Chapter Outline

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Learning Objectives

5.1 Analyze one's own emotional and cognitive reactions to a case study.

5.2 Describe four theories of self in relationships (relational, attachment, feminist, and social identity).

5.3 Summarize the role of stress, crisis, and traumatic stress in human behavior.

5.4 Analyze different styles of coping and adaptation in relation to stress.
5.5 Provide examples of how social support aids coping.

5.6 Critique four approaches to normal and abnormal coping (medical, psychological, sociological, and social work).

5.7 Apply knowledge of self in relationship, stress, and coping to recommend guidelines for social work engagement, assessment, intervention, and evaluation.

**CASE STUDY 5.1**

**DAN’S COPING STRATEGIES**

To summarize more specifically how Dan (whom you met in Chapter 4) was functioning, and how Spencer tried to help him, we begin this chapter with a discussion of the intervention process.

Dan’s goal was to be able to focus on his studies so that he could perform well academically and achieve admission to medical school. He was an intelligent student who had done well through most of his academic career, but for the past year he had been preoccupied with obsessional thoughts about not being able to resolve personal “slights” from his mother, younger sister, and university peers. (He felt comfortable among his Chinese American friends, who included the people in his church congregation and a former girlfriend who lived back home, an hour away.) When Dan experienced “rejection” from his family or peers, he became angry, and later sad, thinking that if those persons only understood the “rationality” of his admonitions and advice, they would see his point of view and admit that they were “wrong” in their perceptions of the interpersonal issue. Further, Dan would only feel vindicated if they apologized for their behaviors toward him.

Spencer, while validating Dan’s feelings, believed that his goals were unrealistic. He hoped Dan would eventually come to perceive that his influence over others was limited, that people might respect him even as they did not always agree with his advice, and, most basically, that people have different ideas regarding what is best for them. He shared his concerns with Dan, who was willing to consider other ways of assessing situations despite feeling skeptical of the utility of this process. Spencer used some psychodynamic and cognitive interventions during their year of working together, but he experienced 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 of weekly sessions Dan 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 so apparent to him.
The Self in Relationships

In this chapter, we focus on how the psychological person manages challenges to social functioning, particularly stress. We look at the common processes by which we all try to cope with the stresses we experience in life. 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 begin by considering 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 psychodynamic and interpersonal theoretical perspectives (which focus on relationships as the driving force of personality development) has come to be called relational theory (Berzoff, 2016). 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.

Relational theory 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 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. 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 (McKenzie, 2011). 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 relegating the two parties into dominant and subordinate roles.

To expand on these points, relational theory incorporates a major focus on the intersubjective basis of self-development (Storolow, 2013). There is a mutual recognition of the self and the other as people with unique experiences and perspectives, and each person influences the other in conscious and unconscious ways. This does not imply a neglect of appropriate boundaries, for the social worker must maintain a clear sense of self while engaged in the emotional and cognitive integration necessary for empathy to be effective. The intervention process features many enactments, or discussions about the ways the social worker and client are relating to one another. Through this process the client gradually becomes able to recognize other people’s uniqueness, developing capacities for sensitivity and a tolerance of difference. The client is freed from the “pull” of problematic relationship patterns.

Researchers who investigate evidence-based practice techniques do not always focus on the significance of the social worker–client relationship, but there is considerable evidence of its importance in literature reviews. Sommers-Flanagan (2015) developed a practice model based on such a review that incorporates the factors of congruence and genuineness, the working alliance, unconditional positive regard or radical acceptance, empathic understanding, the ability to manage relationship ruptures, and managing countertransference. Cameron’s (2014) common factors model includes the social worker factors of well-being, acceptance, genuineness, and empathy, and the social worker–client interactional factors of relationship engagement, engagement in change work, productive direct and indirect communication, and collaboration. The assumptions of relational theory are also consistent with the findings of the American Psychological Association (APA) on the significance of the social 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) (Norcross & Wampold, 2011). Three other relationship elements (congruence/genuineness, repairing alliance ruptures, and managing countertransference) were deemed promising.

**Attachment Theory**

To understand how we develop our initial relationship patterns, it may be useful to consider one model of parent–child attachment here. 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).

**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 much of their attention to maintaining attachments to inconsistent, unavailable, or rejecting parents, rather than engaging in exploratory behaviors. Because these children are only able to maintain proximity to the parents by behaving as if the parents are not needed, the children may learn not to express needs for closeness or attention.

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

**Avoidantly attached** infants seem to be relatively undisturbed both when their parent figures leave and when they return. These children want to maintain proximity to their parent figures, but this attachment style enables the children to maintain a sense of proximity to parents who otherwise may reject them. Avoidant children thus suppress expressions of overt distress and, rather than risk

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**PHOTO 5.1** Relationships with significant others are resources for coping with stress.

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Romantic love has many definitions, but it is generally agreed to include passion and sexual attraction (for initial bonding), attachment with intimacy (to generate interdependence), and commitment (to keep partners together and suppress the search for other mates) (Fletcher, Simpson, Campbell, & Overall, 2015). It is thus shaped in part by attachment styles but features additional characteristics as well.

Romantic love is a cultural and perhaps an evolutionary development in the human species to provide a motivating force for bonding related to birthing and raising children. It features distinct emotional, behavioral, hormonal (testosterone and estrogen), and neurological (oxytocin) processes that support pair-bonding, which is a positive predictor of health and survival in both offspring and adults. Certain social phenomena such as arranged marriages, polygamy, divorce, and infidelity may represent cultural differences in romance. (Gay and lesbian couples were recently considered deviant in our own culture but are now legally able to conceive and raise children in the United States and some other countries.)

Because it is tied to reproductive functions, however, romantic love is not permanent in all its manifestations. Shared feelings of passion between committed couples tend to diminish over time, although at different rates. Infatuation is not necessarily associated closely with attachment style, so when people have come together as committed couples in this pair-bonding way, the compatibility of their underlying attachment styles eventually becomes more significant in determining the strength and duration of their relationship (Heffernan, Fraley, Vicary, & Brumbach, 2012).

**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. Back in 1998 results of a large-scale Adverse Childhood Experiences (ACEs) study indicated that five categories of such experiences (physical, sexual, or emotional abuse; physical or emotional neglect; violence against the mother; living with household members who were substance abusers, mentally ill or suicidal, or ever imprisoned; and parental separation or divorce) were associated with negative adult health behaviors and diseases such as alcoholism, drug abuse, depression, suicide attempts, smoking, poor self-rated health, sexually transmitted diseases, physical inactivity, obesity, and a variety of other adult diseases (Felitti et al., 1998). Those with more than four childhood risk factors were especially susceptible to those negative outcomes. The implications of that major study still guide further rejection in the face of attachment figure unavailability, may give up on their proximity-seeking efforts.

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

Although 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.

If you are concerned that your own early relationships might have been problematic, don’t worry. Relational theorists do not assert that caregivers need to be perfect (whatever that might be), only that they communicate a sense of caring and permit the child to develop a sense of self (Elkins, 2016). Even if early attachments are problematic, a person’s ability to develop trusting relationships can always be improved, sometimes with therapy.

Cultural psychologists argue that most Western psychological theories assume an independent, autonomous self as the ideal self-in-relationship (de Carvalho, Seiglde-Moura, Martins, & Viera, 2014). They suggest that in many cultures of the world, including Asian, African, Latin American, and southern European cultures, the ideal self is an interdependent self that recognizes one’s behavior as influenced, even determined, by the perceived thoughts, expectations, and feelings of others in the relationship. Markus and Kitayama (2003) note that in U.S. coverage of the Olympics, athletes are typically asked about how they personally feel about their efforts and their success. In contrast, in Japanese coverage, athletes are typically asked, “Who helped you achieve?” This idea of an interdependent self is consistent with relational theory, as well as feminist perspectives on relationships.

You may have experienced romantic relationships with varying degrees of intensity, and you may wonder how those processes fit with attachment theory themes. Romantic love has many definitions, but it is generally agreed to include passion and sexual attraction (for initial bonding), attachment with intimacy (to generate interdependence), and commitment (to keep partners together and suppress the search for other mates) (Fletcher, Simpson, Campbell, & Overall, 2015). It is
the research of professionals who work with children (e.g., Amaya-Jackson, 2016). It is clear that relational elements of our early environments permanently alter the development of central nervous system structures that govern our autonomic, cognitive, behavioral, and emotional responses to stress (Cacioppo, Cacioppo, Capitanio, & Cole, 2015). These findings support the lifelong significance of specific relationship interactions.

Animal models are common in this research, tracing the physiological aspects of rat and monkey stress responses all the way down to the level of gene expression (Boufleur et al., 2013; Novak, Fan, O’Dowd, & George, 2013). It has been found that high-grooming young rats (pups) develop more receptors in their brains for the substances that inhibit the production of corticotrophin-releasing hormone (CRH), the master regulator of the stress response. As a result of the tactile stimulation they received from mothers, the pups’ brains develop in a way that lowers their stress response—not only while being groomed but throughout life. When the rats are switched at birth to different mothers, the pups’ brain development matched the behavior of the mothers who reared them, not their biological mothers. Furthermore, high-licking and high-grooming (nurturing) mother rats change their behavior significantly when given a substance that stimulates the hormonal effects of chronic stress, raising their CRH and lowering oxytocin, a hormone related to the equanimity many human mothers feel after giving birth. That is, under the influence of these stress hormones, the high-nurturing mothers behaved like the low-nurturing mothers, and their offspring grew up to have the same stress responses.

You may be familiar with the tradition of research on the nurturing practices of rhesus monkeys. Research continues in this area (Ascher, Michopoulos, Reding, Wilson, & Toufexis, 2013). In some of these experiments, monkeys are separated from their mothers at age intervals of 1 week, 1 month, 3 months, and 6 months and raised in a group of other monkeys that includes a different mother. The infants who are separated later (3 or 6 months) exhibit normal behavior in the new setting. Those separated earlier, however, show a variety of abnormalities. The monkeys separated at 1 month initially exhibit a profound depression and refuse to eat. Once they recover, they show a deep need for attachments with other monkeys and also show great anxiety during social separation whenever they feel threatened. The monkeys separated at 1 week showed no interest in social contact with other monkeys, and this behavior did not change as they grew older. Autopsies of these monkeys showed changes in brain development. The timing of separation from the primary caregiver seems to be significant to their later development. These findings in monkeys may have a sad counterpart in human children who are separated at early ages from their mothers.

Although much of this research is being conducted with rats, monkeys, and other animals, it has clear implications for human development. The concept of neuroplasticity, introduced in Chapter 3 in this book, is significant here (Cohen, Quarta, Bravi, Granato, & Minciacci, 2017; Mandolesi et al., 2017). 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 under way explores the relationship between the processes of attachment and specific neurological development in young persons (Feldman, 2017). 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 frontal cortex. Of particular concern to one leading researcher (Schore, 2002, 2017) 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 psychological 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 (as discussed in the previous chapter), 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, given the role of resilience influences (Richards, Lewis, Sanderson, Deane, & Quimby, 2016). According to these authors, five strengths exhibited by resilient youth include social competence, problem-solving skills, critical consciousness, autonomy, and a sense of purpose. Environmental factors associated with resilience include involvement in prosocial organizations, mentors, successful school experiences, competent peer friends, supportive family members, and a close bond with a primary caregiver.
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.

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 may be resilient and have many strengths that can help them overcome these early life stresses. A systematic review by Slopen, McLaughlin, and Shonkoff (2014) found that psychosocial interventions with children can in fact restore their stress-reducing cortisol levels. Researchers are challenged to determine whether interventions such as foster care can remedy the physical, emotional, and social problems seen in children who have experienced poor nurturing and early problems with separation.

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

CRITICAL THINKING QUESTIONS 5.1

Imagine that you are the social worker working with Dan Lee. How would you respond to Dan’s statement: “I don’t know how much I’ve gotten out of this, but I know you tried to help and I appreciate that”? What thoughts and emotions would you have on hearing this evaluation? What would you say to Dan in response to the evaluation? What guidance can you draw from relational theory? What are the policy implications of research on the impact of early nurturing on development?

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. Among the psychological theories are psychoanalytic feminism (Layton, 2016) and gender feminism (Hare-Mustin, 2017). We focus on these two as we consider how feminism has deepened our capacity for understanding human behavior and social interaction. All these theorists begin from the position that women and men approach relationships differently and that patriarchal societies consider male attributes to be superior. You will find further discussion of gender in Chapter 8, Cultures.

Psychoanalytic feminists assert that women’s ways of acting are rooted deeply in women’s unique ways of thinking. Some of these gender 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, hardness, rationality, and emotional control. Psychoanalytic feminists assert that these differences are largely rooted in early childhood relationships. Because women are the primary caretakers in our society, young girls tend to develop and enjoy ongoing relationships with their mothers that promote their valuing of relatedness as well as other feminine behaviors. For young boys, the mother is eventually perceived as fundamentally different, particularly as they face social pressures to begin fulfilling male roles. The need to separate from the mother figure has long-range implications for boys. They tend to lose what could otherwise become a learned capacity for intimacy and relatedness.

Gender feminists tend to be concerned with values of separateness (for men) and connectedness (for women) and how these lead to a different morality for women. Carol Gilligan (1982; see also the section on theories of moral reasoning in Chapter 4 of this book) is a leading thinker in this area. She elucidated a process by which women develop an ethic of care rather than an ethic of justice, based on the value they place on relationships. Gender feminists believe that these female ethics are equal to male ethics, although they have tended in patriarchal societies to be considered inferior. Gilligan asserts that all of humanity would be best served if both sets of 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 feminist 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 traditional 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 (Haslam, 2014). 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, 2013). 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 truly distinct or sequential, however, and people often experience several stages simultaneously.

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

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

3. **Resistance.** In adolescence, or even later, we become aware of the harmful effects of acting on social differences. We have new experiences with members of other social groups that challenge our prior assumptions. We begin to reevaluate those assumptions and investigate our own role in perpetuating harmful attitudes toward differences. We may feel anger at others within our own social group who foster these irrational attitudes. 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
identifier with their groups may come to hold less favorable attitudes about dissimilar groups (Verkuyten, 2016).

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 (Sue, Rasheed, & Rasheed, 2016). 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 (Romanucci-Ross, De Vos, & Tsude, 2006). This sense of belonging is supported by shared heritage, values, traditions, and often languages. Two dimensions of ethnic identity include identity achievement, the developmental process of exploring and committing to one’s identity, and affirmation and belonging, the sense of pride and emotional attachment a person feels for his or her ethnic group (Ghavami, Fingerhut, Peplau, Grant, & Wittig, 2011). The importance of race and ethnicity to a person’s identity, sometimes referred to as centrality (Charmaraman & Grossman, 2010), represents a relatively stable perception of the significance one attributes to his or her racial and ethnic background. Those who face greater racial adversity attribute higher centrality to racial aspects of their identities. In the United States, ethnic identity tends to be strongest among African American persons, followed by Asians and multiethnic adolescents. You will see more discussion of ethnic identity in Chapter 8, Cultures.

CRITICAL THINKING QUESTIONS 5.2

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.

Categories of Stress

Child development scholars identify three types of stress experiences that have very different impacts on physical and emotional development in young children: positive stress, tolerable stress, and toxic stress (Shonkoff, Boyce, & McEwen, 2009).

1. Positive stress is characterized by moderate and temporary increases in one’s heart rate, blood pressure, and stress hormone levels. These changes occur in response to the challenges involved in dealing with the many types of frustration that are common and expected in childhood, such as dealing with minor physical injuries, managing conflicts with parents and friends, or struggling with school work. Experiencing and managing positive stress is an important part of healthy development when experienced in the context of stable adult relationships. With adaptive responses, the stress response system soon returns to its normal levels.

2. Tolerable stress refers to a physical state that might possibly disrupt neural circuits in the brain but is offset by supportive relationships that facilitate adaptive coping. The precipitants of this kind of stress are more serious than those involved with positive stress and may include the experience of possibly traumatic events such as the death of a loved one or a move away from home. Still, the stressor occurs during a limited time span, enabling protective relationships to help bring the child’s stress-response system back to baseline.

3. Toxic stress has the most deleterious effects on a child’s nervous system and refers to the strong, frequent, and perhaps prolonged activation of the stress response system in the absence of adequate adult protection. Some risk factors include physical and emotional abuse or neglect and other forms of family instability or violence. Toxic stress disrupts nervous system
function for extended periods of time and may lead to stress-management systems that are persistently fragile throughout life.

Here is another way to think about stress. In an analysis of the relationship between stress and emotion, Wenner (2007) makes a distinction among three types of psychological stress: harm, threat, and challenge:

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 during the first semester because he had failed once before and, further, 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 & Wenner, 2009; 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.

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 has been established that in many cases an accumulation of daily hassles takes a greater toll on one’s coping capacities than do more severe but relatively rare life events, for example, among professional first responders (Larsson, Berglund, & Ohlsson, 2016).

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 employee. Research on caregiver burden is one example of measuring stress as role strain (Campbell, McCoy, Hoffman, & O’Neil, 2014).

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. For example, it is well documented that the experience of discrimination creates stress for many African Americans. 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).
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 (Kanel, 2015; 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). Situational crises refer to uncommon and extraordinary events that a person has no way of forecasting or controlling. Examples include physical injuries, sexual assault, loss of a job, 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 & Wenner, 2009).

The experience of trauma can be defined as an emotional state of discomfort resulting from memories of a catastrophic experience that shatters the person’s sense of protection from harm, rendering him or her acutely vulnerable to stressors (Mahoney & Markel, 2016). The trauma may be experienced as a single event (a traffic accident or sexual assault), as chronic and repetitive (as with ongoing child abuse or the continual crises associated with refugee status), or as a secondary event, from knowing about the event happening to a significant other person. Chronic, repetitive trauma is referred to as complex trauma. It is important to understand that the experience of a traumatic event does not necessarily imply that the person will be traumatized afterward. The precipitating event is always severe, but the individual may have more or less success coping with it based on available supports and resources, such as friends and family, crisis counselors, or a constitutional hardiness (Lemma, 2010).

Social work’s interest in the effects of trauma on social functioning, while always considerable, has increased over the past 20 years because so much more has become known about its physical and psychological effects and their association with potential long-term negative outcomes for those who experience it. Families, significant others, and in some cases communities (in cases of acting-out behavior) may also be negatively affected (Sangalang & Vang, 2016). In positive or tolerable stress situations, the same physical reactions occur, but only temporarily and to a lesser degree, and they do not typically result in the complete dismantling of a person’s inner world.

This is not a chapter on the biological person, but it is useful to briefly review here how trauma affects the nervous system (Evans & Coccoma, 2014). Physiologically, intense stress raises the levels of certain chemicals in the body that put the nervous system into a state of high alert. Although helpful for managing the stress event, high cortisol levels moving through the body make it hard for the person to attend to important activities of daily living such as processing information, eating, or sleeping. Ideally, once the threat has passed, the cortisol activity shuts down, enabling the body to resume its prior state of effective functioning. In extreme conditions, however, the cortisol fails to adequately shut down the body’s responses to the trauma, leading to ongoing activation and negative effects on the person’s emotional and physical states.

The heightened negative feelings and somatic processes induced by stress are due to chaotic biochemical reactions in parts of the brain that are responsible for processing social and emotional information, bodily states, and attachment. The thalamic in the midbrain registers messages as dangerous. The amygdala in the higher brain hijacks ordinary processes of information processing and broadcasts distress. The hippocampus, the center of emotional processing, is flooded with emotionally laden stimuli that are laid down negatively as body memories. The sympathetic nervous system is responsible for the fight-or-flight response. When this is activated the body is primed for quick action and may run or demonstrate considerable strength. The parasympathetic system releases opioids that contribute to decreased blood pressure and a state of numbness or emotional paralysis. The simultaneous activation of all these systems produces a state of frozen watchfulness and creates problems with self-soothing and disorganized attachment. Some trauma survivors may develop post-traumatic stress disorder (PTSD), which is discussed later in this chapter.

Some occupations—particularly those of emergency workers such as police officers, firefighters, disaster relief workers, and military personnel in war settings—involves regular exposure to traumatic events that most people do not experience in a lifetime. The literature about the stress faced by emergency workers refers to these traumatic events as critical incidents and the reaction to them as critical incident stress (Pack, 2013). 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 (Kapoulitsas & Corcoran, 2015). 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 (Corcoran & Walsh, 2016). Although the biological and psychological dimensions relate to the individual, the social aspect of the framework captures the positive or
adverse effects on the family, community, and wider social culture. The processes within each dimension 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, family, community, and institutional resources that generate and support individuals’ aptitudes and abilities while diminishing the possibility of problem behaviors. These protective influences may offset 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 at several levels and can assist them in identifying and bolstering strengths as well as reducing risks. The framework offers a balanced view of systems in considering risks and strengths, as well as recognizing the complexity of individuals and the systems in which they are nested.

Individual factors encompass the biological and psychological realms. Within biology these include genes, temperament, physical health, developmental stage, and intelligence. At the psychological level it is useful to examine one’s sense of self-efficacy, self-esteem, and coping strategies. Social mechanisms include the family and household; the experience of dangerous or traumatic events; the neighborhood; and societal conditions, including poverty, ethnicity, and access to health care.

Within the risk and resilience perspective, social workers can complete comprehensive assessments to determine the nature of their clients’ problems. Knowledge of the risk and protective influences helps social workers focus interventions on the relevant areas of the client’s life. Finally, the strengths perspective encourages social workers to build on the client’s areas of real or potential resilience in recovering from, or adapting to, mental disorders and in so doing help the client develop a greater sense of self-efficacy.

### Critical Thinking Questions 5.3

Why do you think we easily get diverted from thinking about societal conditions that create stress and come, instead, to focus on helping individuals cope with stress? How does such an approach fit with social work’s commitment to social justice?

### 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 (Bafy & Losalco, 2014; Selye, 1991). Stress is considered the result of any demand on the body (specifically, the nervous and hormonal systems) during perceived emergencies to prepare for fight (confrontation) or flight (escape). A stressor may be any biological process, emotion, or thought.

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

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

The general adaptation syndrome is explained in Exhibit 5.1.

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

Research suggests that females of many species, including humans, respond to stress with “tend-and-befriend” behavior described in
The general adaptation syndrome (Cardoso, Ellenbogen, Serravalle, & Linnen, 2013; Steinbeis, Engert, Linz, & Singer, 2015). That is, under stressful conditions, females have been found to protect and nurture their offspring and to seek social contact. The researchers suggest a possible biological basis for this gender difference in the coping response. More specifically, they note a large role for the hormone oxytocin, which plays a role in childbirth but also is secreted in both males and females in response to stress. High levels of oxytocin in animals are associated with calmness and increased sociability. Although males as well as females secrete oxytocin in response to stress, there is evidence that male hormones reduce the effects of oxytocin. 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 (Fatima & Tahir, 2013).

Those who consider coping to be a trait see it as an acquired defensive style. Defense mechanisms are unconscious, automatic responses that enable us to minimize perceived threats or keep them out of our awareness entirely. Exhibit 5.2 lists the common defense mechanisms identified by ego psychology (discussed in Chapter 4). Some defense mechanisms are considered healthier, or more adaptive, than others. 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 his 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
### EXHIBIT 5.2 • 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>
</tbody>
</table>
Defense Mechanism | Definition | Example
--- | --- | ---
Undoing | Nullifying an undesired impulse with an act of reparation. | 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.

Most "Mature" Defenses

Sublimation | Converting an impulse from a socially unacceptable aim to a socially acceptable one. | An angry, aggressive young man becomes a star on his school’s debate team.

Humor | The expression of painful or socially unacceptable feelings without discomforting the person who is being humorous or (often) the recipient. | An employee manages her discomfort at being in a supervisory meeting by making self-deprecating jokes.

Sources: Adapted from Goldstein, 1995; Schamess & Shilkret, 2016.

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. This perspective is consistent with the idea that cognitive schemata develop through the dual processes of assimilation and accommodation, described in Chapter 4.

Coping Styles

Another way to look at coping is based on how the person responds to crisis. Coping efforts may be problem focused or emotion focused (Rajaei, Khoynezhad, Javanmard, & Abdollahpour, 2016). 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 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 (reappraisal). 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 (Bekteshi & Kayser, 2013). Feminist theorists propose that women are more likely than men to employ the relational coping strategies of negotiation and forbearance, and some research gives credence to the idea that women are more likely than men to use relational coping (e.g., Kim, Han, Trksak, & Lee, 2014). It is important to recognize that all of us use any or several of these mechanisms at different times. None of them is any person’s sole means of managing stress. 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. 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 peers, teachers, family members, and social
EXHIBIT 5.3  • Coping Styles Among Social Work Students

Problem-Focused Coping

Confrontation
- Learn to say no.

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

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

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

Emotion-Focused Coping

Distancing
- Deny that problem exists.
- Procrastinate.

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

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

Self-Control
- Push too hard.

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

Acceptance of Responsibility
- Cry.

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

- Vent on others.
- Curse other drivers.
- Neglect others.
- Watch too much television.

- Maintain flexibility.
- Reframe frustrations as growth opportunities.

- Study all night.
worker, and he also tried with limited success to control
his moods through force of will.

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

Given our discussion in Chapter 4 of conceptions of
the self, it may be interesting to review a stress/coping
model that focuses on the tripartite self (Gaertner et al.,
2012; Hardie, 2005). This model proposes that the self
includes three domains, the relational (experiencing the
self most fully in relationships), individual (a strong sense
of independence, autonomy, and separateness), and
collective (a preference for social group memberships),
and that the relative strength of a person’s domains will
guide his or her preferences for coping styles. Those with
a well-developed self in all three domains will possess
a full range of coping options, and those with a more
limited self-experience will have fewer. A person with a
sense of self that encompasses three domains will also
experience more sources of stress, but this model sug-
gests that when a source of stress matches one’s devel-
oped self-domain, coping will be most effective. That
is, if a highly relational person experiences relational
stress (such as a conflict with a friend), he or she will be
inclined to address the issue in a manner that is likely
to be effective. Dan, on the other hand, has a stronger
sense of an “independent” self than others, so when he
experiences interpersonal conflict, his range of avail-
able coping strategies is limited due to the mismatch.
And though Dan is attached to persons from his cultural
group, he has a limited sense of a broader collective self
and thus tends to have limited judgment or skill in how
to deal with conflict with representatives of other social
groups (including his school peers).

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, but there are some
significant differences (Kramer & Landolt, 2010; Szabo,
Warnecke, Newton, & Valentine, 2017). Because people
tend to have much less control in traumatic situations,
their primary emotion-focused coping strategy is emo-
tional numbing, or the constriction of emotional expres-
tion. They also may make greater use of the defense mechanism
denial. Confiding in others and the search for meaning
take on greater importance, and transformation in per-
sonal identity is common. Further, the process of coping
tends to take much longer time, months or even years.

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 follow-
their experiences with traumatic stress (Koss &
Figueroed, 2004). A majority of children who experience
such atrocities as war, natural disasters, community
violence, physical abuse, catastrophic illness, and traum-
atic 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 disor-
These symptoms include the following:

- Exposure to actual or threatened death, serious
  injury, or sexual violence either directly, by
  witnessing it, or by learning about it
- 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
Several factors related to the traumatic event put a person at risk for PTSD, including a higher degree and intensity of exposure to the event, a higher degree of physical violation, longer duration of the event, greater frequency of the experience, a greater sense of unpredictability and vulnerability, a closer relationship with the offender (if there is one), younger age, and an unsupportive social environment (Dalenberg, 2014).

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. It is also important to understand that persons with PTSD can recover from the disorder. It is difficult to determine how often this occurs, but in one large-scale study of persons with PTSD who received 12 weeks of cognitive-behavioral intervention 56% achieved symptom remission in 5 months or less, 27% achieved remission in 15 months or less, and only 17% showed continued impairment after 9 months (Galatzer-Levy et al., 2013). 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.

A person who experiences significant trauma may benefit from social work interventions that attend to both the cognitive and emotional aspects of mental life discussed in Chapter 4 (Black, Woodworth, Tremblay, & Carpenter, 2012; McCormick, Guthrie, & Bulanda, 2016). The goal of intervention should be to help the person move from a state of relative fear and powerlessness to one of positive agency and heightened assertiveness. It is essential for the social worker to first develop a relationship of trust with the person and provide a safe and secure base from which he or she can begin to face the trauma. Through the recognition of appropriate social supports and gradual encouragement of affective expression the client may begin to regain a sense of emotional control. The client can learn to manage the negative physical sensations associated with feelings of stress through relaxation and other mindfulness exercises. Eventually the person will feel secure enough to become able to reflect on the trauma and its meaning more directly. The social worker can help the client become aware of the differences between safe and unsafe situations, develop new self-care skills, practice safety skills, learn and practice appropriate problemsolving and emotional coping skills, and become better able to face feared situations through exposure.

**CRITICAL THINKING QUESTIONS 5.4**

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

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**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 has many definitions, but it can be understood as the interpersonal interactions and relationships that provide us with assistance or feelings of attachment to persons we perceive as caring (Razurel, Kaiser, Sellenet, & Epiney, 2013). The following are three types of social support resources worthy of a social work provider’s attention (Walsh, 2000):

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

Some authors add “social integration” support to the mix, which refers to a person’s sense of belonging. That is, simply belonging to a group, and having a role and contribution to offer, may be an important dimension of support (Lu & Hampton, 2017). This is consistent with the “main effect” hypothesis of support, discussed shortly.

Our **social network** includes not just our social support but all the people with whom we regularly interact and the patterns of interaction that result from exchanging resources with them (Gillieatt et al., 2015). Members of your own social network might
include some student peers, your coworkers, the school librarians, and the Starbucks barista. Network relationships often occur in clusters (distinct categories such as nuclear family, extended family, friends, neighbors, community relations, school, work, church, recreational groups, and professional associations). Network relationships are not synonymous with support; they may be negative or positive. But the scope of the network does tend to indicate our potential for obtaining social support. Having supportive others in a variety of clusters indicates that we are supported in many areas of our lives, rather than being limited to relatively few sources. Our personal network includes those from the social network who, in our view, provide us with our most essential supports (Ellwardt, van Tilburg, Aartsen, Wittek, & Stevernik, 2015).

Exhibit 5.4 displays Dan’s social network. He is supported emotionally as well as materially by his family members, with whom he keeps in regular contact, although the relationship with his father is strained. Dan particularly looks to his sister for understanding and emotional support, while at the same time being critical of her failure to be adequately supportive of him. Dan does not see his grandmother except for the trips he takes to China every 3 or 4 years, but he feels a special closeness to her and writes to her regularly. Dan has had an on-again, off-again relationship with his girlfriend Christine, who lives 1 hour away in his hometown and keeps in touch with him primarily by e-mail and text messaging. Their communications are civil, and Dan seems to enjoy giving her advice when she needs to make certain decisions about her jobs and daily living activities. Dan has instrumental relationships with his landlord and several other tenants in his apartment building, and one neighbor is a friend with whom he has lunch or dinner every few weeks. Dan is further instrumentally connected with several other students because they represent consistency in his life and are casually friendly and supportive. This is also true of two peers with whom he performs volunteer work in the medical center lab. It is apparent from Dan’s social network that he receives most of his emotional support from peers at the church where he attends services and social activities every Sunday.

In total, Dan has 19 people in his social support system, representing seven clusters. He identifies 9 of these people as personal, or primary, supports. It is noteworthy that 7 of his network members provide only instrumental support, which is important but the most limited type. We cannot determine based on numbers whether Dan’s support system is adequate to meet his needs, because people are very different in the desired nature of their supports. Still, the social worker might explore with Dan his school, neighborhood, and work clusters for the possibility of developing more active or meaningful supports.

If Dan has an inadequate support network, he is not alone. McPherson, Smith-Lovin, and Brashears (2006) found that 43.6% of their 2004 sample reported having either no one or only one person with whom they discuss important matters in their lives. Further, it is well established that persons across the life span who experience a lack of adequate social support are at risk for many adverse health consequences, including an earlier death (Holt-Lunstad, Smith, Baker, Harris, & Stephenson, 2015). Interestingly, feelings of loneliness and social isolation take a greater emotional toll on younger adults compared to those over 65.

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. Although 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. Indeed, the number of people with whom people physically interact has fallen in recent years, and research has produced mixed findings regarding the effects of social media use on perceived social support. For example, in two large-scale national studies, it was found that social media contacts produced an increased perception of social support for many, but not all, people and that the heaviest users of social media may in fact perceive less support than those with less frequent use (Lu & Hampton, 2017; Shensa, Sidani, Lin, Bowman, & Primak, 2016).

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 although 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, 2015), among
EXHIBIT 5.4  ●  Dan’s Social Network

<table>
<thead>
<tr>
<th>Network Cluster</th>
<th>Network Member</th>
<th>Type of Support</th>
</tr>
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<tbody>
<tr>
<td>Family of origin</td>
<td>Mother*</td>
<td>Material and emotional</td>
</tr>
<tr>
<td></td>
<td>Father*</td>
<td>Material and emotional</td>
</tr>
<tr>
<td></td>
<td>Sister*</td>
<td>Emotional</td>
</tr>
<tr>
<td>Extended family</td>
<td>Grandmother (Taiwan)*</td>
<td>Emotional</td>
</tr>
<tr>
<td>Intimate friends</td>
<td>Christine (girlfriend)*</td>
<td>Emotional</td>
</tr>
<tr>
<td>Neighborhood</td>
<td>Landlord</td>
<td>Instrumental</td>
</tr>
<tr>
<td></td>
<td>Alan</td>
<td>Instrumental, emotional</td>
</tr>
<tr>
<td></td>
<td>Perry</td>
<td>Instrumental</td>
</tr>
<tr>
<td></td>
<td>Jason</td>
<td>Instrumental</td>
</tr>
<tr>
<td>School</td>
<td>Lucy</td>
<td>Instrumental</td>
</tr>
<tr>
<td></td>
<td>Joan</td>
<td>Instrumental</td>
</tr>
<tr>
<td></td>
<td>Spencer*</td>
<td>Emotional</td>
</tr>
<tr>
<td>Work</td>
<td>Thomas</td>
<td>Instrumental</td>
</tr>
<tr>
<td></td>
<td>Laura</td>
<td>Instrumental</td>
</tr>
<tr>
<td>Church</td>
<td>Chen*</td>
<td>Emotional</td>
</tr>
<tr>
<td></td>
<td>Michelle*</td>
<td>Emotional</td>
</tr>
<tr>
<td></td>
<td>Garrett*</td>
<td>Emotional</td>
</tr>
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<td>Ming</td>
<td>Emotional</td>
</tr>
<tr>
<td></td>
<td>Russell</td>
<td>Emotional</td>
</tr>
</tbody>
</table>

* = Identified as close personal support.

others, is concerned about the unpredictable ways social technology may alter the nature of our relationships. As one disconcerting yet very real example of this process, she writes at length about the coming use of robots to provide people with major interpersonal support, existing as their full-time companions. She is also concerned about the use of electronic communication as a substitute for face-to-face interaction, arguing that face-to-face interaction is “where we develop the capacity for empathy” (Turkle, 2015, p. 3).

How Social Support Aids Coping

As noted earlier, the experience of stress creates a physiological state of emotional arousal, which reduces the efficiency of our cognitive functions. 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 & 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 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. This topic is explored in Chapter 6.

Two schools of thought have emerged around the question of how we internalize social support (Gottlieb & Bergen, 2010).

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

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

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

Perceived support is consistently linked to positive mental health, which is typically explained as resulting from objectively supportive actions that buffer stress. Yet this explanation does not fully account for the often-observed main effects between support and mental health. *Relational regulation theory* hypothesizes that main effects occur when people regulate their affect, thoughts, and actions through ordinary, yet affectively consequential, conversations and shared activities, rather than through conversations about how to cope with stress (Lakey, Vander Molen, Fles, & Andrews, 2016). This form of regulation is primarily relational in that the types of people and social interactions that help recipients are mostly a matter of personal taste. Dan reports that he receives emotional support from nine people, but he is not necessarily drawn to these people to the same degree, which is partly why he does not experience adequate social support.

### 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 (Tinajero, Martinez-Lopez, Rodriguez, Guisande, & Paramo, 2015). An example of a more complex procedure involves measuring eight indicators of social support: available listening, task appreciation, task challenge, emotional support, emotional challenge, reality confirmation, tangible assistance, and personal assistance (Rosenfeld & Richman, 2003). One practical model for social work practice 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

Normality is characterized by conformity with our community and culture. We can be deviant from some social norms, so long as our deviance does not impair our reasoning, judgment, intellectual capacity, and ability to make personal and social adaptations (Rashed & Bingham, 2014). 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 who has a mental illness 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. This represents a medical perspective, only one of many possible perspectives on human behavior, although it is a powerful, socially sanctioned one. 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 5.5 summarizes the format for diagnosing mental disorders as developed by psychiatry in the United States and published in the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 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. That is, through their own decisions and determination, and sometimes with the help of a professional, the person can change certain problematic (abnormal)
Dan, at age 24, is struggling with the development stages of normal development (see Exhibit 5.6). Dan's current difficulties would be related to his lack of intimacy as opposed to feeling socially empty or isolated. 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 (Mustaine, 2015). 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 (LeMahieu, Nordstrum, & Gale, 2017).

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-psychosocial-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, 2017).

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 5.7: 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.

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 a diagnosis of adjustment disorder or persistent depressive 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
### EXHIBIT 5.7  ●  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. Power
   2. Ambivalence
   3. Responsibility
   4. Dependency
   5. Loss
   6. Isolation
   7. Victimization
   8. Mixed
   9. Other

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

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

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

#### Factor II: Environmental Problems

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

B. Specific type of problem within each social system

C. Severity of problem

D. Duration of problem

#### Factor III: Mental Health Problems

A. Clinical syndromes (Axis I of DSM)

B. Personality and developmental disorders (Axis II of DSM)

#### Factor IV: Physical Health Problems

A. Disease diagnosed by a physician

B. Other health problems reported by client and others
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.

CRITICAL THINKING QUESTIONS 5.5

How important is virtual support to you? Which types of virtual support are the most meaningful to you? What have you observed about how technology is affecting the way people give and receive social support? What do you see as the contributions of the medical, psychological, sociological, and social work perspectives on normal and abnormal coping? What do you see as the downsides of each of these perspectives?

Implications for Social Work Practice

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

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

Key Terms

<table>
<thead>
<tr>
<th>Term</th>
<th>Page</th>
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<tr>
<td>adaptation</td>
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<tr>
<td>coping</td>
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<td>crisis</td>
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<td>daily hassles</td>
<td>139</td>
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<td>defense mechanisms</td>
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<tr>
<td>emotion-focused coping</td>
<td>145</td>
</tr>
</tbody>
</table>
Active Learning

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

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

3. Consider several recent situations in which you have 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? How does the tripartite conceptual framework help you to understand your choice of strategy?

Web Resources

The Ainsworth Attachment Clinic and the Circle of Security: www.theattachmentclinic.org/index.html

The Mary Ainsworth Attachment Clinic provides evaluation, intervention planning, and consultation for children who have experienced significant challenges or disruptions to their relationships or attachment bonds with parents or other caregivers. The evaluation and treatment protocols used for families with attachment-caregiving concerns require extensive training and certification and are available for Virginia communities only through the Attachment Clinic.

Feminist Theory Website: www.cddc.vt.edu/feminism/enin.html

This website, provided through Virginia Tech University, provides research materials and information for students, activists, and scholars interested in women’s conditions and struggles around the world. The goals of the website are to encourage a wide range of research into feminist theory and to encourage dialogue between women (and men) from different countries around the world, practices that will hopefully result in new connections, new ideas, and new information about feminist theory and women’s movements.

(Continued)
Institute of Contemporary Psychotherapy and Psychoanalysis: www.icpeast.org
This site contains information on conferences, training, and links to other resources on contemporary self and relational psychologies.

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.

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.

MIT Initiative on Technology and Self: www.mit.edu/~sturkle/welcome.html
The goal of the MIT Initiative on Technology and Self is to be a center for research and reflection on the subjective side of technology and to raise the level of public discourse on the social and psychological dimensions of technological change. The initiative features seminars, work groups, conferences, research, and publications.

National Center for Post-Traumatic Stress Disorder: www.ptsd.va.gov
Site presented by the National Center for PTSD, a program of the U.S. Department of Veterans Affairs, contains facts about PTSD, information about how to manage the traumatic stress of terrorism, and recent research.