The Role of Coping in Support Provision:  
The Self-presentational Dilemma 
of Victims of Life Crises

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People who are suffering or are under severe stress appear to have a special need for close, supportive interactions with others (Coates, Wortman, & Abbey, 1979). Moreover, evidence is accumulating to indicate that such close social ties lessen the destructive impact of negative life events on physical and mental health (see Cohen, 1988; House, Umberson, & Landis, 1988; or Kessler, Price, & Wortman, 1985, for reviews). Yet, in our own research and practical experience, we have been confronted with evidence suggesting that victims of life crises sometimes have difficulty gaining the support they desire and need (DeLongis, O'Brien, Silver, & Wortman, 1990; Lehman, Ellard, & Wortman, 1986; Wortman & Lehman, 1985). For example, cancer patients report experiencing problems with others as a function of their disease, such as friends acting uncomfortable in their presence (Peters-Golden, 1982; see Wortman & Dankel-Schetter, 1987, for a review). Such negative reactions appear to cancel out the benefits of positive support attempts (see, for example, Barrera, 1981; Porritt, 1979). In fact, research that compared the relative impact of positive and negative social exchanges found negative responses from others to be even more detrimental to well-being than positive responses are beneficial (Fiore, Becker, & Coppel, 1983; Pagel, Erdly, & Becker, 1987; Rook, 1984).

Approximately a decade ago, Wortman and her associates developed a theoretical model to account for the support problems that people seem to encounter following a life crisis (see Coates et al., 1979; Coates & Wortman, 1980; Wortman, 1983).

1We use the term victim merely to reflect someone who has experienced a stressful life event over which he or she has little or no control. It is not meant to imply inferior status or to convey that the person views himself or herself as passive and helpless in the face of the event.
man & Dunkel-Schetter, 1979). Drawing from theoretical work in social psychology, as well as from practical experience with victimized populations, this model highlighted how vulnerability engendered by contact with victims of stressful life events may interfere with the effective provision of support. It was suggested that reactions to a person in need of support are a function of a conflict between (1) the feelings of vulnerability and helplessness that are evoked in potential helpers during an interaction and (2) beliefs about appropriate reactions to display when interacting with people who have experienced life crises (e.g., optimism and cheerfulness). Wortman and her colleagues argued that this conflict may result in behavioral responses, such as avoidance and displays of discomfort, that are unintentionally harmful to people who have suffered negative life events.

Until this point, this model focused primarily on ways in which the support provider's negative feelings may interfere with the effective provision of support. However, victims of stressful life events are not passive recipients of support provision. Because support is an interactive process, it is important to consider behaviors of the support recipient that may minimize the support provider's feelings of vulnerability and helplessness and may elicit responses that are truly supportive. In fact, relatively limited research attention has been paid to recipient variables that may influence the provision of support (Dunkel-Schetter, Folkman, & Lazarus, 1987; Wortman & Dunkel-Schetter, 1987). Some notable exceptions include the study of such recipient characteristics as gender and race (e.g., Riley & Eckenrode, 1986) and such dispositional variables as social skills (e.g., Heller & Swindle, 1983; Sarason, Sarason, Hacker, & Basham, 1985) or support-seeking orientations (e.g., Eckenrode, 1983; Mitchell & Trickett, 1980).

In this chapter, we attempt to establish a link between our work on coping with life crises (Silver & Wortman, 1980; Wortman & Silver, 1989) and our work on social support, by suggesting that how a person copes with a life crisis is likely to be a powerful determinant of the support he or she receives. In earlier work, we reported that those who express difficulties in coping with a stressful life event may elicit more rejection from others than do those who appear to be coping well (see Coates et al., 1979). The implications of these findings are distressing, as they suggest that those in greatest need of social support may be least likely to get it. A few subsequent studies offered evidence that the way a person copes with problems is associated with the amount of social support that he or she receives (Billings & Moore, 1981; Dunkel-Schetter et al., 1987). Surprisingly, however, this variable has received relatively little attention from theorists interested in support provision. If they want to maximize their chances of obtaining effective support, what should victims of life crises convey about how they are coping with their problems?

We believe that victims of life crises are faced with a dilemma regarding how to present their situation to others. If they display their distress and report difficulties in coping, they may drive others away. But if they fail to exhibit their distress, they may not signal a need for support. Are there ways in which the individual can present himself or herself so as to convey need without initiating negative feelings from potential support providers? Are there conditions under which distress can be expressed so as to elicit sympathy (cf. Coates et al., 1979) rather than avoidance? As early as 1959, Goffman identified the importance of self-presentation in facilitating effective social interactions and satisfactory social relationships (see Baumeister, 1982; Jones & Pittman, 1982; and Schlenker, 1980, for more recent discussions). In this chapter, we propose that victims of stressful life events can shape the support interaction by means of their self-presentations of how they are coping. First, we present a brief overview of our theoretical approach, illustrating how victims of stressful life events can unintentionally initiate feelings of vulnerability and helplessness in others. Next, we describe the process through which these feelings may interfere with the effective provision of support. Third, we consider possible self-presentations regarding how one is coping that may be expressed to potential support providers, and review the possible consequences of each. In particular, we note the probable social costs of seeking support by displaying signs of distress. Then, drawing from theory and research, we offer a potential solution to the self-presentation dilemma we have identified, and describe an experiment designed to test our ideas. In the concluding section of the chapter, we consider the implications of our analysis for subsequent research and theoretical development in this area.

THE VICTIMIZATION PERSPECTIVE

Earlier papers argued that a victim's plight is a powerful stimulus in its ability to arouse negative feelings in others (Coates et al., 1979; Dunkel-Schetter & Wortman, 1982; Wortman & Dunkel-Schetter, 1979; Wortman & Lehman, 1985). Based on social psychological work on victimization, these papers maintained that contact with others who are suffering may shatter a person's sense of invulnerability. That is, an individual's initial reaction to another's victimization is often a sharp sense of his or her own vulnerability (i.e., a sense that "it could have been me"). Learning that a friend or associate has lost a loved one or developed a life-threatening illness forces outsiders to acknowledge that such outcomes can happen to anyone at any time (Wortman, 1983).

As a result of increased contact with victims of life crises (see Wortman, Abbey, Holland, Silver, & Janoff-Bulman, 1980), we became aware of another source of negative affect among potential support providers: feelings of helplessness. When interacting with a person who has experienced a life crisis, it is common to feel overwhelmed by the magnitude and the scope of his or her problems (see Chesler & Barbarin, 1984). For example, when a cancer patient reveals that her prognosis is poor, she is in constant pain, her finances are in chaos, her husband is anxious, and her children are "acting out" in school, what can one possibly say or do to help? In fact, the more in need the victim appears to be and the more distress he or she consequently conveys, the more that others' feelings of helplessness are likely to be heightened. Personally, we found it difficult to engage in conversations with individuals who conveyed that they were distressed and overwhelmed by their problems, and we preferred spending time with those who were able to maintain a more optimistic perspective on their situation. It occurred to us that because of our own feelings of discomfort and helplessness,
we were probably devoting most of our time and attention to those individuals who were least in need of them.

People may be more inclined to help another if they believe that such help will lead to concrete improvements in that person’s situation. Conversely, efforts to help that result in no noticeable change are likely to be frustrating and upsetting (see Brickman et al., 1982; Chesler & Barbarin, 1984; Coates & Wortman, 1980). Moreover, if a potential support provider feels unable to do anything to alleviate the problem, he or she may be particularly likely to derogate the victim. In fact, in a study of 20-minute telephone conversations between distressed and nondistressed college students (Dunkel-Schetter, Silver, & Wortman, 1989), we found that the more helpless subjects felt when interacting with a person perceived to be distressed, the more they reported negative feelings toward and rejection of the target. Derogating distressed individuals by attributing negative feelings and fears to their own inadequacies in coping with the crisis can relieve the potential support provider’s sense of personal responsibility for being unable, or even unwilling, to help (Dunkel-Schetter & Wortman, 1982).

Although people may harbor negative feelings toward those who have experienced life crises, they are likely to believe that they should not express these feelings to the victim directly. To the contrary, they are likely to assume that for the victim’s benefit, they must act cheerful and encouraging (see Wortman & Lehman, 1985). But these discrepant feelings may be immobilizing, and such conflict and indecisiveness may result in unintentional avoidance of the victim. If they do find themselves in contact with someone who has experienced a life crisis, potential support providers may feel confused and uncertain about how to behave or what to say. Their attempts to be cheerful and to provide reassurance are, accordingly, unlikely to be convincing. Despite their best intentions, their interactions with the victim may be characterized by awkwardness and tension. Such discomfort might be expected to “leak out” nonverbally during the interaction or to result in inconsistencies between verbal and nonverbal behavior (see Wortman & Lehman, 1985, for a more detailed discussion).

There is evidence that victims of negative life events are nonetheless acutely aware of the discomfort that their distress creates for potential support providers, and consequently they withhold expressions of it. Several researchers have reported that distressed individuals hide their needs and negative feelings from members of their social network so as not to burden, upset, or scare them off, as well as to ensure that others do not form an impression of them as weak or needy. For example, almost 90% of the cancer patients that Dunkel-Schetter (1984) interviewed admitted that they sometimes kept their thoughts and feelings to themselves, usually because of their fears regarding how outsiders might react. More than three-quarters of the cancer patients interviewed by Meyerowitz, Yarkin-Levin, and Harvey (1988) reported having times when they would have liked to discuss their reactions to their illness with friends and family, but did not do so (see also Meyerowitz, Watkins, & Sparks, 1983). Similarly, Chesler and Barbarin (1984) found that parents of cancer patients limited their self-disclosures, even to their close friends. Koch (1985) discussed how many siblings of cancer patients withheld expressing their needs and feelings, even to their parents. Finally, Parkes and Weiss (1983) reported that because they feared social ostracism, bereaved individuals often hid their grief from others.

CONVEYING DISTRESS: SOCIAL VERSUS PERSONAL CONSEQUENCES

Our analysis suggests that in attempting to cope with their difficulties, victims may unwittingly exhibit behaviors that are upsetting to others and that lead others to respond in ways that are not supportive. Thus, there appear to be social costs in conveying distress to potential support providers. Indeed, victims seem to be aware of these social costs and so may withhold their distress for strategic purposes. However, it is widely believed among researchers and health care professionals that it is therapeutic for victims to express their feelings of distress (see Wortman & Silver, 1987). There also is evidence that victims desire opportunities to discuss their feelings and concerns and perceive these discussions to be beneficial (see, for example, Lehman, Ellard, & Wortman, 1986). Such interactions may aid the victim in achieving cognitive clarification (Clark, 1988) or in finding meaning in the experience (Silver & Wortman, 1980). In fact, a lack of opportunities to communicate distress may intensify the strain of the victimization (see Silver & Wortman, 1980). Thus, if victims maximize their chances for personal adjustment by openly expressing their distress, they may risk alienating their social network. In our own longitudinal study of coping with the loss of an infant to Sudden Infant Death Syndrome (SIDS), we found that the more distress the parents felt over the death, the more they wanted to talk to others about their feelings. However, the more they did so, the more they felt others were trying to suppress this ventilation. Over time, such suppression by outsiders increased the parents’ distress (see DeLongis et al., 1990).

This suggests that victims face a difficult choice in deciding what to reveal about their victimization, and how they are coping with it, to potential support providers. Undoubtedly, the circumstances surrounding most victimizing experiences and one’s reactions to them are complex and multifaceted. The victim must choose which aspects of his or her experience to share with others, and this choice is likely to have important consequences for the support received. Yet, beyond the aforementioned evidence that individuals under stress are sometimes strategic in their self-presentations, even among intimates (cf. Ginsberg & Brown, 1982; Kleck, 1968b), we know very little about the interpersonal consequences of particular types of disclosures. Because signals of distress may be necessary for outsiders to know that social support is needed or even desired (Ginsberg & Brown, 1982; Tait & Silver, 1989), it is unlikely that overly positive self-presentations will result in offers of support. So, although the general tendency of victims of negative life events might be to withhold their negative feel-
ings from others, securing support may sometimes require highlighting, or even exaggerating, their needs (see, for example, Voysey, 1972). Surprisingly, we have been unable to locate any research that has systematically investigated this question: Are there any ways that individuals can convey their distress so as to elicit effective support from outsiders, rather than avoidance or rejection?

THE SELF-PRESENTATIONAL DILEMMA OF SUPPORT-SEEKING

Although a number of authors have noted the self-presentational concerns of victimized individuals and the impression management strategies they adopt to improve their social interactions (see, Albrecht & Adelman, 1987; Jones et al., 1984; Kline, 1968b; Voysey, 1972; Wright, 1983), none have offered solutions to the self-presentational dilemma of support-seeking that we have identified. Logically, there are several possible ways a victim might present distress in an interaction with a potential support provider. We shall consider each of these alternatives and review the limited available evidence suggesting their likely consequences.

Positive Coping Self-presentation

When interacting with a victim of life crisis, outsiders’ feelings of vulnerability and helplessness may be minimized if the victim conveys that he or she is coping well. For this reason, individuals who present themselves as coping effectively with a victimization, despite its stressful aspects, may be unlikely to elicit derogation and rejection from others. However, our society also insists on the presence of distress following negative life events (see Wortman & Silver, 1987, for an expanded discussion). Labeled the “requirement of mourning” by Denbo, Leviton, and Wright (1956), it is hypothesized that outsiders are motivated to insist on the presence of suffering in any individual whom they deem to be in an unfortunate position (see also Jones et al., 1984; Wright, 1983). If, however, that person appears not to be suffering, then others will “devalue the unfortunate person because he or she ought to suffer” (Denbo et al., 1956, p. 21). Wright (1983) suggested that such a phenomenon may be due to outsiders’ imagining how they might feel in the same situation, imagining their own distress, and projecting this onto the victim, as well as to the outsiders’ need to preserve and elevate their own superior status. There is evidence that outsiders indeed expect individuals who have experienced a negative life event to go through a period of intense distress (see Wortman & Silver, 1987, 1989, for reviews). At this point, however, it is not clear how support provision is affected by the failure to express distress following a victimization.

Although the research is limited, there is some laboratory evidence that individuals who adopt a positive coping stance in response to a victimization are not derogated or disliked by outsiders. In a study that explored self-presentations among the handicapped, Hastorf, Wildfogel, and Cassman (1979) demonstrated that an open acknowledgment of one’s disability fosters positive feelings in outsiders, and a desire for future interaction. Interestingly, these investigators employed a manipulation in which a handicapped confederate, while acknowledging that the handicap was a significant one, nonetheless stated that he had “learned to accept the inconveniences” (p. 1792). The results of a similar study (Bazakas, 1979/1979) suggested that acknowledgment of a disability leads to favorable impressions (less discomfort, more positive affect, less personal distance) only when the disabled individual portrays himself or herself as coping well with the limitations. In a study conducted in our own lab (Coates et al., 1979), rape victims who maintained, six months after the rape, that they had been able to “put the rape behind them,” continued to feel happy, and reported feeling “very fortunate that I have so much to look forward to in my life” (p. 38) were rated as significantly more attractive than were victims who reported having continuing difficulty adjusting to the rape. Similarly, a study that manipulated coping portrayals following two recent negative life events (rejection by law school and breakup of a relationship) found that individuals who presented themselves as coping well were rated as significantly more attractive than were those who reported distress following the events, and no less attractive than individuals who reported experiencing no negative life events (Winer, Bonner, Blaney, & Murray, 1981).

There is even some evidence that individuals who portray themselves as well-adjusted to their victimization are preferred to and evaluated more positively than individuals who have not been victimized at all (see Kline, 1968a; Kline, Ono, & Hastorf, 1966, Study 1), although they may elicit some signs of nonverbal discomfort. Like media portrayals of “supercopers” (cf. Wood, Taylor, & Lichtman, 1983), such individuals might be viewed as deserving special respect and admiration for having “risen above” their victimization.

Individuals who indicate that they are coping well with their victimization may generate positive responses from outsiders because this self-presentational stance may minimize the outsiders’ feelings of discomfort. Nonetheless, such positive self-presentations are unlikely to signal a need for support. Moreover, to the extent that such a portrayal is simply strategic (i.e., the public expression is intentionally discrepant from one’s private experience; cf. Tait & Silver, 1989), it may lead the victim to feel alienated from the social environment and to doubt the validity of any positive responses that he or she receives (Coates & Wortman, 1980).

Poor Coping Self-presentation

Victims may communicate a need for support by stressing the difficulties they are encountering or by highlighting the negative aspects of their situation (see Dankel-Schetter & Wortman, 1982; Jones et al., 1984). As we noted, however, the victimization model postulates that expressions of distress may enhance feelings of vulnerability and helplessness in potential support providers and consequently lead to rejection. In fact, a body of research on depression has provided evidence consistent with this view. This work has systematically examined self-
presentations of distress by manipulating the presence or absence of a target's depression and then observing the reactions of others. In general, this research has found that exposure to interactions with depressed individuals leads to derogation, rejection, and/or discomfort in others (see Gurtman, 1986, for a review). Unfortunately, in some of this research, the individual's behavior during the interaction (e.g., amount of inappropriate self-disclosure; cf. Coyne, 1976) is confounded with his or her expressed affect (see Coates et al., 1979, for a further discussion of this point). The study of rape victims conducted by Coates et al. (1979), described earlier, was designed to eliminate this type of confound. In that study, all aspects of the rape victim's experience and behavior were held constant. Nonetheless, women who conveyed poor coping following the rape experienced more derogation and rejection from observers than did those who appeared to be coping well (see Winer et al., 1981, for a comparable finding). Taken together, these results suggest that highlighting one's distress is a risky strategy to employ when seeking support.

Providing No Information About Distress

If a positive portrayal of one's coping fails to signal a need for support, and a negative portrayal appears to elicit negative feelings and result in rejection, might providing no information regarding distress solve the dilemma? We think not.

The Coates et al. (1979) study of rape victims described above also included a "no information regarding distress" control group. Subjects exposed to this condition failed to rate this target as significantly more attractive than the distressed target. In fact, she was rated as significantly more maladjusted than was the victim who reported that she was coping well. Similarly, in a study of interactions with disabled persons, nondisabled individuals who were given no information about the handicapped person's adjustment to his disability exhibited a number of behavioral signs of discomfort (Kleck & et al., 1966, Study 2). We suspect that when individuals are given no direct evidence about how a victim is coping, they may be more likely to respond according to their stereotypes of victims (see Jones et al., 1984) or myths about the adjustment process following negative life events (see Wortman & Silver, 1987, 1989). Unless they are provided with evidence to the contrary, outsiders may assume that the victim is suffering anyway (i.e., the requirement of mourning). In fact, Wright (1983) offered numerous examples of unsolicited assistance being forced on disabled individuals who neither needed nor desired it. Even if displays of distress are not obvious during an initial interaction, outsiders might assume that such distress nonetheless exists and will "leak out" in subsequent interactions (Wortman & Silver, 1987, 1989).

As Albrecht and Adelman (1987) pointed out, potential providers of support themselves are often faced with a dilemma about whether or not to provide support, particularly if they feel that it might be upsetting to the victim. In the absence of direct signals of need, outsiders may be reluctant to offer assistance, fearing their attempts will be rejected or perceived as intrusive. The general uncertainty about what to say or do in response to another's victimization (Dunkel-Schetter & Wortman, 1982; Peters-Golden, 1982; Wortman & Lehman, 1985) may add to this reluctance. Thus, unless victims communicate their needs explicitly, potential support providers may misjudge the extent or types of support desired.

"Balanced" Coping Self-presentation

As we described above, the self-presentational dilemma faced by the individual who desires support concerns how to convey his or her distress to others so as to encourage support provision without exacerbating feelings of discomfort. There is unlikely to be an easy solution to this problem. Other than perhaps minimizing the presentation of the victimization's negative features to a potential support provider, there may be little a victim can do to decrease the feelings of vulnerability that may be evoked in the interaction. In fact, we expect that whether or not feelings of vulnerability are elicited in an outsider is likely to depend on factors outside the victim's control, such as the outsider's probability of encountering a similar problem.

However, as we noted earlier, we obtained data in our laboratory indicating that following an interaction with a distressed target, greater rejection of the target is accompanied by increased feelings of helplessness among outsiders (Dunkel-Schetter et al., 1989). This suggests that the rejection of and negative responses toward an individual who has experienced a life crisis might be reduced if the outsider's feelings of helplessness in alleviating the victim's distress were minimized. In contrast to perceptions of vulnerability, we hypothesize that the degree to which encounters with victims arouse feelings of helplessness in others may, to some extent, be modifiable by victims themselves. For example, to the extent that a victim appears to be taking steps to alleviate his or her own distress, that is, by taking "responsibility for the solution" (cf. Brickman et al., 1982), the outsider's sense of responsibility for doing so may be attenuated. Consequently, feelings of helplessness may be less likely to be elicited, even in the face of signs of distress.

Such a "balanced" self-presentation, in which the disclosure of distress is simultaneously accompanied by clear signals that the person is engaging in coping efforts on his or her own behalf, is both intuitively and theoretically appealing. Unfortunately, we have been able to find little empirical research that pertains to the likely consequences of such a stance. Nonetheless, the limited evidence we have uncovered suggests that such a self-presentational strategy may be effective. Experiment 3 of the Hastorf et al. (1979) report that we described above exposed nondisabled subjects to videotapes of two disabled confederates. One acknowledged that his handicap was a significant one and stated that he had learned to accept its inconveniences, but he did so while exhibiting obvious nonverbal signs of discomfort (i.e., clasping his hands tightly together, avoiding eye contact, running his hand through his hair). The second confederate neither acknowledged his condition nor signaled any signs of distress. Although the investigators had predicted otherwise, 65% of the subjects chose the distressed confederate when
asked to select a partner for a subsequent session of the study. The authors speculated that although some subjects acknowledged that the confederate appeared uncomfortable with his condition, they nonetheless “may have chosen the nervous confederate because he was trying to cope with his handicap” (p. 1795, italics in original). Unfortunately, this hypothesis was not tested directly.

In the only other study we were able to locate that offers data relevant to our hypothesis (Dunkel-Schetter et al., 1987), middle-aged community residents were interviewed monthly over a six-month period about stressful events they had experienced during the previous month. Results indicated that those individuals who reported using problem-focused coping strategies to deal with their situation (e.g., endorsing such active problem-solving items as “I knew what had to be done, so I doubled my efforts to make things work” or “I made a plan of action and followed it,” and cognitively reconceptualizing the problem so as to make it more soluble) received greater amounts of social support from a larger number of sources in their network. The authors speculated that the use of such strategies may have provided cues to network members that support was both needed and desired and may have made support providers feel more comfortable offering aid. Nevertheless, the data were correlational in nature, and the researchers noted that their results are also consistent with the interpretation that social support influenced the ways in which the individuals coped.

Thus, although the available data are suggestive, up to this point the interpersonal impact of a balanced self-presentational stance (i.e., offering signals of distress along with evidence of coping efforts) has not been subjected to any direct empirical study. Nor has it been compared with any alternative self-presentations. For example, are outsiders likely to focus on the negative affect expressed in a balanced portrayal and to derogate or reject the victim despite his or her attempts to cope? Or will such a balanced self-presentation be viewed favorably? How might such a stance be received when contrasted with a positive coping self-presentation or with one in which no information is provided about distress? Clear answers are unlikely to be obtained outside a controlled setting. So with these questions in mind, we designed a laboratory experiment in which we could manipulate and compare, in the context of an interaction between a victim and a nonvictim, these four possible self-presentational strategies.

THE STUDY

In our study, we hypothesized that the self-presentation of how one is coping with a stressful life experience constitutes a major determinant of a potential help provider’s feelings and behavior toward a person who has been victimized. Specifically, we predicted that individuals who indicate that they are coping poorly with a negative life event will intensify others’ negative feelings, and hence will elicit more derogation and avoidance from potential support providers than will those who convey a more balanced view of how they are coping, or those who indicate that they are coping well. We were particularly interested in how others would react to a balanced portrayal of the victimizing experience. As noted above, we felt that this alternative may be a possible solution to the self-presentational dilemma faced by victims of life crises, as it allows for the expression of distress and thus signifies the need for support; yet it does so in a way that may minimize feelings of helplessness on the part of the support provider.

In order to test these hypotheses, a number of conditions had to be met. First, we felt that it was important to structure our study around a live encounter between a subject and a person who had been through a victimizing experience. Live encounters make it possible to examine a wide range of dependent measures. Many of the early studies on victims were based solely on questionnaire measures designed to assess the victim’s attractiveness (see Wortman, 1976, for a review). Because these early studies did not involve an actual interaction between the parties, there was no possibility of exploring the behavior of the subject during the interaction. The victimization perspective predicts that the prospect of interacting with someone who has been victimized will elicit conflicting feelings. An individual is likely to experience negative affect yet be motivated not to display these feelings out of concern for the victim. In order to test this model, it is essential to supplement self-report evaluations of a target with an assessment of a wide range of behaviors during the interaction. Moreover, as Gurin (1986) pointed out, rejection of distressed individuals may take one of two forms: attempts to distance oneself (e.g., avoidance) and affectively based negative evaluations. Each may differ in the extent to which it is under a respondent’s conscious control, and each may also be differentially affected by experimenter demand. In fact, a number of studies have demonstrated a discrepancy between signs of behavioral discomfort and evaluative ratings of a target (e.g., Gottlib & Robinson, 1982; Kleck, 1986a; Meyerowitz et al., 1988). For all of these reasons, we included a variety of behavioral and evaluative measures in our investigation.

Second, we felt it was necessary to select a truly serious victimizing experience. In order to determine whether the self-presentation regarding the victimizing experience could alter likely negative feelings and behaviors in the outsider, it was important to select a life crisis that would engender such negative feelings. For our study, we decided to focus on cancer. Cancer appears to exert a dark, negative influence on the public imagination (Sontag, 1978). The limited data that are available (see Dunkel-Schetter & Wortman, 1982, for a review) indicate that cancer indeed makes other people feel uncomfortable. Although systematic investigation is rare, several reports suggest that cancer patients are often subjected to negative behaviors from others, ranging from discomfort and avoidance to blatant social ostracism—for example, being the only one at a party to receive plastic eating utensils (see Dunkel-Schetter & Wortman, 1982; Peters-Golden, 1982). We also chose to study reactions to cancer because of this disease’s prevalence. The American Cancer Society (1988) reports that one out of every five deaths in the United States is caused by cancer and that the disease strikes approximately three out of four American families. In view of these statistics, our
results should have wide-ranging applicability to a problem that touches many people's lives. Finally, because we had worked for several years with cancer patient self-help groups (see Wortman et al., 1980), we felt that we were knowledgeable enough about this disease to develop stimulus materials and manipulations that would be credible.

A third requirement for the design was that respondents be exposed to actual cancer patients, rather than to confederates who pretended to be cancer patients. We noted earlier that victimized individuals, such as cancer patients, may be treated differently by nonvictims. If so, they may adopt subtle changes in their behavior to cope with others' negative reactions. It is also possible that a victimized status may affect behaviors in ways that are unknown to confederates who are not familiar with the role. For example, individuals with spinal cord injuries often shift their weight from side to side during an interaction to prevent the development of pressure ulcers. A confederate attempting to play the part of a spinal cord injured person may not be aware of this mannerism, which might affect others' reactions. Because of our contacts in the cancer community, we anticipated that we would be able to recruit and involve cancer patients in the study with relatively little difficulty.

Fourth, the study had to be designed so as to permit a clean and unconfounded manipulation of the victim's self-presentation. In order to assess the impact of the cancer patient's self-presentation about how he or she was coping with the disease, it was necessary to select a paradigm that would allow us to vary this self-presentation while holding constant other information about the disease. In the present design, we accomplished this by asking respondents to listen to a taped interview with a female cancer patient prior to interacting with her. The tapes were spliced so that the target person's description of herself and her illness was identical for all respondents, and only her self-presentation of coping was varied.

Overview of the Study

In this study, the respondents were asked to participate in an interaction with a female cancer patient. Before the interaction, the target's self-presentation was experimentally varied by asking the subjects to listen to a tape-recorded interview with her. The patient provided some information about her background (marital status, work, children), discussed her illness, and provided information about how she was coping with her disease. The segment of the tape dealing with coping was experimentally varied to convey good coping, a balanced portrayal of the patient's coping efforts, poor coping, or no information about the target's coping. In addition, a control condition (no disease) was included in which the target provided the background information only. Following the presentation of the tape, a face-to-face interaction was arranged between the target person and the subject. The dependent variables included questionnaire ratings of attraction to the target person and distress following the interaction, observer ratings of the subject's nonverbal signs of comfort during the interaction, and measures of interpersonal distance and desire for future interaction.

Procedure

Eighty undergraduates from a midwestern university participated in this experiment in order to fulfill a requirement in introductory psychology. The sample (N = 16 per cell) was composed of slightly more females than males. The subjects were scheduled for individual sessions of an experiment that supposedly involved the acquaintance process. They were told that the study was part of a larger program of research on first impressions. We explained that most earlier studies had been based on interactions between college students but that in this study, we wanted to examine the first impressions created by a more diverse group of people. The subjects were told that many different types of people had been recruited to participate in the study, including some adults from the Chicago area who led normal, everyday existences, such as teachers, housewives, or salespeople, and some who had had unusually stressful or difficult lives—for example, parents of retarded children, spouses of alcoholics, or victims of illness or accidents.

The subjects were told that they would be meeting with an adult from the Chicago area who had already participated in the study once before. To prepare for this meeting, the subjects were asked to listen to a tape-recorded conversation between the adult, or target person, and an interviewer that had supposedly been made during the target person's first session. The subjects were told that after listening to the tape, they would be asked to complete a questionnaire regarding their impressions of the target person. We explained that following the presentation of the tape and questionnaire, they would meet the target person and participate in a brief "get acquainted" session and then answer a few questions about their meeting.

Manipulation of Independent Variables

The independent variables were manipulated through the tape-recorded conversation between the target person and an interviewer. In fact, this conversation followed a prearranged script that had been prepared by the investigators in collaboration with cancer patients. In all conditions, the conversation began with a general discussion centering on such topics as the target person's work, family, hobbies and interests, and plans for the future. After approximately 15 minutes, the manipulations were introduced. They began in response to a question about the target person's health. There were five experimental conditions: four cancer conditions (good coping, balanced coping, poor coping, and no information about coping) and a "no-cancer" control condition. In each of the cancer conditions, the target person revealed that she had Hodgkin's disease. Hodgkin's disease was...
chosen because although it is a serious form of cancer that has debilitating symptoms, it is not intrinsically mutilating. Hence, for a given target person, we could experimentally vary whether or not subjects believed her to have Hodgkin’s disease.

Table 15.1 provides excerpts of material from the good, balanced, and poor coping scripts. In the “good coping” condition, the target person expressed an optimistic view of her illness and appeared to be coping well. In the “balanced coping” condition, she conveyed distress about what was happening to her but indicated that she was trying her best and acknowledged some limited success at coping. In the “poor coping” condition, she displayed distress about what was happening to her and appeared to have difficulties coping with her circumstances. In the fourth cancer condition, she conveyed no information about her coping. In the no-cancer control condition, the target person presented herself as a healthy individual. The subjects in this condition heard only the “acquaintance” part of the discussion, followed by a brief statement from the target person alluding to her good health.

Confederates

Four confederates served as target persons for the study. All were female and ranged in age from their mid-thirties to early fifties. Two of these women were cancer patients and two were not. The cancer patients were recruited through a local chapter of Make Today Count, an organization dedicated to the self-help and emotional support of cancer patients. Nocancer confederates were recruited through an advertisement in the newspaper. Each confederate recorded a tape for each condition, and each confederate was paired with four subjects per condition. During the live interaction with the subject, confederates were blind to the subject’s experimental condition. The use of both cancer and nocancer confederates enabled us to examine the impact of disease status on our findings, and the use of multiple confederates allowed us to examine the generality of the findings with different individuals.

Pretesting of Tapes

To ensure that the manipulations were perceived as intended, the tapes were pretested. Undergraduate subjects in groups ranging in size from 10 to 20 heard each confederate’s version of each tape and then answered questions regarding the confederate’s health status and coping. This pretest revealed that as expected, the confederates in the “good coping” condition were perceived as being significantly happier and more optimistic, as having a more positive outlook, as being better adjusted, and as coping better than were confederates in the “balanced coping” condition. The confederates in the “balanced” condition were rated significantly higher on each of these variables than were the confederates in the “poor coping” condition. As we hoped, there were no significant differences among any of these conditions on such variables as friendliness, warmth, ease in conversation, sincerity, or amount of suffering, suggesting that we had not inadvertently confounded coping ability with the target’s personal qualities or her degree of suffering. All subjects correctly perceived the disease condition. As expected, those confederates portraying a cancer patient were rated as suffering significantly more than were the confederates portraying a healthy person. There were no systematic differences between the confederates who had cancer and those who did not, nor among individual confederates.

Dependent Measures

The following dependent measures were included in the study:

1. Questionnaire ratings of attraction to the target person. After listening to the tape recording, but before meeting the confederate, the subjects were asked to complete a questionnaire designed to assess their rating of the target person’s attractiveness. Using seven-point scales, the subjects rated the target person on each of eight different items designed to measure attraction, such as how likable the target was and whether the subject would admit the target to his or her circle of friends. These items were summed to create a composite measure of attraction.

2. Measure of interpersonal distance. After the subject listened to the tape and completed the questionnaire measure of attraction, the experimenter took him or her into an adjoining room to meet the target person. The experimenter asked the subject to bring in his or her own chair. The distance, in inches, that the subject sat from the target person was measured following their meeting.

3. Observers’ rating of subject’s comfort during the interaction. The experimenter asked the confederate and the subject if they would like tea or coffee before beginning the second part of the study. The confederate was instructed to respond positively to this request. At this point, the experimenter excused herself to get the coffee and began timing the interaction. This five-minute interaction was rated surreptitiously by two observers who were seated behind a one-way mirror. Each experimental session was rated by a different pair of observers who also received course credit for their participation in the study. The observers were told that the study involved first impressions. They were not able to hear the conversation, and they were not told anything about the participants involved in the conversation. They were asked to focus primarily on the subject, who was seated facing them. Following the interaction, they were asked to rate the subject, using seven-point scales, on 14 different adjectives or phrases designed to assess his or her comfort during the interaction. The scale included such items as how much the subject enjoyed talking to the target person, how comfortable the subject seemed, and how interested he or she
| Interview Question          | "Good Coping" Script                                                                                                                                                                                                 | "Balanced Coping" Script                                                                                                                                                                                                 | "Poor Coping" Script                                                                                                                                                                                                 |
|----------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| What kinds of things have you been feeling? | My reaction to having cancer has changed from the fear, the panic, that I originally experienced to an attitude of acceptance. I now value my life a lot more than I ever did before. . . . I feel much more aware of the good things in my life—like family and friends who love me—than I ever did before I discovered the cancer. Now I am determined to live to the fullest what time I have left. | Some days, I feel that it was a random thing, you know, cancer just happens; it just strikes someone. Other days I feel like I really need to have someone to blame—I mean, why did it have to happen to me? So . . . I just go on trying to deal with these problems and trying to make the best of whatever time I have left. | I guess I feel really cheated, cheated out of a lot of the best experiences, the best times of my life. I mean, it's totally unfair that I have to put up with these problems—hospital visits and doctor's appointments and X-ray treatments . . . and worst of all, worrying constantly, just worrying, over the least little pain or cough. . . . With all the problems associated with the treatment, it's hard for me to enjoy life or feel hopeful about anything. |
| What does your treatment involve? | Oh, another side effect is that the treatments have caused most of my hair to fall out. After my first series, it took a couple of months for it to grow back in decently. So, since I've been undergoing this therapy, I've managed to find several wigs that are reasonably priced and attractive. Here again, I feel very lucky that the drawbacks associated with radiotherapy are ones that can be remedied. | Another embarrassing side effect is that the treatments have caused most of my hair to fall out. After my first series, it took a couple of months for it to grow back in decently. It's true that this isn't the worst thing that could happen to me—I mean, I can always wear wigs. But still, the fact that I have to wear them, if I want to look like a normal woman, can really drag my spirits down. I try to console myself with the fact that wigs at least provide a means of dealing with my situation. It's something I can do. | The treatments have another embarrassing side effect. They have caused most of my hair to fall out, and it took a couple of months for it to grow back in decently. This has been extremely damaging to my feelings of attractiveness. I can wear wigs, of course, but they are often uncomfortable and inconvenient, and, as any woman knows, it's just not the same as having your own hair. |
| How has your family been affected? | I have had to consider the possibility that I may not live long enough to enjoy my children's maturity . . . to see them graduate from college and begin careers, or start families of their own. This knowledge has served the purpose of intensifying and improving the time I spend with them now. Having gone through the experience of cancer has helped me to relate to people in a much more rewarding and productive way. | Sometimes it is difficult for me to be around my children. This is only because I'll look at them and happen to think of their graduation from college, or their weddings, which I'm afraid I won't see. Sometimes these thoughts crowd into my mind, and I end up reacting poorly towards people, even people I love. In some ways, I feel cheated and jealous because others don't have to put up with Hodgkin's disease, and I do. On the other hand, sometimes that same pain enables me to be more sensitive and understanding towards another's problems and actually draws me closer to them. | Lately, when I look at my children, I can only think that I may not be around to see them graduate from college or get married and start families of their own. It's difficult for me to relate to people who used to be my friends because I know that they will enjoy these things—retirement with their husbands, watching their children mature—and I'm afraid that I won't. |
| How are you handling your situation? | I act as if any encounter that I have with a person is of the highest importance—I try to focus in on them and really be caring. This has really raised my awareness and improved the quality of my life. | Sometimes, I feel depressed and hopeless about my situation, while on other days, I can work through things and stay aside the grief. On those days, I feel halfway optimistic and happy just to be alive. I guess all I can do is keep on trying. | All of these things make it hard for me to have a positive attitude about anything. I feel depressed about my situation, and getting through most days is a struggle. |
seemed in the interaction. The observers’ ratings, which were highly correlated, were pooled for the analysis. A composite rating of observer-assessed comfort was created by summing the observer ratings into a single score.

4. **Self-report of distress following interaction.** At the end of the five-minute period, the experimenter returned with the coffee and told both participants that the experiment was over because the project supervisor had not shown up. They were told that they need only complete a brief questionnaire before they left. The subject then completed a 10-item self-report measure of distress (e.g., discomfort, anxiety, depression, anger) following the interaction. Each of these items was rated on a seven-point scale, and they were summed to create a composite measure of distress.

5. **Desire for future interaction.** Following the interaction, subjects were informed that the study would be continuing for the next several weeks. They were told that we wanted to study relationships as they developed over time and that we would like them to volunteer for additional sessions with the target person each week. They were informed that how they spent the time during their meetings was up to them and that we would be asking them some questions about the way the relationship was developing over time. The subjects were asked to volunteer for any number of one-hour sessions, up to 20.

**Debriefing**

At the conclusion of the study, all the subjects were fully debriefed. Because the experimental procedures had relied on deception at many points, great care was taken to construct a debriefing that was thorough and honest and that attempted to anticipate and respond to the subjects’ feelings and reactions. Virtually all the subjects expressed strong interest in the study and positive feelings about having participated in it.

**Results and Discussion**

The results of the study are summarized in Table 15.2, which lists the means for each of the major dependent measures. A number of conclusions can be drawn from the pattern of findings that we obtained. First, our results provide clear evidence that the subjects responded less favorably, across a wide range of indicators, to the target who presented herself as coping poorly. In comparison with the good and balanced copers, the subjects reported significantly less attraction to the poor coper, sat farther away from her during the interaction, reported significantly more distress following the interaction, and expressed less willingness to interact with her in the future. The observers also detected significantly more nonverbal signs of discomfort in subjects who interacted with poor copers than they did in subjects who interacted with balanced copers.

**Table 15.2. Reactions to Cancer Patients’ Self-presentation**

<table>
<thead>
<tr>
<th></th>
<th>Control (No Cancer)</th>
<th>No Information on Coping</th>
<th>Cancer Patient</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>“Good” Coper</td>
<td>“Balanced” Coper</td>
<td>“Poor” Coper</td>
</tr>
<tr>
<td>Self-report of Attraction to Target1</td>
<td>2.65a</td>
<td>2.67a</td>
<td>2.74a</td>
</tr>
<tr>
<td>Distance Sat from Person (inches)</td>
<td>28.75a</td>
<td>50.25c</td>
<td>41.94b</td>
</tr>
<tr>
<td>Observers’ Rating of Subject’s Comfort with Target1</td>
<td>2.67a</td>
<td>3.72c</td>
<td>3.53b</td>
</tr>
<tr>
<td>Self-report of Distress Following Interaction1</td>
<td>2.50a</td>
<td>3.19b</td>
<td>3.09b</td>
</tr>
<tr>
<td>Self-report of Desire for Future Interaction2</td>
<td>7.56a</td>
<td>1.19e</td>
<td>3.06b</td>
</tr>
</tbody>
</table>

Note: Means that do not share superscripts are significantly different at the p < .05 level.

1 Mean composite ratings on 7-point scales; higher number = less attraction, more discomfort, greater distress.

2 Mean number of hours desired.

Thus, we have again demonstrated what by now appears to be a rather robust finding: Individuals who convey that they are coping poorly with a victimization are likely to elicit unfavorable responses from nonvictimized others. A unique feature of our study, in comparison with previous studies on coping with victimization (e.g., Coates et al., 1979; Winer et al., 1981), is that it included a broad range of outcome variables. In fact, we found that the rejection exhibited toward targets was multifaceted, taking the form of behavioral avoidance, nonverbal signals of discomfort, and relatively negative evaluations of them. Although we did not ask the confederates to rate perceptions of support explicitly, it is unlikely that they would have felt supported during an interaction in which such conflicting signals were conveyed. This provides further evidence for the distressing conclusion offered by Coates et al. (1979) that "in their darkest moments, victims may find only social isolation and ostracism" (p. 48).

As we had expected, providing no information about how one is coping appears not to be a viable solution to the self-presentation dilemma of support-seeking. Although those individuals who took this stance were rated as highly as were the targets in the other four experimental conditions on self-report measures of attractiveness, their interaction partners demonstrated significant behavioral avoidance in the interaction and expressed little willingness to engage in future interaction with them. In fact, the subjects were no more willing to interact with victims who provided no information than they were with victims who displayed poor coping. We suspect that the confusion and uncertainty about how to respond to a victim may be intensified if the victim fails to provide any information about his or her needs. Moreover, in the absence of evidence to the contrary, people may assume that distress is being concealed and will "leak out" in subsequent interactions.
We expected the subjects to react quite favorably to the targets who conveyed either positive or balanced coping self-presentations, and our results illustrate that this was indeed the case. In 9 out of 10 comparisons, the responses to confederates who portrayed positive or balanced coping were significantly more favorable than were responses to poor copers. Moreover, those confederates who presented positive and balanced coping presentations experienced significantly less avoidance than did cancer patients who offered no information regarding coping. Despite this fact, even positive and balanced copers elicited significantly more discomfort, distress, and avoidance (on four out of five dependent measures) than did those confederates who portrayed a healthy (no-cancer) role. Thus, it is important to recognize that although discomfort and avoidance by others may be minimized by a particular coping self-presentation, the mere existence of the victimization appears to be sufficient to elicit these negative reactions to some degree. That is, there appears to be no self-presentation that is effective in making potential support providers feel as comfortable as they would be if they were interacting with a person without cancer.

Interestingly, despite the clear expression of distress by the balanced coping target, the positive coping self-presentation was not preferred to the balanced coping stance on any of the five major dependent measures. On the contrary, the observers rated those individuals who interacted with balanced copers as exhibiting significantly fewer nonverbal signs of discomfort during the interaction than did those individuals who interacted with good copers. In addition, the subjects expressed significantly more interest in future contact with the balanced copers than with the good copers. There are several possible factors that may underlie this pattern of results. First, the nonverbal discomfort exhibited in interactions with the positive copers may be a signal that the targets felt the target was disingenuous. The presence of positive affect in a situation in which suffering is expected (i.e., the requirement of mourning) may simply lead others to see the positive self-presentation as a strategic concealment of distress. If so, the subjects may have expressed little desire for subsequent interaction with this target because they expected the distress to be revealed in future encounters. In contrast and as predicted, a balanced portrayal of coping appeared to allow the person to disclose a considerable amount of distress with few apparent negative consequences.

IMPLICATIONS OF OUR ANALYSIS

In this chapter, we have argued that victims’ self-presentations may have important effects on the provision of support by others. We presented evidence that in a live interactional setting, others’ reactions to victims of life crises are strongly influenced by the victim’s coping portrayal. In fact, our results suggest that given a victimized status, a positive or balanced portrayal of one’s coping efforts can lead to relatively favorable responses from others. In the final sections of this chapter, we would like to move beyond this particular study to consider the more general issues raised by our findings. In so doing, we will explore the ramifications of each of these coping portrayals for both support providers and recipients. Although our ideas are somewhat speculative, they suggest a variety of avenues to explore in subsequent research on this topic.

Possible Solutions to the Self-Presentational Dilemma: Positive Versus Balanced Coping

A Positive Coping Portrayal

We noted earlier that a positive self-presentational strategy may be unlikely to signal to potential providers that support is desired or needed. However, even if it does elicit aid from outsiders, we nonetheless feel that there are a number of drawbacks to the positive self-presentational stance that may ultimately limit its effectiveness.

In some cases, a positive coping portrayal may be strategic in that it is intentionally implemented and is discrepant from the victim’s true feelings. Earlier, we discussed several reasons why victims might attempt to hide their distress and present themselves as coping well. However, there will undoubtedly be times or situations in which such a strategy will be difficult to maintain. In fact, this is most likely to be true as distress increases and as the effort and energy needed to conceal one’s distress and to maintain a positive self-presentation are less available. In such instances, positive coping portrayals may be unconvincing, and distress may “leak out” nonverbally. Support providers may thus receive ambiguous or mixed messages, leading to discomfort and confusion about whether or how to offer assistance.

Another disadvantage of strategically positive self-presentations is that they fail to permit validation of the victim’s true feelings (Coates & Wortman, 1980). Others cannot convey an understanding of what the victim is going through if his or her negative feelings are strategically concealed. Thus, such a strategy is likely to result in feelings of alienation and estrangement from others. Moreover, even if others respond favorably to the victim’s strategic portrayal, the support received may have little meaning, especially if victims are aware that they had to distort their true feelings in order to get it. In fact, the greater the discrepancy between a person’s coping portrayal and his or her true feelings, the less value any support received is likely to have (cf. Jones & Wortman, 1973). A further consequence of hiding one’s negative feelings from others is that it may make such feelings less accessible to self-reflection and cognitive processing.

Our discussion suggests that the strategic concealment of distress may have negative consequences for both parties in the interaction. But what if a person’s
The portrayal of positive coping actually reflects his or her underlying feelings? Even in this circumstance, we feel this portrayal is unlikely to facilitate the receipt of effective support. As noted earlier, independent of whether or not a positive coping portrayal is accurate, others may be skeptical and doubt its veracity. In fact, members of the social network may experience feelings of alienation in the presence of such presumed dishonesty. Others may also come to devalue or react judgmentally toward anyone who appears not to evidence sufficient distress following a life crisis (cf. Dembo et al., 1956). Moreover, outsiders may experience discomfort in the face of victims’ positive coping portrayals, whether or not they are veridical, because such portrayals set unrealistically high standards for others. When they are confronted by individuals who convey positive coping with life’s greatest tragedies, nonvictims may feel ashamed or inadequate for experiencing distress in response to more minor difficulties.

In addition to the problem that such high standards may create for nonvictims, individuals who present a positive coping stance may lead members of their social network to expect that they will continue to cope well. If their distress continues or perhaps increases over time, however, victims may not be able to meet these high expectations. Unfortunately, in such cases, any deviations from a positive stance may be met with negative reactions from others, who have come to expect positive coping (Silver, Hawkins, & Urbanowicz, 1990).

A Balanced Coping Portrayal

At least as operationalized in our research, there appear to be few costs associated with the balanced coping portrayal, in which distress is shared and coping efforts are highlighted. In fact, our study suggests that victims may be more likely to get maximal support if they can adopt such a coping stance toward their victimization, at least in initial encounters. Displays of confusion and distress are possible as long as they are counterbalanced by evidence that the individual is making coping efforts on his or her own behalf. If individuals appear to be taking steps toward managing the instrumental demands placed on them or appear to be trying to regulate their emotions by employing certain self-help tactics, potential support providers may be more likely to add their own support and aid. Thus, by minimizing the support provider’s feelings of helplessness in the face of distress, the victim can maximize the likelihood that support will be forthcoming. In addition, a balanced self-portrayal may influence not only whether support is offered in response to cues of distress but also the type of support that is provided. In the presence of active efforts at problem-solving on the victim’s part, outsiders may be less likely to become overwhelmed in the problem, to offer advice, or to engage in other behaviors that are typically viewed as unhelpful (see Coyne, Wortman, & Lehman, 1988; Lehman et al., 1986; Wortman & Lehman, 1985).

We believe that victims may thus benefit most by conveying that although they are distressed by what is happening to them, they are attempting to cope through their own efforts. Support providers may then try to reinforce the belief that active coping efforts can affect subsequent outcomes. If they do not have to take full responsibility for a victim’s well-being, support providers may feel less threatened and hence may be able to provide more effective assistance (cf. Coyne et al., 1988). In addition, a balanced self-presentation allows others to offer support, not because of any perception of deficiency of effort on the victim’s part, but simply as supplemental assistance. Such a stance is thus likely to foster respect, rather than derogation, from members of the support-seeker’s social environment.

From the victim’s perspective, validation of one’s feelings and concerns is possible only if such issues can be shared openly with others. Thus, another important advantage of the balanced coping portrayal is that victims may obtain benefits from having the opportunity to express their feelings freely. For example, sharing one’s distress in the presence of a supportive other is likely to facilitate adjustment through the development of empathic understanding, which Tholts (1986) has argued is a necessary condition for support provision to be effective. As noted earlier, open discussion can also foster the development of cognitive clarity or help the victim find meaning in a negative life event. Victims may erroneously assume that by sharing their problems, and the extent to which they are struggling to overcome them, they will convey weakness to others. To the contrary, our data provide no evidence that such negative judgments will be made. Because it appears to provide the individual with the opportunity to obtain the benefits of sharing distress without negative social consequences, the balanced coping stance has much to recommend it.

DIRECTIONS FOR FUTURE RESEARCH

We have demonstrated that in initial encounters between victims and potential support providers, the self-presentational coping stance taken by the victim can play an important role in the support provider’s reaction. However, we still know very little about the ways in which the support process is affected by the self-presentation of coping efforts. Next, we will consider possible limitations to the conclusions we have drawn and will identify issues needing further theoretical and empirical attention.

Factors Influencing the Role of Coping in Support Provision

The Nature and Stage of the Relationship

First and foremost, it is important to consider how the findings and processes we described may be influenced by the degree of intimacy that exists between the victim and the potential support provider. In our research, we concentrated on how victims were judged and evaluated by relative strangers during an initial meeting. There are several reasons why it is important to understand the dynamics of initial encounters between victims and nonvictims. Through the course of their experiences, victims typically encounter a wide range of strangers and acquaintances who may have a considerable impact on their lives, such as health professionals, employers, or co-workers. In close relationships, victims are
afforded many opportunities to identify and correct any misunderstandings that may occur. But they may have only a few moments to present themselves and their problems to important strangers (Coates et al., 1979). Moreover, there also is evidence that following a life crisis, people retreat from their former social network and form new ties (see Silver et al., 1990, for a review). These new ties may be particularly important in facilitating effective adjustment following such events, and our analysis may be relevant to the formation of these ties.

Nonetheless, we know very little about the role of self-presentation in the context of an ongoing relationship. In initial encounters, outsiders appear to tolerate the distress conveyed in a balanced coping portrayal. Over time, however, continuing displays of distress may be upsetting to others, regardless of the self-presentation of coping efforts. In fact, there is evidence that over time, outsiders become increasingly rejecting if the distress does not abate, despite signs that the victim is trying (Winer et al., 1981). Ongoing distress, even when accompanied by continuing coping efforts, may be even less tolerable to intimates for whom the victim’s distress has important negative implications (Coyne et al., 1988; Silver et al., 1990). In close relationships, the balanced self-presentation may also set up expectations for continuing effort and eventual positive coping. Thus when such expectations appear to be violated by ongoing signs of distress, this may lead to frustration and, ultimately, to the ineffective provision of support (Silver et al., 1990).

In addition, the extent to which the self-presentation concerns we identified will hold in relationships among individuals who share the same victimization (i.e., similar others) is not known. However, there is evidence that derogation following a self-presentation of poor coping may be unlikely among similarly distressed individuals (Hunsley, Silver, & Lee, 1989), suggesting that a balanced coping portrayal may be unnecessary.

The Nature of the Victimizing Experience

The study described in this chapter examined the role of self-presentation strategies in one victimizing experience—cancer. In subsequent research, it is important to consider the extent to which the processes we described are influenced by specific characteristics of the victimizing experience, such as how it was caused, its prevalence (and hence likelihood of occurrence), or its severity. Are potential support providers less tolerant of distress in lung cancer patients, whose behavior may have contributed to their disease, than in patients who apparently played no causal role in the development of their illness? Are they more threatened by displays of distress if the life crisis is one that they expect to encounter? For example, is an elderly woman, who anticipates becoming widowed herself, more compassionate or more rejecting in the face of a widowed friend’s distress? Are individuals less tolerant of displays of distress in reaction to minor life problems than of equivalent displays in the face of a more serious difficulty? Or are they more tolerant of distress because the problems themselves are less threatening and upsetting?

The Nature, Source, and Timing of the Distress Conveyed

Victimizing experiences also appear to differ in the kinds of emotional reactions they are most likely to engender in victims, and perhaps in providers. Unexpected, untimely events, such as the death of a child or the death of a young spouse (cf. Wortman & Silver, 1987), may be particularly likely to evoke feelings of anger and outrage. Especially when the incident has occurred through no fault of the victim and has come about through the negligence of others, it may be accompanied by feelings of bitterness and resentment than with those who express sadness or depression. It is unclear what the impact of a balanced coping portrayal will be in such cases.

In addition to the type of distress, the manner in which distress is conveyed may influence the processes we described. Are support providers more capable of tolerating another’s distress if it is conveyed in a controlled manner? Previous research suggests that there is considerable variability in how distress is likely to be expressed, with some people remaining calm and composed and others crying uncontrollably (see Silver & Wortman, 1980, for a review of this literature). Is it especially important for victims who are unable to control their distress to present a balanced coping portrayal, or are they likely to elicit avoidance and rejection in any case?

Others’ discomfort in the face of distress, particularly when it is uncontrollable, may also be strongly influenced by characteristics of the victim (i.e., gender, status, etc.), independent of any self-presentation strategies that he or she may employ. For example, it is possible that displays of distress from males will evoke more discomfort than equivalent displays from females. It may also be discomforting to be confronted with displays of distress from those in a superior social role, such as one’s boss. Moreover, it may be particularly troubling to encounter displays of distress from those on whom one depends for support and guidance, such as one’s parents (see Silver et al., 1990, for a further discussion of these issues).

Finally, the extent to which distress is tolerated by potential support providers may depend on the length of time that has elapsed since the onset of the victimizing experience. There is a great deal of evidence in the stress and coping literature that outsiders hold a number of assumptions about the time course of adjustment following stressful life events. As we have detailed elsewhere (see Wortman & Silver, 1987, 1989), it is expected that shortly after the crisis, individuals will respond with intense distress that will abate after a relatively brief period of time. This suggests that signs of distress may be tolerated in the early period following the event, but may not be tolerated for very long.

Additional Research Questions

Until now, we have focused on the impact of the victim’s self-presentation on the potential support provider. However, we view the processes discussed in this
chapter as transactional and dynamic (cf. Coyne et al., 1988). Therefore, it is important to consider how such processes unfold as the interaction progresses. Several surveys, described earlier, suggest that victims are aware of the discomfort they elicit in others and so take steps to reduce it. However, such surveys fail to clarify whether victims are accurate perceivers of any discomfort created. At this point, it is unclear whether victims are overly sensitive to their status and perceive rejection, regardless of others' behavior toward them (cf. Kleck & Strenta, 1980). Alternatively, they may reinterpret or minimize the presence of any discomfort that is conveyed. This matter could be clarified by controlled research that experimentally manipulated support providers' behaviors and examined victims' reactions to them. It would also be useful to study later stages in the interactional sequence to determine the strategies that victims employ to deal with others' negative reactions. Several studies have reported that outsiders' well-intentioned attempts to provide support are frequently perceived as unhelpful (see, for example, Davidowitz & Myrick, 1984; Helmrath & Steinitz, 1978; Lehman et al., 1986; Maddison & Walker, 1967; Peters-Golden, 1982). What self-presentational strategies, if any, do victims use to deal with such unhelpful social responses, and how does that influence the kinds and amounts of support they subsequently receive?

Another issue of major theoretical importance, but not addressed in our research, is the consequences of the self-presentational stances for victims themselves. Undoubtedly, individuals are sometimes aware of the extent to which they are concealing their distress or are presenting themselves in a more favorable light for others' benefit. But such behavior may not always occur as a result of conscious deliberation and in fact may become automatic or overlearned (see Arkin, 1980; Jones et al., 1984). Moreover, in the absence of any obvious cues, people may come to believe their own self-presentations (Arkin, 1980; Rhode- walt, 1986). In future studies, it will be important to determine how victims are affected by the coping portrayals they display to others. For example, do cancer patients who adopt a balanced coping stance, and hence emphasize that they are trying to cope with their problems, come to see themselves as more efficacious? If so, does this facilitate their adjustment to their illness, or to a recurrence?

In conclusion, an examination of the links between coping portrayals and support processes seems to be a promising focus of inquiry. The experiment we reported suggests that victims' self-presentations about how they are coping can indeed shape others' responses. Although much more research is needed, we suspect that coping portrayals exert a powerful influence on the course of the interaction and on the nature and quality of support received. We hope that the foregoing analysis will encourage research that will further elucidate the role that coping portrayals may play in the effective provision of support.

REFERENCES


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