologist, 33*(3), 193-202.

- Stroebe, M. (2001). Gender differences in adjustment to bereavement: An empirical and theoretical review. *Review of General Psychology, 5*, 62-83.
- Stroebe, M., Stroebe, W., & Schut, H. (2003). Bereavement research: Methodological issues and ethical concerns. *Palliative Medicine, 17*, 235-240. doi:10.1191/0269216303pm768rr
- Sullivan, W. P. (1993). "It helps me to be a whole person": The role of spirituality among the mentally challenged". *Psychosocial Rehabilitation Journal, 16*, 125-134. doi:10.1037/h0095669
- Suls, J., David, J. P., & Harvey, J. H. (1996). Personality and coping: three generations of research. *Journal of Personality, 64*, 711-735. doi: 10.1111/j.1467-6494.1996.tb00942.x
- Summerfield, D. (2001a). The man who had 42 psychiatrists – and rising- a memorable patient. *British Medical Journal, 322(7293)*, 1026.
- Summerfield, D. (2001b). Does psychiatry stigmatize? *Journal of the Royal Society of Medicine, 94*, 148-149.
- Summerfield, D. (2004). Cross cultural perspectives on the medicalisation of human suffering. In G. Rosen (Ed.), *Post-traumatic stress disorder: Issues and controversies* (pp. 233-245). London: John Wiley.
- Summerfield, D. (2005). "My whole body is sick ... my life is not good". *Forced Migration and Mental Health: International and Cultural Psychology Series 2005*, 97-114.
- Summerfield, D. (2006). Depression: epidemic or pseudoepidemic? *Journal of the Royal Society of Medicine, 99*, 161-162. doi:10.1258/jrsm.99.3.161

- Summerfield, D. (2008). How scientifically valid is the knowledge base of global mental health. *British Medical Journal*, 336, 992-994.
doi:10.1136/bmj.39513.441030.AD
- Summerfield, D. (2011). Income inequality and mental health problems. *The British Journal of Psychiatry*, 198, 239. doi:10.1192/bjp.198.3.239
- Summerfield, D. (2012a). Afterword: Against “global mental health”.
Transcultural Psychiatry, 49, 1-12. doi:10.1177/1363461512454701
- Summerfield, D. (2012b). Depression in the workplace: what is depression?. *The British Journal of Psychiatry*, 201, 327. doi:10.1192/bjp.201.4.327
- Summerfield, D. (2012c). Why export mental health? Transcultural psychiatry. McGill Blogs. (Psychiatry Video file). Retrieved from:
<http://blogs.mcgill.ca/tcpsych/2012/12/07/derek-summerfield-why-export-mental-health-2/>
- Summerfield, D., & Veale, D. (2008). Proposals for massive expansion of psychological therapies would be counterproductive across society. *The British Journal of Psychiatry*, 192, 326-330.
doi:10.1192/bjp.bp.107.046961.
- Sweeney, A., Beresford, P., Faulkner, A., Nettle, M., & Rose, D. (2009). *This is survivor research*. Ross-on-Wye: PCCS Books.
- Sykes, R. (2012). The DSM 5 website proposals for somatic symptom disorder: Three central problems. *Psychosomatics*, 53, 524-531.
- Straus, J. S. (1969). Hallucinations and delusions as points on continua function. *Archive General Psychiatry*, 2, 581-586.
doi:10.1001/archpsyc.1969.017402230069010

- Szasz, T. S. (1960). The myth of mental illness. *American Psychologist*, *15*, 113-118.
- Szasz, T. S. (1971). *The manufacture of madness: a comparative study of the inquisition and the mental health movement*. London: Routledge & Kegan Paul.
- Szasz, T.S. (1974). *The second sin*. New York: Doubleday.
- Szasz, T.S. (1977). *Psychiatric slavery*. London: The free press, Collier Macmillan Publishers.
- Tabachnick, B. G ., & Fidell, L. (1989). *Using multivariate statistics* (second edition). New York: Harper Collins.
- Tamres, L. K., Janicki, D., & Helgeson, V. S. (2002). Sex differences in coping behaviour: A meta-analytic review and examination of coping. *Personality and Social Psychology Review*, *6*, 2-30.
doi:10.1207/S15327957PSPR0601_1
- Taylor, S. E., Lerner, J. S., Sherman, D. K., & McDowell, N. K. (2003a). Portrait of the self-enhancer: Well adjusted and well liked or maladjusted and friendless? *Journal of Personality and Social Psychology*, *84*, 165-176.
doi:10.1037/0022-3514.84.1.165
- Taylor, S. E., Lerner, J. S., Sherman, D. K., & McDowell, N. K. (2003b). Are self-enhancing cognitions associated with healthy or unhealthy biological profiles? *Journal of Personality and Social Psychology*, *85*, 605-615.
doi:10.1037/0022-3514.85.4.605
- Taylor, S. E., & Stanton, A. L. (2007). Coping resources, coping processes, and mental health. *Annual Review of Clinical Psychology*, *3*, 377-401.
doi:10.1146/annurev.clinpsy.3.022806.091520

- Tennen, H., Affleck, G., Armeli, S., & Carney, M. A. (2000). A daily process approach to coping: linking theory research and practice. *American Psychologist*, *55*, 626-636. D10.1037//0003-066X.55.6.626
- Tepper, L., Rogers, S. A., Coleman, E. M., & Maloney, H. N. (2001). The prevalence of religious coping among persons with persistent mental illness. *Psychiatric Services*, *52*, 660-665. doi:10.1176/appi.ps.52.5.660
- Terracciano, A., & McCrae, R.R. (2006). Cross-Cultural studies of personality traits and their relevance to psychiatry. *Epidemiol Psychiatr Soc.* *15*, 176-184.
- Tew, J. (Ed.). (2005). *Social perspectives in mental health: developing social models to understand and work with mental distress*. London: Jessica Kingsley.
- Tharaldsen, K. B., & Bru, E. (2011). Validation of the mindful coping scale. *Emotional and Behavioural Difficulties*, *16*, 87-103.
doi:10.1080/13632752.2011.545647
- The British Psychological Society, (2011). Response to the American Psychiatric Association: DSM-5 Development. *The British Psychological Society*. 1-26. http://apps.bps.org.uk/_publicationfiles/consultation-responses/DSM-5%202011%20-%20BPS%20response.pdf
- Thomas, P., Bracken, P., & Timini, S. (2012). The limits of evidence-based medicine in psychiatry. *Philosophy, Psychiatry & Psychology*, *19*, 295-308.
- Tischler, V. (2009). "I'm not coping, I'm surviving: Understanding coping in a marginalised population. *Qualitative Research in Psychology*, *6*, 191-202.
doi:10.1080/14780880701826176

- Titmarsh, S., & Goodyer, I. (2011). Psychiatric diagnosis needs a more scientific approach. *Progress in Neurology and Psychiatry, 15*, 21-23.
doi:10.1002/pnp.206
- Tobin, D. L. (2000). *Coping strategies therapy for bulimia nervosa*. Washington: American Psychological Association.
- Tschoner, A., Engl, J., Laimer, S., Kaser, M., Rettenbacher, W.W. . . .
Ebenbichler, C F. (2007). Metabolic side effects of antipsychotic medication. *International Journal of Clinical Practice, 61*, 1356-1370.
doi:10.1111/j.1742-1241.2007.01416.x
- Turner, I., & Newnes, C. (1993). Inpatient views of the service at Shelton Psychiatric Hospital. *Clinical Psychology Forum, 56*, 23-29.
- Tyler, M. (1995). Somatic symptoms in schizophrenia. *Schizophrenia Research, 18*, 87-88.
- Usall, J., Arava, S., Ochoa, S., Busquets, E., Gost, A., & Marquez, M. (2001). Gender differences in a sample of schizophrenic outpatients. *Comprehensive Psychiatry, 42*, 301-305.
- Vallient, G. E. (1977). *Adaptation to life*. Boston: Little, Brown.
- Vallient, G. E. (2000). Adaptive mental mechanisms: Their role in a positive psychology. *American Psychologist, 55*, 89-98. Doi:10.1037//0003-066X.55.1.89
- Van Os, J., Hanssen, M., Bijl, R.V., & Ravelli, A. (2000). Straus (1969) revisited: a psychosis continuum in the general population? *Schizophrenia Research, 45*, 11-20.

- Vicary, D., & Andrews, H. (2000). Developing a culturally appropriate psychotherapeutic approach with Indigenous Australians. *Australian Psychologist, 35*, 181-185. doi:10.1080/00050060008257476
- Vilma, H., & Hillevi, A. (1996). Sex differences in coping and depression among adults. *Social Sciences & Medicine, 43*, 1453-1460.
- Walsh, K., Fortier, M.A., & DiLillo, D. (2010). Adult coping with childhood sexual abuse: A theoretical and empirical review. *Aggressive Violent Behaviour, 15*, 1-13. doi: 10.1016/j.avb.2009.06.009.
- Walter, K. H. (2000). The assessment of surgery-related coping: The coping with surgical stress scale (COSS). *Psychology & Health, 15*, 135. doi:10.1080/08870440008400294
- Ward, M., Cichy, K., & Almeida, D. (2008). Getting emotional: Examining the links between emotion focused coping, daily stressors, number of physical symptoms and symptom severity. *The Gerontologist, 48*, 757.
- Wassermann, S., Welsman, A., & Suro, G. (2012). Nonreligious coping and religious coping as predictors of expressed emotion in relatives of patients with schizophrenia. *Mental Health, Religion and Culture, 16*(1), 16-30. doi:10.1080/13674676.2011.642347
- Watson, S. B, Goh, Y. W., & Sawang, S. (2011). Gender influences on the work-related stress-coping process. *Journal of Individual Differences, 32*, 39-46.
- WAYS, Mindgarden.com.” (n.d.). Retrieved from <http://www.mindgarden.com/products/wayss.htm>
- Weich, S., Patterson, J., Shaw, R., & Stewart-Brown, S. (2009). Family relationships in childhood and common psychiatric disorders in later life:

systematic review of prospective studies. *The British Journal of Psychiatry*, 194, 392-398. doi:10.1192/bjp.bp.107.042515

Western Australia Mental Health Act. (1996). Available from

http://www.health.wa.gov.au/mhareview/resources/legislation/wa_mental_health_act_1996.pdf

What is schizophrenia? Retrieved from health.gov.au:

[http://www.health.gov.au/internet/main/publishing.nsf/Content/2FDE7D9511A8856BCA257BF0001B5ED0/\\$File/whatsch2.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/2FDE7D9511A8856BCA257BF0001B5ED0/$File/whatsch2.pdf)

Wilkinson, R., & Pickett, K. (2009). *The spirit level: Why more equal societies almost always do better*. London: Allen Lane.

Williams, J. (1999). Social inequalities and mental health. In C. Newnes, G. Holmes & C. Dunn (Eds.), *This is madness; A critical look at psychiatry and the future of mental health services* (pp.29-50). Ross-on-Wye, UK: PCCS Books.

Williams, S., Arnold, P., & Mills, J. (2005). Coping with stress: a survey of Murdoch University veterinary students. *Journal of Veterinary Medical Education*, 32, 201-212.

Wise, M. (2004). *Mad science: discourses of 'schizophrenia' and 'therapy' for hearing voices*. PhD thesis, Murdoch University.

Wisniewski, V., & Frydenberg, E. (1995). Coping skills of intellectually disabled young adults: An exploratory investigation. *The Australian Educational and Developmental Psychologist*, 12, 8-17.
doi:<http://dx.doi.org/10.3138/jvme.32.2.201>

WorldHealth Organization (WHO). (2011). Mental health: a state of well-being.

Retrieved from:

http://www.who.int/features/factfiles/mental_health/en/index.html

Wu, L. M., Chin, C. C., Chen, C. H., Lai, F. C., & Tseng, Y. Y. (2010).

Development and validation of the paediatric cancer coping scale.

Journal of Advanced Nursing, 67, 1142-1151. doi:10.1111/j.1365-

2648.2010.05567.x

Yanos, P. T. (2001). Proactive coping among persons diagnosed with severe

mental illness: An exploratory study. *Journal of Nervous and Mental*

Disease, 189, 121-123. doi:10.1097/00005053-200102000-00009

Yap, P. M. (1960). The possession syndrome: A comparison of Hong Kong and

French findings. *The British Journal of Psychiatry*, 106, 114-137.

Zeidner, M. (1994). Personal and contextual determinants of coping and anxiety

in an evaluative situation: A prospective study. *Personality and*

Individual Differences, 16, 899-918. doi:10.1016/0191-8869(94)90234-8

Ziolkowska, J. (2011). The representation of illness manifestation during the first

psychiatric interview with patients preliminary diagnosed with depressive

illness. *Polish Psychological Bulletin*, 42, 123-128. doi:10.2478/v10059-

011-0017-7

APPENDIX A

Chapter 4 Study A and B

Consists Of The Following Tables and figures from Chapter 4 Study A and B

- Psychiatric Patients: Chi Square Test for Independence: Actual and Expected Counts of Men and Women Classified by Gender and Diagnosis
- Psychiatric Sample: Gender Diagnosis Cross Tabulation
- Psychiatric Sample: Preliminary Analysis of Subscale data Box plots and Histograms, Gender = Male
- Psychiatric Sample: Preliminary Analysis of Subscale data Box plots and Histograms, Gender Female:
- FACTOR ANALYSIS – Psychiatric Sample- Scree Plot

MACTHED STUDY – Study B

- Coping strategies in the psychiatric group matched for age and sex: t-tests for each matched subscale
- Wilcoxon Signed Ranks Tests for Male Matched Sample
- Correlational Matrix – Psychiatric Sample

Psychiatric Patients: Chi Square Test for Independence: Actual and Expected Counts of Men and Women Classified by Gender and Diagnosis

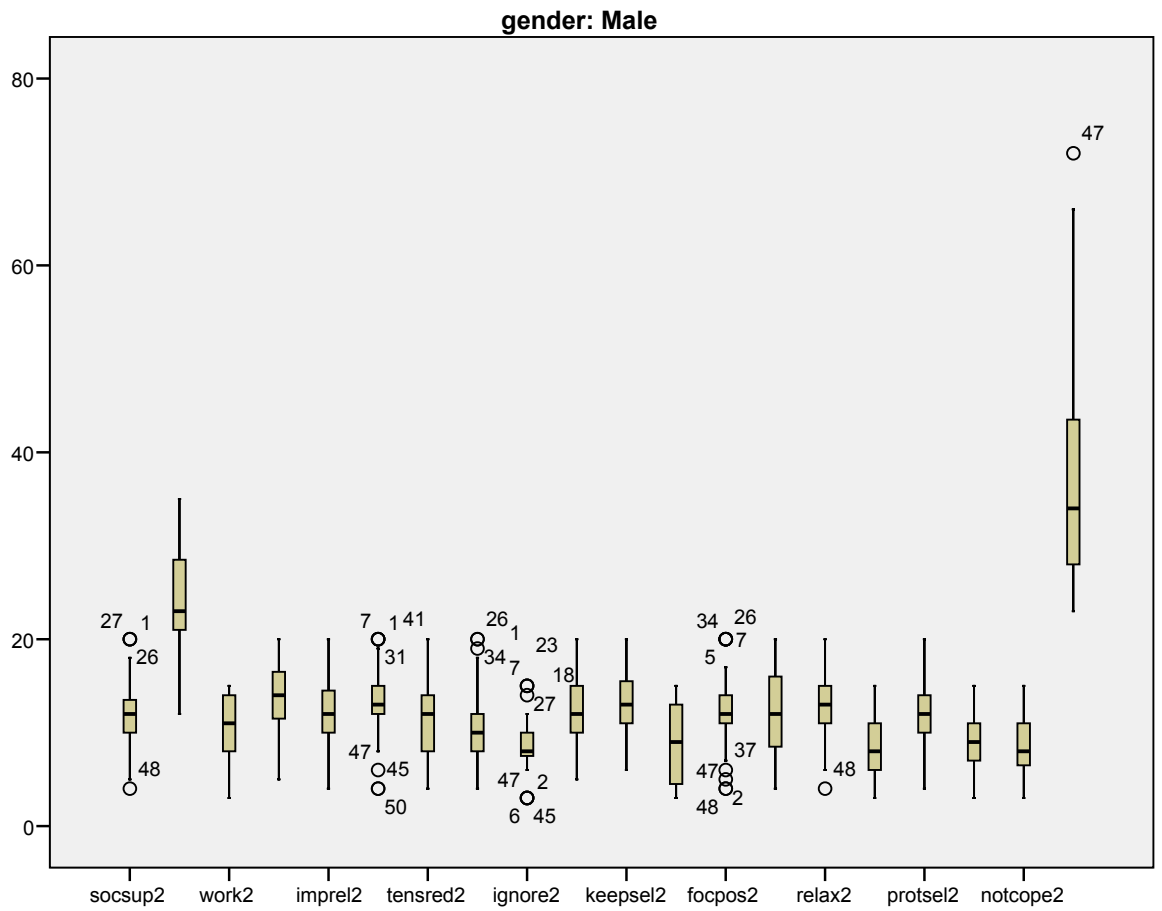
Diagnosis		Schizophrenia	Depression	Bipolar Disorder	Personality (PD)	Not Otherwise Specified (NOS)	Total
Gender							
Male	Count	30	12	7	2	4	55
	Expected Count	25.0	11.0	11.5	4.5	3.0	55.0
Female	Count	20	10	16	7	2	55
	Expected Count	25.0	11.0	11.5	4.5	3.0	55.0
	Count	50	22	23	9	6	110
Total	Expected Count	50.0	22.0	23.0	9.0	6.0	110.0

Psychiatric Sample: Gender Diagnosis Cross Tabulation

		<i>Diagnosis</i>				Total
		<i>schizophrenia</i>	<i>Depression</i>	<i>Bipolar Disorder</i>	<i>Other</i>	<i>Schizophrenia</i>
Gender	Male					
	Count	30	12	7	6	55
	Expected Count	25.0	11.0	11.5	7.5	55.0
	Std. Residual	1.0	.3	-1.3	-.5	
Female	Count	20	10	16	9	55
	Expected Count	25.0	11.0	11.5	7.5	55.0
	Std. Residual	-1.0	-.3	1.3	.5	
Total	Count	50	22	23	15	110
	Expected Count	50.0	22.0	23.0	15.0	110.0

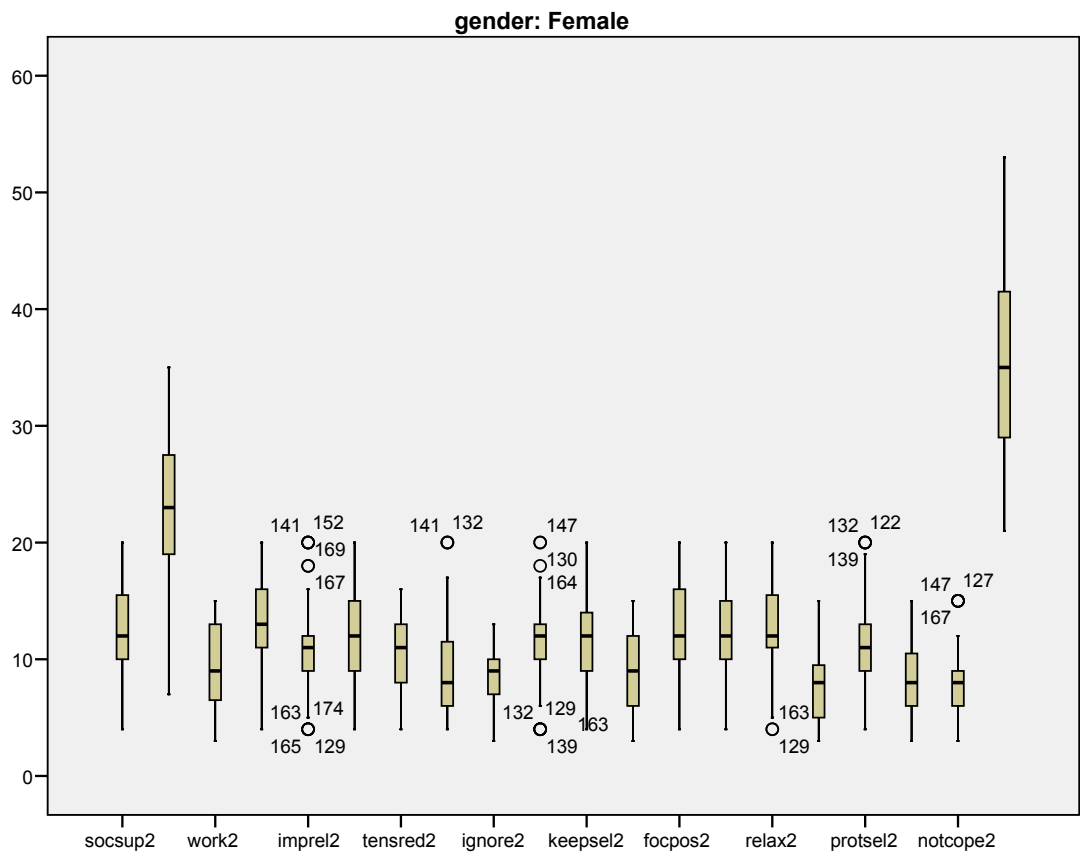
Psychiatric Sample: Preliminary Analysis of Subscale data Box plots and Histograms

Gender = Male



Psychiatric Sample: Preliminary Analysis of Subscale data Box plots and Histograms

Gender Female:



FACTOR ANALYSIS – Psychiatric Sample

Scree Plot

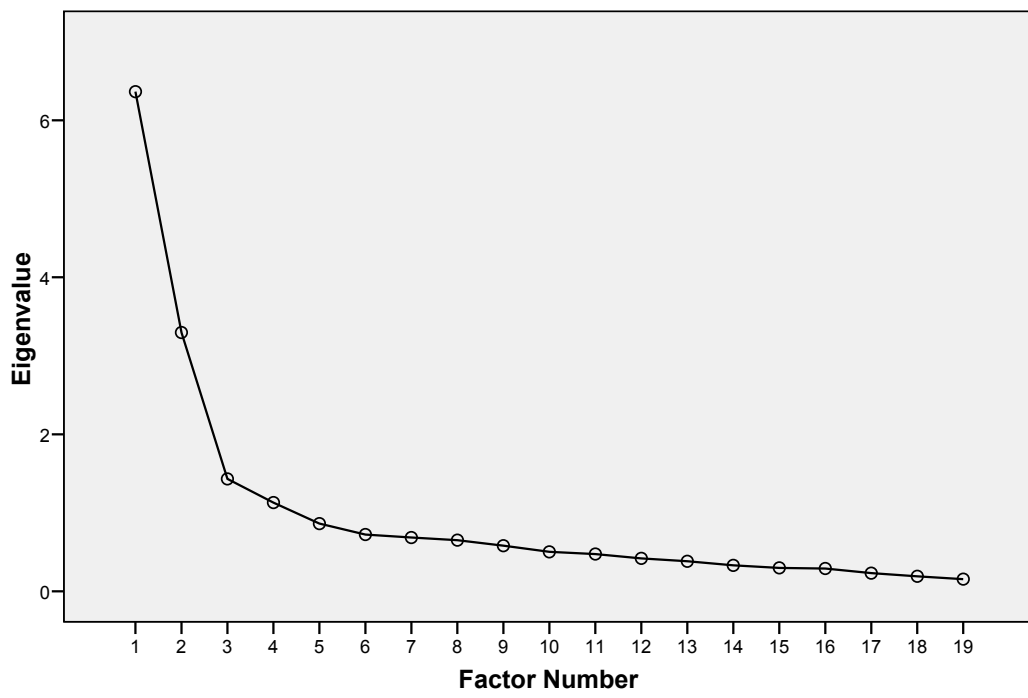


Figure: Scree Plot

Study B - Matched study

Coping strategies in the psychiatric group matched for age and sex: t-tests for each matched subscale.

Strategy	Psychiatric Sample		Community Sample		Difference	SD	p values
	N=20 \bar{X}	SD	N=20 \bar{X}	SD			
Seek social support	12.05	4.76	13.85	3.28	-1.80	5.48	0.158
Focus on Solving the Problem	24.25	7.95	26.8	4.54	-2.55	8.40	0.191
Work hard and achieve	10.1	4.15	11.6	2.32	-1.50	4.54	0.157
Worry	13.95	4.50	11.5	3.37	2.45	6.37	0.102
Improve relationships	12.95	4.89	10.25	3.00	2.70	5.62	0.045
Wishful Thinking	13.90	4.67	10.65	2.15	3.25	5.36	0.014
Tension reduction	10.90	4.73	10.35	2.49	0.55	5.13	0.637
Social action	10.35	4.90	6.90	2.67	3.45	4.28	0.002
Ignore the problem	9.2	2.60	7.55	2.11	1.65	3.58	0.054
Self blame	12.15	5.15	12.85	3.85	-0.70	6.64	0.643
Keep to self	13.75	4.27	11.2	3.87	2.55	5.49	0.052
Seek spiritual support	9.90	4.54	5.80	2.19	4.10	5.21	0.002
Focus on the positive	13.25	5.84	12.80	3.28	0.45	5.375	0.712
Seek professional help	12.25	4.99	9.30	4.93	2.95	7.17	0.082
Relax	12.85	5.05	13.45	2.21	-0.60	4.13	0.524
Physical recreation	8.50	4.14	7.90	3.50	0.60	4.14	0.525
Protect self	12.25	5.19	11.1	2.69	1.15	5.51	0.363
Humour	9.80	4.16	9.15	2.53	0.65	5.18	0.582
Not Coping	9.05	3.79	7.90	2.90	1.15	5.53	0.365

Note: significant at p= 0.0026

Wilcoxon Signed Ranks Tests for Male Matched Sample

Matched Scale	Mean	Z score	P value
Social support Community	12.6	-0.102	0.939
Social support - Psychiatric	12.6		
Problem focused- Community	28.5	-0.891	0.406
Problem focused-Psychiatric	25.9		
Work hard and achieve-Community	12.6	-1.199	0.273
Work hard and achieve - Psychiatric	11.5		
Worry- Community	10.8	-1.368	0.191
Worry- Psychiatric	13.5		
Improve relationships- Community	9.8	-1.68	0.102
Improve relationships - Psychiatric	13.5		
Wishful thinking – Community	10.7	-2.20	0.031
Wishful thinking- Psychiatric	14.7		
Tension reduction – Community	10.3	-1.02	0.332
Tension reduction-Psychiatric	12.4		
Social acceptance – Community	7.9	-2.204	0.021
Social acceptance - Psychiatric	11.0		
Ignore the problem-Community	8.1	-0.672	0.523
Ignore the problem - Psychiatric	8.8		
Self Blame- Community	11.7	-0.059	0.969
Self Blame – Psychiatric	11.6		
Keep to self – Community	12.7	-0.060	0.992
Keep to self - Psychiatric	13.0		
Seek spiritual support – Community	6.5	-1.79	0.080
Seek spiritual support - Psychiatric	10		
Focus on the positive – Community	14.1	-0.280	0.820
Focus on the positive - Psychiatric	13.5		
Seek professional help – Community	7.8	-0.1482	0.158
Seek professional help - Psychiatric	11.1		
Seek relaxing diversions- Community	13.1	-0.778	0.469
Seek relaxing diversions- Psychiatric	14.1		
Protect self- Community	11.6	-0.655	0.512
Protect self - Psychiatric	12.9		
Physical recreation – Community	9.8	-0.360	0.752
Physical recreation - Psychiatric	9.5		
Humour- Community	9.6	-1.077	0.320
Humour- Psychiatric	11.2		
Not Cope – Community	6.8	-0.893	0.426
Not Cope - Psychiatric	8.3		

Note: significant at p=0.0026.

Wilcoxon Signed Ranks Tests for Female Matched Sample

Matched Scale	Mean	Z score	P value
Social support Community	15.1	-2.105	0.035
Social support - Psychiatric	11.5		
Problem focused- Community	25.1	-0.816	0.443
Problem focused-Psychiatric	22.6		
Work hard and achieve-Community	10.6	-1.129	0.297
Work hard and achieve - Psychiatric	8.7		
Worry- Community	12.2	-1.023	0.336
Worry- Psychiatric	14.4		
Improve relationships- Community	10.7	-0.981	0.367
Improve relationships - Psychiatric	12.4		
Wishful thinking – Community	10.6	-1.068	0.324
Wishful thinking- Psychiatric	13.1		
Tension reduction – Community	10.4	-1.075	0.301
Tension reduction-Psychiatric	9.4		
Social acceptance – Community	5.9	-2.045	0.041
Social acceptance - Psychiatric	9.7		
Ignore the problem-Community	7.0	-2.094	0.047
Ignore the problem - Psychiatric	9.6		
Self Blame- Community	14.0	-0.474	0.680
Self Blame – Psychiatric	12.7		
Keep to self – Community	9.7	-2.045	0.043
Keep to self - Psychiatric	14.5		
Seek spiritual support – Community	5.1	-2.077	0.039
Seek spiritual support - Psychiatric	9.8		
Focus on the positive – Community	13.0	-0.831	0.441
Focus on the positive - Psychiatric	11.5		
Seek professional help – Community	10.8	-0.869	0.385
Seek professional help - Psychiatric	13.4		
Seek relaxing diversions- Community	13.8	-1.546	0.141
Seek relaxing diversions- Psychiatric	11.6		
Protect self- Community	10.6	-0.459	0.678
Protect self - Psychiatric	11.6		
Physical recreation – Community	6.0	-0.566	0.621
Physical recreation - Psychiatric	7.5		
Humour- Community	8.7	-0.103	0.957
Humour- Psychiatric	8.4		
Not Cope – Community	9.0	-0.408	0.717
Not Cope - Psychiatric	9.8		

Note: significant at p=0.0026.

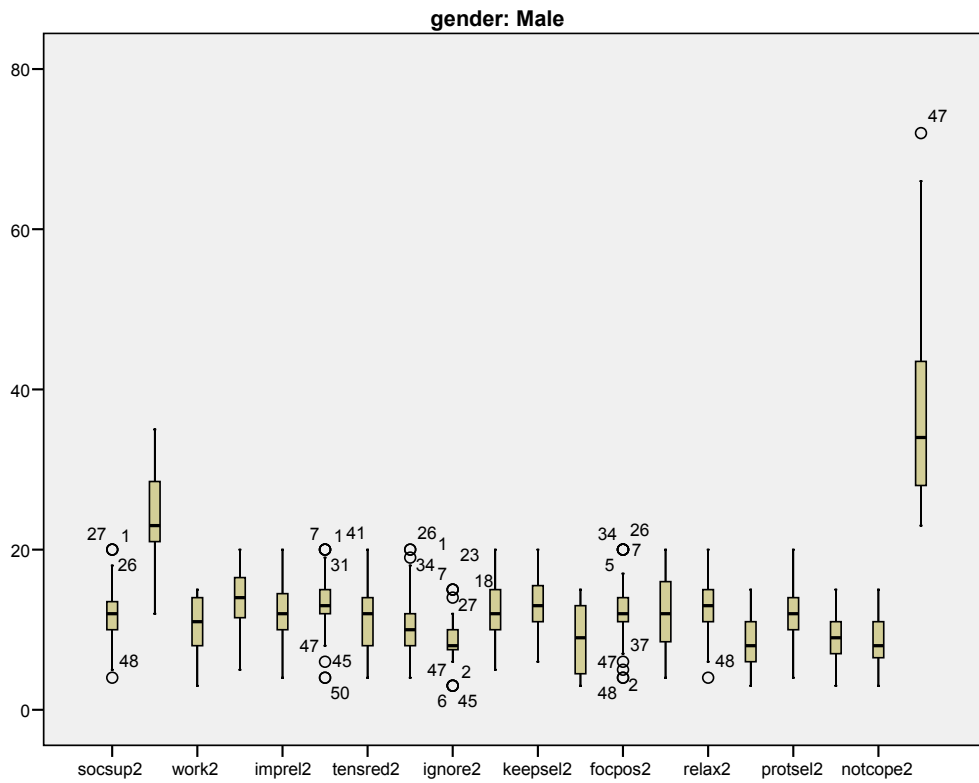
APPENDIX B

Chapter 4 Study C

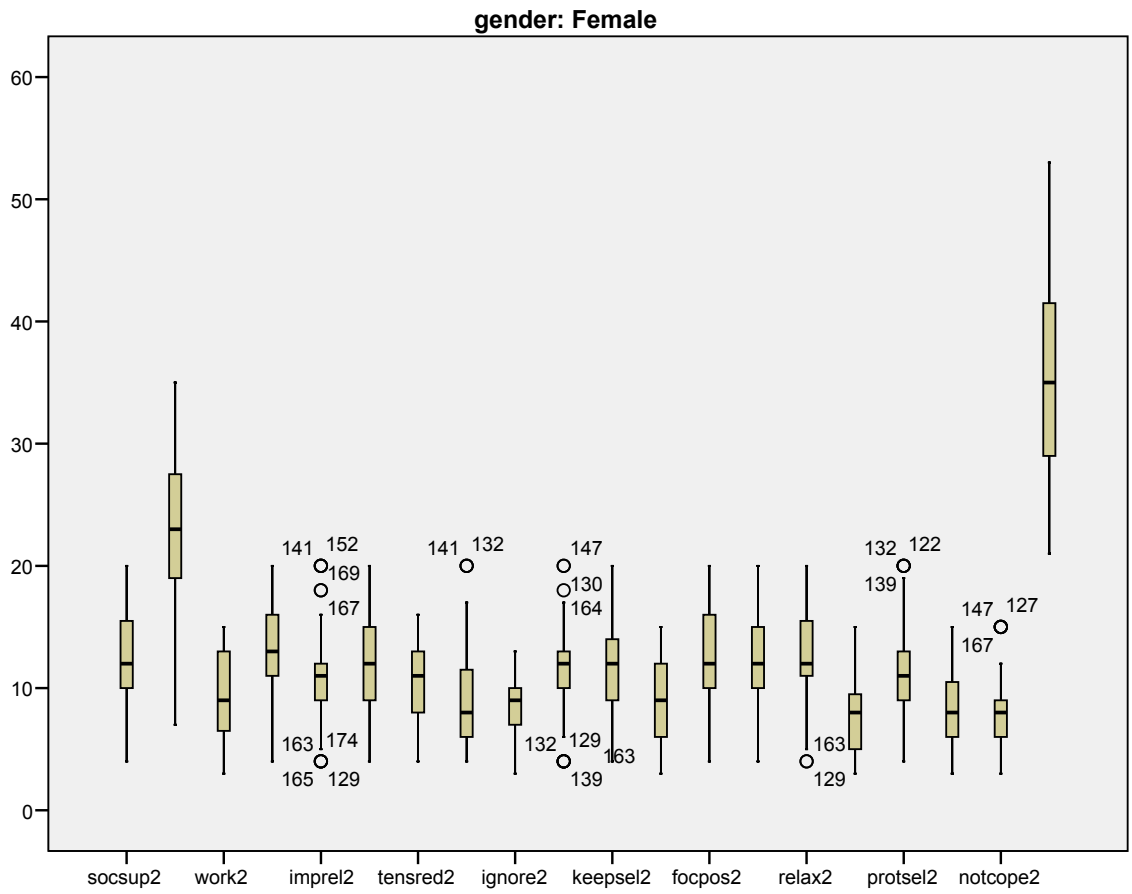
Consists Of The Following Tables and figures from Chapter 4 Study C

- University Sample: Preliminary Analysis of Subscale data Box plots and Histograms for males
- University Sample: Preliminary Analysis of Subscale Data Box Plots and Histograms for Females
- Sample Descriptive Statistics University Sample – Mean and Standard Deviations by Gender
- Coping Strategies Used by Adult Samples: University and Normative Sample (Adopted Normative Table From: Frydenberg & Lewis, 2002, Table 2. P647).
- Factor Analysis – University Sample – Scree Plot
- Figure. Age by Gender And Group Interaction Plot (University and Psychiatric Sample).
- Correlational Matrix – University Sample

University Sample: Preliminary Analysis of Subscale data Box plots and Histograms for males.



University Sample: Preliminary Analysis of Subscale Data Box Plots and Histograms for Females.



Sample Descriptive Statistics University Sample – Mean and Standard Deviations by Gender

Descriptive Statistics for Gender – University Sample

	Gender	N	Mean	Std. Deviation	Std. Error Mean
Age	Male	55	26.9818	5.24754	.70758
	Female	55	33.7091	10.57193	1.42552

*Coping Strategies Used by Adult Samples: University and Normative Sample
(Adopted Normative Table From: Frydenberg & Lewis, 2002, Table 2. P647).*

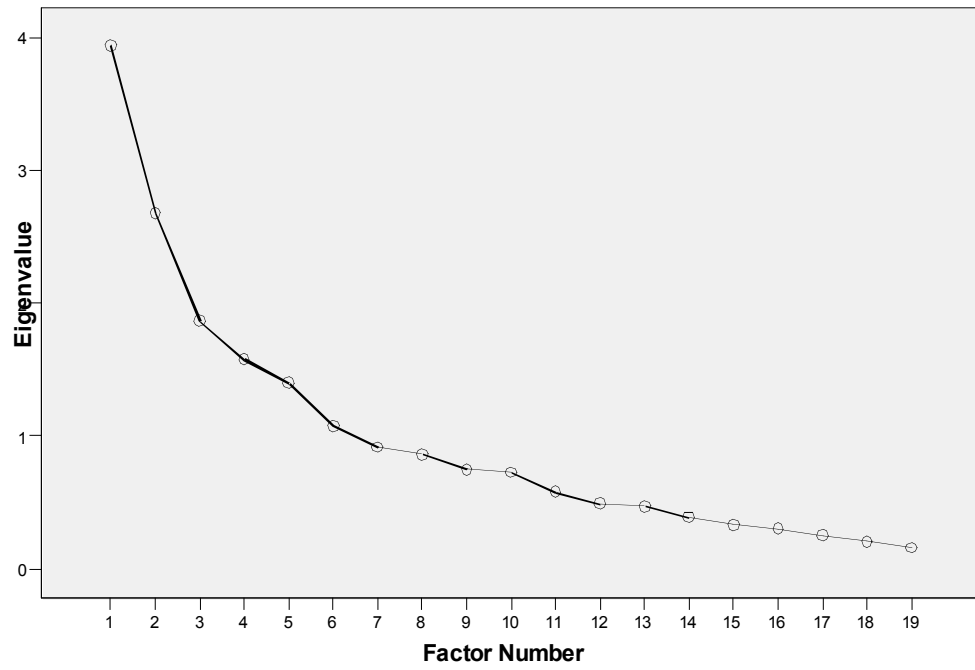
Strategy	University (N=110)		Normative (N=369)		<i>p</i> values
	Mean	SD	Mean	SD	
Seek social support	13.43	3.81	12.65	3.12	0.52
Focus on Solving the Problem	26.10	4.11	25.59	4.61	0.268
Work hard and achieve	11.20	2.16	12.01	3.19	0.002*
Worry	10.85	3.49	11.26	3.26	0.274
Improve relationships	10.79	3.17	12.07	4.18	0.001*
Wishful thinking	11.14	2.97	10.07	3.84	0.002*
Tension reduction	9.69	3.10	8.69	3.19	0.004
Social action	7.52	2.96	7.23	2.93	0.367
Ignore the problem	7.17	2.12	6.51	2.43	0.006
Self blame	11.13	3.99	11.36	3.17	0.580
Keep to self	10.04	3.50	11.43	3.61	0.000*
Seek spiritual Put here support	6.09	3.57	5.49	2.44	0.101
Focus on the positive	12.60	2.98	12.75	3.30	0.652
Seek profession help	8.26	2.99	7.95	3.52	0.361
Relax	14.90	2.64	14.45	3.62	0.154
Physical recreation	8.15	2.94	8.24	3.09	0.781
Protect self	11.95	3.06	12.14	3.52	0.582
Humour	8.84	3.04	7.87	2.94	0.004
Not Coping	6.89	2.75	6.71	2.66	0.545

*

Note: significant at $p = 0.0026$

Factor Analysis – University Sample- Scree Plot

Scree Plot



University Sample: Scree Plot



- *Figure. Age by Gender And Group Interaction Plot (University and Psychiatric Sample).*

APPENDIX C

- Part 2- Chapter 6. Table of Patient Demographics (N=38)

Patient	Sex	Year born	Diagnosis	Admissions	Suicide attempts	Family history of illness	Psychiatric medication	Counselling offered	Drug use	No fixed address	Deceased
1. Tanya	F	1974	Depression	3	0	No	Yes	Yes	Yes	Yes	No
2. Ben	M	1970	Bipolar	26	26	Yes	Yes	Yes	Yes	Yes	No
3. Anna	F	1971	BPD	11	11	No	Yes	Yes	Yes	Yes	No
4. Jim	M	1972	Bipolar	3	0	No	Yes	Yes	Yes	Yes	No
5.	M	1964	Schiz	7	4	No	Yes	No	No	No	No
6. Rose	F	1972	Schiz	3	0	Yes	Yes	Yes	Yes	Yes	No
7. Mark	M	1977	Depression	2	2	Yes	Yes	No	No	No	No
8. Tara	F	1968	Schiz	9	1	No	Yes	No	No	No	No
9.	M	1973	Schiz	6	1	No	Yes	No	Yes	No	No
10. Maria	F	1962	Bipolar	5	5	No	Yes	No	No	Yes	Yes
11.	F	1952	Depression	2	1	No	Yes	No	No	Yes	No
12.	F	1955	Schiz	1	0	Yes	Yes	No	Yes	Yes	No
13.	F	1967	Personality	3	3	Yes	Yes	Yes	Yes	No	No
14.	F	1958	Bipolar	6	2	No	Yes	Yes	No	Yes	No
15.	F	1953	Bipolar	6	2	No	Yes	Yes	No	Yes	No
16.	M	1967	Schiz	21	19	Yes	Yes	No	Yes	No	No
17.	M	1965	Personality	13	13	No	Yes	No	Yes	Yes	Yes
18.	M	1962	Schiz	4	3	Yes	Yes	No	Yes	No	No
19.	M	1955	Schiz	15	11	No	Yes	No	No	No	No
20.	M	1962	Schiz	7	2	Yes	Yes	No	Yes	Yes	Yes
21.	F	1975	Schiz	1	1	No	Yes	No	No	Yes	No
22.	F	1962	Schiz	1	0	No	Yes	No	No	No	No
23.	M	1975	Schiz	3	3	No	Yes	No	No	No	No
24.	M	1957	Depression	1	1	Yes	Yes	No	Yes	No	No
25.	M	1963	Depression	2	2	Yes	Yes	Yes	Yes	No	No
26. Phil	M	1968	Schiz	15	11	Yes	Yes	Yes	Yes	No	No
27.	M	1973	Bipolar	5	0	No	Yes	No	Yes	Yes	No
28.	M	1977	Bipolar	1	1	No	Yes	No	No	Yes	No
29.	M	1937	Bipolar	7	0	No	Yes	No	Yes	Yes	Yes
30.	M	1971	Schiz	9	0	No	Yes	No	No	No	No
31.	M	1970	Schiz	2	0	Yes	Yes	No	Yes	Yes	No
32.	M	1965	Schiz	1	0	Yes	Yes	No	Yes	Yes	No
33.	M	1972	Schiz	5	2	No	Yes	No	Yes	Yes	No

(continued)

Patient	Sex	Year born	Diagnosis	Admissions	Suicide attempts	Family history of illness	Psychiatric medication	Counselling offered	Drug use	No fixed address	Deceased
34.	M	1973	Schiz	5	5	Yes	Yes	No	Yes	Yes	No
35.	F	1982	Schiz	2	1	No	Yes	No	Yes	No	No
36.	M	1972	Schiz	12	6	Yes	Yes	No	No	No	No
37.	M	1976	Schiz	3	2	Yes	Yes	No	Yes	No	No
38. James	M	1957	Schiz	53	12	No	Yes	No	Yes	Yes	No