The Psychological Person

Joseph Walsh

CASE STUDY: The Premed Student
Cognition and Emotion
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Cognitive Theory
Information Processing Theory
Social Learning Theory
Theory of Multiple Intelligences
Theories of Moral Reasoning
Theories of Cognition in Social Work Practice
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The Sociological Approach: Deviance
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Key Terms
Active Learning
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Learning Objectives

LO 4.1 Analyze their emotional and cognitive reactions to a case study.
LO 4.2 Define cognition and emotion.
LO 4.3 Compare and contrast five major theories of cognition (cognitive, information processing, social learning, multiple intelligences, and moral reasoning) and cognitive behavioral intervention theory.
LO 4.4 Compare and contrast four major categories of theories of emotion (physiological theories, psychological theories, social theories, and social work practice theories).
LO 4.5 Recognize how cognitive and emotional characteristics can be involved in cognitive and emotional “disorders.”
LO 4.6 Describe four theories of self in relationships (relational, attachment, feminist, and social identity).
LO 4.7 Summarize the role of stress, crisis, and traumatic stress in human behavior.
LO 4.8 Analyze different styles of coping and adaptation in relation to stress.
LO 4.9 Critique four different approaches to normal and abnormal coping (medical, psychological, sociological, and social work).
LO 4.10 Apply knowledge of cognition, emotion, self, the self in relationship, stress, and coping to recommend guidelines for social work assessment and intervention.
Dan Lee was a 24-year-old single Chinese American male undergrad student working toward admission into medical school when he came to the university counseling center to get help with his feelings of anxiety, tension, sadness, and anger and also for some ongoing interpersonal conflicts. Dan was having difficulty concentrating on his studies and was in danger of failing a course he needed to pass in order to stay on track for medical school. He was specifically preoccupied with perceived personal slights from several friends, his sister, and his mother. Dan told the social worker that he needed help learning how to get these significant others to behave more responsibly toward him so that he could focus more intensively on his own work. Dan reported that he also had been diagnosed several years ago with an auditory processing disorder, which meant he was slow to process other people’s verbal communications at times and prepare his responses to them.

Dan is the older of two children (his sister was 22) born to a couple who had grown up in Taiwan and moved to the United States before the children were born. His father, a surgeon, and his mother, a homemaker, had divorced when Dan was 7. He and his sister had lived with their mother since then and only had occasional contact with their father. Dan had internalized the values of his family and culture; he understood that he needed to assume primary responsibility for the well-being of his mother and sister while also achieving high social status for himself. He also exhibited the cultural value of obedience to authority and saw himself as the family’s primary authority figure, being the only male member. While a student at the diverse university, Dan maintained cultural ties through his membership in a church that served the Chinese American community.

Dan tried hard to be a good son and brother but held a firm position that others should always accede to his directives. He believed he was always “right” in decisions he made about his mother and sister (regarding where they lived, how his mother spent her time, and what kinds of friends and career choices his sister should make). Regarding his friends, who were mostly limited to casual contacts at school and at his volunteer job at a community health center, Dan felt that whenever there was a conflict or misunderstanding it was always “their fault.” He felt disrespected at these times and became so preoccupied with these “unjust slights” that he couldn’t concentrate on much else for days afterward. Dan gave one example of a friend who had arrived more than 20 minutes late on two occasions for scheduled social outings. The second time he demanded that the friend apologize for being irresponsible and insensitive, and when the friend did not do so to Dan’s satisfaction, the relationship ended. These kinds of relationship disruptions were common in his life. Dan’s family and friends often did not accept his admonitions, and he wanted to learn from the social worker how to better help these other people see that he was always “rational” and “correct” in his thinking. Dan had warmer feelings toward his peers at church, all of whom were Asian Americans. He spent most of his Sunday afternoons there, participating in social events and singing in the choir. Dan was also in regular contact with an ex-girlfriend, mostly by e-mail but occasionally by phone. He had broken up with her 6 months ago, and whereas she hoped they would resume a romantic relationship, Dan did not think this would happen.

Spencer, the social worker, was a U.S.-born Caucasian male, several years older than Dan, who had some understanding of the Chinese value system in which the client was raised. He liked Dan, appreciating his intelligence, his motivation to get help, and his ability to articulate his concerns, but he also observed that Dan demonstrated a striking rigidity in his attitudes toward others. Still, he initially validated Dan’s perspective on the presenting issues. Spencer easily engaged Dan in substantive conversations each time they met, reflecting back to Dan the difficulty of his competing demands and desire to help his family lead safe and productive lives. Before
Dan's problems at college reflect his personal psychology, which can be defined as his mind and his mental processes. His 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 reflection. Cognition includes taking in relevant information from the environment, synthesizing that information, and formulating a perspective on interpersonal differences and Dan's inability to distinguish disagreement from disrespect. During the course of their year of working together, Spencer employed the following interventions, which alternately focused on Dan's thinking and emotions: cognitive therapy (restructuring), behavioral change, and psychodynamic therapy (so that Dan might become more aware of the range of his feelings and how the sources of his anger might be based in his family history and early upbringing). Whereas Dan noted little progress for several months, Spencer was encouraged by the fact that he continued coming in faithfully, week after week.

Spencer’s work with Dan experienced its most success with a series of behavioral interventions. Spencer helped Dan to use relaxation techniques and to consider the environments in which he was best able to focus on his studies. They determined, for example, that Dan was best able to concentrate during the middle of the day and when there were people around him. They set up a schedule of study in the medical library, where Dan could sit at a table with other students (whom he did not necessarily know). Spencer rehearsed deep-breathing activities with Dan, which helped calm his anxieties, and he further suggested that Dan study after a physical workout, when his body was calmer (Dan enjoyed swimming). Spencer also suggested that physical activity might help him release some of his anger after an interpersonal conflict.

Dan never articulated openly that his ideas about the appropriate behavior of others were anything but “correct,” but over time he reported fewer conflicts with his sister, mother, and peers, and his study habits and grades improved to the point that he was admitted to medical school. After a year-long weekly intervention Dan finally decided to terminate because of his busy medical school schedule. During their final session together, he said to Spencer, “I don’t know how much I’ve gotten out of this, but I know you tried to help, and I appreciate that.”

Reviewing the intervention with his supervisor, Spencer regretted that he had felt such frustration with Dan, but he felt he had been able to contain those feelings. Further, despite Dan’s ongoing misgivings about the quality of the intervention, he had continued meeting with Spencer for a full year and eventually demonstrated behaviors evident of improvement. It seemed that Dan had reached a higher level of adaptability even though it wasn’t as apparent to him.

**COGNITION AND EMOTION**

Dan's 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 reflection. Cognition includes taking in relevant information from the environment, synthesizing that information, and formulating a
Beliefs, key elements of our cognition, are ideas 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 is a difficult concept to define but can be understood as a feeling state characterized by our appraisal of a stimulus, changes in bodily sensations, and displays of expressive gestures (Mulligan & Scherer, 2012). The term emotion is often used interchangeably in the study of psychology with the term affect, but the latter refers only to the physiological manifestations of feelings. Affect may be the result of drives (innate compulsions to gratify basic needs), which generate both conscious and unconscious feelings (those of which we are not aware but that influence our behavior). In contrast, emotion is always consciously experienced. Likewise, emotion is not the same as mood, a feeling disposition that is more stable than emotion, usually 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 cognition and emotion—their origins, 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 development 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 saw the four stages presented in Exhibit 4.1 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 normal physical and neurological development as necessary for cognitive development.

A central concept in Piaget’s theory is that of the 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
EXHIBIT 4.1 • Piaget’s Stages of Cognitive Operations

<table>
<thead>
<tr>
<th>STAGE</th>
<th>DESCRIPTION</th>
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<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>
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<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>
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<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>
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<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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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 Dan’s difficulties with his college peers as an inability to achieve equilibrium by assimilating new interactive experience within his existing schemata. Dan was accustomed to functioning within a relatively small group of family and friends from his own cultural background, where roles were clearly defined. He could not easily adjust to the challenge of managing relationships among a much larger and more diverse student population, where the members’ motivations and worldviews were difficult to comprehend.

INFORMATION PROCESSING THEORY
Cognitive theory has been very influential, but, as you might guess, it 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 (Logan, 2000). This theory makes a clear distinction between the thinker and the external environment; each is an independent, objective entity in the processing of inputs and outputs. We receive stimulation from the outside and code it with sensory receptors in the nervous system. The information is first represented in some set of brain activities and is then integrated (by accommodation or assimilation) and stored for purposes of present and future adaptation to the environment. All of us develop increasingly sophisticated problem-solving processes through the evolution of our cognitive patterns, which enable us to draw attention to particular inputs as significant. 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. 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.

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 puts forth 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 Dan’s reaction to the behavior of his peers is very different from how many of them might react to each other. Bandura 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. For example, Dan may have made some negative self-judgments about his competence to complete his pre-med studies that are affecting his functioning.

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 cognition and emotion in some areas of life but not others. In this theory, 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 of us have a unique blend of intelligences derived from these modules. Gardner has delineated eight intelligences, which are described 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 most consistent with traditional notions of intelligence. 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).

The theory of multiple intelligences is rather new and has not yet been empirically validated by research (Waterhouse, 2010). Still, it has proven useful in understanding a person’s range of strengths and can even serve as a guide for social work practitioners in deciding on interventions that will maximize client motivation and participation (for example, art therapy for persons with strong visual-spatial intelligence) (Booth & O’Brien, 2008). 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. Dan has a strong logico-mathematical intelligence that contributes to his ability to master difficult physiological concepts.

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.
may benefit from help, however, in further development of his intrapersonal and interpersonal domains, especially outside his cultural group.

THEORIES OF MORAL REASONING

Morality is our sensitivity to, and perceptions 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.

Kohlberg (1969) formulated six stages of moral development, divided into three levels, 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 Dan 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 (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 and interdependence 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 (see, e.g., Donleavy, 2008; Hauser, Cushman, Young, Mikhal, & Jin, 2007; Malti, Gasser, & Buchmann, 2009).

Part II: The Multiple Dimensions of the Person

With his great concern about individual achievement, along with a desire to care for his sister and mother, Dan seems to fall into Kohlberg’s stage of conventional morality and Gilligan’s stage of conventional care, but this may reflect both gender and culture. Researchers have found 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 (Gardiner & Kosmitzki, 2011). Gardiner and Kosmitzki (2011) argue that moral development may not follow a universal script across cultures and suggest that the ecological system in which 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 Haan (1991) and Neff and Helwig (2002), who suggest that moral reasoning comes from the understanding of the interdependence of self and others that develops through social interactions. They propose 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 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 emotions. Research has tended to support the idea that moral development unfolds in stages across cultures (Gibbs, Basinger, Grime, & Snarey, 2007).

**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 (Walsh, 2014).

According to cognitive theory, we are “rational” to the extent that our schemata, the basis for our perceptions, accommodate available environmental evidence and our decisions do not rely solely on preconceived notions about the external world. So long as our cognitive style helps us to achieve our goals, it is considered healthy. However, 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 distortions are habits of thought that lead us at times to distort input from the environment and experience psychological distress (A. T. Beck, 1976; J. S. Beck, 2005).

As a social worker, you could use cognitive theory to surmise that Dan is distressed because he subjectively assesses some of his life situations in a distorted manner. For example, arbitrary inferences may lead him to conclude that because other students do not share his perspectives on how they should behave, they do not respect his point of view. Because he concludes this, he may also conclude that he will continue to feel isolated from his peers, and this thought produces his emotional response of sadness.

To adjust his emotions and mood, Dan needs to learn to evaluate his external environment differently. He needs to consider changing some of the beliefs, expectations, and meanings he attaches to events, because they are not objectively true. He might conclude, for example, that people possess honest differences of opinion and that some of his peers appreciate him more than he assumes. He may even notice that their opinions are consistent with his more than he realizes. Cognitive theorists would make Dan’s thinking the primary target of change activity, assuming that cognitive change will in turn produce changes in his emotional states.

Cognitive theory is a highly rational approach to human behavior. Even though the theory assumes that some 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 and identify the source of his or her difficulties as being rooted in cognitive deficits, distortions, or accurate assessment of a situation. During intervention, the social worker helps the client adjust his or her cognitive processes to better facilitate the attainment of goals. As a result, the client will also experience more positive emotions. It is important to emphasize that clients are not encouraged to rationalize all of their problems as involving faulty assumptions, because many challenges people face are due to oppressive external circumstances. Still, Dan’s belief that his family and peers do not value his feedback is an arbitrary inference. To help him overcome this distortion, the social worker could review the available evidence of that conclusion, helping Dan to understand that his significant others may often give consideration to his points of view even though they do not always accede to them.

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 Dan feels socially isolated due to his lack of skills at engaging in casual conversation, the social worker would first help him understand that improved social skills might help him feel more connected to his peers. Through behavioral rehearsal, Dan could learn through step-by-step modeling and role-playing how to informally interact with his classmates more effectively. His positive reinforcers might include the sense of interpersonal connection, a new sense of efficacy, and reduced anxiety.

Assessing and intervening with a person’s thought processes, and then helping the client to identify and develop reinforcing new ways of thinking and behavior, is known as cognitive-behavioral therapy (CBT). Most cognitive practitioners use cognitive-behavioral methods because it is important to help the client experience rewards for any changes he or she risks.

### EXHIBIT 4.5 • Common Cognitive Distortions

<table>
<thead>
<tr>
<th>COGNITIVE ERROR</th>
<th>DESCRIPTION</th>
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<tbody>
<tr>
<td>Absolute thinking</td>
<td>Viewing experiences as all good or all bad and failing to understand that experiences can be a mixture of both</td>
</tr>
<tr>
<td>Overgeneralization</td>
<td>Assuming that deficiencies in one area of life necessarily imply deficiencies in other areas</td>
</tr>
<tr>
<td>Selective abstraction</td>
<td>Focusing only on the negative aspects of a situation and consequently overlooking its positive aspects</td>
</tr>
<tr>
<td>Arbitrary inference</td>
<td>Reaching a negative conclusion about a situation with insufficient evidence</td>
</tr>
<tr>
<td>Magnification</td>
<td>Creating large problems out of small ones</td>
</tr>
<tr>
<td>Minimization</td>
<td>Making large problems small and thus not dealing adequately with them</td>
</tr>
<tr>
<td>Personalization</td>
<td>Accepting blame for negative events without sufficient evidence</td>
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</tbody>
</table>
The more we learn about cognition, however, the more complex it becomes. For example, psychologist and economist Daniel Kahneman (2011) suggests that people place too much confidence in the rationality of their judgment. In fact, his research concludes that we all have built-in cognitive biases. One of these is that we are more driven to avoid pain than to experience pleasure, but more problematic is our “optimistic bias,” which generates a false sense of control of our lives. This bias may be adaptive in an evolutionary sense, but as a result we fail to comprehend and take complexity into account in assessing past and present events, and our understanding of the world consists of small, not necessarily representative sets of observations. One implication of this bias is that we tend to be overconfident in our judgments; our “rational” minds generally do not account for the role of chance in events and thus falsely assume that future events will mirror past ones. Kahneman’s work provides a reminder that there is much to be learned about the nature of cognition and the potential for people to act “rationally.”

### CRITICAL THINKING Questions 4.1

How important do you think conscious thinking is in human behavior in general and for Dan Lee in particular? What do you think of Daniel Kahneman’s thesis that we place too much confidence in the rationality of our judgments?

### 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. That is, some emotional experience is an interpretation and not merely given by our physiological state. 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, Fischer, & Manstead, 2005). **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). **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. Secondary emotions may result from combinations of primary emotions (Plutchik, 2005), and their greater numbers also imply that our processes of perception, though largely unconscious, are significant in labeling them. 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 key to our processing of emotion (Bentley & Walsh, 2014). 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. 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**

Early physiological theories of emotion were proposed by William James (1890) and Walter Cannon (1924), but physiology-based theories of emotion lost favor in the mid-20th century. Recent brain research is once again suggesting a strong link between physiological processes and emotion. The *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 the primary emotions of happiness, sadness, fear, anger, and interest/excitement. These emotions are instinctual, hardwired into our brains, and 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, Dan has a persistent bias toward sadness, which may reflect some personal or material losses that occurred long before he started college. His episodes of sadness produce the temporary physical responses of a slowing down and decreased general effort. The sadness thus allows Dan time to reevaluate his needs and regain energy for more focused attempts to reach more achievable goals. It is also a signal for others to provide Dan with support. (You can certainly recall times when the sadness of another person prompted your own empathic response.) Of course, it is likely that “appearing sad” may have been more functional for Dan in his home community, where he was more consistently around people who knew and took an interest in him. In contrast, the emotion of anger tends to increase a person’s energy and motivate behavior intended to overcome frustration. Furthermore, it signals others to respond with avoidance, compliance, or submission so that the person may resolve the problem. Dan becomes angry rather frequently, and his sullen demeanor clearly encourages his peers, but not necessarily his family, to give him space.

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, and it is clear that many areas of the brain have a role (Farmer, 2009). Furthermore, it is now widely accepted that cultural patterns shape the ways in which environmental input is coded in the brain (Kagan, 2007).

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 primary emotions described earlier may travel there directly from the thalamus, bypassing any cognitive apparatus, to produce an immediate reaction that is central 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 (schemas) that interpret this stimulation may, through feedback loops to the thalamus, actually shape the neural pathways that will be followed by future stimuli. In other words, neural schemata tend to become rigid patterns of information processing, shaping subsequent patterns for making sense of the external world.

Richard Davidson’s research has focused on the neurological processes underlying emotion, and he understands the interactions between the prefrontal cortex and amygdala to play an important role (Davidson & Begley, 2012). Through brain imaging research he has found that the greater the number of connections between the amygdala and prefrontal cortex, the better we tend to be at managing our emotions. As one example, activity in the left prefrontal cortex is higher in persons who are more resilient to negative emotions, and from this Davidson infers that the left prefrontal cortex sends inhibitory messages to the amygdala.

Davidson claims that we all have different *emotional styles*, composed of combinations of six components, that determine how we react to experiences in our lives and how likely we are to have particular moods (see Exhibit 4.7). The interrelation between the

**EXHIBIT 4.7 • Davidson’s Six Components of Emotional Style**

<table>
<thead>
<tr>
<th>Component</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Resilience</strong></td>
<td>How quickly we recover from negative emotions.</td>
</tr>
<tr>
<td><strong>Outlook</strong></td>
<td>The duration of our positive emotions.</td>
</tr>
<tr>
<td><strong>Context</strong></td>
<td>The degree to which we modulate our emotional responses in a manner appropriate to the context (for example, not directly taking out our work-related anger on the boss).</td>
</tr>
<tr>
<td><strong>Social intuition</strong></td>
<td>Our sensitivity to social cues, including all verbal and nonverbal expressions, that reflect our ability to understand and empathize with other people’s emotional worlds.</td>
</tr>
<tr>
<td><strong>Self-awareness</strong></td>
<td>The extent to which we are aware of emotional signals within our own bodies and minds. The more aware we are of our emotions, the better we will manage them.</td>
</tr>
<tr>
<td><strong>Attention</strong></td>
<td>The extent to which we can focus our attention on one thing at a time rather than becoming easily distracted.</td>
</tr>
</tbody>
</table>

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prefrontal cortex and amygdala plays a major role in determining these emotional styles. People with fewer connections tend to be less effective emotional regulators, making them more irritable, quick-tempered, and less able to manage their emotions in a healthy way. Davidson further cites research suggesting that genes associated with emotional styles can gradually change their expression based on our environments, behaviors, and life experiences.

**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, object relations, and relational theory, 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 influenced by those unconscious impulses 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 our 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 Dan has a normal, healthy drive for pleasure. He may also be angry with his father for breaking up the family, providing it with limited resources and leaving him in a responsible position at such a young age. This anger might be repressed into unconsciousness, however, because Dan is also emulating his father professionally and may believe, due to his cultural background, that it is not permissible for a child to be angry with a parent. Dan's unconscious anger, having been turned inward at himself, may be contributing to his frustrations and inability to experience joy. An analytical social worker might suspect from Dan's presentation that he experiences this anger but is not aware of it. The social worker might try to help Dan uncover the feeling by having him reflect on his family history in detail, in a safe clinical environment. With the insights that might result from this reflection, Dan's anger may become conscious, and he can then take direct measures to work through it.

**Ego Psychology**

Ego psychology, which emerged in the 1930s (Goldstein, 2009), 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 functioning. 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 continues 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, concentration, 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 internal 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 internal conflicts related to drive frustration. It is also possible that we are experiencing person–environment conflicts in which our coping efforts are not
Dan labels his emotion as resentment because he concludes that his classmates are incorrectly perceiving him 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, and the ability to motivate oneself, understand and regulate one’s own emotions, and read and deal effectively with other people’s feelings. This is a relatively new concept in psychology.

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 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 necessitates the intellectual ability to calculate the implications of behavioral alternatives. To understand how and why we feel as we do, and other people feel as they do, demands emotional awareness and intellectual reasoning. Emotional intelligence is more important to excellence in many aspects of life than pure intellect because it includes intellect plus other capacities. As we have already seen, Dan generally lacks emotional self-awareness.

**SOCIAL THEORIES OF EMOTION**

Social theories of emotion also take the view that perception, or the interpretation of a situation, precedes emotion. These interpretations are learned and become automatic (unconscious or preconscious) over time. 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 (2012) social constructionist theory states that emotions can be understood as socially constructed, transitory roles. They are socially constructed because they originate in our appraisals of situations, transitory in that they are time limited, and roles because
they include a range of socially acceptable actions that may be performed in a certain 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 functions 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 for persons 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 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. Dan’s lack of eye contact and physical distancing from others are manifestations of his anxiety. Other persons, in response, may choose either to offer him support or, more likely in a classroom or lab setting, to avoid him if they interpret his expressions as a desire for distance. Dan was accustomed to people noticing his sadness at home and not responding to it by reaching out to him, but in the faster-paced, more impersonal context of the university culture, this was not happening. One reason he may be continuing contact with his ex-girlfriend is that, despite their differences, she perceives and affirms his sadness.

L. S. Greenberg (2011) has offered an emotion-focused practice theory, similar to psychoanalytic theory, that may be helpful 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.

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 George Herbert 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 Dan’s distress as an example. Perhaps he accurately perceives wariness in others (due to his standoffish demeanor). His need to be in control is threatened by this appraisal, and the intensity of his reaction to this frustration becomes problematic, making it hard for him to concentrate on his studies. His emotional patterns evoke his tendencies at times to become confrontational almost to the point of verbal abuse.

Personal reality, then, may be as much a product of emotion as cognition. In any situation, the meanings we construct may automatically determine our conscious responses. It is when we directly experience primary emotions that we are functioning in an adaptive manner.

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 reflection and change when necessary. Emotional reactions, cognitive appraisals, and action tendencies may then be identified more clearly by the client. Affective needs can be identified, and a new sense of self may emerge along with an improved capacity for self-direction.

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

CRITICAL THINKING Questions 4.2

We have just looked at three types of theories of emotion: physiological theories, psychological theories, and social theories. What did you find most interesting about these different ways of thinking about emotion? Which ideas did you find most appealing? Most convincing? Explain. Some research suggests that emotional intelligence is more important to career success than intelligence measured as IQ. Does that make sense to you? Why or why not?

COGNITIVE AND 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 Diagnostic and Statistical Manual of Mental Disorders (DSM-5, American Psychiatric Association [APA], 2013) 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 purpose of the manual is to provide clear descriptions of diagnostic categories so that practitioners of all disciplines can diagnose, communicate about, and treat people with mental and emotional disorders. The DSM includes 20 chapters of disorders that address, among others, neurodevelopmental (such as autism spectrum disorder), schizophrenia spectrum, bipolar, depressive, anxiety, obsessive-compulsive, trauma, dissociative, eating, elimination, sleep-wake, disruptive, substance-related, neurocognitive (such as Alzheimer’s disease), personality, and paraphilic disorders, as well as sexual dysfunctions and gender dysphoria.

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 (Corcoran & Walsh, 2010).

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 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 obsessed 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 persistent depressive disorder (PDD) and agoraphobia. PDD, a mood disorder, is characterized by a lengthy period of depression. It features the emotion of sadness, which tends to persist 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 being overwhelmed by anxiety for reasons that are not consciously clear.

As a social worker, you might note that Dan displays symptoms of obsessive-compulsive disorder. He experiences persistent and unwanted ideas and thoughts that significantly intrude on his desire to do or think of other things. He does not, however, experience compulsions or illogical impulses to perform certain behaviors (such as repeatedly checking to see if his apartment door is locked). You might thus conclude that Dan's problems are primarily cognitive. However, Dan's cognitive patterns have contributed to, and been affected by, his development of negative emotions. His difficulties at school sustain his chronic anxiety, and his distorted beliefs about the attitudes of others contribute to his sadness at being isolated from them. It is rarely the case that only cognitive factors or only emotional factors are behind a client's problems.

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THE SELF

It remains for us to integrate elements of 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 summarized here.

- 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 unfolding potential. A conscious, fluid, unfolding self that strives to actualize inherent potentials.
- 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 shared symbolic experience. A sense of meaning about who we are developed through interaction with our physical and social environments and through our perceptions of how others perceive us.
- The self as flow of experience. The self in process, the changing self.

THE SELF IN RELATIONSHIPS

Cultural psychologists suggest that all of these perspectives assume an independent self, but in many cultures of the world, the self is an interdependent one that cannot be detached from the context of human relationships (Markus & Kitayama, 2009). And, indeed, as Dan understood but had trouble managing, 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 relational, attachment, feminist, and social identity theories, and evidence demonstrating the importance of early nurturing in the ability to build relationships throughout life.

RELATIONAL THEORY

In recent years, an integration of the psychoanalytic and interpersonal theoretical perspectives (which focus on relationships as the driving force of personality development) has come to be called relational theory (Borden, 2009). In relational theory the basic human tendency (or drive) is for relationships with others, and our personalities are structured through ongoing interactions with others in the social environment. In this theory 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 assumes that all patterns of behavior are learned in the give-and-take of relational life and are adaptive ways of negotiating experience in the context of our need to elicit care from, and provide care for, others. Serious relationship problems are seen as self-perpetuating because we all have a tendency to preserve continuity in our interpersonal worlds. What is new is threatening because it lies beyond the bounds of our experience in which we recognize ourselves as cohesive beings.

For social work practice, the relational perspective enriches the concept of empathy by adding the notion of...
All children seek proximity to their parents, and they develop attachment styles suited to the types of parenting they encounter.

**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 nonattachment-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.

**Anxiously-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. These children employ “hyperactivation” strategies. Their parents, whereas 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 hyper-vigilant 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 attachment styles suited to the types of parenting they encounter.

**ATTACHMENT THEORY**

To understand how we develop our initial relationship patterns, it may be useful to consider one model of parent–child attachment here (Shorey & Snyder, 2006). All children seek proximity to their parents, and they develop attachment styles suited to the types of parenting they encounter. Ainsworth and her colleagues (Ainsworth, Blehar, & Waters, 1978) identified three infant attachment styles—secure, anxious-ambivalent, and avoidant types. A fourth attachment style has been identified more recently—the disorganized type (Madigan, Moran, & Pederson, 2006).

Contrary to traditional analytic notions, the relational social worker expresses a range of thoughts and feelings “in the moment” with the client to facilitate their mutual connection (Freedberg, 2007). Intervention focuses on here-and-now situations in the client’s life, including those involving the social worker and client. Current social work literature reflects diverse views regarding the degree to which practitioners should self-disclose with their clients, but the general consensus calls for the worker to maintain a neutral, objective persona (Walsh, 2000). In relational theory, however, the more the worker expends energy on keeping parts of herself or himself out of the process, the more rigid and less genuine he or she will be with the client. Relational theorists encourage the social worker’s natural, authentic manner of engagement; the strategic use of self-disclosure; and the encouragement of the client to regularly comment on the intervention process. The social worker also tries to avoid relegateing the two parties into dominant and subordinate roles. This does not imply a neglect of appropriate boundaries, however, because the social worker must maintain a clear sense of self while engaged in the emotional and cognitive integration necessary for empathy to be effective.

Despite its limitations with regard to empirical validation, the assumptions of relational theory are consistent with the findings of the American Psychological Association (APA) on the significance of the worker–client relationship. The APA has systematically evaluated the significance of the practitioner–client relationship in determining intervention effectiveness and concluded that several relationship variables used in practice were demonstrably effective (the alliance in individual and family therapy; cohesion in group therapy; empathy; and collecting client feedback), and others were probably effective (attention to goal consensus, collaboration, and positive regard). Three other relationship elements (congruence or genuineness, repair alliance ruptures, and managing countertransference) were deemed promising (Norcross & Wampold, 2011).

Mutuality between the social worker and client. The ability to participate in a mutual relationship through empathic communication contributes to the client's growth. Contrary to traditional analytic notions, the relational social worker expresses a range of thoughts and feelings “in the moment” with the client to facilitate their mutual connection (Freedberg, 2007). Intervention focuses on here-and-now situations in the client’s life, including those involving the social worker and client. Current social work literature reflects diverse views regarding the degree to which practitioners should self-disclose with their clients, but the general consensus calls for the worker to maintain a neutral, objective persona (Walsh, 2000). In relational theory, however, the more the worker expends energy on keeping parts of herself or himself out of the process, the more rigid and less genuine he or she will be with the client. Relational theorists encourage the social worker’s natural, authentic manner of engagement; the strategic use of self-disclosure; and the encouragement of the client to regularly comment on the intervention process. The social worker also tries to avoid relegateing the two parties into dominant and subordinate roles. This does not imply a neglect of appropriate boundaries, however, because the social worker must maintain a clear sense of self while engaged in the emotional and cognitive integration necessary for empathy to be effective.
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 children with disorganized attachments typically do not attain senses of being cared for, the avoidant and anxious-ambivalent children do experience some success in fulfilling their needs for care.

**IMPACT OF EARLY NURTURING ON DEVELOPMENT**

We have been looking at theories that deem relationships to be important throughout our lives. Turning to both human and animal research, we can find physiological evidence that, as suggested by relational and attachment 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.

A large body of research is devoted to studying the links between early life experiences and physical and mental health risks (e.g., Lally, 2011). This work demonstrates that negative early life 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 (Farmer, 2009). These findings tend to support the lifelong significance of specific relationship interactions.

Although much of this research is being conducted on rats, monkeys, and other animals, it has clear implications for human development. The concept of neuroplasticity (discussed in Chapter 3) is significant here (Bryck & Fisher, 2012). Humans may have a window of opportunity, or a critical period for altering neurological development, but this window varies, depending on the area of the nervous system. Even through the second decade of life, for example, neurotransmitter and synapse changes are influenced by internal biology, but perhaps by external signals as well. In other words, the brain is not a static organ.

Much research currently underway explores the relationship between the processes of attachment and specific neurological development in young persons (Diamond & Fagundes, 2010). Persistent stress in an 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 orbitofrontal cortex (OFC) of the brain. Chronic levels of stress contribute to fewer neural connections between the prefrontal cortex and the amygdala, a process significant to psychosocial functioning. The OFC is particularly active in such processes as our concentration, judgment, and 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 evidence that the first few years of life are not all-important (Korosi & Baram, 2010). 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, & McChincock, 2000).

In summary, research indicates that secure attachments play a critical role in shaping the systems that underlie our reactivity to stressful situations. When infants begin to form specific attachments to adults, the presence of warm and responsive caregivers begins to buffer or prevent elevations in stress hormones, even in situations that distress the infant. In contrast, insecure relationships are associated with higher CRH levels in potentially threatening situations. Secure emotional relationships with adults appear to be at least as critical as individual differences in temperament in determining stress reactivity and regulation (Eagle & Wolitzky, 2009).

Still, there is much to be learned in this area. Many people 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 remediate the physical, emotional, and social problems seen in children who have experienced poor nurturing and early problems with separation.

We now consider theories about social influences on one’s sense of attachment to persons outside the family.

**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, or 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 latter two as we consider how feminism has deepened our capacity for understanding human behavior and interaction. All of these theorists begin from the position that women and men approach relationships differently and that patriarchal societies consider male attributes to be superior.

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

Gender feminists tend to be concerned with values of separateness (for men) and connectedness (for women) and how these lead to a different morality for women. Carol Gilligan (1982, 1988) 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 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.

All psychological feminism theories promote the value of relationships and the importance of reciprocal interpersonal supports. Dan was raised to be achievement- and task-oriented. These are admirable characteristics, but they represent male perspectives. Dan’s inclinations for interpersonal experience may have been discouraged, which was harmful to his overall development.

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 others (Hornsey, 2008; Nesdale, 2004). This is especially important to consider because the population in the United States and many other countries is becoming increasingly diverse. During the past decade, Hispanic and Asian populations have increased by 43% in the United States, compared with total population growth of 9.7% (U.S. Census Bureau, 2013a). It is estimated that by 2050 Latinos will make up 25%, and Asians 8%, of the nation’s population.

Social identity development can be an affirming process that provides us with a lifelong sense of belonging and support. I might feel good to have membership with a Roman Catholic or Irish American community. Because social identity can be exclusionary, however, it can also give rise to prejudice and oppression. I may believe that my race is more intelligent than another or that persons of my cultural background are entitled to more social benefits than those of another.

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

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

2. Acceptance. Older children and young adolescents learn the distinct ideologies and belief systems of their own and other social groups. During this stage, we learn that the world’s institutions and authority figures have rules that encourage certain behaviors and prohibit others, and we internalize these dominant cultural beliefs and make them a part of our everyday lives. Those questions that emerged during the stage of naïveté are submerged. We come to believe that the way our group does things is normal, makes more sense, and is better.

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

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

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

For all ethnic groups, higher levels of ethnic identity are associated with higher levels of self-esteem, purpose in life, and self-confidence (Rogers-Sirin & Gupta, 2012). Further, ethnic identity is associated with lower levels of depression among White, African American, and Asian youth. Social identity theory is sometimes used, however, to explain a process by which those who most strongly identify with their groups may come to hold less favorable attitudes about dissimilar groups (Negy, Shreve, Jensen, & Uddin, 2003). One study showed that the more Caucasian and Hispanic persons embraced their identity, the more negative views they held toward people who did not belong to their respective ethnic groups. Interestingly, this trend was not found among African American persons. Another theory, **multicultural theory**, proposes more positively that affirmations toward one's group, particularly with regard to ethnicity, should correspond with higher levels of acceptance toward dissimilar groups. Ethnic identity is defined as a sense of belonging to an ethnic group and the part of one's thinking, perceptions, feelings, and behavior that is due to group membership (Smith, Smith, Levine, Dumas, & Prinz, 2009).

**CRITICAL THINKING Questions 4.3**

How important is culture in influencing the nature of the self? How important do you think it is for your sense of self? For Dan Lee’s sense of self? What are the policy implications of research on the impact of early nurturing on human development? 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 our ability to cope with stress. **Stress** can be defined as any event in which environmental or internal demands tax our adaptive resources. 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). Dan experienced psychological stress, of course, as evidenced by his negative feelings resulting from marginalization and perceived rejection, but he also experienced other types of stress. He experienced biological stress because, in an effort to attend all his classes and study every day, he did not give his body adequate rest. As a result, he was susceptible to colds, which kept him in bed for several days each month and compounded his worries about managing coursework. Dan also experienced social stress, because he was functioning in a social system that he perceived to be threatening, and he had few positive relationships there.

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. Dan minimized interactions with his classmates during much of the semester, which may have led them to decide that he is aloof and that they should not try to approach him socially. Dan has to accept that this rejection happened and that some harm has been done to him as a result, although he 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. Dan felt threatened when he walked into a classroom because he anticipated rejection from his classmates. We can be proactive in managing threats to ensure that they do not in fact occur and result in harm to us.

3. **Challenge**. An event we appraise as an opportunity rather than an occasion for alarm. We are mobilized to struggle against the obstacle, as with a threat, but our attitude is quite different. Faced with a threat, we are likely to act defensively to protect ourselves. Our defensiveness sends a negative message to the environment: We don't want to change; we want to be left alone. In a state of challenge, however, we are excited, expansive, and confident about the task to be undertaken. The challenge may be an exciting and productive experience for us. Because Dan has overcome several setbacks in his drive to become a physician, he may feel more excited and motivated than before when resuming the program. He might be more aware of his resilience and feel more confident.

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, even positive ones, 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 (Gordon, Pruchno, Wilson-Genderson, Murphy, & Rose, 2010).

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 possibility of changing societal conditions that create stress and toward the management of ourselves as persons who respond to stress (Becker, 2005). For example, it is well documented that the experience of discrimination creates stress for many African Americans (Anderson, 2013). 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 discrimination, working motherhood, poverty, and road rage. It may be that the appeal of the stress concept is based on its diverting 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 (James & Gilliland, 2013). 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 a flood or fire). We can regard anxiety, guilt, shame, sadness, envy, jealousy, and disgust as stress emotions (Zyskinsa & Heszen, 2009). 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).

Crisis can be classified into three types (Lantz & Walsh, 2007). Developmental crises occur when events in the normal flow of life create dramatic changes that produce extreme responses. Examples of such events include going off to college, college graduation, the birth of one's child, a midlife career change, and retirement from work. People may experience these types of crises if they have difficulty negotiating the typical developmental challenges outlined by Erikson (1968) and Gitterman (2009). Situational crises refer to uncommon and extraordinary events that a person has no way of foreseeing or controlling. Examples include physical injuries, sexual assault, loss of a job, major 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.

Dan's poor midterm grades during his first semester of taking courses that would help him qualify for medical school illustrate some of these points. First, he was overwhelmed by the negative emotions of anger and sadness. Then, he occasionally retreated to church and his hometown, where he received much-needed support from his friends, mother, and sister. Finally, as the situation stabilized, Dan concluded that he could try to change some of his behaviors to relieve his academic-related stress.

**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 crises. 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, 2013). 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 (Adams, Boscarino, & Figley, 2006). Any professionals who work regularly with trauma survivors are susceptible to compassion stress. Many social workers fall into this category.

**VULNERABILITY TO STRESS**

Many social work practitioners and researchers use a biopsychosocial risk and resilience framework for understanding how people experience and manage stress (Scholz, Blumer, & Brand, 2012). Although the biological and psychological levels relate to the individual, the social aspect of the framework captures the positive or adverse effects of the family, community, and wider social culture. The processes within each level interact, prompting risks for stress and impaired coping and the propensity toward resilience, or the ability to function adaptively despite stressful life circumstances. Risks can be understood as hazards occurring at the individual or environmental level that increase the likelihood of impairment. Protective mechanisms involve the personal, familial, community, and institutional resources that cultivate individuals' aptitudes and abilities while diminishing the possibility of problem behaviors. These protective influences may counterbalance or buffer against risk and are sometimes the converse of risk. For instance, at the individual level, poor physical health presents risks whereas good health is protective. The biopsychosocial framework provides a theoretical basis for social workers to conceptualize human behavior.
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, perceptions, or lifestyle.

Biological Coping

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

In this view, the body's response to a stressor is called the general adaptation syndrome (explained in Exhibit 4.8). 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 the cumulative wear and tear of multiple stress episodes can gradually deplete our body's resources. Common outcomes of chronic stress include stomach and intestinal disorders, high blood pressure, heart problems, and emotional problems. If only to preserve healthy physical functioning, we must combat and prevent stress.

This traditional view of biological coping with stress came from research that focused on males, either male rodents or human males. Since 1995, the federal government has required federally funded researchers to include a broad representation of both men and women in their study samples. Consequently, recent research on stress has included female as well as male participants, and gender differences in responses to stress have been found. Recent research (Cardoso, Ellenbogen, Serravalle, & Linnen, 2013; Taylor & Stanton, 2007) suggests 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 protect and nurture their offspring and to seek social contact. 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. This is thought to, in part, explain the gender differences in response to stress.

Psychological Coping

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

Those who consider coping to be a trait see it as an acquired defensive style. Defense mechanisms are unconscious, automatic responses that enable us to minimize perceived threats or keep them out of our awareness entirely. Exhibit 4.9 lists the common defense mechanisms identified by ego psychology. Some defense mechanisms are considered healthier, or more adaptive, than others. Dan's denial of his need for intimacy, for example, did not help him meet his goal of developing relationships with peers. But through the defense of sublimation (channeling the need for intimacy into alternative and socially acceptable outlets), he has been an effective and nurturing tutor for numerous high school science students.

Those who see coping as a state, or process, observe that our coping strategies change in different situations. After all, our perceptions of threats, and what we focus on in a situation, change. The context also has an impact on our perceived and actual abilities to apply effective coping mechanisms. From this perspective, Dan's use of denial of responsibility for relationship problems would be adaptive at some times and maladaptive at others. Perhaps his denial of needing support from classmates during the first academic semester helped him focus on his studies, which would help him achieve his goal of receiving an education. During the summer, however, when classes are out of session, he might become aware that his avoidance of relationships has prevented him from attaining interpersonal goals. His efforts to cope with loneliness might also change when he 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 based on 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, Dan was concerned about his professors' insensitivity to his learning disability (auditory processing disorder). When he took action to educate them about it and explain more clearly how he learns best in a classroom setting, he was using problem-focused...
### EXHIBIT 4.9 • Common Defense Mechanisms

<table>
<thead>
<tr>
<th>DEFENSE MECHANISM</th>
<th>DEFINITION</th>
<th>EXAMPLE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DEVELOPMENTALLY EARLIER</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acting out</td>
<td>Direct expression of impulses to avoid tension that would result from their postponement.</td>
<td>An adolescent steals money from her mother to buy alcohol and gets into constant arguments with her older sister who tries to monitor her behavior.</td>
</tr>
<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 she is maintaining good self-care by dieting.</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 she is angry at him.</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>
<tr>
<td>Splitting</td>
<td>The tendency to see the good and bad aspects of the self or others as separate; to see the self and others as alternately “all good” or “all bad.”</td>
<td>A primary-school child “hates” his teacher when reprimanded and “loves” his teacher for praise and behaves accordingly.</td>
</tr>
<tr>
<td><strong>DEVELOPMENTALLY LATER</strong></td>
<td></td>
<td></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>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>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>Repression</td>
<td>Keeping unwanted thoughts and feelings entirely out of awareness.</td>
<td>A son may begin to generate an impulse of hatred for his father, but because the impulse would be consciously unacceptable, he represses the hatred and does not become aware of it.</td>
</tr>
<tr>
<td>Somatization</td>
<td>Converting intolerable impulses into somatic symptoms.</td>
<td>A person who is unable to express his negative emotions develops frequent stomachaches as a result.</td>
</tr>
<tr>
<td>Undoing</td>
<td>Nullifying an undesired impulse with an act of reparation.</td>
<td>A man who feels guilty about having lustful thoughts about a coworker tries to make amends to his wife by purchasing a special gift for her.</td>
</tr>
<tr>
<td><strong>MOST “MATURE” DEFENSES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sublimation</td>
<td>Converting an impulse from a socially unacceptable aim to a socially acceptable one.</td>
<td>An angry, aggressive young man becomes a star on his school’s debate team.</td>
</tr>
<tr>
<td>Humor</td>
<td>The expression of painful or socially unacceptable feelings without discomforting the person who is being humurous or (often) the recipient.</td>
<td>An employee manages her discomfort at being in a supervisory meeting by making self-deprecating jokes.</td>
</tr>
</tbody>
</table>

SOURCE: Adapted from Goldstein, 1995; Schamess & Shilkret, 2011.
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 Dan learns that one of his professors has no empathy for students with learning disabilities, he 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. Relational coping takes into account actions that maximize the survival of others—such as our families, children, and friends—as well as ourselves (Zunkel, 2002). Feminist theorists propose that women are more likely than men to employ the relational coping strategies of negotiation and forbearance, and some research (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 another. 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 Dan used many problem-focused coping strategies to manage stressors at the university, even though he was mostly ineffective because of the specific strategies he used. For example, he directly confronted his professors and classmates, tried to understand their behavior, and tried to control his moods through force of will.

COPING AND TRAUMATIC STRESS

People exhibit some similarities between the way they cope with traumatic stress (described earlier) and the way they cope with everyday stress. 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, 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 (Koss & Figueredo, 2004). A majority of children who experience such atrocities as war, natural disasters, community violence, physical abuse, catastrophic illness, and traumatic injury also recover, demonstrating their resilience (Husain, 2012; Le Brocque, Hendrikz, & Kenardy, 2010).

However, many trauma survivors experience a set of symptoms known as post-traumatic stress disorder (PTSD) (American Psychiatric Association, 2013). 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.
- Negative alterations in cognition or mood after the event, such as memory problems, negative emotions, and distorted beliefs about the event (such as self-blame).
- 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 20 years after (Middleton & Craig, 2012). 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 result in serious, long-term limitations in social functioning. Complete recovery from symptoms occurs in 30% of cases, mild symptoms continue over time in 40%, moderate symptoms continue in 20%, and symptoms persist or get worse in about 10% (Becker, 2004). 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 support groups.

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 (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).

Virtual Support
I don’t need to tell you, of course, that much social support is now provided through connective technologies that allow people to be “in contact” without being physically present with one another. Facebook, Skype, e-mail, blogging, tweets, and texts put people in touch with one another instantaneously, regardless of where they are or what they are doing. Whereas there is much to be admired about these developments, and they clearly allow us to be in touch with significant others we might never otherwise see, they also create the potential for us to reduce the frequency of, and even our desire for, face-to-face contacts and thus redefine the nature of relationships, support, and intimacy. The number of people with whom people physically interact has fallen in recent years. Dan, like many of his peers, spent several hours per day on the Internet communicating with others; in his case it was primarily through e-mail. Spencer believed this was a mixed blessing for his client, because whereas it did help Dan feel connected to his support system, it prevented any efforts he might otherwise expend for intimate interaction with people whose lives physically intersected with his own. Turkle (2011), among others, is concerned about the unpredictable ways social technology may alter the nature of our relationships.

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 10 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 (Francis, 2013). For example, Dan was concerned that other students at the university perceived him as abnormal because of his ethnicity and social isolation. Most likely, other students did not notice him much at all. It is interesting that, in Dan’s view, his physical appearance and demeanor revealed him as abnormal. However, he was one of many Asian American students at the university, and his feelings were not as evident to others as he thought.

Social workers struggle just as much to define normal and abnormal as anybody else, but 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 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. Significant abnormality in perceived thinking, behavior, and mood may even classify as a mental disorder. In fact, the current definition of mental disorder used by the American Psychiatric Association (2013), which is intended to help psychiatrists and many other professionals distinguish between normality and
abnormality, is a “syndrome characterized by clinically significant disturbance in an individual’s cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning” (p. 20). Such a disorder usually represents significant distress in social or occupational functioning. The medical definition focuses on underlying disturbances within the person and is sometimes referred to as the disease model of abnormality. This model implies that the abnormal person must experience changes within the self (rather than create environmental change) in order to be considered “normal” again.

In summary, the medical model of abnormality focuses on underlying disturbances within the person. An assessment of the disturbance results in a diagnosis based on a cluster of observable symptoms. Interventions, or treatments, focus on changing the individual. The abnormal person must experience internal, personal changes (rather than induce environmental change) in order to be considered normal again. Exhibit 4.10 summarizes the format for diagnosing mental disorders as developed by psychiatry in the United States and published in the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 2013). Many people in the helping professions are required to follow this format in mental health treatment facilities, including social workers.

**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.

Psychological theory is quite broad in scope, 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 well known in social work is that of Erik Erikson (1968), who proposed eight stages of normal psychosocial development (see Exhibit 4.11 for a summary of these stages). Dan, at age 24, is struggling with the developmental stage of young adulthood, in which the major issue is intimacy versus isolation. 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, Dan’s current difficulties would be related to his lack of success in negotiating one or more of the five preceding developmental phases or challenges, and reviewing this would be an important part of his intervention.

From this perspective, Dan’s experience of stress would not be seen as abnormal, but his inability to make coping choices that promote positive personal adaptation would signal psychological abnormality. For example, at the university, he was having difficulty with relationship development and support seeking. He avoided social situations such as study groups, recreational activities, and university organizations in which he might learn more about what kinds of people he likes, what interests he might share with them, and what insecurities they might share as well. From a stage theory perspective, Dan’s means of coping with the challenges of intimacy versus isolation might 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, one of which is...
derived from symbolic interactionism. It states that those who cannot constrain their behaviors within role limitations that are acceptable to others become labeled as deviant. Thus, deviance is a negative label assigned when one is considered by a majority of significant others to be in violation of the prescribed social order (Curra, 2011). 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. (It should be emphasized, however, that sociologists are increasingly using the term positive deviance to describe those persons whose outstanding skills and characteristics make them “outliers” in a constructive sense.)

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

**THE SOCIAL WORK PERSPECTIVE: SOCIAL FUNCTIONING**

The profession of social work is characterized by the consideration of systems and the reciprocal impact of persons and their environments (the bio-psycho-social-spiritual perspective) on human behavior. Social workers tend not to classify individuals as abnormal. Instead, they consider the person-in-environment as an ongoing process that facilitates or blocks one's ability to experience satisfactory social functioning. In fact, in 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, 2013).

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 Dan'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.

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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>

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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 classification system, Dan might be given an Axis I diagnosis of adjustment disorder or dysthyemic disorder, and his auditory processing disorder might also be diagnosed. With the PIE system, the social worker would, in addition to addressing mental and physical health concerns, assess Dan’s overall social and occupational functioning, as well as any specific environmental problems. For example, Dan’s problems with the student role that might be highlighted on PIE Factor I include his isolation, the high severity of his impairment and its 6-month to a year’s duration, and the inadequacy of his coping skills. His 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 Dan and the social worker with more avenues for intervention, which might include personal, interpersonal, and environmental systems.

**EXHIBIT 4.12 • The Person-in Environment (PIE) Classification System**

**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. No problem
   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

(Continued)
**EXHIBIT 4.12 • (Continued)**

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

<table>
<thead>
<tr>
<th>FACTOR III: MENTAL HEALTH PROBLEMS</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Clinical syndromes (Axis I of DSM)</td>
</tr>
<tr>
<td>B. Personality and developmental disorders (Axis II of DSM)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>FACTOR IV: PHYSICAL HEALTH PROBLEMS</th>
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</thead>
<tbody>
<tr>
<td>A. Disease diagnosed by a physician</td>
</tr>
<tr>
<td>B. Other Health problems reported by client and others</td>
</tr>
</tbody>
</table>

**IMPLICATIONS FOR SOCIAL WORK PRACTICE**

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 their 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), 93
- adaptation, 111
- assimilation (cognitive), 93
- cognition, 91
- coping, 111
- crisis, 109
- defense mechanisms, 112
- ego, 100
- ego psychology, 100
- emotion, 92
- emotional intelligence, 101
- emotion-focused coping, 114
- multiple intelligences, 94
- preconscious, 102
- primary emotions, 98
- problem-focused coping, 112
- psychoanalytic theory, 100
- psychology, 91
- relational coping, 114
ACTIVE LEARNING

1. Theory analysis and application. Working in small groups, reread the case study at the beginning of this chapter. As you read, discuss what you see as the driving force of Dan’s behavior as he struggles with earning admission to medical school. Is it cognition? Is it emotion? What patterns of thinking and feeling might Dan have developed from his cultural background? What theories presented in the chapter are most helpful to you in thinking about this, and why? Now, review the big ideas of different theoretical perspectives presented in Exhibit 2.9 in Chapter 2. Find three big ideas that best reflect the way you understand Dan’s situation. What are the implications of these big ideas for helping Dan to reach his goals?

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 used 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

American Psychiatric Association DSM-5 Implementation and Support
www.dsm5.org/Pages/Default.aspx
Site includes information on implementation of the manual, answers frequently asked questions, lists DSM-5 corrections, and provides a mechanism for submitting questions and feedback regarding implementation of the manual. Links are provided to educational webinars about the DSM-5 and trainings being conducted throughout the United States and abroad.

Association for Moral Education
www.amenetwork.org
AME was founded in 1976 to provide an interdisciplinary forum for professionals interested in the moral dimensions of educational theory and practice. The association is dedicated to fostering communication, cooperation, training, curriculum development, and research that links moral theory with educational practice. It supports self-reflective educational practices that value the worth and dignity of each individual as a moral agent in a pluralistic society.

Howard Gardner
http://howardgardner.com
The website of Howard Gardner of Harvard Graduate School of Education includes information about his and others’ research on multiple intelligences.

Jean Baker Miller Training Institute (JBMTI)
www.jbmti.org
The JBMTI at the Wellesley Centers for Women is the home of relational-cultural theory (RCT), which posits that people grow through and toward relationships throughout the life span and that culture powerfully impacts relationship. JBMTI is dedicated to understanding the complexities of human connections as well as exploring the personal and social factors that can lead to chronic disconnection.

MedlinePlus: Stress
Site presented by the National Institute of Mental Health presents links to the latest news about stress research; coping; disease management; specific conditions; and stress in children, seniors, teenagers, and women.

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.

University of Wisconsin–Madison Center for Healthy Minds
http://www.centerhealthy minds.org
The Center for Healthy Minds, directed by Dr. Richard Davidson, is engaged in a broad program of research on the brain mechanisms that underlie emotion and emotion regulation in normal individuals throughout the life course and in individuals with various psychiatric disorders.
**LEARNING OBJECTIVES** | **FOR FURTHER EXPLORATION AND APPLICATION**
--- | ---
**LO 4.1:** Analyze their emotional and cognitive reactions to a case study. |  
**LO 4.2:** Define cognition and emotion. |  
**LO 4.3:** Compare and contrast five major theories of cognition (cognitive, information processing, social learning, multiple intelligences, and moral reasoning) and cognitive behavioral intervention theory. |  
**LO 4.4:** Compare and contrast four major categories of theories of emotion (physiological theories, psychological theories, social theories, and social work practice theories). |  
**LO 4.5:** Recognize how cognitive and emotional characteristics can be involved in cognitive and emotional "disorders." |  
**LO 4.6:** Describe four theories of self in relationships (relational, attachment, feminist, and social identity). |  
**LO 4.7:** Summarize the role of stress, crisis, and traumatic stress in human behavior. |  
**LO 4.8:** Analyze different styles of coping and adaptation in relation to stress. |  
**LO 4.9:** Critique four different approaches to normal and abnormal coping (medical, psychological, sociological, and social work). |  
**LO 4.10:** Apply knowledge of cognition, emotion, self, the self in relationship, stress, and coping to recommend guidelines for social work assessment and intervention. |