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How is human behavior influenced by cognitions, emotions, and relationships?
What are some different approaches to coping with stress?

Key Ideas

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

1. Cognition and emotion are different but interrelated internal processes, and the nature of their relationship has long been debated.

2. Cognition includes the conscious thinking processes of taking in relevant information from the environment, synthesizing that information, and formulating a plan of action based on that synthesis. Cognitive theory in social work practice asserts that thinking, not emotion, should be the primary focus of intervention.

3. Emotions can be understood as feeling states characterized by appraisals of a stimulus, changes in bodily sensations, and displays of expressive gestures.

4. The symptoms of psychological problems may be primarily cognitive or emotional, but both cognition and emotion influence the development of problems.

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

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

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

CASE STUDY

Sheila’s Difficult Transition to University Life

Sheila, age 22 and in her first semester at the state university, experienced a crisis during the seventh week of classes. It was the midpoint of the semester, when instructors were required to give interim grades so that students would clearly understand their academic status before the final date for course drops passed. Sheila knew that she was having trouble in all four of her courses but was shocked to receive two C’s and two D’s. Her chronic sense of sadness became worse; she starting having the occasional thoughts of suicide that she had experienced in the past. Sheila knew that she needed to study that weekend, but instead she made the 5-hour drive to her parents' home, feeling a need to be around familiar faces. She had no close friends at school. Distraught, Sheila considered dropping out, but her parents convinced her to talk to her academic adviser.
first. The adviser immediately became more involved in helping Sheila manage her dyslexia. Sheila learned to become more assertive with her instructors so that they understood her special challenges with the course work. The academic adviser also encouraged Sheila to begin seeing a counselor at the university counseling center. The social worker at the counseling center learned that Sheila had been a troubled young woman for quite some time. In fact, Sheila said that she had felt depressed and inferior to her peers since childhood. The patterns of negative thinking and feeling that influenced Sheila’s current crisis had been in place for 10 years. At this moment, Sheila believed that she simply did not have the intelligence to succeed in college. She did, in fact, have a diagnosed learning disability, a type of dyslexia that made it difficult for her to read and write. A special university adviser was helping her manage this problem, although not all her professors seemed sympathetic to her situation. Sheila also did not believe she had the social competence to make friends, male or female, or the strength of will to overcome her negative moods and outlook. She believed her depression was a basic part of her personality. After all, she couldn’t recall ever feeling different.

Sheila grew up in a rural county in Virginia, several miles from the nearest small town. She was accustomed to spending time with her family and relatives, including her sister, Amy, who is 2 years older. During the previous 2 years, Sheila had commuted from her family home to a nearby community college. She had stayed home and worked for a year after high school graduation, without the motivation or direction to continue with schooling. Amy was, in contrast, the star child who attended a major university to pursue a career in commercial art after winning academic awards throughout her high school years. Sheila watched Amy, so polished and popular, make her way easily and independently into the world. Sheila, by comparison, knew that she could not function so well. Eventually, she decided to enroll in the community college for general education studies. She felt awkward around the other students, as usual, but liked the small size of the school. It was peaceful and kept Sheila near her parents.

After Sheila completed her studies at the community college, she applied for admission to the state university. She decided to major in art preservation, an area of study similar to Amy’s. Sheila’s adjustment to the state university had been difficult from the beginning. She was intimidated by the grand scale of the institution: the size of the classes; the more distant, formal manner of her professors; the large numbers of students she saw on the campus streets; and the crowds in the student union. The university seemed cold and the students unfriendly. Sheila was a White, middle-class student like the majority at her campus, but she believed that the other students saw her as a misfit. She didn’t dress in the latest styles, was not interesting or sophisticated, and was not intelligent enough to stand out in her classes. Even as she sat in the back of her classrooms, she believed that others were thinking of her, in her own words, as a geek. Sheila even felt out of place in her off-campus living quarters. A cousin had found her a basement apartment in a house in which a married couple resided. The walls were thin, and Sheila felt that she lacked privacy. She enjoyed perusing Facebook, the social networking website, but admitted that she felt a marginal connection to her few dozen “friends” there.

Many students experience a difficult transition to college. The counseling center social worker, however, was struck by several family themes that seemed to contribute to Sheila’s low self-esteem. Sheila’s paternal grandmother, a powerful matriarch, had always lived near the family. She disapproved of much of her grandchildren’s behavior, and was frequently critical of them to the point of cruelty. She valued good social graces, and thus was particularly unhappy with Sheila’s lack of social competence. Sheila’s mother was always reluctant to disagree with her mother-in-law or defend her children. This passivity made Sheila angry at her mother, as did the fact that her mother argued with her father quite often and was known to have had several affairs.

Sheila was closer to her father, who was also fond of her, but he maintained a strict work ethic and believed that productive people should have no time for play. He felt that his children showed disrespect to him when they...
Cognition and Emotion

Sheila’s difficult transition to college life reflects her personal psychology, a term used here to mean her mind and her mental processes. Her story illustrates the impact on social functioning of a person’s particular patterns of cognition and emotion. Cognition can be defined as our conscious or preconscious thinking processes—the mental activities of which we are aware or can become aware with probing. Cognition includes taking in relevant information from the environment, synthesizing that information, and formulating a plan of action based on that synthesis (Ronen & Freeman, 2007). Beliefs, key elements of our cognition, are ideas that we hold to be true. Our assessment of any idea as true or false is based on the synthesis of information. Erroneous beliefs, which may result from misinterpretations

of perceptions or from conclusions based on insufficient evidence, frequently contribute to social dysfunction.

Emotion can be understood as a feeling state characterized by our appraisal of a stimulus, by changes in bodily sensations, and by displays of expressive gestures (Parkinson, Fischer, & Manstead, 2005). The term emotion is often used interchangeably in the study of psychology with the term affect, but the latter term refers only to the physiological manifestations of feelings. Affect may be the result of drives (innate compulsions to gratify basic needs). It generates both conscious and unconscious feelings (those of which we are not aware but which influence our behavior). In contrast, emotion is always consciously experienced. Nor is emotion the same as mood, a feeling disposition that is more stable than emotion, less intense, and less tied to a specific situation.
The evolution of psychological thought since the late 1800s has consisted largely of a debate about the origins of cognition and emotion, the nature of their influence on behavior, and their influence on each other. The only point of agreement seems to be that cognition and emotion are complex and interactive.

THEORIES OF COGNITION

Theories of cognition, which emerged in the 1950s, assume that conscious thinking is the basis for almost all behavior and emotions. Emotions are defined within these theories as the physiological responses that follow our cognitive evaluations of input. In other words, thoughts produce emotions.

Cognitive Theory

Jean Piaget’s cognitive theory is the most influential theory of cognition in social work and psychology (Lightfoot, Lalonde, & Chandler, 2004). In his system, our capacity for reasoning develops in stages, from infancy through adolescence and early adulthood. Piaget identified four stages (summarized in Exhibit 4.1), which he saw as sequential and interdependent, evolving from activity without thought to thought with less emphasis on activity—from doing, to doing knowingly, and finally to conceptualizing. He saw physical and neurological development as necessary for cognitive development.

A central concept in Piaget’s theory is schema (plural: schemata), defined as an internalized representation of the world or an ingrained and systematic pattern of thought, action, and problem solving. Our schemata develop through social learning (watching and absorbing the experiences of others) or direct learning (our own experiences). Both of these processes may involve assimilation (responding to experiences based on existing schemata) or accommodation (changing schemata when new situations cannot be incorporated within an existing one). As children, we are motivated to develop schemata as a means of maintaining psychological equilibrium, or balance. Any experience that we cannot assimilate creates anxiety, but if our schemata are adjusted to accommodate the new experience, the desired state of equilibrium will be restored. From this perspective, you might interpret Sheila’s difficulties in college as an inability to achieve equilibrium by assimilating new experience within her existing schemata. As a shy person from

<table>
<thead>
<tr>
<th>Stage</th>
<th>Description</th>
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<tbody>
<tr>
<td>Sensorimotor stage (birth to 2 years)</td>
<td>The infant is egocentric; he or she gradually learns to coordinate sensory and motor activities and develops a beginning sense of objects existing apart from the self.</td>
</tr>
<tr>
<td>Preoperational stage (2 to 7 years)</td>
<td>The child remains primarily egocentric but discovers rules (regularities) that can be applied to new incoming information. The child tends to overgeneralize rules, however, and thus makes many cognitive errors.</td>
</tr>
<tr>
<td>Concrete operations stage (7 to 11 years)</td>
<td>The child can solve concrete problems through the application of logical problem-solving strategies.</td>
</tr>
<tr>
<td>Formal operations stage (11 to adulthood)</td>
<td>The person becomes able to solve real and hypothetical problems using abstract concepts.</td>
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</tbody>
</table>
a rural background, Sheila was accustomed to making friends very slowly in environments where she interacted with relatively small numbers of peers. She could not easily adjust to the challenge of initiating friendships quickly in a much larger and more transient student population.

Another of Piaget's central ideas is that cognitive development unfolds sequentially. Infants are unable to differentiate between “self” and the external world; the primary task in early cognitive development is the gradual reduction of such egocentricity, or self-centeredness. The child gradually learns to perform cognitive operations—to use abstract thoughts and ideas that are not tied to situational sensory and motor information.

**Information Processing Theory**

Cognitive theory has been very influential but, as you might guess, leaves many aspects of cognitive functioning unexplained.

Whereas Piaget sought to explain how cognition develops, information processing theory offers details about how our cognitive processes are organized (G. Logan, 2000). Information processing is a sensory theory in that it depicts information as flowing passively from the external world inward through the senses to the mind. It views the mind as having distinct parts—including the sensory register, short-term memory, and long-term memory—that make unique contributions to thinking in a specific sequence. Interestingly, information processing theory has become important in designing computer systems! In contrast, a motor theory such as Piaget’s sees the mind as playing an active role in processing—not merely recording but actually constructing the nature of the input it receives. In Sheila’s case, information processing theory would suggest that she simply has not experienced a situation like her current one and thus lacks the schemata required to adapt. In contrast, cognitive theory would suggest that a faulty processing of input established somewhere in Sheila’s past is making her adjustment difficult.

**Photo 4.1** Information processing theory would suggest that the information these children are receiving from the computer flows through their senses to their minds, which operate much like computers.
Social Learning Theory

According to social learning theory, we are motivated by nature to experience pleasure and avoid pain. Social learning theorists acknowledge that thoughts and emotions exist but understand them as behaviors in need of explaining rather than as primary motivating factors. Social learning theory relies to a great extent on social behavioral principles of conditioning, which assert that behavior is shaped by its reinforcing or punishing consequences (operant conditioning) and antecedents (classical conditioning). Albert Bandura (1977b) added the principle of vicarious learning, or modeling, which asserts that behavior is also acquired by witnessing how the actions of others are reinforced.

Social learning theorists, unlike other social behavioral theorists, assert that thinking takes place between the occurrence of a stimulus and our response. They call this thought process cognitive mediation. The unique patterns we learn for evaluating environmental stimuli explain why each of us may adopt very different behaviors in response to the same stimulus—for example, why Sheila’s reaction to the crowds in the student union is very different from the reactions of some of her peers. Bandura (1977b, 1986, 2001) takes this idea a step further and asserts that we engage in self-observations and make self-judgments about our competence and mastery. We then act on the basis of these self-judgments. Bandura (2001) criticizes information processing theory for its passive view of human agency, arguing that it omits important features of what it means to be human, including subjective consciousness, deliberative action, and the capacity for self-reflection. It is clear that Sheila made very negative self-judgments about her competence as she began her studies at the university.

Theory of Multiple Intelligences

Howard Gardner’s (1999, 2006) theory of multiple intelligences constitutes a major step forward in our understanding of how people come to possess different types of cognitive skills and how the same person is able to effectively use cognitive skills in some areas of life but not others. In this theory, which is based on anthropological and neuroscientific research, intelligence is defined as a “biopsychosocial potential to process information that can be activated in a cultural setting to solve problems or create products that are of value in a culture” (Gardner, 1999, p. 23).

The brain is understood not as a single cognitive system but as a central unit of neurological functioning that houses relatively separate cognitive faculties. During its evolution, the brain has developed separate organs, or modules, as information-processing devices. Thus, all people have a unique blend of intelligences derived from these modules. Gardner has delineated eight intelligences, which are overviewed in Exhibit 4.2, although in his ongoing research he is considering additional possibilities. Two intelligences, the linguistic (related to spoken and written language) and the logical-mathematical (analytic), are consistent with traditional notions of intelligence. The six others are not, however. You may be interested to note that in one study, social work educators rated intrapersonal, interpersonal, and linguistic intelligences as the most important for social work practice, and the same educators rated bodily-kinesthetic, musical, and spatial intelligences as important for culturally sensitive practice (Matto, Berry-Edwards, Hutchison, Bryant, & Waldbillig, 2006).

One of the most positive implications of the theory of multiple intelligences is that it helps us see strengths in ourselves that lie outside the mainstream. For example, Sheila, so self-critical, might be encouraged to consider that she has a strong spatial intelligence that contributes to her artistic sensibilities. She needs help, however, in further development of both her intrapersonal and interpersonal intelligences.
Theories of Moral Reasoning

*Morality* is our sensitivity to, and knowledge of, what is right and wrong. It develops from our acquired principles of justice and ways of caring for others. Theories of moral reasoning are similar to those of cognitive development in that a sequential process is involved. Familiarity with these theories can help social workers understand how clients make decisions and develop preferences for action in various situations. Both of these issues are important in our efforts to develop goals with clients. The best-known theories of moral reasoning are those of Lawrence Kohlberg and Carol Gilligan. In reviewing these theories, it is important to keep in mind that they are based on studies of men and women in the United States. It is likely that moral development unfolds differently in other cultures, even

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**Linguistic Intelligence:** The capacity to use language to express what is on your mind and to understand other people. Linguistic intelligence includes listening, speaking, reading, and writing skills.

**Logical-Mathematical Intelligence:** The capacity for mathematical calculation, logical thinking, problem solving, deductive and inductive reasoning, and the discernment of patterns and relationships. Gardner suggests that this is the type of intelligence addressed by Piaget’s model of cognitive development, but he does not think Piaget’s model fits other types of intelligence.

**Visual-Spatial Intelligence:** The ability to represent the spatial world internally in your mind. Visual-spatial intelligence involves visual discrimination, recognition, projection, mental imagery, spatial reasoning, and image manipulation.

**Bodily-Kinesthetic Intelligence:** The capacity to use your whole body or parts of your body to solve a problem, make something, or put on some kind of production. Gardner suggests that our tradition of separating body and mind is unfortunate because the mind can be trained to use the body properly and the body trained to respond to the expressive powers of the mind. He notes that some learners rely on tactile and kinesthetic processes, not just visual and auditory processes.

**Musical Intelligence:** The capacity to think in musical images, to be able to hear patterns, recognize them, remember them, and perhaps manipulate them.

**Intrapersonal Intelligence:** The capacity to understand yourself, to know who you are, what you can do, what you want to do, how you react to things, which things to avoid, which things to gravitate toward, and where to go if you need help. Gardner says we are drawn to people who have a good understanding of themselves because those people tend not to make mistakes. They are aware of their range of emotions and can find outlets for expressing feelings and thoughts. They are motivated to pursue goals and live by an ethical value system.

**Interpersonal Intelligence:** The ability to understand and communicate with others, to note differences in moods, temperaments, motivations, and skills. Interpersonal intelligence includes the ability to form and maintain relationships and to assume various roles within groups, and the ability to adapt behavior to different environments. It also includes the ability to perceive diverse perspectives on social and political issues. Gardner suggests that individuals with this intelligence express an interest in interpersonally oriented careers, such as teaching, social work, and politics.

**Naturalist Intelligence:** The ability to recognize and categorize objects and processes in nature. Naturalist intelligence leads to talent in caring for, taming, and interacting with the natural environment, including living creatures. Gardner suggests that naturalist intelligence can also be brought to bear to discriminate among artificial items such as sneakers, cars, and toys.

**SOURCE:** Based on Gardner (1999, 2006).
though more research is needed to investigate these differences (Gardiner & Kosmitzki, 2008).

Kohlberg (1969b) formulated six stages of moral development, which begin in childhood and unfold through adolescence and young adulthood (see Exhibit 4.3). The first two stages represent preconventional morality, in which the child’s primary motivation is to avoid immediate punishment and receive immediate rewards. Conventional morality emphasizes adherence to social rules. A person at this level of morality might be very troubled, as Sheila is, by circumstances that make him or her different from other people. Many people never move beyond this level to postconventional morality, which is characterized by a concern with moral principles transcending those of their own society.

One limitation of Kohlberg’s theory is that it does not take into account gender differences (as his participants were all male). In fact, he claims that women do not advance through all six stages as often as men. Addressing this issue, Gilligan (1982, 1988) notes that boys tend to emphasize independence, autonomy, and the rights of others in their moral thinking, using a justice-oriented approach. Girls, on the other hand, develop an ethic of care that grows out of a concern for the needs of others rather than the value of independence. To account for this difference, Gilligan proposed the three stages of moral development listed in Exhibit 4.4. Her stages place greater emphasis than Kohlberg does on the ethic of care and are meant to more accurately describe the moral development of females. The research findings on gender differences in moral reasoning are inconsistent, however (e.g., Galotti, 1989; Hauser, Cushman, Young, Mikhail, & Jin, 2007; Malti, Gasser, & Buchmann, 2009; M. Ryan, David, & Reynolds, 2004). With her great concern about what her parents and grandmother want her to do, Sheila seems to fall into Kohlberg’s stage of conventional morality and Gilligan’s stage of conventional care.

Researchers have also found evidence that culture may have a greater influence on moral reasoning than gender does, with Anglo-Americans putting less emphasis on an ethic of care than members of other ethnic groups (Al-Ansari, 2002; Gardiner & Kosmitzki, 2008; L. Gump, Baker, & Roll, 2000). Gardiner and Kosmitzki argue that moral development may not follow a universal script across cultures and suggest that the ecological system in which

<table>
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<th>Stage</th>
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<tr>
<td>Preconventional</td>
<td></td>
</tr>
<tr>
<td>Heteronomous morality</td>
<td>Accepting what the world says is right</td>
</tr>
<tr>
<td>Instrumental purpose</td>
<td>Defining the good as whatever is agreeable to the self and those in the</td>
</tr>
<tr>
<td></td>
<td>immediate environment</td>
</tr>
<tr>
<td>Conventional</td>
<td></td>
</tr>
<tr>
<td>Interpersonal experiences</td>
<td>Seeking conformity and consistency in moral action with significant others</td>
</tr>
<tr>
<td>The societal point of view</td>
<td>Seeking conformity and consistency with what one perceives to be the</td>
</tr>
<tr>
<td></td>
<td>opinions of the larger community</td>
</tr>
<tr>
<td>Postconventional</td>
<td></td>
</tr>
<tr>
<td>Ethics</td>
<td>Observing individual and group (societal) rights</td>
</tr>
<tr>
<td>Conscience and logic</td>
<td>Seeking to apply universal principles of right and wrong</td>
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Exhibit 4.3 Kohlberg’s Stages of Moral Development
early social interactions occur shapes moral thought and behavior. For understanding moral reasoning across cultures, they recommend a social constructionist theory of moral development proposed by Norma Haan (1991), in which she suggests that moral reasoning comes from the understanding of the interdependence of self and others that develops through social interactions. She proposes that the most mature moral reasoner is the one who makes moral decisions that balance the person’s own needs and desires with those of others who are affected by the issue at hand. Haan found that people who are able to control their own emotions in order to think about possible solutions engage in higher levels of moral action than people who are not able to control their own emotions.

Theories of Cognition in Social Work Practice

When theories of cognition first emerged, they represented a reaction against psychodynamic theories, which focused on the influence of unconscious thought. Many practitioners had come to believe that although some mental processes may be categorized as unconscious, they have only a minor influence on behavior. Rather, conscious thinking is the basis for almost all behavior and emotions (J. Walsh, 2010).

According to cognitive theory, we are “rational” as long as our schemata accommodate available evidence and our decisions do not rely solely on preconceived notions of the external world. So long as a person’s cognitive style helps to achieve his or her goals, it is considered healthy. However, a person’s thinking patterns can become distorted, featuring patterns of bias that dismiss relevant environmental information from judgment, which can lead in turn to the maladaptive emotional responses described in Exhibit 4.5. These cognitive errors are habits of thought that lead people to distort input from the environment and experience psychological distress (A. T. Beck, 1976; J. S. Beck, 1995).

As a social worker, you could use cognitive theory to surmise that Sheila feels depressed because she subjectively assesses her life situations in a distorted manner. For example, arbitrary inferences may lead her to conclude that because the university students do not approach her in the crowded student union, they are not friendly. Because she mistakenly concludes that they are not friendly, she may also conclude that she will continue to be lonely at the university, and this thought produces her emotional response of sadness.

To adjust her emotions and mood, Sheila needs to learn to evaluate her external environment differently. She needs to change some of the beliefs, expectations, and meanings she attaches to events, because they are not objectively true. She might conclude, for example, that the union is simply not an appropriate place to meet people, because it is crowded and students tend to be hurrying through lunch and off to classes. Sheila can either change her perceptions or change the troubling environments by seeking out new situations. In either case, cognitive theorists would make Sheila’s thinking the primary target of change activity, assuming that cognitive change will in turn produce changes in her emotional states.
Cognitive theory is a highly rational approach to human behavior. Even though the theory assumes that many of a person’s beliefs are irrational and distorted, it also assumes that human beings have great potential to correct these beliefs in light of contradictory evidence. In clinical assessment, the social worker must assess the client’s schemata, identify any faulty thinking patterns, and consider the evidence supporting a client’s beliefs. During intervention, the social worker helps the client adjust his or her cognitive process to better facilitate the attainment of goals. As a result, the client will also experience more positive emotions.

It is important to emphasize at the same time that clients are not encouraged to rationalize all of their problems as involving faulty assumptions, as many challenges people face are due to oppressive external circumstances. Still, Sheila’s belief that other students in the busy union have critical thoughts about her as she passes by is an arbitrary inference, based on her own inclination to think poorly of herself. To help her overcome this cognitive error, the social worker could review the available evidence, helping Sheila to understand that the other students probably did not notice her at all.

Social learning theory takes the tendency in cognitive theory to deemphasize innate drives and unconscious thinking even further. Some practitioners in the social learning tradition make no attempt to understand internal processes at all and avoid making any inferences about them. Social workers who practice from the behavioral approach conceptualize thoughts and emotions as behaviors subject to reinforcement contingencies (Thyer, 2005). That is, we tend to behave in ways that produce rewards (material or emotional) for us. Thus, behaviors can be modified through the application of specific action-oriented methods, such as those listed in Exhibit 4.6. If Sheila is depressed, the social worker would help to identify the things that reinforce her depressed behavior and adjust them so that her emotional states (as revealed in behaviors) will change in response. Through desensitization and behavioral rehearsal, for example, Sheila could learn step-by-step to approach a small group of students at a lunch table and ask to join them. Her positive reinforcers might include success in these measured experiences, a new sense of efficacy, reduced anxiety, and the affirmation of her social worker.

The combination of assessing and intervening with a person’s thought processes, and then helping the client to identify and develop reinforcers for new ways of thinking and behaving, is known as...
cognitive-behavioral therapy. Most cognitive practitioners actually use cognitive-behavioral methods, because it is important to help the client experience rewards for any changes he or she risks.

THEORIES OF EMOTION

Emotion is physiologically programmed into the human brain (see Chapter 3). Its expression is primarily mediated by the hypothalamus, whereas the experience of emotion is a limbic function. But emotion also involves a cognitive labeling of these programmed feelings, which is at least partially a learned process. For example, two students might feel anxious walking into the classroom on the first day of a semester. The anxiety would be a normal reaction to entering a new and unfamiliar situation. However, one student might interpret the anxiety as a heightened alertness that will serve her well in adjusting to the new students and professor, whereas the other student might interpret the same emotion as evidence that she is not prepared to manage the course material. The first student may become excited, but the second student becomes distressed. Many theorists distinguish between primary and secondary emotions (Parkinson et al., 2005). The primary emotions may have evolved as specific reactions with survival value for the human species. They mobilize us, focus our attention, and signal our state of mind to others. There is no consensus on what the primary emotions are, but they are usually limited to anger, fear, sadness, joy, and anticipation (Panksepp, 2008). The secondary emotions are more variable among people and are socially acquired. They evolved as humans developed more sophisticated means of learning, controlling, and managing emotions to promote flexible cohesion in social groups. The secondary emotions may result from combinations of the primary emotions (Plutchik, 2005). These emotions include (but are not limited to) envy, jealousy, anxiety, guilt, shame, relief, hope, depression, pride, love, gratitude, and compassion (Lazarus, 2007).

The autonomic nervous system is central to our processing of emotion (Bentley & Walsh, 2006). This system consists of nerve tracts running from the base of the brain, through the spinal cord, and into the internal organs of the body. It is concerned with maintaining the body’s physical homeostasis. Tracts from one branch of this system, the sympathetic division, produce physiological changes that help make us more alert and active. These changes are sustained by the release of hormones from the endocrine glands into the bloodstream. As part of the feedback control mechanism, parasympathetic system nerve tracts produce opposite, or calming, effects in the body. The two systems work together to maintain an appropriate level of physical arousal.

Still, psychologists have debated for more than a century the sources of emotion. Theories range from those that emphasize physiology to those that
emphasize the psychological or the purely social context, and they give variable weight to the role of cognition.

**Physiological Theories of Emotion**

A theory of emotion (W. James, 1890) developed over a century ago speculated that our bodies produce automatic physiological reactions to any stimulus. We notice these reactions after the fact and then attempt through cognition to make sense of them. This “making sense” involves labeling the emotion. Thus, emotion follows cognition, which itself follows the physiological reaction to a stimulus. The original theory stated that a distinct emotion arises from each physiological reaction.

A few decades later, another theory was developed (Cannon, 1924) that argued that physiological arousal and the experience of emotion are unrelated. Our physiological responses to a stimulus are nonspecific and only prepare us for a general fight-or-flight response (to confront or avoid the stimulus). This response in itself has nothing to do with the experience of emotion, because any particular physiological activity may give rise to different emotional states and may not even involve our emotions at all. Thus, a separate process of perception produces our feeling of emotion. Emotion derives from the associations we make based on prior attempts to understand the sensation of arousal.

Physiology-based theories of emotion lost favor in the mid-20th century, but recent brain research is once again suggesting a strong link between physiological processes and emotion. *Differential emotions theory* (Magai, 2001) asserts that emotions originate in our neurophysiology and that our personalities are organized around “affective biases.” All of us possess five primary human emotions: happiness, sadness, fear, anger, and interest/excitement. These emotions are instinctual, are in a sense hardwired into our brains, and are the source of our motivations. When our emotions are activated, they have a pervasive influence on our cognition and behavior. A key theme in this theory is that emotions influence cognition, a principle opposite to that stressed in cognitive theory.

For example, Sheila has a persistent bias toward sadness, which may reflect some personal or material loss long before she started college. Her sadness has a temporary physical response: a slowing down and a decrease in general effort. It also leads her to withdraw in situations where her efforts to recover the loss would likely be ineffective. The sadness thus allows Sheila time to reevaluate her needs and regain energy for more focused attempts to reach more achievable goals. It is also a signal for others to provide Sheila with support. The sadness of others promotes our own empathic responses. Of course, it is likely that “appearing sad” may have been more functional for Sheila in her home community, where she was more consistently around people who knew and took an interest in her. In contrast, anger tends to increase a person's energy and motivate behavior that is intended to overcome frustration. Furthermore, it is a signal to others to respond with avoidance, compliance, or submission so that the person may resolve the problem.

Researchers have speculated for decades about the precise locations of emotional processing in the brain. Much has been learned about structures that participate in this process, but many areas of the brain have a role (LeDoux & Phelps, 2008). The physiology of emotion begins in the thalamus, a major integrating center of the brain. Located in the forebrain, the thalamus is the site that receives and relays sensory information from the body and from the environment to other parts of the brain. Any perceived environmental event travels first to the thalamus and then to the sensory cortex (for thought), the basal ganglia (for movement), and the hypothalamus (for feeling). The **amygdala**, part of the limbic system, is key in the production of emotional states. There are in fact two routes to the amygdala from the thalamus. Sensations that produce the primary emotions described above may travel there directly from the thalamus, bypassing any cognitive apparatus, to produce an immediate reaction that is key
to survival. Other inputs first travel through the cortex, where they are cognitively evaluated prior to moving on to the limbic system and amygdala to be processed as the secondary emotions.

Culture and the characteristics of the individual may influence the processing of stimulation because the cognitive structures (schemata) that interpret this stimulation may, through feedback loops to the thalamus, actually shape the neural pathways that will be followed by future stimuli (J. Kagan, 2007). In other words, neural schemata tend to become rigid patterns of information processing, shaping subsequent patterns for making sense of the external world.

Psychological Theories of Emotion

Perhaps the most contentious debates about the role of cognition in emotion have taken place among psychological theorists. Some psychologists have considered emotion as primary, and others have considered cognition as primary. Psychological theories in the social behavioral perspective, somewhat like physiology-based theories, assume an automatic, programmed response that is then interpreted as emotion, perhaps first consciously but eventually (through habit) unconsciously.

Psychoanalytic Theory

Freud’s landmark work, The Interpretation of Dreams, first published in 1899, signaled the arrival of psychoanalytic theory. Freud’s theories became prominent in the United States by the early 1900s, immediately influencing the young profession of social work, and were a dominant force through the 1950s. Psychoanalytic thinking continues to be influential in social work today, through the theories of ego psychology, self psychology, and object relations, among others.

The basis of psychoanalytic theory is the primacy of internal drives and unconscious mental activity in human behavior. Sexual and aggressive drives are not “feelings” in themselves, but they motivate behavior that will presumably gratify our impulses. We experience positive emotions when our drives are gratified and negative emotions when they are frustrated.

Our conscious mental functioning takes place within the ego, that part of the personality responsible for negotiating between internal drives and the outside world. It is here that cognition occurs, but it is driven by those unconscious thoughts that are focused on drive satisfaction.

In psychoanalytic thought, then, conscious thinking is a product of the drives from which our emotions also spring. By nature, we are pleasure seekers and “feelers,” not thinkers. Thoughts are our means of deciding how to gratify our drives.Defense mechanisms result from our need to indirectly manage drives when we become frustrated, as we frequently do in the social world, where we must negotiate acceptable behaviors with others. The need to manage drives also contributes to the development of our unconscious mental processes. According to psychoanalytic theory, personal growth cannot be achieved by attending only to conscious processes. We need to explore all of our thoughts and feelings to understand our essential drives. Change requires that we uncover unconscious material and the accompanying feelings that are repressed, or kept out of consciousness.

Let us grant, for example, that Sheila has a normal, healthy drive for pleasure. She may thus be angry with her father for the manner in which he discourages her from developing a social life and also burdens her with his personal problems. This feeling of anger might be repressed into unconsciousness, however, because Sheila is close to her father in many ways and may believe that it is not permissible for a daughter to be angry with a well-meaning parent. Sheila’s unconscious anger, having been turned onto herself, may be contributing to her depression. A psychoanalytically oriented social worker
might suspect from Sheila’s presentation that she experiences this anger. The social worker might try
to help Sheila uncover this by having her reflect
on her feelings about her father in detail, in a safe
clinical environment. With the insights that might
result from this reflection, Sheila’s feeling may become conscious, and she can then take direct
measures to work through her anger.

Ego Psychology

Ego psychology, which emerged in the 1930s
(E. Goldstein, 2008), shifted to a more balanced
perspective on the influences of cognition and emotion in social functioning. As an adaptation of
psychoanalytic theory, it signaled a reaction against
Freud’s heavy emphasis on drives and highlighted
the ego’s role in promoting healthy social function-
ing. Ego psychology represents an effort to build a
holistic psychology of normal development. It was
a major social work practice theory throughout
much of the 20th century because of its attention to
the environment as well as the person, and it con-
tinues to be taught in many schools of social work.

In ego psychology, the ego is conceived of as
present from birth and not as derived from the need to reconcile drives within the constraints of
social living, as psychoanalytic theory would say.
The ego is the source of our attention, concentra-
tion, learning, memory, will, and perception. Both past and present experiences are relevant in
influencing social functioning. The influence of the
drives on emotions and thoughts is not dismissed,
but the autonomy of the ego, and thus conscious
thought processes, receives greater emphasis than
in psychoanalytic theory. The ego moderates inter-
nal conflicts, which may relate to drive frustration,
but it also mediates the interactions of a healthy
person with stressful environmental conditions.

If we experience sadness, then, it is possible that
we are having conflicts related to drive frustration
that are internal in origin. However, it is also possible
that we are experiencing person-environment con-
licts in which our coping efforts are not effective;
the negative emotion may result from a frustration
of our ability to manage an environmental stressor
and thus may arise from cognitive activities. Sheila
may be experiencing both types of conflict. Her
anger at the lack of adequate nurturance in her early
family history may have been turned inward to pro-
duce a depression that has persisted in all of her envi-
nronments. At the same time, the mismatch between
her personal needs for mastery and the demands of
this particular academic environment may be con-
tributing to her frustration and depression.

Attribution Theory

(A Cognitive Perspective)

Attribution theory was the first of the psychological
theories of emotion to give primacy to cognition as
a producer of emotions (Schacter & Singer, 1962).
Attribution theory holds that our experience of
emotion is based on conscious evaluations we make
about physiological sensations in particular social
settings. We respond to situations as we understand
them cognitively, which leads directly to our expe-
rience of a particular emotion. For example, Sheila
has often experienced anxiety, but she interprets it
differently in dealing with her strict father (who
makes her feel guilty about enjoying life) and her
fellow students (who make her feel ashamed of who
she is). The nature of the social setting is key to the
process of emotional experience.

A further refinement of attribution theory
states that our initial reactions to any stimulus
are limited to the sense of whether it will have
positive or negative consequences for us (Weiner,
2008). This is an automatic, preconscious process.
Afterward, we consider what has caused the event,
which leads to modification of the emotion we feel.
Our perceptions of internal versus external cause
determine in part the type of emotion that we expe-
rience. For example, if we experience frustration,
the emotion of shame may emerge if we decide that
it is due to our own behavior. However, we may
experience anger if we decide that the frustration
is due to the actions of someone else.

Richard Lazarus (2001) has proposed a three-
part psychological theory of emotion based on
appraisals of situations. He suggests that emotion develops when we assess a situation as somehow relevant to a personal value or life concern. First, we make an unconscious appraisal of whether a situation constitutes a threat. This appraisal is followed by coping responses, which may be cognitive, physiological, or both, and may be conscious or unconscious. Once these coping mechanisms are in place, we reappraise the situation and label our associated emotion. This process implies that our feelings originate with an automatic evaluative judgment. We decide whether there is a threat, take immediate coping action to deal with it, and then take a closer look to see exactly what was involved in the situation. At the end of this process, we experience a specific emotion.

A major life concern for Sheila is feeling secure in her interpersonal environments. She feels secure in familiar environments (such as her hometown) but feels threatened in unfamiliar places. When she walks into a new classroom, she experiences anxiety. The feeling seems to Sheila to be automatic, because her need for security is threatened in the situation. Her means of coping is to ignore the other students, neither speaking to nor making eye contact with them, and to sit in a relatively isolated area of the room. Sheila then makes at least a partly conscious appraisal that the room is not only occupied with strangers, but that they will quickly judge her in negative ways. Sheila labels her emotion as shame, because she concludes (erroneously, we would think) that her classmates are correct in perceiving her as socially inferior.

**Theory of Emotional Intelligence**

Emotional intelligence is a person’s ability to process information about emotions accurately and effectively and consequently to regulate emotions in an optimal manner (Goleman, 2005). It includes self-control, zest and persistence, ability to motivate oneself, ability to understand and regulate one’s own emotions, and ability to read and deal effectively with other people’s feelings. This is a relatively new concept in psychology. The idea of integrating the emotional and intellectual systems was considered contradictory for many years, but recently psychologists have determined that emotional stimulation is necessary for activating certain schematic thought patterns.

Emotional intelligence involves recognizing and regulating emotions in ourselves and other people. It requires emotional sensitivity, or the ability to evaluate emotions within a variety of social circumstances. A person who is angry but knows that certain expressions of anger will be counterproductive in a particular situation, and as a result constrains his or her expressions of anger, is emotionally intelligent. On the other hand, a person with this same knowledge who behaves angrily in spite of this awareness is emotionally unintelligent.

People are not necessarily equally emotionally intelligent about themselves and other people. We may be more emotionally intelligent about other people than we are about ourselves, or vice versa. The first possibility helps to explain why some people, social workers included, seem to be better at giving advice to others than they are to themselves.

Emotional intelligence requires an integration of intellectual and emotional abilities. Recognizing and regulating emotions requires emotional self-awareness and empathy, but it also requires the intellectual ability to calculate the implications of different behavioral alternatives. To understand how and why we feel as we do, and other people feel as they do, requires emotional awareness and intellectual reasoning. Emotional intelligence is more important to excellence in many aspects of life than pure intellect (as measured by IQ tests), because it includes intellect plus other capacities.

One of Sheila’s great assets, and one that she herself can “own,” is her sensitivity to preadolescent children. She likes them and is always attuned to the nuances of their thoughts and emotions. Sheila functions exceptionally well as a sitter for her friends and neighbors because children pick up on her sensitivity and reciprocate those positive feelings. On the other hand, as we have already seen, Sheila generally lacks emotional self-awareness and intensity. It seems that her negative moods and
attitudes contribute to her generally flat emotional style with most people. She is able to engage emotionally with children because, unlike her peers and older persons, they do not constitute any kind of threat to her.

Social Theories of Emotion

Social theories of emotion take the view that perception, or the interpretation of a situation, precedes emotion. These interpretations are learned, and as such they become automatic (unconscious or preconscious). Social theories emphasize the purpose of emotion, which is to sustain shared interpersonal norms and social cohesion. Two social theories are considered here.

James Averill’s (1997) theory states that emotions can be understood as socially constructed, transitory roles. They are socially constructed because they originate in our appraisals of situations. They are transitory in that they are time limited. Finally, emotions are roles because they include a range of socially acceptable actions that may be performed in a certain social context. We organize and interpret our physiological reactions to stimuli with regard to the social norms involved in the situations where these reactions occur. Emotions permit us, in response to these stimuli, to step out of the conventional social roles to which people not experiencing the emotion are held. For example, in our culture, we generally would not say that we wish to harm someone unless we were feeling anger. We would generally not lash out verbally at a friend or spouse unless we felt frustrated. We would generally not withdraw from certain personal responsibilities and ask others for comfort unless we felt sad. Because of the social function of emotions, we often experience them as passions, or feelings not under our control. Experiencing passion permits unconventional behavior because we assume that we are somehow not “ourselves,” not able to control what we do at that moment. Our society has adopted this mode of thinking about emotions because it allows us to distance ourselves from some of our actions. Emotions are thus legitimized social roles or permissible behaviors when in particular emotional states.

George Herbert Mead (1934), the originator of symbolic interaction theory, took a somewhat different view. He suggested that emotions develop as symbols for communication. He also believed that humans are by nature more sensitive to visual than to verbal cues. Emotional expressions are thus particularly powerful in that they are apprehended visually rather than verbally. Our emotional expression is a signal about how we are inclined to act in a situation, and others can adjust their own behavior in response to our perceived inclinations. Sheila’s lack of eye contact, tendency to look down, and physical distancing from others are manifestations of her sadness. Other persons, in response, may choose either to offer her support or, more likely in a classroom setting, to avoid her if they interpret her expressions as a desire for distance. Sheila was accustomed to people noticing her sadness at home, and responding to it in helpful ways, but in the faster-paced, more impersonal context of the university culture, this was not happening.

Theories of Emotion in Social Work Practice

The preceding theories are useful in assessment and intervention with clients because they enhance the social worker’s understanding of the origins of emotional experiences and describe how negative emotional states may emerge and influence behavior. The social worker can help the client develop more positive emotional responses by providing insight or corrective experiences. What follows, however, is a theory that is even more precise in identifying the processes of emotional experience.

L. S. Greenberg (2008) has offered an emotion-focused practice theory, similar to psychoanalytic theory, that promises to help in social work interventions. Greenberg asserts that all primary emotions—those that originate as biologically based rapid responses—are adaptive. Every primary emotion we experience has the purpose of helping
us adjust our relationship with an environmental situation to enhance coping. Secondary emotions emerge from these primary emotions as a result of cognitive mediation. Problems in social functioning may occur in one of four scenarios, summarized in Exhibit 4.7.

From this perspective, it is the unconscious or preconscious (mental activity that is out of awareness but can be brought into awareness with prompting) appraisal of situations in relation to our needs that creates emotions. Furthermore, as Mead (1934) pointed out, we experience our emotions as images, not as verbal thoughts. Emotions are difficult to apprehend cognitively, and in our attempts to do so, we may mistake their essence. The bad feelings that trouble us come not from those primary emotional responses, which, if experienced directly, would tend to dissipate, but from defensive distortions of those responses. We tend to appraise situations accurately with our primary emotions, but our frustration in achieving affective goals can produce distortions. Thus, in contrast to the assumptions of cognitive theory, distortions of thought may be the result of emotional phenomena rather than their cause.

Consider Sheila’s depression as an example. Perhaps she is interpersonally sensitive by nature and accurately perceives aloofness in others. Her affective goals of closeness are threatened by this appraisal, and the intensity of her reaction to this frustration becomes problematic. Her emotional patterns evoke tendencies to withdraw temporarily and to become less active in response to discouragement or sadness. To this point, the process may be adaptive, as she may be able to rest and regain energy during her temporary withdrawal. This particular feeling state, however, may become a cue for negative thoughts about herself, which then prevent her from actively addressing her frustrations.

In emotion-focused practice, the social worker would attempt to activate the person’s primary emotional reactions, making them more available to awareness within the safety of the social worker–client relationship and making secondary emotional reactions amenable to change when necessary. Emotional reactions, cognitive appraisals, and action tendencies may then be identified more clearly by the client.

From this perspective, a social worker could help Sheila understand that she carries much anger at her family because of their long-term lack of adequate support for her emotional development. Sheila could be encouraged within the safety of the social worker–client relationship to experience and ventilate that anger, and gain insight into her pattern. Once Sheila can consciously identify and experience that negative emotion, she may be less incapacitated by the depression, which is a secondary emotion resulting from her suppression of anger. She would then have more energy to devote to her own social and academic goals and to develop new ways of interacting with others in the university setting.

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**Exhibit 4.7** Four Sources of Emotion-Based Problems in Social Functioning

1. A primary emotion may not achieve its aim of changing our relationship with the environment to facilitate adaptation.
2. We may, prior to awareness of a primary emotion, deny, distort, avoid, or repress it and thus become unable to constructively address our person-environment challenge.
3. We may develop cognitive distortions, or irrational “meaning construction” processes, that produce negative secondary emotions.
4. We may regulate our appropriate emotional experiences poorly, by either minimizing or not maintaining control over them.
Critical Thinking Questions 4.1

How would you compare and contrast Daniel Goleman's theory of emotional intelligence with Howard Gardner's theory of multiple intelligences? Why do you think social work educators rated intrapersonal, interpersonal, and linguistic intelligences as the most important for social work practice? Would you agree with that? Why do you think the same educators rated bodily-kinesthetic, musical, and spatial intelligences as important for culturally sensitive practice? Would you agree with that? Shouldn’t all social work practice be culturally sensitive?

COGNITIVE/EMOTIONAL “DISORDERS”

As social workers, we are reluctant to label people as having cognitive or emotional “disorders.” Instead, we conceptualize problems in social functioning as mismatches in the fit between person and environment.

Still, in our study of the psychological person, we can consider how problems are manifested in the client’s cognitive and emotional patterns.

Many social workers are employed in mental health agencies and use the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR [text revision]; American Psychiatric Association, 2000) to make diagnoses as part of a comprehensive client assessment. The DSM has been the standard resource for clinical diagnosis in the United States for more than half a century. The manual states that its purpose is to “provide clear descriptions of diagnostic categories in order to enable clinicians and investigators to diagnose, communicate about, study, and treat people with various mental disorders” (p. xi). The DSM includes 16 chapters that address, among others, disorders diagnosed in infancy, childhood, or adolescence; cognitive disorders; substance-related disorders; psychotic disorders; mood disorders; anxiety disorders; sexual disorders; eating disorders; personality disorders; and adjustment disorders. As summarized in Exhibit 4.8, the diagnostic system includes five

<table>
<thead>
<tr>
<th>Exhibit 4.8</th>
<th>DSM-IV Classification of Mental Disorders</th>
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<tbody>
<tr>
<td><strong>Axis I</strong></td>
<td>Clinical or mental disorders</td>
</tr>
<tr>
<td></td>
<td>Other conditions that may be a focus of clinical attention</td>
</tr>
<tr>
<td><strong>Axis II</strong></td>
<td>Personality disorders</td>
</tr>
<tr>
<td></td>
<td>Mental retardation</td>
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<tr>
<td><strong>Axis III</strong></td>
<td>General medical conditions</td>
</tr>
<tr>
<td><strong>Axis IV</strong></td>
<td>Psychosocial and environmental problems</td>
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<tr>
<td></td>
<td>Primary support group</td>
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<td></td>
<td>Social environment</td>
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<td></td>
<td>Educational</td>
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<td></td>
<td>Occupational</td>
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<tr>
<td></td>
<td>Housing</td>
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<tr>
<td><strong>Axis V</strong></td>
<td>Global assessment of functioning (based on the clinician's judgment):</td>
</tr>
<tr>
<td></td>
<td>90–100 Superior functioning in a wide range of activities</td>
</tr>
<tr>
<td></td>
<td>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</td>
</tr>
</tbody>
</table>

categories, or “axes,” for each client. Axis I includes clinical or mental disorders, Axis II includes personality disorders and mental retardation, Axis III lists any medical conditions the client may have, Axis IV pertains to psychosocial and environmental problems, and Axis V includes a global assessment of functioning.

It is important to recognize that the DSM provides a medical perspective on human functioning. There is tension between the social work profession’s person-in-environment perspective and the requirement in many settings that social workers use the DSM to “diagnose” mental, emotional, or behavioral disorders in clients (J. Corcoran & Walsh, 2006). More will be said about this later in the chapter.

With this brief introduction, we can consider four examples of disorders selected from the DSM to illustrate how either cognitive or emotional characteristics may predominate in a client’s symptom profile, even though both aspects of the psychological person are always present:

- Two disorders that feature cognitive symptoms are obsessive-compulsive disorder and anorexia nervosa. Obsessive-compulsive disorder is an anxiety disorder that, when featuring obsessions, is characterized by persistent thoughts that are experienced as intrusive, inappropriate, unwelcome, and distressful. The thoughts are more than excessive worries about real problems, and the person is unable to ignore or suppress them. In anorexia nervosa, an eating disorder, the person becomes obsessive about food, thinking about it almost constantly. The person refuses to maintain a reasonable body weight because of distorted beliefs about physical appearance and the effects of food on the body.

- Two disorders that feature emotional symptoms are dysthymia and agoraphobia. Dysthymia, a mood disorder, is characterized by a lengthy period of depression. It features the emotion of sadness, which persists regardless of external events. Agoraphobia is an anxiety disorder characterized by fear. The person is afraid to be in situations (such as crowds) or places (such as large open areas) from which escape might be difficult or embarrassing. The person must restrict his or her range of social mobility out of fear of having a panic attack (being overwhelmed by anxiety) for reasons that are not consciously clear.

As a social worker, you might note that Sheila is depressed and also has a mild form of agoraphobia. She feels uncomfortable and insecure on the large, crowded campus, and developed fears of having panic attacks when in the student union. This building includes several large open areas that are highly congested at certain times of the day. Sheila is concerned that people there look at her critically. You might conclude that Sheila’s problems are primarily emotional. However, Sheila’s cognitive patterns have contributed to the development of her negative emotions. Her overall negative self-assessment sustains her depression, and her distorted beliefs about the attitudes of others contribute to her fears of being in the crowded union. It is rarely the case that only cognitive factors or only emotional factors are behind a client’s problems.

THE SELF

It remains for us to integrate cognition and emotion into a cohesive notion of the self. This is a difficult task—one that may, in fact, be impossible to achieve. All of us possess a sense of self, but it is difficult to articulate. How would you define self? Most of us tend to think of it as incorporating an essence that is more or less enduring. But beyond that, what would you say? Thinkers from the fields of philosophy, theology, sociology, psychology, and social work have struggled to identify the essence of the self, and they offer us a range of perspectives (Levin, 1992):

- The self as soul. A constant, unchanging self, existing apart from its material environment and material body, perhaps transcending the life of the physical body.
• The self as organizing activity. The initiator of activity, organizer of drives, and mediator of both internal and person-environment conflicts; an evolving entity in the synthesizing of experiences
• The self as cognitive structure. The thinker and definer of reality through conscious activities that support the primacy of thought
• The self as verbal activity. The product of internal monologues (self-talk) and shared conversation with others; the product of what we tell ourselves about who we are
• The self as experience of cohesion (self psychology). The sense of cohesion achieved through action and reflection; the three-part self (grandiose self based on positive affirmation, idealized parent image, and twinship or connected self)
• The self as flow of experience. The self-in-process, the changing self

THEORIES OF THE SELF IN RELATIONSHIPS

Cultural psychologists suggest that all of the above perspectives on the self assume an independent self, but in many cultures of the world, the self is an interdependent self that cannot be detached from the context of human relationships (Markus & Kitayama, 2009). And, indeed, 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 turn to examination of several theories that address the issue of how we exist in the context of relationships, including the object relations, feminist, relational, Afrocentric, and social identity theories.

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 is 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 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.

Photo 4.2 Some see the self as an ongoing process of experience. The play and exploration of these schoolgirls in Bhutan contribute to their developing self-concepts.
These early relationships are a primary determinant of our personality and the quality of our interpersonal functioning (L. M. Flanagan, 2008; E. Goldstein, 2001).

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” an emotional 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 in 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 not only exist as memories but are also part of our psychological makeup—they are a part of who we are.

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 identity. 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 &
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, & Wall, 1978) identified three infant attachment styles—secure, anxious-ambivalent, and avoidant types. A fourth attachment style has been identified more recently—the disorganized type (Madigan, Moran, & Pederson, 2006).

**Securely attached** infants act somewhat distressed when their parent figures 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. Infants who are not securely attached must direct their attention to maintaining their attachments to inconsistent, unavailable, or rejecting parents, rather than engaging in exploratory behaviors. 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.

**Anxious-ambivalently attached** infants, in contrast, are distraught when their parent figures leave. Upon their parents’ return, these infants continue to be distressed even as they want to be comforted and held. 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 parent figures leave and when they return. These children want to maintain proximity to their parent figures, 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 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 a sense of being cared for, the avoidant and anxious-ambivalent children do experience some success in fulfilling their needs for care.

**Relational Theory**

In recent years, there has been an integration of the psychoanalytic, object relations, and interpersonal theoretical perspectives, and this is broadly termed relational theory (Borden, 2009). In relational theory, as with object relations, the basic human tendency (or drive) is relationships with others, and our personalities are structured through ongoing interactions with others in the social environment. In this theory, however, there is a strong value of recognizing and supporting diversity in human experience, avoiding the pathologizing of differences, and enlarging traditional conceptions of gender and identity. It is assumed that all patterns of human behavior are learned in the give-and-take of relational life and thus they are all adaptive, reasonable ways to negotiate experience in the context of circumstances and our need to elicit care from others. Also consistent with object relations concepts, serious problems in living are seen as self-perpetuating because we all have a tendency to preserve continuity, connections, and familiarity in our interpersonal worlds. Our problematic ways of being and relating are perpetuated because they preserve our ongoing
experience of the self. What is new is threatening because it lies beyond the bounds of our experience in which we recognize ourselves as cohesive, continuous beings. That is, problematic interpersonal patterns are repeated because they preserve our connections to significant others in the past.

The relational perspective provides contexts of understanding for social workers in their ongoing efforts to connect biological, psychological, and social domains of concern and to enlarge conceptions of persons in their environments. If this sounds to the reader like social work’s long-standing focus on person-in-environment, it should! It seems in this sense that social work was ahead of some other disciplines. Relational practitioners encourage a variety of activities familiar to social workers including brief intervention, case management, environmental development, and advocacy.

The relational approach enriches the concept of practitioner empathy by adding the notion of mutuality. The ability to participate in a mutual relationship through the use of empathic communication is seen as a goal for the client’s growth and development. Current social work literature reflects different views regarding the degree to which workers should remain emotionally detached from clients, but the general consensus calls for the worker to maintain a neutral, objective persona and a sense of separateness. In relational theory, the more the worker expends energy on keeping parts of himself or herself out of the process, the more rigid, and less spontaneous and genuine, he or she will be in relating to the client system. The worker–client relationship runs the risk of becoming organized into dominant and subordinate roles.

**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 (Angers, 2008) and gender feminism (Marecek, Kimmel, Crawford, & Hare-Mustin, 2003). 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, nurturing, intuitiveness, sensitivity, and unselfishness. Masculine behavior is characterized by strength of will, ambition, courage, independence, assertiveness, hardness, 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, which 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 is a leading thinker in this area. As reported earlier, 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 (1982, 1988) 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 (2002, 2005) 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.

**Afrocentric Relational Theory**

The origins of Afrocentric relational theory (which can be considered a type of the broader relational theory discussed above) 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 (Y. R. Bell, Bouie, & Baldwin, 1998; R. L. Jackson, 2004). 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 such as the social worker–client relationship. 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 (Hornsey, 2008; 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 in 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 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. 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.

3. Resistance. In adolescence, or even later, if at all, 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 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. 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.

RESEARCH ON THE IMPACT OF EARLY NURTURING

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; Stansfeld, Head, Bartley, & Fonagy, 2008). 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.

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 by external signals as well.

There is also much research underway that is exploring the relationship between the processes
of attachment and specific neurological development in young persons (Schore, 2001, & 2002). Persistent stress in the infant or toddler results in an overdevelopment of areas of the brain that process anxiety and fear, and the underdevelopment of other areas of the brain, particularly the cortex. Of particular concern to one leading researcher (Schore, 2002) is the impact of the absence of nurturance on the orbital frontal cortex (OFC) of the brain. Chronic levels of stress contribute to fewer neural connections between the prefrontal cortex and the amygdala, a process that is significant to psychosocial functioning. The OFC is particularly active in such processes as concentration and judgment as well as the ability to observe and control internal subjective states. Further, the frontal cortex is central to our emotional regulation capacity and our experience of empathy. The amygdala, part of the limbic system, is attributed with interpreting incoming stimuli and information and storing this information in our implicit (automatic) memory. The amygdala assesses threat and triggers our immediate responses to it (the fight, flight, or freeze behaviors). A reduction in neural connections between these two areas suggests that the frontal cortex is not optimally able to regulate the processing of fear, resulting in exaggerated fear responses.

Stress can clearly affect brain development, but there is little evidence that the first 3 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).

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 levels of stress hormones 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 (Eagle & Wolitzky, 2009).

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.

Critical Thinking Questions 4.2
How important is culture in influencing the nature of the self? Does religion or spirituality play a role in the development of self? If so, how? Give some thought to social identity theory. With what social groups do you identify? How did you come to identify with these groups? How might your social identities affect your social work practice?

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 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, 2007):

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 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. 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, 2007). 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).

Social workers should be aware that as increasing emphasis is placed on the deleterious effects of stress on the immune system, our attention and energies are diverted from the project of changing societal conditions that create stress toward individual methods of stress management (D. Becker, 2005). With the influence of the medical model, we should not be surprised when we are offered individual or biomedical solutions to such different social problems as working motherhood, poverty, and road rage. It may be that the appeal of the stress concept is based on its attention away from the environmental causes of stress. This is why social workers should always be alert to the social nature of stress.
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 (R. K. 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 biological (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 (Zautra, 2003). 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 contributes to our sense of being overwhelmed. We are particularly receptive to receiving help from others at this time.
3. The crisis episode ends, either negatively (unhealthy coping) or positively (successful management of the crisis).

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Crises can be classified into three types (Lantz & Walsh, 2007). Developmental crises occur as events in the normal flow of life create dramatic changes that produce extreme responses. Examples include going off to college, college graduation, the birth of one’s child, a midlife career change, and retirement from work. 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 overwhelming 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 identified: natural (such as flood, tornado, earthquake) and technological (such as nuclear) disasters; war and related problems (such as concentration camps); and individual trauma (such as being raped, assaulted, or tortured) (Aldwin, 2007). 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—involve regular exposure to traumatic events that most people do not experience in a lifetime. Emergency workers, particularly police officers and firefighters, may experience threats to their own lives and the lives of their colleagues, as well as encounter mass casualties. Emergency workers may also experience **compassion stress**, a feeling of deep sympathy and sorrow for another who is stricken by misfortune, accompanied by a strong desire to alleviate the pain (Figley, 2002). 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. 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 (S. Jones & Fernyhough, 2007).

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.

Exhibit 4.9 The General Adaptation Syndrome

<table>
<thead>
<tr>
<th>Alarm</th>
<th>Resistance</th>
<th>Exhaustion</th>
</tr>
</thead>
</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 | Gradual reversal of all processes |
| - Activation of hypothalamus (link between brain and endocrine system)  
- Production of corticotrophin-releasing factor (CRF)  
- Activation of pituitary gland by CRF  
- Release of adrenocorticotropic hormone (ACTH) by pituitary gland  
- ACTH impact on adrenal cortex  
- Secretion of cortoids for:  
  - Energy and adaptation  
  - Enzymatic activation of connective tissue inflammatory potential (which protects all organ systems) | | Cumulative wear and tear on the body’s resources |

In this view, the body’s response to a stressor is called the general adaptation syndrome (explained in Exhibit 4.9). 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.

In this context, resistance means 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 adaptation to stress, but cumulative wear and
ternal 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 U.S. 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 (S. E. Taylor et al., 2002; S. E. Taylor & Stanton, 2007) 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 (J. Y. E. 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 4.10 lists the common defense mechanisms identified by ego psychology. 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. 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.

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.

Coping Styles

Another way to look at coping is by how the person responds to crisis. Coping efforts may be problem-focused or emotion-focused (Sideridis, 2006). 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
## Exhibit 4.10  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 unacceptable 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>
<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>
</tbody>
</table>
educate them about it 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 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. 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. Relation 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 (S. E. Taylor et al., 2002; S. E. Taylor & Stanton, 2007) 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 (Lippa, 2005). We need to give clients credit for the extraordinary coping efforts they may make in hostile environments.

We might note that Sheila did not initially employ many problem-focused coping strategies to manage stressors at the university, and she over-used 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.
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, 2007). 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 post-traumatic stress disorder (PTSD) (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.
- **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 post-traumatic stress disorder have been noted as soon as 1 week following the traumatic event, or as long as 30 years after (Sadock & Sadock, 2007). It is important to understand that the initial symptoms of post-traumatic stress are normal and expectable, and that PTSD should only be considered a disorder if those symptoms do not remit over time and present the person with serious long-term limitations in social functioning (D. Becker, 2004). 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%. 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 post-traumatic 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 defined as the interpersonal interactions and relationships that provide us with assistance or feelings of attachment to persons we perceive as caring (Hobfoll, 1996). Three types of social support resources are available (J. Walsh, 2000): material support (food, clothing, shelter, and other concrete items); emotional support (interpersonal support); and 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 (Wethington, Moen, Glasgow, & Pillemer, 2000).

Our social network includes not just our social support, but also 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).

How Social Support Aids Coping

The experience of stress creates a physiological state of emotional arousal, which reduces the efficiency of cognitive functions (Caplan & Caplan, 2000). 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; Caplan & Caplan, 2000):

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 5.

**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 & Smith, 1997). 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 (Uchino, 2009):

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 1 or 2 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.

**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. As noted earlier, the DSM is the standard resource for diagnosing mental disorders.

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 for individuals, families, or small groups.

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 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 4.11). 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.

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

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**Exhibit 4.11**  
Erikson’s Stages of Psychosocial Development

<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>

Social constructionist perspective
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 biopsychosocial-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, 2010).

Three types of situations are most likely to produce problems in social functioning: stressful life transitions, relationship difficulties, and environmental unresponsiveness (Gitterman, 2009). 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 4.12: 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 Maura O’Keefe (2008), 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.

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 6 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 6 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.

Critical Thinking Questions 4.3

What biases do you have about how people should cope with discrimination based on race, ethnicity, gender, sexual orientation, and so on? How might the coping strategy need to change in different situations, such as receiving service in a restaurant, being interviewed for a job, or dealing with an unthinking comment from a classmate?
### Factor I: Social Functioning Problems

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

B. Type of problem in social role
   1. Power
   2. Ambivalence
   3. Responsibility
   4. Dependency
   5. Loss
   6. Isolation
   7. Victimization
   8. Mixed
   9. Other

C. Severity of problem
   1. No problem
   2. Low severity
   3. Moderate severity
   4. High severity
   5. Very high severity
   6. Catastrophic

D. Duration of problem
   1. More than five years
   2. One to five years
   3. Six months to one year
   4. Two to four weeks
   5. Two weeks or less

E. Ability of client to cope with problem
   1. Outstanding coping skills
   2. Above average
   3. Adequate
   4. Somewhat inadequate
   5. Inadequate
   6. No coping skills

### Factor II: Environmental Problems

A. Social system where each problem is identified
   1. Economic/basic need
   2. Education/training
   3. Judicial/legal
   4. Health, safety, social services
   5. Voluntary association
   6. Affectional support

B. Specific type of problem within each social system

C. Severity of problem

D. Duration of problem

### 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
The study of the psychological person as a thinking and feeling being and as a self in relationship has many implications for social work practice:

- Be alert to the possibility that practice interventions may need to focus on any of several systems, including family, small groups, organizations, and communities. The person's transactions with all of these systems affect psychological functioning.
- Where appropriate, help individual clients to develop a stronger sense of competence through both ego-supportive and ego-modifying interventions.
- Where appropriate, help individual clients to enhance problem-solving skills through techniques directed at both cognitive reorganization and behavioral change.
- Where appropriate, help individual clients strengthen the sense of self by bringing balance to emotional and cognitive experiences.
- Help clients consider their strengths in terms of the unique sets of intelligences they may have, and show how these intelligences may help them address their challenges in unique ways.
- 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, and to social and environmental conditions that give rise to stress.
- Help clients assess the effectiveness of particular coping strategies for specific 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.
- When working with persons in crisis, attempt to alleviate distress and facilitate a return to the previous level of functioning.

### Key Terms

- accommodation (cognitive)
- adaptation
- assimilation (cognitive)
- cognition
- coping
- crisis
- defense mechanisms
- ego
- ego psychology
- emotion
- emotional intelligence
- emotion-focused coping
- multiple intelligences
- neural plasticity
- object relations theory
- preconscious
- primary emotions
- problem-focused coping
- psychoanalytic theory
- psychology
- relational coping
- relational theory
- schema (schemata)
- secondary emotions
- self
- social network
- social support
- state
- stress
- trait
- traumatic stress
- unconscious

### Active Learning

1. Reread the case study at the beginning of this chapter. As you read, what do you see as the driving force of Sheila's behavior as she makes the transition to the university? Is it cognition? Is it emotion? What patterns of thinking and feeling might Sheila have developed from her rural background? What theories presented in the chapter are most helpful to you in thinking about this?
2. What is your own perspective on the nature of the self? How does this affect your work with clients, when you consider their potential for change?

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**

- **The Consortium for Research on Emotional Intelligence in Organizations**
  www.eiconsortium.org
  Site contains recent research and model programs for promoting the development of emotional intelligence in the work setting.

- **Institute of Contemporary Psychotherapy ad Psychoanalysis**
  www.icpeast.org/index.html
  Site contains information on conferences, training, and links to other resources on contemporary self and relational psychologies.

- **Lawrence Kohlberg’s Stages of Moral Development**
  www.xenodocy.org/ex/lists/moraldev.html
  Site maintained by Ralph Kenyon, contains an overview and critique of Kohlberg’s stage theory of moral development.

- **MEDLINEplus: Stress**
  Site maintained by the National Institute of Mental Health, includes links to latest news about stress research; coping; disease management; specific conditions; and stress in children, seniors, teenagers, and women.

- **Multiple Intelligences for Adult Literacy and Education**
  http://literacyworks.org/mi/home.html
  Site presented by Literacyworks, contains a visual overview of Howard Gardner’s theory of multiple intelligences, guidelines for assessment, and suggestions for putting the theory to practice in adult literacy programs.

- **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.

- **Object Relations Theory and Therapy**
  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.

- **Piaget’s Developmental theory**
  www.learningandteaching.info/learning/piaget.htm
  Site maintained by James Atherton of the United Kingdom overviews Jean Piaget’s key ideas and developmental stages.

- **Self Psychology Page**
  www.selfpsychology.com
  Site maintained by David Wolf contains a definition of the self psychology of Heinz Kohut, bibliography, papers, discussion groups on self psychology, and links to other Internet sites.
Stone Center  
www.wcwonline.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.

Stress Management  
http://mentalhealth.about.com/od/stress/stress_management.htm

Site presented by About.com, which is owned by the New York Times, includes a large number of articles and links about topics related to stress management in a variety of contexts.