THE PSYCHOSOCIAL PERSON

RELATIONSHIPS, STRESS, AND COPING

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Key Ideas

Case Study: Sheila’s Coping Strategies for College

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KEY IDEAS

As you read this chapter, take note of these central ideas:

1. Understanding the nature of a person's relationship patterns is important for evaluating her or his susceptibility to stress and potential for coping and adaptation. A variety of psychological (object relations, feminist) and social (Afrocentric, social identity development) theories are useful toward this end.

2. The quality of one's relationships with primary caregivers in infancy and childhood affects neurological development and has lasting effects on the capacity for mental and physical health in later life.

3. Stress, an event that taxes adaptive resources, may be biological, psychological, or social in origin; psychological stress can be categorized as harm, threat, and challenge.

4. Traumatic stress refers to events that are so overwhelming that almost anyone would be affected—events such as natural and technological disasters, war, and physical assault.

5. Our efforts to master the demands of stress are known as coping.

6. All people rely on social supports as means of dealing with stress.

7. Classification of human behavior as normal or abnormal differs among the helping professions. Psychiatry focuses on personal inadequacy in goal attainment and in social presentation from a context of disease or disorder. Psychology focuses on personal inadequacy in a developmental context and often deemphasizes the idea of disease. Sociology considers abnormality, or deviance, as an inability to fulfill a significant social role within a range of accepted behaviors as assessed by significant others in the community. Social work is reluctant to label persons as abnormal, because all behavior is conceptualized as interactional and related to the nature of the social context.
The Self in Relationships

In this chapter, we focus on how the psychological person manages challenges to social functioning, particularly stress. Sheila was fortunate: In addition to her personal strengths, she had access to support systems that helped her confront and begin to overcome the stress she was experiencing. We look at the common processes by which we all try to cope with the stresses we experience in life. As Sheila learned, the ability to form, sustain, and use significant relationships with other people is a key to the process of successful coping and adaptation. With this theme in mind, we begin by considering several theories that address the issue of how we exist in the context of relationships, including object relations theory, feminist and Afrocentric theories, social identity theory, and evidence demonstrating the importance of early nurturing in the ability to build relationships throughout life.

Object Relations Theory

The basic assumption of object relations theory is that all people naturally seek relationships with other people. The question is how well an individual forms interpersonal relationships
and how any deficiencies in social functioning might have arisen. The term *object relations* are synonymous with *interpersonal relations*. An “object” is another person but may also be the mental image of a person that we have incorporated into our psychological selves.

**Object relations theory** is a psychodynamic theory of human development that considers our ability to form lasting attachments with others to be based on early experiences of separation from and connection with our primary caregivers. Many social workers see this theory as an advance over psychoanalytic theory because it considers people in the context of relationships rather than as individual entities. We internalize our early relationship patterns, meaning that our first relationships make such an impression on us that they determine how we approach relationships from that point on. These early relationships are a primary determinant of our personality and the quality of our interpersonal functioning (Goldstein, 2001; St. Clair, 1999).

The ideal is to be raised by caregivers who help us gradually and appropriately move away from their physical and emotional supervision while communicating their availability for support. In such conditions, we acquire the capacity to form trusting attachments with others. This is known as *object constancy*. If, on the other hand, we learn (because of loss or negative caregiver behavior) that we cannot count on others for support as we take risks to move away, we might “internalize” a schema that other people cannot be counted on. Stable object relations result in our ability to form stable relationships, to trust others, and to persist with positive relationships during times of conflict. This idea of internalization is very important, as it implies that we carry our attachments with us. Those significant others in our lives do not only exist as memories, but are part of our psychological makeup—they are a part of who we are.

**Photo 5.1** Significant others can shape our sense of self positively or negatively through their support.
Object relations theorists have suggested a variety of stages in this process of developing object constancy, but we need not get into that level of detail. Suffice it to say that, in addition to the process of developing object relations in early childhood, we also experience a second such process in early adolescence. At that time (at least in Anglo American society), we begin to move away from the pervasive influence of our families and test our abilities to develop our own identities. This is another time of life in which we need to feel that we can trust our primary caregivers as we experiment with independence.

If you are concerned that your own early relationships might have been problematic, don’t worry. Object relations theorists do not assert that caregivers need to be perfect (whatever that might be), only that they communicate a sense of caring and permit the child to develop a sense of self (Winnicott, 1975). Even if early object relations are problematic, a person’s ability to develop trusting relationships can always be improved, sometimes with therapy.

It may be useful for us to consider one model of parent-child attachment here (Shorey & Snyder, 2006). All children seek close proximity to their parents, and they develop attachment styles suited to the types of parenting they encounter. Ainsworth and her colleagues (Ainsworth, Blehar, & Waters, 1978) identified three infant attachment styles—secure, anxious-ambivalent, and avoidant types. A fourth attachment style has been identified more recently—the disorganized type (Carlson, 1998; Main, 1996).

**Securely attached** infants act somewhat distressed when their mothers leave, but greet them eagerly and warmly upon return. Parents of secure infants are sensitive and accepting. Securely attached children are unconcerned about security needs and are thus free to direct their energies toward non-attachment-related activities in the environment. Insecure infants, rather than engaging in exploratory behaviors, must direct their attention to maintaining their attachments to inconsistent, unavailable, or rejecting parents. Because these children are only able to maintain proximity to the parents by behaving as if the parents are not needed, the children may learn not to express needs for closeness or attention.

**Anxiously-ambivalently attached** infants, in contrast, are distraught when their mothers leave. Upon their mothers’ return, these infants continue to be distressed even as they want to be comforted and held. These children employ “hyperactivation” strategies. Their parents, while not overtly rejecting, are often unpredictable and inconsistent in their responses. Fearing potential caregiver abandonment, the children maximize their efforts to maintain close parental attachments and become hypervigilant for threat cues and any signs of rejection.

**Avoidantly attached** infants seem to be relatively undisturbed both when their mothers leave and when they return. These children want to maintain proximity to their mothers, but this attachment style enables the children to maintain a sense of proximity to parents who otherwise may reject them. Avoidant children thus suppress expressions of overt distress, and rather than risk further rejection in the face of attachment figure unavailability, may give up on their proximity-seeking efforts.

The **disorganized attachment** style is characterized by chaotic and conflicted behaviors. These children exhibit simultaneous approach and avoidance behaviors. Disorganized infants seem incapable of applying any consistent strategy to bond with their parents. Their conflicted and disorganized behaviors reflect their best attempts at gaining some sense of security from parents who are perceived as frightening. When afraid and needing reassurance, these children have no options but to seek support from a caregiver who also is frightening. The parents may be either hostile or fearful and unable to hide their apprehension from their children. In either case, the child’s anxiety and distress are not lessened, and one source of stress is merely traded for another.
Although the children with disorganized attachments typically do not attain senses of being cared for, the avoidant and anxious-ambivalent children do experience some success in fulfilling their needs for care.

**Feminist Theories of Relationships**

The term *feminism* does not refer to any single body of thought. It refers to a wide-ranging system of ideas about human experience developed from a woman-centered perspective. Feminist theories may be classified as liberal, radical, Marxist, socialist, existential, postmodern, multicultural, and ecofeminist (Lengermann & Niebrugge-Brantley, 2007). Among the psychological theories are psychoanalytic feminism and gender feminism (Tong, 1998). We focus on these two as we consider how feminism has deepened our capacity for understanding human behavior and interaction. All of these theorists begin from the position that women and men approach relationships differently, and that patriarchal societies consider male attributes to be superior.

**Psychoanalytic feminists** assert that women’s ways of acting are rooted deeply in women’s unique ways of thinking. These differences may be biological, but they are certainly influenced by cultural and psychosocial conditions. Feminine behavior features gentleness, modesty, humility, supportiveness, empathy, compassion, tenderness, nurturance, intuitiveness, sensitivity, and unselfishness. Masculine behavior is characterized by strength of will, ambition, courage, independence, assertiveness, hardiness, rationality, and emotional control. Psychoanalytic feminists assert that these differences are largely rooted in early childhood relationships. Because women are the primary caretakers in our society, young girls tend to develop and enjoy an ongoing relationship with their mothers that promotes their valuing of relatedness as well as the other feminine behaviors. For young boys, on the other hand, the mother is eventually perceived as fundamentally different, particularly as they face social pressures to begin fulfilling male roles. The need to separate from the mother figure has long-range implications for boys: They tend to lose what could otherwise become a learned capacity for intimacy and relatedness.

**Gender feminists** tend to be concerned with values of separateness (for men) and connectedness (for women) and how these lead to a different morality for women. Carol Gilligan (1982; see also Chapter 4 of this book) is a leading thinker in this area. She elucidated a process by which women develop an ethic of care rather than an ethic of justice based on the value they place on relationships. Gender feminists believe that these female ethics are equal to male ethics, although they have tended in patriarchal societies to be considered inferior. Gilligan asserts that all of humanity would be best served if both ethics could be valued equally. Other gender feminists go further, however, arguing for the superiority of women’s ethics. For example, Noddings (1989, 2002) asserts that war will never be discarded in favor of the sustained pursuit of peace until the female ethic of caring, aimed at unification, replaces the male ethic of strenuous striving, aimed at dividing people.

All psychological feminist theories promote the value of relationships and the importance of reciprocal interpersonal supports. They encourage us to note that Sheila’s father raised her to be achievement- and task-oriented. These are admirable characteristics, but they represent male perspectives. Sheila’s inclinations for interpersonal experience may have been discouraged, which was harmful to her overall development.
Afrocentric Relational Theory

The origins of Afrocentric relational theory are in traditional Africa, before the arrival of European and Arabian influences. The Afrocentric worldview values cultural pluralism and, in fact, values difference in all of its forms. It does not accept hierarchies based on social differences, however. Eurocentric thinking, emphasizing mastery rather than harmony with the environment, is seen as oppressive. The three major objectives of Afrocentric theory are to provide an alternative perspective that reflects African cultures, to dispel negative distortions about African people held by other cultures, and to promote social transformations that are spiritual, moral, and humanistic.

Afrocentric relational theory assumes a collective identity for people rather than valuing individuality (Bell, Bouie, & Baldwin, 1990; Jackson, 2004; Schiele, 1996). It places great value on the spiritual or nonmaterial aspects of life, understood broadly as an “invisible substance” that connects all people. It values an affective approach to knowledge, conceptualizing emotion as the most direct experience of the self. This is of course in contrast to the Western emphasis on cognition and rationality. In its emphasis on the collective, Afrocentrism does not distinguish between things that affect the individual and things that affect larger groups of people, and it sees all social problems as related to practices of oppression and alienation. Personal connection and reciprocity are emphasized in helping relationships. Like feminism, Afrocentrism counters the object relations emphasis on individuality and independence with attention to collective identity and human connectedness.

Social Identity Theory

Social identity theory is a stage theory of socialization that articulates the process by which we come to identify with some social groups and develop a sense of difference from other social groups (Hardiman & Jackson, 1997; Nesdale, 2004). Social identity development can be an affirming process that provides us with a lifelong sense of belonging and support. I might feel good to have membership with a Roman Catholic or Irish American community. Because social identity can be exclusionary, however, it can also give rise to prejudice and oppression. I may believe that my race is more intelligent than another, or that persons of my cultural background are entitled to more benefits than those of another.

Social identity development proceeds in five stages. These stages are not truly distinct or sequential, however; people often experience several stages simultaneously.

1. **Naïveté.** During early childhood we have no social consciousness. We are not aware of particular codes of behavior for members of our group or any other social group. Our parents or other primary caregivers are our most significant influences, and we accept that socialization without question. As young children we do, however, begin to distinguish between ourselves and other groups of people. We may not feel completely comfortable with the racial, ethnic, or religious differences we observe, but neither do we feel fearful, superior, or inferior. Children at this stage are mainly curious about differences.

2. **Acceptance.** Older children and young adolescents learn the distinct ideologies and belief systems of their own and other social groups. During this stage, we learn that the world’s institutions and authority figures have rules that encourage certain behaviors and
prohibit others, and we internalize these dominant cultural beliefs and make them a part of our everyday lives. Those questions that emerged during the stage of naïveté are submerged. We come to believe that the way our group does things is normal, makes more sense, and is better. We regard the cultures of people who are different from us as strange, marginal, and perhaps inferior. We may passively accept these differences or actively do so by joining organizations that highlight our own identity and (perhaps) devalue others.

3. **Resistance.** In adolescence, or even later, we become aware of the harmful effects of acting on social differences. We have new experiences with members of other social groups that challenge our prior assumptions. We begin to reevaluate those assumptions and investigate our own role in perpetuating harmful differences. We may feel anger at others within our own social group who foster these irrational differences. We begin to move toward a new definition of social identity that is broader than our previous definition. We may work to end our newly perceived patterns of collusion and oppression.

4. **Redefinition.** Redefinition is a process of creating a new social identity that preserves our pride in our origins while perceiving differences with others as positive representations of diversity. We may isolate from some members of our social group and shift toward interactions with others from our social group who share our level of awareness. We see all groups as being rich in strengths and values. We may reclaim our own group heritage but broaden our definition of that heritage as one of many varieties of constructive living.

5. **Internalization.** In the final stage of social identity development, we become comfortable with our revised identity and are able to incorporate it into all aspects of our life. We act unconsciously without external controls. Life continues as an ongoing process of discovering vestiges of our old biases, but now we test our integrated new identities in wider contexts than our limited reference group. Our appreciation of the plight of all oppressed people, and our enhanced empathy for others, is a part of this process. For many people, the internalization stage is an ongoing challenge rather than an end state.

**The Impact of Early Nurturing**

We have been looking at theories that deem relationships to be important throughout our lives. Turning to the empirical research, we can find evidence that, as suggested by object relations theory, the quality of our early relationships is crucial to our lifelong capacity to engage in healthy relationships, and even to enjoy basic physical health.

There is a large body of research devoted to studying the links between early life experiences and physical and mental health risks (e.g., Gerhardt, 2004; Gunnar, Broderson, Nachimas, Buss, & Rigatuso, 1996; Hertsgaard, Gunnar, Erickson, & Nachimas, 1995; Nachimas, Gunnar, Mangelsdorf, Parritz, & Buss, 1996). This work demonstrates that negative infant experiences such as child abuse, family strife, poverty, and emotional neglect correlate with later health problems ranging from depression to drug abuse and heart disease. Relational elements of our early environments appear to permanently alter the development of central nervous system structures that govern our autonomic, cognitive, behavioral, and emotional responses to stress.

Animal models are common in this research, tracing the physiological aspects of rat and monkey stress responses all the way to the level of gene expression (Ainsman, Zaharia, Meaney, & Merali, 1998; Bredy, Weaver, Champagne, & Meaney, 2001; Lupien, King, Meaney,
It has been found that highly groomed young rats (pups) develop more receptors in their brains for the substances that inhibit the production of corticotropin-releasing hormone (CRH), the master regulator of the stress response. As a result of the tactile stimulation they received from mothers, the pups’ brains develop in a way that lowers their stress response—not only while being groomed, but also throughout life! When the rats are switched at birth to different mothers, the pups’ brain development matched the behavior of the mother who reared them, not their biological mothers. Furthermore, high-licking and high-grooming (nurturing) mother rats change their behavior significantly when given a substance that stimulates the hormonal effects of chronic stress, raising their CRH and lowering oxytocin, a hormone related to the equanimity many human mothers feel after giving birth. That is, under the influence of these stress hormones, the high nurturing mothers behaved like the low nurturing mothers, and their offspring grew up the same way.

Some of you may be familiar with the tradition of research on the nurturing practices of rhesus monkeys. Research continues in this area (Nelson & Carver, 1998; Suomi, 2005; Webb, Monk, & Nelson, 2001). In some of these experiments, monkeys are separated from their mothers at age intervals of 1 week, 1 month, 3 months, and 6 months and raised in a group of other monkeys that includes a different mother monkey. The infants who are separated later (3 or 6 months) exhibit normal behavior in the new setting. Those separated earlier, however, show a variety of abnormalities. The monkeys separated at 1 month initially exhibit a profound depression and refusal to eat. Once they recover, they show a deep need for attachments with other monkeys and also show great anxiety during social separation whenever they feel threatened. The monkeys separated at 1 week showed no interest in social contact with other monkeys, and this behavior did not change as they grew older. Autopsies of these monkeys show changes in brain development. The timing of separation from the primary caregiver seems to be significant to their later development. These findings in monkeys may have a sad counterpart in human children who are separated at early ages from their mothers.

Although much of this research is being conducted on rats, monkeys, and other animals, it has clear implications for human development. The concept of neural plasticity, which refers to the capacity of the nervous system to be modified by experience, is significant here (Knudsen, 2004; Nelson, 2000). Humans may have a window of opportunity or a critical period for altering neurological development, but this window varies, depending on the area of the nervous system. Even through the second decade of life, for example, neurotransmitter and synapse changes are influenced by internal biology but perhaps by external signals as well.

Stress can clearly affect brain development, but there is little evidence to assume that the first three years of life are all-important (Nelson, 1999). A study of 2,600 undergraduate students found that even in late adolescence and early adulthood, satisfying social relationships were associated with greater autonomic activity and restorative behaviors when confronting acute stress (Cacioppo, Bernston, Sheridan, & McClintock, 2000). Higher CRH levels characterized chronically lonely individuals.

In summary, the research evidence indicates that secure attachments play a critical role in shaping the systems that underlie our reactivity to stressful situations. At the time when infants begin to form specific attachments to adults, the presence of caregivers who are warm and responsive begins to buffer or prevent elevations in stress hormones, even in situations that distress the infant. In contrast, insecure relationships are associated with higher CRH levels in potentially threatening situations. Secure emotional relationships with adults appear to be at least as critical as individual differences in temperament in determining stress reactivity and regulation.
Still, there is much to be learned in this area. Many people who have been subjected to serious early life traumas become effective, high functioning adolescents and adults. Infants and children are resilient and have many strengths that can help them overcome these early-life stresses. Researchers are challenged to determine whether interventions such as foster care can remedy the physical, emotional, and social problems seen in children who have experienced poor nurturing and early problems in separation.

The Concept of Stress

One of the main benefits of good nurturing is, as you have seen, the way it strengthens the ability to cope with stress. Stress can be defined as any event in which environmental or internal demands tax the adaptive resources of an individual. Stress may be biological (a disturbance in bodily systems), psychological (cognitive and emotional factors involved in the evaluation of a threat), and even social (the disruption of a social unit). Sheila experienced psychological stress, of course, as evidenced by her troublesome thoughts and feelings of depression, but she also experienced other types of stress. She experienced biological stress because, in an effort to attend classes, study, and work, she did not give her body adequate rest. As a result, she was susceptible to colds and the flu, which kept her in bed for several days each month and compounded her worries about managing course work. Sheila also experienced social stress, because she had left the slow-paced, interpersonally comfortable environments of her rural home and community college to attend the university.

Three Categories of Psychological Stress

Psychological stress, about which we are primarily concerned in this chapter, can be broken down into three categories (Lazarus & Lazarus, 1994):

1. **Harm**: A damaging event that has already occurred. Sheila avoided interaction with her classmates during much of the first semester, which may have led them to decide that she is aloof and that they should not try to approach her socially. Sheila has to accept that this rejection happened and that some harm has been done to her as a result, although she can learn from the experience and try to change in the future.

2. **Threat**: A perceived potential for harm that has not yet happened. This is probably the most common form of psychological stress. We feel stress because we are apprehensive about the possibility of the negative event. Sheila felt threatened when she walked into a classroom during the first semester, because she anticipated rejection from her classmates. We can be proactive in managing threats to ensure that they do not in fact occur and result in harm to us.

3. **Challenge**: An event we appraise as an opportunity rather than an occasion for alarm. We are mobilized to struggle against the obstacle, as with a threat, but our attitude is quite different. Faced with a threat, we are likely to act defensively to protect ourselves. Our defensiveness sends a negative message to the environment: we don’t want to change; we want to be left alone. In a state of challenge, however, we are excited, expansive, and confident about the task to be undertaken. The challenge may be an exciting and productive experience for us. In her second year at the university, Sheila may feel more excited than before about
entering a classroom full of strangers at the beginning of a semester. She may look forward with more confidence to meeting some persons who may become friends.

Stress has been measured in several ways (Aldwin & Yancura, 2004; Lazarus & Lazarus, 1994). One of the earliest attempts to measure stress consisted of a list of life events, uncommon events that bring about some change in our lives—experiencing the death of a loved one, getting married, becoming a parent, and so forth. The use of life events to measure stress is based on the assumption that major changes involve losses and disrupt our behavioral patterns.

More recently, stress has also been measured as daily hassles, common occurrences that are taxing—standing in line waiting, misplacing or losing things, dealing with troublesome coworkers, worrying about money, and many more. It is thought that an accumulation of daily hassles takes a greater toll on our coping capacities than do relatively rare life events.

Sociologists and community psychologists also study stress by measuring role strain—problems experienced in the performance of specific roles, such as romantic partner, caregiver, or worker. Research on caregiver burden is one example of measuring stress as role strain (Bowman, 2006).

**Stress and Crisis**

A crisis is a major upset in our psychological equilibrium due to some harm, threat, or challenge with which we cannot cope (James & Gilliland, 2001). The crisis poses an obstacle to achieving a personal goal, but we cannot overcome the obstacle through our usual methods of problem solving. We temporarily lack either the necessary knowledge for coping or the ability to focus on the problem, because we feel overwhelmed. A crisis episode often results
when we face a serious stressor with which we have had no prior experience. It may be bio-
logical (major illness), interpersonal (the sudden loss of a loved one), or environmental
(unemployment or a natural disaster such as flood or fire). We can regard anxiety, guilt,
shame, sadness, envy, jealousy, and disgust as stress emotions (Lazarus, 1993). They are the
emotions most likely to emerge in a person who is experiencing crisis.

Crisis episodes occur in three stages:

1. Our level of tension increases sharply.
2. We try and fail to cope with the stress, which further increases our tension and con-
tributes to our sense of being overwhelmed. We are particularly receptive to receiv-
ing help from others at this time.
3. The crisis episode ends, either negatively (unhealthy coping) or positively (successful
management of the crisis).

Crises can be classified into three types (Lantz & Lantz, 2001). Developmental crises occur
as events in the normal flow of life create dramatic changes that produce extreme responses.
Examples include the birth of one’s child, going off to college, college graduation, a midlife
career change, and retirement from work. People may experience these types of crises if they
have difficulty negotiating the typical challenges outlined by Erikson (1968) and Germain and
Gitterman (1996). Situational crises refer to uncommon and extraordinary events that a
person has no way of forecasting or controlling. Examples include physical injuries, sexual
assault, loss of a job, illness, and the death of a loved one. Existential crises are characterized
by escalating inner conflicts related to issues of purpose in life, responsibility, independence,
freedom, and commitment. Examples include remorse over past life choices, a feeling that
one’s life has no meaning, and a questioning of one’s basic values or spiritual beliefs.

Sheila’s poor midterm grades during her first semester illustrate some of these points.
First, she was overwhelmed by the negative emotions of shame and sadness. Then she retreated
to her parents’ home, where she received much-needed support from her family. With their
encouragement, she sought additional support from her academic adviser and a counselor.
Finally, as the crisis situation stabilized, Sheila concluded that she could take some actions to
relieve her feelings of loneliness and incompetence (a positive outcome).

**Traumatic Stress**

Although a single event may pose a crisis for one person but not another, some stressors are
so severe that they are almost universally experienced as crisis. The stress is so overwhelm-
ing that almost anyone would be affected. The term **traumatic stress** is used to refer to
events that involve actual or threatened severe injury or death, of oneself or significant others
(American Psychiatric Association, 2000). Three types of traumatic stress have been identi-
cified: natural (such as flood, tornado, earthquake) and technological (such as nuclear) disas-
ters; war and related problems, such as concentration camps; and individual trauma, such as
being raped, assaulted, or tortured (Aldwin, 1994). People respond to traumatic stress with
helplessness, terror, and horror.

Some occupations—particularly those of emergency workers such as police officers,
firefighters, disaster relief workers, and military personnel in war settings—involvregular
exposure to traumatic events that most people do not experience in a lifetime. The literature about the stress faced by emergency workers refers to these traumatic events as critical incidents (CIs) and the reaction to them as critical incident stress (Prichard, 1996). Emergency workers, particularly police officers and firefighters, may experience threats to their own lives and the lives of their colleagues, as well as encountering “mass casualties of a gory and grotesque nature” (Prichard, 1996, p. 19). Emergency workers may also experience compassion stress, a “feeling of deep sympathy and sorrow for another who is stricken by suffering or misfortune, accompanied by a strong desire to alleviate the pain or remove its cause” (Figley, 1995, p. 299). Any professionals who work regularly with trauma survivors are susceptible to compassion stress. Many social workers fall into this category.

Vulnerability to Stress

Our experience of stress is in part related to our individual biological constitutions and our previous experiences with stress. Research from the field of mental illness underscores this point. In an attempt to understand the causes of many mental disorders, several researchers have postulated stress/diathesis models of mental illness (Ingram & Luxton, 2005). These models are based on empirical data indicating that certain disorders (psychotic and mood disorders for example) develop from the interaction of environmental stresses and a diathesis, or vulnerability, to the disorders. The diathesis may be biological (a genetic or biochemical predisposition), environmental (history of severe stressors), or both (Sadock & Sadock, 2005). Most models, however, emphasize biological factors.

Stress/diathesis models suggest that all persons do not have an equal chance of developing mental disorders, because it depends in part on one’s chemical makeup. A person at risk may have an innate inability to manage high levels of stimulation from the outside world. For example, one model postulates that the onset of schizophrenia is 70% related to innate predisposition and 30% related to external stress (Gottesman, 1991).

The stress/diathesis view highlights a probable interaction between constitutional and environmental factors in our experience and tolerance of stress. It suggests that a single event may pose a crisis for one person but not another. In its broadest versions, it also suggests that vulnerability to stress is related to one’s position in the social structure, with some social positions exposed to a greater number of adverse situations—such as poverty, racism, and blocked opportunities—than others (Ingram & Luxton, 2005).

Coping and Adaptation

Our efforts to master the demands of stress are referred to as coping. Coping includes the thoughts, feelings, and actions that constitute these efforts. One method of coping is adaptation, which may involve adjustments in our biological responses, in our perceptions, or in our lifestyle.

Biological Coping

The traditional biological view of stress and coping, developed in the 1950s, emphasizes the body’s attempts to maintain physical equilibrium, or homeostasis, which is a steady state of
functioning (Selye, 1991). Stress is considered the result of any demand on the body (specifically, the nervous and hormonal systems) during perceived emergencies to prepare for fight (confrontation) or flight (escape). A stressor may be any biological process, emotion, or thought.

In this view, the body’s response to a stressor is called the general adaptation syndrome. It occurs in three stages:

1. **Alarm**: The body first becomes aware of a threat.
2. **Resistance**: The body attempts to restore homeostasis.
3. **Exhaustion**: The body terminates coping efforts because of its inability to physically sustain the state of disequilibrium.

The general adaptation syndrome is explained in Exhibit 5.1.

In this context, *resistance* has a different meaning than is generally used in social work: an active, positive response of the body in which endorphins and specialized cells of the immune system fight off stress and infection. Our immune systems are constructed for

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**Exhibit 5.1 The General Adaptation Syndrome**

<table>
<thead>
<tr>
<th>Alarm</th>
<th>Resistance</th>
<th>Exhaustion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Activation of hypothalamus (link between brain and endocrine system)</td>
<td>Production of corticotrophin-releasing factor (CRF)</td>
<td>Gradual reversal of all processes</td>
</tr>
<tr>
<td>Production of corticotrophin-releasing factor (CRF)</td>
<td>Activation of pituitary gland by CRF</td>
<td></td>
</tr>
<tr>
<td>Release of adrenocorticotropic hormone (ACTH) by pituitary gland</td>
<td>ACTH impact on adrenal cortex</td>
<td></td>
</tr>
<tr>
<td>Secretion of cortoids for:</td>
<td>Energy and adaptation</td>
<td>Cumulative wear and tear on the body’s resources</td>
</tr>
<tr>
<td>- Energy and adaptation</td>
<td>Enzymatic activation of connective tissue inflammatory potential (which protects all organ systems)</td>
<td></td>
</tr>
<tr>
<td>Hormonal secretions</td>
<td>Adrenalin (for energy)</td>
<td></td>
</tr>
<tr>
<td>- Increases pulse rate</td>
<td>- Increases blood pressure</td>
<td></td>
</tr>
<tr>
<td>- Increases blood circulation</td>
<td>- Stimulates central nervous system activity</td>
<td></td>
</tr>
</tbody>
</table>

Transmission of signals about some threat via nervous and vascular (blood) systems

First mediator effects:
- Hormone discharge
- Stimulation of lymphatic organs
- Enlargement of adrenal glands
- Feelings of fatigue

Hormonal secretions
- Adrenalin (for energy)
adaptation to stress, but cumulative wear and tear of multiple stress episodes can gradually deplete our body’s resources. Common outcomes of chronic stress include stomach and intestinal disorders, high blood pressure, heart problems, and emotional problems. If only to preserve healthy physical functioning, we must combat and prevent stress.

This traditional view of biological coping with stress came from research that focused on males, either male rodents or human males. Since 1995, the federal government has required federally funded researchers to include a broad representation of both men and women in their study samples. Consequently, recent research on stress has included female as well as male participants, and gender differences in responses to stress have been found.

Research by Shelley Taylor and colleagues (Taylor, Klein, et al., 2000; Taylor, Lewis, et al., 2002) found that females of many species, including humans, respond to stress with “tend-and-befriend” rather than the “fight-or-flight” behavior described in the general adaptation syndrome. Under stressful conditions, females have been found to turn to protecting and nurturing their offspring and to seek social contact. The researchers suggest a possible biological basis for this gender difference in the coping response. More specifically, they note a large role for the hormone oxytocin, which plays a role in childbirth but also is secreted in both males and females in response to stress. High levels of oxytocin in animals are associated with calmness and increased sociability. Although males as well as females secrete oxytocin in response to stress, there is evidence that male hormones reduce the effects of oxytocin. Taylor and colleagues believe this explains the gender differences in response to stress.

Psychological Coping

The psychological aspect of managing stress can be viewed in two different ways. Some theorists consider coping ability to be a stable personality characteristic, or trait; others see it instead as a transient state—a process that changes over time depending on the context (Lau, Eley, & Stevenson, 2006).

Those who consider coping to be a trait see it as an acquired defensive style. Defense mechanisms are unconscious, automatic responses that enable us to minimize perceived threats or keep them out of our awareness entirely. Exhibit 5.2 lists the common defense mechanisms identified by ego psychology (discussed in Chapter 4). Some defense mechanisms are considered healthier, or more adaptive, than others. Sheila’s denial of her need for intimacy, for example, did not help her meet her goal of developing relationships with peers. But through the defense of sublimation (channeling the need for intimacy into alternative and socially acceptable outlets), she has become an excellent caregiver to a friend’s child.

Those who see coping as a state, or process, observe that our coping strategies change in different situations. After all, our perceptions of threats, and what we focus on in a situation, change. The context also has an impact on our perceived and actual abilities to apply effective coping mechanisms. From this perspective, Sheila’s use of denial would be adaptive at some times and maladaptive at others. Perhaps her denial of loneliness during the first academic semester helped her focus on her studies, which would help her achieve her goal of receiving an education. During the summer, however, when classes are out of session, she might become aware that her avoidance of relationships has prevented her from attaining interpersonal goals. Her efforts to cope with loneliness might also change when she can afford more energy to confront the issue.
### Exhibit 5.2 Common Defense Mechanisms

<table>
<thead>
<tr>
<th>Defense Mechanism</th>
<th>Definition</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denial</td>
<td>Negating an important aspect of reality that one may actually perceive.</td>
<td>A woman with anorexia acknowledges her actual weight and strict dieting practices, but firmly believes that she is maintaining good self-care by dieting.</td>
</tr>
<tr>
<td>Displacement</td>
<td>Shifting feelings about one person or situation onto another.</td>
<td>A student's anger at her professor, who is threatening as an authority figure, is transposed into anger at her boyfriend, a safer target.</td>
</tr>
<tr>
<td>Intellectualization</td>
<td>Avoiding undesirable emotions by thinking or talking about them rather than experiencing them directly.</td>
<td>A person talks to her counselor about the fact that she is sad but shows no emotional evidence of sadness, which makes it harder for her to understand its effects on her life.</td>
</tr>
<tr>
<td>Introjection</td>
<td>Taking characteristics of another person into the self in order to avoid a direct expression of emotions. The emotions originally felt about the other person are now felt toward the self.</td>
<td>An abused woman feels angry with herself rather than her abusing partner, because she has taken on his belief that she is an inadequate caregiver. Believing otherwise would make her more fearful that the desired relationship might end.</td>
</tr>
<tr>
<td>Isolation of Affect</td>
<td>Consciously experiencing an emotion in a “safe” context rather than the threatening context in which it was first unconsciously experienced.</td>
<td>A person does not experience sadness at the funeral of a family member, but the following week weeps uncontrollably at the death of a pet hamster.</td>
</tr>
<tr>
<td>Projection</td>
<td>Attributing unacceptable thoughts and feelings to others.</td>
<td>A man does not want to be angry with his girlfriend, so when he is upset with her, he avoids owning that emotion by assuming that she is angry at him.</td>
</tr>
<tr>
<td>Rationalization</td>
<td>Using convincing reasons to justify ideas, feelings, or actions so as to avoid recognizing true motives.</td>
<td>A student copes with the guilt normally associated with cheating on an exam by reasoning that he was too ill the previous week to prepare as well as he wanted.</td>
</tr>
<tr>
<td>Reaction Formation</td>
<td>Replacing an unwanted unconscious impulse with its opposite in conscious behavior.</td>
<td>A person cannot bear to be angry with his boss, so after a conflict he convinces himself that the boss is worthy of loyalty and demonstrates this by volunteering to work overtime.</td>
</tr>
</tbody>
</table>

(Continued)
The trait and state approaches can usefully be combined. We can think of coping as a general pattern of managing stress that allows flexibility across diverse contexts. This perspective is consistent with the idea that cognitive schemata develop through the dual processes of assimilation and accommodation, described in Chapter 4.

### Coping Styles

Another way to look at coping is by the way the person responds to crisis. Coping efforts may be problem-focused or emotion-focused. The function of **problem-focused coping** is to change the situation by acting on the environment. This method tends to dominate whenever we view situations as controllable by action. For example, Sheila was concerned about her professors’ insensitivity to her learning disability. When she took action to educate them and explain more clearly how she learns best in a classroom setting, she was using problem-focused coping. In contrast, the function of **emotion-focused coping** is to change either the way the stressful situation is attended to (by vigilance or avoidance) or the meaning to oneself of what is happening. The external situation does not change, but our

---

**Exhibit 5.2** (Continued)

<table>
<thead>
<tr>
<th>Defense Mechanism</th>
<th>Definition</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regression</td>
<td>Resuming behaviors associated with an earlier developmental stage or level of functioning in order to avoid present anxiety. The behavior may or may not help to resolve the anxiety.</td>
<td>A young man throws a temper tantrum as a means of discharging his frustration when he cannot master a task on his computer. The startled computer technician, who had been reluctant to attend to the situation, now comes forth to provide assistance.</td>
</tr>
<tr>
<td>Repression</td>
<td>Keeping unwanted thoughts and feelings entirely out of awareness.</td>
<td>A son may begin to generate an impulse of hatred for his father, but because the impulse would be consciously unacceptable, he represses the hatred and does not become aware of it.</td>
</tr>
<tr>
<td>Somatization</td>
<td>Converting intolerable impulses into somatic symptoms.</td>
<td>A person who is unable to express his negative emotions develops frequent stomachaches as a result.</td>
</tr>
<tr>
<td>Sublimation</td>
<td>Converting an impulse from a socially unacceptable aim to a socially acceptable one.</td>
<td>An angry, aggressive young man becomes a star on his school’s debate team.</td>
</tr>
<tr>
<td>Undoing</td>
<td>Nullifying an undesired impulse with an act of reparation.</td>
<td>A man who feels guilty about having lustful thoughts about a coworker tries to make amends to his wife by purchasing a special gift for her.</td>
</tr>
</tbody>
</table>

*SOURCE: Adapted from Goldstein (1995).*

---

The trait and state approaches can usefully be combined. We can think of coping as a general pattern of managing stress that allows flexibility across diverse contexts. This perspective is consistent with the idea that cognitive schemata develop through the dual processes of assimilation and accommodation, described in Chapter 4.
U.S. culture tends to venerate problem-focused coping and the independently functioning self and to distrust emotion-focused coping and what may be called relational coping. Relational coping takes into account actions that maximize the survival of others—such as our families, children, and friends—as well as ourselves (Zunkel, 2002). Feminist theorists propose that women are more likely than men to employ the relational coping strategies of negotiation and forbearance, and Taylor’s recent research (Taylor, Klein et al., 2000; Taylor, Lewis et al., 2002) gives credence to the idea that women are more likely than men to use relational coping. As social workers, we must be careful not to assume that one type of coping is superior to the other. Power imbalances and social forces such as racism and sexism affect the coping strategies of individuals (Banyard & Graham-Bermann, 1993). We need to give clients credit for the extraordinary coping efforts they may make in hostile environments.

Richard Lazarus (1993) has identified some particular behaviors typical of each coping style:

- **Problem-focused coping**: confrontation, problem solving
- **Emotion-focused coping**: distancing, escape or avoidance, positive reappraisal
- **Problem- or emotion-focused coping (depending on context)**: self-control, search for social support, acceptance of responsibility

Behaviors or attitudes change with respect to it, and we may thus effectively manage the stressor. When we view stressful conditions as unchangeable, emotion-focused coping may dominate. If Sheila learns that one of her professors has no empathy for students with learning disabilities, she might avoid taking that professor’s courses in the future, or decide that getting a good grade in that course is not as important as being exposed to the course material.
Lazarus emphasizes that all of us use any or several of these mechanisms at different times. None of them is any person’s sole means of managing stress.

Using Lazarus’s model, we might note that Sheila did not initially employ many problem-focused coping strategies to manage stressors at the university, and she overused emotion-focused methods. For example, she accepted responsibility (that is, blamed herself) for her difficulties at first and tried without success to control her moods through force of will. Later, she distanced herself from her emotions and avoided stressors by spending more time away from campus working, and she was in fact quite skilled at this job. When she began seeking social support, she became more problem-focused.

I probably don’t need to tell you that college students face many predictable stressors when attending to the demands of academic work. A few years ago, I wanted to learn more about how students use both problem- and emotion-focused coping strategies in response to stress. I surveyed social work students in two Human Behavior in the Social Environment courses at a large urban university at the beginning of an academic year about their anticipated stressors and the ways they might cope with them. The results of this informal survey are outlined in Exhibit 5.3. The students chose problem- and emotion-focused coping strategies almost equally—a healthy mix (although they may not have been forthcoming about some socially “unacceptable” strategies).

Coping and Traumatic Stress

People exhibit some similarities between the way they cope with traumatic stress and the way they cope with everyday stress. For both types of stress, they use “problem-focused action, social support, negotiation skills, humor, altruism, and prayer” (Aldwin, 1994, p. 188). However, coping with traumatic stress differs from coping with everyday stress in several ways (Aldwin & Yancura, 2004):

- Because people tend to have much less control in traumatic situations, their primary emotion-focused coping strategy is emotional numbing, or the constriction of emotional expression. They also make greater use of the defense mechanism of denial.
- Confiding in others takes on greater importance.
- The process of coping tends to take a much longer time. Reactions can be delayed, for months or even years.
- A search for meaning takes on greater importance, and transformation in personal identity is more common.

Although there is evidence of long-term negative consequences of traumatic stress, trauma survivors sometimes report positive outcomes as well. Studies have found that 34% of holocaust survivors and 50% of rape survivors report positive personal changes following their experiences with traumatic stress (Burt & Katz, 1987; Kahana, 1992).

However, many trauma survivors experience a set of symptoms known as posttraumatic stress disorder (American Psychiatric Association, 2000). These symptoms include the following:

- Persistent reliving of the traumatic event: intrusive, distressing recollections of the event; distressing dreams of the event; a sense of reliving the event; intense distress when exposed to cues of the event
## Exhibit 5.3 Coping Styles Among Social Work Students

### Problem-Focused Coping

**Confrontation**
- Learn to say no.

**Problem Solving**
- Exercise.
- Work with other students.
- Talk with professors.
- Go to the beach (for relaxation).
- Manage time.
- Undertake self-care.
- Reserve time for oneself.
- Stay ahead.
- Use relaxation techniques.
- Walk.

**Self-Control**
- Bear down and “gut it out.”
- Take on a job.

**Search for Social Support**
- Talk.
- Network with others.
- Demand support from others.
- Reserve time with family.

- Clean the house.
- Carry own lunch (save money).
- Aim for good nutrition.
- Take breaks.
- Look for “free” social activities.
- Pursue art interest.
- Organize tasks.
- Carefully budget finances.
- Plan for a job search.

### Emotion-Focused Coping

**Distancing**
- Deny that problem exists.
- Procrastinate.

**Escape or Avoidance**
- Drink.
- Smoke.
- Drink too much caffeine.
- Overeat, undereat.
- Give up.

**Positive Reappraisal**
- Think of money produced by job.
- Maintain perspective.

**Self-Control**
- Push too hard.

**Search for Social Support**
- Seek intimacy.
- Engage in sex.
- Participate in therapy.

**Acceptance of Responsibility**
- Cry.

- Vent on others.
- Curse other drivers.
- Neglect others.
- Watch too much television.
- Neglect other important concerns.
- Use charge cards.
- Maintain flexibility.
- Reframe frustrations as growth opportunities.
- Study all night.
Persistent avoidance of stimuli associated with the traumatic event: avoidance of thoughts or feelings connected to the event; avoidance of places, activities, and people connected to the event; inability to recall aspects of the trauma; loss of interest in activities; feeling detached from others; emotional numbing; no sense of a future

Persistent high state of arousal: difficulty sleeping, irritability, difficulty concentrating, excessive attention to stimuli, exaggerated startle response

Symptoms of posttraumatic stress disorder have been noted as soon as one week following the traumatic event, or as long as 30 years after (Sadock & Sadock, 2005). Complete recovery from symptoms occurs in 30% of the cases, mild symptoms continue over time in 40%, moderate symptoms continue in 20%, and symptoms persist or get worse in about 10% (Sadock & Sadock, 2005). Children and older adults have the most trouble coping with traumatic events. A strong system of social support helps to prevent or to foster recovery from posttraumatic stress disorder. Besides providing support, social workers may be helpful by encouraging the person to discuss the traumatic event and by providing education about a variety of coping mechanisms.

Social Support

In coping with the demands of daily life, our social supports—the people we rely on to enrich our lives—can be invaluable. Social support can be formally defined as the interpersonal interactions and relationships that provide us with assistance or feelings of attachment to persons we perceive as caring (Hobfoll, Freedy, Lane, & Geller, 1990). Three types of social support resources are available (Walsh & Connelly, 1996):

1. Material support: food, clothing, shelter, and other concrete items
2. Emotional support: interpersonal support
3. Instrumental support: services provided by casual contacts, such as grocers, hairstylists, and landlords

Some authors add “social integration” support to the mix, which refers to a person’s sense of belonging. That is, simply belonging to a group, and having a role and contribution to offer, may be an important dimensions of support (Cameron, Vanderwoerd, & Peirson 1997). This is consistent with the “main effect” hypothesis of support, discussed below.

Our social network includes not just our social support but all the people with whom we regularly interact and the patterns of interaction that result from exchanging resources with them (Moren-Cross & Lin, 2006). Network relationships often occur in clusters (distinct categories such as nuclear family, extended family, friends, neighbors, community relations, school, work, church, recreational groups, and professional associations). Network relationships are not synonymous with support; they may be negative or positive. But the scope of the network does tend to indicate our potential for obtaining social support. Having supportive others in a variety of clusters indicates that we are supported in many areas of our lives, rather than being limited to relatively few sources. Our personal network includes those from the social network who, in our view, provide us with our most essential supports (Bidart & Lavenu, 2005).

Exhibit 5.4 displays Sheila’s social network. She now has two close friends at the university with whom she spends much time. She met both Christine and Ben in her classes.
Christine has a young child, Tiffany, for whom Sheila frequently baby-sits. Sheila feels a special closeness to the infant, who makes her feel unconditionally accepted and worthwhile. Ironically, Sheila finds herself doing much advice-giving and caregiving for these friends while wanting (but lacking) nurturing for herself. Still, Sheila feels good about the nature of these relationships, because she does not want to confide too much in her friends. She is concerned that they might reject her if they get to know her too well. Sheila feels some instrumental connection with several coworkers because they represent consistency in her life and affirm her competence as a worker. She is also supported emotionally as well as materially by her family members, with whom she keeps in regular contact. Sheila particularly looks to her sister for understanding and emotional support, and uses her sister as a model in many ways. She has always enjoyed seeing her parents and, ironically, even the grandmother who can be so critical of her. They make her feel more “whole” and reinforce her sense of identity, even though, like many young adults working toward independence, she has mixed feelings about spending more than a few days at a time with them. At school, Sheila has casual relationships with two classmates, her academic adviser, and a couple of faculty members, although she does not identify them as significant. They qualify as instrumental resources for her.

In total, Sheila has 16 persons in her social support system, representing 6 of a possible 10 clusters. She identifies 8 of these people as personal, or primary, supports. It is noteworthy that

### Exhibit 5.4 Sheila’s Social Network

<table>
<thead>
<tr>
<th>Network Cluster</th>
<th>Network Member*</th>
<th>Type of Support</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family of origin</td>
<td>Mother*</td>
<td>Material and emotional</td>
</tr>
<tr>
<td></td>
<td>Father*</td>
<td>Material and emotional</td>
</tr>
<tr>
<td></td>
<td>Sister*</td>
<td>Emotional</td>
</tr>
<tr>
<td>Extended family</td>
<td>Grandmother*</td>
<td>Emotional</td>
</tr>
<tr>
<td>Intimate friends</td>
<td>Christine*</td>
<td>Emotional</td>
</tr>
<tr>
<td></td>
<td>Tiffany*</td>
<td>Emotional</td>
</tr>
<tr>
<td></td>
<td>Ben*</td>
<td>Emotional</td>
</tr>
<tr>
<td>Neighborhood</td>
<td>Landlord</td>
<td>Instrumental</td>
</tr>
<tr>
<td>Informal community relations</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>School</td>
<td>Barbara</td>
<td>Instrumental</td>
</tr>
<tr>
<td></td>
<td>Terri</td>
<td>Instrumental</td>
</tr>
<tr>
<td></td>
<td>Academic adviser</td>
<td>Instrumental</td>
</tr>
<tr>
<td></td>
<td>Instructor</td>
<td>Instrumental</td>
</tr>
<tr>
<td></td>
<td>Paul* (counselor)</td>
<td>Emotional</td>
</tr>
<tr>
<td>Work</td>
<td>Kim</td>
<td>Instrumental</td>
</tr>
<tr>
<td></td>
<td>Thomas</td>
<td>Instrumental</td>
</tr>
<tr>
<td></td>
<td>Laura</td>
<td>Instrumental</td>
</tr>
<tr>
<td>Church/religion</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>Recreation</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>Associations</td>
<td>None</td>
<td></td>
</tr>
</tbody>
</table>
half (8) of her network members provide only instrumental support, which is an important type but the most limited. Because persons in the general population tend to identify about 25 network members (Dunbar & Spoors, 1995; Vaux, 1988), we can see that Sheila’s support system, on which she relies to cope with stress, is still probably not adequate for her needs at this time in her life.

One recent research report suggests that Sheila is not alone in having an inadequate support network. McPherson, Smith-Lovin, and Brashears (2006) found that 43.6% of their 2004 sample reported that they have either no one or only one person with whom they discuss important matters in their lives, in contrast to an average of three such persons reported in a 1985 sample. These findings raise several important questions for further exploration. Is it possible that people have larger, but less intimate networks? How is the level of intimate exchange affected by time spent in electronic communication? Do the trends in the United States toward increased time spent at work and in commuting have a negative impact on social support networks?

How Social Support Aids Coping

The experience of stress creates a physiological state of emotional arousal, which reduces the efficiency of cognitive functions (Caplan, 1990). When we experience stress, we become less effective at focusing our attention and scanning the environment for relevant information. We cannot access the memories that normally bring meaning to our perceptions, judgment, planning, and integration of feedback from others. These memory impairments reduce our ability to maintain a consistent sense of identity.

Social support helps in these situations by acting as an “auxiliary ego.” Our social support, particularly our personal network, compensates for our perceptual deficits, reminds us of our sense of self, and monitors the adequacy of our functioning. Here are ten characteristics of effective support (Caplan, 1990):

1. Nurtures and promotes an ordered worldview
2. Promotes hope
3. Promotes timely withdrawal and initiative
4. Provides guidance
5. Provides a communication channel with the social world
6. Affirms one’s personal identity
7. Provides material help
8. Contains distress through reassurance and affirmation
9. Ensures adequate rest
10. Mobilizes other personal supports

Some of these support systems are formal (service organizations), and some are informal (such as friends and neighbors). Religion, which attends to the spiritual realm, also plays a distinctive support role (Caplan, 1990). This topic is explored in Chapter 6.
Two schools of thought have emerged around the question of how we internalize social support (Bal, Crombez, & Oost, 2003; Cohen & Wills, 1985; Zimmerman, Ramirez-Valles, & Zaper, 2000):

1. **Main effect model.** Support is seen as related to our overall sense of well-being. Social networks provide us with regular positive experiences, and within the network a set of stable roles (expectations for our behavior) enables us to enjoy stability of mood, predictability in life situations, and recognition of self-worth. We simply don’t experience many potential stressors as such, because with our built-in sense of support, we do not perceive situations as threats.

2. **Buffering model.** Support is seen as a factor that intervenes between a stressful event and our reaction. Recognizing our supports helps us to diminish or prevent a stress response. We recognize a potential stressor, but our perception that we have resources available redefines the potential for harm or reduces the stress reaction by influencing our cognitive, emotional, and physiological processes.

Most research on social support focuses on its buffering effects, in part because these effects are more accessible to measurement. Social support as a main effect is difficult to isolate, because it is influenced by, and may be an outcome of, our psychological development and ability to form attachments. The main effect model has its roots in sociology, particularly symbolic interaction theory, in which our sense of self is said to be shaped by behavioral expectations acquired through our interactions with others. The buffering model, more a product of ego psychology, conceptualizes social support as an external source of emotional, informational, and instrumental aid.

### How Social Workers Evaluate Social Support

There is no consensus about how social workers can evaluate a client’s level of social support. The simplest procedure is to ask for the client’s subjective perceptions of support from family and friends (Procidano & Heller, 1983). One of the most complex procedures uses eight indicators of social support: available listening, task appreciation, task challenge, emotional support, emotional challenge, reality confirmation, tangible assistance, and personal assistance (Richman, Rosenfeld, & Hardy, 1993). One particularly useful model includes three social support indicators (Vaux, 1988):

1. **Listing of social network resources.** The client lists all the people with whom he or she regularly interacts.

2. **Accounts of supportive behavior.** The client identifies specific episodes of receiving support from others in the recent past.

3. **Perceptions of support.** The client subjectively assesses the adequacy of the support received from various sources.

In assessing a client’s social supports from this perspective, the social worker first asks the client to list all persons with whom he or she has interacted in the past one or two weeks. Next, the social worker asks the client to draw from that list the persons he or she perceives to be supportive in significant ways (significance is intended to be open to the client’s interpretation). The client is asked to describe specific recent acts of support provided by those
significant others. Finally, the social worker asks the client to evaluate the adequacy of the support received from specific sources, and in general. On the basis of this assessment, the social worker can identify both subjective and objective support indicators with the client and target underused clusters for the development of additional social support.

Sheila's support network is outlined in Exhibit 5.4. From a full assessment of her social supports, a social worker might conclude that her personal network is rather small, consisting only of her sister, counselor, and three friends. Sheila might report to the social worker that she does not perceive many of her interactions to be supportive. The social worker might explore with Sheila her school, neighborhood, and work clusters for the possibility of developing new supports.

Normal and Abnormal Coping

Most people readily assess the coping behaviors they observe in others as “normal” or “abnormal.” But what does “normal” mean? We all apply different criteria. The standards we use to classify coping thoughts and feelings as normal or abnormal are important, however, because they have implications for how we view ourselves and how we behave toward those different from us. For example, Sheila was concerned that other students at the university perceived her as abnormal because of her social isolation and her inadequacy. Most likely, other students did not notice her at all. It is interesting that, in Sheila’s view, her physical appearance and her demeanor revealed her as abnormal. However, her appearance did not stand out, and her feelings were not as evident to others as she thought.

Social workers struggle just as much to define normal and abnormal as anybody else. And their definitions may have greater consequences. Misidentifying someone as normal may forestall needed interventions; misidentifying someone as abnormal may create a stigma or become a self-fulfilling prophecy. To avoid such problems, social workers may profitably consider how four different disciplines define normal.

The Medical (Psychiatric) Perspective

One definition from psychiatry, a branch of medicine, states that we are normal when we are in harmony with ourselves and our environment. Normality is characterized by conformity with our community and culture. We can be deviant from some social norms, so long as our deviance does not impair our reasoning, judgment, intellectual capacity, and ability to make personal and social adaptations (Bartholomew, 2000).

The current definition of mental disorder used by the American Psychiatric Association (2000), which is intended to help psychiatrists and many other professionals distinguish between normality and abnormality, is a “significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (e.g., a painful symptom) or disability (i.e., impairment in one or more important areas of functioning) or with significantly increased risk of suffering death, pain, disability, or an important loss of freedom” (p. xxiii). The syndrome or pattern “must not be an expectable and culturally sanctioned response to a particular event” (p. xxiii). Whatever its cause, “it must currently be considered a manifestation of behavioral, psychological, or biological dysfunction in the individual” (p. xxiii). Neither deviant behavior nor conflicts between an individual and society are to be considered mental disorders unless they are symptomatic of problems within the individual.
In summary, the medical model of abnormality focuses on underlying disturbances within the person. An assessment of the disturbance results in a diagnosis based on a cluster of observable symptoms. This is sometimes referred to as the disease model of abnormality. Interventions, or treatments, focus on changing the individual. The abnormal person must experience internal, personal changes (rather than induce environmental change) in order to be considered normal again. Exhibit 5.5 summarizes the format for diagnosing mental disorders as developed by psychiatry in the United States and published in the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 2000), generally referred to as *DSM-IV-TR*. Many people in the helping professions follow this format, including social workers in some service settings.

**Psychological Perspectives**

One major difference between psychiatry and psychology is that psychiatry tends to emphasize biological and somatic interventions to return the person to a state of normalcy, whereas psychology emphasizes various cognitive, behavioral, or reflective interventions.

The field of psychological theory is quite broad, but some theories are distinctive in that they postulate that people normally progress through a sequence of life stages. The time context thus becomes important. Each new stage of personality development builds on

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**Exhibit 5.5**  
*DSM-IV Classification of Mental Disorders*

| Axis I | Clinical or mental disorders  
<table>
<thead>
<tr>
<th></th>
<th>Other conditions that may be a focus of clinical attention</th>
</tr>
</thead>
</table>
| Axis II | Personality disorders  
|        | Mental retardation |
| Axis III | General medical conditions |
| Axis IV | Psychosocial and environmental problems  
|        | Primary support group  
|        | Educational  
|        | Occupational  
|        | Housing  
|        | Economic  
|        | Access to health care services  
|        | Interaction with the legal system  
|        | Other psychosocial and environmental problems |
| Axis V | Global assessment of functioning (based on the clinician’s judgment):  
|       | 90–100 Superior functioning in a wide range of activities  
|       | 0–10 Persistent danger of severely hurting self or others, persistent inability to maintain personal hygiene, or serious suicidal acts with clear expectation of death |

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previous stages, and any unsuccessful transitions can result in abnormal behavior—that is, a deviant pattern of coping with threats and challenges. An unsuccessful struggle through one stage implies that the person will experience difficulties in mastering subsequent stages.

One life-stage view of normality very well known in social work is that of Erik Erikson (1968), who proposed eight stages of normal *psychosocial development* (see Exhibit 5.6). Sheila, although 22 years old, is still struggling with the two developmental stages of adolescence (in which the issue is identity vs. diffusion) and young adulthood (in which the issue is intimacy vs. isolation). Common challenges in adolescence include developing a sense of one’s potential and place in society by negotiating issues of self-certainty versus apathy, role experimentation versus negative identity, and anticipation of achievement versus work paralysis. Challenges in young adulthood include developing a capacity for interpersonal intimacy as opposed to feeling socially empty or isolated within the family unit. According to Erikson’s theory, Sheila’s difficulties are related to her lack of success in negotiating one or more of the four preceding developmental phases.

<table>
<thead>
<tr>
<th>Life Stage</th>
<th>Psychosocial Challenge</th>
<th>Significant Others</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infancy</td>
<td>Trust versus mistrust</td>
<td>Maternal persons</td>
</tr>
<tr>
<td>Early Childhood</td>
<td>Autonomy versus shame and doubt</td>
<td>Parental persons</td>
</tr>
<tr>
<td>Play Age</td>
<td>Initiative versus guilt</td>
<td>Family</td>
</tr>
<tr>
<td>School Age</td>
<td>Industry versus inferiority</td>
<td>Neighborhood</td>
</tr>
<tr>
<td>Adolescence</td>
<td>Identity versus identity diffusion</td>
<td>Peers</td>
</tr>
<tr>
<td>Young Adulthood</td>
<td>Intimacy versus isolation</td>
<td>Partners</td>
</tr>
<tr>
<td>Adulthood</td>
<td>Generativity versus self-absorption</td>
<td>Household</td>
</tr>
<tr>
<td>Mature Age</td>
<td>Integrity versus disgust and despair</td>
<td>Humanity</td>
</tr>
</tbody>
</table>

From this perspective, Sheila’s experience of stress would not be seen as abnormal, but her inability to make coping choices that promote positive personal adaptation would signal psychological abnormality. For example, in her first semester at the university, she was having difficulty with role experimentation (identity vs. identity diffusion). She lacked the necessary sense of competence and self-efficacy to allow herself to try out various social roles. She avoided social situations such as study groups, recreational activities, and university organizations in which she might learn more about what kinds of people she likes, what her main social interests are, and what range of careers she might enjoy. Instead, she was stuck with a negative identity, or self-image, and could not readily advance in her social development. From a stage theory perspective, her means of coping with the challenge of identity development would be seen as maladaptive, or abnormal.

**The Sociological Approach: Deviance**

The field of sociology offers a variety of approaches to the study of abnormality, or deviance. As an example, consider one sociological perspective on deviance derived from symbolic...
interactionism. It states that those who cannot constrain their behaviors within role limitations acceptable to others become labeled as deviant. Thus, *deviance* is a negative labeling that is assigned when one is considered by a majority of significant others to be in violation of the prescribed social order (Downes & Rock, 2003). Put more simply, we are unable to grasp the perspective from which the deviant person thinks and acts; the person’s behavior does not make sense to us. We conclude that our inability to understand the other person’s perspective is due to that person’s shortcomings rather than to our own rigidity, and we label the behavior as deviant. The deviance label may be mitigated if the individual accepts that he or she should think or behave otherwise and tries to conform to the social order.

From this viewpoint, Sheila would be perceived as abnormal, or deviant, only by those who had sufficient knowledge of her thoughts and feelings to form an opinion about her allegiance to their ideas of appropriate social behavior. She might also be considered abnormal by peers who had little understanding of rural culture. Those who knew Sheila well might understand the basis for her negative thoughts and emotions and in that context continue to view her as normal in her coping efforts. However, it is significant that Sheila was trying to avoid intimacy with her university classmates and work peers so that she would not become well known to them. Because she still views herself as somewhat deviant, she wants to avoid being seen as deviant (or abnormal) by others, which in her view would lead to their rejection of her. This circular reasoning poorly serves Sheila’s efforts to cope with stress in ways that promote her personal goals.

**The Social Work Perspective: Social Functioning**

The profession of social work is characterized by the consideration of systems and the reciprocal impact of persons and their environments (the bio-psycho-social-spiritual perspective) on human behavior. Social workers tend not to classify individuals as abnormal. Instead, they consider the person-in-environment as an ongoing process that facilitates or blocks one’s ability to experience satisfactory social functioning. In fact, in clinical social work, the term *normalization* refers to helping clients realize that their thoughts and feelings are shared by many other individuals in similar circumstances (Hepworth, Rooney, Rooney, Strom-Gottfried, & Larsen, 2006).

Three types of situations are most likely to produce problems in social functioning: stressful life transitions, relationship difficulties, and environmental unresponsiveness (Germain & Gitterman, 1996). Note that all three are related to transitory interactions of the person with other persons or the environment and do not rely on evaluating the client as normal or abnormal.

Social work’s **person-in-environment (PIE) classification system** formally organizes the assessment of individuals’ ability to cope with stress around the four factors shown in Exhibit 5.7: social functioning problems, environmental problems, mental health problems, and physical health problems. Such a broad classification scheme helps ensure that Sheila’s range of needs will be addressed. James Karls and Karin Wandrei (1994), the authors of the PIE system, state that it “underlines the importance of conceptualizing a person in an interactive context” and that “pathological and psychological limitations are accounted for but are not accorded extraordinary attention” (p. x). Thus, the system avoids labeling a client as abnormal. At the same time, however, it offers no way to assess the client’s strengths and resources.
### Exhibit 5.7 The Person-in-Environment (PIE) Classification System

#### Factor I: Social Functioning Problems

<table>
<thead>
<tr>
<th>A. Social role in which each problem is identified</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Family (parent, spouse, child, sibling, other, significant other)</td>
<td></td>
</tr>
<tr>
<td>2. Other interpersonal (lover, friend, neighbor, member, other)</td>
<td></td>
</tr>
<tr>
<td>3. Occupational (worker/paid, worker/home, worker/volunteer, student, other)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>B. Type of problem in social role</th>
<th></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>C. Severity of problem</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. No problem</td>
<td>4. High severity</td>
</tr>
<tr>
<td>2. Low severity</td>
<td>5. Very high severity</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>D. Duration of problem</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. More than five years</td>
<td>4. Two to four weeks</td>
</tr>
<tr>
<td>2. One to five years</td>
<td>5. Two weeks or less</td>
</tr>
<tr>
<td>3. Six months to one year</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>E. Ability of client to cope with problem</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Outstanding coping skills</td>
<td>4. Somewhat inadequate</td>
</tr>
<tr>
<td>2. Above average</td>
<td>5. Inadequate</td>
</tr>
<tr>
<td>3. Adequate</td>
<td>6. No coping skills</td>
</tr>
</tbody>
</table>

#### Factor II: Environmental Problems

<table>
<thead>
<tr>
<th>A. Social system where each problem is identified</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Economic/basic need</td>
<td>4. Health, safety, social services</td>
</tr>
<tr>
<td>2. Education/training</td>
<td>5. Voluntary association</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>B. Specific type of problem within each social system</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>C. Severity of problem</td>
<td></td>
</tr>
<tr>
<td>D. Duration of problem</td>
<td></td>
</tr>
</tbody>
</table>

#### Factor III: Mental Health Problems

| A. Clinical syndromes (Axis I of DSM) |  |
| B. Personality and developmental disorders (Axis II of DSM) |  |

#### Factor IV: Physical Health Problems

| A. Disease diagnosed by a physician |  |
| B. Other health problems reported by client and others |  |
With the exception of its neglect of strengths and resources, the PIE assessment system is appropriate for social work because it was specifically developed to promote a holistic biopsychosocial perspective on human behavior. For example, at a mental health center that subscribed to psychiatry’s DSM-IV classification system, Sheila might be given an Axis I diagnosis of adjustment disorder or dysthymic disorder, and her dyslexia might be diagnosed on Axis III. In addition, some clinicians might use Axis IV to note that Sheila has some school adjustment problems. With the PIE, the social worker would, in addition to her mental and physical health concerns, assess Sheila’s overall social and occupational functioning, as well as any specific environmental problems. For example, her problems with the student role that might be highlighted on PIE Factor I include her ambivalence and isolation, the high severity of her impairment, its six months’ to a year’s duration, and the inadequacy of her coping skills. Her environmental stressors on Factor II might include a deficiency in affectional support, of high severity, with a duration of six months to a year. Assessment with PIE provides Sheila and the social worker with more avenues for intervention, which might include personal interventions, interpersonal interventions, and environmental interventions.

IMPLICATIONS FOR SOCIAL WORK PRACTICE

Theory and research about the psychosocial person have a number of implications for social work practice, including the following:

- Always assess the nature, range, and intensity of a client’s interpersonal relationships.
- Help clients identify their sources of stress and patterns of coping. Recognize the possibility of particular vulnerabilities to stress.
- Help clients assess the effectiveness of particular coping strategies for specific situations.
- Where appropriate, help clients develop a stronger sense of competence in problem solving and coping. Identify specific problems and related skill-building needs, teach and rehearse skills, and implement graduated applications to real-life situations.
- Where appropriate, use case management activities focused on developing a client’s social supports through linkages with potentially supportive others in a variety of social network clusters.
- Recognize families as possible sources of stress as well as support.
- Recognize the benefits that psychoeducational groups, therapy groups, and mutual aid groups may have for helping clients cope with stress.
- Where appropriate, take the roles of mediator and advocate to attempt to influence organizations to be more responsive to the needs of staff and clients. When appropriate, take the roles of planner and administrator to introduce flexibility into organizational policies and procedures so that agency/environment transactions become mutually responsive.
- Link clients who experience stress related to inadequate community ties to an array of formal and informal organizations that provide them with a greater sense of belonging in their communities.
- When working with persons in crisis, attempt to alleviate distress and facilitate a return to the previous level of functioning.
- Assess with clients the meaning of hazardous events, the precipitating factors, and potential and actual support systems. When working with persons in crisis, use a
here-and-now orientation, and use tasks to enhance support systems. Help clients connect current stress with patterns of past functioning and to initiate improved coping methods. As the crisis phase terminates, review tasks accomplished, including new coping skills and social supports developed.

**KEY TERMS**

adaptation  
Afrocentric relational theory  
coping  
crisis  
daily hassles  
defense mechanisms  
emotion-focused coping  
general adaptation syndrome  
homeostasis  
neural plasticity  
relational coping  
role strain  
oneutral stress  
object relations theory  
personal network  
person-in-environment (PIE) classification system  
personal network  
posttraumatic stress disorder  
problem-focused coping  
relational coping  
role strain  
social identity theory  
social network  
social support  
state  
stress  
state  
stress/diathesis models  
trait  
traumatic stress

**Active Learning**

1. You have been introduced to four ways of conceptualizing normal and abnormal coping: mental disorder, psychosocial development, deviance, and social functioning. Which of these ways of thinking about normality and abnormality are the most helpful to you in thinking about Sheila’s situation? For what reasons?

2. Think of your own social support network. List all persons you have interacted with in the past month. Next, circle those persons on the list who you perceive to be supportive in significant ways. Describe specific recent acts of support provided by these significant others. Finally, evaluate the adequacy of the support you receive from specific sources, and in general. What can you do to increase the support you receive from your social network?

3. Consider several recent situations in which you have utilized problem-focused or emotion-focused coping strategies. What was different about the situations in which you used one rather than the other? Were the coping strategies successful? Why or why not?

**WEB RESOURCES**

**Object Relations Theory and Psychopathology**

[www.objectrelations.org](http://www.objectrelations.org)

Site maintained by Thomas Klee, Ph.D., clinical psychologist, contains information on object relations theory, a method of object relations psychotherapy, and current articles on object relations theory and therapy.

**Stone Center**

[www.wcconline.org](http://www.wcconline.org)

Site presented by the Stone Center of the Wellesley Centers for Women, the largest women’s research center in the United States, contains theoretical work on women’s psychological development and model programs for the prevention of psychological problems.
MEDLINEplus: Stress
Site presented by the National Institute of Mental Health presents links to latest news about stress research, coping, disease management, specific conditions, and stress in children, seniors, teenagers, and women.

Stress Management
mentalhealth.about.com/od/stress/
Site presented by “About, Incorporated,” which has an affiliation with the New York Times, includes a large number of articles and links about topics related to stress management in a variety of contexts.

National Center for Posttraumatic Stress Disorder
www.ncptsd.org
Site presented by the National Center for PTSD, a program of the U.S. Department of Veterans Affairs, contains facts about PTSD, information about how to manage the traumatic stress of terrorism, and recent research.