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Coping strategies selection and effectiveness

Diane June Pfahler

COPING STRATEGIES:
SELECTION AND EFFECTIVENESS

A Thesis Presented to

the Faculty of

California State University, San Bernardino

In Partial Fulfillment

of the Requirements for the Degree

Master of Arts

in

Psychology

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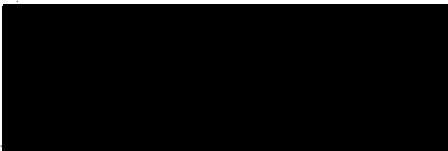
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ABSTRACT

This study was designed to examine the relationship between coping and support efforts. The subjects were 116 undergraduate students who completed three questionnaires: self-coping strategies (Folkman & Lazarus, 1986); coping strategies received from others; and coping strategies delivered to others, when recalling a loss of a relationship (other than through death) for themselves and for someone they supported. Use and effectiveness measures were included. Results showed that there were positive relationships between: use of self-coping strategies and use of strategies delivered to others; effectiveness of self-coping strategies and use of strategies delivered to others; and effectiveness of self-coping strategies and effectiveness of strategies delivered to others. The strongest relationship was found for effectiveness of self-coping strategies and effectiveness of strategies received from others.

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INTRODUCTION

In recent years there has been a major increase in interest in the concepts of coping and social support. This is demonstrated by the number of treatment programs that utilize these concepts in the designing of therapeutic assistance interventions. This increasing interest can be attributed to several factors (Cohen & Syme, 1986; Folkman, Lazarus, Dunkel-Schetter, DeLongis & Gruen, 1986). First, coping and social support may have a role in the etiology of disease and illness. Secondly, they may play a part in treatment and rehabilitation programs following the onset of illness. Finally, these concepts have the potential for aiding in the conceptual integration of the diverse literature on psychosocial factors and disease.

Interestingly, the areas of coping theory and research have been generally separated from the areas of social support theory and research despite the fact that both fields focus on how people adjust to stressors (Thoits, 1983, 1986). For example, the coping literature indicates that there are three broad methods of adjustment: situational control; emotional control; and perceptual control. These methods are very similar to the methods of adjustment revealed by the social support literature: instrumental support; emotional support; and informational

support (House, 1981). In other words, social support can be viewed as coping assistance - employing the coping strategies that a person uses with himself or herself to other persons in need of support (Folkman & Lazarus, 1985; Thoits, 1983).

This research explores the relationship between coping strategies a person uses with himself or herself and the coping strategies a person uses with others when offering social support. It is designed to identify: coping strategies a person uses with himself or herself; coping strategies that person then uses with others; and the coping strategies that person receives from others. It also explores the effectiveness of similar strategies that are used by self, used with others, and received from others.

Coping

Research on coping reflects a growing belief that coping plays a significant role in the relationship between stressful events and the resulting outcomes, such as depression, psychological symptoms, and somatic illness (Folkman, Lazarus, Dunkel-Schetter, DeLongis, & Gruen, 1986; Schaefer, 1983). Coping, itself, as defined by Folkman and Lazarus (1985), refers to "a person's constantly changing cognitive and behavioral efforts to manage (reduce, minimize, master, or tolerate) the internal and external demands of the person-environment transaction that is appraised as taxing or exceeding the person's resources"

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(p. 993). There are three major features of this definition (Folkman, Lazarus, Dunkel-Schetter, DeLongis, & Gruen, 1986). First, coping is process-oriented. It focuses on what a person actually thinks and does in a specific situation, and the adjustments that are made by the individual as the situation progresses. Looking at the process of coping is, therefore, different from trait approaches which are concerned with what a person usually does, emphasizing stability rather than change. Secondly, coping is seen as contextual. It is influenced by how a person assesses both the actual demands of the situation and the available resources for managing them. The coping efforts selected are affected by both the particular person and the situational variables. Finally, there are no previously developed assumptions about what constitutes good or bad coping. Coping is defined purely as the efforts that are made regardless of the outcome. If not viewed this way, the coping process becomes confounded with the outcomes it is used to explain (Folkman & Lazarus, 1985).

Coping has two major functions. It is used to deal with the problem that is causing the distress (problem-focused coping) and it is employed to regulate emotions (emotion-focused coping). Previous research (Folkman & Lazarus, 1980, 1985) has shown that people use both of those types of coping in essentially every type of stressful situation. Both forms of coping were represented in over 98%

of the stressful encounter reports by middle-aged men and women (Folkman & Lazarus, 1980) and in an average of 96% of the self-reports of how college students coped in a stressful examination (Folkman & Lazarus, 1985).

Eight forms of problem-focused coping and emotion-focused coping have been identified by Folkman, Lazarus, Gruen, and DeLongis (1986). In this study, an intraindividual analysis was used with a sample of 85 community-residing married couples with at least one child to compare the same person's appraisal and coping processes in a variety of stressful situations. The three forms of problem-focused coping identified were: confrontive coping; rational, well-planned efforts; and seeking social support. Emotion-focused forms of coping included: distancing; self-controlling; escape-avoidance; accepting responsibility; and positive reappraisal. Other findings in this study indicated that when people felt the threat to self-esteem was high, they used more confrontive coping, self-controlling, escape-avoidance, and accepted more responsibility, compared to when the threat to self-esteem was low. They also sought less social support when they felt the threat to self-esteem was high. Planful problem-solving was used more in situations that people felt could ultimately end up well and distancing was used more when situations were considered difficult to change. The findings also indicated that coping strategies were related

to the quality of the outcomes of situations, but appraisal was not. Confrontive coping and distancing were associated with unsatisfactory outcomes whereas planful problem-solving and positive reappraisal were associated with satisfactory outcomes.

Research by Folkman, Lazarus, Dunkel-Schetter, DeLongis, and Gruen (1986) explored the relationship between personality factors, primary appraisal, secondary appraisal, eight forms of problem- and emotion-focused coping, and somatic health status and psychological symptoms. In a sample of 150 community-residing adults, the appraisal and coping processes were assessed in five different stressful situations that subjects experienced in their day-to-day lives. When the coping and appraisal processes were entered into a regression analysis of somatic health and psychological symptoms, the variables did not explain a significant amount of the variance in somatic health status, but they did explain a significant amount of the variance in psychological symptoms. The pattern of the relations indicated that certain variables were also positively or negatively associated with symptoms. When mastery and interpersonal trust were entered with the coping and appraisal variables, mastery, interpersonal trust, and concern for a loved one's well-being were negatively associated with psychological symptoms, whereas confrontive coping, concern about financial security, and concern about

one's own physical well-being were being positively

associated with psychological symptoms. Mastery and

interpersonal trust were significantly correlated with

psychological symptoms, even after appraisal and coping were

controlled for. In general, the more subjects had at stake

(primary appraisal) over diverse encounters, the more likely

they were to experience psychological symptoms.

Social Support

Social support is a flourishing area of research and

has been related to health and illness. Researchers

concerned with factors that help individuals cope with

stress have frequently focused on it (Abbey, 1983).

Individuals suffering from a varied group of stressors, such

as malignant disease, death of a close friend, rape, and job

loss, have all been found to adjust better when they receive

social support (Dunkel-Schetter & Wortman, 1982; House,

1981; Sales, Baum, & Shore, 1984; Sarason, Sarason, &

Shearin, 1986).

Research on social support (Rook, 1985) suggests that

social relationships facilitate adjustment to stressful

events and thereby decrease vulnerability to stress-related

disorders. The potential for social support is fundamental

to social relationships, but researchers have yet to agree

on a definition of social support. Cobb's (1976) frequently

cited definition characterizes social support as information

that causes one to believe that he/she is cared for and

involved with others. Cohen and Syme (1985) define social support as the resource provided by other persons that may alleviate the impact of the stressful experience. Thoits (1983) views social support as coping assistance. Specifically, it is the direct application of techniques to a stressed other that one might use on oneself.

More recently, however, Sarason, Sarason, and Shearin (1986) have defined social support as the existence or availability of people on whom we can rely. These are people who let us know that they care about, value, and love us. Bowlby's theory of attachment (cited in Sarason, Levine, Basham, & Sarason, 1983) incorporates this interpretation of social support. When social support is available early in childhood in the presence of an attachment figure, Bowlby believes children become self-reliant, have a decreased likelihood of psychopathology, and learn to take a supportive role with others. It also appears that this availability of social support at an early age results in a person's increased capacity to deal with frustrations and problem-solving situations.

A variety of research efforts seem to support this. For example, Sarason, Levine, Basham, and Sarason (1983) found that there was a positive relationship between the perceived availability of social support in adults with their perceived adequacy of childhood relationships. In a 30-year longitudinal study of Harvard University male

undergraduates, Vaillant (cited in Sarason, Levine, Basham, & Sarason, 1983) found that a supportive early family environment was correlated with positive adult adjustment and lack of psychiatric disorders. Henderson (cited in Sarason, Levine, Basham, & Sarason, 1983) concluded that a deficiency in social bonds may, independent of other factors, be a cause of some forms of behavioral dysfunction.

Regardless of how social support is conceptualized, however, it would seem to have two basic elements. There is a perception by a person that there is a sufficient number of available others to whom one can turn in times of need and there is a degree of satisfaction with the available support. A social support network provides a person with psychosocial supplies for the maintenance of mental and emotional health, according to Caplan (1974). It also allows for increased feelings of stability, predictability, and control because this network provides the opportunity for regular social interaction and feedback that permits adoption of appropriate roles and behaviors (Cohen & Syme, 1985; Thoits, 1983). Very low levels of social support and dissatisfaction with social support has also been associated with decreases in well-being (House, 1981).

One point of controversy among researchers has been determining how satisfaction or dissatisfaction with social support should be assessed. Researchers disagree about whether social support refers to the objective helping

behaviors directed toward a person in need or to the recipient's subjective evaluation of such behaviors. Resource definitions of social support appear to view social support as objective (Cohen & Syme, 1985; Thoits, 1983). Statements of liking or the offering of material goods and services presumably could be recorded by an impartial observer or reported with reasonable accuracy by a recipient and thus represent objective support. Cobb's (1976) definition, however, defines social support as information that leads people to believe they are cared about. From this viewpoint, social support is the subjective experience of feeling valued and cared for by others. This distinction is important because receiving help from others does not always produce feelings of being supported. Help-giving may be perceived as supportive only if the helper conveys an attitude of caring toward the recipient (Caplan, 1979). People may also feel unsupported if the help offered does not meet their personal expectations for support. People may evaluate identical helping behaviors very differently because of the differing expectations for support (Rook, 1985). According to Rook (1985), rather than debate the merits of objective versus subjective satisfaction or dissatisfaction with social support, researchers should recognize the value of both. Several recently developed measures of social support avoid this problem by assessing both objective and subjective support (Sarason, Levine,

Basham, & Sarason, 1983).

Researchers have also had a difficult time in trying to identify the components of social support and have concluded that there are different types of social support. Thoits (1983) describes three types of support - instrumental, emotional, and informational. These types of support allow for changing the objective situation, offering reassurance of love and concern, and providing advice and personal feedback. Rook (1985) includes those three areas and adds appraisal. This type of support assists with altering the perception of the situation. Caplan (1979) conceptualizes the components in terms of the objective versus subjective dimensions of social support and the tangible versus psychological dimensions.

Describing how social support functions is an equally difficult task. Cohen and Syme (1985) indicate that recent research offers evidence for both a direct (main) effect and a buffering effect of social support on health and well-being. The main effects hypothesis suggests that health and well-being may be directly affected by using mechanisms involved in all four areas presented by Rook (1985) irrespective of the stress level. The buffering hypothesis indicates that social support will indirectly have a positive effect on health and well-being by protecting people from the pathogenic effects of stressful events. It may only utilize the mechanisms of the emotional and/or

appraisal areas.

How the mechanisms specifically work, however, is not clearly established. Rook (1985) suggests that social support works by enhancing coping. This results in an increase in motivation, positive affective consequences, a change in cognitive analysis, and the presence of needed resources. Cohen and Syme (1985) feel that social support may reduce the importance of the perception that a situation is stressful. The appraisal aspect of coping may, in some way, tranquilize the neuroendocrine system so that people are less reactive to perceived stress or it may facilitate healthful behaviors. Thoits (1983) offers a complicated four-factor theory of emotion and emotional dynamics that suggests that social support efforts work by replacing negative feelings elicited by stressors with positive ones.

As all of these factors have been investigated, numerous therapeutic models have been developed incorporating the research findings. Brickman et al. (1982) present four models that are generally descriptive of many of the approaches being utilized today in offering support. These models are based on establishing attribution of responsibility for a problem and attribution of responsibility for a solution to a problem. When these two attributions have been assessed, strategies for offering social support can be determined. These models are: the moral model; the enlightenment model; the compensatory

model; and the medical model.

In the moral model, people are attributed responsibility for both creating and solving their problems. No one beside the individual must act must act in order for the individual to change. However, peers may be helpful by encouraging them to change and improve. This type of support is reflected by self-help groups such as est.

When people are not held responsible for their problems, but are expected to be responsible for the solutions, the model is described as compensatory. Problems are attributed to the social environment and support efforts are directed toward assisting the person in his/her effort to transform the environment. Organizations such as AA sometimes function under the philosophy behind this model.

Under the enlightenment model, people are believed to have caused their problems, but are not responsible for the solutions. Support includes helping people to accurately attribute responsibility for their problems to themselves and to recognize the need to submit to social control so that others may solve the problem for them. Most AA groups utilize this model today as well as a number of religious organizations.

The medical model holds that people are neither responsible for their problems nor for the solutions. People are seen as ill or incapacitated. Support givers are seen as experts who are there to solve the problems.

Numerous forms of psychotherapy and some AA groups adhere to this school of thought.

Models for individual helpers have also been developed. Tyler (1961) suggested a program for training helpers based upon the social influence model. While also rooted in attributional theory, this model indicates that people simply have the need to attribute their thoughts and feelings to "something." Therefore, the supporter's task is to allow the person to do that and then assist them with the resulting needed attitude changes and control issues. This is done by promoting cognitive dissonance. Egan (1982) offers his support to this model, describing it as a problem-management support. The helper is responsible for establishing a relationship, understanding others from their point of view and communicating this to them (empathy), helping people to develop new perspectives on themselves and their problems, and developing and implementing programs that will assist them in achieving goals that they jointly establish.

Schoenberg, Carr, Peretz, and Kutscher (1970) suggest that the role of supporter should include assisting others to see that their feelings are normal and encouraging them to express them. Information can be supplied if asked for, but the primary role is that of empathetic listener. It is assumed that reactions, if not assessed to be pathological, will proceed along a route to acceptance of problems and awareness of solutions gradually with this type of support.

Attribution of responsibility, while it may be present, is not a factor in the development of this model. Pennebaker (1986) also supports this role for the supporter, indicating that being an empathetic listener helps individuals to cope. Confiding in others helps a person organize, structure, and find meaning to the experiences. Being able to translate traumatic experiences into language with an empathetic other may be sufficient.

Brickman et al. (1982) point out that the helpers offering support within any of these models will tend to be those who support the underlying philosophy and personally use the specific coping strategies called for themselves. This may be due to past experience with the same particular stressors. It may also be the result of helpers selecting to work in systems that they identify as using the same coping strategies that they use, regardless of the stressor. As indicated by Thoits (1983), people tend to give others the same types of social support that they give to themselves.

Negative Social Support

In most of the early research efforts, it was assumed that support attempts made by helpers would automatically be of value and appreciated by receivers. There has now been a growing awareness that in many cases, however, even well-intentioned support efforts may not only be regarded by receivers as unhelpful, but may also result in negative

consequences for both the receiver and helper (House, 1981;
Wortman & Lehman, 1985). Numerous research efforts now
indicate that a number of variables play a role in
determining whether or not support attempts will be
perceived as as nonsupportive (Dunkel-Schetter & Wortman,
1982; Pennebaker, 1986; Ruback, Greenberg, & Westcott, 1984;
Sales, Baum, & Shore, 1984; Wortman & Lehman, 1986). Some
of these include: the type of problem; misconceptions of the
helpers; the degree of distress suffered by the receiver;
social interests and norms; the amount of help needed; and
the attribution of responsibility for the problem and/or
solution.

Different types of negative life experiences evoke
different types of feelings in others. Many problems, such
as the death of a spouse or divorce, are considered socially
acceptable. When they occur, receivers can readily relate
their experiences to others with the expectation of
receiving empathy and affection (Pennebaker, 1986). Other
experiences, such as rape, are less acceptable, and victims
may not be able to discuss their feelings with anyone.
Dunkel-Schetter and Wortman (1982) found that cancer
patients, for example, had major difficulties in trying to
elicit satisfactory responses from others. For five years,
Dunkel-Schetter and Wortman (1982) served as facilitators in
peer support groups for cancer patients and their families
established by the Make Today Count organization. They

found that people frequently reported being upset and confused by the responses of supporters. Patients often indicated that spouses were unwilling to acknowledge the disease and the prognosis and to discuss these with them. Patients often frequently complained of others being tense and/or awkward in their presence and perceived that they were being avoided by friends. The group members reported that others were generally intolerant of their negative affects, closed off discussions about issues of concern to them, and minimized the importance of these issues.

It also appears that supporters have many misconceptions that lead them to offer ineffective and/or detrimental support efforts. According to Wortman and Lehman (1985), many people have misconceptions about the emotional impact that is associated with an undesirable life event. Most people seem to assume that when a life crisis occurs, an individual will initially experience distress as he/she attempts to cope with it. However, the individual is then expected to work this through and recover quickly. In coping with life-threatening illness, for example, Vachon (cited in Wortman & Lehman, 1985) found that breast cancer patients were expected to resume their roles quickly following treatment because the disease should no longer have an effect on their lives. However, a number of studies, including that by Maguire (cited in Wortman & Lehman, 1985), provide evidence that many breast cancer

patients display symptoms of distress long after treatment, even if the disease has not recurred.

The amount of distress experienced and expressed by a victim will also be reflected in the quality and quantity of support given. As Wortman and Lehman (1985) point out, when victims need support the most, they are the most likely not to receive it. When the consequences of victimization are serious, negative feelings about it, anxieties about providing support, and misconceptions about how the victim will react are much more likely to determine the response given by a supporter. He/she may discourage open discussion of feelings and encourage recovery or movement to the next stage before the victim is ready (Schoenberg et al., 1970). The supporter may fall back one automatic or scripted support attempts, such as saying, "I know how you feel", which may seem to dismiss or trivialize the victim's problems.

This does not seem to reflect a lack of knowledge about what to say. In fact, supporters appear to be well-informed concerning interventions that would be helpful. Lehman, Ellard, and Wortman (1986) investigated the long-term effects of bereavement with 94 subjects and 100 control subjects. It was found that strategies that might have been thought to be helpful, such as offering advice and giving encouragement, were found to be unhelpful. Contact with similar others and the opportunity to ventilate were two

strategies that were assessed to be helpful. The results further indicated that the strategies assessed as either helpful or unhelpful by the subjects were similarly assessed by the control group when asked what support they felt would help the bereaved. While it appears that people are well-informed, the inability to then offer these positive strategies to others seem to be more a reflection of the inability to deal with their own anxiety, discomfort in the presence of distress, and lack of personal experience.

Without previous life experience, it would appear that some supporters do not know what to say. These supporters hold prior assumptions about how victims should react based upon social norms and dictates for behavior and have formed ideas of what types of comments and interactions are likely to be helpful based upon those. They may be cheerful, for example, and encourage the victim to "look on the bright side" (Dunkel-Schetter & Wortman, 1982). Supporters with previous experience may also hold prior assumptions about how victims should behave. Medical personnel, for example, appear not only to hold these assumptions, but also be affected by self-interest and the interest of society (Sales et al., 1984). Medical personnel who dealt directly with post-assault victims were observed and interviewed. It was found that personnel were often indifferent to a victim's needs, even when the victim had physical trauma. Priority was given to the police and others trying to obtain

information rather than to the treatment of a victim. Sales et al. (1984) indicated that the self-interests of the medical personnel, per se, may have been a result of not wanting to accumulate personal costs. People are generally thought to be more cost-oriented than reward-oriented (Rook, 1984) and serious personal costs are associated with being a supporter (Kessler, McLeod, & Wethington, 1984).

Brickman et al. (1982) have also considered why it is that potential supporters often turn against receivers of help. They reviewed considerable data that suggests that the greater the help that is needed and given, the more likely helpers are to turn against the receivers. Even if receivers deserve help, supporters may feel upset if they feel that the receivers get more support than they really deserve. The act of providing help, in itself, may lessen the supporter's regard for the receiver. Brickman et al. (1982) concluded that the reaction of members of a receiver's support network to his/her need for help may depend on their attributions regarding responsibility for the causes of as well as the solutions to his/her problems. Help is most reluctantly given when people are seen as responsible for both the cause and the solution of their problems and most willingly given when they are seen as responsible for neither.

Attribution of responsibility suggests that problems will arise between supporters and receivers because

supporters are more likely to attribute causality to the
dispositions of the receivers while receivers are more
likely to attribute responsibility to situational cues
(Rodin, 1985). The bias of helping professionals, too,
toward the dispositional rather than situational
attributions extends to their judgment about receivers as
well. Helping professionals often view receivers as having
been the cause of their own problems rather than suffering
from situational circumstances. Rodin points out that
blaming the victim becomes more frequent when the true
causes are distal and complex and when the operational
paradigm is a medical model. For example, Ruback et al.
(1984) found that medical personnel were more likely to
attribute responsibility for a rape to the victim if the
victim had been raped before. The stability of the victim's
behavior across time suggests that the locus of causality
resides within the individual rather than in the environment.
Conflict then arises for the supporter in this situation as
the medical model in which he/she functions states that the
victim is not responsible for either the problem or the
solution (Brickman et al., 1982). According to Sales et al.
(1984), victims in this situation are either treated
callously or ignored.

It would appear that many variables, individually or
working in conjunction with others, may lead to support
efforts that are seen as either nonsupportive or that have

negative consequences. This resulting process of what might
be termed "secondary victimization" is a process by which
victims are then hurt again by the awkward or ineffective
efforts of others (Brickman et al., 1982). This appears to
have two major phases. Janoff-Bulman and Bulman and Wortman
(cited in Brickman et al., 1982) found that victims tended
to blame themselves for problems during the first phase.
Supporters were unable to recognize this as an attempt to
regain control and responded in an approach-avoidance
manner. Victims then became aware of the discomfort of the
supporters and withdrew, not sharing their feelings. In the
second phase, supporters were ready for victims to begin
resuming responsibility for themselves. However, since the
victims had not been able to share their feelings and make
sense of the event, they were not ready to do so.
Supporters then began to blame the victims for not trying
hard enough and withdrew their support.

In this process, victims are forced to inhibit their
behavior. To actively inhibit ongoing behavior, however, is
associated negatively with physiological activity
(Pennebaker, 1986). Not talking about events appears to
lead to obsessive thinking which ultimately may lead to
health problems. In a study to evaluate the relationship
between talking about an extremely traumatic event with
others, thinking about the event, and health, Pennebaker
found that, among a stratified sample of individuals whose

spouses had either committed suicide or died in a car accident during the previous year, the increase in the illness rate from before to after the death of the spouse was negatively related to talking with friends about the death. The more the subjects had talked with friends about the death, the less they had ruminated about it.

Victims seeking professional support found that the consequences of ineffective support were equally as serious (Rodin, 1985). Seeking professional help implies that victims do not feel in control. Under the medical and enlightenment models, victims will then be put in a position of giving up whatever control they do have. Rodin suggests that this loss of control depersonalizes the victim and that victims respond to this by becoming either "good" or "bad" patients. The former role leads to the victim becoming helpless and depressed while the latter role leads to anger. Rodin states that both roles produce physiological, cognitive, behavioral, and affective consequences that can directly interfere with the course of recovery and, thus, indirectly affect their health.

The damage done by negative support efforts is so severe that it will not be off-set or balanced by positive efforts. Rook (1984) found that negative social interactions among the elderly were more potent in terms of their effects on well-being than were positive social interactions. Rook sampled 120 widowed women and found that

negative social outcomes were more consistently and more

strongly related to well-being than were positive social

outcomes. Negative social interactions appeared to have a

disproportionate impact on well-being because they were

rarer and, hence, more salient. Abbey (1985) also found

that social support and social conflict did not off-set each

other. They were two independent concepts, not merely

opposite ends of the same continuum. Social support, for

example, appeared correlated with positive psychological

concepts such as self-esteem and perceived life quality.

Social conflict, however, appeared most influential with

negative psychological concepts such as anxiety and

depression.

Helpers as well as victims appear to suffer serious

personal costs when offering nonsupportive or negative

support efforts (Kessler et al., 1984). If the support

given does not result in the expectations held by the

supporter, anxiety, frustration, anger, and a lowering of

self-esteem tends to occur. If the supporter then

withdraws, the resulting guilt and anger leads, in some

cases, to health problems (Rodin, 1985).

Among helping professionals, burn-out tends to occur

more when efforts have been unsuccessful. This involves a

loss of concern for the people with whom the helper is

working (Rodin, 1985). In addition to physical exhaustion

and sometimes even illness, burn-out is characterized by

emotional exhaustion. As a result of this, victims are
viewed in even a more negative way and are blamed for their
problems. Given the tendency to make attributions of
responsibility, helping professionals are also more likely to
blame themselves as well.

In the presence of nonsupportive or negative support
efforts, both the victim and helper may suffer. The victim
may feel isolated, unimportant, abnormal, unloved, and be
deprived of the communication, support, and caring that
he/she needs to successfully work through the crisis. The
helper may feel anxious, helpless, inadequate, burdened,
angry, and not valued.

Present Research

In this study, the focus is on coping strategies,
social support, and negative social support. This research
explores the relationships between coping strategies a
person uses with himself/herself and the coping strategies a
person uses with others when offering social support. It is
designed to identify: coping strategies a person uses with
himself/herself; coping strategies that person then uses
with others; and coping strategies that person receives from
others. It also explores the effectiveness (positive or
negative) of similar strategies that are used by self, used
with others, and received from others.

Previous research has shown that a person uses problem-
and emotion-focused coping with himself/herself in virtually

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every type of stressful encounter (Folkman & Lazarus, 1980, 1985). Folkman, Lazarus, Gruen, and DeLongis (1986) found that subjects used an average of 6.5 forms of coping in each stressful encounter. The amount of each form of coping used varied according to what was at stake and the appraised changeability of the encounter. In their study, even though subjects tended to cope differently from encounter to encounter, by the time the subjects had described how they had coped with the demands of five separate encounters, subjects had probably drawn upon most of the available forms of coping. As with other research efforts, the selection of strategies varied according to: primary appraisal (what was at stake); secondary appraisal (what the coping options were); the quality of the outcomes of situations; and personality variables (Folkman & Lazarus, 1980, 1985; Folkman, Lazarus, Dunkel-Schetter, DeLongis, & Gruen, 1986).

There is reason to believe that the coping strategies that a person uses with himself/herself in a particular situation may be the same strategies that person uses with others in similar situations. Thoits (1983) supports this and points out the similarities between the categories of emotional, informational, and instrumental support in the social support literature and the three methods of adjustment in the coping literature - situational control, emotional control, and perceptual control. Thoits states that social support is, therefore, the presence of

significant others suggesting alternative techniques and/or assisting directly in a person's coping efforts. Like coping, these types of support are directed at situational demands and emotional responses to these demands.

Dunkel-Schetter and Wortman (1982) offer support to this also by pointing out that effective social support efforts are less likely to be given when the supporter has not experienced the same crisis as the victim. This implies that the supporter is more available when he/she can draw upon personal experience for ways in which to be supportive. Thoits (1983) states that the importance of this experiential similarity is reflected in the growing numbers of self-help groups in this society that are focused on specific and shared problems. Helpers who have faced or who are facing similar stressors are likely to have detailed knowledge of the situation and its emotional effects. Through trial-and-error, these helpers have determined strategies that are effective.

Brickman et al. (1982) point out that the philosophy behind that attributional model that a professional helper works within will affect his/her choices of coping strategies for both himself/herself and to be used with others. In fact, a helper may select to work within a particular system because it uses the strategies the person is familiar or deals with a particular stressor that the helper has experienced.

It is possible, however, that even effective coping strategies when used with oneself may not be effective when used with others. The strategies a person uses to handle his/her own stress may be viewed negatively when mediated by another person. For example, Sarason, Sarason, and Shearin (1986) indicate that positive reappraisal as a coping strategy is often viewed positively when used by a person with himself/herself. Positive appraisal refers to an improved assessment of a problem on the basis of new information from the environment. As a coping strategy, it consists of any effort that reinterprets the past more positively or deals with present harms and threats by viewing them in less damaging or threatening ways (Lazarus & Folkman, 1984). Wortman and Lehman (1985) point out, however, that positive reappraisal may be viewed negatively when delivered by someone else. In a study among cancer patients (Dunkel-Schetter & Wortman, 1982), for example, statements such as "things could be worse" were negatively viewed when mediated by another person.

The research in this area raises several questions. Are the coping strategies utilized by a person the same strategies most likely to be used when that person gives to others? Secondly, are the strategies a person uses to handle his/her stress viewed negatively when mediated by another person? Finally, will the answers to these two questions result in a paradoxical relationship? Research

shows that it has been assumed that support efforts will be helpful (House, 1981; Wortman & Lehman, 1985). Therefore, there should be a positive relationship between the strategies that we use with ourselves that are effective and those strategies that we use with others (Thoits, 1983). Further, there is an assumption that those strategies we use with ourselves will be positively viewed when those strategies are used by us with others. Self-strategies, however, may only be effective when used with oneself. For example, Folkman and Lazarus (1985) indicated that when using emotion-focused coping, people did tell themselves that "things could be worse" and found it an effective self-strategy. As Dunkel-Schetter and Wortman (1982) pointed out, however, this was viewed negatively when delivered by others. Perhaps the strategies we use with ourselves are negatively viewed by us when delivered by others to us or when we use our self-strategies with others. If this is the case, the resulting paradoxical relationship may offer one explanation for the nonsupportive and negative support efforts that are now being recognized.

Summary of Hypotheses

The coping strategies that a person uses with himself/herself are those strategies that a person uses to help others.

The coping strategies that are viewed as effective for self are those strategies that a person delivers to others.

The coping strategies that are viewed as effective for self are those strategies that are negatively viewed when received by him/her from others.

The coping strategies that are viewed as effective for self are those strategies that are viewed positively by him/her when delivered to others.

METHOD

Subjects

The subjects were 116 undergraduate students from the volunteer subject pool at CSUSB with a defined crisis in common - loss of a relationship other than through death. This type of crisis is reasonably common and the three types of coping are appropriate to this type of loss. It also addresses both the person and environmental variables by limiting the kinds of stressors. "Stressors" generally refer to the situational features that require behavioral responses that the individual assesses as either beyond the current capabilities or taxing to the capabilities and therefore threatening to some aspect of self-perception (Thoits, 1983). Different kinds of problems bring out selective coping strategies. For example, planful problem-solving is used more with problems that people ultimately feel can end up well and distancing is used more when the problems are considered difficult to change (Folkman, Lazarus, Gruen, & DeLongis, 1986). Further, problems that only affect a specific group, such as cancer or wife-battering, also elicit specific coping strategies (Dunkel-Schetter & Wortman, 1982). Use of a fairly universal crisis or stressor holds this variable constant.

There were 90 female subjects and 26 male subjects

participating for extra credit. The age range was 18 to 57 years with a mean age of 27.9 years. One female served as experimenter.

Measures

The Ways of Coping Checklist

This measure is a 50 item checklist and is the most recent form of the Ways of Coping Scale (Lazarus & Folkman, 1985). It identifies a broad range of coping and behavioral strategies that people use to manage internal and external stressful encounters (see Appendix A). It was revised by Folkman and Lazarus (1985) from the original 67 item checklist by factor analysis procedures.

The eight coping scales (strategies) identified in this checklist are: confrontive coping; distancing; self-control; accepting responsibility; planful problem-solving; positive reappraisal; seeking social support; and escape-avoidance (see Appendix B). The first five scales represent emotion-focused coping while the remaining three represent problem-focused coping. An example of each of these strategies can be found in Appendix C.

The standard response format is a four-point Likert scale assessing the degree to which particular strategies are used. For the purposes of this study, this scale was changed to a "Yes" or "No" dichotomous response format to indicate whether a strategy was used or not. Scale scores were comprised of the sum of the items contained in each

scale. Thus, the use scale scores reflected how many strategies were used with a score of one for each category used. To rate the effectiveness of each strategy, a nine-point Likert scale ranging from "Very Unhelpful" to "Very Helpful" was also presented with each strategy.

Prior testing of this checklist by Folkman and Lazarus (1985) indicated an alpha of .70. Alphas for the individual scales were: .70 for confrontive coping; .61 for distancing; .70 for self-controlling; .76 for social support; .66 for accepting responsibility; .72 for escape-avoidance; .68 for planful problem-solving; and .79 for positive reappraisal.

The Ways Others Help Me Cope Checklist

This measure is a 67 item checklist and a product of a study involving 23 subjects from the undergraduate volunteer subject pool at CSUSB (see Appendix D). It was revised from an original 118 item checklist by reliability measures. It is concerned with assessments of the selection and effectiveness of coping strategies that are received from others. This scale was developed by transforming the Ways of Coping Checklist (Folkman & Lazarus, 1986) measures into items that measure selection and effectiveness of coping strategies that are received from others (see Appendix E). Those transformations included both direct and indirect measures of each strategy. For example, "I acted as if nothing had happened", an escape-avoidance strategy from the Ways of Coping Checklist (Folkman & Lazarus, 1986)

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was transformed into "Someone acted as if nothing had happened " (direct) and "Someone encouraged me to act as if nothing had happened" (indirect). This procedure of transforming was repeated for each of the fifty strategy items used in the Ways of Coping Checklist. Further, after a review of the literature on negative social support, additional items were generated that covered strategies reflecting negative feelings, downward comparison, upward comparison, philosophical perspective, and encouraging recovery. One other category, identification of feelings, was originally included and then deleted after subjects indicated difficulty in responding to the effectiveness rating for each item. The difficulty was probably not a response to the strategy itself but more likely a response to poorly written items. Identification of feelings appears to be an important concept in the literature on negative social support and may be a difficult one to capture with traditional psychometric methods.

Each strategy required a "Yes" or "No" response to indicate whether or not it had been used. A nine-point Likert scale was used to rate the effectiveness of each strategy. Subjects were asked to also evaluate how effective they felt a strategy might have been had it been used when they indicated that they had not used it. The order of questions was determined from random number tables.

The items which contributed to the highest item-total

score reliabilities for each scale, using the original 23 pilot subjects, were retained for the final measures. The measures resulting from the pilot data indicated an alpha of .69. Alphas for the individual scales were: .65 for confrontive coping; .70 for distancing; .48 for self-controlling; .37 for accepting responsibility; .62 for escape-avoidance; .50 for planful problem-solving; .48 for positive reappraisal; .83 for social support; .30 for encouraging recovery; .69 for philosophical perspective; .58 for downward comparison; .67 for negative feelings; and .30 for upward comparison.

The items administered to the final 116 respondents which again resulted in the highest alpha levels for each scale were retained, eliminating those items which did not contribute to the reliability of the scales using the 116 respondents. Thus, the final items which comprised each scale and tested the hypotheses were filtered twice - first on the basis of pilot data and then on the basis of the final sample alphas.

The Ways I Help Others to Cope Checklist

This measure is a 69 item checklist and was also developed from the original sample of 23 subjects (see Appendix F). The checklist was revised from an original 117 item checklist by the same method used with the Ways Others Help Me Cope Checklist. It is concerned with the assessment of the selection and effectiveness of coping strategies that

are delivered to others. This scale was developed by transforming the Ways of Coping Checklist (Folkman & Lazarus, 1986) measures into items that measure the selection and effectiveness of coping strategies that are delivered to others(see Appendix G). Those transformations included both direct and indirect measures of each strategy. For example, "I acted as if nothing had happened", an escape-avoidance strategy from the Ways of Coping Checklist (Folkman & Lazarus, 1986), was transformed into, "I treated him/her as if nothing had happened" (direct) and "I encouraged him/her to act as if nothing had happened" (indirect). The same procedures for refining the Ways Others Help Me Cope Checklist were used for refining the Ways I Help Others to Cope scales.

The same procedure was used to select items for the Ways I Help Others to Cope Checklist as for the Ways Others Help Me Cope Checklist. The pilot data items chosen to be included in the measure administered to the final sample had indicated an alpha of .73. Alphas for the individual scales were: .55 for confrontive coping; .95 for distancing; .48 for self-controlling; .39 for accepting responsibility; .85 for escape-avoidance; .51 for planful problem-solving; .79 for positive reappraisal; .80 for social support; .86 for encouraging recovery; .76 for philosophical perspective; .61 for downward comparison; .73 for negative feelings; and .31 for upward comparison.

Painfulness/Significance Measures

A measure was included to assess the degree of painfulness and the significance of the event selected by the subject for himself/herself and also the event he/she selected for the person he/she helped. This control variable was scored on a five-point Likert scale ranging from a low score of "Not at all" to a high score of "Extremely" (see Appendix H).

Consent Form

Each subject also received a separate consent form for the experiment with a brief description of the experiment and the subject's right to withdraw participation at any time (see Appendix I).

Procedure

The questionnaires were administered during the second week of the Spring Quarter, 1987, at CSUSB. The experimenter introduced herself and stated the purpose of the experiment. Each subject was then given a questionnaire and general instructions (see Appendix J).

Subjects were told that the questionnaires could be done at home or elsewhere and although they had one week to return them, the questionnaires should be completed at one sitting. They were also requested to read the consent form first and sign it if they agreed to participate.

Once subjects had completed and returned the questionnaires the experimenter invited and answered all

questions the subjects had regarding any aspects of the experiment and let subjects know how they could receive the results of the experiment. Subjects were thanked for their participation and cooperation and given extra credit slips.

RESULTS

Checklist Scale Means and Reliabilities

The Ways of Coping Checklist

The checklist mean was 4.37. The range was 1.72 to 6.61. The average correlation for each item was .35 with a range of .05 to .60 . The average scale alpha was .60. Scale means, standard errors, standard deviations, alphas, and number of items are presented in Table 1.

The Ways Others Help Me Cope Checklist

The checklist mean was 4.0. The range was 1.72 to 7.10. The average correlation for each item was .41 with a range of .13 to .73. The average scale alpha was .70. Scale means, standard errors, standard deviations, alphas, and number of items are presented in Table 1.

The Ways I Help Others to Cope Checklist

The checklist mean was 3.84. The range was 1.29 to 7.16. The average correlation for each item was .46 with a range of .10 to .75. The average scale alpha was .73. Scale means, standard errors, standard deviations, alphas, and number of items are found in Table 1.

Table 1

<u>Descriptive Statistics</u>

Checklist Scale	mean	std err	SD	alpha	# of items
Ways of Coping Checklist:					
Confrontive coping	4.13	.108	1.165	.45	6
Distancing	3.03	.144	1.552	.72	5
Self-controlling	4.44	.106	1.140	.56	6
Social support	5.46	.106	1.141	.59	6
Accepting responsibility	3.93	.130	1.403	.45	4
Planful problem-solving	5.33	.102	1.099	.72	7
Positive reappraisal	5.61	.102	1.100	.64	8
Escape-avoidance	2.67	.114	1.230	.66	8
Ways Others Help Me Checklist:					
Confrontive coping	4.89	.110	1.190	.55	4
Distancing	2.47	.149	1.606	.81	5
Self-controlling	3.38	.140	1.512	.69	4
Social support	6.31	.094	1.008	.83	10
Accepting responsibility	3.80	.112	1.209	.58	7
Planful problem-solving	4.97	.104	1.125	.67	7
Positive reappraisal	5.05	.110	1.190	.72	8
Escape-avoidance	2.73	.132	1.425	.82	8
Negative feelings	1.94	.141	1.516	.80	4
Downward comparison	3.53	.151	1.625	.63	3
Upward comparison	4.40	.160	1.723	.32	2
Philosophical perspective	4.43	.131	1.415	.57	4
Encouraging recovery	4.72	.157	1.690	.73	3
Ways I Help Others Cope Checklist:					
Confrontive coping	5.07	.108	1.168	.51	4
Distancing	2.05	.155	1.670	.84	5
Self-controlling	3.10	.151	1.623	.76	4
Social support	6.30	.083	.890	.80	10
Accepting responsibility	3.59	.116	1.253	.66	7
Planful problem-solving	5.05	.108	1.160	.62	5
Positive reappraisal	5.10	.108	1.164	.77	8
Escape-avoidance	2.53	.162	1.749	.89	8
Negative feelings	2.00	.141	1.517	.82	5
Downward comparison	3.24	.165	1.773	.72	3
Upward comparison	4.26	.169	1.816	.39	2
Philosophical perspective	4.19	.137	1.476	.67	4
Encouraging recovery	4.67	.142	1.527	.73	3

A correlational analysis of the items of the 8 Ways of Coping Checklist effectiveness scales yielded an average total-interitem correlation for each item of .21 with a range of -.15 to .55.

The intercorrelations of the coping scales are found in Table 2. The average correlations were: r=.27 for confrontive coping; r =.28 for distancing; r =.31 for self-controlling; r =.19 for accepting responsibility; r =.11 for positive reappraisal; r =.26 for planful problem-solving; r =.20 for social support; and r =.26 for escape-avoidance.

Table 2

Interscale Correlations of the Self-Coping Effectiveness Scales

Scale	CC	D	SC	AR	PR	PPS	SS	EA
CC	–	.26*	.28*	.33*	.15*	.26*	.23*	.41*
D	.26*	–	.54*	.35*	.11	.18*	-.03	.51*
SC	.28*	.54*	–	.17*	.15*	.41*	.17*	.45*
AR	.33*	.35*	.17*	–	.10	.03	.03	.40*
PR	.15	.11	.15*	.10	–	.45*	.53*	-.04
PPS	.26*	.18*	.41*	.03	.45*	–	.46*	.05
SS	.23*	-.03	.17*	.03	.53*	.46*	–	.05
EA	.41*	.51*	.45*	.40*	-.04	.05	.05	–

Note. CC = confrontive coping. D = distancing. SC = self-controlling. AR = accepting responsibility. PR = positive reappraisal. PPS = planful problem-solving. SS= social support. EA = escape-avoidance.

* = $p < .05$.

While these results are modest enough to suggest a separateness between coping scales, the overall positive correlations do reflect some relationship. In particular, the relationships between escape-avoidance, confrontive coping, distancing, self-controlling and accepting responsibility, while moderate, were positive at significant levels. This was also the case for positive reappraisal, planful problem-solving, and social support.

A factor analysis of the 8 scales of the Ways of Coping Checklist using principal axes showed factor 1 (34.8% of the variability and factor 2 (22.8% of the variability) accounting for 57.5% of the variance. Confrontive coping (.47), distancing (.71), self-controlling (.60), accepting responsibility (.49), and escape-avoidance (.78) loaded together on factor 1 whereas positive reappraisal (.68), planful problem-solving (.69) and social support (.73) loaded together on factor 2.

A principal axes factor analysis of the twelve scales of the Ways Others Help Me Cope Checklist showed factor 1 (33.9% of the variability), factor 2 (21.1% of the variability, and factor 3 (8.6% of the variability) accounting for 70.6% of the variance. Loading together on factor 1 were: distancing (.70); self-controlling (.63); accepting responsibility (.72), escape-avoidance (.71), negative feelings (.61), downward comparison (.69), encouraging recovery (.41), upward comparison (.47), and

philosophical perspective (.45). Loading together on factor 2 were: positive reappraisal (.61), planful problem-solving (.51), and social support (.73). Confrontive coping (.50) loaded on factor 3.

A principal axes factor analysis of the twelve scales of the Ways I help Others Checklist showed factor 1 (42.3% of the variability, factor 2 (18.8% of the variability), and factor 3 (8.8% of the variability) accounting for 69.9% of the variance. Loading together on factor 1 were: distancing (.89), self-controlling (.79), accepting responsibility (.66), escape-avoidance (.85), negative feelings (.74), downward comparison (.64), and encouraging recovery (.43). On factor 2, confrontive coping (.69), planful problem-solving (.82), and social support (.77) loaded together. Upward comparison (.52) and philosophical perspective (.81) loaded together on factor 3.

The literature on negative social support indicates that certain coping strategies tend to be associated, although not necessarily positive or negative (Folkman & Lazarus, 1987). For example, in a recent study by Folkman and Lazarus (1987), the relationship between coping and emotions were explored. It was found that with older subjects, planful problem-solving, positive reappraisal, and social support were useful strategies for increasing positive emotions and decreasing stress. Confrontive coping and distancing were associated with a decrease in positive

emotions and an increase in stress.

Hypotheses Testing

Four sets of relationships tested the four hypotheses: 1) the relationships between the use of self-coping scales and the use of coping scales delivered to others; 2) the relationships between the effectiveness of self-coping scales and the use of coping scales delivered to others; 3) the relationships between the effectiveness of self-coping scales and the effectiveness of coping scales received from others; 4) and the relationships between the effectiveness of self-coping scales and the effectiveness of coping scales delivered to others. Additional relationships between measures were examined. These included: the relationships between the use and effectiveness of self-coping strategies; the relationships between the degree of painfulness and/or significance of loss and the use and effectiveness of coping strategies; and the relationships between checklists.

The Relationships Between the Use of Self-Coping Strategies and the Use of Coping Strategies Delivered to Others

Hypothesis 1 was tested with a correlational analysis of the relationships between the use of self coping scales and the use of coping scales delivered to others to determine if people deliver those scales they use to cope themselves to others more than the scales they do not use themselves. correlations of the relationships between the use of self-

coping scales and the use of scales delivered to others ranged from .01 to .45 with a mean of .21. Individual scale correlations are listed in Table 3. Hypothesis 1 was partially supported. The strongest relationships between the use of self-coping scales and the use of scales delivered to others were escape-avoidance and distancing followed by planful problem-solving, social support, and positive reappraisal. No relationships were found between the self-use of coping strategies and the use of strategies delivered to others for confrontive coping, self-controlling, and accepting responsibility.

It should be noted that the correlations may be attentuated with the selection ratings because the sum of the use categories were dichotomously scored. Thus, there may have been a restriction of the range with this variable.

The Relationships Between Effectiveness of Self-Coping Strategies and the Use of Strategies Delivered to Others

Hypothesis 2 was tested with a correlational analysis of the relationships between the effectiveness of self-coping scales and the use of scales delivered to others to determine if the coping scales that people view as effective are delivered more to others than the self-coping scales people do not view as effective. The correlations ranged from .07 to .44 with a mean of .21 (see Table 3). Hypothesis 2 was partially supported. The strongest relationship between effectiveness of self-coping scales and the use of

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scales delivered to others was found for self-controlling
followed by escape-avoidance, distancing, planful problem-
solving, and positive reappraisal. No relationships between
the effectiveness of self-coping scales and the use of
scales delivered to others were found for confrontive
coping, accepting responsibility, and social support. The
average intercorrelations of the effectiveness of five self-
coping scales for helping others were the same as for the
effectiveness of self-coping scales and the use of strategies
delivered to others with means of .21.

The Relationships Between the Effectiveness of
Self-Coping Strategies and the Effectiveness of Coping
Strategies Received from Others

Hypothesis 3 was tested by a correlational analysis of
the relationships between the effectiveness of self-coping
strategies and the effectiveness of coping strategies
received from others to determine if the self-coping
strategies people view as effective are those strategies
viewed as more effective when received from others than the
self-coping strategies people viewed as less effective. The
correlations ranged from .14 to .59 with a mean of .42 (see
Table 3). Hypothesis 3, with a predicted inverse
relationship, was not supported. In fact, these
correlations were higher in a positive direction than the
correlations tested for Hypothesis 1 or Hypothesis 2. The
highest correlation was for escape-avoidance, followed by

accepting responsibility, positive reappraisal, social support, planful problem-solving, accepting responsibility, self-controlling, and confrontive coping. No significant relationship was found for distancing.

The Relationships Between the Effectiveness of Self-Coping Strategies and the Effectiveness of Coping Strategies Delivered to Others

Hypothesis 4 was tested with a correlational analysis of the relationships between the effectiveness of self-coping strategies and the effectiveness of strategies delivered to others to determine if the self-coping strategies that people rate as effective are viewed as more effective when delivered to others than the self-coping strategies that are not rated as effective. The correlations ranged from .19 to .66 with a mean of .40 (see Table 3). Hypothesis 4 was generally supported with all correlations significant at positive levels. The strongest relationships were found for distancing and escape-avoidance, followed by self-controlling, positive reappraisal, social support, planful problem-solving, accepting responsibility, and confrontive coping.

The Relationships Between the Use and Effectiveness of Self-Coping Strategies

The relationships between the use and effectiveness of self coping strategies was tested to determine if people rate those strategies they use to cope as more effective

than those strategies they do not use. A correlational
analysis of the relationships between the use and
effectiveness of self coping strategies from the eight
scales ranged from .18 to .63 with a mean of .37 (see Table
3). The relationships between the use and effectiveness of
self-coping strategies, were all significant. The strongest
relationship between use and effectiveness was found for
positive reappraisal, followed by confrontive coping,
distancing, self-controlling, accepting responsibility,
social support, planful problem-solving, and escape-
avoidance.

Table 3

Correlations of Use and Effectiveness Scales

Scales	UC-EC	UC-UI	EC-UI	UC-E	EC-IH	EO-EI
Confrontive coping	.23**	.08	.11	.26**	.19**	.30***
Distancing	.42***	.45***	.25**	.14	.59***	.59***
Self-controlling	.25**	.04	.44***	.32***	.42***	.57***
Accepting responsibility	.40***	.01	.07	.41***	.30***	.65***
Positive reappraisal	.63***	.20*	.17*	.59***	.37***	.52***
Social support	.42***	.18*	.12	.56***	.31***	.50***
Planful problem-solving	.45***	.44***	.22**	.44***	.35***	.46***
Escape-avoidance	.18**	.28***	.27**	.62***	.66***	.74***

Note. EC = Ways of Coping Checklist effectiveness ratings. UC = Ways of Coping Checklist use ratings. EO = Ways Others Help Me Checklist effectiveness ratings. UO = Ways Others Help Me to Cope Checklist use ratings. EI = Ways I Help Others to Cope Checklist effectiveness ratings. UI = Ways I Help Others to Cope use rating.

* =p<.05. ** =p<.01. *** =p<.001.

Relationships Between Checklists

A correlational analysis was done by scale on the effectiveness measure across the three checklists to determine if significant differences between the sets of correlations would be found (see Table 4). A difference score was obtained between the three correlations by variable 1 being correlated with variable 2 and then variable 1 is correlated with variable 3. These data are thus correlated because variable 1 occurs in both rs. The resulting z is significant at either 1.96 ($p<.05$) or 2.58($p<.01$). (Downie & Starry, 1977, p. 201).

Scores were only obtained between the Ways Others Help Me Cope Checklists and the Ways I Help Others Cope Checklists for encourage recovery, negative feelings, downward comparison, upward comparison, and philosophical perspective. These items were not added to the Ways of Coping Checklist before testing.

The z scores for the scales were:$z=.72$ for confrontive coping;$z=.63$ for distancing;$z=.17$ for self-controlling;$z=2.32$ for accepting responsibility;$z=4.61$ for positive reappraisal;$z=1.31$ for planful problem-solving;$z=4.52$ for social support; and$z=.3.79$ for escape-avoidance. Significant differences in correlations were found on the positive reappraisal, social support, accepting responsibility, and escape-avoidance measures.

Table 4

Correlational Analysis of Scale Effectiveness
Between Checklists

Scale	C – O	C – I	O – I
Confrontive coping	.26**	.19*	.30***
Distancing	.61***	.59***	.59***
Self-controlling	.32***	.42***	.57***
Accepting responsibility	.41***	.30***	.66***
Positive reappraisal	.59***	.37***	.52***
Planful problem-solving	.44***	.35***	.46***
Social support	.56***	.31***	.50***
Escape-avoidance	.62***	.66***	.74***
Encourage recovery			.59***
Negative feelings			.53***
Downward comparison			.49***
Upward comparison			.56***
Philosophical perspective			.65***

Note. C = Ways of Coping Checklist. O = Ways Others Help Me
to Cope Checklist. I = Ways I Help Others to Cope Checklist.
* = $p < .05$. ** = $p < .01$. *** = $p < .001$.

When the correlations were compared two at a time within sets using the formula for testing the difference between two Fisher's zs (Downie & Starry, 1977, p. 200), there was no significant differences ($z>1.96$) for confrontive coping, distancing, self-controlling, or planful problem-solving, indicating that they address a similar level of effectiveness across the three checklists. With accepting responsibility, there was a significant difference found between the effectiveness of strategies received from others/strategies delivered to others and the effectiveness of self-coping strategies/strategies delivered to others of $z>2.06$. This was obtained by using the z formula for testing the significance of the difference between two Pearson$\underline{r}$s. When the correlations were compared two at a time within sets, no significant differences were found for positive reappraisal, social support, and escape-avoidance.

A further correlational analysis was done to determine if the correlations between the same scales on different checklists was higher than the correlations of different scales. This assesses the specificity of the relationship for the same scales beyond a response style bias or a tendency to use all strategies or see all strategies as effective (see Appendix K). For example, confrontive coping had an $\underline{r}$ of .26 between the Ways of Coping and the Ways Others Help Me Cope Checklists. Confrontive coping from the Ways of Coping Checklist was then compared to an average of

all the other Ways Others Help Me Cope Checklist scale $\underline{r}$s

excluding the confrontive coping scale. The correlations

with the same scale items across the three checklists were

positive and stronger than the correlations of the Ways of

Coping scale items with the averages of the other scales

from the two other checklists minus the related item. The

stronger relationships between the same scale items across

checklists than with different scales or relationships

suggests that correlations were not accountable for the

response bias overall but due to sets of the same scales.

A correlational analysis of selection was done by scale

between across the three checklists (see Table 5). The z

scores, found by the same method previously described for

looking at the differences between three variables, for the

scales were: $\underline{z}$=3.56 for confrontive coping; $\underline{z}$=2.46 for

distancing; $\underline{z}$=-.16 for self-controlling; $\underline{z}$=1.29 for

accepting responsibility; $\underline{z}$=5.71 for social support; $\underline{z}$

=2.05 for positive reappraisal; $\underline{z}$=.15 for planful

problem-solving; $\underline{z}$=1.27 for escape-avoidance. Thus,

significant differences for use scales correlations were

found on confrontive coping, distancing, social support, and

positive reappraisal scales.

As with the effectiveness measures, use scores were

only obtained between the Ways of Coping Checklist and the

Ways I Help Others to Cope Checklist for encourage recovery,

negative feelings, downward comparison, upward comparison, and philosophical perspective. These items were not added to the Ways of Coping Checklist before testing.

Table 5

Correlational Analysis of Selection Between Checklists

Scale	C - O	C - I	O - I
Confrontive coping	.41***	.08	.24**
Distancing	.24**	.45***	.28***
Self-controlling	-.02	.04	.09
Accepting responsibility	.15	.01	.31***
Social support	.57***	.18*	.33***
Positive reappraisal	.39***	.20**	.28***
Planful problem-solving	.45***	.44***	.30***
Escape-avoidance	.38***	.28***	.44***
Negative feelings			.38***
Encouraging recovery			.47***
Downward comparison			.34***
Upward comparison			.39***
Philosophical perspective			.35***

Note. C = Ways of Coping Checklist. O = Ways Others Help Me
to Cope Checklist. I = Ways I Help Others to Cope Checklist.
* = p<.05. ** = p<.01. *** = p<.001.

When the correlations were compared two at a time within sets using the formula for testing the difference between two Fisher's zs (Downie & Starry, 1977, p. 200), there were no significant differences for self-controlling, accepting responsibility, planful problem-solving, and escape-avoidance, indicating that they address a similar level of use across the three checklists. With confrontive coping (z) =3.06) and social support (z=2.20) the relationship between the use of self-coping strategies/strategies received from others was stronger than the relationship between the use of self-coping strategies/ strategies delivered to others.

The Relationships Between the Degree of Painfulness and/or Significance of Loss and the Coping Strategies

The degrees of painfulness to others and to self and the significance of the the loss to others and self were correlated with all of the scales across the three checklists to determine if the degree of painfulness and/or significance of the loss had a significant relationship with the use and effectiveness of coping strategies. The means for the measures were: 4.20 for painfulness to self; 4.03 for significance to self; 4.39 for painfulness for others; and 4.17 for significance to others. All four measures had a range of 1 to 5. The painfulness and significance of the events for self or others was not related to ratings of strategies received from or delivered to others.

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Additionally, significance to self was not related to self-coping strategies. The painfulness, however, of the loss to oneself was significantly related to the selection of self-coping strategies for six of the eight strategies. The relationship between the painfulness and the use of self-coping strategies was negative for social support, self-controlling, and distancing, and positive for confrontive coping and escape-avoidance. No relationship was found between the painfulness and the use of self-coping strategies for positive reappraisal and planful problem-solving. The correlations between degree of painfulness to self and the self-coping strategies are; r=.41 for confrontive coping; r=.36 for distancing; r=-.17 for self-controlling; r=-.36 for social support; r=.24 for accepting responsibility; and r=.43 for escape-avoidance.

DISCUSSION

The present findings are among the first to document the relationships between coping and support efforts. Further, it looks at the relationships between the use and effectiveness of coping strategies. These relationships are: the coping strategies that a person uses with himself/herself and the strategies that a person uses to help others; the coping strategies that are viewed as effective for self and the strategies that are used with others; the coping strategies that are viewed as effective for self and the strategies that are viewed as effective when received from others; and the coping strategies that are viewed as effective for self and the strategies that are viewed positively by him/her when delivered to others. Previous research has tended to focus on either the selection of self-coping strategies and the situations in which strategies are used or the effectiveness and resulting outcomes. This research extends previous research by focusing on the relationship between use and effectiveness.

As anticipated, some (five of the eight) coping strategies that a person used for himself/herself were the strategies that he/she delivered to others. These included: distancing; planful problem-solving; escape-avoidance; positive reappraisal; and social support. As indicated by

Thoits (1983) it does appear that people tend to give others the same types of strategies that they use for themselves and are familiar with. Examples of this pattern are reflected in the development of self-help groups such as AA and other attributional models described by Brickman et al, (1982). A person joining these types of groups is affected both in terms of what strategies to use for himself/herself that will be acceptable to the group and also what strategies to give to others. As pointed out by Brickman et al (1982), a person may select a group to belong to because he/she recognizes that the underlying philosophy advocates the strategies that person is familiar with. With many of the models, as with this study, the stressor or stressors present are similar. With similar personal experiences, people may simply have an increased knowledge about the strategies they use and feel less anxious about delivering them to others. As indicated by Lehman, Ellard, and Wortman (1986), when people do not have similar life experiences, there appears to be an increased anxiety about delivering help to another.

What was surprising, however, is that some of the more negatively viewed strategies from the negative support literature, such as distancing and escape-avoidance (Folkman, Lazarus, Dunkel-Schetter, DeLongis, & Gruen, 1986), were as highly correlated between the coping strategies a person uses with himself/herself and the coping

strategies he/she uses with others as the more positively

viewed strategies of planful problem-solving and positive

reappraisal. This may imply, as demonstrated by the past

research of Folkman, Lazarus, Gruen, and DeLongis (1986),

that with this particular stressor - the loss of a

relationship (other than through death) - the threat to

self-esteem is high. With an increased threat to self-

esteem, people may project their own needs onto those of

others. They found that when self-esteem was threatened,

people tended to use more escape-avoidance, self-

controlling, confrontive coping, and accepting of

responsibility. These strategies are all viewed as negative

types of coping in the literature and, in fact, they all

tended to load together in the factor analysis that was done

for this study. As previously reported, it was found that

distancing was used more when situations were difficult to

change (Folkman, Lazarus, Gruen, and DeLongis, 1986).

There was also some support in this study for the

hypothesized relationship between the coping strategies a

person views as effective for himself/herself and the

strategies that person then delivers to others.

Relationships between the strategies a person views as

effective for self and the strategies he/she used to deliver

to others were found for self-controlling, distancing,

escape-avoidance, positive reappraisal and planful

problem-solving. Again, the particular stressor in this

study may contribute to a loss of self-esteem and the helper who has suffered the same loss may generalize to the needs of the recipients. The use of strategies to deliver to others, therefore, may not just be based on familiarity with a particular strategy, but also a belief that a strategy may help to alleviate distress and/or regulate emotions - the desired effect for coping strategies (Folkman and Lazarus, 1980,1985).

The relationships between the effectiveness of self-coping strategies and the strategies selected to deliver to others may be the most significant in understanding the issues behind negative support efforts. While the people in this study had a similar stressor in common with those they were to be delivering help to, this is often not the case in everyday life. Without similar life experiences, helpers may not know what self-strategies are effective and thereby use strategies that are ineffective, negatively viewed, or offer no assistance at all.

The expected paradoxical result that the coping strategies a person views as effective with himself/herself are the strategies he/she will view negatively when received from others was not supported. Significant unanticipated positive correlations between the coping strategies that a person views as effective with himself/herself and the strategies he/she views positively when received from others were found for all strategies with

the exception of distancing. Past research efforts, however, indicate that effective self-coping strategies may not be effective when received by others. Positive reappraisal, for example, while often viewed positively as a self-coping strategy (Sarason, Sarason, and Shearin, 1986) may be viewed negatively as found by Dunkel-Schetter and Wortman (1982) in their study with cancer patients. Positive reappraisal statements such as "things could be worse" were negatively viewed when delivered by another. That was not the case in this study.

These results may, in part, have been due to item wording. While "things could have been worse" was viewed negatively, an item such as "Someone encouraged me to believe I came out of the situation better than I went in" may be viewed quite differently although both represent positive reappraisal strategies. Also, the severity and timing of the particular encounter may have affected the results. In the Dunkel-Schetter and Wortman (1982) study, cancer patients had faced a life-threatening event whereas the people in this study had not. Also, the participants in this study could select the event they wished to address, thereby having control over the severity of the issue they dealt with. In fact, no participants selected an event occurring within the past year. It possibly may be that the effectiveness of those strategies which should show a negative relationship with the effectiveness of ones

received from others are those strategies that are most aversive during the initial phase of a crisis.

A positive relationship was found between the effectiveness of the coping strategies that a person uses and the strategies that were positively viewed by him/her when delivered to others was found. This was true for all strategies. What was surprising again was that the strategies that loaded together that are viewed in the literature as the more negative strategies had stronger relationships than the strategies positively viewed. Escape-avoidance, distancing, and self-controlling were seen as the strategies most strongly relating to this relationship between the coping strategies that a person views as effective for self and the strategies seen as effective when delivered to others. Social support, on the other hand had a lower significant correlation. Some strategies used in helping others may be universally considered effective, such as social support. Hence, individual differences in idiosyncratic self-coping effectiveness ratings would be expected to result in higher correlations for the more negatively viewed strategies. The stronger correlations for the more negatively viewed strategies may reflect larger individual differences on perceived effectiveness of negative strategies.

There were several additional findings in this study that were unexpected and surprising. First, when considering

the relationship between the degree of painfulness a person experienced and his/her use of self-strategies, social support was negatively related to use. The more painful the loss, the less likely a person was to seek social support. There may be several reasons for this. Sarason, Levine, Bashan, and Sarason (1983) indicated that social support is related to perceived positive outcomes. Given the assigned stressor to this study, the outcomes were not perceived to be positive as the outcomes were already known and resulted in a loss. Further, seeking social support negatively relates to increased threats to self-esteem (Folkman, Levine, Gruen, and DeLongis, 1986). The loss of a relationship may well reflect such an increased threat to self-esteem. Finally, Wortman and Lehman (1985) have demonstrated that when people need support the most, they are the least likely to receive it. The more suffering experienced by a person, the more anxiety, confusion, and discomfort are experienced by a helper. Ruback et al. (1986) also found that those needing assistance for serious or painful experiences may be unlikely to receive it. The stressor may be "labeled" and the person then stigmatized for experiencing that particular event. Given the mean age of the participants in the study - 27.9 years - they have probably experienced a number of crises personally or have been around others who have. It is reasonable to assume that from these experiences they may have already learned that

when people need support the most, they are the least likely to receive it. Therefore, the lowered score for seeking social support may, in fact, represent a self-coping strategy to avoid displaying behavior - seeking social support - that may be rejected, further lowering self-esteem (Pennebaker, 1986).

As one might suspect, the relationships between effectiveness and effectiveness across checklists had the strongest positive relationship with all strategies. These relationships include: effectiveness of self-coping strategies; the effectiveness of strategies received from others; and the effectiveness of strategies delivered to others and all combinations tested between these three situations. What people think is effective for themselves is what they think is effective for others. What they see as effective in coping themselves is also seen as effective when delivered to others and what they see as effective in giving to others is also seen as effective when receiving from others. This finding is related to the research of Lehman, Ellard, and Wortman (1986) who found that people seemed to be very knowledgeable about the strategies that are considered helpful by actual victims. Clearly, people do not differentiate between their own coping and others' coping strategies and what they want from others. One reason for that may be that individual differences show projection of a person's own strategies. Another reason may be the effect of

a nine-point effectiveness rating scale versus the two-point
use scale. The negative strategies added to the Ways Others
Help Me to Cope Checklist and the Ways I Help Others to Cope
Checklist show the same relationships. People who see
negative strategies as more effective when delivering to
others also have high effectiveness ratings for these
strategies delivered to themselves. Encouraging recovery,
negative feelings, downward comparison, upward comparison,
and philosophical perspective were all significantly
positively related to their counterparts in these two
checklists.

While these results indicate some clear trends and
tendencies, they must be viewed with caution. The
measurements tools, while statistically reliable, need
further testing. The reliabilities of some of the scales
fell below the optimal score of .70 (Nunnally, 1978). From
the Ways of Coping Checklist, those scales included:
confrontive coping; self-controlling; social support; and
accepting responsibility. From the Ways Others Help Me to
Cope, those scales included: confrontive coping; upward
comparison; and philosophical perspective. From the Ways I
Help Others to Cope, those scales included: confrontive
coping and upward comparison. The five scales added to the
Ways Others Help Me to Cope Checklist and the Ways I Help
Others to Cope Checklist need to be transformed and added to
the Ways of Coping Checklist. These include: encouraging

recovery, negative feelings, upward comparison, downward comparison, and philosophical perspective. Larger samples are also needed. The rating scales should also be addressed in future studies. As indicated before, the correlations may have be attentuated with the use ratings because there were only two possible choices.

A question arose, too, about the selection of a universal stressor that was not time-limited. Recency may have an effect on both the use of particular strategies and the effectiveness ratings of certain strategies. The differences in the time periods between the events recalled and the present may have affected the ratings of the degree of painfulness and/or the significance of the event. Further research is needed to address these methodological issues.

Many unanswered questions need more research efforts as well. Why were the results of negative feelings so positive and significant? On what do people base selection of strategies if not on effectiveness? Did other variables not addressed here play a significant role in the outcomes? For example, data was collected and significant sex differences were found in certain areas. However, this was a small sample and was not the focus of the study. Further,it seems important to explore the relationships between the use and effectiveness of coping strategies and the existing organized models for the giving of coping assistance and the role those play in terms of outcomes. If coping does play

the significant role in the relationship between stressful events and the resulting outcomes (Folkman, Lazarus, Dunkel-Schetter, DeLongis, & Gruen, 1986), answers to these questions relating to the relationships between coping and support efforts may have the potential for improving the quality of life.

APPENDIX A

Ways of Coping Checklist

The following questions ask about the loss of a relationship in your life. Please read each item below and indicate, by "Y" or "N", whether or not you used it in the particular situation you have recalled. Then, please indicate, by selecting a number from the scale below, the degree of effectiveness of the item in that situation. If a particular item was not used, we would like you to evaluate how effective you feel it would have been had it been used.

Effectiveness Scale
0 = Very unhelpful	5 = Slightly helpful
1 = Quite unhelpful	6 = Somewhat helpful
2 = Somewhat unhelpful	7 = Quite helpful
3 = Slightly unhelpful	8 = Very helpful
4 = No effect	

Y/N   E

_____ ___   1. I just concentrated on what I had to do next
              - the next step.
_____ ___   2. I did something I didn't think would work,
              but at least I was doing something.
_____ ___   3. Tried to get the person responsible to
              change his or her mind.
_____ ___   4. Talked with someone to find out more about
              the situation.
_____ ___   5. Criticized or lectured myself.
_____ ___   6. Tried not to burn my bridges, but to leave
              things somewhat open.
_____ ___   7. Hoped a miracle would happen.
_____ ___   8. Went along with fate; sometimes I just have
              bad luck.
_____ ___   9. Went on as if nothing had happened.
_____ ___ 10. I tried to keep my feelings to myself.
_____ ___ 11. Looked for the silver lining, so to speak;
              tried to look on the bright side of things.

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_____ ___ 12. Slept more than usual.
_____ ___ 13. I expressed anger to the person(s) who caused the problem.
_____ ___ 14. Accepted sympathy and understanding from someone.
_____ ___ 15. I was inspired to do something creative.
_____ ___ 16. Tried to forget the whole thing.
_____ ___ 17. I got professional help.
_____ ___ 18. Changed or grew as a person in a good way.
_____ ___ 19. I apologized or did something to make up.
_____ ___ 20. I made a plan of action and followed it.
_____ ___ 21. I let my feelings out somehow.
_____ ___ 22. Realized I brought the problem on myself.
_____ ___ 23. I came out of the experience better than when I went in.
_____ ___ 24. Talked to someone who could do something concrete about the problem.
_____ ___ 25. Tried to make myself feel better by eating, drinking, smoking, using drugs or medication, etc.
_____ ___ 26. Took a big chance or did something very risky.
_____ ___ 27. I tried not to act too hastily or follow my first hunch.
_____ ___ 28. Found new faith.
_____ ___ 29. Rediscovered what is important in life.
_____ ___ 30. Changed something so things would turn out all right.
_____ ___ 31. Avoided being with people in general.
_____ ___ 32. Didn't let it get to me; refused to think about it too much.
_____ ___ 33. I asked a friend or relative I respected for advice.
_____ ___ 34. Kept others from knowing how bad things were.
_____ ___ 35. Made light of the situation; refused to get too serious about it.
_____ ___ 36. Talked to someone about how I was feeling.
_____ ___ 37. Stood my ground and fought for what I wanted.
_____ ___ 38. Took it out on other people.
_____ ___ 39. Drew on my past experiences; I was in a similar position before.
_____ ___ 40. I knew what had to be done, so I doubled my efforts to make things work.
_____ ___ 41. Refused to believe that it had happened.
_____ ___ 42. I made a promise to myself that things would be different next time.
_____ ___ 43. Came up with a couple of different solutions to the problem.
_____ ___ 44. I tried to keep my feelings from interfering

         with other things too much.

_____ ___ 45. I changed something about myself.

_____ ___ 46. Wished the situation would go away or somehow be over with.

_____ ___ 47. Had fantasies about how things might turn out.

_____ ___ 48. I prayed.

_____ ___ 49. I went over in my mind what I would say or do.

_____ ___ 50. I thought about how a person I admire would handle the same situation and used that as a model.

APPENDIX B

Ways of Coping Checklist Scale Items

Scale 1: Confrontive coping

Questions 2, 3, 13, 21, and 37

Scale 2: Distancing

Questions 8, 9, 16, 32, and 35

Scale 3: Self-controlling

Questions 6, 10, 27, 34, 44, and 49

Scale 4: Social Support

Questions 4, 14, 17, 24, 33, and 36

Scale 5: Accepting responsibility

Questions 5, 19, 22, and 42

Scale 6: Escape-avoidance

Questions 7, 12, 25, 31, 38, 41, 46, and 47

Scale 7: Planful problem-solving

Questions 1, 20, 30, 39, 40, 43, and 50

Scale 8: Positive reappraisal

Questions 11, 15, 18, 23, 28, 29, 45, and 48

APPENDIX C

Examples - Ways of Coping Checklist Items

Confrontive coping: 13. I expressed anger to the person(s) who caused the problem.

Distancing: 32. Didn't let it get to me; refused to think about it too much.

Self-controlling: 10. I tried to keep my feelings to myself.

Accepting   19. I apologized or did something to
responsibility: make up.

Escape-avoidance: 46 Wished the situation would go away or somehow be over with.

Planful   43. Came up with a couple of
Problem-solving: different solutions to the problem.

Positive reappraisal: 29. Rediscovered what is important in life.

Social support: 14. Accepted sympathy and understanding from someone.

Ways Others Help Me to Cope Checklist

The following questions ask about the loss of a
relationship in your life. Please read each item and
indicate, by "Y" or "N", whether or not others used it with
you in the particular situation you have recalled. Then,
please indicate, by selecting a number from the scale below,
the degree of effectiveness of the item when others used it
with you in that situation. If a particular item was not
used, we would like you to evaluate how effective you feel
it would have been had it been used.

Effectiveness Scale

0 = Very unhelpful   5 = Slightly helpful
1 = Quite unhelpful   6 = Somewhat helpful
2 = Somewhat unhelpful 7 = Quite helpful
3 = Slightly unhelpful 8 = Very helpful
4 = No effect

Y/N   E

_____ ___ 1. Someone encouraged me to look for the silver
             lining, so to speak; tried to get me to look
             on the bright side.
_____ ___ 2. Someone felt responsible to ease my
             difficulties.
_____ ___ 3. Someone encouraged me to find new faith.
_____ ___ 4. Someone mentioned a person who had the same
             problem and handled it well.
_____ ___ 5. Someone encouraged me to avoid being with
             people in general.
_____ ___ 6. Someone was available to help me do
             something concrete about the problem.
_____ ___ 7. I encouraged him/her to wish the situation
             would go away or somehow be over with.
_____ ___ 8. Someone encouraged me to change something so
             things would turn out all right.

_____ ___ 9. Someone encouraged me to rediscover what is important in life.

_____ ___ 10. Someone congratulated me for being brave and cheerful.

_____ ___ 11. Someone tried to get me to look honestly at my situation.

_____ ___ 12. Someone encouraged me to realize that I had brought the problem on myself.

_____ ___ 13. Someone came up with a couple of different solutions.

_____ ___ 14. Someone tried to provide a model for me by mentioning a person I admire and how that person might handle the same situation.

_____ ___ 15. Someone encouraged me to come up with a couple of different solutions to the problem.

_____ ___ 16. Someone felt angry toward me.

_____ ___ 17. Someone told me that he or she could never have taken what I'd been through.

_____ ___ 18. Someone encouraged me to forget the whole thing.

_____ ___ 19. Someone encouraged me to make a promise to myself that next time things would be different.

_____ ___ 20. Someone offered a religious interpretation of the situation.

_____ ___ 21. Someone treated me as if nothing had happened.

_____ ___ 22. Someone encouraged me not to let others know how bad things were.

_____ ___ 23. Someone told me I was fortunate compared to others.

_____ ___ 24. Someone encouraged me to apologize or do something to make up.

_____ ___ 25. Someone encouraged me to take responsibility for what I had done.

_____ ___ 26. Someone made light of the situation; refused to get too serious about it.

_____ ___ 27. Someone told me I was going to be just fine.

_____ ___ 28. Someone let me know that I was important to him or her.

_____ ___ 29. Someone felt disappointed in my ability to cope.

_____ ___ 30. Someone encouraged me to see myself as a person who had changed or grown in a good way.

_____ ___ 31. Someone told me that there is a purpose to everything in life.

_____ ___ 32. Someone told me to cheer up.

_____ ___ 33. Someone encouraged me to control myself and get myself together.

_____ ___ 34. Someone provided sympathy and understanding.
_____ ___ 35. Someone avoided me.
_____ ___ 36. Someone told me there is "good in all bad."
_____ ___ 37. Someone encouraged me to express my anger to the person(s) who caused the problem.
_____ ___ 38. Someone tried to get me to face what really happened.
_____ ___ 39. Someone felt tense when interacting with me.
_____ ___ 40. Someone was available so I could talk and find out more about the situation.
_____ ___ 41. Someone encouraged me to make a plan of action and follow it.
_____ ___ 42. Someone encouraged me to keep my feelings to myself.
_____ ___ 43. Someone encouraged my recovery; did what he or she could to get me to feel better right away.
_____ ___ 44. Someone encouraged me to go on as if nothing had happened.
_____ ___ 45. Someone encouraged me to try and feel better as soon as possible.
_____ ___ 46. Someone listened to me express my feelings.
_____ ___ 47. Someone tried to provide a philosophical perspective to help me.
_____ ___ 48. Someone talked about people who had gone through the same situation but were worse off.
_____ ___ 49. Someone changed the subject whenever I started to talk about the situation (or started to get upset.
_____ ___ 50. Someone told me that he or she loved me and really cared about me.
_____ ___ 51. Someone encouraged me to keep my feelings from interfering with other things too much.
_____ ___ 52. Someone encouraged me to ask a friend or relative I respected for advice.
_____ ___ 53. Someone strongly identified with my feelings.
_____ ___ 54. Someone directly expressed how he or she felt about it.
_____ ___ 55. Someone encouraged me to just concentrate on what I had to do - the next step.
_____ ___ 56. Someone encouraged me to believe that I came out of the situation better than I went in.
_____ ___ 57. Someone acted cheerful around me.
_____ ___ 58. Someone felt it was up to him or her to help me.
_____ ___ 59. Someone was available if I wanted any advice.
_____ ___ 60. Someone tried to minimize what had happened.
_____ ___ 61. Someone encouraged me to find out what had

to be done so that I could double my efforts
to make things work.

_____ ___ 62. Someone encouraged me to talk to someone
about how I was feeling.
_____ ___ 63. Someone accepted responsibility to do
something about my situation.
_____ ___ 64. Someone acted as if nothing had happened.
_____ ___ 65. Someone talked about other things.
_____ ___ 66. Someone acted as if he/she hoped a miracle
would happen.
_____ ___ 67. Someone encouraged me to wish the situation
to go away or somehow be over with.
_____ ___ 68. Someone tried to make me forget about it.

APPENDIX E

Ways Others Help Me to Cope Checklist Item Numbers

Scale 1: Confrontive coping

Questions 11, 37, 38, and 54

Scale 2: Distancing

Questions 18, 21, 26, 44, and 49

Scale 3: Self-controlling

Questions 22, 33, 42, and 51

Scale 4: Social support

Questions 6, 28, 34, 40, 46, 50, 52, 53, 59, and 62

Scale 5: Accepting responsibility

Questions 2, 12, 19, 24, 25, 58, and 63

Scale 6: Escape-avoidance

Questions 5, 7, 60, 64, 65, 66, 67, and 68

Scale 7: Planful Problem-solving

Questions 8, 13, 14, 15, 41, 55, and 61

Scale 8: Positive reappraisal

Questions 1, 3, 9, 10, 27, 30, 56, and 57

Scale 9: Encouraging recovery

Questions 32, 43, and 45

Scale 10: Negative feelings

Questions 16, 29, 35, and 39

Scale 11: Downward comparison

Questions 17, 23, and 48

Scale 12: Upward comparison

Questions 4 and 14

Scale 13: Philosophical perspective

Questions 20, 31, 36, and 47

Note: Question 14 appears for both planful problem-solving

and upward comparison.

APPENDIX F

How I Help Others Checklist

The following questions ask about the loss of a relationship in the life of someone you know. Please read each item and indicate, by "Y" or "N", whether or not you have used it when helping that person. Then, please indicate, by selecting the number from the scale below, the degree of effectiveness of the item when you used it with that person. If a particular item was not used, we would like you to evaluate how effective you feel it would have been had you used it.

Effectiveness Scale

0 = Very unhelpful		5 = Slightly helpful	
1 = Quite unhelpful		6 = Somewhat unhelpful	
2 = Somewhat unhelpful		7 = Quite helpful	
3 = Slightly unhelpful		8 = Very helpful	
4 = No effect			

Y/N   E

1. I tried to get him or her to look honestly at his/her situation.
2. I felt responsible to ease his or her difficulties.
3. I told him/her to cheer up.
4. I encouraged him or her to make a promise to himself/herself that things would be different the next time.
5. I felt it was up to me to help him/her.
6. I told him/her that there is a purpose to everything in life.
7. I encouraged that person to rediscover what is important in life.
8. I encouraged him/her to forget the whole thing.
9. I treated him/her as if nothing had

happened.

_____ ___ 10. I wasn't afraid to tell him/her what I thought about it.

_____ ___ 11. I came up with a couple of different solutions.

_____ ___ 12. I encouraged that person to control himself/herself and to get himself/herself together.

_____ ___ 13. I strongly identified with his/her feelings.

_____ ___ 14. I was available if he/she wanted any advice.

_____ ___ 15. I told that person that most people could never take what he/she had been through.

_____ ___ 16. I felt tense when interacting with him/her.

_____ ___ 17. I made light of the situation; refused to get too serious about it.

_____ ___ 18. I felt he/she wasn't really trying to get over the situation.

_____ ___ 19. I tried to provide a philosophical perspective to help him/her.

_____ ___ 20. I hoped a miracle would happen.

_____ ___ 21. I was available to help him/her do something concrete about the problem.

_____ ___ 22. I tried to provide a model for him/her by mentioning a person he/she admires and how that person might handle the situation.

_____ ___ 23. I avoided him or her.

_____ ___ 24. I encouraged him/her to wish the situation to go away or somehow be over with.

_____ ___ 25. I offered a religious interpretation to the situation.

_____ ___ 26. I encouraged him/her to go on as if nothing had happened.

_____ ___ 27. I encouraged that person to talk to someone about how he/she was feeling.

_____ ___ 28. I encouraged him/her not to let others know how bad things were.

_____ ___ 29. I mentioned a person who had the same problem and had handled it well.

_____ ___ 30. I encouraged him/her to take responsibility for what he/she had done.

_____ ___ 31. I encouraged that person to believe that he/she had come out of the experience better than when he/she went in.

_____ ___ 32. I talked about people who had gone through the same situation but were worse off.

_____ ___ 33. I felt disappointed in his/her ability to cope.

_____ ___ 34. I told him/her that there is "good in all bad."

_____ ___ 35. I encouraged that person to keep his/her

feelings to himself/herself.

_____ ___ 36. I encouraged him/her to just concentrate on what he/she had to do next - the next step.

_____ ___ 37. I encouraged him/her to look for the silver lining, so to speak; to look on the bright side.

_____ ___ 38. I told him/her that he/she was fortunate compared to others.

_____ ___ 39. I felt angry toward him or her.

_____ ___ 40. I directly expressed how I felt about it.

_____ ___ 41. I let that person know that he/she was important to me.

_____ ___ 42. I told him/her that I loved him/her and cared about him/her.

_____ ___ 43. I acted cheerful around him or her.

_____ ___ 44. I encouraged him/her to apologize or do something to make up.

_____ ___ 45. I changed the subject whenever he/she tried to talk about the situation.

_____ ___ 46. I accepted responsibility to do something about his/her situation.

_____ ___ 47. I encouraged that person to express his/her anger to the person(s) who caused the problem.

_____ ___ 48. I congratulated him/her for being brave and cheerful.

_____ ___ 49. I encouraged him/her to see himself/herself as a person that had changed or grown in a good way.

_____ ___ 50. I tried to get him/her to face what really happened.

_____ ___ 51. I was available so he/she could talk and find out more about the situation.

_____ ___ 52. I encouraged him/her to find out what had to be done so that he/she could double his/her efforts to make things work.

_____ ___ 53. I listened to that person express his/her feelings.

_____ ___ 54. I encouraged him/her to make a plan of action and follow it through.

_____ ___ 55. I encouraged his/her recovery; did what I could to get him/her to feel better right away.

_____ ___ 56. I encouraged him/her to try to feel better as soon as possible.

_____ ___ 57. I provided sympathy and understanding.

_____ ___ 58. I told him/her that he/she was going to be just fine.

_____ ___ 59. I encouraged him/her to realize that he/she had brought the problem on himself/herself.

_____ ___ 60. I encouraged that person to keep his/her

feelings from interfering with other things
too much.

		61.	I encouraged that person to ask a relative or friend that he/she respected for advice.
_____	___	61.	I encouraged that person to ask a relative or friend that he/she respected for advice.
_____	___	62.	I encouraged him/her to change something so that things would turn out all right.
_____	___	63.	I encouraged him/her to find new faith.
_____	___	64.	I acted as if nothing had happened.
_____	___	65.	I talked about other things.
_____	___	66.	I encouraged him/her to avoid being with people in general.
_____	___	67.	I encouraged him/her to get some medications or drugs.
_____	___	68.	I tried to minimize what had happened.
_____	___	69.	I tried to make him/her forget about it.

APPENDIX G

Ways I Help Others to Cope Checklist Item Numbers

Scale 1: Confrontive coping

    Questions 1, 10, 40, 47, and 50

Scale 2: Distancing

    Questions 8, 9, 17, 26, and 45

Scale 3: Self-controlling

    Questions 12, 28, 35, and 60

Scale 4: Social support

    Questions 13, 14, 21, 27, 41, 42, 51, 53, 57, and 61

Scale 5: Accepting responsibility

    Questions 2, 4, 5, 30, 44, 46, and 59

Scale 6: Escape-avoidance

    Questions 20, 22, 24, 64, 65, 66, 67, and 68

Scale 7: Planful Problem-solving

    Questions 11, 36, 52, 54, and 62

Scale 8: Positive reappraisal

    Questions 7, 31, 37, 43, 48, 49, 58, and 63

Scale 9: Encouraging recovery

    Questions 3, 55, and 56

Scale 10: Negative feelings

    Questions 16, 18, 23, 33, and 39

Scale 11: Downward comparison

       Questions 15, 32, and 38

Scale 12: Upward comparison

Questions 22 and 29

Scale 13: Philosophical perspective

Questions 6, 19, 25, and 34

APPENDIX H

Painfulness/Significance Ratings

In the space below would you briefly describe the loss of a relationship that you have thought of. Please include: the type of relationship (i.e. friend, spouse, etc.); how stressful and/or painful this loss was to you; and how important or significant a loss this was in your life. Would you then please respond to the same questions as they apply to the loss you have thought of that someone else had.

Loss of a relationship in your life:

Brief description -

How stressful and/or painful this loss was to you -
(please circle number)

```
     1          2          3          4          5
  Not at    Slightly   Somewhat    Very     Extremely
   all
```

How important or significant a loss in your life -
(please circle number)

```
     1          2          3          4          5
  Not at    Slightly   Somewhat    Very     Extremely
   all
```

Loss of a relationship that someone else had -

Brief description -

How stressful and/or painful this loss was to
him/her - (please circle number)

```
   -----------------------------------------------
   1          2           3           4           5
 Not at     Slightly    Somewhat     Very      Extremely
  all
```

How important or significant a loss in his/her life -
(please circle number)

```
   -----------------------------------------------
   1          2           3           4           5
 Not at     Slightly    Somewhat     Very      Extremely
  all
```

APPENDIX I

Participation Consent

This study is designed to investigate the effectiveness of coping strategies that a person uses with himself/herself, the effectiveness of coping strategies that others use with that person, and the effectiveness of coping strategies that person uses with others. Your participation will involve selecting a situation in your life reflecting a loss of a relationship and filling out three scales that ask you to indicate whether or not you have used, received, or given particular coping strategies by yes (Y) or no (N) and then rating the effectiveness of the strategies using the provided number scale. Your participation in this project is greatly appreciated.

1. The coping strategies effectiveness study has been explained to me and I understand the explanation that has been given and what my participation will involve.

2. I understand that I am free to discontinue my participation in this study at any time, and without penalty.

3. I understand that my responses will remain anonymous, but that group results of the study will be made available to me at my request.

4. I understand that my participation in the study does not

guarantee any beneficial results to me.

5. I understand that, at my request, I can receive additional explanation of this study after my participation is completed.

Signed_____   Date_____

APPENDIX J

General Instructions

There are many different ways of coping that people use to deal with problems or crises. We are interested in how effectively people cope with their own problems, how effectively others help them to cope with their problems, and how effectively they help others to cope. For two of the questionnaires, we would like you to think of a loss of a relationship in your life (other than through death) and answer the questions as they apply to that particular situation. You are first asked to indicate if a particular strategy was used or not by placing "Y" for yes or "N" for no on the line under the Y/N column. You are then asked to evaluate the effectiveness of that item in the particular situation you have recalled using the scale below. In the column headed "E", please place the number that best represents your rating of effectiveness. If a particular item was not used, we would like you to evaluate how effective you feel it would have been if it had been used. In a third questionnaire, we would like you to think of a loss of a relationship (other than through death) that someone you know has had and answer the same questions as they apply to that particular situation."

Effectiveness Scale

0 = Very unhelpful

1 = Quite unhelpful

2 = Somewhat unhelpful

3 = Slightly unhelpful

4 = No effect

5 = Slightly helpful

6 = Somewhat helpful

7 = Quite helpful

8 = Very helpful

APPENDIX   K

Correlation of Specific Coping Scales With Other Scales

Scale	Checklist		Checklist with scales averaged	r
Confrontive coping	C	–	O	.11
	C	–	I	.23
Distancing	C	–	O	.24
	C	–	I	.30
Self-controlling	C	–	O	.18
	C	–	I	.24
Accepting responsibility	C	–	O	.14
	C	–	I	.17
Positive reappraisal	C	–	O	.14
	C	–	I	.12
Planful problem-solving	C	–	O	.05
	C	–	I	.11
Social support	C	–	O	.08
	C	–	I	.01
Escape-avoidance	C	–	O	.20
	C	–	I	.31

Note. C = Ways of Coping Checklist. O = Ways Others Help Me
to Cope Checklist. I = Ways I Help Others to Cope Checklist.

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