Coping Theory and Research: Past, Present, and Future

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INTRODUCTION

In this essay in honor of Donald Oken, I emphasize coping as a key concept for theory and research on adaptation and health. My focus will be the contrasts between two approaches to coping, one that emphasizes style—that is, it treats coping as a personality characteristic—and another that emphasizes process—that is, efforts to manage stress that change over time and are shaped by the adaptational context out of which it is generated.

I begin with an account of the style and process approaches, discuss their history briefly, set forth the principles of a process approach, describe my own efforts at measurement, and define coping and its functions from a process standpoint. This is followed by a digest of major generalizations that resulted from coping process research. The essay concludes with a discussion of special issues of coping measurement, in particular, the limitations of both coping style and process approaches and how these limitations might be dealt with.

There has been a prodigious volume of coping research in the last decade or two, which I can only touch on very selectively. In this essay, I also ignore a host of important developmental issues that have to do with the emergence of coping and its cognitive and motivational bases in infants, as well as a growing literature on whether, how, and why the coping process changes with aging.

APPROACHES TO COPING: STYLE VERSUS PROCESS

In one form or another the concept of coping has been with us for a long time, though it began to come into its own formally during the 1960s and 1970s, along with the burgeoning interest in stress.

If we think of coping as a generic concept that includes ego-defenses, which deal with threats to one's psychological integrity, then the psychoanalytic interest in defense was clearly its forerunner. The earliest psychoanalytic interest in defense centered on its role in psychopathology as a characteristic style for managing threat. A powerful psychoanalytic concept, which greatly influenced personality and clinical psychology, was that each form of psychopathology was associated with a particular *defensive style*. For example, hysterical neuroses were linked to repression, obsessive-compulsive neuroses to intellectualization and undoing, paranoia to projection, and so forth.

This view flowed from the theoretical convergence postulated in Freudian theory between three developmental variables: (a) the psychosexual stage of childhood development at which trauma occurs; (b) the primary impulses and conflicts of each particular stage—for example, oral dependency, anal-centered struggles over the social control of instinctual drives, and phallic and oedipal conflicts; and (c) the child's cognitive characteristics at each stage, which presumably shape the defensive style.

Despite the elegance and potential power of this formulation, the close association between developmental stage, the content of impulses, and cognitive characteristics does not show up clearly enough in observation to provide adequate support for it. The link between forms of psychopathology and specific defenses is also a bit too neat to be generally applicable—it is more a conceptual ideal rather than a clinical reality. In many quarters, psychosexual theory has given way to a greater emphasis on other cognitive-motivational processes—an outlook articulated in psychoanalytic ego-psychology—such as the development of competence and control and, of course, defense. In any case, the psychosexual formulation has lost influence in clinical research and practice.

Some of the familiar writers who were actively pursuing variants of this psychoanalytic thesis included Rapaport et al. (1) with their influential monograph, *Diagnostic Psychological Testing*, Schafer (2), Holzman and Gardner (3), Witkin et al. (4), Klein (5), Shapiro (6), and their many ego-psychology and developmental mentors (see also Ref. 7 for a detailed historical account). These are classic works that were greatly admired by many of us of an earlier generation.

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Received for publication May 11, 1992; revision received August 4, 1992.

0033-3174/93/5503-0234$03.00/0

Coping as Hierarchical Styles

The work of Menninger (8), and more recently Haan (9) and Vaillant (10), drew on a hierarchical approach to coping derived from the developmental psychoanalytic formulation. Some defenses were said to be more healthy or less regressed than others—presumably as a result of stress or trauma. For example, Haan proposed a tripartite hierarchy with *coping* as the most healthy and developmentally advanced process of adaptation, *defense* as a neurotic process, and *ego-failure* as the most severely regressed and perhaps psychotic adaptive process.

A Chicago research group, headed by Roy Grinker, Sr., at Michael Reese Hospital (e.g., Ref. 11)—which, incidently, included Donald Oken—focused less on the strictly Freudian developmental formulations with its emphasis on early childhood and more on the contemporary scene of the patient's life. For this group, too, coping and defense were also central concepts.

Hierarchical, developmental approaches tended to spawn trait measures of coping, such as the contrast between repression (avoidance or denial in some versions)—sensitization (vigilance, isolation, or intellectualization in some versions). In a review of coping theory and assessment, Cohen (12) cites a number of questionnaire measures of this contrast, treated either as a single dichotomy or a continuous dimension. Her list includes a questionnaire published by Byrne (13), another by Epstein and Fenz (14), and a non-questionnaire measure developed by Goldstein (15), named the Coping-Avoidance Sentence Completion Test. She also cites two Rorschach indexes, one by Gardner et al. (16), the other by Levine and Spivack (17), which employ the related language of repression-isolation. Finally, two multidimensional sets of measures, The Defense Mechanism Inventory of Gleser and Ihilevich (18), and the Coping-Defense Measure of Joffe and Naditch (19), are also mentioned.

Not all research on coping style draws on standardized measures, such as those cited above. Many are ad hoc procedures using in-depth clinical interviews (20–22). Still others have employed Grounded Theory (23), which does not employ interpretive criteria in advance but generates models and hypotheses about what is happening from spoken or written products (e.g., Ref. 24).

Coping as Process

In the late 1970s a major new development in coping theory and research occurred in which the hierarchical view of coping, with its trait or style emphasis, was abandoned in favor of a contrasting approach, which treated *coping as a process*. From a process perspective, coping changes over time and in accordance with the situational contexts in which it occurs.

A hierarchy of coping strategies based on preconceived notions about their inherent health or pathology runs the danger of confounding process and outcome, which is particularly evident in Vaillant's otherwise impressive longitudinal research. Diagnoses of the type of defense employed by his subjects depended to some unkown extent on prior notions about how healthy they are as coping strategies, which may well have influenced later evaluations of the quality of adaptation. As we shall see, a tenet of process approaches is that process and outcome should be measured independently.

My own approach to the study of the coping process had its origins in stress film and sound track research at Berkeley in the 1960s (see Refs. 25–29, 76). In the late 1970s, and within a few years of each other, a number of researchers including myself (e.g., Refs. 30, 31; see also a review of 10 years of research by Lazarus and Folkman (32); also Refs. 33–35) developed measurement approaches bearing the same metatheoretical stamp. These pioneering efforts were followed by additional questionnaire versions designed also to measure and study coping as a process and examine its consequences for adaptation. These additional versions overlapped heavily with earlier ones (e.g., Refs. 36, 37).

Principles of the Process Approach

Below is a set of the metatheoretical principles my colleagues and I have enunciated over the years that, I believe, is reasonably representative of most current approaches to coping as a process:

1. Coping thoughts and actions under stress must be measured *separately from their outcomes* in order to examine, independently, their adaptiveness or maladaptiveness. I make the contextualist assumption—with considerable empirical support—that whether a coping process is good or bad, adaptationally speaking, depends on the particular person, the specific type of encounter, in the short or long run, and the outcome modality being studied, for example, morale, social functioning, or somatic health. There may be no universally good or bad coping processes, though some might more often be better or worse than others.

Thus, denial, which was once regarded by ego-

psychologists as pathogenic, may be useful for adaptation under certain definable circumstances, as I proposed some years ago in discussing its costs and benefits (38). Although a full analysis of definitional and measurement problems with respect to denial has not been made—for example, to what extent denial is different from avoidance and illusion—much interest in the consequences of denial for somatic and mental health has been generated in recent years. Health-related targets of this interest include heart attacks, surgery, asthma, and other illnesses.

In this vein, observations of the course of a heart attack suggest that denial has different consequences, a) when symptoms first arise and must be interpreted by the victim to decide what to do, b) during the post-coronary period in the hospital, and c) after discharge from the hospital. Denial appears to be counterproductive and dangerous when the person is interpreting symptoms—it commonly results in delays in getting help at a most dangerous time—however, it is useful in the post-coronary hospital care period, but again becomes increasingly counterproductive and dangerous if it continues as a strategy of coping too long after discharge from the hospital (e.g., Refs. 39, 40). A full current review of this kind of research would, I think, be a very worthwhile enterprise.

Research has also suggested that denial has favorable consequences for several adaptational outcomes of surgery, for example, rate of healing, presence of minor complications, and the duration of hospitalization (41). The story is different for asthma, however. Although denial leads to lower levels of apprehension when symptoms of an upcoming asthmatic attack begin to appear, it is also associated with a greater likelihood of hospitalization for an acute asthmatic attack. Vigilant coping, on the other hand, may lead to effective efforts to abort the attack by, say, using an inhaler or taking other medication, so that patients who cope in this way are rarely hospitalized (42).

2. If one asks patients how they cope post-surgically with, say, breast cancer, the answer is apt to be misleading because the coping strategy depends on whether, at any given time, they are dealing with one or another of the diverse threats engendered by the disease. Thus, what a person does to cope depends on the *context* in which the disease occurs, and this will change over time because what is attended to, and the threats themselves, also change (43–45).

The threat focused on by the patient at any moment might be the likelihood of recurrence of the malignancy—depending, of course, on whether it is near the time at which a post-surgical diagnostic examination is scheduled. If it is, then the danger of recurrence will probably be at the center of attention. However, at other times thoughts about recurrence may be avoided. Alternatively, the focus of threat may be having to tell a spouse, friends, parents, or children about what is happening. The stage of the illness, that is, whether the cancer is early or well-advanced, strongly influences the patient's state of mind. An advanced cancer may create the need in a patient to thank about whether to continue or discontinue debilitating treatment, to deal with the growing imminence of death (46), and so forth.

The principle here is that the process of coping employed for the different threats produced by cancer, or any other complex source of psychological stress, whether disease-based or not, varies with the diverse adaptational significance and requirements of these threats. Therefore, when studying how the patient copes with this illness, it is necessary to specify the particular threats of immediate concern to the patient and to treat them separately rather than broadening the focus of attention to the overall illness.

3. What is most needed in coping measurement is to *describe* what a person is *thinking and doing* in the effort to cope with stressful encounters. The inference about how the person is coping is then made not by the person being studied but by the professional observer.

This sort of measurement should also be employed repeatedly over time and across diverse stressful encounters in research designs that are *intraindividual as well as interindividual*. This would enable the researcher to examine both consistencies and inconsistencies in the way individuals cope over time and across stressful encounters.

A combined intra- and interindividual research design allows us to view coping in both its state and trait aspects, state representing instability (flux) or change, trait representing stability or consistency across diverse conditions. If we emphasize coping consistency over time and across encounters, we are dealing with the trait concept; if we emphasize contextual influences and coping inconsistency over time and across encounters, we are dealing with the state concept or process. They are two sides of the same coin, and both sides are usually relevant. The more consistency, the more the trait side stands out; the more inconsistency, the more the state (or process) side stands out. The trait-process (state) issue cannot be studied empirically unless coping strate-

gies are examined in the same persons over time or across stressful encounters.

These considerations, in part, led the Berkeley Stress and Coping Project to develop the *Ways of Coping Questionnaire* (47), which is currently the most widely used technique of its kind, whether it is used in the form of an interview or self-administered. This approach was designed to make possible a process, contextually oriented approach to coping rather than to study coping as a stable disposition. Our process coping scales—and others like them—invite the subject to endorse whatever thoughts and actions, presented as a list, were employed to cope with *a particular stressful encounter*. The most sophisticated versions are factor-analyzed to generate a set of different strategies, constructed on the basis of both theory and the way the items behave psychometrically.

There are eight factors in the Ways of Coping Questionnaire. Table 1 presents sample items from each scale. The scales developed by other researchers contain overlapping, though not identical, items and are defined by overlapping, though not identical, conceptual labels.

4. From a process standpoint, *coping is defined* as ongoing cognitive and behavioral efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person. The definition can be simplified—though with a loss of some information—by saying merely that coping consists of cognitive and behavioral efforts to manage psychological stress. From a measurement and research standpoint, this type of formulation emphasizes that the coping *effort* is independent of the *outcome* so that its role in influencing adaptational outcomes can be independently assessed.

Notice that the term coping is used whether the process is adaptive or nonadaptive, successful or unsuccessful, consolidated or fluid and unstable. *Adaptive* refers to the effectiveness of coping in improving the adaptational outcome, for example, morale, physical health, and social functioning. *Success* refers to the extent a coping-related (or defen-

TABLE 1. Sample Items from the Ways of Coping Questionnaire

Factor	
1. Confrontive coping	
	46 Stood my ground and fought for what I wanted.
	7. Tried to get the person responsible to change his or her mind.
	17 I expressed anger to the person(s) who caused the problem.
2. Distancing	
	44. Made light of the situation; refused to get too serious about it
	41. Didn't let it get to me; refused to think about it too much.
	21. Tried to forget the whole thing.
3. Self-controlling	
	14. I tried to keep my feelings to myself.
	43. Kept others from knowing how bad things were.
	35. I tried not to act too hastily or follow my first hunch.
4. Seeking social support	
	8. Talked to someone to find out more about the situation.
	31. Talked to someone who could do something concrete about the problem.
	42 I asked a relative or friend I respected for advice.
5. Accepting responsibility	
	9. Criticized or lectured myself.
	29. Realized I brought the problem on myself.
	51. I made a promise to myself that things would be different next time.
6. Escape-avoidance	
	58. Wished that the situation would go away or somehow be over with.
	11. Hoped a miracle would happen.
	40 Avoided being with people in general.
7. Planful problem solving	
	49 I knew what had to be done, so I doubled my efforts to make things work.
	26. I made a plan of action and followed it.
	39. Changed something so things would turn out all right.
8 Positive reappraisal	
	23. Changed or grew as a person in a good way.
	30. I came out of the experience better than when I went in.
	36. Found new faith.

From Folkman and Lazarus, 1988 (Ref. 47).

sive) reappraisal is believed by the person. *Consolidated* means that the person has achieved a stable way of coping or defending under a variety of circumstances; most coping processes, including defenses, are probably the result of a fluid, contextually sensitive struggle to appraise what is happening in a way that is responsive to the realities of a situation yet is also hopeful or even optimistic about how things are going. For example, a person might try unsuccessfully to deny a threat saying, as in an internal dialogue, "I tried to tell myself I was not dying, but I couldn't make it stick."

5. The theory of coping as a process emphasizes that there are at least two major *functions of coping*, problem-focused and emotion-focused. The distinction is suscribed to widely by coping researchers. The function of *problem-focused coping* is to change the troubled person-environment relationship by acting on the environment or oneself. The function of *emotion-focused coping* is to change either a) the way the stressful relationship with the environment is attended to (as in vigilance or avoidance) or b) the relational meaning of what is happening, which mitigates the stress even though the actual conditions of the relationship have not changed (48). The latter involves a more benign or less threatening reappraisal, as illustrated, for example, in denial and distancing.

Changing the *relational meaning* of what is happening is a very powerful—and widely employed—device for regulating stress and emotion. For example, a loved one makes a disparaging comment, which is taken as demeaning. Now suppose the recipient of the provocation wishes very much to avoid feeling and displaying the resulting anger with its potentially negative consequences. If that recipient is capable of making excuses for the loved one, for example, that he or she is ill, worn out, or besieged by work stress—which calls for empathy and forbearance rather than anger—the provocation can be overlooked and the anger need not then be felt or expressed.

In passing, I have long been tempted to think that this strategy of coping is a healthy form of repression or denial. It is not that a recurrent, threatening impulse is blocked from consciousness, but that a reappraisal of what is happening has been made, which eliminates the threat. That the threatening impulse is no longer relevant, and does not have to be blocked from consciousness or from being acted out, makes this change of meaning a healthy and powerful approach to coping. Perhaps some of what we call repression and denial is of this sort.

Of the two functions of coping, problem-focused and emotion-focused, there is a strong tendency in western values to venerate the former and distrust the latter. Taking action against problems rather than reappraising the relational meaning seems more desirable. Nevertheless, there is ample evidence that under certain conditions—particularly, those in which nothing useful can be done to change the situation—rational problem-solving efforts can be counterproductive, even likely to result in chronic distress when they fail; then emotion-focused efforts would offer the best coping choice (49).

MAJOR GENERALIZATIONS FROM RESEARCH ON COPING AS A PROCESS

Our research using the Ways of Coping, and by others using scales with a similar outlook and methodology, has produced a number of important and widely replicated generalizations that can be summarized as follows:

1. People use most of the factor analytic strategies of coping in every stressful encounter (31). Why should this be so? Because stressful encounters are complex and take time. However, it is difficult to say to what extent coping strategies are linked either to *particular facets* of the encounter—say, the threat contents, the goal that is at stake, prior beliefs—or to *temporal factors*; for example, people might try one strategy but change to another on the basis of feedback about its consequences. This profound question about whether coping strategies depend on particular threat contents or trial and error over time has not yet been addressed in research. To find the answers requires a microgenetic type of research design.

2. Some strategies of coping are more stable or *consistent* across stressful encounters than others. For example, in one study we explored five major stressful encounters in the same persons, one per month over 5 months (44, 45). Autocorrelations were used to evaluate the degree of consistency in the same persons across encounters.

We found that some coping strategies were somewhat consistent and others very inconsistent across stressful encounters. For example, seeking social support was very inconsistent, whereas positive reappraisal was modestly—but significant statistically—consistent. In effect, if given persons sought social support in one encounter, there was little likelihood that they would seek it in another. However, if given persons employed positive reappraisal in one encounter, they were also likely to employ it in other encounters. Thus, one could reasonably say

that seeking social support is highly dependent on the social context while positive reappraisal can be viewed to some extent as a stable coping disposition.

In a similar vein, Scheier et al. (37) have shown that the tendency to be optimistic or pessimistic influences the way the person copes with stressful encounters, thus implicating a personality trait in the coping process. Much more research of this sort is needed to reveal the degree to which diverse coping strategies are influenced by the social context, personality variables, or both.

3. *Coping also changes from one time to another* in any given stressful encounter. This is an empirical statement of what it means to talk about coping as process. A college examination is not a unitary event but involves a complex series of stages related to the formal testing arrangements specified by the instructor. The stages consist of a period of warning of the imminence of the examination, a waiting period after the examination has been taken but before grades are announced, and a period after the grades are announced. There is also a confrontation stage when the students are actually taking the examination, but it is not practical to try to study this stage directly during the examination because students would not cooperate with research that would interfere with their performance when their grade depended on it.

The adaptational demands and information available are quite different in these separate stages. In a quasi-experimental study that separated each of the other stages for observation, Folkman and Lazarus (43) demonstrated that the emotion and coping patterns of students changed dramatically across these stages. With respect to coping, seeking information and social support occurred quite frequently in the anticipatory stage, but dropped sharply in later stages; distancing was the most frequently employed coping strategy during the waiting period but was infrequently employed during other stages.

Thus, if the examination had been treated as a single stressful encounter, and coping had been summated across stages, there would have been great distortion in what might have been learned. To collapse what is happening over time is apt to produce findings that are at best uninterpretable and at worst misleading. Smith and Ellsworth (50) have made similar observations about appraisal, coping and emotion in a college examination, with comparable findings.

It troubles me that in spite of the popularity of our method of coping measurement, the consistent theoretical logic that lies behind it, and the substantial evidence that coping changes with the context and over time as the status of a problem changes, few studies on coping pay more than lip service to the basic idea, even when they use these scales or ones that are comparable.

4. When stressful conditions are viewed by a person as *refractory to change*, emotion-focused coping predominates; when they are appraised as *controllable by action*, problem-focused coping predominates (see, for example, Refs. 31, 32). This frequently replicated finding links secondary appraisal, which has to do with the options for coping, with the coping strategy employed, and is reminiscent of the sensible, epigrammatic motto of Alcoholics Anonymous, which goes: "God grant me the courage to try to change what can be changed, the serenity to accept what cannot be changed, and the widsom to know the difference."

5. Coping is capable of mediating the emotional outcome, that is, it changes the emotional state from the beginning to the end of the encounter. Folkman and Lazarus (51) assessed subjects' emotional states at the beginning and end of a number of stressful encounters, focusing on the amount and direction of change as a function of the coping strategy reported. We found that some coping strategies, such as planful problem solving and positive reappraisal, were associated with changes in emotion from negative to less negative or positive, while other coping strategies, such as confrontive coping and distancing, correlated with emotional changes in the opposite direction, that is, toward more distress.

In another study (44) subjects reported on a multiple choice scale that the stress had either been a) unresolved or made worse, b) not changed, c) resolved but not to their satisfaction, d) resolved but improved, or e) resolved to their satisfaction. Satisfactory outcomes were defined as those rated as unresolved but improved (d above) or resolved to their satisfaction (e above).

The relationships between each coping scale and outcome are shown in Table 2. Inspection shows that some coping strategies, such as planful problem solving and positive reappraisal, were significantly associated with satisfactory outcomes, whereas others, such as confrontive coping and distancing, were associated with unsatisfactory outcomes, though these latter two only approached statistical significance.

Since the research design employed in this study required subjects to reconstruct stressful encounters and coping strategies after the stressful encounter had ended, these findings cannot prove the causal role of coping, though they are consistent with theoretical expectations. However, in a prospective

TABLE 2. Relation between Coping and Encounter Outcomes: Intraindividual Analysis

Univariate Tests	Unsatisfactory Outcomes (M)	Satisfactory Outcomes (M)	F	p
Coping scale				
1. Confrontive coping	3.98	3.31	3.34	0 071
2. Distancing	3.35	2.78	3.38	0 069
3. Self-controlling	5.98	5 36	2.53	0.115
4. Seeking social support	4.71	5.16	1.22	0.281
5 Accepting responsibility	1.92	1.65	1.10	0.298
6. Escape-avoidance	2.86	2.64	0.50	0.482
7. Planful problem-solving	6.33	7.59	8.67	0.004
8. Positive reappraisal	2.70	3.90	9.67	0.003

Note. Multivariate $F(8,76) = 4.64$, $p < 0.001$.
From Folkman, Lazarus, Dunkel-Schetter, DeLongis, and Gruen, 1986, (Ref. 44).

study in which coping was measured after the start of the stressful encounter but before the outcome, Bolger (52) obtained findings that strongly supported the proposition that coping plays a causal, mediational role in the emotional outcome.

With respect to the coping mediators of emotion, I might add in passing that under conditions different from those above, for example, in the examination stress study already discussed, when students had nothing to do but wait for word about their grades (43), *distancing* was a very useful coping strategy, which illustrates the point about the dangers of generalizing about the adaptational value of coping strategies without considering the context in which they occur. Again and again we have found that a coping strategy that produces positive outcomes in one context, or in one person, may not in another. We need research to develop rules about the circumstances in which particular coping strategies may have good or bad outcomes.

Another illustration of this applies to *wishful thinking*, which consists of a subset of items falling within the broader coping factor of escape-avoidance. We have noted that escape-avoidance may have positive adaptational value, but this seems never to have been the case in our research thus far for the wishful thinking subset of the escape-avoidance scale. It is tempting to think that we have, at last, found a universally bad coping strategy. After all, one will normally not try to do anything about a negative person-environment relationship if one's coping strategy is to dream or wish that it will go away by itself.

I am reluctant to make this generalization, however, because, like denial, if there is nothing to be done, then wishing should not be harmful. The contextual principle should still be that only when denial or wishful thinking prevents a person from trying more productive strategies in a situation that can be ameliorated should these strategies have negative consequences. We need more observation to resolve this question.

6. Coping research tends to be directed at two separate but related issues, namely, a) the variables influencing choice of coping strategies and b) the effects of these strategies on adaptational outcomes. With respect to outcomes, the theory of coping links efficacy to the quality of the fit between the coping strategy, its execution, and the adaptational requirements of the encounter. This fit will surely depend on the appraisal that is made, as well as on the extent to which the encounter provides viable coping options.

Although there are many reports of significant effects on adaptational outcomes using process coping scales, the weakest set of generalizations about coping has to do with empirical *evidence of its adaptational effects*. In much of the research in this area, these outcomes have tended to be based on self-reports of emotional distress or psychological symptoms (for a small sample, see Refs. 22, 44, 53, 54).

Heavy dependence on *self-report criteria* of adaptational outcomes in coping research, illustrated by my own cited above (51), increases the possibility that the correlations are, in some unknown degree, *confounded* by overlapping antecedent and consequent measures. This is a perennial problem that has plagued research in stress and health, as evidenced by the debate between Dohrenwend et al. (55) and Lazarus et al. (56); see also Lazarus (57), for further discussion of this.

There are, however, some notable exceptions. The most impressive prospective study I have found—using independent observer judgments of adaptational outcomes—is an unpublished dissertation (20)

in which an effort was made to predict individual differences among cancer-induced laryngectomy patients in how rapidly and effectively they learned to talk with a prosthesis. This is—for many—a very difficult, discouraging, and stressful process, but it is accomplished quite well by some and badly by others. Neither the objective severity of the surgical damage nor the personality traits that were measured beforehand predicted these individual differences. Yet how the subjects appraised and coped with the learning task were strongly predictive of later rehabilitative success, which was reliably evaluated by clinical judgment.

It is very difficult to mount multimethod research in which behavioral and physiological criteria are employed, which is one reason for the extensive dependence on self-reports. Nor would I want to venerate other methods, which have serious problems of their own, by denigrating the value of self-reports. However, multimethod research could demonstrate whether obtained relationships between coping and adaptational outcomes, such as self-reported emotional distress and dysfunction, are capable of being replicated across different research methods or are merely instances of method variance. A general review of research on coping and adaptational outcomes would be valuable, since it would address a major reason for the study of coping, namely, its role in these outcomes.

SOME SPECIAL ISSUES OF COPING MEASUREMENT

The two approaches to coping measurement, those of style and process, ask different questions and provide different types of answers about coping. Coping style emphasize personality dispositions or traits, which to some extent transcend the influence of situational context and time on the choice of coping strategy. Coping process emphasizes temporal and contextual influences on coping, and the changes associated with them.

A number of important limitations inhere in both the style and process approaches. These limitations have important implications that I would like now to address. I shall not take up purely psychometric issues here because they are tactical or methodological rather than strategic or theoretical, and being somewhat parochial, they are of less interest to the general reader. A few writers have been concerned with the psychometric issues that apply to process measures (58, 59).

Limitations of the Coping Style Approach

The emphasis on coping style emerged out of an ego-psychology theoretical perspective, which was centered on inner psychodynamics rather than on external environmental forces. In the 1970s, the emphasis shifted for a time to the environment, especially environmental change or life events. However, because the current emphasis is on both sets of factors, the person *and* the environment which are said to interact, person-environment relationships and especially relational meanings about them are an even more appropriate focus than the simple contrast between intrapsychic and environmental.

If, for example, one is concerned with emotional and coping traits, which are dysfunctional in particular clients in treatment, the main interest lies in the consistent ways these clients interpret self and the world and, therefore, how they cope with stress. Presumably the appraisal and coping processes these clients draw on recurrently are what get them into adaptational trouble. The pathogenic dispositions that lead to dysfunctional appraisals and coping processes are, therefore, at the center of treatment designed to lead to changed ways of relating to the world (see Refs. 60, 61, for discussions of emotion traits and processes in psychotherapy). Then one would want to examine coping dispositions or styles in clinical assessment.

The most serious problem with this emphasis is that one ends up assessing overbroad styles of relating to the world, often as a single continuum or dichotomy, such as repression-sensitization. Styles do not provide us with a description of the detailed, specific strategies of coping employed in particular stress contexts. For example, what do different people think and do when self-esteem has been threatened, when they feel unequal to a task on which social- and self-esteem depends, when there is a threat to health, functioning, and survival, when there has been an irrevocable loss, when another person whose acceptance or affection is an important goal has given signs of rejection or lack of affection, and so on?

To sum up, broad coping styles do not adequately explain or predict intraindividual variations in the way given sources of stress are dealt with in specific contexts. The unidimensional typologies are, perhaps, too restricted in what they say about complex adaptational struggles to have much utility in explaining and predicting what people do when confronted with the many forms of harm, threat, and challenge to which all persons are exposed. Even when multidimensional measures are employed, as