Stress, Social Support, and Disorder

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The concepts of social support and stress have been closely tied in both theoretical and empirical work on the influence of support on health and well-being (Cassell, 1976; Cobb, 1976; Cohen & Syme, 1985; House, 1981). Social supports are thought to contribute to the generation of stressful events, the avoidance of stressful events, the appraisal of events, and the ability to cope with events and their consequences. Conversely, stressful events and coping responses are thought to influence the stability of social networks as well as the availability and maintenance of social supports. This chapter provides an overview of the interrelations between stress and social support with implications for health outcomes.

SUPPORT CONCEPTS

There is little agreement among members of the scientific community in regard to a precise definition of social support (Cohen & Syme, 1985; Shumaker & Brownell, 1984; Wilcox & Vernberg, 1985). Moreover, existing studies apply the term to a broad range of social networks and functions that they provide (House, 1981; Turner, 1983). Rather than attempt an all-encompassing definition, I propose broad categorical classifications of the concepts commonly included under the social support rubric. Three classes of support concepts (measures) are proposed: social networks, perceived social support, and supportive behaviors.

Social networks refer to the structure of social relationships—the existence, quantity, and type of relationships. Perceived social support refers to the function of social relationships—the perception that social relationships will (if necessary) provide resources such as emotional support or information. Finally, supportive behaviors refer to the mobilization and receipt of behaviors intended to aid persons in the face of stressful events.

THE TRANSACTIONAL MODEL OF STRESS

Figure 1 depicts the major concepts and mechanisms involved in relations between stress and support in the prediction of disorder. Disorder is broadly used here to refer to both psychological and physiological symptoms and disease states. For the sake of simplicity and brevity, the figure does not include all possible relations between represented concepts.

The core of Figure 1 is the transactional model of stress and disorder (e.g., Lazarus & Folkman, 1984). (The “core” concepts key to the transactional model
are in the octagonal boxes.) In short, potentially stressful events are appraised as either stressful or benign in the context of an individual's own values, beliefs, experiences, and coping resources. The appraisal of events as stressful can result in a range of psychological and physiological changes that put a person at risk for disorder.

As apparent from the figure, there are a number of objective event characteristics that contribute to whether or not stressful events result in stress and disorder. These include severity, context in which they occur, duration, and timing of the events in relation to the life course. There is also evidence that specific types of events are risk factors for specific disorders. For example, depressive affect and clinical depression appear to be triggered by interpersonal events (e.g., Bolger, DeLongis, Kessler, & Schilling, 1989; Brown & Harris, 1989). Finally, the accumulation of multiple events may, within a specific category (e.g., interpersonal events, economic events) or across categories, create a greater risk than single events.

As noted earlier, stress appraisal occurs in the context of a person's values, beliefs, experiences, and coping resources. Appraisal represents the meaning of events to the individual—specifically, the extent to which the demands of situations are greater than the ability to cope.

In the current discussion, we use the term stress to refer to both the psychological and physiological effects of stress appraisal. Psychological effects of appraisal that are implicated in disorder include increased negative affect, lowered self-
esteem, and lowered feelings of control. Physiological changes in response to stress appraisal are presumed to be mediated by these changes in affect, esteem, and control. Physiological stress effects implicated in physical disorder include changes in cardiovascular response, such as increased heart rate and blood pressure; secretion (into the bloodstream) of a range of hormones, including catecholamines, CRF, ACTH, cortisol, and growth hormone; and changes in immune function (Rabin, Cohen, Ganguli, Lysle, & Cunnick, 1989).

The remainder of Figure 1 depicts the interrelations of social networks, perceived support, and support behaviors within the transactional model. This includes their effects on the components of the core model and their effects on one another. The figure is intended as an organizational tool, not as the representation of a formal model. The following discussion reviews what is known about the interrelations represented in the figure and speculates about relations when data are insufficient. The reader may want to refer to Figure 1 as an organizational guide while reading this discussion.

SOCIAL NETWORKS, STRESS, AND DISORDER

Social networks can influence both the occurrence and appraisal of stressful life events. Event occurrence can be affected by social norms. For example, prohibitions of divorce, birth control, and abortion can operate to create and/or maintain acute and chronic stressors. Alternatively, norms supporting the use of birth control and "safe" sex practices could prevent unwanted pregnancies and sexually transmitted diseases (e.g., Fisher, 1988). Likewise, network availability of appropriate information can help people avoid certain stressful life events (e.g., unwanted pregnancies), whereas inappropriate information may facilitate their occurrence.

Network membership itself provides the possibility for stressful interpersonal events, such as social conflicts and losses, that are less likely for more isolated persons. However, networks also generate events, such as religious and ethnic ceremonies, whose occurrences mark different stages of the life cycle. These events contribute to the development of senses of self, predictability, and control that are essential for maintenance of psychological well-being. The nonoccurrence of these normative events among relatively isolated persons may also be stressful interpersonal events (Schulz & Rau, 1985; Rabkin & Struening, 1976). Interpersonal events (occurrence or nonoccurrence) may put people at greater risk for disorder than nonsocial events. Interpersonal events play primary roles as risk factors in psychological distress (e.g., Bolger et al., 1989; Monroe & Simons, in press; Fiore, Becker, & Coppel, 1983; Falg, Erdly, & Becker, 1987; Thoits, 1985), clinical depression (e.g., Brown & Harris, 1989; Paykel, 1974), and physical illness (e.g., Graham, Douglas, & Ryan, 1986; Meyer & Haggerty, 1962).

Social networks can also influence the appraisal of stressful events (see path from social networks to stress appraisal in Figure 1). Social norms and information networks provide a social context in which events are appraised (Brown & Harris, 1978, 1989; Lazarus & Folkman, 1984; Monroe & Depue, 1991). For example, unwanted pregnancies, divorces, and abortions are considerably more stressful when network norms forbid or stigmatize them than when norms are accepting or even facilitating. Social networks also directly influence perceptions of support (see path from social networks to perceived social support in Figure 1). Support
norms prescribe when support should be provided to other network members. Similarly, expected reciprocity norms prescribe supporting others who have provided support in the past.

**PERCEIVED SOCIAL SUPPORT AND THE STRESS-BUFFERING MODELS**

The stress-buffering hypothesis posits that support "buffers" (protects) persons from the potentially pathogenic influence of stressful events. The majority of research on this hypothesis tests what Wheaton (1985) refers to as the interactive model of buffering. In this model, support operates as a moderating variable—an existing condition (e.g., the perception of available support) under which stress has substantially less impact (see path from perceived social support to stress appraisal in Figure 1). This effect is statistically represented by a stress by social support interaction (House, 1981; Cohen & Wills, 1985; Veiel, Chapter 17; Wheaton, 1985). The following discussion addresses this model. Our later discussion on the effectiveness of support behaviors in coping with stressful events may in some cases reflect the interactive model but in many cases may reflect an additive model (Wheaton, 1985). In the additive model stressors result in the mobilization of support (supportive behaviors) that dampen the overall stressor impact (see path from stress to support behaviors in Figure 1).

Perceived availability of social support has been found to act as a stress buffer (stressful events by perceived support interaction) over a wide range of studies; hence I focus on perceived support as the source of stress buffering (Cohen & Wills, 1985; Kessler & McLeod, 1985; Schwarzer & Leppin, 1989; Wethington & Kessler, 1986). The two prominent theories of why perceived support operates as a stress buffer are discussed here.

**Stressor-Resource Matching**

The matching hypothesis proposes that stress buffering occurs only when there is a match between the needs elicited by the stressful event and the functions of support that are perceived to be available (Cohen & McKay, 1984; Cohen & Wills, 1985). For example, having someone who would loan you money may be useful in the face of a temporary job loss, but useless in the face of the death of a friend. Cohen and Wills (1985) also argue that certain types of support may be useful in coping with all or many stressors. Specifically, having people to talk to about problems (appraisal or informational support) and having people who make you feel better about yourself (self-esteem or esteem support) may be generally useful because these are coping requirements elicited by most stressors. A corollary of the globally useful resource argument is that confidants who tend to be good sources of appraisal and self-esteem support are universally effective support sources. Although existing research supports the effectiveness of confidants as stress buffers (see review by Cohen & Wills, 1985), there is a strong suggestion that women show more benefit from confidant support than men (Husaini, Newbrough, Neff, & Moore, 1982; Henderson, Byrne, & Duncan-Jones, 1981),
indicating the possibility of sex differences in the effectiveness of "globally" useful resources.

Although literature reviews generally conclude that existing evidence is consistent with matching notions (Cohen & Wills, 1985; Cutrona & Russell, 1990), there are few studies designed to test specific hypothetical predictions. The lack of studies is to some degree attributable to the difficulty in providing an adequate test of the matching hypothesis. It requires the definition and measurement of distinct categories of stressors and of social support, relatively orthogonal measures of subtypes within each category, and a conceptual link between stress and support categorizations (Cohen & McKay, 1984; Tetzloff & Barrera, 1987).

An elaboration of the matching model proposed by Cutrona (1990; Cutrona & Russell, 1990) provides some of this specificity. Cutrona suggests that the controllability of a stressor is the primary dimension in terms of an appropriate match. Potentially controllable stressful events are presumed to elicit needs for problem-focused coping (informational and tangible support) to aid in preventing event occurrence or consequences. Uncontrollable events are presumed to elicit needs for emotion-focused coping (emotional support) to help persons recover from the negative emotions elicited by an event. Like Cohen (Cohen & McKay, 1984; Cohen & Wills, 1985), Cutrona also emphasizes matching support to the needs elicited by specific stressor domains. In her scheme, stressors are viewed as events that create deficits or losses (Hobfoll, 1989; Stroebe & Stroebe, 1985). The nature of the loss is presumed to affect the nature of the required replacement. For example, a loss of assets (tangible resources and physical capabilities) would be associated with a need for tangible support. Because stressors (by definition) create deficits, domain specific matching should apply to replacing a deficit whether it is controllable or not. However, Cutrona argues that it is especially important for long-term uncontrollable deficits such as those created by the loss of an intimate relationship. This conceptualization of the matching model is promising but awaits empirical verification.

**Perceived Support as a Proxy for Positive Interpersonal Schemas**

An alternative explanation for why perceived support acts as a stress buffer views support as a stable individual difference that generates changes in cognition or self-concept (Sarason, Sarason, & Pierce, 1990). The specific argument is that early experiences with attachment relationships (particularly parental attachments) have enduring effects on schemas about relationships (i.e., the meaning of relationships) and support expectancies (Sarason et al., 1990). In this approach, perceived support is a manifestation of a set of positive interpersonal schemas. Presumably, persons with positive expectancies about relationships feel less constrained in revealing needs to network members and in asking for help (Reis, 1990). Positive expectancies may also influence how supportive transactions are interpreted. For example, expectancies for support have been associated with responding more positively to supportive behaviors and viewing them as more helpful (Lakey & Cassady, 1990). Sarason et al. (1990) also argue that relationship schemas include a “sense of acceptance”—the belief that others accept us for who we are, including our best and worst points. This sense of acceptance is presumed to contribute to the development of competencies, which aid persons in dealing with stressful events.
Perceived Support as a Personality Measure

A striking difference between the need-matching and the positive interpersonal schema explanations of stress buffering is that the former suggests that perceived support measures reflect support provided from the social environment and the latter that perceived support reflects an enduring characteristic of personality. It is likely that both are partly correct. That is, some of the variance in perceived support measures is based in personality, whereas other variance is based on the availability of support in the environment. In support of the personality argument are data indicating that high levels of perceived support are related to a number of personality characteristics including social competence, internal locus of control, and low anxiety (Sarason et al., 1990; see also Lakey & Cassidy, 1990). There are also data indicating relatively high test-retest correlations for perceived support over periods of several months.

In support of the argument that perceived support is environmentally based are data indicating that: (a) test-retest correlations over several months are much attenuated among persons adapting to a new social environment (Cohen, Sherrod, & Clark, 1986); (b) using factor analysis perceived support has been shown to be independent of self-esteem, control, depression, and anxiety (Lakey & Cassidy, 1990); (c) stress-buffering effects remain after controlling for the possible role of social skills (Cohen et al., 1986); (d) existing studies do not indicate that related personality variables operate as stress buffers (Cohen & Edwards, 1989); and (e) perceived support is strongly associated with the nature and pattern of persons' social interactions (Cutrona, 1986; Reis, personal communication; Vinokur, Schul, & Caplan, 1987).

A recent proposal suggests an integration of the matching and sense of acceptance explanations. Sarason et al. (1990) argue that viewing social support in terms of disaggregated social needs and provision leads to a focus on short-term effects—for example, coping with particular setbacks or solving a current problem. On the other hand, viewing social support as a sense of acceptance leads to a focus on long-term effects, such as the development of feelings of personal control and self-efficacy that facilitate the ability to cope with stressful events. However, the distinction between short- and long-term stressor effects is probably too simple to provide a resolution of this problem. For example, how would this resolution treat the importance of matching needs (deficits) incurred when stressors have long-term implications—for example, the loss of a spouse or intimate friend (Cutrona, 1990)?

SUPPORT BEHAVIORS

The processes of support seeking, providing, and receiving have received little attention relative to their complexity and importance in understanding how others' behaviors may be helpful in confronting stress. The following discussion highlights some important issues about seeking, providing, and receiving aid in the face of stressful events. The concepts discussed in this section are represented in Figure 1 in the support behavior box and in the feedback loops connecting support behaviors to stress and stress appraisal.

Support behaviors may be helpful or harmful to persons who appraise a situation as stressful. An important factor in assessing the effectiveness of support is
whether or not it is requested. Support is often made available naturally in the
course of normal social interactions without specific requests for aid (Cohen &
Wills, 1985; Pearlman & Schooler, 1978; Bolger, Kessler, & Schilling, unpublished
manuscript; Coyne & Bolger, 1990). Asking for aid entails different interpersonal
processes (e.g., Fisher, Nadler, & DePaulo, 1983) and often implies the lack of a
relationship that is close enough that a request would not be required. In many
cases, support provided without request may be more effective than that which one
must request. The following discussion is not concerned with active seeking (ask-
ing for) aid but rather with receiving unsolicited support when the need arises.
(See Wills & DePaulo, 1991, for a recent discussion of help seeking.)

Who provides social support? The provision of support is thought to vary with
gender, relationship between the giver and receiver, social-cultural context, and
personality characteristics of the giver. At least in regard to emotional support, it is
generally thought that women are more likely to provide it to both men and women
(e.g., Kessler, McLeod, & Wethington, 1985). This might occur because women
take greater responsibility for members of their social networks, because they are
more open in regard to discussing emotions, because they place a greater weight
on the importance of relationships, or because they have better interpersonal skills
than men.

Closer relations such as family members and close friends are more likely to
provide support than acquaintances (e.g., Dakof & Taylor, 1990). This more obvi-
ous finding is probably attributable to normative support responsibilities, greater
concern for a close relation, and reciprocity expectations. Support provision may
also be influenced by group structure and social determinants such as community
size and resources, SES, ethnic group customs, and cultural norms (Wortman &
Conway, 1985).

The provision of support is to a great extent dependent on the appropriateness
of specific sources. The appropriateness depends on the nature of the stressful
event, its impact on the individual, and the source’s relevance for an event. For
example, emotional support for cancer patients may be best provided by close
friends and relatives, whereas information support may be best provided by physi-
cians and others with cancer (Dakof & Taylor, 1990). An acquaintance or work
supervisor, however, may find it inappropriate to provide emotional or informa-
tional support to a cancer patient.

Who receives social support? Individual differences play a role in the receipt of
support. For example, persons with high self-esteem (Newcomb, 1990) and with
social skills such as sociability, assertiveness, comfort with intimacy, and ability to
empathize with others are more able to maintain and draw upon support networks
(Clark & Reis, 1988; Cohen et al., 1986; Heller & Swindle, 1983; Shumaker &
Brownell, 1984). In research on a number of other individual differences, internal
locus of control, positive beliefs in the benefits of help seeking, and higher levels
of education were all found to be positively related to the number of persons who
actually provided aid in the face of stressful events and to reported effectiveness of
support under stress (e.g., Eckenrode, 1983; Riley & Eckenrode, 1986). Although
some have postulated that females receive more support than males (Belle, 1989),
gender differences in support receipt are not well documented. It is probable that if
such differences exist, they are moderated by both the gender of the giver and type
of support.

When (under what conditions) is support sought or desired? Social comparison
models of support seeking argue that there are conditions under which support will be neither desired nor effective in reducing stress (Cohen & McKay, 1984). Particularly, support will only be sought (or have stress-reducing effects) when (a) the stressor is one that is socially acceptable and does not result in feelings of guilt and shame, (b) discussion of the stressor will not be detrimental to one's relationship with the supporter, (c) the support is provided by people who are perceived as providers of accurate information (e.g., others who have similar attitudes, personalities, and the like, or others who have experienced a similar stressor), and (d) the supporter communicates a relatively calm reaction to the potential stressor.

When (under what conditions) is support provided? Dunkel-Schetter and Skokan (1990) propose four classes of factors influencing the willingness to provide support: (a) stress appraisal factors, (b) recipient factors, (c) relationship factors (provider-recipient history), and (d) provider factors. Stress appraisal refers to whether the situation is perceived as stressful by the potential recipient. Support will be offered if it is. Recipient characteristics that are generally presumed to increase aid include increased distress (excepting severe distress; e.g., Coyne, 1976), active coping, and personality characteristics such as mastery and high self-esteem (e.g., Dunkel-Schetter, Folkman, & Lazarus, 1987). Support is more likely to be provided in intimate relationships, when persons are satisfied with their relationship, and when social norms indicate the appropriateness of aid. Other provider characteristics that may influence aid include affect, empathy regarding another's fate, altruistic motivation to help, guilt, and perception of responsibility for the other person.

What kinds of behaviors are supportive? Studies reporting interviews of cancer patients (Dakof & Taylor, 1990; Dunkel-Schetter, 1984) and the recently bereaved (Lehman, Ellard, & Wortman, 1986) indicate that victims generally perceive emotional support as most effective. These perceptions are consistent with evidence that emotional support from significant or primary others is the most powerful predictor of reduced psychological distress (Cohen & McKay, 1984; Heller, 1979; House, 1981; Turner, 1983; Thoits, 1985). They are also consistent with Cutrona's (1990) argument that uncontrollable events are best buffered by emotional support and Cohen and Wills' (1985) argument that emotional support is a globally useful support function.

Even in the context of traumatic and victimizing events like cancer, the perceived helpfulness of an act is partly dependent on the source. For example, Dakof and Taylor (1990) found that intimate others were most valued for the esteem/emotional support they provided, whereas information support and tangible aid were less frequently experienced as helpful. Other cancer patients and physicians, on the other hand, were most valued for information support.

There is also theoretical work suggesting some specific behaviors that are predicted to be inappropriate or ineffective. For example, Wortman and Dunkel-Schetter (1979, 1987) theorized that victimizing events (e.g., cancer) often elicit ineffective responses from the social network such as (a) physically avoiding the victim, (b) avoiding open communication about the victimizing event and its consequences, or (c) engaging in forced cheerfulness or minimizing of the victim's circumstances. Recent data, however, suggest that although these behaviors are usually perceived as unsupportive, primary supporters of cancer patients—spouse and close family members—seldom behave in this manner (Dakof & Taylor, 1990).
A series of studies of the effectiveness of spouse (living partner) support for quitting smoking indicates some rather clear classifications of behaviors that result in successful quitting. "Positive" behaviors (those expressing cooperation, participation, and reinforcement) increased probability of success and "negative" behaviors (nagging, shunning, and policing) decreased the probability of success (e.g., Coppotelli & Orleans, 1985; Mermelstein, Cohen, Lichtenstein, Baer, & Kamarck, 1986). Moreover, the effectiveness of these behaviors is dependent on the content and context of a relationship (Cohen & Lichtenstein, 1990). First, the effectiveness of positive and negative behaviors is dependent on the base rate of smoking relevant support behaviors that occur within the relationship. This is demonstrated by results indicating that higher positive to negative behavior ratios were better predictors of successful smoking cessation and maintenance of abstinence than either the frequencies of positive or negative behaviors (Cohen & Lichtenstein, 1990). Second, prequitting expectations of the frequency of supportive behaviors that a spouse or partner would provide moderated the effectiveness of the behaviors that were actually provided. Those receiving more positive to negative behaviors than they expected before they began the quitting process were most successful, those who received what they expected fell in the middle, and those who received less support than expected were the least successful (Cohen, in press).

How long will persons provide support? There is little theory (or data) on the dynamics of support giving. For the purpose of this discussion, however, we will make a number of assumptions about what determines the onset and offset of support: (a) the giver’s perception that the receiver is under stress, (b) the nature of the relationship between giver and receiver, (c) the amount of time and effort required in providing support, (d) the duration of support needs, (e) the apparent effectiveness of support, and (f) the indication that the supportee appreciates the effort. Factors (d) through (f) are probably moderated by giver expectancies about what is appropriate or prescribed for specific stressors and relationships. In other words, to the extent that the need for support exceeds givers’ expectancies of appropriate support, givers will be more likely to withdraw, induce conflict, or experience the support giving as a stressor (e.g., Schulz, Tompkins, & Rau, 1988). Discrepancies between supporter expectancies and supportee needs are probably common (see Melamed & Brenner, 1990). For example, in our own work on spousal support for quitting smoking, spouses often feel that their work is done a couple of weeks after cessation, but many former smokers continue to have strong cravings months later.

We have suggested a view of support maintenance as a balance between costs of giving and relationship with the person receiving support. However, for some relationships, even extreme costs are accepted without withdrawal. For example, caregiving for close others with terminal or progressively deteriorating diseases (e.g., cancer and Alzheimer’s) can have uniquely high costs for the supporter. Because the act of support requires constant observation of and contact with a loved one who is suffering, a great deal of emotional pain can result for the supporter. Sometimes the support role can be transferred to (or shared with) another, either a professional or a member of the support system. However, often no alternative supporters are available and withdrawal from the relationship is normatively unthinkable.

How do social relationships influence adaptation? Social relationships probably
influence both problem- and emotion-focused coping. Problem-focused coping refers to instrumental attempts to manipulate stressful events and persons' relations to events. Emotion-focused coping refers to adjustments to emotional and psychological (e.g., loss of self-esteem or control) responses to stressful events (Lazarus & Folkman, 1984). Discussions of support and problem-focused coping primarily focus on the social environment as a source of information or material-coping resources (Cohen, 1988; Thoits, 1986). These resources may assist persons to change a situation or the meaning of a situation and hence their stress appraisal. These processes are represented in Figure 1 as a feedback loop connecting support behaviors to stress appraisal. The availability of coping assistance and/or the coping success of that assistance has also been viewed as a contributor to feelings of specific control over a stressor as well as generalized expectancies of control (e.g., Cohen, 1988; Krause, 1987; Pearlin, Menaghan, Lieberman, & Mullan, 1981; Thoits, 1985).

Discussions of support and emotion-focused coping have centered on the regulation of self-esteem and/or affect. These processes are represented in Figure 1 as feedback loops connecting support behaviors to stress. Most theories of support effects on self-esteem postulate support contributions to esteem maintenance (Brown & Harris, 1978; Heller, Swindle, & Dusenbury, 1986; Kessler & Essex, 1982; Krause, 1987; Pearlin et al., 1981; Wills, 1985). For example, Thoits (1985) argues that emotional support from significant others may buffer or reduce distress by bolstering one or more aspects of self that have been threatened by objective difficulties (most often, negative role changes and role-related strains). However, some have argued that receiving (needing) support can undermine self-esteem (DiMatteo & Hays, 1981; Wortman & Conway, 1985). This would presumably occur when aid is provided in a domain in which the receiver perceives him or herself as competent or when the support comes from a person whose aid threatens perceptions of competence. This is represented in Figure 1 by the arrow labeled "inappropriate support."

Another of the feedback loops connecting support behaviors to stress in Figure 1 is network failure. Brown and Harris (1989) have insightfully suggested that psychological distress and disorder may be less a consequence of stressor exposure and appraisal and more a consequence of the network's failure to respond when a person is in need. Evidence consistent with the importance of network responsiveness is provided in a study of caregivers for Alzheimer's patients (Pagel, Erdly, & Becker, 1987). Caregivers' degree of upset with their networks was negatively associated with their satisfaction with their social networks and positively associated with depression.

Figure 1 also includes a feedback loop from supportive behaviors to perceived support. This loop represents the influence of previous experiences with support on expectations of future support. The final feedback loop connects supportive behaviors to the social network and represents network deterioration as a result of the support process (Schulz & Tompkins, 1990). This deterioration might occur because of prolonged demands on support exceeding the expectancies and/or norms of a network.

CONCLUSION

Given the myriad published research on stress and social support, our understanding of these processes is disappointing. This is because we: (a) tend to poorly
conceptualize and operationalize stressors and supports, (b) have an insufficient understanding of how stressors influence various disorders, (c) have an insufficient understanding of how support concepts interact with the stress process, and (d) lack an integrated theoretical perspective to drive empirical research.

Conceptualization and Measurement of Stressors and Supports

The disagreements and problems in defining and measuring stress are well documented elsewhere and are beyond the scope of this chapter (e.g., Ostfield & Eaker, 1985). An elaborate interview methodology allowing for disaggregation of event categories and assessment of the meaning of events for the individual is available (Brown & Harris, 1989); however, good life event measures taking less time, and hence useful in a broader range of studies, are harder to come by. A focus on persons experiencing single traumatic events (e.g., bereavement or divorce) provides an alternative to the conceptual and methodological problems that are intrinsic to cumulative life event measurement (Cohen & Williamson, 1991). Measurement issues also plague assessment of other conceptions of stress such as perceived stress, psychological distress, and affect. However, because these concepts are "perceived" in nature, self-report instruments are presumed to be face valid.

The three categories of support discussed in this chapter represent a reasonable starting point, but more refined typologies of the social environment as it affects these processes would be welcome. Measures of social networks used in the stress and disorder literature generally suffer both conceptually and psychometrically. The great shame is the failure to use a formal social network theory to provide concepts and measures of social networks (Hall & Wellman, 1985; Hirsch, 1981). Several psychometrically valid perceived support measures are available (e.g., Cohen & Hoberman, 1983; Sarason, Levine, Basham, & Sarason, 1983; Procidano & Heller, 1983), but there is still a major challenge in the measurement of supportive behaviors (see Cohen & Lichtenstein, 1990; Reis et al., 1985). There is too little theory and data on supportive behaviors themselves. We need to know the types of behaviors that are supportive and the social contexts under which the same behaviors are supportive or not. Additional microlevel analyses (e.g., daily diary data) of support content and context, and of perceptions of support by supporter and supportee, are imperative (e.g., Bolger, DeLongis, & Kessler, 1989; Cohen & Lichtenstein, 1990). There is also a need to develop psychometrically valid measurement instruments specific to a number of domains (e.g., support for persons with cancer, Alzheimer's, and AIDS, and for caregivers of the elderly and chronically ill).

How Stressors Influence Various Disorders

A major problem in studying the interrelations of stress and social support as applied to a disorder model is our poor understanding of the relations between stress and disorder. Although the hypothesis that stressful events result in both psychological and physiological disorder is generally accepted by the press and public, the evidence for such effects is less than impressive. Although a thorough
discussion of this issue is not possible in this context, it is worth emphasizing some of the things that may result in a clearer understanding of the role of stressful life events in disorder: (a) a clearer theoretical distinction between events (severity, duration, controllability, event clusters, and categories, etc.) (Brown & Harris, 1989; Thoits, 1983), (b) identification of the role of specific stressful events (or event domains) in specific disease processes (diseases and disease stages) (Cohen, 1988; Cohen & Williamson, 1991; Harris, 1989), and (c) distinction between processes involved in stressor influences on illness behaviors (symptom and illness reporting and health utilization) and those involved in verified clinical disease (Cohen & Syme, 1985; Cohen, 1988; Cohen & Williamson, 1991).

How Support Concepts Interact with the Stress Process

We need more broadly conceived theories of social support. As a start, these theories need to recognize and incorporate the different conceptions of social support and their various implications for the pathways through which support may influence the relation between stress and disorder. New theories also need to recognize and identify differences in stressors. For example, interpersonal stressors present unique problems for stress-support models, because the stressors themselves may impact the nature of social networks, availability of support, and type and quality of support behaviors. At the same time, we know interpersonal stressors are important contributors to the development of disorder and disease, possibly because they are simultaneous indicators of both a stressor and the disruption of social networks and supports.

Another important issue is the relationship of support provision to the time course of stressor and disease processes (Jacobson, 1986). Support that is appropriate and effective at one point in the unfolding of a stressful event may be useless or harmful at another (Cohen & McKay, 1984). For example, emotional support may be most appropriate when a person loses a job and the offer of tangible aid may be inappropriate. Several months later, however, the offer of aid might be most appropriate.

Lack of an Integrated Theoretical Perspective

It is easy to criticize this area for lacking a broader-integrated theoretical perspective, but it is much more difficult to derive such an approach. This chapter contains a rough outline of the issue involved in such an endeavor. Hopefully, future work will build on an understanding of the concepts and mechanisms proposed, and will aid in the development of a truly integrated theory of the role of social networks, supports, and supportive behaviors in a stress and disorder model.

REFERENCES


STRESS, SOCIAL SUPPORT, AND DISORDER


