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THE EFFECTS OF COPING, SELF-ESTEEM, AND SOCIAL SUPPORT ON STRESS AND WELLBEING

being

A Thesis Presented to the Graduate Faculty

of the Fort Hays State University in Partial Fulfillment of the

Requirements for the Degree of Master of Science

by

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ABSTRACT

The present study aimed to add to the literature on the internal and external factors that may "buffer" the negative effects of stress. Specifically, the present study examined the effects of coping styles, self-esteem, and social support on both psychological wellbeing and stress. Participants (N = 198) were administered a measure of coping styles (COPE), self-esteem (Rosenberg's Self-Esteem Scale), social support (SSQ-R), psychological wellbeing (MHI), and stress (ICSRLE). Results showed problem-focused coping and emotion-focused coping were associated with better psychological wellbeing and lower stress. Avoidant coping was associated with lower psychological wellbeing and higher stress. Self-esteem was also related to higher psychological wellbeing and lower stress. Overall social support network size was predictive of psychological wellbeing in the overall sample, but not predictive of stress; however, in the college age group, overall social support was not predictive of wellbeing or stress. Satisfaction with social support was predictive of both wellbeing and stress. In general, the findings of the present study agreed with the findings of previous research. Exceptions and implications are discussed.

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INTRODUCTION

Stress is ubiquitous in our modern society. Feeling "stressed out" is a common occurrence for many individuals. The annual survey on stress by the American Psychological Association (APA, 2012) found a majority of American adults report moderate to high stress levels. The survey showed 22% of Americans reported extreme stress over the past year. According to the APA's survey, the most commonly cited sources of stress include money, work, and the economy. Other reported sources include family and interpersonal relationships and health problems. While the sources of stress are numerous, this list illustrates the universality of the stressful situations individuals face in their everyday lives.

It is a commonly held belief that stress can affect physical and psychological wellbeing. Empirical support for the link between stress and wellbeing has been found by a number of studies. In 2010, the APA's Stress Survey found respondents with fair/poor health were more likely to report higher levels of stress than their healthier counterparts. Common physical symptoms of high stress levels include changes in appetite and sleep, headaches, and fatigue, while the psychological symptoms include feelings of sadness, anxiety, and lack of motivation (APA, 2010). Associations between stress and physical conditions such as coronary heart disease, cancer recovery rates, rheumatoid arthritis, asthma, and multiple sclerosis illustrate the deleterious effects of stress (Mohr et al., 2000; Petticrew, Fraser, & Regan 1999; Tennant, Palmer, Langeluddecke, Jones, &

Nelson, 1994; Walker, Littlejohn, McMurray, & Cutolo, 1999; Wright, Rodriguez, & Cohen, 1998).

Although the mechanisms through which stress affects health are not fully understood research indicates exposure to a variety of stressors can impact the immune system (Kemeny, 2003). The 'fight-or-flight' response illustrates the relationship between stressor and physiological stress reactions (Kemeny, 2003). Emergencies or threatening situations activate the autonomic nervous system and the release of the hormone epinephrine. Epinephrine is responsible for physiological responses, such as increased heart rate and respiration, which prepare individuals to physically respond to threats. Autonomic nervous system activity has been linked to immune system functioning. Exposure to threats can also stimulate the release of the hormone cortisol, which can suppress the functions of the immune system (Kemeny, 2003). These physiological stress responses are adaptive for survival situations in which physical strength and endurance are necessary such as when escaping from an attacker. However, research indicates exposure to a variety of psychological stressors, including giving a speech, taking an exam, or job loss, can elicit physiological stress responses.

As mentioned previously, stress can influence immune system functioning. However, the type of stress encountered influences the physiological responses (McEwen, 2000). Acute stressors can have an enhancing effect on the immune system, related to the fight or flight phenomenon, while exposure to chronic stressors actually suppresses immune system functioning. Chronic exposure to stress can influence brain

structure through adaptive plasticity. Investigations of mental disorders associated with stress, such as recurrent depression and post-traumatic stress disorder, reveal possible damage to several regions of the brain including the hippocampus, amygdala, and prefrontal cortex. The changes in the brain structures may be attributable to exposure to the severe stress of trauma and the long-term stress related to the disorders.

Definition of Stress

It is clear stress can have deleterious effects on physical and psychological wellbeing. It is therefore important to clearly define the term stress. The very word "stress" conjures up a variety of ideas for individuals, with individuals using the word to match their own perceptions and experiences. Unfortunately, the field of stress research in the social sciences has suffered from a similar lack of coherency. The definition of stress in the social sciences has been conceptualized in different ways by theorists with more biological or cognitive orientations; it has also suffered from a general use of the word for a variety of related concepts (i.e., anxiety).

In the biological view, stress is viewed as a response to nonspecific, outside stressors (Selye, 1936; 1982/1991). In this view of stress, the presence of non-specific (physical or psychological) stressors elicit uniform physiological responses. The build-up of the long-term stress responses is detrimental to health. Stressors can be physical challenges or emotions such as fear, anger or frustration. Selye (1936; 1982/1991) termed his theory of stress-response the *general adaptation syndrome*, also called the *biologic stress syndrome* wherein stress is understood as a three step process: the alarm reaction,

resistance, and exhaustion. Singer and Davidson (1991) explain this model using the example of a broken leg and food poisoning. A person may break their leg (a stressor) and have a stress reaction including the release of the hormones described above. Later, the same person experiences a case of food poisoning (another stressor) that affects their gastrointestinal functioning. As a result of the food poisoning, a stress reaction occurs that also includes the same hormones. The similarity of the stress responses is what Selye refers to as non-specificity.

The definition of stress as the response to stressors, however, fails to account for, or even question, the individual differences in stress reactions. The appraisal of potential stressors as challenges or threats has been found to elicit different physiological responses in relation to the autonomic nervous system (Kemeny, 2003). Challenges would be stimuli that require active responses towards goals, but do not present threats to individuals. In contrast to challenges, threats would be stimuli that are perceived as exceeding the resources individuals. In response to both challenges and threats, the sympathetic nervous system responds with increased arousal (i.e., increased heart rate) however, only in the case of appraisal of threat does increased blood pressure occur. The differential challenge and threat responses underlie a key criticism of the generality model of stress. Namely, a simple stimulus-response model of stress does not account for individual differences in stress reactions.

The stimulus-response view has been criticized by theorists who argue for a transactional view of stress as an interaction between individual processes and the

environment (Lazarus & Folkman, 1984). Lazarus (1966) introduced the concept of appraisal as a moderator in the stress-distress relationship. The focus of cognitively oriented definition is on the adaptation process of appraising and responding to stressors. Since its publication in 1966, the appraisal theory of stress and coping (also termed the *transactional theory*) has informed much of the research into stress reactions in human populations. According to Lazarus (1966), stress involves a process of cognitive appraisal, perception of a threat, and fear of not having the resources to handle the stressor adequately. Lazarus and Folkman (1984) provide the following definition: "Psychological stress, therefore, is the relationship between the person and the environment that is appraised by the person as taxing or exceeding his or her resources and endangering his or her wellbeing" (p. 21). For example, the most commonly cited sources of stress from the APA's 2012 Stress Survey, was money. If a person receives an unanticipated bill, the appraisal of threat will be more likely (and likely more severe) if the bill exceeds the person's resources—either financial, or other skills or resources to handle the unexpected expense. The transactional view of stress has great utility because it allows researchers to explore the differences in individual reactions to stressors and examine the factors that may protect individuals from experiencing the negative consequences associated with stress reactions. It is this transactional definition of stress that informs the present study.

Singer and Davidson (1991) purport that the biological and cognitive models of stress are not so much in opposition to each other as they vary in their focus. Theorists

who follow biological model of stress concentrate on the physiological reactions to stressors (McEwen, 2000). This vein of research has yielded valuable information about the connection between stress and health. In comparison, the cognitive model of stress places emphasis on psychological factors that influence stress perception and outcomes. This distinction may best be illustrated in the two model's differing definitions of a stressor. In the biological model, a stressor is s stimuli—such as an event, object, trauma, et cetera— that elicits a stress reaction (usually physiological). In the cognitive model, a stressor as defined by the biological model may not be interpreted as stressful depending on a number of factors. However, an event that is perceived as stressful will result in a stress reaction (usually psychological) as described in the biological stress model. As Singer and Davidson (1991) espouse, the biological and cognitive models of stress both add new perspective to the discourse on stress and depth can be added by considering both.

Stress is a relational concept involving both individual factors, which will be discussed in detail later, and an environmental stimulus. Lazarus and Cohen (1977) proposed three basic types of environmental stressors: major events that effect large numbers of people (i.e., natural disasters, war); major life events for an individual (i.e., sexual assault, bereavement); and daily hassles (i.e., losing one's keys, arguments with a significant other). Each of these stressors received attention in the stress literature including studies of natural disaster survivors (Lu, 2011), health issues (Peticrew, Bell, &

Hunter, 2003), developmental changes (Dumont & Provost, 1999), and daily hassles (DeLongis, Lazarus, & Folkman, 1988).

Previous research largely concentrated on the effects of major stressful or traumatic events on health and wellbeing (Delongis, Coyne, Dakof, Folkman, & Lazarus, 1982). The life events approach has been countered by supporters of a daily hassles stress model. The daily hassles model seeks to explain the effects of stress by looking at the perceived stressfulness of everyday events such as traffic jams, losing the keys, or struggling to pay the bills. Daily hassles are defined as relatively stable, chronic stressors that are commonly experienced in everyday life (Lazarus & Cohen, 1977). It is thought the cumulative stress of these events (subjectively appraised by each individual) can influence health and wellbeing.

Delongis and colleagues (1982) argue daily hassles have greater impact on health because of their immediacy. In other words, the ongoing strain of daily hassles has a greater impact on daily mood and stress levels due to their chronic and proximal nature. In Delongis et al.'s (1982) study of the relationship between stress and health, the impact of both life events and daily hassles were compared. Participants in the study completed measures of stressful life events, daily hassles, and health. Results indicated daily hassles accounted for more variance in health than stressful life events.

The daily hassles approach is consistent with research concerning the effects of chronic stress on health. As mentioned previously, chronic stress exposure is associated with more negative health consequences (McEwen, 2000). In the instance of acute

stressors, individuals' physiological responses would most likely be adaptive for coping with the situation. For example, an individual who is involved in a car accident may experience an "adrenaline surge" that allows them to physically handle the trauma experienced. However, it is assumed that their body will return to a state of homeostasis after the incident (McEwen, 2000). In the case of chronic stressors, such as daily hassles, the effects of increased physiological and psychological arousal can have a cumulative effect.

Age Differences in Stress Exposure

Age differences in daily hassles were probed by Folkman, Lazarus, Pimley, and Novacek (1987). The study compared the frequency of daily hassles between a younger (mean age approximately 40 years old) and older (mean age approximately 68 years old) adult sample. The results supported developmental differences in the type and frequency of stressors between groups. Overall, the younger sample reported significantly more hassles concerning finances, work home maintenance, personal life, family and friends than the older sample. Proportionally, the older sample reported more hassles related to health problems and home maintenance related hassles compared to work and finances reported by the younger sample.

The differences in coping daily hassle exposure can be in part attributed to developmental differences (Folkman, Lazarus, Pimley, & Novacek, 1987). Individuals at different stages of life acquire different roles (i.e., parenting and work) that influence their exposure to different hassles. These developmental differences have led to a number

of different hassles measures based on population, including college students (Kohn, Lafreniere, & Gurevich, 1990). College students are a commonly used research population based largely on accessibility. However, college students also face a unique set of stressors and developmental changes.

It has been suggested college students face high levels of stress from both developmental and situational stressors. Studies of college students reveal moderate to high levels of stress are common for many students (Piercall & Kiem, 2007; Sax 1997, 2003). Research and theory suggest stress results from the combination of stressful situation/event and the experience of having insufficient resources, such as time, coping skills, and abilities (Broughman, Zail, Mendoza, & Miller, 2009). Another theorized source of stress for college students is the developmental tasks of emerging adulthood. For many students, they are experiencing their first foray into the adult world and independent living, including handling finances, establishing their own social network, and making occupational decisions. Research indicates other sources of stress among students include academics, interpersonal relationships, finances, and daily hassles (Brougham, Zail, Mendoza, & Miller, 2009). These pressures leave students especially vulnerable to the strains heavy class loads, financial hardships, and developmental issues place upon them. A study of incoming freshman found 29.1% reported feeling overwhelmed (Pryor, Hurtado, DeAngelo, Palucki Blake, & Tran, 2010). Women were much more likely than men to endorse feeling overwhelmed in the survey (38.8% versus 17.6 %). In consideration of their increased vulnerability to stress, due to developmental

and life changes, college students as a group deserve attention in the stress literature. College students may benefit from prevention and intervention efforts to reduce stress and minimize the negative effects. The following section introduces research on the individual and external factors that may influence the relationship between the experience of stress and subsequent distress.

Protective Factors

Given the combination of high levels of stress reported by many and the deleterious effects of stress, there is an interest in factors that buffer individuals from stress. The essential question is what factors promote resiliency, and conversely what factors lead to greater vulnerability to the negative effects of stress? Previous studies examined correlations between stress and factors such as social support, self-esteem, self-efficacy, and coping strategies (Achat, Kawachi, Levine, Berkey, Coakley, & Colditz, 1998; Chao, 2011; Thoits, 1995). No clear consensus exists in the literature about the relationship between stress and these factors (Thoits, 1995). However, the study of individual and external factors and the stress-distress relationship has yielded valuable insights into differential stress reactions. The following section reviews three of these potential stress buffers—coping strategies, self-esteem, and social support.

Coping strategies

Coping strategies refer to the various ways individuals deal with stress. The seminal work on psychological coping by Lazarus (1966) defines coping as the strategies

used to deal with stress. Lazarus explains coping is not simply problem-solving or mastery, but encompasses all attempts to deal with a threat or stressor. *Coping* is a three step process that occurs within the cognitive framework of stress perception (Lazarus, 1966; Lazarus & Folkman, 1984). When faced with potential stressors individuals first engage in *primary appraisal* in which threat is evaluated. If a stressor is perceived as a threat, individuals then engage in *secondary appraisal* in which personal and social resources are evaluated. Finally, *coping* is the response to the threat. In an anthology of coping theory and research, Monat and Lazarus (1991) write of coping as "an individual's efforts to master demands (conditions of harm, threat, or challenge) that are appraised (or perceived) as exceeding or taxing his or her resources" (p. 5).

Coping styles have been broadly categorized into three styles based on the focus of the strategy: problem-focused (i.e., addressing the source of the stressor), emotion-focused (i.e., addressing the emotions associated with the stress), and avoidant coping styles (i.e., abandoning the goals associated with the stressor). Coping research has probed the efficacy of coping styles at reducing stress. Thoits (1995) notes there is no clear consensus in the coping literature as to which coping style promotes better health outcomes. Generally, problem-solving strategies are thought to be most efficacious because such strategies seek to eliminate the source of the stress. Yet, studies have provided only mixed support for this hypothesis (Thoits, 1995). The discrepancy between theory and empirical support may exist for a number of reasons. One very salient reason could be the conceptual differences in coping measures used across studies. In addition,

there is also evidence to suggest coping strategies are not used in isolation as may be suggested by many studies (Carver & Scheier, 1994). For example, in confronting a stressor a person may both take steps to eliminate the stressor (problem-focused) and alleviate the emotional experience of stress (emotion-focused).

Despite inconsistencies, there are some identifiable trends in the coping-stress relationship. In general, both problem-solving and emotion-focused coping strategies have been found to be more effective than avoidant coping strategies. Chao (2011) studied the relationship between stress, coping, and social support in among college sample. Problem-focused coping was found to moderate the relationship between stress and negative consequences to wellbeing. There is also compelling evidence that avoidance coping strategies are associated with higher levels of stress. In the college population, problem-focused and emotion-focused coping strategies have been associated with lower stress levels than avoidance-focused coping strategies (Dwyer and Cummings, 2001). Chao (2011) found avoidant coping strategies were associated with lower wellbeing in college students. Broughman et al. (2009) found female students reported higher levels of stress overall and more frequent use of emotion-focused coping strategies than males.

Assessing Coping. Attempts at creating an adequate measure of coping have met with varying degrees of success. Lazarus and Folkman (1980) created the Ways of Coping scale (WOC). The WOC dichotomized coping into two strategies: *problem-focused coping* and *emotion-focused coping*. The WOC has been criticized on two main

points: 1) for the lack of theoretical backing for the coping styles chosen for study, and 2) for its limited range of responses (Adler, 1991). On this basis, the construct validity of the WOC has been questioned. Although the scale has been widely used in research, the dichotomy it creates has been criticized as overly simplistic (Adler, 1991; Carver, Scheier, & Weintraub, 1989).

In response to such criticisms Carver, Scheier, and Weintraub (1989) created a new measure of coping strategies. The COPE was created to encompass a diversity of coping strategies. The original COPE produced 15 subscales: Active Coping, Planning, Seeking Instrumental Social Support, Seeking Emotional Social Support, Suppression of Competing Activities, Religion, Positive Reinterpretation and Growth, Restraint Coping, Acceptance, Focus on and Venting Emotions, Denial, Mental Disengagement, Alcohol/Drug Use, and Humor. The last two subscales were exploratory in nature and excluded from the published instrument.

Active coping is taking action to address or eliminate the stressor. *Planning* is cognitively deciding how to address and cope with a stressor. *Seeking instrumental support* is seeking out social resources to deal with the stressor (i.e., advice, information, assistance.) *Seeking emotional support* is seeking out empathy or validation from someone. *Suppression of competing activities* involves suppressing concentration on other activities to focus more fully on the dealing with the stressor. *Religion* entails increasing one's religious involvement in face of a stressor. *Positive reinterpretation and growth* is "making the best" of a situation through thinking of the situation as an

opportunity for personal growth. *Restraint* is holding coping attempts until they are most useful. *Acceptance* is accepting the stressor as real. *Focus on and venting of emotions* involves both an increased awareness of affect and the tendency to ventilate emotions. *Denial* is the refusal to accept the stressor. *Mental disengagement* is the psychological disengagement from the goal that the stressor interferes with through such means as day-dreaming or self-distraction. *Behavioral disengagement* is abandoning attempts to achieve the goal with which the stressor interfered.

The advantage of the COPE is it offers a more complex measure of coping, capturing more of the diversity of coping strategies. Each COPE subscale measures distinct aspects of problem-focused coping, emotion-focused coping, and dysfunctional coping strategies. Five scales measure problem-focused styles (active coping, planning, suppression of competing activities, restraint, and seeking of instrumental emotional support), five scales measure emotion-focused coping styles (seeking emotional social support, positive reinterpretation, acceptance, denial, and turning to religion), and three scales are considered dysfunctional coping styles, also referred to as avoidant coping styles (focus on and venting of emotions, behavioral disengagement, mental disengagement).

Self-Esteem

Self-esteem is defined as a person's global assessment of their own worth (Rosenberg, 1965). Higher self-esteem is associated with greater valuation of abilities and competencies. Rosenberg (1965) draws an important distinction in pointing out that

high self-esteem does not involve social comparison to achieve superiority over others, but rather can be equated to self-acceptance. High self-esteem reflects the valuation that one is adequate and valuable as an individual. High self-esteem also implies self-respect. In contrast, low self-esteem implies self-rejection and dissatisfaction with one's self (Rosenberg, 1965). It is postulated that those with higher self-esteem have greater belief in their ability to control stressful situations and respond effectively.

Self-esteem has received less attention in the stress literature than other protective factors; however, there is evidence self-esteem plays a role in managing stress (Thoits, 1995). DeLongis, Folkman, and Lazarus (1988) studied the individual and social resources that mediate the relationship between daily stress on mood and physical health in 75 married couples. Lower self-esteem and less supportive social resources were associated with increased somatic complaints. Dolbier and colleagues (Dolbier, Jaggars, & Steinhardt, 2009) studied stress-related growth in college students. Stress-related growth refers to the positive change that can emerge from stressful circumstances. Higher self-esteem was associated with greater stress-related growth. In a study of 713 college students, Eisenbarth (2012) found self-esteem interacted significantly with stress in predicting depressive symptoms. Participants with higher self-esteem reported lower rates of depression than those with lower self-esteem. These findings suggest self-esteem may influence the experience of stress by influencing the appraisal of threat. Higher self-esteem indicates a greater belief in the ability to handle a potential stressor, which may lead to lower stress and related symptomology.

Social Support

Social support has long been thought of as related to overall wellbeing. Social support has been conceptualized as the size of individuals' social network and/or the quality of their social support system. A number of studies suggest social support plays an important role in the stress-health relationship (Achat et al., 1998; Delongis, Folkman, & Lazarus, 1988; Herman-Stahl & Peterson, 1996; Thoits, 1995).

The mechanism through which social support influences health outcomes is referred to as the *buffering hypothesis* (Cohen & McKay, 1984). The buffering hypothesis holds that those with a stronger social support system will experience fewer negative stress effects. It is postulated that social support acts in two main ways to buffer stress by providing non-psychological and psychological support.

Social support is often associated with tangible, or material, support. For example, a family member may lend financial support that eliminates or lessens a financial stressor. Tangible support may then influence the appraisal process by determining what is viewed as a threat based on social support resources. Psychological support is another aspect of social support. The social support network can provide information to help relieve stress or eliminate the stressor, or offer emotional support. Social support can provide other benefits, such as promoting healthy behaviors, supporting self-esteem and efficacy in the face of stressors, and serving as a source of tangible assistance.

Research supports the idea that social support can serve as a protective factor as well. In a large scale study by Achat et al. (1998), social support was found to be related to greater health related quality of life in the face of stressors. Lu (2011) studied health deterioration in the aftermath of Hurricanes Katrina and Rita among displaced residents of Federal Emergency Management Agency trailer parks. Social involvement and integration was found to buffer individuals against some of the negative health consequences of the traumatic displacement experience.

Present Study

It is evident the experience of stress impacts physical and psychological functioning. Therefore, it is necessary to understand not only the effects of stress, but also the ways in which individual factors can protect, or buffer, individuals from these negative consequences. As noted previously, research has explored a number of factors as potential "buffers" in the stress-distress relationship. Extending this vein of research, several researchers have examined the ability of these individual factors to identify stress reactions. Both Herman-Stahl and Peterson (1996) and Dumont and Provost (1999) probed the differences between those who are "resilient" to stress (i.e., experience high stress, but low symptomology), those who are well-adjusted and those who are vulnerable.

The idea of categorizing individuals based on adjustment to stress was introduced by Herman-Stahl and Peterson (1996) in their study of adolescents. The researchers created 4 groups based on crossing depression and perceived stress indices. The resulting

groups represented well-adjusted (low stress and low depression), resilient (high stress and low depression), vulnerable (high stress and high depression), and non-adjusted adolescents (low stress and high depression). In this model, both the resilient and vulnerable groups have high levels of stress yet the resilient group does not suffer from the negative effects of stress. A comparison of the characteristics of these groups provides information on what internal and external factors may buffer stress.

Dumont and Provost (1999) followed this same categorical procedure in their own study of stress-buffering factors among adolescents. The study examined the predictive ability of several internal (coping strategies, self-esteem) and external (social support, social activities) factors in determining adjustment among an adolescent sample. Dumont and Provost's (1999) improved Herman-Stahl and Peterson's (1996) method by using the top third of the distribution compared to the bottom third. Herman-Stahl and Peterson (1996) used a less strict criterion of comparing the top third of the distribution to the remaining two-thirds.

Both Herman-Stahl and Peterson (1996) and Dumont and Provost (1999) found the individuals in each group have unique characteristics with regards to coping strategies. Resilient individuals tend to use more active and problem-solving coping strategies than the other groups (Dumont & Provost, 1999; Herman-Stahl & Peterson, 1996). Both resilient and well-adjusted individuals use avoidance coping less than those who are considered vulnerable (Herman-Stahl & Peterson, 1996). This is in accordance with findings from previous research (Thoits, 1995).

The groups also differ with regards to self-esteem and social resources. In Dumont and Provost's (1999) study, self-esteem was the primary predictor of group membership with higher levels of self-esteem among the resilient group than the vulnerable group and still higher levels among the well-adjusted group than the resilient group. This finding is in accordance with previous research that supports the link between self-esteem and better stress outcomes (Thoits, 1995). As discussed above, those with higher self-esteem have better overall evaluations of their worth and abilities. Higher self-esteem may influence the way individuals interpret stressors, including the level of threat assigned to a particular stressor. For example, a person in the well-adjusted group with higher self-esteem may not view an impending exam as being as stressful because of the belief in his/her academic abilities. Furthermore, high self-esteem may bolster belief in resilient individuals' coping abilities in dealing with a stressor leading them to manage stressors in a more adaptive way than the vulnerable group.

Herman-Stahl and Peterson (1996) found positive social relationships were related to better adjustment to stress. Having more satisfactory interpersonal relationships has been found to be a predictor of more positive outcomes in a number of stress studies (Thoits, 1995). As explored above, it is hypothesized that social support can act as a buffer in the stress-distress relationship by adding to tangible and psychological resources. Social support did not differentiate between the groups in Dumont and Provost's study, even though previous research suggests social support plays a role in buffering stress (Achat et al., 1998; Chao, 2011).

The multivariable approach used by Dumont and Provost (1999) and Herman-Stahl and Peterson (1996) has yielded valuable data on stress buffering in adolescents. This study seeks to extend and add to this work using a college population. Further, a positive adjustment approach will be used by defining adjustment in terms of wellness rather than the absence of depressive symptoms. In a non-clinical population, it is hoped defining adjustment in terms of wellness will yield more information on how individuals thrive in the face of stress. To this end, the present study will focus on the factors that may buffer stress in "resilient" individuals. The factors to be explored include internal factors (coping strategies and self-esteem) and external factors (social support) that influence resiliency to stress in young adults. In the present study, participants completed an online survey that contained measures of psychological wellbeing, stress, coping styles, self-esteem, and social support. Participants' scores on the measures of psychological wellbeing and stress measures were utilized to examine the impact of coping styles, self-esteem and social support.

Hypothesis I

Problem-focused and emotion-focused coping was expected to be associated with higher wellbeing and lower stress. The research concerning the efficacy of problem-focused and emotion-focused coping in reducing stress is mixed (Thoits, 1995). Some research indicates the overall college students, and especially women, engage in mainly in emotion-focused coping styles (Broughman et al., 2009). A number of studies indicate that problem-focused coping can be especially efficacious at reducing stress levels

(Thoits, 1995). It is the contention at this study that both problem-focused and emotion-focused coping strategies contribute to the reduction of stress and greater wellbeing. This idea is in accordance with Lazarus and Folkman's (1984) view of coping as a process rather than a static and rigid "style." Through the appraisal and coping processes individuals may choose to address a stressor by using a number of coping strategies. For instance, a student may feel stressed about an upcoming exam. The student may cope by both preparing for the exam (problem-focused) and venting to a friend about the upcoming exam (emotion-focused). Therefore, it was hypothesized that both problem-focused and emotion-focused coping styles would be associated with lower stress and higher wellbeing.

Hypothesis II

Avoidance coping was expected to be associated with lower wellbeing and higher stress. For individuals with higher stress, avoidance coping has been associated with decreased wellbeing (Chao, 2011.) Avoidance coping involves abandoning the goal of the stressor which can lead to a build-up of the stressor. For example, avoiding studying for an exam could lead to increased distress about academic performance. It was therefore hypothesized that individuals whom engage in avoidance coping would have lower levels of wellbeing and higher levels of stress.

Hypothesis III

Higher self-esteem was expected to be associated with higher wellbeing and lower stress. It is presumed those with higher self-esteem possess a greater sense of self-worth and mastery which leads them to feel more competent in the face of stressors. In a review of the stress literature, Thoits (1995) notes self-esteem appears to be related to emotional health outcomes in a number of studies, including depressive symptoms as was found by Dumont and Provost (1999). The sense of personal competence and worth may buffer them against the negative effects of stress and perhaps influence the choice and efficacy of their coping strategies.

Hypothesis IV

Greater overall social support was expected to be associated with higher wellbeing and lower stress. According to the buffering hypothesis (Cohen & McKay, 1984) social support influences the resources available during the appraisal of threat and during the coping process. More social resources may lead to individuals being less likely to view a stimulus as a stressor. For example, an individual may turn to their social support network for tangible help with a problem such as lending financial assistance. Moreover, social support can also provide emotional support. In observation of the buffering hypothesis, it was hypothesized that participants with greater overall social support scores would experience higher wellbeing and lower stress.

Hypothesis V

More satisfaction with social support will be associated with higher wellbeing and lower stress. As noted above, research supports the idea that social support can act as a buffer to social support (Cohen & McKay, 1984). Specifically, it appears individuals' satisfaction with their social support network is more important than the size of their social network (Thoits, 1995). Therefore, it was hypothesized that participants' social support satisfaction score would be associated with higher wellbeing and lower stress.

Method

Participants

Participants for this study were 197 college students (129 women, 67 men) enrolled in introductory psychology classes at a small Midwestern university. Three participants were excluded due to their being outside the approved age range; 2 participants were younger than 18 years old and 1 participant was over 65 years old. Participants included in the data analysis ranges in age from 18-59 with a mean age of 26.18 (*SD* = 9.1). Participants were predominately Caucasian (82.2%). 31% were freshman, 16.2% were sophomores, 24.4% were juniors, 17.8% were seniors, and 9.6% were fifth year and above or graduate students.

Materials

All participants were administered an online survey consisting of 6 instruments: a daily hassles measure, a psychological wellbeing measure, a coping styles questionnaire, a self-esteem scale, a social support measure, and a demographics survey.

Inventory of College Students Recent Life Experiences. The Inventory of College Students Life Experiences (ICSRLE) was a decontaminated daily hassles measure designed to measure hassles relevant to the college population (Kohn, Lafreniere, & Gurevich, 1990; see Appendix B). The ICSRLE assesses exposure to daily hassles without contaminating responses by implying psychological or physical distress within the items. This is an important distinction because hassles scales are often used to predict distress; contaminated scales may contribute to an inflation of the relationship between hassles and negative consequences.

The inventory contained 49 items about stressors experienced over the preceding month. Items cover topics related to such areas as interpersonal relationships, academics, and finances. The items were presented as statements such as, "Too many things to do at once" and "Struggling to meet the academic standards of others." Participants rate the statements on a 4-point Likert-type scale ranging from 1 (*not at all part of my life*) to 4 (*very much part of my life*). Scores are computed by summing the items. Scores can range from 0 to 147. The ICSRLE was based partially on two well accepted daily hassles measures; additional categories and items were added to add relevancy for the college population. Kohn et al. (1990) report good reliability for the ICSRLE ($\alpha = .89$). The

ICSRLE was correlated to the Perceived Stress Scale, a standard for measuring the experience of stress (r = .67).

Mental Health Inventory. The Mental Health Inventory (MHI) was a 38-item questionnaire that measures psychological distress and wellbeing (see Appendix C). The present study utilized only the psychological wellbeing scale which was comprised of 14 items and is considered an acceptable outcome measure (Veit & Ware, 1983). The psychological wellbeing scale is reversed scored; scores were computed by summing the 14 reverse scored items. Scores range from 14-84 with higher scores indicating greater wellbeing. The MHI Psychological Wellbeing Scale was comprised of two subscales: general positive affect and emotional ties. Participants were presented with questions such as "During the past month, how much of the time have you felt that the future looks hopeful and promising?" Participants rated the items on a 6-point Likert-type scale that ranges from 1 (*all of the time*) to 6 (*none of the time*). The MIH has demonstrated concurrent and convergent validity based on correlations with measures of positive affect (Chao, 2011). The authors report good reliability for all subscales on the MIH, ranging from .83 to .96 (Veit & Ware, 1983).

The COPE. The COPE contained 60 items that assess coping strategies (see Appendix D). Each statement was rated on a 4-point Likert scale ranging from 1 (*I usually don't do this at all*) to 4 (*I usually do this a lot*). The original COPE included 2 exploratory subscales for a total of 15. The present study excluded the two exploratory scales (drug/alcohol abuse and humor) for a total of 13 subscales. Therefore, the version

of the COPE used in this study contained only 52 items. The exclusions were based on the exploratory scales not loading onto the three coping styles of interest: problem-focused coping, emotion-focused coping, and avoidant coping styles. Five scales measured problem-focused styles (active coping, planning, suppression of competing activities, restraint, and seeking of instrumental emotional support), five scales measured emotion-focused coping styles (seeking emotional social support, positive reinterpretation, acceptance, denial, and turning to religion), and three scales were considered dysfunctional coping styles, also referred to as avoidant coping styles (focus on and venting of emotions, behavioral disengagement, mental disengagement). Scores were computed by summing the items to create a score for each scale. See the introduction for a more complete description of the COPE scales and their creation.

Carver et al. (1989) report good internal consistency for all scales which all fall above .6 with the exception of mental disengagement. The authors note that the lower reliability of mental disengagement is not entirely surprising because of the multiple-act criterion. The 11 factor structure of the COPE was supported by the findings of an exploratory factor analysis with two notable exceptions. In both instances, a single factor was emerged from what was intended to be two separate scales. First, active coping and planning loaded onto a single factor. Similarly, items that reflected seeking social support also loaded onto a single factor.

Rosenberg Self-Esteem Scale. The Rosenberg Self-Esteem Scale (Rosenberg, 1965, 1989) measured global self-esteem (see Appendix E). The scale consisted of 10

items that participants rate their agreement with on a 4-point Likert scale ranging from 0 (*strongly disagree*) to 3 (*strongly agree*). Five of the items were reversed scored. Scores are computed by summing the items; scores ranging from 0-30 with higher scores indicating higher self-esteem. The Rosenberg Self-Esteem Scale is a widely used measure and has high reliability ($\alpha = .92$).

Social Support Questionnaire – Short Form. The Social Support Questionnaire short form (SSQSR) had 12 total items (Sarason, Sarason, Sheerin, & Pierce, 1987; see Appendix F). The SSQSR provided both a SSQ Number score, consisting of 6-items, which measured social network size and a SSQ Satisfaction score, consisting of 6-items which measured support satisfaction. The SSQSR asked participants to list all of the people (maximum of 9) who can provide help or support for each question (i.e., "Whom can you really count of to be dependable when you need help?") Participants were then asked to rate how satisfied they were with the support for each set of responses on a 6-point Likert-type scale ranging from 1 (*very dissatisfied*) to 6 (*very satisfied*). If there is no one who provides support for a certain question, a "no one" option is provided, but participants were still asked to rate their satisfaction. The SSQ Number score, for the size of the network, was calculated by adding the number of people listed for each of the odd questions and dividing by 6. The SSQ Satisfaction score, for satisfaction with the support, was calculated by summing the even numbered questions and dividing by 6. There was also an option to calculate a Family and Non-Family score by asking participants to list

each person's relationship. This score was used to determine the ratio of support received from family and non-family sources.

Sarason et al. (1987) report good internal reliability; alpha ranged from .90 to .93 across three study samples. The reliabilities for the SSQ Number ranged from .97 to .98 and .96 to .97 for the SSQ Satisfaction. The authors report concurrent validity with the original SSQ; the SSQSR correlated highly with the original 27-item SSQ, even when the items on the SSQSR were removed (Sarason et al., 1987).

Demographics Survey. The demographics survey contained questions about the participants' age, gender, ethnicity, and class standing (see Appendix G).

Results

Data were screened for violations of test assumptions; no violations were found. Data were also screened to ensure that participants met age criteria resulting in three participants being excluded for ethical reasons (see Participants section above). Due to the present study's emphasis on early adulthood developmental influences, statistical analyses were run on the entire study sample and on a traditional college age group defined as 18-24 years old.

Gender Differences

Gender differences were analyzed for exploratory purposes to identify any significant trends between genders. The data were analyzed using an independent samples *t*-test comparing men and women on psychological wellbeing, stress, coping,

self-esteem, and social support. There was a significant difference in emotion-focused coping between women and men, $t(189) = -3.8$, $p < .01$. Women ($M = 51.9$, $SD = 7.2$) tended to use more emotion-focused coping than men ($M = 47.7$, $SD = 6.9$).

Family Support

The influence of depending on family for a majority of social support on wellbeing, stress, coping strategies, self-esteem, and social satisfaction was examined using an independent samples *t*-test. Two groups were created defining low family support (N = 100) as 0-50% and high family support (N = 87) as 51% and higher. No significant differences were found.

Hypothesis I

Multiple regression analysis was conducted to determine the extent to which psychological wellbeing can be predicted by the use of problem-focused and emotion-focused coping styles, $F(2, 188) = 11.24$, $p < .01$, $Adj.\ R^2 = .10$. The overall model accounted for 10 % of the variance in wellbeing. After controlling for emotion-focused coping, problem-focused coping was significant, $\beta = .18$, $t(188) = 2.37$, $p < .05$. Participants who used more problem-focused coping strategies had higher wellbeing scores. After controlling for problem-focused coping, emotion-focused coping was also significant, $\beta = .21$, $t(188) = 2.72$, $p < .01$. The same analysis was run restricting age to traditional college age participants, defined as age 18-24 ($N = 110$). Both models were similar.

Multiple regression analysis was conducted to determine the extent to which stress levels can be predicted by the use of problem-focused and emotion-focused coping styles, $F(2, 188) = 3.16$, $p < .05$, *Adj.* $R^2 = .02$. Emotion-focused and problem-focused coping were poor predictors of stress levels; the overall model accounted for only 2 % of the variance in stress levels. After controlling for emotion-focused coping, problem focused coping was significant, $\beta = -.19$, $t(188) = -2.40$, $p < .05$. After controlling for problem-focused coping, emotion focused coping was not significant, $\beta = .03$, $t(188) = .34$, $p > .05$. Comparisons with the college age group revealed that both models were similar.

Hypothesis II

A simple linear regression analysis was run to determine if wellbeing could be predicted by avoidant coping. The results indicate that a significant portion of the variance in wellbeing was accounted for by avoidant coping, $F(1, 189) = 13.68$, $p < .01$, *Adj.* $R^2 = .06$. Avoidant coping significantly predicted wellbeing, $\beta = -.26$, $t(189) = -3.7$, $p < .01$. Avoidant coping appears to be a poor predictor of wellbeing as the model accounted for only 6% of the variance in wellbeing. The model was similar for the college age group.

A simple linear regression analysis was run to examine the relationship between avoidant coping and stress levels. Results indicate that avoidant coping significantly predicts stress, $F(1, 189) = 65.81$, $p < .01$, *Adj.* $R^2 = .25$. Avoidant coping was significant,

β = .51, $t(189) = 8.11$, $p < .01$. The model accounted for 25% of the variance in stress levels. The model was similar for the college age group.

Hypothesis III

A simple linear regression was conducted to examine the extent to which self-esteem predicts wellbeing. Results indicate that self-esteem significantly predicts wellbeing, $F(1,189) = 131.79$, $p < .01$, *Adj.* $R^2 = .41$. Self-esteem was significant, β = .64, $t(189) = 11.48$, p < .01. The model accounted for 41 % of the variance in wellbeing. The model was similar for the college age group.

A simple linear regression was run to examine the extent to which self-esteem can predict stress levels. The results suggest that self-esteem significantly predicts stress levels, $F(1, 189) = 112.1$, $p < .01$, *Adj.* $R^2 = .37$. Self-esteem was significant, β = -.61, $t(189) = -10.59$, $p < .01$. The model accounted for 37 % of the variance in stress levels. The model was similar for the college age group.

Hypothesis IV

A simple linear regression was conducted to examine the relationship between social support and wellbeing, $F(1, 187) = 6.40$, $p < .05$, *Adj.* $R^2 = .03$. Social support was significant, β = .18, $t(187) = 2.53$, $p < .05$. The model appears to be a poor predictor of psychological wellbeing as it accounted for only 3 % of the variance in wellbeing. For the traditional college age group, social support was not a significant, β = .17, $t(110) = 1.9$, *p*

> .05. In this population, overall social support was not a significant predictor of wellbeing, $F(1, 110) = 3.43$, $p > .05$, $Adj.\ R^2 = .02$.

A simple linear regression was used to examine the extent to which stress levels can be predicted by social support. Social support was not significant, $F(1, 187) = .56$, $p > .05$, $Adj.\ R^2 = -.002$. Although social support showed a negative relationship with stress levels it was not significant, $\beta = -.06$, $t(187) = -.75$, $p > .05$. The model for the college age group was similar.

Hypothesis V

A simple linear regression was run to determine the extent to which social satisfaction predicts wellbeing. Results suggest that social satisfaction significantly predicts wellbeing, $F(1, 188) = 36.26$, $p < .01$, $Adj.\ R^2 = .16$. Social satisfaction was significant, $\beta = .40$, $t(188) = 6.02$, $p < .01$. The model accounted for 16% of the variance in psychological wellbeing. The model was similar for the college age group.

A simple linear regression was used to determine the extent to which social satisfaction predicts stress levels. Results indicate that social support significantly predicts stress levels, $F(1, 188) = 6.98$, $p < .01$, $Adj.\ R^2 = .03$. Social satisfaction was significant, $\beta = -.19$, $t(188) = -2.64$, $p < .01$. The model accounted for only 3% of the variation in stress levels. The model was similar for the college age group.

Discussion

The aim of this study was to examine the relationships between stress and the internal and external factors that buffer the negative effects of stress. As discussed above, college students face particular developmental stressors associated with early adulthood in addition to the unique demands of college life. Specifically, the present study looked at coping strategies, self-esteem, and social support as possible buffers against the negative effects of stress on psychological wellbeing among college students. In general, the results are in agreement with previous research on stress and health with a few exceptions discussed below.

Coping

In the present study, women reported more overall use of emotion-focused coping than did men. Broughman et al. (2009) noted a similar trend among college students. The Broughman et al. study also found that women reported more overall stress than men. The present study, however, did not find a significant difference between men and women's reported levels of daily hassles. Although past research has also found that women report greater levels of overall stress, Broughman et al. notes that gender differences are less consistent in regards to specific stressors. This departure from the trend found in past research may in part be due to the use of the daily hassles definition of stress in the present study. Daily hassles represent chronic, everyday stressors, as described above. The present study also utilized a measure specific to the college population. Due to the emphasis on everyday stress, rather than the cumulative and

subjective experience of stress, it is less surprising that men and women reported similar levels of exposure to daily hassles. It appears that among our sample, men and women similarly experienced stressors related to such areas as there social lives and academics.

It was hypothesized that coping strategies would influence both psychological wellbeing and stress levels. Specifically, emotion and problem-focused coping were hypothesized to be related to better psychological health and lower stress levels; this hypothesis was partially supported. Problem-focused coping was associated with both better psychological wellbeing and lower stress levels. This finding is not out of context with previous research which consistently suggests problem-focused coping is more effective at reducing stress. However, emotion-focused coping was associated with better psychological wellbeing, but not lower stress levels. As Thoits (1995) elucidates, the findings on emotion-focused coping are mixed in the literature. The results of the present study suggest that emotion-focused coping may not be the most effective means for managing stress. An examination of the present study's population may be pertinent here. It is important to recall that the present study focused on early adulthood developmental stressors and in particular, stressors among college students. College students face many unique stressors such as examinations, heavy course loads, and financial stressors. For many of these stressors, a more action-oriented approach may indeed be the most effect way to reduce stress (i.e., studying for an exam.) An emotion-focused approach may help reduce feelings of stress temporarily, but not provide relief from pressures of the stressor.

The findings on avoidant coping are clearer. Avoidant coping was significantly related to both poorer psychological wellbeing and increased stress among all age groups, as hypothesized. Avoidant coping strategies are defined as coping skills that avoid the goal associated with the stressor. For example, a student who is stressed about an upcoming exam might put off studying or skip class. A growing body of evidence suggests that avoidance-coping strategies are less effective at managing stress than other strategies (Dwyer & Cummings, 2001; Thoits, 1995). In relation to wellbeing, Choa (2011) also reported lower wellbeing associated with avoidance coping styles.

Self-Esteem

According to the results of this study, self-esteem appears to be the best predictor of both psychological wellbeing and stress among both age groups. This is in line with previous findings on the importance of self-esteem in managing stress. DeLongis, Folkman, and Lazarus (1998) reported that higher self-esteem was associated with a decrease in somatic complaints. Dolbier, Jaggars, and Steinhardt (2009) found that higher self-esteem promoted personal growth related to stressful circumstances. Similarly, Eisenbarth (2012) found that self-esteem was associated with lower levels of depressive symptoms. Dumont and Provost (1999) also found self-esteem to be a protective factor against depressive symptoms. These findings, in conjunction with the findings of the present study suggest that self-esteem plays an important role in the stress-distress relationship. Self-esteem appears to both reduce stress and increase psychological wellbeing, as found in the present study. As suggested earlier, self-esteem may influence

the stress appraisal process. That is to say, individuals with higher self-esteem may view a situation as less threatening than someone with lower self-esteem. For example, students with an upcoming exam may feel stressed, but if they have higher self-esteem they may feel more confident about their ability to do well. In addition, higher self-esteem may influence the way individuals cope with stress. Consider students with an upcoming exam. If they have higher self-esteem, their confidence in their abilities may lead them to choose more effective coping skills such as a problem-focused strategy (i.e., studying for the exam) rather than an avoidance strategy (i.e., skipping class on the exam day.)

Social Support

The findings on the importance of social support are mixed in the present study. Overall social support significantly predicted wellbeing in the total study sample, but did not significantly predict wellbeing in the college sample. In addition, overall social support was not significantly related to stress levels among either sample. The finding that overall social support influences wellbeing fits with the findings of previous research (Achat et al., 1998; Delongis, Folkman, & Lazarus, 1988; Herman-Stahl & Perterson, 1996; Thoits, 1995). Social support is thought to influence wellbeing through providing both psychological support and non-psychological support (e.g., the buffering hypothesis; Cohen & McKay, 1984). Among the total sample, overall social support did significantly influence wellbeing as predicted. However, among the college sample this predication did not hold true. This finding may be related to the nature of college students' social

networks. For students who are away from home for the first time, they may be relying on relatively newer social connections (i.e., friends or roommates). Newer social connections may not be able to supply the same buffering supports as longer-term relationships provide. By the same token, if a student is relying on older connections, such as family who may be geographically removed, perhaps they cannot provide the same supports. For instance, a student may not be able to receive the support needed from parents who are many miles away.

Interestingly, satisfaction with social support was significantly related to higher psychological wellbeing and lower stress levels, as hypothesized. This finding, in conjunction with the findings on overall social support, supports previous research on the importance of social support quality rather than quantity (Thoits, 1995). The findings of the present study support the idea that it is not the size of individuals' social network, but the network's ability to provide them with adequate support.

Limitations

The present study has several notable limitations. First, the measurement of social support and coping presents some challenges for college age young adults. While theoretically young adults are branching out from their families, the phenomena of *helicopter parenting* might cause some issues. Helicopter parenting is a popular culture term which refers to parents who tend to solve, or "hover" over, their children's problems rather than allow them to problem solve. Padilla-Walker and Nelson (2012) studied helicopter parenting as a unique form of parental control in emerging adulthood; research

suggests that helicopter parenting is an empirically based form of parenting. Helicopter parenting may represent a confounding variable for coping research in the college population. If students have not had to cope with many of their own stressors it may be difficult to measure their coping strategies. Padilla-Walker and Nelson (2012) suggest that while helicopter parenting may not be destructive to the child, it may interfere with healthy development in emerging adulthood. An attempt to address this issue was made by examining differences between those who depend on their family for the majority of their social support and those who depend on other sources (i.e., friends, coworkers, etc.) As discussed above, no significant differences were found. However, the impact of helicopter parenting on coping may still confound the results. For example, students may not possess well developed problem-solving coping skills due to relying on their parents to supply the necessary support.

Another limitation of this study is the reliance on solely self-report surveys. The validity of results is dependent on participants' accuracy and honestly in reporting, as well as their own self-awareness of the constructs measured. Finally, the study sample was drawn from a population of narrow diversity. Participants were all drawn from psychology courses at a small Midwestern university. The sample was predominantly white and female. The limited diversity of the sample restricts the generalizability of the results.

Implications

The present study has several implications for clinical settings. The goal of this study was to focus on internal and external factors that buffer individuals from the negative effects of stress on psychological health. The clinical implications for this research are especially salient for preventative interventions. First, students may benefit from interventions that promote problem-focused coping strategies. Problem-focused coping has consistently been shown to reduce negative symptoms and promote wellbeing (Thoits, 1995). Such interventions might be especially important for women due to their tendency to use more emotion-focused coping strategies as was found in this study and by Broughman et al. (2009). Second, the present study, in addition to previous findings, speaks to the importance of self-esteem in buffering individuals' from the negative impact of stress on psychological wellbeing. Students would benefit from services that promote and build self-esteem as a protective and preventative factor. Finally, the present study underlies the importance of adequate social support, rather than a large social support network. Students would benefit from services building their social connectedness and strengthens social support systems. A large social network may not adequately provide the psychological and non-psychological supports necessary to positively impact wellbeing and decrease stress. It is therefore vital that students are able to establish and maintain adequate social support.

In conclusion, this study adds to the literature on stress and health. The results largely support the findings of previous research on the connections between stress and

wellbeing and coping styles, self-esteem, and social support. By focusing on the promotion of protective factors to promote psychological wellbeing and reduce stress, the results highlight some useful clinical implications specific to the college populations and preventative interventions.

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APPENDIX A

FORT HAYS STATE UNIVERSITY

Forward thinking. World ready.

OFFICE OF SCHOLARSHIP AND SPONSORED PROJECTS

DATE:	March 29, 2013
TO:	Emily Kubalik
FROM:	Fort Hays State University IRB
STUDY TITLE:	[434863-1] THE EFFECTS OF COPING, SELF-ESTEEM, AND SOCIAL SUPPORT ON STRESS AND WELLBEING
IRB REFERENCE #:	13-097
SUBMISSION TYPE:	New Project
ACTION:	DETERMINATION OF EXEMPT STATUS
DECISION DATE:	March 29, 2013
REVIEW CATEGORY:	Exemption category # *2*

Thank you for your submission of New Project materials for this research study. The departmental human subjects research committee and/or the Fort Hays State University IRB/IRB Administrator has determined that this project is EXEMPT FROM IRB REVIEW according to federal regulations.

Please note that any changes to this study may result in a change in exempt status. Any changes must be submitted to the IRB for review prior to implementation. In the event of a change, please follow the Instructions for Revisions at http://www.fhsu.edu/academic/gradschl/irb/.

The IRB administrator should be notified of adverse events or circumstances that meet the definition of unanticipated problems involving risks to subjects. See http://www.hhs.gov/ohrp/policy/AdvEvntGuid.htm.

We will put a copy of this correspondence on file in our office. Exempt studies are not subject to continuing review.

If you have any questions, please contact Leslie Paige at lpaige@fhsu.edu or 785-628-4349. Please include your study title and reference number in all correspondence with this office.

APPENDIX B

ICSRLE

Following is a list of experiences which many students have some time or other. Please indicate for each experience how much it has been a part of your life *over the past month* according to the following guide:

Intensity of Experience over the Past Month

0 = not at all part of my life

1 = only slightly part of my life

2 = distinctly part of my life

3 = very much part of my life

1. Conflicts with boyfriend's/girlfriend's/spouse's family
2. Being let down or disappointed by friends
3. Conflict with professor(s)
4. Social rejection
5. Too many things to do at once
6. Being taken for granted
7. Financial conflicts with family members
8. Having your trust betrayed by a friend
9. Separation from people you care about
10. Having your contributions overlooked
11. Struggling to meet your own academic standards
12. Being taken advantage of
13. Not enough leisure time
14. Struggling to meet the academic standards of others

15. A lot of responsibilities
16. Dissatisfaction with school
17. Decisions about intimate relationship(s)
18. Not enough time to meet your obligations
19. Dissatisfaction with your mathematical ability
20. Important decisions about your future career
21. Financial burdens
22. Dissatisfaction with your reading ability
23. Important decisions about your education
24. Loneliness
25. Lower grades than you hoped for
26. Conflict with teaching assistant(s)
27. Not enough time for sleep
28. Conflicts with your family
29. Heavy demands from extracurricular activities
30. Finding courses too demanding
31. Conflicts with friends
32. Hard effort to get ahead
33. Poor health of a friend
34. Disliking your studies
35. Getting “ripped off” or cheated in the purchase of services
36. Social conflicts over smoking
37. Difficulties with transportation

38. Disliking fellow student(s)
39. Conflicts with boyfriend/girlfriend/spouse
40. Dissatisfaction with your ability at written expression
41. Interruptions of your school work
42. Social isolation
43. Long waits to get service (e.g., at banks, stores, etc.)
44. Being ignored
45. Dissatisfaction with your physical appearance
46. Finding course(s) uninteresting
47. Gossip concerning someone you care about
48. Failing to get expected job
49. Dissatisfaction with your athletic skills

Appendix C

Mental Health Inventory (MHI)

INSTRUCTIONS: Please read each question and tick the box by the ONE statement that best describes how things have been FOR YOU during the past month. There are no right or wrong answers.

1. How happy, satisfied, or pleased have you been with your personal life during the past month?

1. Extremely happy, could not have been more satisfied or pleased

2. Very happy most of the time

3. Generally, satisfied, pleased

4. Sometimes fairly satisfied, sometimes fairly unhappy

5. Generally dissatisfied, unhappy

6. Very dissatisfied, unhappy most of the time

2. During the past month, how much of the time have you felt that the future looks hopeful and promising?

1. All of the time
2. Most of the time
3. A good bit of the time
4. Some of the time
5. A little of the time
6. None of the time

3. How much of the time, during the past month, has your daily life been full of things that were interesting to you?

1. All of the time
2. Most of the time
4. Some of the time
5. A little of the time

3. A good bit of the time 6. None of the time

4. How much of the time, during the past month, did you feel relaxed and free from tension?

1. All of the time 4. Some of the time

2. Most of the time 5. A little of the time

3. A good bit of the time 6. None of the time

5. During the past month, how much of the time have you generally enjoyed the things you do?

1. All of the time 4. Some of the time

2. Most of the time 5. A little of the time

3. A good bit of the time 6. None of the time

6. During the past month, how much of the time have you felt loved and wanted?

1. All of the time 4. Some of the time

2. Most of the time 5. A little of the time

3. A good bit of the time 6. None of the time

7. When you have got up in the morning, this past month, about how often did you expect to have an interesting day?

1. Always 4. Sometimes

2. Very often 5. Almost never

3. Fairly often 6. Never

8. How much of the time, during the past month, were you able to relax without difficulty?

1. All of the time
2. Most of the time
3. A good bit of the time
4. Some of the time
5. A little of the time
6. None of the time

9. How much of the time, during the past month, have you felt calm and peaceful?

1. All of the time
2. Most of the time
3. A good bit of the time
4. Some of the time
5. A little of the time
6. None of the time

10. How much of the time, during the past month, did you feel that your love relationships, loving and being loved, were full and complete?

1. All of the time
2. Most of the time
3. A good bit of the time
4. Some of the time
5. A little of the time
6. None of the time

11. During the past month, how much of the time has living been a wonderful adventure for you?

1. All of the time
2. Most of the time
3. A good bit of the time
4. Some of the time
5. A little of the time
6. None of the time

12. How much of the time, during the past month, have you felt cheerful, lighthearted?

1. All of the time
2. Most of the time
3. A good bit of the time
4. Some of the time
5. A little of the time
6. None of the time

13. During the past month, how much of the time were you a happy person?

1. All of the time
2. Most of the time
3. A good bit of the time
4. Some of the time
5. A little of the time
6. None of the time

14. How often, during the past month, have you been waking up feeling fresh and rested?

1. Always, every day
2. Almost every day
3. Most days
4. Some days, but usually not
5. Hardly ever
6. Never wake up feeling rested

APPENDIX D

The COPE

We are interested in how people respond when they confront difficult or stressful events in their lives. There are lots of ways to try to deal with stress. This questionnaire asks you to indicate what you generally do and feel, when you experience stressful events. Obviously, different events bring out somewhat different responses, but think about what you usually do when you are under a lot of stress.

Then respond to each of the following items by selecting one number for each, using the response choices listed just below. Please try to respond to each item separately in your mind from each other item. Choose your answers thoughtfully, and make your answers as true FOR YOU as you can. Please answer every item. There are no "right" or "wrong" answers, so choose the most accurate answer for YOU--not what you think "most people" would say or do. Indicate what YOU usually do when YOU experience a stressful event.

1 = I usually don't do this at all

2 = I usually do this a little bit

3 = I usually do this a medium amount

4 = I usually do this a lot

1. I try to grow as a person as a result of the experience.
2. I turn to work or other substitute activities to take my mind off things.
3. I get upset and let my emotions out.
4. I try to get advice from someone about what to do.
5. I concentrate my efforts on doing something about it.
6. I say to myself "this isn't real."
7. I put my trust in God.
9. I admit to myself that I can't deal with it, and quit trying.
10. I restrain myself from doing anything too quickly.

11. I discuss my feelings with someone.
13. I get used to the idea that it happened.
14. I talk to someone to find out more about the situation.
15. I keep myself from getting distracted by other thoughts or activities.
16. I daydream about things other than this.
17. I get upset, and am really aware of it.
18. I seek God's help.
19. I make a plan of action.
21. I accept that this has happened and that it can't be changed.
22. I hold off doing anything about it until the situation permits.
23. I try to get emotional support from friends or relatives.
24. I just give up trying to reach my goal.
25. I take additional action to try to get rid of the problem.
27. I refuse to believe that it has happened.
28. I let my feelings out.
29. I try to see it in a different light, to make it seem more positive.
30. I talk to someone who could do something concrete about the problem.
31. I sleep more than usual.
32. I try to come up with a strategy about what to do.
33. I focus on dealing with this problem, and if necessary let other things slide a little.
34. I get sympathy and understanding from someone.
37. I give up the attempt to get what I want.
38. I look for something good in what is happening.

39. I think about how I might best handle the problem.
40. I pretend that it hasn't really happened.
41. I make sure not to make matters worse by acting too soon.
42. I try hard to prevent other things from interfering with my efforts at dealing with this.
43. I go to movies or watch TV, to think about it less.
44. I accept the reality of the fact that it happened.
45. I ask people who have had similar experiences what they did.
46. I feel a lot of emotional distress and I find myself expressing those feelings a lot.
47. I take direct action to get around the problem.
48. I try to find comfort in my religion.
49. I force myself to wait for the right time to do something.
51. I reduce the amount of effort I'm putting into solving the problem.
52. I talk to someone about how I feel.
54. I learn to live with it.
55. I put aside other activities in order to concentrate on this.
56. I think hard about what steps to take.
57. I act as though it hasn't even happened.
58. I do what has to be done, one step at a time.
59. I learn something from the experience.
60. I pray more than usual.

APPENDIX E

Rosenberg Self-Esteem Scale

Below is a list of statements dealing with your general feelings about yourself. If you strongly agree, circle **SA**. If you agree with the statement, circle **A**. If you disagree, circle **D**. If you strongly disagree, circle **SD**.

1.	On the whole, I am satisfied with myself.	SA	A	D	SD
2.*	At times, I think I am no good at all.	SA	A	D	SD
3.	I feel that I have a number of good qualities.	SA	A	D	SD
4.	I am able to do things as well as most other people.	SA	A	D	SD
5.*	I feel I do not have much to be proud of.	SA	A	D	SD
6.*	I certainly feel useless at times.	SA	A	D	SD
7.	I feel that I'm a person of worth, at least on an equal plane with others.	SA	A	D	SD
8.*	I wish I could have more respect for myself.	SA	A	D	SD
9.*	All in all, I am inclined to feel that I am a failure.	SA	A	D	SD
10.	I take a positive attitude toward myself.	SA	A	D	SD

APPENDIX F

Social Support Questionnaire 6 (SSQ6)

Instructions:

The following questions ask about people in your life who provide you with help or support. Each question has two parts. For the first part, list all the people you know, excluding yourself, whom you can count on for help or support in the manner described. Give the person's initials and their relationship to you (see example). Do not list more than one person next to each of the numbers beneath the question.

For the second part, circle how satisfied you are with the overall support you have. If you have no support for a question, check the words "No one," but still rate your level of satisfaction. Do not list more than nine persons per question.

Please answer all questions as best you can. All your answers will be kept confidential.

Example:

Who do you know whom you can trust with information that could get you in trouble?

No one

1) T.N. (brother)	4) T.N. (father)	7)
2) L.M. (friend)	5) L.M. (employer)	8)
3) R.S. (friend)	6)	9)

How Satisfied?

6 – very satisfied	5 – fairly satisfied	4 – a little satisfied	3 – a little dissatisfied	2 – fairly dissatisfied	1 – very dissatisfied

1. Whom can you really count on to be dependable when you need help?

No one

1)	2)	3)

4) 6) 8)

5) 7) 9)

How Satisfied?

6 – very satisfied	5 – fairly satisfied	4 – a little satisfied	3 – a little dissatisfied	2 – fairly dissatisfied	1 – very dissatisfied

2. Whom can you really count on to help you feel more relaxed when you are under pressure or tense?

No one

1) 4) 7)

2) 5) 8)

3) 6) 9)

How Satisfied?

6 – very satisfied	5 – fairly satisfied	4 – a little satisfied	3 – a little dissatisfied	2 – fairly dissatisfied	1 – very dissatisfied

3. Who accepts you totally, including both your worst and your best points?

No one

1) 4) 7)

2) 5) 8)

3) 6) 9)

How Satisfied?

6 – very satisfied	5 – fairly satisfied	4 – a little satisfied	3 – a little dissatisfied	2 – fairly dissatisfied	1 – very dissatisfied

4. Whom can you really count on to care about you, regardless of what is happening to you?

No one

1) 3) 5)

2) 4) 6)

7) 8) 9)

How Satisfied?

6 – very satisfied	5 – fairly satisfied	4 – a little satisfied	3 – a little dissatisfied	2 – fairly dissatisfied	1 – very dissatisfied

5. Whom can you really count on to help you feel better when you are feeling generally down-in-the dumps?

No one

1) 4) 7)

2) 5) 8)

3) 6) 9)

How Satisfied?

6 – very satisfied	5 – fairly satisfied	4 – a little satisfied	3 – a little dissatisfied	2 – fairly dissatisfied	1 – very dissatisfied

6. Whom can you count on to console you when you are very upset?

No one

1) 4) 7)

2) 5) 8)

3) 6) 9)

How Satisfied?

6 – very satisfied	5 – fairly satisfied	4 – a little satisfied	3 – a little dissatisfied	2 – fairly dissatisfied	1 – very dissatisfied

Appendix G

Demographics

Gender
___Male
___Female

Race
___White, Non-Hispanic ___ African American ____Native American
___ Hispanic ___ Asian-Pacific Islander ___ Other

Year
___Freshman
___Sophomore
___Junior
___Senior
___Fifth year and beyond

Age _____

APPENDIX H

Emily Ann Kubalik
2801 N. Rock Rd., Apt. 803 * Wichita, KS 67226 * (402) 364-3233 * ekubalik@gmail.com

Education

Fort Hays State University, Hays, KS
Masters of Science in Clinical Psychology Anticipated August 2013
GPA: 4.0/4.0

The School of Professional Psychology at Forest Institute, Springfield, MO
MACL/PsyD Program August 2011 - August 2012
GPA: 4.00 / 4.00 (Transferred)

University of Nebraska at Kearney, Kearney, NE
Bachelors of Science in Psychology
Minor in Sociology May 2011
GPA: 3.962 / 4.00

Research Presentations

- Kubalik, E. (November, 2012) "Mental Health Issues among Survivors of Childhood Sexual Abuse". Presented at the joint meeting of the Nebraska Psychological Association and the Association for Psychological and Educational Research in Kansas, Hastings, NE.

- Chowpakman, K., Kubalik, E., & Pinnamonti, J. (April, 2012). "The Effects of Childhood Sexual Abuse throughout the Lifespan". Presented at the annual meeting of the Missouri Association of Marriage and Family Therapists, Springfield, MO.

Clinical Experience

Internship KVC Wheatland Psychiatric Hospital, Spring 2013
Hays, Kansas

- Performed assessment of child and adolescent mental health
- Conducted individual, family, and group therapy with clients
- Interviewed families to understand concerns
- Developed initial and master treatment plans
- Evaluated client's progress towards treatment goals
- Collaborated with multidisciplinary treatment team

Volunteer On-call Advocate, S.A.F.E. Center, Fall 2009/Spring 2010
Kearney, NE

- Volunteered as an on-call advocate for victims of domestic abuse and sexual assault
- Completed 30 hours of domestic violence and sexual assault awareness training
- Took overnight shifts answering 24 hour crisis line serving a five county area

Professional Development

- *Motivational Interviewing*, High Plains Mental Health Center Spring 2013
- *Trauma-Focused Cognitive Behavioral Therapy* (online training) Spring 2013
- *Trauma Systems Therapy Training*, KVC – Wheatland Spring 2013
- *Children and Grief,* Continuing Education Workshop, Forest Institute Spring 2012
- *Art in Therapy,* Continuing Education Workshop, Forest Institute Spring 2012