**Contemporary Issues in Health Professionals' Education and Research in South Africa.**

# Application of Lazarus's Cognitive Transactional Model of stress-appraisal-coping in an undergraduate mental health nursing programme in the Western Cape, South Africa

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## Abstract

This article describes how the cognitive transactional model of stress-appraisal-coping can be applied in the sense making process for students working in the challenging mental health care environment. Primary and secondary literature was searched by means of computer-assisted data bases using key words. An overview of emotions, emotion functioning and regulation is alluded to, to give credence to the application of the transactional model of stress and coping as purported by Lazarus & Folkman. The model is cognitive because it is based on the assumption that students' thinking processes, memory and the meaning that those events have for the student experiencing them - will act to mediate in determining stress and coping resources. The definition of stress emphasises the subjective responses in the relationship between the student and the mental health care environment. Coping, on the other hand, refers to the cognitive and behavioural attempts made by students to manage the demands of the mental health care environment but are appraised as exceeding the resources they possess. The central assumption of this theory is that the interaction between an individual and the environment creates stress experienced by the individual. In order to contextualise the discussion theoretical perspectives on emotions are alluded to. A simplistic example is given to show how undergraduate mental health nursing students may appraise an encounter with a mentally ill person and the outcome of that appraisal within the students' sense making process.

**Keywords:** stress, cognitive appraisal, mental health nursing programme, Lazarus's cognitive transactional model of stress-appraisal-coping.

## Introduction

Student nurses experience of stress whilst working in the mental health care setting may be due to a myriad of factors. Some may be related to aspects within the environment such as shortage of skilled staff and the stigma associated with mental illness (Warne & McAndrew, 2004). Other factors include educational preparedness and the emotional demands inherent in the nature of the work which is sometimes referred to as 'emotional labour' (Gray, 2009).

Shortage of skilled nursing staff is a global problem. However, the recruitment and retention of staff to address this in mental health care settings is compounded by the stigma related to mental health nursing. Mental health nursing is not seen as 'real nursing' as the work is perceived to be routine and mundane (Happell, 1999; Wells, Ryan & McElwee, 2000). This means that mental health nursing is often perceived as having a lower status than general nursing (Munnukka, Pukuri, Linnainmaa & Kilkku, 2002). Many people also hold views that people with mental illness are all violent, unpredictable and sometimes responsible for their own illness. This negative and stigmatising view is often also held by student nurses (Frisch & Frisch, 2011).

Educational unpreparedness may mean that student nurses do not feel confident to work in mental health care settings due to lack of experience (Happell, 1999). The emotional demands of mental health nursing, which includes the use of the self as a therapeutic instrument, further compounds the student nurses' distress (Frisch & Frisch, 2011).

Regardless of the potential stressors related to the mental health nursing, it is requirement for the mental health nursing programme and registration as a nurse with the South African Nursing Council. Aspects within the mental health nursing programmes at Higher Education included theory and practice, among other. Within the practice aspect there is a clinical component. This means that students undertaking a four year baccalaureate nursing programme in South Africa will work in the mental health care settings to attain the clinical learning objectives of the programme. These settings include psychiatric hospitals (including hospitals for intellectual disabled individuals) and community mental health clinics.

Placements are relatively short, with students spending 24 hours per week at the mental health care facility. This means that students do not have time to develop nurse/patient relationships, as patients may have been discharged when they return to the mental health care setting. The question then arises: How do students experience the mental health care setting according to Lazarus's cognitive transactional model of stress-appraisal-coping, to make sense of the encounters and cope in the environment? An explanation of the theoretical perspectives on emotion is necessary to contextualise the discussion.

**Methodology**

A literature review was conducted during the proposal writing stage for a PhD study to provide a theoretical framework which would serve to underpin the study, which aimed to develop a model of emotional support for students working in mental health care settings. Primary and secondary sources were searched using key words aided by computer-assisted data based bibliographies

such as MEDLINE (Medical Literature Online), Academic search premier, Nexus and CINAHL (Computer Index to Nursing and Allied Health Literature), Ebscohost, SpringerLink, Science Direct, Scopus and the library. Permission was not sought for use of articles as these are available for research purposes and generating discussion. Authors were acknowledged. Ethical clearance was not necessary for reasons cited above. Data obtained was synthesized for application to student nurses working within a mental health care environment.

## Results

In order to understand emotions within the context of the mental health care setting, it is necessary to provide an overview of how emotions are viewed by various researchers, what causes emotions, the functions of emotions, and how students regulate their emotions.

Emotions are central to all human experiences and functioning. Common understandings are determined by the context in which they occur. Whilst the subjective experience of emotions differs from one person to the next, these emotional functioning is described using verbal descriptions, such as being cut off from emotions, emotionally distant and emotionally expressive (Stanley & Burrows, 2001).

*Emotion and emotion causation*

Whilst many authors have attempted to define emotions, Moore (2010) suggests that in order to obtain a broader definition rather than a list of components of an emotion prototype, the term 'emotion episode' is deemed appropriate. Components of an emotional episode would include: 1) a cognitive component; 2) a feeling component which would be referred to as the emotional experience; 3) a motivational component which includes readiness for action; 4) a somatic component which includes physiological responses; and a 5) motor component which consists of expressive behaviour. These components correspond with functions of stimulus evaluation or appraisal; monitoring; preparation and support of action; and action.

Some components may be necessary for emotion, but no component appears to be unique. Some theorists have added additional criteria to the content of the component to assist with setting boundaries. One criteria specifies the content for the appraisal component, thus implying that emotions occur when the stimulus is appraised as being relevant to the person's goal (Moore, 2010). This is consistent with Lazarus's view on the transactional nature of the student nurse working within the mental health environment that is person/environment interaction.

There are three core features of emotion: emotions arise out of the meaning a situation has for the individual and the relevance the situation has for the goal of the individual; emotions are complex which include changes in subjective experience, behaviour and central and peripheral physiology; and emotions force themselves upon our awareness thus making emotion regulation possible and necessary (Gross & Thompson, 2007).

Emotion or emotional episode can then be described as "experiences of arousal that are associated with physical activation, changes in behaviour and subjective cognitive events" (Harper & van Vuuren, 2012: 130). There are few primary emotions. Primary emotions paired include fear-anger; joy-grief (sadness); disgust-trust (acceptance); and surprise-anticipation (expectancy) (Plutchik, 1962). Student nurses would use this array of emotions to cope, whether adaptively or maladaptively, in the mental health care setting.

*Functions of emotion*

Emotions are thought to have an adaptive or nurturing function. Through the experience of emotions, protective processes are activated against situations which signify danger, threat or loss. These processes also seek emotional support to nurture human needs. Adaptive functions of emotion include attention shift, motivation arousal, social communication, and precipitating behaviours (Stanley & Burrows, 2001). This implies that during a transactional encounter within the environment, emotion directs the individual's attention towards a relevant event and away from what is less relevant. Through cognitive interpretation of the event as one that elicits emotion, affective and behavioural responses are activated. These serve to resolve the situation, thus promoting adaptation. Human emotions direct much of human functioning and are present in both interpersonal and personal behaviours. Emotions allow student nurses in mental health care settings to communicate the impact events have on them verbally, non-verbally and behaviourally. When they observe emotions in the mentally ill patients, empathetic responses may be elicited which may allow students to engage in caring behaviours without experiencing the emotions themselves (Stanley & Burrows, 2001). However dysfunctional emotions may arise from interpretations of the psychosocial world. Anxiety which emanates from perceived threat may interfere with the students' functioning thus resulting in inability to display caring behaviours towards patients. Regulation of the students emotions take place in order to deal with the experience.

*Emotion regulation*

Emotion regulation is about how individuals influence their emotions and the experience and expression of these emotions (Gross & Thompson, 2007). In other words, emotion regulation means the way in which students deal with their

emotions to make sense of the experience in mental health care settings. This may happen automatically or in a controlled way and be conscious or unconscious (Gross, 1999). Emotion regulation includes both intrinsic and extrinsic processes. This implies that regulating emotions in others is extrinsic and the self-regulation of emotions is an intrinsic process (Gross & Thompson, 2007).

In this discussion, emotion regulation focuses on the intrinsic processes of how students self-regulate their emotions to enable self- reliance in the cognitive process of making sense of their encounters in the mental health care setting. A modal model of specifying the processes in emotion generation which potentially target regulation was developed by Gross (2001), and is discussed for clarification of the processes. According to Gross (2001) students can regulate their emotions at five points. These include: 1) situation selection, where situations are chosen by students to give rise to positive emotions. This is important for students placed in mental health care settings, because based on prior knowledge (information from friends about the mental health care setting) or experience, they may choose where and who they want to work with. However, this is not possible throughout the placement period as they have objectives to attain thus are placed in wards or situations that give rise to negative emotions. Choice is not an option for students in nurse education and training. 2) Situation modification, whereby students modify the mental health environment to avoid potentially distressing situations thus altering the emotional impact. Lazarus (1984) refers to this as "problem-focused coping" as a function of coping. Problem-focused coping changes the person-environment relationship by acting on the environment itself or on oneself. The students' belief in their ability to solve problems influences the emotions they experience in encounters in the mental health care setting. 3) Attentional deployment occurs when students redirect their attention during a patient interaction to influence the emotional response (Gross, 2007). This refers to the individual selecting from active 'internal situations', such as redirecting attention from a painful situation by using distraction. Distraction is important in coping with the mental health care environment as the student can change the internal focus when experiencing distressing memories of events or situations. 4) Cognitive change occurs when students' change how a situation is appraised to alter the emotional significance. Lazarus (1993) refers to this process as reappraisal of the event. Students encounter many patients with different life circumstances which may have contributed to their mental illness. In some instances patients may refuse to talk about their personal history when students are conducting an assessment. The students may interpret this as being directed at themselves and their perceived incompetence. Reappraisal or cognitive change about the situation may be that it is too distressing or insignificant for the patient to talk about. The interpretation of the situation, whether it is correct or incorrect, may change the intensity (how much emotion) and quality (which emotion) of the students emotional response.

5) Response modulation refers to the physiological, experiential or behavioural responses which are directly influenced during a student/patient interaction (Gross & Thompson, 2007). In mental health care settings this involves the student suppressing anxiety when confronted with mentally ill patients and taking control of the situation in order to cope with the experience.

**Discussion**

Lazarus's cognitive transactional model of stress-appraisal-coping (1984) is a process model. This implies that the focus is on how an individual construes (interprets/appraises) an event as harmful, threatening or challenging. The model is cognitive because it is based on the assumption that students thinking processes, memory and the meaning those events have for the student experiencing them, will act to mediate in determining stress and coping.

Within the definition of stress, the relationship between the student and the mental health environment is emphasised. This relationship is referred to as a transaction between the student and the mental health environment. Psychological stress refers to the person/environment relationship which is deemed important by the person for his/her well-being but exceeds the person's available coping resources (Lazarus & Folkman, 1984). This implies that the stress experienced by students in the mental health environment may be deemed to be negative, as it may have exceeded the student's ability to cope with the experience. Coping, on the other hand, refers to the cognitive and behavioural attempts made by students to manage the demands of the mental health care environment but are appraised as exceeding the resources they possess (Lazarus, 1993).

The model focuses on cognitive appraisal of stressors from the perspective of the person experiencing it and how the person copes within the stressful environment to make sense of the experience. The central assumption of this theory is that any event is potentially stressful. Two processes which serve as mediators within this person-environment transactions are important: cognitive appraisal and coping. Cognitive appraisal is the student's evaluation of the personal significance of the event or the occurrence. This concept is necessary to explain how different student's emotional response in quality, intensity and duration differ in an equally objective environment such as the mental health environment (Scherer, 2005). Whether coping or stress occurs, and in what form, depends on each individual student's way of construing (appraising) his/her relationship to environmental events. Appraisals are determined by personal and situational factors. Personal factors include motivational dispositions, goals, values and expectancies whilst situational factors refer to predictability, controllability and imminence of a potentially stressful event. The event elicits a

response from the student and this is influenced by how the student perceives the event (Lazarus & Folkman, 1984).

According to Lazarus and Cohen-Charash, (2001) cognitive appraisal consists of primary and secondary appraisal, of which there are six components. Primary appraisal refers to when the student assesses the challenge or the demand made by the situation. At this stage, if the student receives support, this may influence the interpretation of the event and promote a clearer understanding of the stressor (adaptive). Three components are distinguished within primary appraisal. *Goal relevance* is the extent to which the encounter refers to issues about which the person cares, or that are relevant to the student's well-being. If the student believes that there is no goal at stake, then no emotion will be elicited. *Goal congruence* defines the extent to which the event is aligned with personal goals. This implies that if the student appraises the situation or event as being congruent (helps) to his well-being, positive emotions will be elicited. If the situation is appraised as being incongruent (hinders) than negative emotions are elicited. *Type of ego involvement* includes aspects of personal commitment such as self-esteem, moral values, ego-ideal or ego- identity. These ego-involvements refer to goals that centre on the self and will determine the emotions felt.

Secondary appraisal refers to the student's estimation of his/her ability to cope or their 'counter-harm' resources. Three components of secondary appraisal are identified. *Accountability* (blame or credit) refers to the individual's appraisal of who is responsible for the event. For example, the patient may be physically violent towards the student. The student may construe this as it may be in reaction to something he/she (student) said or did, or the student may assign blame to the patient for the behaviour as he/she acted in what is perceived as a caring way but the patient responded negatively. *Coping potential* refers to the individual's evaluation of generating behavioural and cognitive mechanisms that will positively influence a personally relevant encounter. The student assesses his/her ability of dealing with the event by using his/her thought process or behaviour. *Future expectancy* refers to how the future of the event is predicted with respect to goal congruence or incongruence (Lazarus and Folkman, 1984).

Specific types of primary appraisal include irrelevant, benign-positive and stressful. When the event holds no significance for the individual, then it is referred to as *irrelevant*. A *benign-positive* appraisal occurs when the event produces a perceived pleasurable outcome. *Stress* appraisals are harm/loss, threat or challenge. Harm/loss appraisal refers to the damage or loss already experienced by the individual. When anticipated harms or losses are perceived, the appraisal is threatening. This implies that the student may perceive a mentally ill patient approaching him/her as someone who is going to attack. The event is then evaluated as being threatening to the students' person. Challenging appraisals refers to when the event is perceived to be challenging, the individual

focuses on potential for growth rather than the risks associated with the event. Challenges also produce stress despite the emotions associated with it being perceived as positive. The individual then uses coping mechanisms to confront the new encounter (Lazarus & Folkman, 1984).

A secondary appraisal is made by the individual in response to the harm/loss, threat or challenge appraisal. Secondary appraisal refers to the assessment of skills, resources and knowledge that the individual possesses to deal with the encounter. Evaluation is based on:

- What coping strategies are available to me?
- Will the option I choose be effective in this situation?
- Do I have the ability to use the strategy in an effective manner?

The adaption response is determined by the primary appraisal of the event and the secondary appraisal of available coping strategies. Cognitive appraisal is context based as what is perceived as stressful for one student may be perceived as challenging for another student. Regardless of this, it is important for students so that they are able to discern between situations which are benign or dangerous. Physiological, psychological, sociological and organizational factors are taken into account when the student appraises the mental health care setting as benign or threatening (Lazarus & Folkman, 1984). These factors may emanate from real experiences, personal background, student personality characteristics among others. Depending on the various emotional responses, coping becomes relevant and specific to the encounter.

Coping is "on going cognitive and behavioural efforts to manage specific external and or/internal demands that are appraised as taxing or exceeding the resources of the person (Lazarus, 1993: 237). Coping is seen as a process which changes over time depending on the situational context (Lazarus, 1993). The term coping is used to refer to either adaptive or maladaptive coping. Thus whether the coping process is perceived as good or bad depends on the student, specific type of encounter and the mode of outcome. According to Lazarus (1993) there are no universally good or bad coping processes though some may be better or worse than others in adaptational terms. Some coping strategies are stable and consistent over encounters thus implying that the student uses the same coping strategies to deal with specific events if they are perceived as having been effective previously.

The process of coping has two major functions, problem-focused and emotion-focused coping. Problem-focused coping changes the person-environment relationship by acting on the environment itself or on oneself. The students' belief in their ability to solve problems influences the emotions they experience in the encounter. The function of emotion-focused coping is either to change the

way the stressful environment is attended to or the relational meaning of what is happening, without changing the actual conditions of the relationship. The student's belief in their ability to handle the situation psychologically or that the situation must be tolerated, influences the emotions they experience in the encounter (Lazarus, 1993).

In order to clarify the transactional model in mental health care settings an example is given below.

*Individual in transaction*: Student nurse
*Behaviour setting*: Admission unit in a psychiatric hospital
*Environmental demand*: Mentally ill patient verbally abuses the student
*Primary appraisal* (How significant is the threat): The student assesses the demand as the patient's response to being admitted against his will.
*Secondary appraisal* (Coping): Student overcomes the initial anger and bases coping on the fact that the patient is mentally ill. The student states firmly that verbal abuse will not be tolerated.
*Reappraisal* (How effective was coping): Student waits for the patient to respond. The patient apologises for the verbal abuse. The nurse decides that a firm approach is an effective coping strategy.

## Conclusion

Lazarus's transactional model of stress-appraisal-coping provides a point of departure to elucidate the processes which occur when a student nurse has an encounter with a mental health patient. The findings suggest that cognitive processes occur somewhat seamlessly throughout the encounter but are nevertheless relevant to comprehend the complexity of the nurse/patient interaction.

## References

Frisch, N.C. & Frisch, L.E. (2011). *Psychiatric Mental Health Nursing*. New York: Delmar.

Gray, B. (2009). The emotional labour of nursing- defining and managing emotions in nursing work. *Nurse Education Today*, 29, 168-175.

Gross, J.J. (1999). Emotion regulation: Past, present, future. *Cognition and Emotion*, 13, 551-573.

Gross, J.J. (2001). Emotion regulation in adulthood: Timing is everything. *Current Directions in Psychological Science*, 10, 214-219.

Gross, J.J. (Ed.) (2007). *Handbook of Emotion Regulation*. New York: Guilford Press.

Gross, J.J. & Thompson, R.A. (2007). Emotion regulation: Conceptual foundations. In J.J. Gross (Ed.), *Handbook of Emotion Regulation* (pp. 3-24). New York: Guilford Press.

Harper, M. & van Vuuren, A. (2012). Motivation and emotion. In A. van Vuuren (Ed.), *21st Century Psychology for Nurses: An Introduction* (pp. 119- 137). Pretoria: Van Schaik.

Happell, B. (1999). Who wants to be a psychiatric nurse? Novice student nurses' interest in psychiatric nursing. *Journal of Psychiatric and Mental Health Nursing,* 6(6), 479-484.

Lazarus, R.S. (1984). *Appraisal and Coping.* USA: Springer.

Lazarus, R.S. (1993). From psychological stress to the emotions: A history of changing outlooks. *Annual Review of Psychology, 44,* 1–21.

Lazarus, R. S., & Folkman, S. (1984). *Stress, Appraisal and Coping.* NewYork: Springer-Verlag.

Lazarus, R.S. & Cohen-Charash, Y. (2001). Discrete emotions in organisational life. In R.L. Payne & C.L. Cooper (Eds.), *Emotions at Work: Theory, Research and Applications For Management* (pp. 45-81) West Sussex: John Wiley & Sons.

Moore, A. (2010). Theories of emotion causation: A review. In J. De Houwer & D. Hermans. (Eds.), *Cognition and Emotion. Reviews of Current Research and Theories* (pp. 1-37). East Sussex: Psychology Press.

Munnukka, T., Pukuri, T., Linnaunmaa, P. & Kilkku, N. (2002). Integration of theory and practice in learning mental health nursing. *Journal of Psychiatric and Mental Health Nursing,* 9(1), 5-14.

Plutchik, R. (1962). *The Emotions: Facts, Theories and a New Model.* New York: Random House.

Scherer, K.R. (2005). What are emotions? And how can they be measured. *Social Science Information,* 44(4), 695–729.

Stanley, R. & Burrows, G. (2001). Varieties and functions of human emotion. In R.L. Payne & C.L. Cooper (Eds.), *Emotions at Work: Theory, Research and Applications for Management* (pp. 3-19). England: John Wiley & Sons.

Warne, T. & McAndrew, S. (2004). The mental health assistant practitioner: An oxymoron. *Journal of Psychiatric and Mental Health Nursing,* 11, 179-184.

Wells, J.S.G., Ryan, D. & McElwee, C.N. (2000). 'I don't want to be a psychiatric nurse'; An exploration of factors inhibiting recruitment to psychiatric nursing in Ireland. *Journal of Psychiatric and Mental Health Nursing,* 7, 79-87.

CONTENTS
EDITORIAL
NOTES ON CONTRIBUTORS