SOCIAL FACTORS AND PSYCHOPATHOLOGY: Stress, Social Support, and Coping Processes

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"Stress, Social Support, and Coping Processes" was the subtitle of the last Annual Review chapter on social factors in psychopathology (Kessler et al 1985). Whereas earlier reviews (King 1978; Strauss 1989; Dohrenwend &
Dohrenwend 1981; Eron & Peterson 1982) had been concerned primarily with group differences in psychopathology, the attention Kessler et al (1985) gave to race, gender, and socioeconomic factors comprised part of a larger discussion of how support and coping influence adaptation to stress. Continuing trends in the field warrant that we, too, emphasize stress, support, and coping processes.

Over the past decade there has been an avalanche of studies that have adopted the “stress process” hypothesis, which explains psychopathology in terms of exposure to stress and ameliorative factors (mainly social support and coping). This model is currently the dominant research approach to the relationship between social factors and psychopathology. One citation analysis concluded that the study of stress, anxiety, depression, and support, has become the single most active research front in social science (Garfield 1987).

While methodological and theoretical advances evident in some recent studies have addressed several of the problems and ambiguities that Kessler et al identified as hampering our understanding of the stress process, they have also revealed additional problems. We have learned much about the shortcomings of ostensibly superior methodologies and about the limitations of attempts to relate social factors and psychopathology in a simple, unambiguous way.

Other developments suggest the need for changes in current approaches and emphases in studying social factors in psychopathology. First, just as psychiatrists have begun again to use formal diagnosis, epidemiologists have turned from representing psychopathology as a continuum of distress to viewing it in terms of categorical diagnoses. Self-report symptom checklists have given way to semi-structured interviews with formal diagnostic criteria. Although this is a recent change, accumulating findings already call into question many of our assumptions about the nature of psychopathology and how it should be studied. Second, researchers have become increasingly aware of the intergenerational transmission of family disruption, troubled relationships, and childhood adversity (Elder et al 1986; Quinton & Rutter 1988) and of the scope of intimate violence and its consequences for mental health (Koss 1990). The growing recognition of high rates of childhood physical and sexual victimization in the pasts of adult psychiatric patients (Bryer et al 1987) challenges what has been the rather exclusive focus of stress research on temporally proximal stressors in understanding the etiology of disorder. Evidence that spouse abuse is prevalent has also accumulated, and attention has been drawn to its possible etiological significance in psychopathology (Walker 1987). Finally, research on assortative mating (Merikangas 1982), marital problems associated with psychopathology (Weissman 1987), concurrent psychological distress in adults who live with depressed persons (Coyne et al 1987), and psychological disturbance in their offspring (Downey
Social Factors

& Coyne 1990) has complicated the effort to understand psychopathology in terms of individuals confronting stressful events, mobilizing support, and engaging in problem- and emotion-focused coping. Such studies suggest the need to examine how interdependent individuals adapt to stress within the context of troubled relationships.

Research on social factors and psychopathology is at a critical juncture. There are ample reasons to doubt the adequacy not only of current concepts and methods but also of the questions being addressed. It is difficult to do research that substantially advances our knowledge of basic issues. We are faced with a choice. Should we continue to do studies that arrive at foregone conclusions simply by exploiting the nonindependence of measures? (Such studies inevitably find that stress is generally bad, that perceiving relationships as supportive is good, and that coping—though this is difficult to demonstrate—must be good.) Or should we undertake the much more difficult task of identifying the complex and dynamic links among persons’ experiencing recurrent periods of disruption and dysfunction in their lives, how they lead their lives, and the nature of their social contexts?

The Relationship between Distress and Psychopathology: A Changing View

Focus on Diagnosis

Following decades of theoretical and empirical disrepute, formal diagnosis in psychiatry was enthusiastically reborn in the 1970s (Klerman 1989; Robins & Helzer 1986). In the preceding period, mental disorder and normal functioning had been conceived as aspects of a single continuum—a view compatible with etiological theories that emphasized social rather than constitutional factors. In reaction to this view and to more broadly based criticisms of the field of psychiatry, psychiatric researchers undertook to develop reliable and valid diagnostic criteria based on clearly defined symptoms involving minimal etiological inferences (Klerman 1989). Among methodological innovations was the development of semi-structured interviews to obtain standardized information about the person’s history, social functioning, and symptom status—e.g. the Schedule for Affective Disorders and Schizophrenia (SADS; Endicott & Spitzer 1978), the NIMH Diagnostic Interview Schedule (DIS; Robins et al 1981), and the Structured Clinical Interview for DSM-III (SCID). Operational criteria and algorithms for assigning persons to diagnostic categories were also specified (Feighner et al 1972; Spitzer et al 1978), and this approach was adopted in the DSM-III (American Psychiatric Association 1980).

More than previous chapters on the topic of social factors in psychopathology we can draw on studies that use direct interview assessment of the
signs and symptoms of psychopathology and well-specified diagnostic criteria with improved reliability. We integrate studies of psychiatric patients with community studies employing interview-based diagnosis. We pay particular attention to results emerging from the NIMH Epidemiologic Catchment Area Study (ECA; Regier et al 1984), which utilized the DIS with over 18,000 persons in 5 communities.

We have much more to say about depressive disorders than about other forms of psychopathology. This could be justified by the prevalence of depression and the social costs associated with it, but there are more basic conceptual and methodological reasons for the literature’s greater attention to depression. Until publication of the DSM-III-R (American Psychiatric Association 1987), hierarchical rules caused the diagnosis of an anxiety disorder to be preempted by the diagnosis of another disorder (e.g. depression or schizophrenia). When such rules are relaxed it becomes apparent that generalized anxiety and phobias are as common as major depression. Furthermore, over their lifetimes, most persons who become depressed have another diagnosable disorder, the most common being an anxiety disorder (Robins & Regier 1991). Another reason for the lack of attention to anxiety disorders is that the widely used SADS does not produce such a diagnosis. With the advent of DSM-III-R, the SCIDS, and the DIS, the relationships among social factors and anxiety disorders will undoubtedly receive more attention. Already, the ECA study has found that panic disorder is associated with as much social impairment, marital dysfunction, and suicidal tendency as major depression, and these relationships are not explained by the frequent association of panic disorder with depression (Markowitz et al 1989).

The attention to diagnosable disorder—in particular to the study of depression—can be seen as the third stage of research on social factors in psychopathology. Early studies focused on the social correlates of general malaise (Gurin et al 1960; Langner 1962). The next stage centered on self-reported symptoms of depression (Radloff 1975; Kaplan et al 1987). Measures of general malaise and of depressive symptoms are highly correlated, and so they were usually related to psychosocial factors in similar ways. The belief that depression could be construed as being on a continuum with distress led to the additional assumption that the social correlates of general malaise and depressive symptoms were related to clinical depression in similar ways. This conveniently sanctioned the use of self-report symptom inventories in place of more expensive structured interviews, and it permitted the generalization to clinical depression from questionnaire surveys of normal populations.

However, as findings based on self-report surveys and structured interviews have been compared, problems with this assumption have emerged. Most people from community samples with high scores on self-report depres-
sion scales do not meet the diagnostic criteria for clinical depression. Many of the depressive symptoms identified in this way indicate only mild and transient distress (Coyne & Gotlib 1983). One can even score in the “depressed” range on such a questionnaire without having a single symptom that would contribute to a diagnosis of major depression (Schulberg et al 1985). Finally, current self-report depression scales may do as good a job of identifying anxiety disorders as they do of identifying clinical depression (Hough et al 1985).

Particularly relevant to understanding the relation between social factors and psychopathology are recurrent findings that self-reported symptoms and interview-based diagnosis of depression have different social correlates. Poverty is associated both with a heightened risk of a DSM-III diagnosis (Holzer et al 1986) and with more depressive symptoms, but it does not increase the risk of major depression (Weissman 1987). Some other chronic stressors (e.g. having a handicapped child) are associated with substantial increases in depressive symptoms, but not with greater risk of major depression (Breslau & Davis 1986). Whereas both minor and major life events are related to increases in depressive symptoms, it appears that only serious life events requiring long-term adjustment predict subsequent clinical depression (Brown & Harris 1978). Thus, if one is interested in predicting depressive symptoms, stronger correlations are obtained with a broad sampling of major and minor events, and current life-event inventories seem to have adopted a philosophy of “more is better.” Yet only about a dozen items on a typical inventory are consistently related to clinical depression (Dohrenwend et al 1986), and broader samplings of events produce an underestimate of the strong association found with the dirty dozen. Brugha et al (1985) found that 12 of 67 categories of life events accounted for 77% of the events with etiological significance and that these events alone entailed greater relative risk for depression than the full list.

Difficulties in generalizing about depression on the basis of self-reported symptoms have only begun to be documented, but it is obvious this practice entails considerable confusion. The social correlates of distress and depressive symptoms remain a viable topic of research. Level of depressive symptoms predicts symptoms nine years later (Kaplan et al 1987) and risk for depressive disorder in the more immediate future (Lewinsohn et al 1988). Even in the absence of a diagnosable disorder, depressive symptoms are associated with more functional impairment than diabetes or hypertension (Wells et al 1989). However, studies of depressive symptoms are not justified if depressive disorders are the phenomena of interest. While most clinically depressed persons have scores in the depressed range on self-report questionnaires (although see Hopkins et al 1989), comparatively few persons with high scores would be diagnosed with depression. Thus such a diagnosis will
have fewer correlates with more common social factors than does a high score on a depression questionnaire (Robins et al. 1977). This implies that many findings from self-report questionnaires will not generalize to those based on categorical diagnoses of depression.

In sum, the study of how social factors affect depressive disorder is distinct from the study of the social correlates of distress. As we come to terms with this, a needed shift from self-reported symptoms to interview-based diagnosis will make it considerably more costly to study psychopathology. As if this were not problem enough, accumulating studies of social factors and the nature and course of psychopathology suggest a host of other complications.

**An Emerging View of Depression and Other Psychopathology**

We now probably know more about the natural history of depressive disorders than we do about that of other disorders, although long-term longitudinal studies are documenting the variable, episodic course of schizophrenia (Harding et al. 1987). It was once assumed that depression occurs in a single episode that usually resolves without enduring impairment. We now believe depression is best conceptualized as a recurrent, episodic condition with a heterogeneous course, associated with varying degrees of social impairment, recovery, and susceptibility to relapse. Most people who experience major depression will have at least one subsequent episode; fewer than half recover without relapse in a two-year period; and one fifth do not recover in the two-year period (Keller 1985). One quarter will suffer six or more episodes in their lifetimes, and after the onset of major depression, 20% of each sufferer’s lifetime will be spent in a depressive episode (Angst 1986). As many as 40% of depressed persons have a “double depression,” with major depression superimposed on a preexisting dysthymia that may persist after recovery from the acute episode of major depression and increase the risk for recurrence (Keller & Shapiro 1982).

Most studies of the stress-depression relation attempt to address the implications of stress for the onset of psychopathology, whether it is measured as an increase in symptoms or a diagnosis. With a few notable exceptions, study designs reflect the implicit assumption that the stress-psychopathology relation works similarly for everyone and at all stages of the disorder (Hammen et al. 1986). It has been noted that studies of the relation between life events and increase of symptoms should take into account symptom status prior to the event (Depue & Monroe 1986; Hammen et al 1986), but there has been too little attention to the history of prior episodes.

A prospective community study of depressive disorder illustrated complications that can arise when this problem is ignored (Lewinsohn et al. 1988). Persons who were maritally distressed but not clinically depressed at an initial interview exhibited a heightened risk of depression eight months later,
suggesting that marital distress is a risk factor for depression. However, the strongest predictor of depression during the study period was a history of depression: Over 90% of the persons who became depressed in the eight-month period had been depressed previously. When this factor was controlled, the increased risk associated with marital problems disappeared. Thus many prospective studies that purport to examine the antecedents of depression may actually be identifying precipitants of its recurrence and/or residual effects of past occurrences. Given the recurrent, episodic nature of depression, efforts to disentangle the effects of prior episodes from enduring social factors may prove difficult.

Implications for the Study of Social Factors and Psychology

The view that depression and other psychopathologies are recurrent and episodic requires an even more complex conceptualization than the diathesis-stress models currently in the ascendant. The recognition that most people confronted with severe stress do not develop psychopathology has prompted the suggestion that becoming depressed depends on a preexisting vulnerability to depression. Proposed causes of vulnerability include biological dysregulation (Goplerud & Depue 1985), negative self-concept (Hammen 1988), and coping strategies such as rumination (Nolen-Hoeksema 1987).

Such diathesis-stress models are a considerable advance over the less sophisticated view that everyone is equally susceptible to stress. However, this approach to linking person and context in the course of psychopathology has important limitations. Most crucial are the nondynamic nature of the model (it views psychopathology as a status rather than a process that unfolds over time) and its neglect of changes in vulnerability over time. The vulnerabilities identified have generally been viewed as fixed attributes of the person that interact with contextual stressors to influence the onset of psychopathology. Such a view ignores how vulnerabilities to psychopathology originate, what circumstances maintain or modify them, and what personal and social resources are available to confront stress.

The emerging view of depression and other psychopathologies is that they have a variable, episodic course that is influenced by a changing environment. Thus, in understanding the implications of social factors for a disorder, we must be concerned not only with the onset of a disorder, but also with stage in the life course of the disorder (e.g. whether it is a first or later episode) and the cumulative effects of experiences with disorder and dysfunction. We must also be aware of the interplay between the disorder and the normative developmental tasks of adulthood. Persons who experience psychopathology may spend considerable portions of their adult life in recurrent episodes of disturbance with interludes of wellness or residual distress. During this time, they may also face such tasks as completing their education, pursuing voca-
tional goals, marrying, becoming parents, and perhaps getting divorced and married again.

Difficulties with adult social roles both contribute to and are in turn increased by depression. The interplay between depression and role functioning is well illustrated by the study of depressed mothers (Downey & Coyne 1990), whose conflicts with their children further exacerbate their distress and vice versa.

Childhood experience has also been linked with adult role functioning in ways that affect risk for psychopathology (Elder et al 1986; Quinton & Rutter 1988). Whereas there is growing evidence that early loss of a parent per se does not greatly affect subsequent risk for psychopathology (Brier et al 1988), prolonged family disruption in childhood may do so both directly and by being linked to adversity in adulthood. For example, in two independent samples Brown and his colleagues (Harris et al 1987) documented a link between lack of care in childhood (following loss of a mother) and affective disturbance in adult women, an influence mediated by premarital pregnancy and marital dysfunction. Specifically, they reported that such inadequate care increases the risk of early premarital pregnancy, which in turn increases the risk of marriage to an undependable partner. Marriage to such a partner, in addition to being low in intimacy, increases the risk both of serious life events (such as trouble with the law, discoveries of infidelities, and threats of eviction) and of poverty. Such findings indicate the value of a life-course developmental perspective alert to how individuals' strengths and vulnerabilities, their manifestations of psychopathology, and their social environments constrain and influence each other in different ways over time. Although the application of such a perspective to psychopathology is just beginning (Cummings & Cicchetti 1990; Strauss et al 1985; Walker 1990), its contribution to a broader understanding of how persons and contexts are linked in the course of development has been well established (Bronfenbrenner 1988; Elder et al 1986; Bolger et al 1988).

THE STRESS PROCESS

Stress

Studies documenting the association between scores on inventories of life events, on the one hand, and either self-report depression scores or diagnoses, on the other, have supported the development of the stress model of psychopathology, but the weakness of the relationships typically found has been a major source of frustration (Dohrenwend & Dohrenwend 1981). Various efforts at improving the inventories (e.g. increasing the range of events sampled and including respondents' ratings of events' stressfulness) have failed to increase their predictive power appreciably and have introduced new
problems of interpretation (Kessler et al. 1985). The limitations of checklist inventories as a means of assessing the stress-psychopathology association may be fundamental.

Items on life-event checklists are ambiguous and "thin descriptions" (Geerwitz 1973) of complex situations. Not only the interpretation of an event, but also its character and the circumstances surrounding it must differ between persons. Citing the case of a respondent whose husband had just died, but who had not seen him in two years, Shroul et al. (1989) note the shortcomings of checklist assessments of even normatively severe events. A promising alternative to self-report checklists are semi-structured interviews. These can either (a) allow raters to take into consideration situational and personal factors that influence the threat posed by events (Brown & Harris 1978) or (b) use descriptive information about what actually happened before, during, and after each event to identify potent life events (Dohrenwend et al. 1986). The key difference between the two interview-based approaches is that the former utilizes contextual factors (i.e. having preexisting debts and dependent children) to make judgments about the severity of the threat posed by an event, whereas the latter focuses exclusively on features of the event itself (being laid off owing to a plant closing rather than being fired) to arrive at consensual judgments.

Interview approaches to life events have generally attempted to ascertain whether or not the events in question occurred independently of the respondent's prior symptoms and behavior. As a result they have demonstrated strong relationships between the occurrence of independent events and risk for depression (Brown & Harris 1978; Shroul et al. 1989), the onset of acute schizophrenia (Day et al. 1987), and schizophrenic relapse (Ventura et al. 1989). Finlay-Jones & Brown (1981) demonstrated some specificity in the relationship between classes of events and combinations of depression and anxiety. For instance, loss events much more frequently preceded the onset of pure depression and mixed anxiety/depression than they did the onset of pure anxiety; danger events preceded anxiety but not pure depression. Mixed anxiety/depression was preceded by events that involved both threat and loss. Dohrenwend et al. (1986) found that disruptive loss events that were independent of the individual's behavior increased the risk for both onset and recurrence of major depression, whereas a variety of life events (including those related to health problems, role performance, and loss in the social network) predicted depression only in individuals with a history of recurrent psychopathology.

Research focusing on events shown to be independent of the individual's psychopathology or behavior is important, but an exclusive focus on such events can be misleading and may prevent other issues from being addressed. For example, early research found that an increase in arguments with their
husbands was the single most frequent life change reported by depressed women for the months prior to the onset of depression (Paykel et al. 1969). Today, however, life-events researchers rarely include marital turmoil or other interpersonal disputes in their assessments, the independence of events and pathology being too difficult to establish. Yet establishing the role of interpersonal conflict in the onset and recurrence of depression is crucial. Difficulties in interpersonal relationships; the most common form of stress (Bolger et al. 1989), may be the most important precipitants of depression.

There are other reasons for giving more consideration to stress that cannot be presumed to be independent of the psychological state and behavior of the individuals confronting it. McGuffin et al. (1988) found that first degree relatives of depressed persons had personally experienced more life events immediately prior to the inquiry than had relatives of controls (even excluding events related to the depressed proband). This raises the possibility that the tendency to experience adversity may be familial. The mechanism of transmission remains unclear. Akiskal (1989) has found that losses of parent(s) early in life are associated not with overt mood disorders but with immaturity, hostile dependency, manipulativeness, impulsiveness, and low threshold for alcohol and drug abuse in adulthood. Without directly affecting the lifetime risk for depression, these characteristics may precipitate life events that then trigger depression earlier in life and result in more frequent episodes of depression. Similarly, the 40% of depressed patients who have personality disorders experience more life stress, an earlier onset of depression, and poorer recovery than those without such disorders (Black et al. 1988; Huffman et al. 1984). If we take seriously the need for an interactive developmental conception of psychopathology, we must study potentially non-independent life events, which may both express and influence vulnerability to depression.

How are past episodes of depression and susceptibility to life events related? A number of studies have found that elevated rates of negative events are more likely to precede early episodes of depression than later episodes (Dolan et al. 1985; Ezquiga et al. 1987; Perris 1984). Thus persons who have repeated episodes of depression may differ in kind from those who have single or few episodes. These findings have also been interpreted in terms of a biological sensitizing effect (Post et al. 1986), such that the threshold of stress necessary to precipitate depressive episodes lowers with their repetition. However, it should be noted that whether depression is associated with neuroendocrine markers or vegetative symptoms does not strongly reduce its correlation to life events (Dolan et al. 1985). Furthermore, repeated episodes of depression may have analogous sensitizing effects on the sufferer’s social environment, causing support and tolerance for dysfunctional behavior progressively to decrease (Coyne et al. 1990).
Research into the effects of chronic stress on psychopathology continues to lag behind the study of life events. The contribution of chronic stress to risk for depression is presumed to be smaller than that of acute severe events (Brown & Harris 1978), but methodological expediency is probably the major factor for ignoring chronic stress (Kessler et al. 1985). It is difficult to show that chronic stress exists independent of an earlier disorder and, given a chronic source of stress, to determine why an individual becomes depressed at a certain point.

Pearlin (1989) has challenged the notion that life events indicate “a discrete change rather than a marker or surrogate indicator of an ongoing life course in a particular social context” (p. 244). A focus on life events may distract us from the problematic and relatively intractable continuities in persons’ lives. As noted above, certain childhood adversities may be linked to adverse environments in adulthood in ways beyond the control of the individual, such that both “independent” stressful events and chronic stressors are more likely to befall persons raised in adverse environments (Quinton & Rutter 1988; Harris et al. 1987). We should be careful not to minimize such continuities in people’s life situations. We must also be careful not to infer personal shortcomings, poor coping, or incompetency from what are actually effects of enduring features.

One can readily see in much of the earlier research on stress and psychopathology an effort to approximate the experimental control lost in the shift from laboratory studies to field research. Investigators construed life events as experiments provided by nature. Researchers attempted to identify situations in which people’s experiences of life events were analogous to random protocol assignments in an experimental manipulation. But truly random events may not be the most common or the most theoretically interesting precipitants of psychopathology, nor is it clear that many stressful events of interest are actually independent from individuals’ life courses. Efforts to grapple with the basic interdependence of individual and context have led to a new set of theoretical questions and methodological challenges, which may ultimately result in abandonment of the laboratory experiment and the tidy ANOVA-based experimental design as metaphors for understanding the relationship between social factors and psychopathology.

Social Support

Early studies of the social networks of psychiatric patients found those of psychotics to be smaller and kin-based and those of neurotics to be looser and sparser than those of controls (Kessler et al. 1985; see Mueller 1980 for a review). More recently, the bulk of research has focused on the perceived supportiveness of relationships, asking how well social support buffers the effects of stress and what contribution it makes directly to mental health (see
Cohen & Wills 1985; Lin et al 1986). Most of this research is based on depression questionnaire scores rather than depressive disorder, and persistent ambiguities are evident with respect to what measures of perceived support capture. Curiously, although the perception of support is assumed to reflect what is conveyed in supportive transactions. Reports of having sought (Coyne et al 1981; Lieberman & Mullin 1978) or received (Barrera 1981) support are related negatively to adaptational outcomes.

Compared with controls, persons with DSM III diagnoses of depression report less contact with friends, fewer friends nearby who can help, less satisfaction with friends and relatives, less confiding in their spouses, and less satisfactory marital relationships (Leaf et al 1984). These findings parallel those for depressed patients (Billings & Moos 1984). The quality of close relationships, notably that with the spouse, correlates more positively with DSM III diagnosis than does the quality of more distant relationships (Leaf et al 1984). The same holds for new cases of depression (Brown & Harris 1978). A number of studies have now replicated Brown & Harris's (1978) findings that depression in the face of life events or chronic difficulties is more likely when an intimate relationship with a spouse is lacking. It appears that the lack of an intimate relationship is also a risk factor for depression in the absence of life events—i.e. intimacy has direct as well as buffering effects (See Oatley & Bolton 1985 for a review).

Such findings of an association between measures of support and adaptational outcomes do not justify the conclusion that the supportiveness of relationships protects against depression (House et al 1988). Social support may not be a fundamentally unipolar construct. That is, while reports of “low support” may sometimes reflect the absence of a supportive relationship, they may more often signify the presence of a negative, conflictive relationship (Coyne & Bolger 1990). Perceived-support scales anchored by “high” and “low” support do not permit distinguishing these alternative meanings of low support.

Negative features of social relationships appear to correlate more strongly than positive features with measures of both perceived support and psychological symptoms (Fiore et al 1983; Pagel et al 1987; Rook 1984). “It is primarily the problematic features that cause, maintain, or fail to reduce psychological symptoms” (Pagel et al 1987:794). The ECA study has yielded provocative data on this issue (Weissman 1987). The risk of clinical depression for people who are married and can talk to their spouses is modestly lower than that of people who are single, separated, or divorced. This reduction may be viewed as a benefit of emotional support or intimacy, a positive effect of a good marriage, and thus a finding consistent with the conventional interpretation of the benefits of social support. Yet this positive effect is dwarfed by the negative one of being married and unable to talk to one’s spouse. The adjusted
odds-ratio for depression associated with being married and unable to talk to one's spouse was over 25 for both men and women. This effect size is extraordinary for epidemiological studies. As a concurrent association, it does not address questions of causality, but it offers evidence for the view that we may need to turn the concept of social support on its head. The apparent benefits of having support may in large part represent freedom from the deleterious effects of relationships that are conflictual, insecure, or otherwise not sustaining.

Such a change in interpretive perspective has profound conceptual and theoretical implications. The question of how social support buffers stress is supplemented by that of how involvement in dysfunctional relationships impairs coping with stress. Instead of focusing on social transactions presumed to convey support, we emphasize the conflict, inhibited communication, and lack of stability in close relationships that reduce the sense of support. In addition, if the observed association between social support and depression has its greatest effects in intimate relationships, and if the negative features of such relationships are more important than the positive, then literatures on marital distress and depression (Coyne et al 1990) and on expressed emotion (Hooley et al 1986) become especially relevant to our field.

A growing literature documents the complex relation between marital problems and depression, but a sense that such findings concern only marital quality has limited the attention accorded them in discussions of social support. Roy (1978) found that women reporting a lack of intimacy with their husbands were but a subset of those reporting a "bad marriage"; having a bad marriage, not the lack of a confiding relationship per se, leaves women at risk for depression. A number of studies suggest that spouses corroborate depressed persons' negative reports about the quality of their marriages (Coleman & Miller 1975; Kahn et al 1985; Merikangas et al 1985). Simply being married predicts slower recovery (George et al 1989) and diminished response to antidepressant treatment (Keller et al 1984). This effect of marital status may reflect the poorer outcomes for the considerable proportion of depressed persons who have marital problems, both in the short (Rounsaville et al 1979) and longer term (Rounsaville et al 1980). Other studies relate attitudes of the spouse to potential for relapse. Leff & Vaughn (1985) found that most spouses of depressed persons were critical of them; level of hostile criticism from the spouse, a key component of expressed emotion, strongly predicted patient relapse. Hooley et al (1986) replicated this finding (see Coyne et al 1990 for a more extensive review of the marriage and depression literature).

If the effects of social support on depression derive largely from problematic relationships, how should we distinguish between low support and stress? Lennon (1989) proposed that "the distinction between stressors and support
blurs when we conceptualize the unit of study as actors embedded in social relations . . . [because] support and stressors often reside in the same set of interactions and cannot be understood apart from this relational context” (p. 262). And just as we need to understand how stress is embedded in life course and context, we need to understand how dysfunction in close relationships comes about and is perpetuated. Persons who spend a considerable portion of their adult lives in episodes of psychological disturbance may have difficulty maintaining a satisfactory relationship, but there are also questions of selective and assortative mating (Merikangas 1982). Brown et al (1986) found that depressed women with marital difficulties tended to be married to husbands whom raters found to be “grossly undependable.” Several studies suggest that women’s relationships with their spouses may be important mediators of the association between childhood adversity and depression in adulthood, and that the background of the spouse is a crucial determinant of the quality of this relationship. Indeed, it has been suggested that women whose background makes them particularly vulnerable to depression tend to marry men unable to provide a positive intimate relationship, and that early adverse experiences may in large part exert their effects through the selection of the spouse (Parker & Hadzi-Pavlovic 1984; Birtchnell 1980; Quinton, Rutter, & Liddle 1984).

The concept of social support was originally seen as a balance to the more negative view that social relationships were sources of stress. It was further intended to call attention to resources that might buffer or attenuate the effects of life events and other stressors. It now appears that a heterogeneous set of conditions influences perceptions of support but that the negative features of relationships may predominate. Theoretical formulations and techniques of assessing support have not yet come to terms with this balance.

**Coping**

Over the past decade, a consensus has developed on the basic dimensions of coping and how to assess them. Coping has been conceptualized in terms of approach-vs-avoidance (Suls & Fletcher 1985) and in terms of appraisal, problem focus, and emotion focus (Billings & Moos 1984). Appropriate self-report checklists have been developed. Lazarus & Folkman’s (1984) distinction between problem-focused and emotion-focused coping has been by far the most influential conceptualization, and various versions of their Ways of Coping Checklist (WOCC) have been utilized in literally hundreds of studies (Stone et al, in press). In such research, respondents nominate a stressful recent incident and pick checklist items that reflect the thoughts and behaviors they have used to cope with it. Such assessments of coping in specific stressful episodes may be aggregated across situations or combinations of persons and situations (e.g. depressed persons coping with work problems or situations involving loss). Lazarus & Folkman’s work on stress
and coping has also been influential in establishing the notion that dispositional measures of coping do not adequately characterize the range of coping strategies used in dealing with complex situations. Cohen (1987) argues, for example, that because such measures may inadvertently tap personality (rather than coping strategies that predict adaptational outcomes), situational assessments of the kind provided by the WOCC are needed.

Despite the recent outpouring of studies, research on coping and psychopathology still lags considerably behind studies of other aspects of the stress process. The bulk of research relates current distress (rather than depressive disorder) to retrospective reports of coping with stressful episodes. A few studies have used repeated assessments to insure that the distress is not transient (Coyne et al. 1981; Folkman & Lazarus 1986). These find that persons with chronic depressive symptoms do more wishful thinking, escape-avoidance, confrontation, and support-seeking. Such studies depict how distressed persons cope, not how coping reduces or exacerbates the effects of stress or how poor coping precedes the development of distress. It is also important to note that depressive symptoms and depressive disorders are different measures and may correlate differently with coping (Rhode et al. 1990).

Studies of depressed patients have generally employed coping measures other than the WOCC. Depressed patients reported doing less problem-solving and more emotional discharge than controls on a brief measure of how they coped with a recent life event (Billings & Moos 1984); they reported socializing less and engaging in fewer distracting activities, and they rated themselves as more passive (Parker & Brown 1982). Differences between depressed persons and controls may be substantially reduced (Billings & Moos 1985) or disappear (Parker et al. 1986) when the patients recover. In the only prospective study of coping and clinical depression to date, ineffective escapism was related to increases in depressive symptoms and new diagnosis of depression, but cognitive self-control and solace seeking were not (Rhode et al. 1990).

The availability of theoretically derived and easily administered instruments for assessing coping represents an important advance in the field. Overall, however, the results from coping studies have not yet been particularly informative. They offer little wisdom about how to avoid becoming depressed, and little advice to improve the coping of persons vulnerable to depression or other forms of psychopathology. Generally speaking, research utilizing either measures of distress or diagnoses finds that particular coping patterns are positively related to symptoms or to the probability of being depressed; few or no strategies are found to be negatively related (Miller et al. 1985; Coyne et al. 1981; Parker & Brown 1982; Pearlin et al. 1981; Aldwin & Revenson 1987). This positive correlation may reflect nothing more than the
fact that the respondents were already distressed when they began coping with a specific incident; it may indicate that coping efforts become more intense but unfocused when things are not going well. One could conclude from the current literature that coping does little to buffer or attenuate stress; or, believing such a conclusion premature, one could find the research to date inadequate to determine whether the way one copes can reduce the potential for distress or depressive disorder.

Like checklist inventories of life events, coping checklists may open up an area of research without providing much in the way of definitive findings. A single, relatively brief checklist may be insufficient to capture the patterns of coping relevant to our purposes. It may be infeasible to assess the course and content of a stress episode by means of the respondent's choices among dichotomous items devoid of temporal sequence or narrative. We may also err in believing that checklists assess the competencies of the respondent. How one copes is constrained by how other persons involved in a stressful exchange cope (Kahn et al 1985). Differences in how people report they cope may reflect differences in their circumstances, and these may not readily be eliminated by matching or statistical controls. Thus, studies designed to identify the competencies that buffer individuals from the effects of stress almost inevitably confound competency both with level of upset at the time of the episode and with situational factors such as the quality of relationships with other persons involved in the incident.

Advances in the study of coping will likely have to follow the path set by innovations in the study of stress: namely, a reliance on semi-structured interviews and the judgments of trained raters to establish the details of how a stressful encounter unfolds and how well, given its circumstances, it is handled. Statements about effective and ineffective coping will undoubtedly have to be phrased in more specific terms. In our reviews of stress and social support we highlighted the importance of interpersonal discord. It is likely that studies of coping will need to give more attention to how people manage their close relationships. The basic dimensions of problem- and emotion-focused coping will need to be supplemented by considerations of relationship-focused coping: how people in distress deal with those with whom they have enduring relationships—others who offer advice, can have influence on the situation, and to some degree share their fate, despite disagreements and even hostility (Coyne & Smith 1991).

Violence, Sexual Abuse, and Other Victimization

These topics are seldom broached in discussions of stress and coping processes or in more general discussions of the role of social factors in psychopathology, but evidence is mounting that they are significant. Past or current victimization appears to be "a strong risk factor for the development
of . . . lifetime mental health problems” (Kilpatrick et al 1987:65). Although reliable information on the prevalence of physical and sexual abuse is sparse, available data suggest high rates of violence against women. For example, Koss (1988) noted that 38–67% of women experience sexual abuse or assault before age 18 and almost one third of married women report violence in their current marriage. Systematic information on victimization history is not typically obtained from psychiatric patients. However, when such information is actively sought, a considerable proportion of both inpatient and outpatient women report physical and sexual abuse in childhood and in the recent past (Herman 1986; Carmen et al 1984; Jacobson & Richardson 1987).

Studies of the relation between victimization and specific disorders are limited. Nonetheless, physical and sexual victimization by strangers as well as by parents and spouses have been linked with a variety of disorders. Female victims of sexual abuse and assault may be the single largest group experiencing post-traumatic stress disorder (Koss 1990; Foa et al 1987). A childhood history of repeated victimization contributes in important ways to personality disorders (Bryer et al 1987), in particular to dissociative disorders. Ellis et al (1981) reported that 20% of adult survivors of rape and incest were seriously depressed and another 25% were moderately depressed. Childhood physical abuse has also been linked with adult depression and substance abuse (Holmes & Robins 1988).

According to Gelles & Straus (1988), women in violent marriages are compromised in nearly every area of their physical and mental health. Violence that is severe and recurrent leaves victims feeling depressed, demoralized, and powerless. Further investigation of the association between victimization and psychopathology is needed.

Cycles of abuse may be perpetuated across generations, although the extent of cross-generational continuity has not yet been established (Widom 1989a,b). Conversely, persons who have not been abused themselves are unlikely to become abusive adults (Kaufman & Zigler 1987; Quinton & Rutter 1988). Yet the continuities between childhood experience and victimization in adulthood are not clear-cut. Walker (1987) reports that most women in violent marriages were not abused as children. On the other hand the experience of childhood victimization appears to increase the risk of troubled relationships in adulthood (Koss 1990).

Intergenerational continuity of abuse is not inevitable. Several studies have identified a triad of factors that distinguish mothers who broke out of the cycle of abuse from those who abused their own children. The former were more likely to have received support from a nonabusive adult as a child, to have a supportive mate, and to have a reliable income (Egeland et al 1988; Quinton et al 1984; Hunter & Kilstrom, 1979). Egeland et al found that mothers who
reenacted their maltreatment with their own children had themselves been more severely maltreated; they were more anxious, dependent, immature, and depressed than the nonabusive mothers. Such personality characteristics, which may be consequences of severe childhood abuse, may reduce the likelihood of positive adult relationships. Thus, salutary spousal relationships may be most difficult to achieve for those who most need them.

Obtaining valid information on victimization and its role in psychopathology is difficult. Many victims of domestic violence probably do not report the abuse in response to life-events checklist items about criminal victimization. Whether they endorse more specific items about rape, incest, or physical abuse is also questionable. Presumably many victims of spousal violence report a lack of social support from the spouse, but it is inappropriate to construe such marital problems as lack of perceived support. Coping inventories must generally miss how the threat of violence conditions coping efforts. Abused women expend considerable effort to prevent angering their spouses (Gelles & Straus 1988; Walker 1987). Such efforts often compromise potentially supportive relationships with other network members. Thus the experience of marital violence and the threat of its recurrence affect stress and coping processes in crucial ways difficult to identify without knowing that such a threat exists. Similarly, the experience of victimization in childhood may condition adult stress and coping processes.

Past applications of survey methodology to the study of victimization have been severely criticized on methodological grounds. In particular, it has been suggested that surveys may underestimate the prevalence of victimization and overestimate the role of victims in eliciting it (Yllö 1988). Many of the concerns we have raised here about survey and checklist methodologies are particularly applicable to the study of victimization. We hope future Annual Review chapters on social factors in psychopathology will be able to draw on a larger body of methodologically sound studies of victimization. Until this is possible, the absence of reference to victimization in discussions of social factors in psychopathology stands as a criticism of the field, not an indication that the factor is insignificant.

COMMENTARY

The momentum that has made studies of stress processes and depression and anxiety the most active research front in the social sciences is likely to continue. Yet a variety of factors will limit the further contribution of most of this literature to our understanding of the relationship between social factors and psychopathology. It is time for a parting of ways between researchers who are primarily interested in self-reported distress and depressive symptoms and those who are interested in psychopathology. The issue involves
more than a difference between the adaptational outcomes to be examined. The emerging view of psychopathology outlined here dictates a fundamentally different and more complex set of research questions than is required in the study of social factors in distress. Diagnosable psychopathology is likely to have fewer social correlates than does distress. A past history of disturbance is likely to be a marker for increased susceptibility to other risks, including social factors; but such a history is also likely to be a major determinant of the adversities confronting the individual, the resources that are available, and how the stress process unfolds. In turn, there may be largely uncharted, long-term, reciprocal influences between social factors and vulnerability. In ways we are only beginning to grasp, tendencies to experience psychopathology, the major life contexts in which individuals find themselves, and how they meet developmental tasks are complexly intertwined over time.

Here we focus mainly on depression, but as the results of the ECA study become available and the newer diagnostic tools find wider application, our knowledge of the relationship of social factors to other diagnoses, particularly anxiety disorders, should also greatly increase. It remains to be seen to what extent current social factors, prior experience, and constitutional vulnerabilities determine which forms of psychopathology are manifested. Because individuals tend to be diagnosed with disorder more than once over the life course, this question is likely to prove difficult. We should also be alert to the possibility that similar social correlates may reflect very different processes. Thus, persons with a lifetime diagnosis of schizophrenia are more likely to be divorced than persons with major depressive disorder (Robins & Regier 1991), but the reasons for the two sets of divorces may be quite different.

The life-course perspective that we recommend here for the study of social factors and psychopathology requires a change in approach away from many of the simple questions of cause and effect that have dominated the field. Far too often, researchers use statistical analyses as if to approximate a controlled experiment with random assignment. For instance, it is misleading to interpret a regression analysis as indicating that “when marital support is controlled, the use of confrontative coping becomes a predictor of becoming depressed in the next six months.” Such a conclusion neglects a host of complex relationships among history of depression, risk for recurrence, choice of mate, inter-episode adjustment, likelihood and specific nature of marital problems, and types of stressful episodes likely to require coping. As Meehl (1970) argued earlier and Lieberson (1985) has cogently demonstrated more recently, many efforts of social scientists to disentangle causal influences are hopelessly confused (see also Kessler 1987), and the study of social factors and psychopathology is rich with examples of this. Rather than strive for a control we cannot achieve, we can learn much about key influences by simply examining the nature of the nonrandom combinations of variables we would
normally control (Lieberson 1985). Thus, rather than control current symptoms as a nuisance variable, we should examine how symptoms affect susceptibility to life events (see Hammen et al 1986).

Here we challenge the very identity of key variables in the stress process. Seemingly independent life events may be markers for other current adversities, or they may be the direct and indirect results of past experiences, including childhood adversity and victimization, previous episodes of psychopathology, and mate selection. Perceived support may often best be viewed as the absence of particular kinds of adversity in interpersonal relationships, and these adversities might just as well be seen as strains or chronic stressors. Assessments of coping may be unable to distinguish coping skills from distress and situational factors, including the key people in an individual’s life. Matters do not always get this confusing, but we must not assume that stress is what a life-event inventory assesses, that social support is what a social support scale assesses, and that a coping checklist assesses coping and not stressor support. We should not attribute more precision to our concepts than is afforded by the life courses and social contexts of the individuals we study.

Finally, we doubt that various checklists adequately capture the patterns in the particulars of people’s lives. The limitations of such instruments may be fundamental, and their objectivity illusory, particularly when it comes to substantive interpretation of their correlates. The use of semi-structured interviews and trained raters may be indispensable for addressing many theoretical questions about the relationships between social factors and psychopathology. When criteria are well specified and raters well trained, the validity of such data will undoubtedly exceed that of investigators’ blind inferences about what circumstances led a respondent to endorse an item on a checklist.

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