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Social support, psychological distress and the consequences of psychotherapeutic intervention

David Francis King

University of New Hampshire, Durham

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Social support, psychological distress and the consequences of psychotherapeutic intervention

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SOCIAL SUPPORT, PSYCHOLOGICAL DISTRESS AND THE CONSEQUENCES OF PSYCHOTHERAPEUTIC INTERVENTION

BY

DAVID F. KING
B.A., University of Connecticut, 1969
M.A., University of New Hampshire, 1978

DISSERTATION

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September, 1992
This dissertation has been examined and approved.

Arnold Linsky  
Dissertation director, Arnold Linsky  
Professor of Sociology

Lawrence Hamilton  
Professor of Sociology

Michael Kalinowski,  
Associate Professor of Family Studies

Jeffrey Salloway,  
Associate Professor of Health Management and Policy

Murray Straus,  
Professor of Sociology

Aug 10, 1992  
Date
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ABSTRACT

SOCIAL SUPPORT, PSYCHOLOGICAL DISTRESS AND THE CONSEQUENCES OF PSYCHOTHERAPEUTIC INTERVENTION

by

David F. King
University of New Hampshire, September, 1992

Several questions about social support and its relation to mental health over the course of psychotherapeutic intervention are investigated. These include: how do different measures of social support relate to each other at entrance to therapy (time 1) and three months later (time 2), how does social support vary with mental health over time, and how do strategies of therapists affect social support of patients?

Forty patients and their therapists (27) at two community mental health centers were interviewed. Four quantitative standardized measures of social support were used: Donald and Ware's social integration measure (1982), McFarlane's (1980) measure of social networks, Kaplan's perception of social support (Turner and Noh 1983), and Instrumental/Expressive Support developed by Dean et al. (1981). Finally, Goldberg's (1972) General Health Questionnaire measured psychological status. In addition, intensive qualitative interviews concerning the meaning of social support were conducted with patients and their
therapists. The research design incorporated several elements of triangulation (Denzin 1970a) including a) collection of data at two time points, b) the use of multiple indicators of social support, c) systematic comparison between our patient sample and nonpatients studied by other researchers, d) use of multiple informants on the same cases, and e) quantitative standardized measures of the main variables combined with detailed qualitative interviews.

Only some measures of support varied with psychological health: network multiplexity and instrumental-expressive support. Perception of social support was most consistently related with other social support measures at both time points. Social networks and social integration were unrelated to instrumental/expressive support.

Support needs of patients varied with stage in treatment. New patients sought unreciprocated support but were unlikely to receive it. Patient's psychological health after time in treatment was related to financial resources, having close friends, and fewer demands made on them. Financial help at intake to therapy was especially predictive of psychological health at time 2.

Patients' social support was also influenced by therapist's orientations. Therapists who focused on relations with others helped patients reconnect with others who cared about them.
CHAPTER 1

THE NATURE OF SOCIAL SUPPORT AND ITS EFFECTS

Over the past twenty-five years, a growing body of research has established a consistent relationship between social support and psychological well-being. Several studies have found that social supports provide a buffer between life events and psychological health. Others report a direct relationship between social support and psychological health. Additional studies reverse the causal ordering and suggest that psychological health affects the level of support.

Social support is a theoretically rich and fruitful concept in the mental health area, but its meaning and precise relevance remain clouded. One of the difficulties in better understanding the relationship between social support and psychological health is that many studies were cross sections of the population being studied. Longitudinal studies are important to determine how social support and psychological health change over time. Another difficulty is that few studies were conducted with populations undergoing therapeutic intervention. Research studying the social support of populations undergoing therapy is needed. Such studies should assess whether improvements in social support over the course of therapy coincide with improvements in
mental health.

Conceptual confusion adds to the difficulty in understanding the relationship between social support and psychological health. Although the support and health are linked, it remains unclear what it is about support that influences the health status of recipients. Also, there are several distinct dimensions of social support, but studies seldom use more than one measure. Dissimilarities in measures used in studies makes it difficult to understand how the different dimensions relate to each other. It is also difficult to understand how and why the different dimensions affect one's health. The fact that the same measures are not being used repeatedly also means that there are no reasonably standardized measures of social support emerging.

This research employed four measures of social support each representing a different dimension of the concept. The interrelationships among the dimensions were investigated at two time points. Similarly, the relationship of the different dimensions of social support to psychological health was studied before and after treatment.

It is important to use different measures of social support in studies to better understand the concept. It is also important to understand patient expectations of support. Patient expectations of support are important because these expectations provide an understanding of the process of supporting others. Just what do people expect
when they are looking for support? How do they provide support to others? Does social support improve one’s mental health?

This study was designed to correct for the difficulties in measurement described above. Outpatient populations at two community mental health centers were studied at two time points. Data on social support and psychological health were collected at intake to therapy and again three months following intake. Qualitative interviews also were conducted with mental health clients and therapists. These interviews asked patients for their descriptions of social support, and how they supported others. Their purpose was to better understand how people actually support others, and the meanings such support has for the recipients and the supporters.

In addition to interviewing patients, therapists were also interviewed. Therapists represent a formal treatment system. Therapists' intervention strategies were contrasted with patient descriptions of changes that occurred in the patient's support system. The contrasts provided insight into the degree to which two very different treatment systems collaborated with each other.

**Conceptual Confusion: The Many Meanings Of Social Support**

There has been an expanding literature on the psychological effects of major life events over the past twenty-five years. The popularization of the Holmes-Rahe
(1967) life events scale provided a significant boost to this research (Thoits 1983). Throughout this period, the findings have been strikingly consistent: life events are significantly associated with increased psychological disturbance (Thoits 1983). However, Rabkin and Struening (1976) note that correlations between life events and psychological disorder, while significant, are been rather low. The correlations reported in most studies are usually under .30 and seldom over .40. As Thoits (1983) points out, correlations of this magnitude explain at most 9-16% of the variance in psychological outcomes. Thoits (1983) comments that "given the theoretical importance attached by most researchers to life changes as an etiological factor (or set of factors), the weak explanatory power of events is an embarrassment" (p. 42).

One of the primary reasons for the modest relationship between stressful life events and psychological distress is the use of social supports by individuals to reduce the encountered stress (Thoits 1983). Some reviews have concluded that social bonds and supportive interactions are important to the maintenance of a person's health and well-being (Cassell 1974, 1976; Cobb 1976; Mueller 1980; Turner 1983). Variations in social support or social networks are a major factor that influence susceptibility to psychological distress and illness (Turner 1983).

When social supports are unable to reduce stress, psychological distress can occur. If the distress is severe
enough, demoralization will result. Jerome Frank (1975) advocates that relief from demoralization rather than psychological symptoms is necessary to alleviate psychological stress. He argued that all candidates for psychotherapy suffer from demoralization. Demoralization is a state of mind that manifests itself when persons feel unable to cope with problems that they or those around them feel they can handle. Those suffering from mild forms of demoralization are helped by advice and assurance of family and friends. Changes in life situations or job changes that result in a person regaining mastery and connectedness with his group also help reduce demoralization (Frank 1975).

There is considerable evidence that social supports affect the relationship between life events and psychological illness. However, this causal model only specifies that events and support have such an affect (Thoits 1983). Brown (1979) argues that more theoretical understanding is needed about the processes involved between events, support and illness. Thoits (1983) points out that theoretical understanding is necessary not only for scientific purposes but also for applied policy purposes. Causal models may have certain policy implications but their atheoretical nature may cause them to fail. As an example, if a confidant can reduce the impact of a stressful event then a change in treatment approaches for psychological maladies could be one result. One change might be that mental health clinics would assign volunteers to befriend
clients. Unfortunately, such a volunteer may have limited success. Exactly how a confidant relieves stress is unknown and therefore unteachable (Thoits 1983).

Our research investigated some of the questions that need to be answered to develop a better theoretical understanding of the relationship between social supports and psychological distress. It investigates the changes that take place in social supports following therapy. We also studied how changes in social support related to changes in psychological distress.

Definitions of Social Support

Many social support studies have problems with conceptualization and operationalization of the term social support (Thoits 1982). There is currently no consensus on the conceptualization and measurement of the term (House 1980). The expression social support is interchangeably used by some with the term social network and social integration. These terms are often used by others to refer to three distinct aspects of social relationships.

Social Integration. The first dimension of social support we will consider has as its focus the existence or absence of social relationships. This dimension is usually referred to by the term social integration or social isolation (House 1987). Eaton (1978) and Lynch (1977) in approaching social support from the social integration perspective have used marital status as a complete or partial index of social support. They have also estimated
the availability and use of social resources by determining the amount of contact with friends, relatives, and formal and informal voluntary organizations (Turner, Frankel and Leven 1983). Similarly, Brown, Brolchain and Harris (1975) have emphasized the significance of a confiding relationship as a measure of social integration.

**Social Network.** Social network refers to the second dimension of social relationships and refers to the structure of relationships. These are structures that exist between dyadic ties or a set of relationships (House 1987). The dimensions of structures include reciprocity, multiplexity, frequency, density, homogeneity or boundedness (House 1987).

The social network approach attempts a more complex and comprehensive analysis of the immediate social environment. Social support systems are usually thought of as formally recognized entities like family, church, or social organizations. The actual configuration of these groups comprises the real reference group of the individual. The social network approach is one way of getting across formal boundaries and examining the social field embedding the individual (Mitchell and Trichett 1980).

**Social Response.** The final dimension of House's view of social relationships is the functional content which includes interpersonal transactions that involve flows of 1) affect or emotional concern, 2) instrumental or tangible aid like goods and services, 3) information (about the
environment), and 4) appraisal (information important to self-appraisal) (Thoits 1982).

**Perception of Social Support.** Turner et al. (1983) contend that the perception of social support is an important component of social relationships. It must be considered along with the dimensions mentioned above. It also matters to one's physical and mental health. Their interest is consistent with W. I. Thomas' familiar statement that situations defined as real are real in their consequences. For Turner et al. (1983) perceptual reality is psychological reality and is the mediating variable that influences behavior and development. They followed Cobb who in 1976 conceptualized social support 1) information leading the individual to think he or she is cared for and loved, 2) information leading the individual to feel he or she is esteemed and valued, and, 3) information leading the individual to feel he or she belongs to a network of communication and mutual obligation.

Reducing support to availability of resources or to a system capacity or potential should be resisted in Turner et al.'s (1983) view. Measures of perceived social support would constitute useful and direct criteria for determining the relative personal utility of social resources or network characteristics.

**Differences In Effects Of Types Of Support**

The conceptual distinctions just discussed are
important. Not all types of support are equally effective in reducing stress (Thoits 1982). Measures of social integration are associated with better physical and mental health irrespective of exposure to stress (House 1987). However, studies using social integration measures have not been successful in demonstrating pervasive buffer effects (Kessler and McLeod 1985).

Social networks of psychologically distressed patients have been shown to differ in important aspects from those of non-patients (Thoits 1982). On the other hand, the health effects of social network characteristics are somewhat limited. For example, lower density is the number of interconnections among one’s network members. According to House (1987) lower density facilitates divorce or job loss. House also reports that studies have shown that emotional supports do buffer the impact of stress, especially on mental health. However, such supports do not have main or additive effects (Kessler and McLeod 1985, House 1987).

House (1987) argues that social integration and social networks are measures of social structure, and support is usually measured by perceived psychological sentiments. Few studies include even two measures of social relationships. As a result, it is difficult to understand the relationship between the structures and sentiments of support. It is also difficult to understand how and why the structure and content of social support may affect one’s health.

Wortman and Lehman (1985) present evidence that
persisting patterns of behavior intended to be supportive are not always so perceived. It is also possible that certain social integration measures or network characteristics may actually be unsupportive and, in fact, harmful. Without understanding how and why social structure is related to individual attitudes and behavior, it is difficult to understand how social relationships, networks and sentiments of support relate to each other and to stress and health (House 1987). It is also crucial to understand what aspects of social relationships and networks are important to perceptions of support and how and why these perceptions of support are changed (House 1987).

This research will examine how the different conceptual distinctions of social support relate to each other and to psychological distress. Measures of social integration, social networks, content and perception of social support will be used to assess these interrelationships.

**Buffering Effects And Main Effects Of Support On Health: A Review**

Berkman (1985) reports before the early '70's very little information was published on social support. There was considerable literature on the effects of mobility, social disorganization and rapid social changes on maintenance of social ties. The relationship between health and social support was not widely considered until the publications of Cassel (1976) and Kaplan, Cassel and Gore
(1977). These authors published papers indicating that some people were protected from the effects of social upheavals due to social supports. Important elements of these protective factors were the social and community ties of individuals (Gore 1978). However, the measures used in many of these studies contained serious ambiguities. Investigators sought to determine in a more precise way what features of the macro social phenomena might be disease producing (Berkman 1985). They sought to determine what the common characteristics of these conditions were and their consequences for health. One of the characteristics common to these conditions was that individuals experiencing them were without social ties to others. Macrosocial phenomena such as urbanization, mobility, and poverty had been shown to influence the ability to maintain social ties (Litwak 1970).

Much of the literature has been devoted to the hypothesis that social support is a buffer or mediator of life stress (Cassell 1976, Cobb 1976, Lin et al. 1982). When life changes are great or there is chronic exposure to stressors, social support buffers the individual from potential adverse effects on mood and functioning. The buffer effect also facilitates one's ability to cope and function and lessens the likelihood of illness (Gottlieb 1983). When life changes (or stress) are few or of little importance, then regardless of social support, the effect of stress should be low (Lin et al. 1982).
The etiological model which articulates the relations between stress, social supports and illness is depicted in the following model developed by Gore (1978).

Subjective Stress

Objective Stress  Psychological Distress

Social Support

Figure 1.1 The Relationship Of Stress, Support, And Distress (Gore 1978).

Objective Stress. Stressful events are discrete events that can be located in time and measured in a relatively objective fashion. Many studies use the Holmes and Rahe (1967) social readjustment rating scale (Gore 1981) to measure discrete events.

Subjective Stress. Variables measuring subjective stress denote the cognitive threat appraisal processes that are triggered by the recognition of environmental events (Gore 1981).

Personality factors such as self-esteem and locus of control shape people's interpretations of stressful events. Situation-ally specific organismic responses also condition people's responses to life stressors. Lazarus (1974) describes certain cognitive processes and behavioral responses that minimize emotional arousal while aiding
adaptation. He distinguishes between primary and secondary appraisal processes. Primary appraisal processes evaluate the significance of the stressors for personal well-being. Secondary appraisal processes evaluate potential coping resources (Gottlieb 1983). Past experience in dealing with a given stressors is considered an advantage when dealing with the same or similar stressors at a later time. Familiarity represents another individual difference moderating emotional upset following exposure to a stressors (Gottlieb 1983).

Gore (1981) differentiates between subjective and objective stress because determining what types of environmental stimuli provoke the stress response is not equivalent to the subjective meaning. Subjective measures are not true measures of environmental input. The subjective measures of stress are significantly related to self reported outcome measures of psychological distress. Gore (1981) argues that the same cognitive and emotional processes that define psychological distress are also relied upon to define the conditions leading to the disorder. Therefore stress and outcome dimensions are confounded in measurement indicating that certain life events are not independent of the psychosomatic symptoms in which they are expected to result.

To illustrate, Lin, Light and Woelfel (1982) asked subjects if they experienced a major life event in the past six months. They were also asked if the event was perceived
as good or bad. Sixty-one percent of the respondents who mentioned a most important life event perceived the event as good, 30% considered it bad, and the remaining 9% were uncertain. Those perceiving the event as bad scored higher (indicating illness) on a depression scale than those perceiving the event as good.

Gore (1981) also discusses the lack of clarity around the relationship support is expected to buffer. Is support buffering the relationship between objective and subjective stress or subjective stress and psychological distress? She recommends that because of similarities between broad subject estimates of stress and reports of symptoms, one should investigate if the association between objective and subjective stress varies with differences in support.

A host of research studies have been generated to test the buffering hypothesis. For example, Nuckolls et al. (1972) studied the relationship of social stress, social support, and pregnancy complications. They found that life changes were not related to pregnancy complications. They also found that social support ratings were not related to pregnancy complications. When the two variables were considered together, those women with high life change scores and high social support scores had only one-third the complication rate of women with high life changes and low social support scores. When life change scores were low, there was no significant relationship between social support and complications (Turner 1983).
Similarly, Brown et al. (1975) reviewed factors that might influence vulnerability to depression under exposure to distressing events. They examined the consequences of a confiding relationship in reducing the risk of depression in the face of a major life event or long term disability (Turner 1983). Thirty percent of the women who lacked a confiding relationship with a husband or boyfriend developed depression following life stress. Only 4% of women who had a confiding relationship developed depression (Turner 1983).

Lowenthal and Haven's (1968) findings echo Brown's study. They investigated the use of confidants with the elderly who experienced major life events like role losses, or the death of a spouse. Confidants were considered individuals with whom the elderly could discuss intimately their problems or concerns. They found that the presence of a confidant reduced the risk of depression associated with major life events such as death of a spouse (Dean et al. 1981).

Susan Gore (1978) using subjective measures of social support showed. She showed men whose jobs were terminated received a moderating effect on some psychological variables and on certain illness indicators from social support. She also found that low levels of support were associated with higher rates of physical indicators of arthritis (Turner, Frankel & Levin 1983).

Larocco, House and French (1980) examined the influence several sources of support and job stress on general mental
health and job strain. The authors reported that social support buffered the effects of job stress on overall mental health, but social support was unable to protect against the effect of job stress on job-related strain. In addition, they found that job stress and strain are, for the most part, influenced by job-related sources of support. The effects on job strain are largely direct rather than buffering effects. Mental health outcomes, on the other hand, are influenced by a wider range of sources of support that buffer the effects of stress (Turner 1983).

While some studies have found evidence of the buffering effect, the types and sources of support that were examined differed widely. In addition, the measures of functioning used in these studies of the buffering effect of social support also differ considerably. As a result, a coherent theory about the conditions under which social support moderates stress is difficult to articulate (Gottlieb 1983). It is also difficult to identify the exact change processes that underlie the health protective impact of social support (Gottlieb 1983).

**Direct Effects of Social Support.** A number of studies have demonstrated that social support has a positive influence on health regardless of stress levels. People with limited social support have higher probabilities of ill health than those who are socially integrated (Gottlieb 1983). For example, Berkman and Syme (1979) studied a large longitudinal sample of subjects. Subjects with the lowest
levels of social contact at the beginning of the study had mortality rates that were from 2 to 4.5 times greater after 9 years than those with a large number of social contacts (Gottlieb 1983).

Berkman and Syme’s study was replicated by House, Robbins, and Metzner (1982). They found that the mortality rates of men with many social relationships and activities were significantly lower than those men with low support levels 9 to 12 years earlier (Gottlieb 1983).

Several studies have documented a relationship between social support and positive mental health. Henderson et al. (1980) developed an instrument designed to assess availability and adequacy of attachment and social integration. They used their instrument in a community survey of the prevalence of psychiatric distress. Availability, adequacy of attachment, and social integration were significantly related to neurosis and depression for both men and women (Henderson et al. 1980).

LaRocco and Jones (1978) studied the relationship between work stress, support from co-workers and supervisors and distress in Navy men who had served for at least five years. Distress was measured by expressions of intention to leave the job, job dissatisfaction, and poor self-esteem. They found no evidence of the stress buffering role of social support. They did find a direct correlation between leader support and job satisfaction. They concluded that regardless of the levels of stress experienced by the
participants, support was associated with positive job attitudes and positive self attitudes. In addition LaRocco and Jones (1978) noted that social support appeared to be associated with positive mental health (Gottlieb 1983).

There is some evidence that social support defined by social networks is associated with differential psychological well-being (Mueller 1980, Turner 1983). If a social network is generally defined as a specific set of linkages among a defined set of individuals, then a primary network in a general population consists of 25-40 members (Hammer et al. 1978). Within the network, 20% of the possible linkages occur. These linkages often develop into several clusters with 6 or 7 highly interconnected individuals in each cluster (Mueller 1980). Pattison et al. (1975) found such a pattern among 200 subjects in a normative urban sample. The primary networks of neurotics and psychotics had different patterns. The primary networks of neurotics were smaller in size (10-12 persons) including people no longer living or living far away (Mueller 1980). The interconnectedness or density of neurotic networks were low in comparison to the normal sample. Neurotics had fewer contacts outside of kin than normals although numbers of kin did not differ from the normative group. Neurotics reported more negative interactions than controls (Mueller 1980). Psychotics had small primary networks (4-5 members). Network members were mostly kin and the networks were very interconnected.
Interpersonal relationships in the networks of psychotics were ambivalent and asymmetric. The psychotics had smaller, more dense networks and had more non-reciprocal relationships than normal networks (Mueller 1980).

Studies consistently report a direct relationship between support and adjustment. "Considered together, these findings suggest that social support ought to be conceived as an innoculant against stress, not just as a resource that is mobilized for resisting stress induced illness" (Gottlieb 1983: 48).

**Treating Psychological Distress: Social Support or Psychotherapy**

Social support has been shown to be an innoculant against stress, it is also considered an important variable in the treatment of psychological distress. In fact, there are two large bodies of literature that discuss treatment alternatives for psychological distress: the sociological approach or primary group intervention (Gottlieb 1988, Litwak 1985), and the psychological or psychotherapeutic intervention.

**Psychological Intervention.** For most people, psychological intervention is commonly viewed as part of the medical disease model that evolved in the practice of physical medicine. The beliefs underlying this model are applied to mental disease by psychiatric professionals. Their belief system involves nosology, pathology, etiology,
therapy, and professional authority and expertise (Watkins 1965). The nosological beliefs assumed that symptoms were clustered and these symptom clusters could be discerned and recognized. It was also assumed that other discrete disease entities or pathological processes caused the symptoms. Mental diseases were processes responsible for an individual losing control of his or her behavior. Each underlying disease produced a distinct symptomatology. The etiology assumes that a pernicious agent caused a sequence leading to mental disease, and these pathological processes are assumed to be effectively treated (Watkins 1965).

Sociological Intervention. Sociological intervention focuses attention on continuous social aggregates that provide individuals with feedback about themselves and validate their expectations about other people (Caplan 1974). Relationships formed within these social aggregates can protect and enhance health and morale. They increase self-esteem and offer feedback that confirms highly valued self-identities (Gottlieb 1988).

There are two approaches to sociological intervention. The first approach centers on marshalling the support of a partner. Moderation of stressful encounters depends on the proper match. The required match is between the specialized supportive provisions of certain actors in the social field and the special demands and needs provoked by different stressors at different stages. In this approach the support
delivered amounts to befriending. The formation and development of relationships are pursued for their own sake (Gottlieb 1988).

The second approach involves the peer network or primary group. The focus of these interventions is to create long lasting and responsive support systems rather than partnerships (Gottlieb 1988). To accomplish this objective, there are three approaches: 1) restructure the social field, 2) alter the help related transactions occurring among its members, 3) supplement the support group's help on a short-term basis with the specialized help of a new set of associates.

The literature reflects successful interventions utilizing partnerships and support system changes to improve social supports. Specialized support groups are another sociological intervention. The support group has a special purpose and exerts as much influence as the natural network. There is a considerable amount of literature about support groups for varied populations such as widows, heart attack victims, cancer patients, and victims of domestic violence (Gottlieb 1988).

**Psychotherapy: Definition And Description**

Watkins (1965) developed four definitions of psychotherapy: those interventions which attempt to relieve the patient from symptoms, anxiety, and conflict and promote positive personality growth and development; those interventions which perceive the objective of psychotherapy
as the increase in feelings of self-worth and personal maturity; those therapies that seek to improve relations including the ability to give and receive love; and those therapies which seek to achieve adjustment to society and culture.

These definitions concentrate on person centered variables. They pay limited attention to the broader social milieu of the patients being treated (Gottlieb 1983).

Jerome Frank (1975) defined psychotherapy in a more general manner. For Frank, psychotherapy encompasses all those activities by which one individual seeks to relieve distress and beneficially affects the behavior of another person through psychological means. Psychotherapy encompasses all helping activities based on symbolic communications that are primarily verbal. It is offered for a variety of distress and disabilities. Many of the conditions treated have the common characteristic of disturbance in a person's communicative behavior (Frank 1975). Individuals seeking psychotherapy usually suffer from demoralization. Demoralization is a state of mind that occurs when a person feels unable to cope with a problem that he or those about him feel he can. For Frank, demoralization is related to a decrease in social support. He states that an individual suffering from demoralization shows a weakening of ties to his group. This weakening of ties leads to a loss of faith in his reference group's values and beliefs. These values and beliefs had previously
given the individual a sense of security and significance. As a result, the person becomes self-absorbed, loses sight of his long-term goals, and is preoccupied with avoiding future failure (Frank 1975).

Frank describes demoralization as a weakening of ties to a social group. In most psychotherapeutic interventions, no systematic investigation is made of the social resources and supportive transactions that actually occur in the patient’s life space (Gottlieb 1983). Nor is it clear whether demoralization is the result or cause of weakening ties to one’s social group.

While the methods and techniques of psychotherapy are extensive, there are two primary categories: supportive and reconstructive (Watkins 1965). Supportive therapies have as goals the alleviation of symptoms without a change in the basic personality structure. Techniques such as advice, desensitization, directive and non-directive counseling (personal, vocational, marital, chemotherapy) are most often used.

Reconstructive therapies involve those procedures which secure relief of symptoms indirectly. They do this by significantly reorganizing the patient’s basic attitudes toward himself and his customary modes of personal interaction with others. These therapies involve a close personal relationship with the therapist. Insight is thought to be either the result or cause of emotional growth. Some techniques that use reconstruction are
psychoanalysis, gestalt therapy, client centered therapy, the neo freudian approaches of Fromm and Horney and existential analysis and group psychotherapy.

Psychotherapy is individually focused. It results in only a partial assessment of the social ecology. Social support advocates state that without a thorough understanding of the social resources that could be mobilized on the individual’s behalf, treatment options become limited (Gottlieb 1983). Greater attention needs to be made to the range of available support resources. In addition, social support advocates explain that an emphasis on various sources of support will provide a better understanding of how an individual’s social network could be enlisted to improve his or her social and personal functioning (Brodsky Olson and Stewart 1979).

Formal Organizations And Primary Groups:
Psychotherapy is practiced by trained professionals operating in private practice or in community mental health centers. Prior to the early 1950’s, most individuals considered mentally ill were treated in State institutions, located away from their communities. In 1963, Federal legislation was passed creating community mental health centers serving geographic areas of 75,000 - 200,000 people. These organizations along with State hospitals, are the formal representatives of the psychiatric treatment system for the mentally ill.

A second but not as well known component of any
treatment system is the informal or primary treatment system: one's family and friends. The role of social supports in treatment has not been identified because it has not been contrasted with formal organizations (Litwak 1988). Litwak discusses the relationship between formal organizations and primary groups in organizational contingency theory. He states that there is an implicit assumption (following Weber) that technical knowledge is more useful to people in solving their problems than knowledge gained through everyday socialization. In a formal organization, such as mental health centers, individuals are chosen for membership because of their technical training or special job experience. Tasks are predictable and are broken down into simpler components. Formal organizations are impersonal and economic incentives are used to motivate members. In contrast, primary group members are members because of birth or love. Commitment is lifelong and based on duty, affection or bartering for service. Personal ties are encouraged. According to Litwak (1988), groups can manage those tasks that best match their structure. Formal organizations tend to work better with more predictable tasks and unpredictable and varied tasks are best served by primary groups.

Litwak (1988) goes on to argue that both organizations have unique roles to play and each can do better at certain tasks. Rather than one organization assuming an all encompassing approach, it is possible that
each organization makes a different but necessary contribution to the overall treatment of psychological distress.

What is not known about these organizations is just what contribution each makes to the treatment of psychological distress. It is not known if the two organization's efforts are independent of each other, or whether there is a causal relation between psychological intervention social support intervention. For example, does psychological intervention improve the psychological health of an individual? If so, does better mental health lead to improvements personal relationships? Do improvements in social support lead to better mental health with therapy having limited impact? If, as Litwak suggests, each organization makes a necessary contribution to the overall treatment of distress, it is not known what particular combinations of therapeutic interventions and social support interventions are more effective in improving psychological health. If either approach (formal or informal organization) is more effective singularly or in concert, then there are potential impacts on both social policy and practice.

This research will address the following questions related to the conceptualization of social support and its relationship to the psychological distress of patients treated in a community mental health center:

1. If dimensions of social support are changed over the course of therapy, what caused those changes?
2. How do the dimensions of social support relate to one another, and how do changes in one dimension affect other dimensions during therapy?

3. What is the relative importance of objective vs. perceived social support in influencing psychological distress?

4. How do changes in social support relate to the perception of social support?

5. As changes occur in the dimensions of social support over the course of psychotherapy, are there corresponding changes in psychological distress?

6. Do different dimensions of support have a differential impact on psychological distress?

7. How do changes in social support dimensions cause changes in psychological distress?

8. How do strategies of psychotherapists implicitly or explicitly impact on the social support of the patient?

9. Are changes in the social support during psychotherapy the result of a planned psychotherapeutic intervention strategy?

10. How do patients define social support?
CHAPTER 2.

METHODS

Introduction

This chapter presents the research method used to answer the questions posed at the end of chapter 1. This study is exploratory in nature. It is based on data collected from telephone interviews with patients entering two community mental health centers in New Hampshire. Two forms of data collection were used.

The first form was based on survey data that measured the different dimensions of social support. The instruments chosen have been used in previous research, are on standardized schedules, and can be statistically analyzed. However, the number of subjects for this study was not large enough to explore fully all the questions raised in Chapter 1 with the proper statistical methods.

To augment the survey method, a second form of data collection was employed. The second method involved the use of an open ended questionnaire. Subjects were asked about their views of social support and the psychiatric intervention they received. In addition, the therapists, for whom permission was granted and available, were contacted. These questions were asked when the quantitative measures of social support were collected. The open ended questions
allowed for a more in depth discussion of the details and process of social support with the outpatients studied in this research.

Combining the two forms of data collection will help offset some of the drawbacks of each of the methods individually. For example, test-retest effects are a common problem. Panel data are subject to test-retest effects especially when the data are collected at time points not very far apart. Test-retest problems imply that the subject's retest score on a measure is influenced by the practice obtained when taking the original test. The open ended interviews verified if changes reported by respondents on the survey measures actually refer to support changes. The interviews also detailed what changes in social support occurred.

**Triangulation Of Method And Data**

All studies have the problem of trying to adequately rule out rival causal hypotheses (Denzin 1970a). Sociologists use the survey to collect data more often than the experiment. As a result, the rigor needed to establish time order, covariance and the ability to manipulate rival causal factors is unavailable (Denzin 1970a 1970b). On the other hand, experiments tend to use captive audiences like college students. Surveys examine individuals in their natural settings like home or places of work. The differences in samples make valid comparisons between the two methods difficult at best (Denzin 1970b).
Since the control provided by the experimental method is unavailable, the sociologist must use an alternative method. Denzin (1970b) terms this method the multivariate method. Though events remain uncontrolled, the investigator can make comparisons within his or her sample that emulate, as nearly as possible, the experimental method. For example, those married can be compared with those who are divorced, separated or single on level of social support and psychological distress. If marital status produces differences in levels of social support, the independent variable in this case, then the investigator can create comparison groups. He or she can then measure the relationship of social support to psychological distress, the dependent variable, controlling for marital status (Denzin 1970a).

To control for rival causal hypotheses, the time order of variables needs to be determined. Survey investigators classify events as either antecedent or intervening to his or her main variables. Since the survey researcher does not control the time order of his variables, he must infer their relationship (Denzin 1970a).

The panel method allows the same respondents to be interviewed at a later time on the same variables and helps establish time order (Denzin 1970b). These longer term studies allow for analytic induction that permits the direct identification of time order, covariance and rival causal factors (Denzin 1970a). Denzin points out that in
treating the problem of rival causal factors, "the experimental method controls them, the survey method infers them, and analytic induction follows their occurrence over time" (1970a:26).

No single method completely solves the problem of other causal factors. Denzin (1970a 1970b) argues that since no method is ever free of rival causal factors, every investigation needs to employ multiple methods. He calls the use of multiple methods, triangulation. Denzin has expanded the definition to include four types of triangulation 1) data 2) investigator 3) theory and 4) method.

In this research, two types of triangulation were employed: data triangulation and method triangulation. Data triangulation involves searching for as many different data sources as possible that bear on the topic being investigated (Denzin 1970a). In this investigation, patients, and therapists were interviewed to provide different views of the treatment process and its relationship to social support.

Data Triangulation. This method of triangulation involves three levels of analysis: 1) person (such as a survey of individuals) 2) interactive, or the study of the interacting persons like a family in their homes or the laboratory. The emphasis is on the interaction. 3) collectivity (the observational unit is an organization a group or community.

The triangulation issue is especially relevant for our
own study because of some clear limitations involved in the design and the data available.

In our study, there was no control group. We studied only patients. However, other investigators studied nonpatients using the same instruments. Comparing our patients to nonpatients studied by other investigators provides a comparison of two groups, patients and nonpatients. Between these two groups we studied their levels of psychological health, levels of social support and how those levels changed over time. In addition, we compared our sample of patients to laboratory experiments of nonpatients that assessed the interaction between support seekers and support givers. In so doing, the study provides for two types of data triangulation (person and time) and three levels of data triangulation (aggregate person, interactive and collectivity). Each of these represent significantly different data areas within which the same event occurs. This approach is comparable to the use of dissimilar comparison groups as a sampling strategy (Denzin 1970a).

Method Triangulation. Methodological triangulation is the combination of two or more different research strategies in a study of the same entities (Denzin 1970a). The point of method triangulation is increased validity in results. Since all methods have weaknesses, combining methods should help increase our knowledge of rival causal factors and hence, increase the validity of our conclusions.
In our study several methods were used. One method used was the survey. We used standardized survey instruments to measure patient's social support at two time points. The same panel of patients was surveyed at both time points. We also used qualitative interviews with patients and therapists. The interviews asked patients about their experience with support and the meaning of that support in their lives. The qualitative interviews with therapists supplemented patient's reports. Both the intervention strategy used by the therapist and its effect on patient's social support was collected from patient and therapist reports. Finally, we used four different measures of social support which provided a level of depth and comparison that is not usually available. Denzin (1970a) classifies the use of different measures of the same concept as a within-methods form of triangulation.

While this study has limitations, as described below, it also has some methodological strengths that help make up for its shortcomings. The design of the study involves several of the elements of triangulation discussed by Denzin (1970a 1970b). In fact, it employs an unusually high degree of triangulation:

a) Data collected on a panel of subjects at two time points.

b) Multiple indicators of social support.

c) Systematic comparison between the patient sample studied and nonpatients studied in other research using identical instruments.
d) The use of multiple informants (patients and their therapists).

e) Quantitative standardized measures of the main variable combined with in depth qualitative interview material.

Hopefully, the high degree of triangulation will offset some of the limitations of the design discussed below.

The methodological procedures used in the study will now be presented in more detail. To begin, a description of the sample is presented.

**The Sample.**

The mental health centers that participated in the study had a total of five geographical subdivisions representing their combined catchment areas. Each subdivision has an outpatient center serving the population within a defined geographical area. The subdivisions had outpatient offices located in Colebrook, Littleton, Berlin, Rochester and Dover, New Hampshire. Each outpatient office served the towns surrounding that office. In total, all the towns and their populations located in Coos county (with the exception of the Conway, N.H. office which chose not to participate), Strafford county and 14 towns in northern Grafton county were eligible for the services provided by these outpatient sites. The sample of clients to be interviewed were chosen from all five outpatient sites.

**Client Interviews.** All clients participating in the study had to sign forms on which they agreed to 1) participate in the study and 2) agreed to have their
therapist interviewed. These informed consent forms were developed jointly by the clinical directors from one mental health center and by members of an Institutional Review Board. The Institutional Review Board was convened under the auspices of the State of New Hampshire, Department of Health and Human Services, Division of Mental Health and Developmental Services. The chair of this committee was the medical director for the Division of Mental Health and Developmental Services.

Data were collected from 40 patients and 27 therapists from July 1, 1990 to September 15, 1991. Cases were obtained as they appeared for treatment at two community mental health centers. Clients requesting treatment at the mental health center either called or came to the agency to make an appointment (assuming a non-emergency). During the telephone call, an intake worker (therapist) discussed the client's situation to determine 1) the reason for the call, 2) the seriousness of the situation, 3) other relevant information and, 4) an appropriate appointment for an intake meeting at the agency.

On the day of the intake meeting, but before the actual intake session, the client was asked to complete admission forms and sign releases. While the patient was completing the admission forms, a secretary or receptionist presented the release form describing the research study. Patients were asked if they wished to participate in the research. Only individuals more than 18 years of age were
eligible for participation. Clients were offered $5.00 for the interviews. The Release Form appealed to patients for cooperation on the basis of the research value of the study. Confidentiality was assured. No services were offered to the patients, but the form indicated that the research would help further understanding about mental illness. Each interview lasted for about one hour. For one mental health center, the total number of new admissions during the time period of the study was 894. The low number of responses (40) were due to:

1) Reluctance of clients to participate in the research because of lack of familiarity with research. Clients feared the loss of confidentiality. Clients were unable to understand the informed consent form. Clients were unable to tolerate thinking about participation due to their psychological state at the time of admission.

2) Reluctance of the receptionist to hand out the forms or to take the time to explain the form to the client due to work load.

3) Slower than expected turnover of cases due to economic conditions. It was reported that clients were remaining in therapy longer. This in turn caused the build up of waiting lists. As waiting lists grew, only clients were admitted for treatment. Crisis patients were not eligible for inclusion in the study. This policy was part of an agreement with the Institutional Review Board. The Board felt that the informed consent of patients in crisis might be questionable.

While reluctance on the part of the client was assumed, cooperation of the receptionist was expected. In most locations, the receptionists were the responsible for interviewing and explaining intake forms to new patients.
All their work was done at the front desk. They assembled the package of forms for the client before the client’s first meeting with the therapist. Clients were asked to come to their first appointment 15 minutes early. This seldom occurred according to the receptionists. When receptionists were attending to new patients, they were answering phone calls. The volume in all locations was reported as heavy. If a new patient was late, filling out the required forms had to be hurried, because the therapist would be waiting. In addition, patients finishing their hour approached the receptionist to book their next appointment. During these moments, the patient may also have been determining whether to sign the consent form. If the receptionist was able to help the patient review the form and the study, then the probability of participation was enhanced. This was usually not the case. A total of forty-eight signed the consent form. Forty-two were actually reached at the telephone number listed and 40 agreed to participate.

Twenty-nine of the original clients interviewed were available for second interviews. Only one refused to participate during the second interview. The remaining ten were no longer available because a) they either moved out of the area with no forwarding address or phone number, or b) because of highly varying work schedules, they were unavailable after five call backs. Several clients moved but did leave forwarding phone numbers for the researcher with family members. Two subjects who were unavailable were
hiding from abusive husbands/boyfriends and were afraid to be contacted. When at all possible, patients made time for the interview. Therapists made every effort to participate within very busy schedules.

In table 2.1 below, selected characteristics of the patients who participated in the study are compared on those same characteristics with the all the individuals who entered therapy during July 1, 1990 to June 30, 1991, the year in which subjects were selected for the research.

As the data show, there are some differences between our sample and the patient population. The client sample at time 1 is more educated, female and slightly better off financially than the full patient population.

There were some problems with the patient population data submitted by the mental health center. Thirty-six percent of the individuals who applied for services to the mental health center had their education listed as unknown. This large number of unknowns may have skewed the true educational mean of the patient population. It may also account for the differences between the patient population admitted for services to the mental health center, and the sample of patients used in this research.

Another difficulty with the mental health center population data involves the average income of the patient population. Fifty-nine percent or 492 of the the 894 members of the client population listed their income between zero and 9,999. It is not known whether this is the true figure,
Table 2.1 Demographic Comparisons of Client Sample and Client Population at One Community Mental Health Center

<table>
<thead>
<tr>
<th>Age</th>
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<tr>
<td></td>
<td></td>
<td>Time 1</td>
<td>Time 2</td>
<td></td>
</tr>
<tr>
<td>18-59</td>
<td>83%</td>
<td>94.8</td>
<td>96.4</td>
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<td>60+</td>
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<td>5.2</td>
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**Education**

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<td>9-11</td>
<td>22.1</td>
<td>15.0</td>
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<td>12</td>
<td>51.7</td>
<td>30.0</td>
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<td>55.1</td>
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<tr>
<td>17+</td>
<td>4.5</td>
<td>5.0</td>
<td>3.4</td>
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**Sex**

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<tbody>
<tr>
<td>Male</td>
<td>42.0%</td>
<td>35.0%</td>
<td>31.0%</td>
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<tr>
<td>Female</td>
<td>58.0</td>
<td>65.0</td>
<td>69.0</td>
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**Income**

<table>
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<th>Mental Health Center Population</th>
<th>Study Sample</th>
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</thead>
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<tr>
<td>0-9,999</td>
<td>59.6%</td>
<td>35.0%</td>
<td>31.0%</td>
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<tr>
<td>10,000-19,999</td>
<td>22.0</td>
<td>47.5</td>
<td>44.8</td>
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<td>20,000-29,999</td>
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<td>10.0</td>
<td>13.8</td>
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<tr>
<td>30,000+</td>
<td>6.7</td>
<td>7.5</td>
<td>11.3</td>
<td></td>
</tr>
</tbody>
</table>
or if the income data were not collected and the data unknown. The income figure provided by patients at the time of intake determined the amount of money a patient would have to pay to the mental health center for their treatment. The mental health center determines payment for services using a sliding scale. A sliding scale is designed to assess a minimum weekly fee or no fee, depending on the individual financial circumstances of the patient. Obtaining valid income data was considered difficult by the individuals responsible for obtaining this information. Again, the large number of "0" income for the patient population data leaves some doubt about the accuracy of the data, and may be the reason for the differences between the sample and population data.

At time 2, the panel of patients being studied in this research was similar to the sample studied at time 1. There is a slight increase in the percent of subjects who are female. The income for the two samples was comparable as was the education level. Overall, the sample characteristics were reasonably consistent with the characteristics of the patient population. Sample mortality has not affected the characteristics of the panel being studied from time 1 to time 2.

Therapists interviews. The sample of therapists interviewed totaled 27. Some of those not interviewed were interns who were not available at the time of the second interview. Some psychiatrists refused to provide information
without explicit permission from the patient even though there was a signed informed consent form. Securing appropriate permissions was difficult for patients who had left therapy. On the whole, therapist participation was much better than expected. This researcher was gratified at both the participation and helpfulness of the therapists as well as the helpfulness of patients and their families.

To involve the therapists, meetings were held with the clinical directors of each mental health center. Prior to setting up those meetings, permission was granted by the executive directors of the two mental health centers. Their cooperation, as well as the cooperation of the clinical directors was essential and very helpful. Following meetings with the clinical directors, meetings were held with outpatient therapists to explain the study. In some of the regional offices, the clinical director elected to explain the study to the therapists. Therapist interviews lasted 20 minutes on average and all gave their full attention to the questions presented.

The Interview Instruments

Clients were interviewed using the H.I.E. social support questionnaire (Donald and Ware 1984) to measure social integration; the Social Relationship Scale (SRS) to collect social network data (McFarlane 1980); and the Instrumental-Expressive Support Scale (Dean, Lin & Ensel 1981) to collect data on the functional content of social support. Perception of social support data was collected by using the
Shortened Kaplan Scale (Turner, Frankel and Levin 1983). Finally, psychological health was measured by using a shortened version of the General Health Questionnaire (GHQ) (Goldberg 1972). During the course of the interview, clients were asked questions designed to elicit specific actions, events, and comments that were considered supportive by the client.

**The H.I.E. Scale**

The H.I.E. (Health Insurance Experiment) Social Support Scale is an eleven item self-administered scale comprising predominantly two kinds of indicators. The first set of indicators define social resources (like the number of friends one has), and the second set of indicators define contacts (such as the number of times one sees one's friends or the involvement in group activities). The scale does not cover work related performance or times that do not involve interaction, like sports events (McDowell and Newell 1989).

The scale uses forced choice and open ended responses. High scores indicate higher social support. The items can be grouped into two subscales based on a factor analysis and an overall social support score (McDowell and Newell 1989).

**Reliability.** Internal consistency coefficients for the three subscores were .72 for social contacts, .84 for group participation and .60 for the social support index. The test-retest coefficients were .55, .60 and .68 respectively for the three subscores. Coefficients for individual items ranged from .23 to .80.
Validity. To assess the validity of their measure, Donald and Ware (1982) correlated the 11 items of the H.I.E. scale with the three criterion scores. The authors collected data on 4,603 subjects in the Rand Health Insurance Experiment. The criterion scores were a nine item psychological well being scale, a three item measure of emotional ties and another nine item self-rating of health in general. The social support index correlated .32 with psychological well being and .2 with emotional ties. The Social Support Score explained 12% of the variance in mental health as measured by the Rand Mental health Inventory (McDowell and Newell 1989).

While not suggesting high levels of reliability and validity, the studies performed do indicate that the H.I.E. scale is able to predict variations in mental health. The length of the scale and the items used will provide the information needed to measure social support when defined as social integration.

The Social Relationship Scale

The social relationship scale (SRS) measures the extent of an individual’s network of social relationships. It also measures the network’s perceived helpfulness in dealing with the effects of stressful life events. The scale is designed to provide a summary of both quantitative and qualitative aspects of a person’s network of relationships that help that person deal with stress (McDowell and Newell 1989).

The SRS scale is self-administered and covers six areas
of life change. The six areas are: work related events, monetary and financial events, home and family events, personal health events, social events and society in general. Respondents provide the initials of the person they talked to, the type of relationship, the helpfulness of the discussion using a seven point scale, and the reciprocity of the relationship (McDowell and Newell 1989).

Reciprocity is established by adding up the number of people the respondent thinks would come to him for similar problems. The proportion of reciprocal contacts is established by dividing the number of reciprocal contacts by the total number of contacts. The extent of the network can be arrived at by counting the number of different people mentioned. The third score that may be calculated is the quality of the network. This score is calculated by taking the average of the seven point helpfulness ratings (McDowell and Newell 1989).

Reliability. Using a one week interval, test-retest correlations for the numbers of individuals in a person's network ranged from .62 to .99. The median was .91. The helpfulness score correlations ranged from .54 to .94. The median was .78 (McDowell and Newell 1989).

Validity. To assure content validity of the scale, a preliminary version was presented to four psychiatrists. The psychiatrists made suggestions for improvements. Their recommendations were made part of the scale. Discriminant Validity was measured by comparing couples with known
marital problems with couples selected as parent therapists and considered able to communicate with each other. The scale showed significant differences in the ratings of the marital relationships of the two groups (McDowell and Newell 1989).

The SRS is a short scale that can be quickly administered. The scale provides information on effective and ineffective network members and the quality of the network in general. While needing more validity and reliability testing, the SRS scale was chosen for this study for its content, length and ease of administration.

Instrumental-Expressive Support Scale

Dean, Lin and Ensel (1981) operationalized a set of twenty-six items which they felt would reflect the instrumental or expressive support available to the respondent. One objective in constructing the items was to allow respondents to describe various modes of support, regardless of demographics, status and role characteristics of the respondents (Dean and Ensel 1982).

Following an introductory question, a list of twenty-six responses is presented to each client. When the original data were collected, the twenty-six items were subjected to a factor analysis. Dean, Lin and Ensel (1981) found five identified factors 1) money problems, 2) lack of companionship, 3) demands 4) communication problems, and 5) not having children.

The items making up each factor were summed, resulting
in five constructed social support variables tapping the instrumental and expressive support factors.

The authors looked at the relationship between scores on their Instrumental-Expressive Support Scale and the Medalie-Goldbourt Scale (1974) measuring general family problems and relationships. The Medalie-Goldbourt scale was significantly related to both the instrumental and expressive social support scales of Dean, Lin and Ensel (1981). As family problems increased, so did money problems, demands, communication problems and companionship problems (Dean, Lin and Ensel (1981).

While limited in its use, the Instrumental-Expressive Support Scale provides an easy to administer scale. The time to administer the scale and the ease with which respondents could understand the questions via a telephone interview were important criteria in choosing this instrument.

**The General Health Questionnaire**

To deal with the theoretical issues posed in the previous chapter, a measure of the mental status of the subjects was required. The General Health Questionnaire was selected for this purpose. The General Health Questionnaire (GHQ) is a self-administered screening scale. Its purpose is to detect psychiatric disorders in surveys or clinical settings.

The GHQ is used primarily to detect an inability to carry out one's normal functions (McDowell and Newell 1989). The GHQ was designed to cover four identifiable elements of
distress. They are 1) depression 2) anxiety, 3) social impairment and 4) hypochondriases (McDowell and Newell 1989).

The GHQ asks respondents whether they have recently experienced a particular symptom or type of behavior with the emphasis being on change in condition. In so doing, one's present condition is compared to one's normal state. Responses range from less than to much more than usual (McDowell and Newell 1989).

The main version of the GHQ was written with 60 items. However, Goldberg has developed shorter versions. One version contains 30 items, another 20 items and finally a 12 item test. The 60 item survey takes 6 to 8 minutes to complete and the 30 item questionnaire takes 3 to 4 minutes. This study, used the 12 item questionnaire (McDowell and Newell 1989).

Scoring. Goldberg and Hillier (1979) have scored the scale using a likert scoring system (0-1-2-3) and a two point score that rates problems as present or absent (0-0-1-1). Goldberg and Hillier (1979) found little difference in the two scoring methods and recommend the two point approach.

For the G.H.Q. 60, any 12 positive answers identify a probable case. For the G.H.Q. 30, 4/5 is considered the cutting point. For the 12 item test, 1/2 is the cutting point. At the cutting point, the probability of being a case is .5.
Reliability. After 6 months, the test-retest coefficient ranged from .75 to .90. Split half reliability for the G.H.Q. 12 was .92. Interrater reliability on a number of interviews produced disagreement on 4% of the symptom scores (McDowell and Newell 1989).

Validity. The G.H.Q. is a widely tested scale and validation studies have been performed in many countries (McDowell and Newell 1989). Comparing the G.H.Q. 12 with a standardized psychiatric interview developed by Goldberg, four studies have shown sensitivity and specificity values ranging between 71% and 91%. In addition, the G.H.Q. 12 correlated .78 with the Hopkins Symptom Checklist of Physical and Psychological symptoms.

The G.H.Q. is well founded conceptually, and the initial item choice and analysis are well documented (McDowell and Newell 1989). The validation studies have been thorough and extensively carried out in numerous countries. The results of these studies are very consistent (McDowell and Newell 1989). Most criticisms reflect limitations that were deliberately imposed by Goldberg (McDowell and Newell 1989).

The Shortened Kaplan Scale

This scale (SKS) utilizes a story identification technique composed of seven vignettes. Each vignette is composed of three stories that describe individuals who have variable support levels. Respondents are asked to identify themselves with the stories. They are then asked to
complete a five point scale. Vignettes with high scores indicate greater support. The scores for each vignette are summed, and the total score indicates the overall social support of each respondent.

Using Cronbach's alpha coefficient, internal reliabilities were .78 to .83 in two separate studies. To measure construct validity, correlations among four social support measures for each of four studies were compared. The correlations ranged from .31 to .62 with an average of .50 indicating that the four measures include the same universe of content with minimal redundancy (Turner, Frankel & Level 1983).

The SKS is easy to administer and takes little time. Turner, Frankel and Levin (1983) reported that subjects responded very well to the Kaplan scale. In fact, subjects responded so well that Turner, Frankel and Levin (1983) placed the SKS at the end of their questionnaire. This was done to reduce information loss occasioned by the impatience or fatigue of respondents. For these reasons and the aspect of support being measured, the SKS was chosen.

**The Telephone Interview**

The telephone interview method was chosen over face-to-face interviews and mail questionnaires because of three factors: 1) geographical dispersion of the individuals to be included in the study 2) implementation time and 3) response rates. These three variables were among many variables that can be used to compare the three survey
methods. The variables selected were thought to have the greatest impact on the study (Frey 1983).

**Geographical Dispersion**

When determining the best method of data collection, three factors must be considered: sample size, interview length and geographical dispersion (Frey 1983). The catchment areas serviced by the mental health centers participating in the study cover about 70% of the land area of the State of New Hampshire. Since time and cost are important considerations in the choice of any method, it was determined that both time and cost could be significantly reduced using the telephone survey versus a face-to-face interview. In fact, Frey (1983) reports cost savings of more than 45% for telephone surveys when compared to face-to-face surveys.

**Implementation Time**

When a survey needs to be completed before the occurrence of a major event that could affect the distribution of responses, the telephone survey has an advantage over face-to-face surveys (Frey 1983). In the case of this study, the major event is the treatment process and interviews needed to be completed before treatment begins and soon after treatment ends. Telephone interviews can be done much more quickly than face-to-face and mail surveys.

**Response Rate**

Response rates for face-to-face surveys are reported in
a number of studies reviewed by Frey (1983) to be between 74-87%. Telephone response rates ranged from 70% to 85%. Mail surveys from 60% to 70%. While face-to-face surveys report a slightly better response rate than telephone surveys, the telephone survey is certainly within an acceptable range.

Considering the issues of dispersion, time and response rate, the telephone survey provided the best choice of the three alternatives.

**Therapist Interviews**

Therapists were interviewed to determine their sensitivity or awareness of the social support of patients and the degree to which they had a conscious strategy of trying to impact the social support of the outpatients. An open-ended questionnaire was used for these interviews.

**Data Analysis**

The model guiding this research is diagrammed in figure 2.1. To answer some of the questions raised in this research, change scores were calculated for the social support variables and psychological well-being. Once the change scores were calculated, correlations were computed between the social support change scores and the change in psychological well-being using SPSS (Norusis 1991; Loether and McTavish 1974a, 1974b).

Before analyzing the relationship between changes in social support and psychological status over time, comparisons of the different dimensions of social support
Figure 2.1 Diagram of Data Analysis Strategy.
were made with each other and psychological status at time 1 and time 2. Since few studies have used more than one measure of social support, the interrelationship of the different dimensions is unknown. As a result, three measures of the relationship of social support and psychological distress will be calculated: the means of social support and psychological status at time 1 and time 2 (two cross sectional measures) and the change scores from time 1 to time 2 of social support and psychological health (a longitudinal measure).

There is no control group available in this study due to time and resource constraints. Without a control group, it is difficult to discern if the social support scores and psychological distress scores obtained from the patient sample differ from a normal sample. To provide some reference point, scores obtained from the patients studied in this research were compared to normal or patient samples studied by the authors of the measures used in this research. Social support and the psychological status of the patients studied in this research were expected to be lower than the normals studied by other researchers.

To add to our understanding of the data collected through the use of the measures of social support and psychological distress described above, an inductive method of data analysis was enlisted. The inductive method was used to analyze interview responses provided by subjects. The interview questions asked subjects questions like, "how do
you want others to support you?" This question usually resulted in subjects explaining their definition of social support. In analyzing this information, a broad category called social support definition was created. Under this heading, categories of types of social support described were listed. Strauss and Corbin (1990) describe this as open coding or "the process of breaking down, examining, comparing, conceptualizing and categorizing data" (p. 61). In this study, categories like emotional support (listening, showing affection) or instrumental support (lending money, fixing their car or providing transportation) emerged. The categories were defined in terms of behavior described by interviewees.

Open coding was followed by Axial coding. Axial coding puts categories together by finding connections between the categories. To find the connections, a coding paradigm illustrated by Strauss and Corbin (1990) was followed. This coding paradigm attempted to understand the conditions leading to a particular behavior. It also tried to determine under what conditions the behavior occurred or what consequences followed from that behavior.

Once axial coding was accomplished, a process of selective coding was followed. Selective coding lead to the discovery of the core category. The core category was the category around which all other categories were integrated or brought together. The core category was the story line or main theme. To bring the other categories together with the
central category, changes in conditions leading to a particular phenomenon needed to be understood. For example, many of the respondents coming to therapy explained that they were recently divorced, separated or had become estranged from loved ones or friends. A number of patients had lost jobs. They entered therapy to help "get their life straightened out." After time in therapy, patients noted improvements in relationships with others. Many of these relationship improvements were due to contacts the patients made with others. The contacts occurred either in support groups during the course of therapy or outside of therapy. They did not appear to have been due to the actual therapy itself. The above findings are a result of linking social support changes, social support types and therapist orientations and strategies (all categories).

As categories were developed with their particular interrelations and reasons for change, a case by case comparison was made. This is termed a conditional path. Each event or incident is tracked to link it to a category of events. The clustering under particular events helps link action with conditions and consequences.

The approach used to analyze the interview data follows Grounded Theory's procedures and techniques. The study was focused on developing a theoretical structure to interpret how social support is provided based upon questions asked of subjects in the study. In addition, the interview questions helped interpret the statistical relationships between the
variables depicted in the model. The interview questions were analyzed using the Ethnograph. The Ethnograph is a computer program developed for qualitative analysis (Siedel et al. 1988).

In chapter 6, categories of therapist orientation and strategy were developed based on therapist’s descriptions of their training and intervention strategy. These categories were then ordered by the researcher on a scale. The scale measured whether the therapist’s orientation concentrated on affecting intra-individual motives and drives or concentrated on changing patient relationships with others to increase social support. Several scales were developed from the interview data assessing relationship changes, therapist assessments of client reasons for coming to therapy, client assessment of relationship changes before therapy, and the effect of therapeutic intervention on relationship changes. Statistical correlations for ordinal data were performed using the Somer’s D statistic or Spearman’s Rho.

This information helped assess the causal order between dimensions of social support, therapist intervention and psychological distress (Sieber 1978). The integration of field and survey techniques allowed an assessment of the meaning of the different dimensions of social support to the respondents.

Qualitative Interviews. The instruments described in this study are used primarily to gather data about an amount
of support of a certain kind, i.e., large social network, high level of emotional support, high level of social integration. Unfortunately, these scales do not specify how social support is manifested. What is it about belonging to a church group that makes an individual feel supported? What do individuals say or do that communicates emotional support? How do people let others know that they are really wanted? How do co-workers communicate their concern and affection to others?

These questions were not answered by the scales used in this study and in most studies. In order to better understand the relationship between a particular conception of social support and distress, subjects were asked open-ended questions designed to elicit information about the qualities and properties of a particular type of social support. Especially important were those qualities and properties which lead the subject to consider himself or herself supported or not supported.

Limitations

A longitudinal design is used to observe change in social support and psychological health before and after psychotherapy. The study was hampered by three primary limitations. The first limitation was the lack of a defined control group. The changes observed in social support and psychological health or distress cannot clearly be attributed to psychotherapy or some other intervention without a comparison group as those changes could be due to
regression toward the mean. Regression refers to the tendency of scores which are significantly below the mean of a particular test at one point in time to approach the mean on a later test. Comparing the group undergoing treatment with a nontreated group helps assess whether the changes in scores on a particular measure were due to the effect of some treatment or other intervention. In some cases, the changes were just due to a natural consequence such as the passage of time.

The second major limitation involved the sample size. The number of cases did not allow for a detailed analysis of the relationship between social support and distress as they changed over time. Cross-tabular analysis was also hampered because the sample size limited the search for intervening variables. The cell size was not adequate to use a multivariate approach.

The third limitation was sample bias. Clients included in the study were only those admitted to care for mental health treatment. In addition, only those clients who signed a consent form participated in the study. Therefore, caution must be exercised in generalizing any results to the mental health center population and the general population at large.
CHAPTER 3.

PEOPLE SEEKING HELP: VARIATIONS IN LEVELS OF SUPPORT AND DISTRESS

Introduction

Social support has many meanings. As discussed in the first chapter, different terms for social support have been used interchangeably. Social support has been measured in other studies by the extent of a subject's social network, or the amount of social integration (the number of community groups subjects are affiliated with) or a subject's perception of his or her social support. However, the adoption of a particular definition by researchers is not always unselfconscious. Few researchers provide an indication that a choice has actually been made. If they do provide such an indication, there is no rationale for their choice (Vaux 1988). In fact, these different terms for social support were usually seen as different measurement strategies and not as the operationalization of different constructs (Vaux 1988). This confusion has slowed the synthesis of findings and disadvantaged the design of interventions (Vaux 1988).

Understanding the similarities and differences between the different aspects of social support is difficult since few studies include more than one measure of socially supportive relationships, and understanding the relationship
between the various measures is difficult when empirical comparisons are unavailable. This chapter presents comparisons among four measures of social support: social integration, social networks, social resources and social support perception. All four types of social support used in this study were measured during an interview following a client's intake appointment at a community mental health center. The four measures were readministered at a second interview three months after the first interview.

**Comparing Patient and Nonpatient Samples**

The analysis began with the Rand Health Insurance Experiment (H.I.E.) Social Health Battery, a measure of social integration. Results from the community mental health sample were compared with data published about a normal population using the H.I.E. Social Health Battery. The normal population data were taken from a monograph published by Donald and Ware (1982). Similar comparisons are made for measures of social networks, perception of social support, and received support. In addition, a comparison was made for psychological well-being scores. Table 3-1 lists the citations for the nonpatient samples used for comparison with our mental health sample.

The sample utilized in this research is small. Comparisons of selected summary measures produced by this investigation were compared to similar measures from normal samples. These comparisons provided an additional assessment of the validity of the measures of social support employed.
<table>
<thead>
<tr>
<th>Measure Type</th>
<th>Nonpatient Sample Citation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Integration</td>
<td>Donald and Ware (1982)</td>
</tr>
<tr>
<td>Social Networks</td>
<td>McFarlane (1984)</td>
</tr>
<tr>
<td>Instrumental/Expressive</td>
<td>Dean, Lin, and Ensel (1981)</td>
</tr>
<tr>
<td>Perception of Support</td>
<td>Turner and Noh (1983)</td>
</tr>
<tr>
<td>Psychological Well-Being</td>
<td>Goldberg (1972)</td>
</tr>
</tbody>
</table>
For example, when patient and nonpatient samples are compared, differences in amount of social support are expected. Social support differences are expected because the patient sample is expected to be less mentally healthy than the nonpatient sample. If social support and psychological well-being are directly related, then the patient sample, which is less mentally healthy should have lower social support than the nonpatient sample.

Comparisons between patient and nonpatient samples were undertaken for all social support measures. The results are similar for the other nonsocial support measures but not all are reported in this paper.

**Comparing Four Measures of Social Support**

The primary focus of this chapter is the analysis of the relationships between four measures of social support at two points in time. This chapter will examine the interrelationships of the four measures of social support before and after therapy.

Following the analysis of social integration, social networks, instrumental/expressive social support, and perception of social support, a measure of psychological distress will be examined.

A number of questions were raised in Chapter 1 as targets for this research. In this chapter, the following questions will be addressed:

1) How do mental health outpatients score on particular measures of social support before and
after therapy? If there are changes in support, what is causing them?

2) How do the scores on the different measures of social support relate to one another before and after therapy?

3) How are measures of social networks, social integration and received social support related to perceptions of social support at the beginning of therapy and after a period of therapeutic intervention?

**Measuring Social Integration**

Social integration refers to the existence of socially supportive relationships with others (Dunkel-Schetter and Bennett 1990). It is usually measured by the amount of participation in community group activities. The first measure, the Rand Health Insurance Experiment, Social Health Battery, was developed by Donald and Ware (1982). This measure was designed to assess social support using questions that probed for the existence of socially supportive relationships.

**The Social Health Battery.** The Social Health Battery and measures the level of integration into the community through contacts with neighbors and friends and community groups. The H.I.E. Social Health Battery was developed from items adapted from Myers et al. (1972) and Dohrenwend, Dohrenwend, and Cook (1973). The eleven items in the battery
represent three different areas of life where differences in social participation occur: family and home, social life and friendships and community (Donald and Ware 1982). The authors included the most common types of items found in the literature. The items are associated with numbers of contacts with family and friends, and participation in group activities.

From the eleven items, three comprehensive measures of social support were constructed. These measures were intended to: represent the major dimensions of social well being around which there is conceptual agreement; contribute unique information about social well being; have enough variability to detect differences in health; have the fewest number of variables without substantial loss of information; and be reliable (Donald and Ware 1982).

Two construct specific scales were developed. These scales were titled Social Contacts and Group Participation. Because the items to be included in the subscales had different variances, the items were standardized. The items in each subscale defined a particular activity. The social contacts scale includes frequency of visitations with friends and relatives. The group participation scale has two items: the number of groups one belongs to and the level of activity in those groups.

Donald and Ware (1982) constructed a third scale. The third scale or the Social Well Being Index consists of the items in the Social Contact and Group Participation scale.
It also includes additional items which refer to the number of telephone contacts, attendance at religious services, number of neighborhood acquaintances and number of close friends or relatives. Table 3.2 describes the content of questions asked of respondents. In addition, table 3.2 explains how the high and low scores are differentiated.

**Comparing A General Population Sample And A Mental Health Center Sample On Social Integration**

In developing the Social Health Battery, Donald and Ware administered the questionnaire to a general population. Their sample numbered 4,603 respondents. In the current study being reported here, 40 mental health clients, undergoing treatment at two community mental health centers were asked the 11 items comprising the Social Health Battery. The mental health group was administered the Social Health Battery at two points in time. Donald and Ware’s original data were collected at one time point.

For purposes of comparison, a number of tables have been developed. The tables compared the scores from Donald and Ware’s general population sample survey and the scores from the mental health sample interviewed in this research.

Table 3.3 compares the scores on each of the 11 items for the general population sample studied by Donald and Ware and the mental health center sample studied in this research. For each item of the H.I.E Social Health Battery, the means and standard deviation are provided. Time 1 and 2 data are presented for the mental health samples.
### Table 3.2 High And Low Scores For The H.I.E. Social Well-Being Scales

<table>
<thead>
<tr>
<th>Scale</th>
<th>High Scores</th>
<th>Low Scores</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Contacts</td>
<td>Home visits by friends two or three times per month.</td>
<td>Few visits with friends and relatives.</td>
</tr>
<tr>
<td></td>
<td>Visits with friends and relatives and visits.</td>
<td>Few visits to homes of friends. No home visits by friends.</td>
</tr>
<tr>
<td></td>
<td>Visits to home of friends at least once per week.</td>
<td></td>
</tr>
<tr>
<td>Group Participation</td>
<td>More than four group memberships and very active in those groups.</td>
<td>No group memberships.</td>
</tr>
<tr>
<td>Social Well-Being Index</td>
<td>More than eleven neighborhood acquaintances.</td>
<td>No telephone contacts.</td>
</tr>
<tr>
<td></td>
<td>Daily telephone contacts.</td>
<td>No religious service attendance.</td>
</tr>
<tr>
<td></td>
<td>Friends and family networking at least 36.</td>
<td>No neighborhood acquaintances to visit with. Few close friends and relatives to talk to.</td>
</tr>
<tr>
<td></td>
<td>Attendance at religious services more than once per week and the items listed for the group participation social contacts scales above.</td>
<td>Also, the items listed for the social contact and group participation scales above.</td>
</tr>
</tbody>
</table>

**Notes:** *Donald and Ware (1982:106)*
Table 3.3 also shows that the means and standard deviations of the general population sample and the mental health center samples studied are similar for many of the items. In fact, a "t" score was computed for the difference between the mean scores of the mental health sample and the general population sample at both time points. Significant "t" scores were found for the differences between the means of the general population sample and the mental health center sample at time 1 for the following questions: number of neighborhood acquaintances t=1.46, (p=.07); home visits by friends t=2.72 (p=.003); and attendance at religious services t=2.98 (p=.001).

On the other hand, table 3.3 also shows that the general population sample means do not differ significantly from the mental health center group for 7 of the 10 questions at the time of intake to the mental health center. Similarly, only 3 of the 10 questions differ significantly between the general population sample and the patient sample population at time 2. If psychiatric well-being is directly related to social support, the means on more of the questions should be significantly different. This difference should be most apparent when comparing the two samples at time 1. Assuming improvement in mental health status after treatment, the patient means at time 2 and the nonpatient sample means should show more similarity than the time 1 scores.
Table 3.3 Comparing The Means Of A Nonpatient Sample And Mental Health Clients On The H.I.E. Social Health Battery At Time 1

<table>
<thead>
<tr>
<th></th>
<th>Nonpatient Sample</th>
<th>Mental Health Clients</th>
<th>Mental Health Clients</th>
<th>Mental Health Clients</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>Standard Deviation</td>
<td>Mean</td>
<td>Standard Deviation</td>
</tr>
<tr>
<td>Neighborhood Acquaintances</td>
<td>2.51</td>
<td>1.90</td>
<td>2.07*</td>
<td>1.70</td>
</tr>
<tr>
<td>Close friends and relatives</td>
<td>4.62</td>
<td>1.79</td>
<td>4.62</td>
<td>1.70</td>
</tr>
<tr>
<td>Visits with friends/relatives</td>
<td>3.24</td>
<td>0.97</td>
<td>3.35</td>
<td>0.89</td>
</tr>
<tr>
<td>Home visits by friends</td>
<td>2.57</td>
<td>0.74</td>
<td>2.25*</td>
<td>0.73</td>
</tr>
<tr>
<td>Visits to homes of friends</td>
<td>2.30</td>
<td>0.68</td>
<td>2.25</td>
<td>0.67</td>
</tr>
<tr>
<td>Telephone contacts</td>
<td>3.65</td>
<td>1.02</td>
<td>3.77</td>
<td>1.10</td>
</tr>
<tr>
<td>Getting along with others</td>
<td>2.14</td>
<td>0.44</td>
<td>2.08</td>
<td>0.77</td>
</tr>
<tr>
<td>Attendance at religious services</td>
<td>2.22</td>
<td>1.48</td>
<td>1.52*</td>
<td>0.99</td>
</tr>
<tr>
<td>Voluntary group membership</td>
<td>1.03</td>
<td>1.32</td>
<td>0.80</td>
<td>0.99</td>
</tr>
<tr>
<td>Activity in groups</td>
<td>2.12</td>
<td>1.22</td>
<td>1.98</td>
<td>1.12</td>
</tr>
</tbody>
</table>

Notes: student's "t" tests used to compare the means of the general population with the means of the mental health clients at time 1 and time 2.

**p=.01 *p=.05 (One tailed test of significance.)
Companionship or Support Seeking

Why are there so few differences between the general sample and the patient data? I will try to answer this question by first examining the two questions that do show significant differences between the general population sample and the mental health center sample. Those questions ask respondents about attendance at church and number of home visits by friends. These two questions are considered representative of interpersonal interactions by Donald and Ware (1982:132). Other items labeled representative of interpersonal interactions by Donald and Ware (1982) such as the number of close friends, frequency of visits with friends and relatives, visits to homes of friends, or telephone contacts reported by mental health clients did not differ significantly from those reported by the general sample. It seems that mental health clients visit with friends or family with similar frequency to the general population. They differ on the location of the visits. Mental health clients do not have friends or family visit at their homes as frequently as the general sample.

The fact that visits with others are outside of client homes may reflect a distinction Rook (1990) makes between companionship and social support. She hypothesizes that social support is sought more often with the goal of obtaining help with personal problems. Companionship is sought for purely pleasurable contacts like shared leisure activities, private jokes and rituals or playful spontaneity.
(Rook 1990). For Rook, companionship is a more important part of one's everyday daily life. Social Support provided by others is more important only during stressful times. This distinction parallels the distinctions made between the main effects and buffering effects of social support (Rook 1990). The buffering hypothesis argues that social support is an effective aid to psychological well-being only when stress is high. The main effects hypothesis states that social interaction is important for well-being regardless of stress levels. The data in table 3.3 around contact with friends implies that the visits patients have with others occurs when the patients seek out others. They seek out others for support. The others patients seek are close friends and relatives.

There is even some evidence that friends and family have different support functions. Berg and Piner (1988) report that family members are important to individuals when guidance is required about a personal matter. There is a surprising contrasting finding in the gerontological literature. For older adults, contact with family members is unrelated or negatively related to morale (mental attitude). On the other hand, contact with friends is positively related to morale (Rook 1990).

Friends of patients visit significantly less at patient homes. Thus, contacts between the patients and their family and friends depend more on patients going to their family and friends when compared to the general population sample.
If the patient sample was seeking companionship, then one would expect more spontaneous contact with friends and relatives. No differences would be expected in the location of those contacts. The differences reported in location of contacts (going to friends' homes as opposed to friends coming to patient's homes) are more consistent with help seeking (going to others). Companionship implies more spontaneous, reciprocal visitation. The finding emerging here is that patients and nonpatients have similar levels of contacts with family and friends. What differs between the two groups is the reason for the contacts. For the general sample, the contacts are reflective of companionate activities. For the mental health patients, the reasons for contact are for help with a crisis.

Autonomy. Patients do not have friends over to their homes as frequently as nonpatients. I have suggested that this is due to patients going out to seek support from others. There is another reason for the difference between the general and mental health samples on the frequency of home visits by friends. The mental health group may not have encouraged visits to their homes. This lack of encouragement may be part of a patient strategy to control the timing of help and advice from friends. One of the dilemmas of support seeking is how to manage the conflicting motivations of intimacy and privacy and autonomy and dependence (Goldsmith and Parks 1990).

Goldsmith and Parks (1990) investigated how romantically
linked couples resolved their support dilemmas. Based on their results, the authors defined a set of strategies and tactics for managing these dilemmas. One of the identified strategies was selection. Selection was defined as being open and straightforward about one's problems regardless of the risks. This was the most frequently used strategy because the subjects reported deliberately choosing the person whom they felt would be receptive, sympathetic, and knowledgeable.

One way of controlling who provides advice and help is to seek them out. Visiting at other's homes or calling them allows the visitor or caller to select who is being sought for support. Spontaneous visits by others to one's home while experiencing a personal crisis reduces one's ability to select who will help.

In sum, the number of contacts between the two groups are similar but the reasons for those contacts are very different. The differences can be accounted for by nonpatients seeking companionship and patients seeking support in times of crisis. Support seeking involves selecting close family and friends for help and guidance. Companionship includes pleasurable activities that are spontaneous and more often involve friends as opposed to relatives. Companionship support is more often directly related to mental well-being than is support sought in times of crisis. Support sought in times of crisis is indirectly related to well-being depending on stress levels.
This relationship is further explored in chapter 5.

**Church Attendance**

The second item that showed a significant difference between the mental health sample and the general population sample was church attendance. This item did not become part of the social contacts index or the group participation index developed by Donald and Ware (1982). It was used in their overall social well being index.

Membership in a religious group has a number of meanings. Lenski (1963) writes that religious affiliation is a social activity that can be differentiated by 1) degrees of personal meaning between the individual and a deity (devotionalism) 2) orthodoxy or belief in church teachings or 3) ritual behavior in which devotionalism and orthodoxy are low but attendance is high and 4) communal association or the involvement with others in one's community. Here we are most concerned with the association dimension because of its relevance for social support.

**Association and communal church involvement.** Lenski uses church attendance as a measure of associational involvement in the church. He contrasts associational involvement with communal involvement. Associational involvement arises from the need to achieve specific ends without regard for the character of social relationships. Friendship is not necessary in associational ties.

On the other hand, communal groups are formed by like minded individuals. Social relationships are the ends and
not the means to an end. Communal ties are measured by the proportion of friends and relatives who are of the same religious affiliation. Associational ties can give rise to communal ties but the two measures are weakly correlated (Goodman and Kruscal tau = .03) (Lenski 1963).

Associational activities have some similarity to Rook's (1990) companionship activities. Associational activities can be defined as companionate activities (using Rook's definition). Companionate activities are a form of leisure that are structured around interaction with friends or acquaintances. These activities are discontinuous and time limited in nature. Communal ties differ from associational or companionate activities. Communal ties are reserved for close family and friends who are sought out in times of crisis. Following Rook's (1990) approach, communal ties would be more similar to social support that buffers the effects of stress and is only available when stress is high. In this research it is hypothesized that associational activities are related to companionate activities. Further, if companionate activities are directly related to well-being, then church attendance would be expected to be lower in the mental health sample than in nonpatient sample.

However, while associational activities are lower in the patient sample than in the nonpatient sample, contacts with close family and friends need not be. Patients may have contacts with these individuals, but the reasons for the contacts may differ from the nonpatient sample. As discussed
in section on visitations with friends, patients are searching for support at a time of crisis. Support is necessary to help restore their equilibrium rather than to provide them with friendly companionship.

Rook (1990) contrasts companionship with social support, because social support is important when an individual's equilibrium has been disrupted by an unfavorable life event. Social support helps to alleviate anxiety, anger, self doubt, or other states that can lead to further emotional disorder. In short, the job of social support is to restore one's equilibrium. In times of personal crisis, individuals turn to family and friends for support and help with pressing emotional problems. For some, the crisis affects their personal relations with their God. Changes in devotionalism or views of church teachings may occur as the result of a personal crisis. If one is searching for companionship activities, then church is a place to visit. Members of the church are usually community acquaintances and friends. They are not the people who patients turn to in times of crisis.

Table 3.3 shows that the mean attendance score for the patient sample is significantly less than the mean of the general sample. At time 2, the mental health sample does not differ from the general sample in church attendance. Church attendance does show significant improvement from time 1 to time 2 for the mental health sample. With the crisis over and equilibrium restored, associational
activities are sought out.

**Knowing Your Neighbors**

The general population sample and the mental health sample differed significantly on one remaining question. Respondents were asked about the number of families in their neighborhood that they were well acquainted with that they visited in each other's homes. Table 3.4 compares the frequency of responses to this question for the samples. Both time points are exhibited for the mental health sample.

The comparisons between the general population figures furnished by Donald and Ware (1982) and the data from the study show decided differences. The percent of the general population sample reporting zero family contacts in their neighborhood were 20.9%. The mental health center sample, at time 1, reported no neighborhood family contacts 37.5 percent of the time. At time 2, 41.4% of the mental health sample reported no family or neighborhood contacts. In table 3.4, 3.5 percent of the nonpatient sample reported visiting with 11 or more families in their neighborhood. This contrasts with 7.5 percent of the mental health patients at time 1 and zero percent of those same respondents at time 2.

It is consistent with our hypothesis on social support (defined as social integration) that the nonpatients are more involved with families in their neighborhood than individuals being admitted to a mental health center. If social support is directly related to mental health, then those entering a mental health center can be expected to be
<table>
<thead>
<tr>
<th>NUMBER OF FAMILIES</th>
<th>GENERAL POPULATION</th>
<th>MENTAL HEALTH CENTER</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>SUMMARY %</td>
<td>TIME 1 %</td>
</tr>
<tr>
<td>0</td>
<td>20.9%</td>
<td>37.5%</td>
</tr>
<tr>
<td>1</td>
<td>14.9</td>
<td>10.0</td>
</tr>
<tr>
<td>2</td>
<td>17.0 52.8</td>
<td>17.5 65%</td>
</tr>
<tr>
<td>3</td>
<td>14.1 2.5</td>
<td>2.5</td>
</tr>
<tr>
<td>4</td>
<td>9.6 15.0</td>
<td>0.0</td>
</tr>
<tr>
<td>5-10</td>
<td>20.2 10.0</td>
<td>17.2</td>
</tr>
<tr>
<td>11+</td>
<td>3.5 7.5</td>
<td>0.0</td>
</tr>
</tbody>
</table>
less involved with their neighbors and friends. In fact, the patient sample is less involved with friends and family, especially those they are not close to (like neighbors and acquaintances). Even after time in therapy, contact with neighbors does not improve.

Summary

This first section compares the patient sample with a large nonpatient sample on the items comprising Donald and Ware's (1982) H.I.E. Social Health Battery. The Social Health Battery provides a measure of social integration. The patient and nonpatient samples differ significantly on only three items: Visits to the homes of patients or nonpatients by their friends or relatives, church attendance, and number of neighbors that the patients or nonpatients are well enough acquainted with to visit each other's homes. There are no differences between the two samples on frequency of visiting or calling others.

In this section it has been argued that patients differ from nonpatients on visits to their homes by family and friends but do not differ on visits to family and friends. Patients are contacting close friends and family for support. They are looking for help in regaining their equilibrium. Nonpatients are seeking companionship to improve their well-being.

Finally, church attendance is another form of companionate activity. Religious affiliation is related to the type of relationship an individual has with friends and
family. It is also to type of support they provide and how they provide it (Lenski 1963). Attendance at church, a companionate activity, is significantly lower for the patient sample than the nonpatient sample. Contact with family and friends, a communal activity and a support seeking activity does not differ between the two samples. Companionship activities, defined by Rook as supportive activities that directly affect psychological well-being differ from support activities sought in times of crisis. These crisis support activities help buffer individuals against crises. The patient sample differs from the nonpatient sample. There is evidence of lower companionship support for the nonpatient sample.

Indices Of Social Integration: Social Contacts, Group Participation, And Social Well Being

Using factor analytic techniques, Donald and Ware (1982) developed three indices from the 10 items listed in table 3.3: Social Contacts, Group Participation and an overall social well-being index. The social contacts scale consisted of items 3, 4 and 5 in table 3.3. These items asked about the frequency of visits between the patient, friends and relatives. Group participation included questions 10 and 11 in that same table. Question 10 asked how many clubs one belonged to, and question 11 asked the level of involvement in those clubs or organizations.

The overall social well being index included the 5 questions listed above plus questions 1, 2, (number of
neighbors and friends one had contact with), question 6 (phone contacts), and question 9 (church attendance).

The raw scores were standardized and transformed giving a range of 0 to 100. Table 3.5 shows a comparison between the general population sample and the mental health group. The mental health patient scores at time 1 and time 2 were compared to the general population sample studied by Donald and Ware (1982). The patient sample differed significantly from the nonpatient sample on the social contacts and the overall social well-being or support at time 1 and time 2. Group participation did not show significant differences between the nonpatient sample and the mental health sample at time 1 or time 2.

Social contacts and overall social well-being are expected to be lower for the mental health group than the nonpatient sample at time 1. Those individuals experiencing mental health problems will also experience lower levels of social support and less frequent social contacts than members of a nonpatient sample (assuming better mental health in the nonpatient sample). The same can be said of the group participation index. However, the group participation index did not show significant differences between the mental health client sample and the general population sample at either time 1 or time 2.

**Social integration changes for the mental health sample**

Frequency of social contacts (or visits with friends and
relatives) as well as overall social support do not show significant improvements for the mental health population from time 1 to time 2 (see table 3-6). Using paired comparisons "t" tests, the differences in the means of the three indices were examined. Only group participation showed a significant improvement for the mental health clients from time 1 to time 2.

Frequency of social contacts and overall social support do not show significant changes from time 1 to time 2. These indexes remain significantly different from the general population sample at time 2. Group participation does show significant changes for the mental health sample from time 1 to time 2. The mean time 1 score for the patient sample was lower than the general population sample and higher than the general population sample at time 2. While not significantly different from the general population score, there is an increase in group participation for the mental health sample from time 1 to time 2.

The increase in group participation is due in part to a number of mental health clients joining support groups. These support groups have become increasingly popular and are frequently used by therapists as a treatment tool. Some support groups are titled self-help groups.

Self-help support groups include Alcoholics Anonymous, Gambler's Anonymous, Weight Watchers and the Forum. In such groups, the individual obtains support from others who may share similar problems, viewpoints or
Table 3.5 The Mean, Standard Deviation, and Number of Cases Time 1 Interview Scores Of The H.I.E. Social Integration Scale: Comparing The General Sample And The Mental Health Sample At Time 1 And Time 2

<table>
<thead>
<tr>
<th></th>
<th>General Population Sample (Donald and Ware 1982)</th>
<th>Mental Health Sample</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>Time 1 Mean</td>
</tr>
<tr>
<td>Social Contact</td>
<td>72.4 (27.5)</td>
<td>62.1** (24.1)</td>
</tr>
<tr>
<td></td>
<td>4,565</td>
<td>40</td>
</tr>
<tr>
<td>Group Participation</td>
<td>27.5 (29.9)</td>
<td>22.1 (25.1)</td>
</tr>
<tr>
<td></td>
<td>4,478</td>
<td>40</td>
</tr>
<tr>
<td>Overall Social Support</td>
<td>51.6 (15.9)</td>
<td>46.9* (20.4)</td>
</tr>
<tr>
<td></td>
<td>4,351</td>
<td>39</td>
</tr>
</tbody>
</table>

Notes: The mental health sample mean at time 1 and time 2 differs from general population sample at *p<.10, **p<.01 (One tailed level of significance.)

Table 3.6 Paired Comparisons Of The Mental Health Sample Scores On The H.I.E. Social Health Battery Indices At Time I And 2

<table>
<thead>
<tr>
<th>Social Health Battery Index</th>
<th>Mental Health Sample Mean Score</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Time 1</td>
</tr>
<tr>
<td>Social Contacts</td>
<td>65.85</td>
</tr>
<tr>
<td>Group Participation</td>
<td>20.58</td>
</tr>
<tr>
<td>Overall Social Support</td>
<td>48.53</td>
</tr>
</tbody>
</table>

Notes: *p<.05 (Paired comparison t test. Two tailed level of Significance.)
experiences. Group members are not members of the natural network (Fisher et al. 1988). Several of the clients interviewed at time 2 stated that they were participating in alcoholics anonymous or a support group established by the therapist for their particular problem. These support groups supplement the natural networks of clients by making up for deficiencies of the natural network in psychosocial provisions. These groups offer the participants a specialized personal community comprised of people with similar problems, life experiences or misfortunes (Gottlieb 1988). Support groups established by the therapist differ from self help groups because they are professionally led. They combine expert and experiential knowledge, are time limited, have a fixed membership and usually do not engage in lobbying, advocacy, or public education (Gottlieb 1988). It is argued in this that the use of self-help groups (recommended by the therapist) or support groups established by the therapist accounts for the increase in group participation scores on the H.I.E. Social Health Battery at time 2.

Relationships Among The Indices

Table 3.7 presents the intercorrelations of the three indices of social support developed from the H.I.E. Social Health Battery. As shown, the group participation and social contacts scores are not strongly correlated. The group participation scores and the social contacts scores (which are part of the overall social well-being index) are
### Table 3.7 Intercorrelations Of The H.I.E. Social Battery Subscales For The Mental Health Outpatients At Time 1

<table>
<thead>
<tr>
<th></th>
<th>Social Contacts</th>
<th>Group Participation</th>
<th>Social Support</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Contacts</td>
<td>1.000 (N=39)</td>
<td>.02 (N=39)</td>
<td>.61 (N=39)</td>
</tr>
<tr>
<td></td>
<td>P=.45</td>
<td>P=.000</td>
<td></td>
</tr>
<tr>
<td>Group Participation</td>
<td>1.000 (N=39)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>P=.000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social Support</td>
<td>1.000 (N=39)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Table 3.8 Intercorrelations Of The H.I.E. Social Health Battery Subscales At Time 2

<table>
<thead>
<tr>
<th></th>
<th>Social Contacts</th>
<th>Group Participation</th>
<th>Social Support</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Contacts</td>
<td>1.000 (N=28)</td>
<td>.09 (N=28)</td>
<td>.66 (N=28)</td>
</tr>
<tr>
<td></td>
<td>P=.33</td>
<td>P=.000</td>
<td></td>
</tr>
<tr>
<td>Group Participation</td>
<td>1.000 (N=29)</td>
<td>.66 (N=29)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>P=.000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social Support</td>
<td>1.000 (N=28)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
correlated moderately with that index. The intercorrelations of the items in the mental health sample are similar to the relationships reported by Donald and Ware (1982). Group participation and social contacts have correlation coefficients of .60 and .61 respectively with the overall social support index. Donald and Ware (1982:120) report coefficients of .62 and .69 for group participation and social contacts with overall support. Social contacts and group participation have coefficients of .02 in the mental health sample and .05 in the general population sample reported by Donald and Ware. Group participation and social contacts are measuring different aspects of social support for both the mental health sample and Donald and Ware's general population sample at time 1.

At the second administration of the H.I.E. Social Health Battery, the relationships among the dimensions were similar to the relationships reported at time 1 (compare tables 3-5 and table 3-6). Social contacts and Overall social support or well-being correlated .66 and social contacts and group participation had Pearson Product Moment Correlation Coefficients of .09. Social well-being and group participation were significantly correlated with r=.66.

**Summary of Social Integration Measures**

Three indexes of social integration were prepared from the items listed in table 3.3. Social contacts measures the frequency of visits with friends and relatives. Group
participation measures the number of groups one belongs to and the activity level in those groups. The overall social well-being index includes the items listed above. It also includes numbers of neighbors and friends that one visits, frequency of telephone contacts with friends and relatives, and church attendance.

The patient scores on the three indices of social integration were expected to be lower at time 1 (intake to the mental health center) than the nonpatient sample studied by Donald and Ware (1982). Estrangement from one's community, neighbors and friends and church was found by Durkheim (1897/1951) to be more prevalent among those who had committed suicide. Similarly, in this study it is expected that patients entering a mental health center are less socially integrated than nonpatients. The data are consistent with this hypothesis. For example, social contacts and overall social well-being differed significantly from the nonpatient sample at both time points. Group participation for the patient sample was lower than the nonpatient sample at time 1 and higher than the nonpatient sample at time 2. Only group participation showed a significant improvement from time 1 to time 2 and this was attributed to patients joining groups recommended by therapists.

Group participation and social contacts were very weakly correlated at both time points \( (r=.02,.09) \). However, both measures were moderately correlated with overall social
well-being, a summary measure including both of these scores. Social contacts and group participation measure different aspects of social integration. In the first section, it was argued that social contacts was in fact a measure of support seeking to alleviate a personal crisis. If this is the case, then social contacts has a buffering effect and it is not directly related to psychological status.

Group participation is a companionate activity that directly affects psychological well-being. Group participation was the only measure to show significant improvement from time 1 to time 2. Social contacts shows no improvement from time 1 to time 2. If mental health improves from time 1 to time 2, then companionate support arising out of day to day activities is expected to improve. On the other hand, social supports are directly related to psychological well-being. Social supports are indirectly related to psychological well-being and are only used when stress is high. They are not expected to improve as psychological well-being improves. Social contacts, it was previously argued, measures support seeking in times of personal crises. It is a stress buffer and is indirectly related to psychological well-being. Therefore, it will not increase with improvements in psychological well-being.

SOCIAL NETWORKS

A second set of measures of social support that has
received wide attention is that of social networks. The social network measures focus on the social matrix in which supportive efforts take place. The social network approach to social support is based on the assumption that quantitative features of a social network influence the impact that interactions have on network members (Pierce, Sarason and Sarason 1988).

With social network measures, the emphasis has been on obtaining valid and reliable quantitative measures of the structure of relations within a group. There is an assumption that the resulting structural attributes of the social network reflect the extent to which a person receives social support from members of that group. Social support analysis assesses how the connections, or ties within a group influence a member's well-being.

Four aspects of social networks are generally measured. They are size, multiplexity, reciprocity and density. Network size reflects the numbers of different people an individual is in contact with. Multiplexity refers to network members serving multiple roles or functions. Density is defined as the extent to which network members are connected to each other. Increased density should contribute to solidarity and cohesiveness among network members (Berg and Piner 1988). Reciprocity refers to the number of network relations that provide mutual support.

There is a growing body of research that suggests that qualitative measures rather than quantitative measures of
social network characteristics are more related to personal adjustment (Barrera 1984). As a result, McFarlane (1983) developed a measure of the helpfulness of network relationships. Each network relationship was rated by respondents on a 7 point scale ranging from "makes things a lot worse" to "makes things a lot better." The mean of the scores provides a measure of the helpfulness of the network.

**The Social Relationship Scale**

McFarlane et al. (1980) developed the Social Relationship Scale to measure social support. Its purpose was to measure both the quantity and quality of an individual's support network. It measured both the extent of a network and the helpfulness of a network. The social relationship scale (SRS) was designed to capture the supporting relationships in six areas of potential life stress: home and family, work, money and finances, personal health, personal and social and society in general. Respondents are asked to list (using initials) those persons with whom they have had discussions about each area. Helpfulness is rated on a seven point scale in this study. Reciprocity for each network member is measured by asking the respondent which individuals named would come to the respondent for similar discussions around the particular area of life stress (McFarlane et al. 1980).

**Comparing A General Population Sample and The Mental Health Sample**

To test the social relationship scales, McFarlane et
al. (1984) used a random sample of 516 subjects who were patients of ten family physicians in the Hamilton, Ontario area. The sample was stratified, including an equal numbers of subjects in each age decile from 21 to 60. Equal numbers of men and women also comprised each decile. It was determined that 90% of the population of Hamilton sees a family physician. As a result of, the authors conclude that their sample is fairly representative of the general population in that area.

McFarlane et al. (1984) scored helpfulness on a scale ranging from -3 to +3. Four divisions were established based on the average helpfulness score across content areas. The characteristics of each group were then examined.

Table 3.9 presents characteristics of the McFarlane et al. (1984) study and compares McFarlane et al’s. sample with the mental health center sample studied for this research. These comparisons were made to compare our mental health patients with a nonpatient sample. This comparison was performed to help improve the validity of our findings. Recall that no control group was available for this study. (Helpfulness scores were recoded to match the sample’s helpfulness scores depicted in the McFarlane et al. 1984 paper.)

The first comparison in table 3.9 is the percent of the two populations whose helpfulness scores fall within each of the defined helpfulness groups (less than 1.0, unhelpful, 1.0-1.6, limited helpfulness, 1.7-2.2, moderate
helpfulness, and greater than 2.2, very helpful). Two
groups have scores greater than 1.6. The helpfulness scores
of McFarlane’s sample and the mental health sample studied
in this research are very similar. The two samples differ
markedly in the lower two helpfulness groups (<1.0 and 1.0-
1.6). Sixteen percent of the McFarlane’s general population
sample had helpfulness scores below 1.0. In the mental
health sample, 28% had scores in this category. In this
paper, the relationship between social support and mental
health is being hypothesized as a direct relationship. As a
result, the mental health center sample is expected to rate
their social support at the beginning of treatment (time 1)
as less helpful than the general population sample’s scores.

The average network size within the helpfulness rating
shows some differences between the two samples. In the
category of unhelpful network (<1.0), the average size of
the mental health sample is one half the average size of
the Hamilton sample. In the category depicting limited
helpfulness (1.0-1.6) the Hamilton sample has an average
network size of 10.2 and the mental health center sample’s
average network size equal to 6.2 or almost 40% smaller
that the average network size of the Hamilton sample. The
two samples show limited differences in network size in the
two higher helpfulness categories.

McFarlane’s Hamilton sample shows a significant
difference between the most helpful category and the least
helpful category in average network size. In the Hamilton
sample, average network size is smaller in the higher helpfulness categories. About average network size, McFarlane et al. (1984:506) state that "it appears then that it is the perception of receiving help from an inner core of close, intimate or family relationships which is the major contributor to subject's scoring their networks as very helpful." The opposite seems to hold for the mental health center sample. Average network size directly increases with increasing helpfulness for the mental health center sample.

The current research has shown that average network size for mentally ill individuals is smaller than non patient samples (see Chapter 1). The data in table 3-9 show that mental health patients who report low levels of helpfulness from their network also report significantly smaller networks. When network helpfulness improves, the mental health center patients studied in this research report network sizes similar to the nonpatient sample research by McFarlane et al. (1984).

Marital Status. The percent married and helpfulness ratings (see table 3-9) are not significantly related in the general population sample. In the mental health group, there is a significant relationship most notable in the lack of helpfulness category (<1.0). In the lowest helpfulness category (1.0-1.6) the percent married was zero. In the most helpful category (>2.2), 50% of the mental health sample was married. Even more striking are the differences
Table 3.9 Comparing Network And Demographic Characteristics Of A General Population Sample And The Mental Health Client Sample Within Average Helpfulness Of Network Scores

<table>
<thead>
<tr>
<th></th>
<th>Average Helpfulness</th>
<th>Very Helpful</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>&lt;1.0</td>
<td>1.0-1.6</td>
</tr>
<tr>
<td>Per Cent of Subjects</td>
<td></td>
<td></td>
</tr>
<tr>
<td>General Pop</td>
<td>16</td>
<td>33</td>
</tr>
<tr>
<td>Mental Health Clients</td>
<td>28</td>
<td>22</td>
</tr>
<tr>
<td>Average Network Size</td>
<td></td>
<td></td>
</tr>
<tr>
<td>General Population</td>
<td>9.4</td>
<td>10.0</td>
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<tr>
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<td>4.7</td>
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</tr>
<tr>
<td>Proportion of Contacts</td>
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<td></td>
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<tr>
<td>Labeled Reciprocal</td>
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<td>.84</td>
</tr>
<tr>
<td>Mental Health Clients</td>
<td>.89</td>
<td>.91</td>
</tr>
<tr>
<td>Multiplex Contacts</td>
<td></td>
<td></td>
</tr>
<tr>
<td>General Population</td>
<td>2.75</td>
<td>2.75</td>
</tr>
<tr>
<td>Mental Health Clients</td>
<td>2.45</td>
<td>2.56</td>
</tr>
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<td>13.3</td>
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<tr>
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</tr>
<tr>
<td>Per Cent Married</td>
<td></td>
<td></td>
</tr>
<tr>
<td>General Population</td>
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<td>77</td>
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<tr>
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<tr>
<td>Per Cent Female</td>
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</tr>
<tr>
<td>General Population</td>
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<td></td>
</tr>
<tr>
<td>Mental Health Clients</td>
<td>54</td>
<td></td>
</tr>
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</table>

Notes: Chi Square statistic.
** p<.001
* p<.05
between the number married in the general population sample and the mental health group in each helpfulness category. The percent married in the Hamilton sample ranged by category from 78% to 85%. For the mental health center patients, the percent married varied by helpfulness category from 0% to 50%. There is no significant difference in marital status among the helpfulness categories for the general sample. There is a significant difference in marital status among the helpfulness categories for the mental health center outpatients. Marital status differences have been found to be related to health status. The differences reported in table 3.9 between the Hamilton sample and mental health sample are consistent with previous findings. McFarlane et al. (1984) add that the factor reported by the Hamilton sample as contributing most to lack of helpfulness is the lack of success in help-seeking efforts with significant others such as one's spouse. "They are likely to report their relationship with their spouse as not being one in which there is a mutuality in the relationship" (McFarlane et al. 1984:509). For the Hamilton sample, lack of responsiveness from one's spouse is a factor in categorizing one's network as unhelpful. For the mental health sample, help-seeking from spouses is not possible: no spouses are available.

Changes In Network Dimensions Over Time: The Mental Health Sample

Table 3.10 lists the means and standard deviations of
five measures constructed from the interview data collected using the SRS: average number of network members, average helpfulness, average number of multiplex relationships in a network, average proportion of reciprocal relationships and average number of reciprocal contacts. The mental health center outpatients report, on the average, that their social networks consist of 7.45 different individuals. Of those relationships, 3.4 are categorized as multiplex (the same individual is mentioned in three of the six life stress areas listed above). Ninety-one percent of the relationships are characterized as reciprocal in nature. On a 7 point scale (1: "makes things a lot worse" and 7: "makes things a lot better") the average helpfulness of the network is 5.56 or "makes things a little better".

At time 2, the number of members in a network dropped to 6.83 when comparing the 40 respondents at time 1 with the 29 respondents at time 2. The distribution of scores for the number of network members is not normal. A sign test was used to compare time 1 scores with time 2 scores. The difference is not significant from time 1 to time 2.

Helpfulness. The mean of the mental health sample at time 1 is 5.56. The mean at time 2 increased to 5.65. A paired comparisons "t" test was calculated for the two sets of scores, and the increases in average helpfulness show no significant differences from intake to the mental health center and the second interview.

Multiplexity. The average number of multiplex
relationships increased from 3.4 to 4.3 from time 1 to time 2. This increase is significant with \( t=2.05, \ p=.049 \). Increases in multiplexity are equated with increases in the number of close friendships from time 1 to time 2.

**Reciprocity.** The proportion of reciprocal contacts are reported in table 3.10. Respondents were asked whom they talked with about six different areas of life experience. They were then asked to identify the listed network members who have come to the respondents for help. The number of network members who have sought out the respondent were divided by the total number of network members listed.

From time 1 to time 2, the proportion of reciprocal contacts changed from .91 to .89. This difference was significant at the \( p=.05 \) level.

**Receiving And Giving: The Support Bank**

The data on reciprocity in table 3.10 indicate that the number of close friends or family who would come to the respondent for help decreased significantly from time 1 to time 2. One interpretation of these data is that mental health center clients are receiving more help than they are providing to others. How does this imbalance in reciprocity affect social support? Wentkowski (1981) studied the rules of exchange in the relationships of older people. She found that the nature of the relationship and not one's age is the chief characteristic that distinguished relationships between people. Reciprocal exchanges are most often reported by those in relatively superficial relationships. Those in
Table 3.10  Mean, Standard Deviation and Number of Cases of Time 1 Interview Scores of the McFarlane Social Relationship Scale.

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>Mean *</th>
<th>Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Time 1</td>
<td>Time 1</td>
<td>Time 2</td>
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<tr>
<td>Number Of Network Members</td>
<td>7.45</td>
<td>7.62</td>
<td>6.83</td>
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<tr>
<td></td>
<td>(5.95)</td>
<td>(6.74)</td>
<td>(5.98)</td>
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<tr>
<td></td>
<td>N=40</td>
<td>N=29</td>
<td>N=29</td>
</tr>
<tr>
<td>Helpfulness Of Network</td>
<td>5.56</td>
<td>5.73</td>
<td>5.65</td>
</tr>
<tr>
<td></td>
<td>(.74)</td>
<td>(.64)</td>
<td>(.63)</td>
</tr>
<tr>
<td></td>
<td>N=40</td>
<td>N=29</td>
<td>N=29</td>
</tr>
<tr>
<td>Number Of Multiplex Relationships</td>
<td>3.40</td>
<td>3.45</td>
<td>4.34</td>
</tr>
<tr>
<td></td>
<td>(3.59)</td>
<td>(3.80)</td>
<td>(4.34)</td>
</tr>
<tr>
<td></td>
<td>N=40</td>
<td>N=29</td>
<td>N=29</td>
</tr>
<tr>
<td>Proportion Of Reciprocal</td>
<td>.91</td>
<td>.93</td>
<td>.89</td>
</tr>
<tr>
<td>Relationships</td>
<td>(.10)</td>
<td>(.08)</td>
<td>(.11)</td>
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<tr>
<td></td>
<td>N=40</td>
<td>N=29</td>
<td>N=29</td>
</tr>
</tbody>
</table>

Notes: *Means of the 29 respondents at time 1 who were retested at time 2.
long term relationships that are more intimate tended to require less immediate exchange. Long term relationship people assume that equivalence in exchange will eventually be achieved (Antonucci and Jackson 1990).

Antonucci and Jackson (1990) characterize this long term view of equivalence of exchange as similar to a support bank. They write that people maintain an ongoing account of the amount of support or various benefits they have provided and received from others. Support provided to those with whom one has a limited or superficial relationship are labeled short term deposit accounts. Support to more intimate, long term relationships can be seen as deposits that can be drawn on at a later time (Antonucci and Jackson 1990). These withdrawals can be seen as collecting on old debts rather than creating new indebtedness.

Antonucci and Jackson (1990) further report that individuals with disabilities regardless of age, sex, marital status and socio-economic status or resources try to maintain reciprocal, supportive resources. The authors speculate that individuals with disabilities will go as far as reducing the numbers of family network members. They will select others that enable a perception of reciprocity to be maintained (Antonucci and Jackson 1990).

One pattern that emerged in table 3.10 is that the number of network members and helpfulness of the network showed no significant change from time 1 to time 2. But there was a significant increase in the number of multiplex
relationships. Increases in multiplex relationships means that respondents characterized more of their relationships as close at time 2 than at time 1. Clients also reported getting more support from their social network than they were providing at time 1 and time 2. If unequal reciprocity is related to long term relationships, receipt of social support without giving back support may be important for improving mental health. For the support provider, these one way social exchanges may simply be viewed as making deposits in a support bank. The debts will be collected at a later time, or they may be returns against earlier withdrawals.

Antonucci and Jackson (1990) provide some support for this argument in a study of two national samples (one of older whites and one of adult blacks). They found that for whites with great disabilities, unequal exchanges of support were more positively associated with well-being than equal exchanges. For whites, possession of economic resources permits one to maintain unequal support relationships such as giving more to others than one receives. For blacks, happiness was related to receiving more support than they gave to others. Happiness was also related to the amount of equal support relationships. Receiving less support than they gave to others was negatively related to well-being (Antonucci and Jackson 1990). For the mental health clients in this study, their illness may force them to reduce the number of people with whom they have reciprocal exchanges to maintain a perception of reciprocity. This reduction should
result in higher levels of actual or perceived supportive exchanges, especially if the exchanges are based on a lifetime accounting system. The lifetime accounting system with close family and friends will allow the mental health patient to maintain a sense of reciprocity despite their greater need for help (Antonucci and Jackson 1990). Perhaps this is why patients tend to seek support from social contacts during a crisis. The supports they seek will be from those close to them. A sense of reciprocity needs to be maintained, even if they have to reduce the number of friends and family they have contact with.

**Summary of Social Network Variables**

Scores on the Social Relationship Scale (SRS), studied by McFarlane et al. (1984) were compared to our mental health center client scores. The scores by the patients and nonpatients were compared within categories of helpfulness.

Average network size is the first variable discussed. If the size of one's social network is an indicator of social support, then the larger the network, the greater the social support. For the nonpatients studied by McFarlane, average network size decreased with increasing helpfulness. For the patient sample studied in this research, average helpfulness increased with increasing network size. The nonpatient range (from least helpful to most helpful) is 9.4 to 7.9. The patient range is from 4.7 to 8.5. Patients who listed their networks as unhelpful had 50% fewer members in their network than did nonpatients in the same category. The
difference between patient and nonpatient network size is not as pronounced in the most helpful category.

The network size comparisons of patients and nonpatients within helpfulness categories suggest that there is an optimum size of a network that is considered supportive. Too many members in a network is not anymore supportive than too few members.

The average number of multiplex contacts did not differ significantly within helpfulness categories. The mental health clients show a higher average number of multiplex relationships in the higher helpfulness categories. The data on multiplex relations suggest that close relations (multiplex) are considered helpful by patients and nonpatients. Patients need more help at intake to therapy. They need more help from close friends. However, patient networks considered unhelpful are much smaller than nonpatient networks in the same category. Therefore, the extent of people whom they can approach for help is limited. As a result, patients cannot obtain the support they need and classify their networks as unhelpful.

There is a significant relationship between marital status and the helpfulness category for the mental health sample. This relationship does not hold for the non mental health patients. Again, the difference in the range of scores for the two samples is very discrepant. No member of the mental health sample who listed their network as unhelpful was married. Seventy-eight percent of the
nonpatient sample who categorize their network as unhelpful are married. Being married is not related to network helpfulness for nonpatients. For patients, not being married is definitely related to helpfulness. The difference in the percent married between the patients and nonpatients indicates that lack of marriage is an issue for the patient sample.

The lack of marriage is an indicator of poor psychological status. Marital status has also been used as a measure of social support. It may indicate the availability of a confidant or significant other. Separations and divorces mean lost contacts with close family and friends. Being single can indicate loneliness or no contacts with important others.

The percent of mental health respondents listing their network as unhelpful was 28%. Only 16% of the nonpatients listed their network as unhelpful.

For the mental health clients, only the number of multiplex relationships and proportion of reciprocal relationships changed significantly from time 1 to time 2. Increases in multiplexity are equated with increases in close friends. Close friends are more likely to provide support than other network members (Berg and Piner 1988).

Reciprocal relationships showed a significant decrease. Long term relationships that are more intimate require less immediate exchange of support than relatively superficial relationships. Support recipients could draw on help from
others without feelings of guilt. These withdrawals of support can be seen as collecting on old debts. For the support giver, the provision of unreciprocated support can be seen as a deposit that can be drawn on at a later time.

Social networks are important for social support. The importance of social networks is not so much their size, but the number of close friends who can provide unreciprocated support. Very small networks reduce the number of people who can provide support at a time when the support seeker is unable to reciprocate.

**Intercorrelations of the Dimensions of the SRS**

Table 3.11 lists the intercorrelations of the dimensions of the SRS at time 1 and time 2. At time 1, helpfulness of one's network is related to extent, multiplexity and number of reciprocal contacts. Helpfulness is unrelated, at time 1, to the proportion of reciprocal contacts. However, helpfulness measured at time 1 is significantly related to the proportion of reciprocal contacts as measured at time 2. The extent of the network, the number of multiplex relationships, and the number of reciprocal contacts are significantly related at time 1 and time 2.

**The Instrumental-Expressive Support Scales**

Dean, Lin and Ensel (1981) used a 26 item scale to measure the instrumental or expressive support available to a respondent. The 26 items were subjected to a factor analysis and resulted in five factors: monetary problems, demands (each a measure of instrumental support),
Table 3.11 Helpfulness, Network Extent, Multiplexity and Reciprocity: The Dimensions of The SRS and Their Intercorrelations

<table>
<thead>
<tr>
<th>SRS Subscales</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
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<td></td>
<td></td>
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<td></td>
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<td></td>
</tr>
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<td>.28*</td>
<td>.03</td>
<td>.27*</td>
<td>.33*</td>
<td>.20</td>
<td>-.02</td>
<td>.40*</td>
<td>.11</td>
</tr>
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<td>1. Helpfulness</td>
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<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Extent</td>
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<td>-.02</td>
<td>.84**</td>
<td>.35*</td>
<td>.78**</td>
<td>.85**</td>
<td>-.10</td>
<td>.85**</td>
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<td>.84**</td>
<td>-.11</td>
<td>.87**</td>
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<td>.87**</td>
<td>.91**</td>
<td>-.09</td>
<td>.93**</td>
<td></td>
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<td>SRS Subscales</td>
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<td>.38*</td>
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<td>6. Helpfulness</td>
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</tr>
<tr>
<td>7. Extent</td>
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<td>.82**</td>
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<td>.91**</td>
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</tr>
<tr>
<td>8. Multiplexity</td>
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<td>-.16</td>
<td>.96**</td>
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</tbody>
</table>

Notes: *p<.10, **p<.01 (Two tailed test of significance.)
communication problems and lack of companionship (both measures of expressive support). The final dimension was problems with not having children.

Expressive Social Support. This dimension is measured by two factors, communication problems and lack of companionship. Lack of companionship includes items such as not having a close companion or having marital problems. Communication problems focus on items that reflect having no one who understands. Having conflicts with those who are close to the respondent is also another focus of communication problems. Communication problems are characterized by a lack of intimacy in communication with others, a lack of feeling as a unit or lack of relationships that are intrinsically satisfying (Berg and Piner 1988).

Instrumental Support. Support that involves tangible aid or informational support is classified as instrumental support. Tangible aid refers to direct assistance such as financial assistance or physical aid. Informational support includes giving advice or guidance to help someone solve a particular problem. Two factors that comprise the instrumental support scale are money problems and demands. Samples of items comprising Money Problems are: not enough money to do the things you want, or no one to depend on. The Demands factor is made up of items that ask, "are you having problems with too many demands on your time?" Another queries, "do you have problems with too many responsibilities?"
Table 3.12 Instrumental and Expressive Social Support: Mean Scores for Time 1 and Time 2 Administrations.

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>Mean +</th>
<th>Mean</th>
<th>Time 1</th>
<th>Time 1</th>
<th>Time 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Instrumental Support</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adequacy of Finances</td>
<td>8.50</td>
<td>8.62</td>
<td>9.14</td>
<td>(3.78)</td>
<td>(3.68)</td>
<td>(3.36)</td>
</tr>
<tr>
<td>Control of Demands</td>
<td>9.86</td>
<td>9.87</td>
<td>10.33</td>
<td>(3.33)</td>
<td>(3.57)</td>
<td>(3.19)</td>
</tr>
<tr>
<td>Expressive Support</td>
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<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Communication with Others</td>
<td>11.03</td>
<td>11.06</td>
<td>11.97*</td>
<td>(2.95)</td>
<td>(2.64)</td>
<td>(3.43)</td>
</tr>
<tr>
<td>Companionship</td>
<td>13.47</td>
<td>13.11</td>
<td>13.82</td>
<td>(4.89)</td>
<td>(4.66)</td>
<td>(4.20)</td>
</tr>
</tbody>
</table>

Notes: # Paired comparisons "t" test  
*<p<.05 (one tail test of significance)  
+Means of the 29 respondents who were retested at time 2
In table 3.12, the scores on the various dimensions of instrumental and expressive support are presented for the mental health sample for time 1 and time 2. Comparison to a general population sample for this measure was not available.

When the means of the four subscales are compared from time 1 to time 2, only the communication subscale shows a significant difference. The difference is positive and represents an increase in expressive or emotional support over time.

Cutrona and Russell (1990) hypothesize that type of social supports and stressors need to be matched to obtain optimal benefit from social support. For example, loss of relationships are usually considered uncontrollable events. Such losses are associated with a need for understanding and reattachment to others. Losses of property due to storm or hurricane are associated more with tangible aid or physical help to restore the asset lost. Instrumental aid would be helpful to survivors of a hurricane than those mourning the death of someone close.

Expressive support was certainly a need of the mental health patients. Eighty-five percent of the mental health patients at intake to the mental health center were divorced (20%) separated (30%) or single (35%). The items making up the Communication Factor include conflicts with those close to you, no one to understand your problems, problems with children, problems communicating and having an unsatisfying
job. If current marital status reflects loss of close friends or no close relationships with significant others, then emotional support in the form of understanding or sympathy may be needed. Improvements in the Communication Factor indicate improvements in the appropriate type of support. If mental health status improved, then there are expectations of improvement in emotional support for this population. Significant improvement in instrumental support would also be helpful to clients coming to the mental health center. Loss of a spouse or close friend results in financial hardship, child care help and transportation. Cutrona and Russell (1990) state that losses of a key source of support (i.e. spouse) will require replacement of the losses in all areas of support that were previously provided by the lost individual.

Instrumental and Expressive Support Subscales: Their Intercorrelations

Table 3.13 reports the intercorrelations of the four subscales comprising the Instrumental/Expressive (I/E) support measures. As depicted in table 3.13, the expressive items of communication and companionship are significantly correlated at time 1 and time 2 (r=.58 and .50 respectively). The instrumental subscales of adequacy of finances and control of demands correlate significantly (r=.32) at time 1 and time 2. The Demands Subscale correlates strongly at time 1 and 2 with the expressive support subscales. The fact that there is a strong
Table 3.13. Intercorrelations of Instrumental/Expressive Support Sub Scales: Comparing time 1 and time 2

<table>
<thead>
<tr>
<th>Support Measure</th>
<th>Adequacy of Finances</th>
<th>Control of Demands</th>
<th>Communicating With Others</th>
<th>Companionship</th>
</tr>
</thead>
<tbody>
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<td>Adequacy of Finances</td>
<td>1.00</td>
<td>0.32*</td>
<td>0.20</td>
<td>0.23</td>
</tr>
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<td>Control of Demands</td>
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<td>0.45**</td>
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<tr>
<td>Communication with Others</td>
<td>1.00</td>
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<td>0.57**</td>
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<td>Companionship</td>
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<td></td>
<td></td>
<td>1.00</td>
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</table>

**Notes:** **p<.01, *p<.05 (Two tailed test of significance)**
intercorrelation of the subscales indicates that the measures of instrumental and expressive support are not unrelated.

**Summary of Instrumental/Expressive Support Variables**

The instrumental/expressive support scale (Dean, Lin and Ensel 1981) has been used in this research to measure support received from others. Two factors, money problems and demands, are identified by the authors as factors contributing to the lack of instrumental support. Communication problems and lack of companionship adversely impact receipt of expressive support.

The four factors of instrumental/expressive support show improvements from the initial interview to the second interview three months later. However, a paired comparisons "t" test shows only one factor, communication problems, improving significantly. The communication factor is comprised of responses to questions like, "no one to understand your problems", or "problems with children" or "problems communicating with others". These indicators point to individuals who do not have others to provide support. In addition, they are uncomfortable with presenting their issues to others.

The problems of communication listed above are consistent with the results found for the social integration variables and social network variables. Patients are less apt to be married than nonpatients. They have fewer
attachments to their community than nonpatients. Patients are in need of close friends and family who can provide emotional support without asking for anything in return.

**The Shortened Kaplan Scale: The Perception Of Social Support**

The shortened Kaplan Scale is a measure of social support. It is grounded in Cobb's (1976) view of social support as information that one is loved and wanted, valued and esteemed and is a part of a network of others who can be counted on (Turner and Noh 1982). Turner and Noh (1982) used an instrument developed by Kaplan (1977) under Cobb's supervision. The original scale used 16 sets of vignettes. Turner and Noh (1982) adopted 7 sets that they felt most effectively indicated respondent’s perceptions of being supported by others. Each set has three stories describing individuals with varying levels of support. Subjects are asked to identify themselves with the stories by responding on a five point scale. High scores indicate greater support. The seven items are then summed. Scores range from 7 to 35.

**Comparing Mothers Of Newborns And Mental Health Center Respondents**

Turner and Noh (1983) studied 212 mothers residing in Southwestern Ontario who had recently given birth. These mothers were tested when their newborn was between two and four weeks of age. They were tested again when their babies were six months old. The third test occurred when the children reached one year.

Table 3.14 compares the available data for Turner and
Table 3.14 Mean, Standard Deviation and Number of Cases: The Shortened Kaplan Scale: Comparing the Mental Health Outpatient Sample And New Mothers at Times 1 and 2.

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>Standard Deviation</th>
<th>Number Of Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health Outpatients Time 1</td>
<td>22.69</td>
<td>5.08</td>
<td>39</td>
</tr>
<tr>
<td>Mental Health Outpatients Time 1*</td>
<td>23.17</td>
<td>5.22</td>
<td>29</td>
</tr>
<tr>
<td>New Mothers Time 1</td>
<td>26.4</td>
<td></td>
<td>212</td>
</tr>
<tr>
<td>Mental Health Outpatients Time 2</td>
<td>25.4</td>
<td>4.45</td>
<td>29</td>
</tr>
<tr>
<td>New Mothers Time 2</td>
<td>26.2</td>
<td></td>
<td>212</td>
</tr>
</tbody>
</table>

Notes: * Mental health clients who persisted from time 1 to time 2
Noh's sample at time 1 and time 2 with the data from the mental health sample at time 1 and time 2. As seen in Table 3.14 the mental health outpatients have lower scores at time 1 than new mothers at time 1. People entering a mental health center are expected poorer mental health and lower perceptions of social support than new mothers.

At time 2, there is little change in the perception of social support by new mothers after a six month interval. Using a paired comparisons "t" test, the mental health center clients show an increase in perception of social support from 23.17 at time 1 to 25.4 at time 2. This difference produces a significant "t" score (p=.01, using a two tailed test of significance). If mental health status is not an issue for new mothers, and support is related to mental health, one would not expect changes in the perception of social support for new mothers at time 2. On the other hand, mental health outpatients, are expected to show changes in support levels at time 2. Table 3.14 shows that patients' perceptions of support changed from time 1 to time 2 and are consistent with the hypothesis that social support is directly related to mental health.

Lower perception of support at time 1 is also consistent with findings for social integration, social networks and received support. With limited attachments to one's community and neighborhood and being single, separated, divorced or widowed, the capacity to make contacts with others is diminished. Feelings of isolation and lack of
attachment have been found to have direct bearing on suicide. Even Freudian theory attributes the origin of psychological problems to early social relationships (Vaux 1988).

The next questions explore the psychological status of the mental health sample. The psychological health of the patients studied in this research are compared to nonpatients and patients studied by Goldberg, the author of the General Health Questionnaire.

The General Health Questionnaire

The General Health Questionnaire (GHQ) is a 60 item questionnaire that can be self administered. It is used for detecting psychiatric disorder and was developed to aid the primary care physician in detecting patients with mental health problems (Cleary, Goldberg, Kessler, and Nycz 1982).

Other versions of the GHQ have been developed. For this study, the twelve item version was used. (See methods section for details of the psychometric properties of this version.)

The severely ill group. In order to calibrate the questionnaire, Goldberg (1972) adopted three calibration groups: "normals", "mildly ill" and "severely ill". To be included in the severely ill group, members had to be inpatients of a mental hospital. In addition, their attending physician had to rate them a "5" on a five point scale that ranged from a "1" or completely well to "5", severely ill. Goldberg describes a severe rating as,
"Inpatient psychiatric care essential on grounds of mental hospital" (Goldberg 1972:43). A sample of 100 subjects was included in the study.

The Mildly Ill. To be included in the mildly ill group, a patient had to be attending the outpatient department of the Maudsley Hospital. These patients also had to have a rating of "3" on the doctor's rating scale mentioned above. A "3" is described as "Mildly ill-needs some psychiatric help. Quite all right as an outpatient" (Goldberg 1972:43). The sample size was 100.

The Normals. Normals were chosen from a 10% sample of residents from the London, England area. Employees of a commercial polling firm conducted the survey. The goal of the survey was to obtain a sample of 100 subjects matched to the severely and mildly ill groups for age, sex and social class. To be included in this group, six criteria had to be met, 1) Each person was asked to self rate his or her general health as good, fair or poor. Those rating their health as poor were rejected for inclusion in the sample. 2) Individuals who had seen their doctor more than once in the past three months were rejected. 3) Those on a regular regimen of prescription drugs were rejected. 4) Anyone who had been out of work more than two weeks in the past three months was rejected from inclusion in the normal group. 5) Respondents who reported on an open ended question that they suffered from persistent insomnia were rejected. 6) Those respondents who rated themselves as slightly more
nervous or ill than average were excluded from the "normals group".

One hundred and sixty-two individuals were surveyed and 62 did not meet the above criteria for inclusion in the group or were not included because of matching criteria or incomplete questionnaires. Twenty-eight of the 62 non-included respondents were rejected due to matching (5) or incomplete or refusal to complete the questionnaire (23).

**Item analysis.** The responses made by the three samples to each item were grouped together, and an item analysis was performed. An ideal item should be responded to by as few as possible of those in the normal group and by as many as possible in the severely ill group. The mildly ill group would be in some intermediate position. In developing the questionnaire, 143 items were tested. Items that did not discriminate well between the three groups were rejected. The questionnaire now has 4 versions consisting of 60, 36, 28 and 12 items respectively. For this research, the 12 item version was used.

**Comparing Goldberg's General Population Sample With Mental Health Center Clients**

For comparative purposes, the responses of Goldberg's three samples on the 12 GHQ items were compared to our mental health sample. The comparisons were made for times 1 and 2. The scores ranged from '0', the most positive mental health response, to '3' the most negative mental health response. Table 3.15 reports the summary scores from this
Table 3.15 Percentage Of Responses By Scoring Category For Five Populations To Items In The 12 Item General Health Questionnaire.

<table>
<thead>
<tr>
<th>Population</th>
<th>Scoring Category</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Very</td>
</tr>
<tr>
<td></td>
<td>Positive</td>
</tr>
<tr>
<td>Normals*</td>
<td>40%</td>
</tr>
<tr>
<td>Mildly Mentally Ill*</td>
<td>14</td>
</tr>
<tr>
<td>Severely Mentally Ill*</td>
<td>2</td>
</tr>
<tr>
<td>Mental Health Time 1</td>
<td>17</td>
</tr>
<tr>
<td>Mental Health Time 2</td>
<td>38</td>
</tr>
</tbody>
</table>

Notes: *Populations studied by Goldberg (1972)
combination.

On inspection the populations studied by Goldberg (1972) show considerable differences in the percentage of responses by scoring category. The positive categories (0,1) for the normals, mildly mentally ill and severely mentally ill total 96%, 57% and 23% respectively. The positive categories for the mental health center population at times 1 and 2 totaled 47% and 72% respectively.

The positive scores for the mental health outpatient sample at time 1 fall within 10 percentage points of the scores of the Mildly Ill sample studied by Goldberg (1972). Recall that the mild mentally ill studied by Goldberg were those patients seen in an outpatient mental health setting. The severely mentally ill were seen primarily in an inpatient setting. The mental health center sample was comprised entirely of outpatients.

The time 2 scores for the mental health outpatients show a shift from 47% positive scores (0,1) at time 1 to 72% at time 2. This shift toward the more normal scores of Goldberg's samples indicates an improvement in psychological well-being over the course of therapeutic intervention.

To compute the total score on the GHQ, the twelve items for each respondent were summed. Table 3.16 lists the mean scores for the mental health sample at time 1 and time 2, and the means of the three samples studied by Goldberg (1972).

As the total scores show, the normals differ from the
mentally ill groups. The group with the scores closest to the normals is the mental health outpatients at time 2 (three months after intake to the mental health center). The severely mentally ill have the highest score on the distress scale. The mental health group at time 1 and the mildly mentally ill group studied by Goldberg (1972) have means of 19.0 and 16.8 respectively. These two groups should be more similar than the other groups as they are both mental health outpatients. In fact, these groups could have been more similar if there had not been as large a time gap in measurement between the two populations. Goldberg's study was conducted in 1972. There has been a greater move to deinstitutionalize the mentally ill since 1972. Outpatient populations now have individuals who in the past would have been institutionalized. This change could account for the differences between Goldberg's mentally ill sample and our mental health outpatients.

The mental health sample's mean psychological distress score at time 1 is significantly higher than at time 2. A paired comparisons "t" test produced a t=3.81 (p=.001, a two tailed test of significance). These data indicate that from time 1 to time 2 there was a significant improvement in psychological well-being for the mental health outpatients studied in this research.

**Summary of Perception of Social Support and Psychological Status**

The perceptions of social support of the mental health
Table 3.16  Aggregate Psychological Distress Scores: Comparing The Mean Scores of Normals, Mildly Mentally Ill And Severely Mentally Ill With Mental Health Outpatients at Time 1 and Time 2.

<table>
<thead>
<tr>
<th>Population</th>
<th>Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normals</td>
<td>7.8*</td>
</tr>
<tr>
<td>Mild Mentally Ill</td>
<td>16.8*</td>
</tr>
<tr>
<td>Severely Mentally Ill</td>
<td>25.4*</td>
</tr>
<tr>
<td>Mental Health Time 1</td>
<td>19.0</td>
</tr>
<tr>
<td></td>
<td>SD (8.35)</td>
</tr>
<tr>
<td>Mental Health Time 1</td>
<td>19.9+</td>
</tr>
<tr>
<td></td>
<td>SD (7.90)</td>
</tr>
<tr>
<td>Mental Health Time 2</td>
<td>12.6</td>
</tr>
<tr>
<td></td>
<td>SD (9.10)</td>
</tr>
</tbody>
</table>

Notes: *calculated from the scores published by Goldberg (1972).
+Mean of patients at time 1 who were reanalyzed at time 2.
clients studied in this research were compared to the perceptions of social support by mothers of newborns studied by Turner and Noh (1982). Changes in social support perceptions for the mothers did not change significantly from time 1 to time 2. If illness is not an issue at either time point for the mothers, then perceptions of social support should not vary. For the mental health group, illness is an issue. In fact, perception of social support did improve significantly for the mental health group from time 1 to time 2.

Throughout this chapter there has been an assumption that the clients attending the mental health center are mentally ill. To test this assumption, the scores of the mental health center sample were compared to a sample studied by Goldberg (1972) using the GHQ.

When compared to an English sample of severely mentally ill (hospitalized group) mildly mentally ill (mental health outpatients) and normals, the mental health sample fell between the severely ill and the mildly mentally ill patients at time 1. At time 2, the mental health center patients fell between the mild mentally ill sample and the English nonpatient sample. In fact, there was a significant improvement in psychological well-being for the mental health outpatients from time 1 to time 2. These data indicate that the mental health outpatients studied in this research do in fact appear to be suffering from a mental illness at intake to the mental health center. The data also
indicate that there has been a significant improvement from initial intake to the second administration of the GHQ. While the improvement is significant, the actual scores are not similar to the nonpatient sample, as would be expected. The mental health sample was retested after only three months. Not all patients had completed therapy at the time of the retest.

The Interrelationships Of The Measures Of Social Support

As noted in Chapter 1, there has been some conceptual confusion surrounding the idea of social support. One of the reasons for the conceptual confusion about social support is the various ways it is defined. Few studies use more than one measure of social support and even fewer use more than two. Our purpose in this research is to study the interrelationships of some of the different measures of social support at two points in time. The following tables examine the Pearson Product Moment Correlations between four measures of social support at intake to the mental health center and three months following intake.

Comparing Social Integration And Social Networks

Table 3.17 presents the correlation between The H.I.E. Social Health Battery and The McFarlane Social Relationship Scale. The Social Health Battery was employed in this study to measure social integration or the existence of supportive relationships. The Social Relationship Scale (SRS) is a measure of various dimensions of social networks or the
Table 3.17  Intercorrelations of H.I.E. Social Support Scale With The McFarlane Social Relationship Scale at Time 1.

<table>
<thead>
<tr>
<th>Social Relationship Scale</th>
<th>H.I.E. Social Health Battery</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Social Contacts</td>
</tr>
<tr>
<td>LNumber Of Network Members</td>
<td>.08  (40)</td>
</tr>
<tr>
<td></td>
<td>P=.31</td>
</tr>
<tr>
<td>Helpfulness Of Network</td>
<td>.21  (40)</td>
</tr>
<tr>
<td></td>
<td>P=.09</td>
</tr>
<tr>
<td>LNumber Of Multiplex</td>
<td>.08  (40)</td>
</tr>
<tr>
<td>Relationships</td>
<td>P=.30</td>
</tr>
<tr>
<td>LNetwork Reciprocity</td>
<td>.14  (40)</td>
</tr>
<tr>
<td></td>
<td>P=.18</td>
</tr>
</tbody>
</table>

Notes: Two tailed tests of significance. "L" denotes transformed variable. The Log of Network Extent And Multiplexity Are Used To Transform Those Variables. The Proportion Of Reciprocal Contacts Is Transformed To The Power Of Three. These Transformations Are Used In All Subsequent Tables For These Variables.
interpersonal structure of supportive relationships.

In table 3.17, there is a surprising finding. The correlation between H.I.E. social contacts dimension and the SRS number of network members and number of multiplex relations are .07 and .08 respectively. Intuitively social contacts and the number of network members are similar dimensions of social support. However, upon closer examination, one finds that the H.I.E. Social Contacts dimension actually measures the frequency of getting together with or visiting with friends and family. The SRS Number of Network Members is a list, by name or initials, of the different people respondents report that they talk to about different aspects of their life. These aspects are: home and family, work, money and finances, personal health, personal and social, and society in general. Multiplex relations are those individuals who are named by the respondents as being someone they talk to about three of the six aspects of their life listed above.

One of the items (see item 2, table 3.3) on the H.I.E. Social Health Battery asks respondents to list the number of friends and family with whom the respondent feels at ease and can talk with about what is on his or her mind. This item is not included in the Social Contacts Score but is included in the overall social support score of the H.I.E. Social Health Battery. This particular item, when correlated with the SRS Number of Network Member’s score, produces a correlation of .37, p=.01. The frequency of social contacts
with friends and family is not significantly related to the number of people actually named by respondents nor to the number of people who are well acquainted with different aspects of a respondent's life.

**Proportion of reciprocal contacts.** Network reciprocity is the proportion of all network members that were listed by the respondent as those people who would seek out the respondent to talk about issues important to that network member. The proportion of reciprocal network members shows no relationship with the H.I.E. Social Battery's social support measure.

**Helpfulness.** The helpfulness of the network is strongly related to the H.I.E. Social Health Battery. In fact this score has a positive relationship with all dimensions of the H.I.E. Social Health Battery. In particular, as helpfulness increases, social contacts (frequency of contacts) increases. The helpfulness dimension is related to the SRS number of individuals named in one's network dimension ($r=0.35$, $p=0.01$), but helpfulness is not related to item 2 (see above) on the H.I.E. Social Health Battery (the number of people one feels comfortable talking with about things on one's mind).

At the second interview, some interesting relationships emerged (See table 3.18). Helpfulness of the network at time 1 was directly and significantly related to frequency of contacts, group participation and social well-being. At time 2, helpfulness was negatively but not significantly related
to the frequency of social contacts. This implies that the less frequent the contacts with friends or relatives the higher will be their helpfulness. Social well-being at time 2 was unrelated to helpfulness at time 2.

Multiplexity at time 2 is also negatively correlated with frequency of social contacts. Earlier in this chapter, we argued that the H.I.E. social contacts variable was acting like a buffer against a crisis of stress in the lives of patients. The findings at time 2 between social contacts and multiplex relations and helpfulness lend support to this argument. As the crisis subsides, social contacts or support seeking subsides. Once the needed support is obtained, continued support seeking is more a measure of disappointment with the helpfulness of one's close friends.

While social contacts was an important variable at time 1, group participation was unimportant. At time two, these variables reversed in importance. In table 3.6, we see that group participation significantly increased from time 1 to time 2 for the mental health sample. In addition, at time 1, group participation is unrelated to multiplexity. Group participation is related, but not significantly, to network size at time 1. At the second interview, both network extent and multiplexity are significantly related to group participation. If group participation increases because patients join groups established or recommended by therapists, then group participation may lead to increasing one's network. As the patient's network
Table 3.18 Intercorrelations Of The H.I.E. Social Support Scale With The McFarlane Social Relationship Scale At Time 2.

<table>
<thead>
<tr>
<th></th>
<th>Social Contacts</th>
<th>Group Participation</th>
<th>Social Support</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>LNumber Of Network Members</strong></td>
<td>.00</td>
<td>.53</td>
<td>.58</td>
</tr>
<tr>
<td></td>
<td>(28) P=.47</td>
<td>(29) P=.00</td>
<td>(28) P=.00</td>
</tr>
<tr>
<td><strong>Helpfulness Of Network</strong></td>
<td>-.17</td>
<td>.11</td>
<td>.04</td>
</tr>
<tr>
<td></td>
<td>(28) P=.18</td>
<td>(29) P=.58</td>
<td>(28) P=.41</td>
</tr>
<tr>
<td><strong>LNumber Of Multiplex</strong></td>
<td>-.22</td>
<td>.56</td>
<td>.29</td>
</tr>
<tr>
<td>Relationships</td>
<td>(28) P=.13</td>
<td>(29) P=.00</td>
<td>(28) P=.06</td>
</tr>
<tr>
<td><strong>LNetwork Reciprocity</strong></td>
<td>.06</td>
<td>-.11</td>
<td>-.04</td>
</tr>
<tr>
<td></td>
<td>(28) P=.37</td>
<td>(29) P=.58</td>
<td>(28) P=.41</td>
</tr>
</tbody>
</table>

Notes:*Spearman's Rho (significance 1 tailed test)
increases, the opportunity to increase the number of close friends increases.

**Social Integration and Instrumental/Expressive Support**

At intake to therapy, the H.I.E. Social Contacts dimension and the Social Well-Being measure have correlations ranging from .16 to .35 with the Instrumental/Expressive Support Scale (I/E) dimensions (see table 3.19). The strongest relations occur between I/E Companionship (having a close companion, enough close friends, someone to show respondent love and affection) and H.I.E. social contacts (frequency of contacts) \( r = .34 \) and H.I.E. social well-being \( r = .35 \). H.I.E. social contacts was significantly related to I/E Demands, and communication with others. Both dimensions of expressive support are significantly associated with both social contacts and social well-being.

Similarly, both of the dimensions of the I/E instrumental measure were related to social contacts and social well-being. Financial security is significantly related to social well-being and time management is significantly related to H.I.E. social contacts. H.I.E. group participation is unrelated to financial security and companionship. It is negatively related to time management. Such a relation means that individuals with time management problems are likely to be involved in groups at time 1. It is possible that participation in social group activities contributes to time management difficulties for respondents.
Table 3.19  Intercorrelations Of Dimensions Of The H.I.E. Social Integration Questionnaire And The Instrumental/Expressive Support Scale At Time 1.

<table>
<thead>
<tr>
<th></th>
<th>Social Contacts</th>
<th>Group Participation</th>
<th>Social Support</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Money Problems</strong></td>
<td>.18</td>
<td>.11</td>
<td>.31</td>
</tr>
<tr>
<td></td>
<td>( 40)</td>
<td>( 40)</td>
<td>( 39)</td>
</tr>
<tr>
<td>P=.14</td>
<td>P=.24</td>
<td>P=.03</td>
<td></td>
</tr>
<tr>
<td><strong>Lack Of Companionship</strong></td>
<td>.35</td>
<td>-.05</td>
<td>.34</td>
</tr>
<tr>
<td></td>
<td>( 40)</td>
<td>( 40)</td>
<td>( 39)</td>
</tr>
<tr>
<td>P=.01</td>
<td>P=.38</td>
<td>P=.02</td>
<td></td>
</tr>
<tr>
<td><strong>Demands</strong></td>
<td>.26</td>
<td>-.13</td>
<td>.29</td>
</tr>
<tr>
<td></td>
<td>( 40)</td>
<td>( 40)</td>
<td>( 39)</td>
</tr>
<tr>
<td>P=.05</td>
<td>P=.22</td>
<td>P=.03</td>
<td></td>
</tr>
<tr>
<td><strong>Communication Problems</strong></td>
<td>.28</td>
<td>-.05</td>
<td>.24</td>
</tr>
<tr>
<td></td>
<td>( 40)</td>
<td>( 40)</td>
<td>( 38)</td>
</tr>
<tr>
<td>P=.04</td>
<td>P=.39</td>
<td>P=.07</td>
<td></td>
</tr>
</tbody>
</table>

Notes: Two tailed test of significance.

Table 3.20  Intercorrelations Of The Dimensions Of The H.I.E. Social Integration Questionnaire And The Instrumental/Expressive Support Scale At Time 2

<table>
<thead>
<tr>
<th></th>
<th>Social Contacts</th>
<th>Group* Participation</th>
<th>Social Support</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Money Problems</strong></td>
<td>.01</td>
<td>.05</td>
<td>.20</td>
</tr>
<tr>
<td></td>
<td>( 28)</td>
<td>( 29)</td>
<td>( 28)</td>
</tr>
<tr>
<td>P=.47</td>
<td>P=.80</td>
<td>P=.30</td>
<td></td>
</tr>
<tr>
<td><strong>Lack Of Companionship</strong></td>
<td>-.13</td>
<td>-.07</td>
<td>-.09</td>
</tr>
<tr>
<td></td>
<td>( 28)</td>
<td>( 29)</td>
<td>( 28)</td>
</tr>
<tr>
<td>P=.26</td>
<td>P=.73</td>
<td>P=.66</td>
<td></td>
</tr>
<tr>
<td><strong>Demands</strong></td>
<td>-.07</td>
<td>-.15</td>
<td>-.26</td>
</tr>
<tr>
<td></td>
<td>( 28)</td>
<td>( 29)</td>
<td>( 28)</td>
</tr>
<tr>
<td>P=.36</td>
<td>P=.41</td>
<td>P=.17</td>
<td></td>
</tr>
<tr>
<td><strong>Communication Problems</strong></td>
<td>-.09</td>
<td>-.01</td>
<td>.01</td>
</tr>
<tr>
<td></td>
<td>(28)</td>
<td>( 29)</td>
<td>( 28)</td>
</tr>
<tr>
<td>P=.33</td>
<td>P=.95</td>
<td>P=.97</td>
<td></td>
</tr>
</tbody>
</table>

Notes: *Spearman's Rho. Two tailed tests of significance.
At time 2 (see table 3.20), there are major changes in the relationships between Instrumental/Expressive support and social integration. At the first interview, expressive support is significantly correlated with frequency of social contacts and overall social well-being. (Social well-being is a social integration measure. It includes measures of the frequency of social contact, group participation, number of friends and relatives one visits, and church attendance.) At the second interview, expressive support is unrelated to social well-being. I/E communication is unrelated to social contacts. The second dimension of expressive support, companionship, is negatively related to social contacts. Instrumental support at time 2 is related to H.I.E. social well-being. Instrumental support is unrelated to social contacts at time 2, a change from the first administration of the measurement tool. Group participation continues to be unrelated to instrumental/expressive social support. At the beginning of therapeutic intervention, frequency of social contacts and social well-being (both measures of social integration) were related to expressive social support. After some time in therapy, social contacts and social well-being were unrelated to received support.

Perception Of Social Support And Social Integration

Perception of social support is usually defined as the belief that if the need arose at least one person in an
individuals network of friends and family would be available to serve one or more specific functions (Cutrona, Suhr and McFarlane 1988). These authors believe that reliance on another for support requires the experience of being previously supported by the second person (Cutrona et. al. 1988). The fact that perceived support is dependent on transactions with others would lead one to conclude that perceived support is related to the existence of close personal relationships.

At the initial presentation of the Shortened Kaplan Scale and the H.I.E. social integration questionnaire, respondents answers correlate significantly on all dimensions. Frequency of social contacts and social well-being have correlation coefficients exceeding .50. The H.I.E group participation measure was significantly related to the SKS (see table 3.21).

At the time of the second interview, frequency of social visits with friends and relatives was no longer related to one's perception of social support. Overall social well-being decreased in strength of relationship to the SKS, but the strength of the group participation measure of social integration increased markedly with the SKS at time 2.

**A Summary of Social Integration And Its Interrelations**

Tables 3.17 through 3.21 show a shift in the relationship between social support measured as social integration and social support measured by social networks,
Table 3.21 Intercorrelations Of The Dimensions Of The H.I.E. Social Integration Measure And Kaplan's Perception Of Social Support Measure At Time 1.

<table>
<thead>
<tr>
<th>Perception Of Social Support</th>
<th>Time 1</th>
<th>Time 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Contacts</td>
<td>.51</td>
<td>.00</td>
</tr>
<tr>
<td>(39)</td>
<td></td>
<td>(28)</td>
</tr>
<tr>
<td>P=.00</td>
<td></td>
<td>P=.49</td>
</tr>
<tr>
<td>Group Participation*</td>
<td>.27</td>
<td>.41</td>
</tr>
<tr>
<td>(39)</td>
<td></td>
<td>(29)</td>
</tr>
<tr>
<td>P=.05</td>
<td></td>
<td>P=.03</td>
</tr>
<tr>
<td>Overall Social Support</td>
<td>.58</td>
<td>.27</td>
</tr>
<tr>
<td>(38)</td>
<td></td>
<td>(28)</td>
</tr>
<tr>
<td>P=.00</td>
<td></td>
<td>P=.08</td>
</tr>
</tbody>
</table>

Notes: *Spearman's Rho. (Two tailed tests of significance.)
received support, and perception of support. At the initial interview, group participation was related to the helpfulness of one's social network. Group participation was not significantly related to the extent of one's social network or the multiplexity of the network. After a brief time in therapy, group participation was significantly related to the extent of one's network and the multiplexity of the network. If therapists encouraged their clients to join therapy or support groups during treatment, then they may have changed the way clients view their social support. It is likely that participation in therapy groups has lead clients to view their social networks as larger than at time 1. Clients also may view their number of close friends (multiplex relations) as having increased.

In addition, at the beginning of therapy, social integration measured as the frequency of social contacts and overall social well-being is correlated to both dimensions of expressive social support. At time 2, neither instrumental nor expressive social support are significantly correlated to social integration.

Finally, social integration measured as social contacts is strongly related to perception of social support at time 1. At time 2 social contacts are unrelated to perception of social support. Group participation, while significantly related to perception of social support at time 1, is also significantly related to the perception of social support at time 2. In fact the strength of the correlation increases
from time 1 to time 2.

Social Networks and Instrumental Expressive Support

Berg and Piner (1988) developed hypothetical relationships between support, network characteristics, relational needs and interaction characteristics. They argue that small cohesive networks mimic larger but dense networks. Dense networks are important because density is related to feelings of solidarity and cohesiveness between network members. If networks are restricted to those individuals with whom one feels close relationships, then feelings of solidarity and cohesiveness should be present (Berg and Piner 1988). In small, cohesive networks, individuals are more likely to receive emotional support when compared to larger, less dense networks. In one's total network, the amount of emotional support obtained is related more to network density (or the amount of cohesiveness within the total network) than to network size. In small cohesive networks, network size and multiplexity are related to emotional support.

If we assume that the networks presented by the mental health patients are small and cohesive, we would expect that network size and multiplexity are related to emotional support received. Table 3.22 shows that at time 1, there is a relationship between the two dimensions of expressive social support (companionship and communication) and network size and multiplexity. The relationship is not significant.
Table 3.22 Intercorrelations Of The Dimensions Of The McFarlane Social Relationship Scale And The Instrumental/Expressive Questionnaire For Mental Health Patients At Time 1.

<table>
<thead>
<tr>
<th></th>
<th>Network Extent</th>
<th>Helpfulness Of Network</th>
<th>Multiplex Reciprocity Relationships</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adequacy of Finances</td>
<td>.10</td>
<td>.23</td>
<td>-.00</td>
</tr>
<tr>
<td></td>
<td>(40)</td>
<td>(40)</td>
<td>(35)</td>
</tr>
<tr>
<td></td>
<td>P=.26</td>
<td>P=.07</td>
<td>P=.49</td>
</tr>
<tr>
<td>Companionship</td>
<td>.17</td>
<td>.32</td>
<td>.17</td>
</tr>
<tr>
<td></td>
<td>(40)</td>
<td>(40)</td>
<td>(35)</td>
</tr>
<tr>
<td></td>
<td>P=.14</td>
<td>P=.02</td>
<td>P=.16</td>
</tr>
<tr>
<td>Control Of Demands</td>
<td>.23</td>
<td>.33</td>
<td>-.03</td>
</tr>
<tr>
<td></td>
<td>(40)</td>
<td>(40)</td>
<td>(35)</td>
</tr>
<tr>
<td></td>
<td>P=.08</td>
<td>P=.02</td>
<td>P=.42</td>
</tr>
<tr>
<td>Communication With Others</td>
<td>.14</td>
<td>.11</td>
<td>.16</td>
</tr>
<tr>
<td></td>
<td>(39)</td>
<td>(39)</td>
<td>(39)</td>
</tr>
<tr>
<td></td>
<td>P=.20</td>
<td>P=.24</td>
<td>P=.18</td>
</tr>
</tbody>
</table>

Notes: Two tailed test of significance.
At time 2, companionship is unrelated to network size or multiplexity. Communication is related to the two network variables, though not significantly.

There is a reason for the weak relationship between the network variables of size and multiplexity and expressive support. That reason may be that men and women define support differently. For example, Berg and Piner (1988) researched the relationships between loneliness and social networks. They define loneliness as the discrepancy between the quantity and/or quality of social relationships that one has and that one wishes. Berg and Piner (1988) found inconsistencies in the relationship between loneliness and social networks due to differences between men and women on social and emotional isolation.

Shaver and Burmeister (1983) write that loneliness is more related to social isolation for men than women, while emotional isolation is more predictive of women's isolation. The companionship variable on the I/E scale includes factors like "no close companion" or "not enough close friends" or "no one to show love and affection." It shows some interesting relationships when correlated with social network size while controlling for sex. At time 1, network size and companionship are related (r=.22) for women but almost uncorrelated for men (r=.08). At the second interview, network extent and companionship were negatively related for men (r=-.29) (the larger the network, the lower the companionship) and positively related for women.
The second component of I/E emotional support is communication. The items comprising this factor are, "problems communicating", "no one to understand your problems" and "conflicts with those who are close to you". At time 1, the correlation between communication and network size was $r = .04$ when controlling for men and $r = .23$ when controlling for women. At time 2, social networks and communication had a negative relation for men ($r = -.12$) and a strong correlation ($r = .40$, $p = .08$) for women.

Shaver and Burmeister (1983) argue that activities like shared leisure pursuits that are mutually chosen are more related to men's loneliness than to women's. Receipt of emotional support influences women's loneliness more than men's loneliness. Following Shaver and Burmeister's argument, network size and should be more related to emotional support received for women than men. Our findings with regard to network size lend support for their hypothesis.

**Social Networks and Social Perception**

Network extent, network helpfulness and number of multiplex relationships are all significantly related to respondents' perceptions of social support at both time points. The proportion of reciprocal contacts is not related to perception of social support at time 1 or time 2 (See table 3.23).
Table 3.23  Intercorrelations Of Kaplan's Perception Of Social Support Questionnaire And The McFarlane Social Relationship Scale At Time 1.

<table>
<thead>
<tr>
<th>Perception Of Social Support</th>
<th>Time 1</th>
<th>Time 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>LNetwork Extent</td>
<td>.39</td>
<td>.39</td>
</tr>
<tr>
<td>(39)</td>
<td>P=.01</td>
<td>P=.02</td>
</tr>
<tr>
<td>Network Helpfulness</td>
<td>.37</td>
<td>.40</td>
</tr>
<tr>
<td>(39)</td>
<td>P=.01</td>
<td>P=.01</td>
</tr>
<tr>
<td>LNumber Of Multiplex Relationships</td>
<td>.49</td>
<td>.39</td>
</tr>
<tr>
<td>(39)</td>
<td>P=.00</td>
<td>P=.02</td>
</tr>
<tr>
<td>LReciprocity Of Social Support</td>
<td>.02</td>
<td>.05</td>
</tr>
<tr>
<td>(39)</td>
<td>P=.45</td>
<td>P=.39</td>
</tr>
</tbody>
</table>

Notes: Two tailed test of significance.
**Instrumental/Expressive Support And The Perception Of Social Support**

The expressive support dimensions are significantly related to the perception of social support. Instrumental support is also correlated significantly with social support perception. These relationships are similar for both time 1 and time 2 administrations (see table 3.24).

**Conclusions**

This chapter set out to investigate several questions raised in Chapter 1. The first question focused on how mental health outpatients scored on questionnaires measuring different aspects of social support before and after therapeutic intervention. It was found that our mental health outpatient sample at intake to therapy scored consistently lower than nonpatients studied by other investigators using the same measuring instruments. The same results held when the mental health patients studied in this research were compared to patients and nonpatients studied by other investigators.

Three months after intake, our patients show mental health improvements. Their improvements are consistent with the findings of other investigators using the same measuring instrument. Not only are there mental health improvements, but there are improvements in a number of social support dimensions.

The social support dimensions that show particular improvements are group participation, network multiplexity,
Table 3.24 Intercorrelations Of Kaplan's Perception Of Social Support Scale And The Instrumental/Expressive Social Support Questionnaire At Time 1.

<table>
<thead>
<tr>
<th>Perception Of Social Support</th>
<th>Time 1</th>
<th>Time 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adequacy Of Finances</td>
<td>.29</td>
<td>.51</td>
</tr>
<tr>
<td>(39)</td>
<td>P=.04</td>
<td>P=.00</td>
</tr>
<tr>
<td>Companionship</td>
<td>.41</td>
<td>.36</td>
</tr>
<tr>
<td>(39)</td>
<td>P=.00</td>
<td>P=.03</td>
</tr>
<tr>
<td>Control Of Demands</td>
<td>.38</td>
<td>.12</td>
</tr>
<tr>
<td>(39)</td>
<td>P=.00</td>
<td>P=.27</td>
</tr>
<tr>
<td>Communication With Others</td>
<td>.58</td>
<td>.49</td>
</tr>
<tr>
<td>(39)</td>
<td>P=.00</td>
<td>P=.00</td>
</tr>
</tbody>
</table>

Notes: Two tail tests of significance.
proportion of reciprocal contacts (actually a decrease), communication with others and perception of social support. These particular dimensions of support are important given the problems facing the clients coming to the mental health center.

Upon arrival at the mental health center, the majority of the soon to be patients are without close friends and family. Most are divorced, separated or single. They have limited contact with their neighbors and are isolated from their community. The patients studied have small, unhelpful networks with few close friends. They complain of having no one to talk with or no one who cares about them. They perceive that no one "was there for them". The patients spend much time seeking out others to help. Due to a lack of people available, they are unsuccessful and sought help with their life situation from their therapist.

Three months after entering therapy, there were some significant changes in the mental health status of the patients being studied and their social support. The social integration variable of group participation increases significantly for the patients from time 1 to time 2. The number of close friends also shows a significant increase. The proportion of reciprocal relationships decreases significantly for the patients. Our patients are seeking close friends from whom they can get help. They do not want to reciprocate until their problems are settled.

In concert with structural support increases, our mental
health patients show significant improvements in the received support dimension of communication with others. Likewise, their perception of support also increases.

Not all social support variables show significant increases. The social integration variable, social contacts, does not significantly change from time 1 to time 2 for our mental health outpatients. In fact, this variable acts more like a buffer variable for the mental health outpatients. It reflects the mental health outpatients seeking close friends to support them. For nonpatients, this variable represents companionship and is an indicator of positive health status. It seems that it is important to match health status and support variables.

In addition to matching health status and supports, it is also crucial to match supports and gender of the patient population. Males seek instrumental support and females are more inclined to seek emotional support.

Finally, church attendance, a social integration indicator differentiates our mental health patients from the nonpatients studied by Donald and Ware (1982). At the initial interview, the patients were significantly lower in church attendance than the nonpatients. At the time of the second interview, the patients show a significant increase in attendance at church. In fact, at time 2, the mental health patient scores are similar to nonpatient scores. It is argued that at time 1, patients are seeking communal activities. These
activities involve close family and friends because the patient was having problems. At time 2, after the crisis had subsided, patients were seeking associational activities that involve other friends. Some support variables can have different meanings for the same sample at different time points.

Since there are different meanings for the same support variable, attention needs to be paid when choosing a particular measure of social support. In fact, it could be argued that more than one measure needs to be incorporated into study designs.
CHAPTER 4.

PROVIDING SUPPORT: THE ROLE OF FAMILY AND FRIENDS

Introduction

In Chapter 3, mental health outpatient's scores on four measures of social support (social integration, social networks, instrumental/expressive support and perception of social support) were presented. Scores on the four measures were collected at intake to therapy and again at three months following intake. The scores on each variable were compared to nonpatient populations studied by researchers using the same measures employed in this research. The data showed that patients in a mental health center have lower social support than nonpatients. This finding is consistent with the hypothesis that if social support and psychological well-being are directly related, then patients at a mental health center would have less social support than nonpatients. This hypothesis assumes that patients at a mental health center experience more psychological distress than nonpatients. In fact, patient scores on a measure of psychological well-being were found to be lower than nonpatients studied by Goldberg (1972). The mental health patients we studied also have scores which are similar to patients Goldberg characterized as mildly mentally ill.

The last section of Chapter 3 examined the statistical
interrelationships among the four measures of social support within each of the two administrations of the measures. Significant statistical correlations are found among the different dimensions of each social support measure. However, the intercorrelations of some of the different dimensions changed rather dramatically from the intake to three months following intake. For example, group participation is not significantly correlated with network size at time 1, but at time 2, group participation is significantly correlated with network size. This difference is attributed to therapists recommending support groups or using group therapy in their treatment of the patient. The outcome of this intervention is an increase in network size and an increase in the multiplexity of the network.

The fact that intervention such as group participation can affect network size raises a question about the process of social support. As Thoits (1983) points out, understanding the process of social support has policy implications. If social support can affect psychological well-being, then mental health clinics might assign volunteers to befriend clients. Unfortunately, such a volunteer may have limited success because we do not know how a confidante provides social support and therefore cannot teach the skill.

The purpose of this chapter is to explicate the process of social support based on interviews with patients receiving therapy at a community mental health center.
Interviewees were asked open ended questions about social support. The questions were designed to elicit a respondent’s definitions of social support and the importance of social support to the respondent. The two questions that will be addressed in this chapter are related. The first question asked of respondents was, "When you have problems or difficulties, how do you want your family and friends to help you?" The second related question was, "How do you help your family members and friends when they need help?" The data were analyzed using inductive methods outlined in Chapter 2. The focus of the analysis was to develop a model of supporting others based on respondent comments to these two questions.

Other researchers have studied support behaviors. Cutrona et al. (1990) and Goldsmith and Parks (1990) have developed categories of support behaviors. Once our categories were developed, they were compared to the categories of these authors. We found our categories are similar to the support categories developed by Cutrona et al.. To further our understanding of the support process, the two sets of categories were combined. This allowed us to compare our findings with the findings presented by Cutrona et al. (1990) based on a sample of psychology students engaged in a support provision experiment.

Once our model of support provision was developed from the interview material, the relationships were tested using the data provided in Chapter 3. Correlations between the
variables in the model are shown for the variables in the model at time 1 and time 2.

Social Integration

In this study, four definitions of social support are examined. One definition that has historical roots in American Sociology is that of Social Integration. Faris and Dunham (1939), Hollingshead and Redlich (1958), and Leighton (1959) focused on the effects of societal changes associated with the industrial revolution. The societal changes of interest to these researchers were community cohesion, stability, and change (Dean, Lin, and Ensel 1981). Attachments to work, family, and friends and community bolster our sense of self. When these attachments are threatened, our sense of self is threatened. Klerman (1979) states that threats to our sense of self more so than threats to our physical well-being and survival are related to the development of depression.

Social integration refers to the existence of these social attachments. Marital status, contact with friends, relatives, or formal group participation have been used as indicators of social integration. These measures estimate the availability or use of social resources (Turner, Frankel, and Levin, 1982). As an example, in a study by Brown, Bhrolchain, and Harris (1975) confiding relationships were used as a measure of social integration. The presence of husbands, boyfriends, or other males was related to women's differential proneness to depression under stressful
conditions (Brown and Harris 1978). In their study, Brown, Bhrolchain and Harris (1975), defined a confidante as someone who the respondents could talk intimately about themselves or their problems (Turner, Frankel and Levin 1982).

**Intimate Talking.** Confidantes are important to the patients interviewed in this research. For example, when our clients were asked how they wanted their family and friends to help them when they had problems, 9 of the 40 (22%) respondents specifically mentioned they wanted their friends and family to talk to them. The interviewees did not mean **Talking** in the literal sense. They wanted more than just a conversation between two people. For the respondents in this study, talking first means that the friend or family member will be **available** for the respondent to present his or her issues whenever needed. In addition, talking in this context is also meant as more intimate than general conversation. It implies a "shoulder to cry on" and a discussion of issues that are more private than conversation about the weather. It is a very personal or **Intimate Talking.**

Intimate talking implies the **integration** of the individual into a family or friendship group so relationships can be established. Personal relationships are essential for intimate talking to take place. As one woman discussed her reason for returning to New Hampshire, "I had no support group there....In Georgia (we were) not part of the family. (I) felt like an outcast. Wasn't my family. (I)
have a close family here. (Georgia) was different. They were standoffish. I’m outgoing. People there don’t talk.... When we moved back (to New Hampshire it) was open arms time."

The Georgia and New Hampshire families differed on their inclusion of the client. By being "standoffish", the Georgia family was not available for intimate talking. While family members could be named or listed, they were not helpful to the person responding to our question. The respondent’s perception of the Georgia family is that they were unwilling to engage in intimate talking, and they are unsupportive.

Perception of Social Support

In describing her family in New Hampshire, the respondent believes that her New Hampshire family loves and cares for her. This woman’s perception of social support is an important component of being supported. Cutrona et al. (1990:31) define perception of social support as the "belief that if the need arose, at least one person in the individual’s circle of family, friends and associates can serve one or more specific functions." Turner and Noh (1982) describe the perception of social support as information in one or more of the following three categories: 1) information leading one to believe that she is cared for and loved 2) information that leads respondents to believe they are highly valued and esteemed or 3) information leading the individuals to believe that they belong to a network of communication and support. As an illustration, one of this
study's participants offered, "They are just there so I call them on the phone.... It makes me feel like someone is there with me."

Acceptance. For integration with family and friends to be supportive, the respondent must believe that intimate talks with friends or relatives are not only available (because he or she believes they are part of a network of support and communication) but one's friends and family care for and value the respondent. Mental health clients reported that a sign that friends and family care for them and are available when needed was their friend's and families's acceptance of them. Acceptance happens regardless of what has occurred in the client's life. As one respondent explained, "I want them (supporters) to sit down and talk to me and be supportive and not think I'm a bad person because of how I feel." A second client expressed, "I want them to take time to listen to me when I need to, and I know they've really listened and understood, not passed judgment." The risks are substantial for those in need of support as stated by one woman respondent, "Some family members do... (they) judge you, look down on you. (They) don't support you. (They) think your making the wrong decision. (They) ignore you when you need them."

Autonomy. A second important characteristic that impacts one's perception of support is Autonomy. For many clients, autonomy means that supporters may provide advice. They should not expect that the client has to follow that advice.
One professional woman explained, "If you have too many people trying to support you, then you can’t work on problems yourself. You can have too many opinions. Its good to have some and its good to have people call for support and suggestions and fix your car. But not all the time... I want them to listen to me and give advice but not tell me what to do. Another client responded, "Most of the time I try to keep problems to myself. I try to work through them. I don’t want them (friends and family) to help me. I want to make it on my own. I don’t want cash. Talking about problems is okay. They help me by talking about problems. Everybody needs someone to talk to." Finally, an outpatient client described autonomy in response to the question, "How do you want to be supported?", as follows: "Just listen. Be there to let me talk it out. I have to make my own decision." When asked if family and friends did provide support in this way, the client responded, "They are pretty much like this even if they don’t agree. They keep it to themselves."

Autonomy involves the freedom to make one’s own decisions and determine priorities and commitments (La Gaipa 1990). When autonomy is denied in the supportive relationship, the benefits come at a high cost of individuality and freedom (La Gaipa 1990).

The mental health clients in the study stressed that their supporters had to be accepting or nonjudgmental. In addition, clients felt they needed the autonomy or freedom to choose the best course of action or inaction. They did
not want their supporters to give up on them if they did not choose the course of action prescribed by their supporters.

Acceptance and autonomy are important to support seekers because they help reduce the risk of stigma or negative evaluations of the support seeker. For this reason choice of supporter is very important to the support seeker. For some subjects confiding in a friend is better than confiding in a relative or spouse. For example, La Gaipa (1990) points out that women are often unwilling to tell their mothers about quarrels with their husbands. They are unwilling because some mothers will feel guilty that they did not bring their daughters up properly to deal with such conflicts.

**Stigma.** There are potential risks for a daughter to disclose a relationship problem with her husband to her mother, as in the illustration above. One of those risks is stigma. Disclosure can lead to negative evaluations of the support seeker and also the romantic partner (Goldsmith and Parks 1990). Stigma is one risk of support seeking that can lead to the avoidance of support.

Goldsmith and Parks (1990) developed four categories of risks perceived by survey respondents in seeking support. These risks were 1) Negative impressions 2) confidentiality 3) Burden to supporters and 4) disclosure of the problem was inappropriate. To help alleviate these risks, Goldsmith and Parks (1990) found that most respondents choose someone to whom they felt quite close. This person was usually a friend of the same sex and age. The subjects chose someone who was
receptive to the support request. (The support request was not burdensome to the recipient).

Goldsmith and Parks (1990) also developed eight strategies and tactics people use to deal with the conflicting motivations they have about support seeking. Those conflicting motivations are 1) seeking support for the benefits that can be derived like better understanding of the problem, or getting someone to intervene and take care of the problem or developing a closer relationship with the supporter. 2) Reluctance to seek support because of the risks involved (see above). The strategies and tactics people use are derived from a study conducted by Goldsmith and Parks (1990) in which 97 college students discussed a rheumatic problem with someone besides their romantic partner. These strategies included selection (choosing to completely candid about one’s problems in spite of the risks), temporal separation (being candid and open at times and restrained and closed at other times), network separation (asking different members of one’s network for help with different areas of a problem) and behavioral separation (the sending of mixed messages that convey the need for support verbally and communicating not as great a need nonverbally (Goldsmith and Parks 1990).

To understand the factors related to strategy choices, Goldsmith and Parks (1990) looked at the initial situational and relational conditions in which the encounter between the supporter and support seeker took place. As a result,
Goldsmith and Parks (1990) developed 17 relational and situational predictors using a variety of contextual factors. Examples of these factors are: prior relationship among the parties; how much the problem had been discussed in the past; the importance of the problem; and the four risk factors listed above. The seventeen predictors were entered in a stepwise regression equation. The dependent variable was the number of frequently used strategies. Four of the seventeen variables entered the stepwise regression equation significantly. The strongest of these was risk of negative impression. More strategies were used when there was a higher risk of leaving a negative impression (Goldsmith and Parks 1990). Negative impressions can lead to Stigma and fear of lack of support at some future time.

Acceptance and autonomy are important to support seekers because these two concepts help reduce the fear of leaving a negative impression with a supporter. Not being judged by the supporter reduces the risk to the support seeker of leaving a negative impression. Being allowed by the supporter to solve one’s problems in one’s own way (which may mean not following the supporter’s advice) and still be willing to provide support at a later time reduces the risk of disclosure to the support seeker.

The criteria for Intimate Talking are having attachments to a supportive family or friendship group through which close relationships have been formed. These close relationships are perceived as caring, accepting and
respectful of individual choice. Once the criteria have been met, the support seeker will present his or her issues employing different strategies. The strategy of choice, if the above conditions are met, is being completely open about one's problems.

Social support is sought because there is an expectation that some helpful outcome will ensue. Albrecht and Adelman (1987) noted five messages that are seen as supportive: improved control by just being assured and accepted; improved control through catharsis or ventilation; change in the perspective on the cause and effect related to problems presented; improved control through tangible aid; and improved control through skill acquisition. Our respondents interviewed in this research defined outcomes as "giving opinions and suggestions" or "help me try to figure it out" (changing perspective on cause and effect). One elderly woman describes the support provided by her husband as, "he talks, advises or hugs. (He) takes over when I'm unable. My husband does what I need" (tangible aid). Others sought understanding as one individual suffering from chronic alcoholism stated, "I want them to listen or understand. I've been closed out because of alcoholism. Understanding not financial assistance is what I need. Not to be closed out." These outcomes or as they are termed here, Supportive Interventions, can vary depending on the type of problem and the respondent.

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Supportive Interventions: Instrumental and Emotional Support

Cutrona et al. (1990) expanded the supportive outcomes developed by Albrecht and Adelman (1987). To create their definitions of supportive outcomes, Cutrona et al. (1990) developed a list of 33 categories of support intended behaviors. The 33 behaviors were again grouped into five larger classes. These classes were informational support, esteem support, tangible assistance, emotional support and network or belonging support. Information support refers to information, advice, or guidance concerning possible solutions to a problem (Cutrona et al. 1990). Tangible aid includes financial assistance, or transportation. Esteem support is defined as bolstering a person's self-confidence or personal competence. Esteem support includes positive feedback about skills or ability to deal with a crisis. Network support is that support which makes one feel part of a group where members share similar interests. Finally, Emotional Support includes expressions of caring or attachment. Attachments are expressions (verbal or non verbal) of caring sympathy and concern. Behaviors listed by Cutrona et al. (1990) as emotional support were physical affection, listening, encouragement, prayer, sympathy, and confidentiality. Categorizations made by Cutrona et al. were similar to the categories developed in our analysis. For comparative purposes, the responses made by our mental health clients were then categorized within the categories.
Emotional support. The first category shared in Cutrona’s analysis and our analysis is emotional support. In this study of mental health clients, respondents were asked how they wanted to be helped by their family and friends when they were having problems or were in crisis. Twenty-one of forty respondents at time 1 (52%) use the word listen in their response. Many of the respondents qualified their answer in some manner. Nine of the 21 clients who want to be listened to also want advice. These nine clients qualified their answers with comments such as, "listen and give advice if I’m asking for it, or "listen and give advice and be empathetic." Others provide comments more specific to listening behavior by remarking, "Listen and understand. A more expanded comment was to "listen and not interrupt. I’d like people to not bother me with little things when I’ve got a problem. Its nice for them to listen and not interrupt. Other than that, there’s not much they can do." True listening is defined as "just listening. (They) don’t need a response. Just listen. If they have feedback that’s good. I’ve got deep seated old issues. If I talk, they feel they need a response. They can’t. I just want them to listen. I think people just don’t get it. They become self involved. I was brought up to listen. Its something I do."

Instrumental support. Of the 40 clients interviewed at intake to the mental health system, 5 (12%) list supportive interventions that are classified as instrumental support.
Only three respondents indicate loans or financial help as their primary response. As one respondent explained, "I get money, rental subsidy and food stamps but no cash. They give me money for incidentals." Another very directly stated, "Depends on what it is. Money or finances or something like that. Talk or help do a chore or something like that."

Clarification and objective advice are also expressions of instrumental support. Clarification and objectivity are defined by a clients as, "I want them to be supportive but don’t patronize me. Don’t show me. I want their opinion. Let me know if I’m heading in the right direction. You might not be all wrong. So you don’t start second guessing yourself or everyone’s out to get you." Or as another explained, "I want them to be honest. Am I seeing the situation clearly. (They) can be objective. Another person can give their opinion. My friends are honest. My family can’t be as objective. I broke up with my boyfriend. My family didn’t like him and they couldn’t be objective. My friends can be objective."

Esteem Support. Seven percent of the respondents list esteem support as a sought after supportive intervention. In response to how they want to be supported, this group responded as follows: "Support-emotional support. Belief in you as an individual. (They can) give you emotional support by complimenting you on what you have done. Belief or accepting your motives or life." Another respondent wanted a validation of her decisions. She explained, "Supportive. I
guess in whatever decision I make."

**Network presence.** Cutrona et al. developed a category titled network presence. They defined this category as feeling like one is part of a group with similar interests. The definition of network presence is similar to our definition of intimate talking. Intimate talking requires the availability of others. Others will allow the respondent to engage in intimate talking, because they care for that person. Intimate talking infers that integration into a group has occurred, and that personal relationships have developed. If these two definitions can be stretched to accommodate each other, then 25% of the responses of our mental health clients could be categorized as network support. For comparative purposes, the two definitions will be equated.

**Comparing Mental Health Clients And Nonclients On Support Dimensions**

Cutrona et al. (1990) developed a list of 33 support behaviors. They wrote detailed descriptions for each behavior and then conducted a study of dyadic interaction using the coding scheme. Thirty-two undergraduate psychology students ranging in age from 18 to 20 years, made up their sample. Subjects came to the laboratory in pairs. One student in each pair was randomly assigned the helper role and the other subject was instructed to disclose a stressful experience that had occurred in her life within the previous six months. The helper was given instructions to
make the self-discloser feel as comfortable as possible. Each interaction lasted 10 minutes and was videotaped. The videotapes were reviewed and coded by independent raters (two). The raters used the 33 category behavior rating code.

Following their supportive interaction, the subjects completed a questionnaire assessing their perceptions of the interaction (Cutrona et al. 1990). Using the same qualitative rating scale, two independent raters also reviewed the performance of each subject in the helper role. As a result, each supportive interaction had the support behaviors coded from four perspectives. In addition, the subjective supportiveness ratings also included four perspectives. These perspectives were: recipient, provider, and two independent raters.

Two hundred and fifty-eight support behaviors were coded in the Cutrona et al. study. These behaviors were compared in table 4-1 to replies made by the mental health outpatient clients interviewed in this study. Our clients were asked, "How do you want to be helped when you have problems or a crisis?" The mental health clients responded with 71 different behaviors. While it is obvious that the two studies and samples are different, they allow a general comparison of the social support provided by others and the social support requested by support seekers. For purposes of this table 4.1, percentages were calculated using a base of 258 (the total number of behaviors reported) for the Cutrona sample and 71 for the mental health outpatient sample. Table
4.1 compares the results of the two samples on both grouped responses and most frequent individual support behaviors.

As illustrated in Table 4.1, the predominant support intervention provided by psychology students is information support (64% of all behaviors). The requested support behavior by mental health clients reporting in this research is emotional support. Emotional support is (40%) of all requested support behaviors. Looking at individual support behaviors, 35% of all behaviors provided by students were suggestions/advice or opinions. Those same behaviors are requested by mental health clients only 17% of the time. Suggestions and advice and opinions are delivered by helper students with twice the frequency to distressed students as mental health clients indicated they want when in crisis.

These differences are consistent with research on support provision. La Gaipa (1990) writes that behaviors intended to be supportive may be seen as helpful by the recipient if provided at the right time, but are seen as unhelpful if provided at the wrong time. The most important help in the early stages of illness (at diagnosis or soon after) is emotional support. La Gaipa (1990) defines emotional support as simply allowing the patient the opportunity to express feelings (listening). Dunkel-Schetter and Wortman (1981) show how recently diagnosed cancer patients did not want advice or to be told they would be okay (La Gaipa 1990). Chesler and Barbarin (1984) describe how matching support to the true needs of a person is often
Table 4.1 Comparing The Support Behaviors Provided By College Undergraduates With Behaviors Preferred By Mental Health Patients.

<table>
<thead>
<tr>
<th>Support Behavior Groupings</th>
<th>Per Cent of Total Behaviors</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Psychology Students</td>
<td>Mental Health Clients</td>
</tr>
<tr>
<td>Information Support</td>
<td>64%</td>
<td>21%</td>
</tr>
<tr>
<td>Emotional Support</td>
<td>21</td>
<td>40</td>
</tr>
<tr>
<td>Esteem Support</td>
<td>15</td>
<td>9</td>
</tr>
<tr>
<td>Tangible Aid</td>
<td>.4</td>
<td>9</td>
</tr>
<tr>
<td>Network Support</td>
<td>0</td>
<td>21</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
<td>100</td>
</tr>
</tbody>
</table>

Most Frequent Support Behaviors

<table>
<thead>
<tr>
<th></th>
<th>Psychology Students</th>
<th>Mental Health Clients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suggestion/Advice/Opinions</td>
<td>35%</td>
<td>17%</td>
</tr>
<tr>
<td>Clarification</td>
<td>21</td>
<td>3</td>
</tr>
<tr>
<td>Understanding</td>
<td>18</td>
<td>8</td>
</tr>
<tr>
<td>Validation</td>
<td>10</td>
<td>1</td>
</tr>
<tr>
<td>Listen</td>
<td>*</td>
<td>25</td>
</tr>
<tr>
<td>Talk</td>
<td>*</td>
<td>14</td>
</tr>
</tbody>
</table>

Notes:* Data not available
ineffective in real life. As an example, they describe how inappropriate support is provided by members of cancer patients' support network because they have no experience with this crisis. Their attempts at being helpful are usually strained and clumsy (La Gaipa 1990).

There has been limited research investigating the kinds of advice that is most appropriate for people with different kinds of problems (La Gaipa 1990). La Gaipa and Klein (1984) studied advice giving using vignettes. They found that the most effective advice was that in which the advice giver emphasized that the support seeker was not responsible for the problem. (This support is termed 'relief of blame' by Cutrona et al. 1990 and is categorized as Esteem Support. It is not considered advice giving in our definition.)

According to La Gaipa (1990), advice is usually rejected by recipients. Most of the time the recipients are not really interested in solving the problem. In most instances, the advice is usually bad, premature and not adequate (La Gaipa 1990). In fact, "advice is often given without an adequate assessment of the problem and may be strikingly inappropriate and unappreciated" (La Gaipa 1990:125).

Mental Health clients are very specific about their views on listening and advice giving. First and foremost, there is a definite need on the part of mental health patients for supporters who will take the time to listen to the patients. The listeners have to be accepting and respectful of the patient's autonomy. Advice giving has its
place, but it is not the preferred form of support.

The data presented in table 4.1 were from a study conducted by Cutrona et al. (1990) in a laboratory setting. Each experimental setting required one student to present a real, stressful experience to another student (usually a stranger). The supporter students' job was to provide support to the recipient student around that student's real life stressful experience. As described above, the types of support provided was coded. These codes were correlated with recipient perceptions of supporter student helpfulness. Information support, Esteem support and emotional support behaviors provided by student supporters had correlations ranging from .04 to .20 with perceptions of helpfulness. None of the correlations were significant. Cutrona et al. (1990) explain that ten minute interactions between strangers is not an appropriate context to study support. In fact, Cutrona et al. are correct. For Intimate Talking to take place, one must have a sense of attachment or integration in a family or friendship group. Within such a group, personal relationships develop. These relationships foster a perception that one is loved and cared for. They indicate that there are individuals available to talk to (intimate talking) about personal issues. When individuals in need of support have the perception that they have significant others who care about them and are available for help in times of crisis, they (support seekers) will be open about the problems they are encountering. These candid
presentations will lead to a sense of being socially supported. For many mental health outpatients, just having someone listen to their issues provides a sense of emotional support. Figure 4.1 depicts the model of support provision as described above.

**Testing The Model**

In figure 4.1, a model of social support provision is presented. Some of the relationships are compared to similar findings by other researchers (Cutrona et al. 1990). To further explore the relationships hypothesized in this model, the path coefficients between the variables in figure 4-1 were calculated. The data on social support presented in Chapter 3 was used for the calculations. The reader must be mindful of the limitations of the sample discussed in Chapter 2. Generalizations of the results to mental health populations is tentative at best due to the limitations of the sample. While the actual path coefficients between the variables in the model do not indicate causal direction, they do lend support for the hypothesized time order between variables (see figure 4-2). The same variables were examined at time 1 and time 2.

Social integration was measured using the H.I.E. measures of social contacts, group participation and overall social well-being (an index of social integration). Personal relationships were not specifically measured in this study. However, a variable was constructed using the multiplexity of a network (the number of individuals sought out by the
I. Contacts With Friends
   Group Participation -----> Attachments to Others
   Marriage

II. Attachments indicate Social Integration

III. Social Integration -----> Personal----------> Intimate
     Relationships 
     Talking

IV. Intimate Talking includes The Availability Of Others
     And a Feeling of Being Loved And Cared For

V. Availability Of Others and The Feeling of Being Loved
     And Cared For Are the Main Factors Of The
     Perception Of Being Supported By Others

VI. Perception ---> Candid presentation------> Social Support
     of Social of problems or crisis Responses
     Support

     = emotional support
     = information support

VII. Social Support can be equal to
     Responses
     = esteem support
     = tangible aid
     = network support

Figure 4.1 Model of Support Provision
support seekers for talking in three of the six areas of life stress.), and the helpfulness of the network. The interaction of multiplexity and helpfulness would be an indication of close, personal relationships. To construct the variable of personal relationships, the multiplexity score for each subject was multiplied by their helpfulness score.

Two factor weighted indices were constructed to measure the autonomy and acceptance. The items for these were taken from individual questions asked on the four measures of social support. For example, one question on the H.I.E. social integration scale asks "How many close friends do you have—people you feel at ease with and can talk about what is on your mind?" This question was used as an indicator of acceptance. An indicator of autonomy was a question on the Instrumental/Expressive support scale that asked, "Do you have problems feeling too controlled by others?" The items used for the acceptance variable composed of components labeled acceptance, intimate talk, loneliness and availability. The first factor, acceptance, explained 35% of the variance. The remaining factors, intimate talk, loneliness, and availability explained 13, 12 and 10 percent of the variance collectively.

The variables of perception of social support and support response were measured using the Shortened Kaplan Scale. The Instrumental/Expressive social support scale measured social support response (see Chapter 3).
Figure 4.2 diagrams the relationships between the variables in the social support provision model at time 1. The three dimensions of social integration have significant path coefficients with the variable describing personal relationships. The coefficients for group participation and social contacts are negatively associated with personal relationships and the overall social well-being index has a positive association. In Chapter 3, it is argued that the social contacts variable (a measure of frequency of contacts with family and friends) represented support seeking by clients in crisis. The contacts are not thought to be spontaneous and for leisure. If social contacts are actually a measure of spontaneous contacts for leisure, the path coefficient is expected to be positive. In this case the path coefficient is negative. This indicates that the fewer the social contacts, the greater the helpfulness. In other words, the less a patient is attempting to seek support, the more stronger the personal relationships. This relationship supports our view that for patients in this study, social contacts represents patients searching for support.

The path coefficients between perception of social support and personal relationships is significant. The relationship between autonomy and acceptance with perception of social support was calculated with path coefficients.
Figure 4.2 Support Provision Model: Time 1 Variables

Note: Nonsignificant paths omitted.

(N=35)
Autonomy is significantly related to perception of support. The acceptance variable does not have a significant path coefficient.

Finally, the perception of support has a significant path coefficient with social support provision. The model being tested simply states that one must first have attachments or contact with social groups for social support to be possible. Through attachments with social groups, personal relationships with others are formed. Personal relationships provide the availability of support and the sense of being cared for. Availability and the sense of being cared for is important for acceptance. Acceptance of the support recipient's thoughts and deeds as well as a respect for their independent judgment should foster a perception of being supported. This leads the support recipient to strategies of support seeking that are open. Open strategies foster support giving.

The data presented in figure 4.2 suggest that at time 1, this argument is reasonable. However, at time 2, some important changes occur.

The Model At Time 2

At the time of the second interview, some changes in the relationships between variables in the model occur (see figure 4-3). The first change from time 1 to time 2 is the change in sign of the group participation measure of social integration. As stated in Chapter 3 and again in this chapter, therapists recommend that their patients
Figure 4.3 Support Provision Model: Time 2 Variables
Note: Nonsignificant paths omitted.
(N=27).
participate in groups. For patients, attending groups provides them with access to others who are experiencing similar problems. More importantly, access to other group members provides the opportunity of meeting others.

A social integration variable that did not change from time 1 to time 2 was the social contacts variable. Again, the relationship between social contacts and personal relationships is interpreted as a measure of support seeking for those in crisis. The more one seeks support, the fewer are the personal relations available to the support seeker.

Marital status provides an unexpected finding. This variable is unrelated to personal relationships at time 1. At time 2, the path coefficient between marital status and personal relationships is -.29 p=.07. Many of the individuals coming to therapy are divorced or separated. Many recently left spouses or broke off relationships. One interpretation is that those who are divorced or separated after spending time in therapy had better personal relationships. In fact many did. For some patients who entered therapy with marital or relationship problems, there were improvements in their relations with their former spouses or significant others. These improvements came after joining the groups recommended by the therapists, or through help provided by the therapist or through efforts made by the patients themselves (see Chapter 6).

A significant change in the relationships model from time 1 to time 2 occurs between personal relationships and
perception of support. Personal relationships have a path coefficient equal to .00 with perception of social support. However, personal relationships are correlated with perception at time 2 (r=.43, p=.01). Personal relationships are also correlated significantly with autonomy and acceptance at time 2. As a result, the path analysis procedure considers the intercorrelations between variables thereby reducing the effect of personal relationships on perception of support.

At time 1, personal relationships significantly influenced patient’s perception of social support. At time 2, acceptance of the patient by others is more influential on patient’s perception of social support. This change may reflect the patient’s improving their sense of self-esteem and personal confidence after time in therapy.

Finally, the path coefficients from perception of support to support response are all significant except for demands, an instrumental support dimension. The path coefficient between perception of support and financial support is the largest path coefficient at time 2. At time 1, the path between perception of support and financial help had the lowest coefficient. At time 2, not only does perception of social support lead to improved social support (as depicted in our model), but it also leads to a different type of social support. The support received by clients at time 1 was communication with others. At time 2, communication was an important support, but financial
Support was an outcome of the changes in contacts, relationships and improved perception of support.

**Summary**

In this chapter a model of how to provide social support is hypothesized. The model is based on interview data collected at two time points. The subjects of the interview are outpatient mental health clients.

This model was developed when a peculiar change in the relationship between two variables was noted in Chapter 3. The relationship of note was the relationship between group participation and social networks at time 1 and time 2. The correlation between the social integration variable, group participation and the social network variables, network size and multiplexity, increased dramatically. From interviews with mental health therapists and the patients themselves, it was learned that participation in therapy groups or support groups is recommended for many patients. Patients find the group experience helpful. They are put in contact with others who are experiencing similar problems. The sharing of experiences between patients leads to the formation of friendships. For example, one alcoholic in a group home for recovering alcoholics explains that he and his roommate are "stuffers". He means that he and his roommate do not have a tendency to express their feelings. His roommate will sit down with him at 2:00 AM on any given day if he needs to talk to him. He later expressed sadness when his roommate had to leave the program.
These findings indicate there is a time order between social integration variables and social network variables. Attachments to groups or families of friends must first occur to establish contact with others. Through regular contact and the sharing of experiences (social network formation) personal relationships are developed.

Personal relationships are necessary for social support to be effective. Support seekers usually search out close friends who will be receptive to their problems or crises. Support seekers try to avoid risk when seeking social support. An often mentioned risk is leaving a negative impression with the supporter. If the support giver is not a close friend or is thought to be nonreceptive, then the support seeker will employ strategies and tactics aimed at not leaving a negative impression. These strategies and tactics avoid the disclosure of the problem or crisis at hand and lead to unsatisfactory or unwanted types of social support. The support seeker must have the perception that the support giver will be available when needed to discuss personal issues. The support giver must also project that or she cares for and values the support seeker. Support seekers need to feel that they are accepted and not judged negatively by the support givers.

There are many types of social support that can be provided. Advice is often provided by supporters, but is usually unwanted by support seekers. The patients interviewed in this research stressed that supporters need
only listen to them. If supporters feel they have to offer feedback or advice, support seekers did not want future support held hostage to their acceptance or following of the advice given. If support seekers perceive that their autonomy is in jeopardy, then the support received will not be sought or not be considered helpful.

These findings were highlighted in an experiment conducted by Cutrona et al. (1990). They found that students tend to offer advice to the support seeker. The support seeker presented to the student, unknown to the support giver before the experiment, a true personal problem. When the support behaviors of the students were compared to the types of support sought by the mental health patients, there are important differences. The mental health outpatients want others to listen. The student support givers frequently offered advice. The students seeking support generally feel that the support was unhelpful.

It was concluded that the support the students received was unhelpful not only because it was the wrong type of support but the support was provided by the wrong individuals. Strangers are not the supporters of choice. A personal relationship is needed between the support seeker and the support provider.

Two forms of support were prominent in our study. Communication (someone to listen) with others was important to the clients we studied, especially at time 1. At time 2, communication again was important, but help with finances
was more important to clients. It seems that at the time of the initial interviews, someone is needed by the patients to talk to about their problems. After they talk about their problems, patients need to confront other problems of living: finding a job and earning enough money to meet important needs.
CHAPTER 5

THE RELATIONSHIP OF SOCIAL SUPPORT AND PSYCHOLOGICAL DISTRESS: BEFORE AND AFTER THERAPEUTIC INTERVENTION

Introduction

In previous chapters, the focus of the analysis has concentrated on the interrelationships of the different measures of social support, and how these measures relate to each other over time. Each measure has had at least one dimension that has shown significant change from time 1 to time 2. For example, the group participation dimension of the social integration variable increased significantly from the first interview to the second interview. The number of multiplex relationships within respondents' social networks increased between the two administrations of the questionnaire. Communication with others (someone to talk to and who will listen to respondents' problems) improved significantly from time 1 to time 2. Finally, the perception of social support improved dramatically from time 1 to time 2.

The focus of this chapter will be on three comparisons. The first comparison will concentrate on the relationship between social support and psychological distress at admission to therapy, and at three months after admission. In addition, how social support and psychological health
status vary together over time will also be examined.

The second focus will be aimed at an important relationship between social support and psychological distress. Earlier, a distinction was made between the buffering hypothesis and the main effects hypothesis. Briefly, the buffering hypothesis states that social support has an effect on health when stress is high. When stress is low, social support has no affect on health. The main effects hypothesis argues that social support has a direct relation to one's health regardless of stress levels. In this chapter the difference scores for all the social support variables and psychological well-being were calculated (time 2 scores minus time 1 scores). Once the difference scores were obtained, the correlation coefficients between the difference scores of the social support variables and psychological distress were examined. If social support has a main effect on psychological health, then the changes in the variables measuring social support should correlate with changes in psychological well-being.

The third area of concentration examines the causal relation between psychological health and social support. In Chapter 3, it was shown that psychological well-being improves significantly after admission to therapy. There are also important improvements in social support shown. It is important to determine if improvements in psychological well-being and social support are independent of each other or if changes in support affect changes in psychological
status or vice versa. In this chapter, the causal relationship between psychological status and social support is investigated.

**The Relationship Between Psychological Distress and Social Support At Two Time Points**

Table 5.1 presents the correlations between social support and psychological distress at time 1 (intake to therapy) and time 2 (three months following intake to therapy). Of the 12 variables measuring different dimensions of social support, all but two have a relationship with psychological distress. The two support variables with limited relationship to psychological health are network helpfulness and group participation at time 1. Communication, a dimension of instrumental/expressive support has the largest correlation coefficient ($r=.40$, $P=.01$) at time 1.

For this analysis, the relationship of the social support variables to psychological health were examined for spuriousness by controlling for socioeconomic status (an index combining the income, education level and occupation of respondents). The examinations were performed by developing a multiple regression equation with psychological health as the dependent variable and socioeconomic status and a support variable as the independent variables. The standardized regression coefficients from the multiple regression equations were then examined for differences from the values listed in table 5-1. Only the relationship
between group participation and psychological status at time 2 was affected by the introduction of socioeconomic status.

The group participation variable was examined for spuriousness differently than the other variables. Our group participation variable has a nonlinear distribution. To examine this variable's relationship to psychological status, group participation was correlated with psychological status controlling for high and low socioeconomic status. Spearman's Rho was the statistic used.

Social Contacts. In Chapter 3, it was argued that social contacts for mental health clients differ from the social contacts of nonpatients. It was hypothesized that the nonpatient sample's social contacts are focused on companionship activities. These activities are sought for purely pleasure and shared leisure activities. For the mental health sample, social contacts are being made for help seeking. Rook (1990) likened the contacts aimed at companionship activities to the main effects hypothesis. She states that companionship is related directly to psychological health. Contacts that focused on help seeking are indirectly related to psychological health or are buffers against stress. In table 5-1, the social contacts variable of the H.I.E. Social Health Battery shows a correlation of \( r = .18, p = .14 \) with psychological health. Assuming stress is high at intake, a relationship between social contacts and psychological distress is expected. Three months after intake to therapy, and assuming that the
stress has been reduced, a lower correlation between social contacts and psychological distress is hypothesized. As shown in table 5-1, the correlation coefficient between social contacts and psychological distress is reduced significantly. This lends some support to the argument made in Chapter 3 that the frequency of contact with friends and relatives in the nonpatient sample (while similar in frequency to the mental health group studied in this research) differ in reason for contact. The nonpatient sample is enjoying friendships and family contacts at time 1. The mental health group is in crisis and is seeking help at time 1.

**Group Participation.** In tables 3-4 and 3-5, Group participation increases significantly from time 1 to time 2. It increases because therapists involved patients in group experiences. Before entering therapy, patients do not differ significantly in group participation from the nonpatient sample reported by Donald and Ware (1982). One reason for the change in group participation by the patient sample is presented by Fisher et al. 1988. Fisher et al. (1988) explain that many professionals use support groups as an adjunct to therapy (such as the use of Alcoholics Anonymous). As an illustration, Fisher et al. interviewed individuals who had been in a large group training program (the Forum). The participants told investigators that their therapist had recommended their enrollment in the group. In fact Fisher et al. (1988) found that 33% of those joining
self help groups did so based on recommendations made by therapists.

Group Participation at time 1 is not significantly correlated with psychological distress. It seems that for many of those in the mental health sample and the nonpatient sample studied by Donald and Ware (1982), group participation is not a valued activity. Fisher et al. (1988) report similar findings. They compared participants in an enhancement group to a demographically matched control group of nongroup participants. They found that group participants are not characterized by weak or dissatisfying relations with their social networks. They differ in their past experience with peer support groups. Group participants have more experience with peer support activities prior to entering the enhancement group than nongroup participants.

After therapists' encouragement, group participation shows a significant increase for our mental health outpatient sample at time 2. In addition, group participation also shows a significant relationship to psychological well-being at time 2. If these group experiences supplement the natural networks of the patients (as hypothesized in the model discussed in Chapter 4 and are supportive, then at time 2, a positive relationship between group participation and psychological health is expected. There is a counter hypothesis. This second hypothesis is that as patients begin to feel better, they go out and make friends. This hypothesis is also consistent
with our findings. Our interview data suggest that once patients form a relationship with the therapist and are trusting of the therapist's recommendations they elect to join a group. The group provides the needed support to improve the patient's mental health status. The relationship between psychological health and group participation is significant for (rho = .47, p = .06) patients categorized as high socioeconomic status. Patients categorized as low socioeconomic status do not show a significant relationship between their time 2 psychological status and their time 2 group participation. This relationship will be further explored in this and the next chapter.

Social Networks. At intake to therapy, the extent of outpatients' networks and the number of multiplex ties are significantly correlated with psychological status. Helpfulness of the network is uncorrelated with health and reciprocity is negatively correlated with psychological health. Three months following intake to therapy, network extent and multiplexity of ties are positively but not as strongly correlated with psychological well-being at time 2. However, network helpfulness is significantly correlated (r = .33, P = .04) with psychological well-being. Reciprocity is both negatively and weakly correlated with psychological health.

In Chapter 3, it is hypothesized that the proportion of reciprocal contacts is an indication that the outpatient group is receiving more support than they were giving. It
has been argued that receiving more social support than one is giving is an indicator of longer term, close relationships (Antonucci and Jackson 1990). For the mental health client, receiving without giving back support may be important for mental health. At time 1, there is a negative relationship between proportion of reciprocal ties and psychological health. This means that at entrance to therapy, those clients who are receiving more support than they are giving had better mental health than those patients who are giving more support than they are receiving. At time 2 the relationship between proportion of reciprocal contacts and psychological distress is much weaker (r=-.09, p=.32) but in the direction hypothesized.

**Instrumental/Expressive Support.** At intake to therapy, two of the four subscales comprising the Instrumental/Expressive measure of social support are significantly correlated with psychological health.

At time 2, all four of the (I/E) subscales (measures of social support response) are significantly correlated with psychological health. These data indicate that the greater the received support at time 2, the greater the psychological well-being. The relationship between received support and psychological well-being strengthened from time 1 to time 2.

**Perception of Support.** The perception of social support is significantly correlated with psychological well-being at time 1 (r=.36, p=.02) and became stronger three months after
Table 5.1 Correlations Of Psychological Distress And Social Support Dimensions At Time 1 And Time 2.

<table>
<thead>
<tr>
<th>Social Support Measure</th>
<th>Psychological Health</th>
<th></th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Time 1</td>
<td>Time 1*</td>
<td>Time 2</td>
</tr>
<tr>
<td>Social Contacts</td>
<td>.18</td>
<td>.19</td>
<td>-.09</td>
</tr>
<tr>
<td></td>
<td>(36)</td>
<td>(27)</td>
<td>(27)</td>
</tr>
<tr>
<td></td>
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<td>.17</td>
<td>p=.32</td>
</tr>
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<td>Group Participation</td>
<td>.09+</td>
<td>-.09+</td>
<td>.35+</td>
</tr>
<tr>
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<td>(27)</td>
<td>(28)</td>
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<tr>
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<td>.19</td>
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<td>(35)</td>
<td>(27)</td>
<td>(27)</td>
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<tr>
<td></td>
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<td>.30</td>
<td>p=.17</td>
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<td>LNetwork Extent</td>
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<td>(27)</td>
<td>(28)</td>
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<td>p=.05</td>
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<td>.32</td>
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<td></td>
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<td>p=.04</td>
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<td>LNumber Of Multiplex Ties</td>
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<td>.11</td>
</tr>
<tr>
<td></td>
<td>(31)</td>
<td>(24)</td>
<td>(28)</td>
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<tr>
<td></td>
<td>p=.09</td>
<td>p=.06</td>
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<td>-.09</td>
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<td></td>
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<td>(27)</td>
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<td></td>
<td>p=.13</td>
<td>p=.33</td>
<td>p=.32</td>
</tr>
<tr>
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<td>.19</td>
<td>.62</td>
</tr>
<tr>
<td></td>
<td>(36)</td>
<td>(27)</td>
<td>(28)</td>
</tr>
<tr>
<td></td>
<td>p=.14</td>
<td>p=.16</td>
<td>p=.00</td>
</tr>
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<td>.16</td>
<td>.44</td>
</tr>
<tr>
<td></td>
<td>(36)</td>
<td>(27)</td>
<td>(28)</td>
</tr>
<tr>
<td></td>
<td>p=.20</td>
<td>p=.21</td>
<td>p=.01</td>
</tr>
<tr>
<td>Control Of Demands</td>
<td>.34</td>
<td>.29</td>
<td>.60</td>
</tr>
<tr>
<td></td>
<td>(36)</td>
<td>(27)</td>
<td>(28)</td>
</tr>
<tr>
<td></td>
<td>p=.02</td>
<td>p=.07</td>
<td>p=.00</td>
</tr>
<tr>
<td>Communication With Others</td>
<td>.40</td>
<td>.43</td>
<td>.58</td>
</tr>
<tr>
<td></td>
<td>(36)</td>
<td>(27)</td>
<td>(28)</td>
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<tr>
<td></td>
<td>p=.01</td>
<td>p=.01</td>
<td>p=.00</td>
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<td>Perception Of Social Support</td>
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<td>.31</td>
<td>.52</td>
</tr>
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<td></td>
<td>(35)</td>
<td>(27)</td>
<td>(28)</td>
</tr>
<tr>
<td></td>
<td>p=.02</td>
<td>p=.06</td>
<td>p=.00</td>
</tr>
</tbody>
</table>

Notes to table 5.1: * Time 1 cases that were retested at Time 2.
+ Spearman’s Rho.
(Two tail test of significance.)
intake to the mental health center ($r=.53$, $p=.00$). These data indicate that the more one has feelings of being loved and respected by an available group of friends and family the greater will be one's psychological well-being.

**Social Support Predictors Of Psychological Health**

At both measurement points, several different dimensions of social support are related to psychological well-being. To further explore the relationship between social support and psychological well-being for the mental health outpatients, a stepwise, multiple regression equation was produced (see table 5.2) for both time points. Each equation was developed using the variables listed in table 5.1. The dependent was psychological health and the independent variables were the various social support measures listed in table 5.1. In addition to these variables, a socioeconomic control variable was included. (No difference in the multiple correlation coefficient was noted by including a measure of socioeconomic status at either time 1 or time 2).

As presented in table 5.2, communication with others is the only variable to enter the stepwise regression for the time 1 variables. The multiple correlation coefficient of .46 between communication and psychological well-being explains 18% of the adjusted variance in psychological well-being.

At time 2, three variables enter the multiple regression equation. They are: Adequacy of Finances,
Table 5.2 Stepwise Multiple Regression Equation: Social Support On Psychological Well-Being At Time 1 And 2

**Time 1**
Dependent Variable: Psychological Well-Being
Variable entered on step number 1: Communication

| Multiple R | .46 |
| R Square   | .21 |
| Adjusted R Square | .18 |
| Standard Error   | .79 |

Analysis of Variance

<table>
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<th></th>
<th>DF</th>
<th>Sum of Squares</th>
<th>Mean Square</th>
</tr>
</thead>
<tbody>
<tr>
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<td>463.94</td>
<td>463.94</td>
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<td>Residual</td>
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<td>1735.56</td>
<td>61.98</td>
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</table>

F = 7.48  Significance of F = .01 (N=30)

Variables in the Equation

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<tr>
<th>Variable</th>
<th>B</th>
<th>SE B</th>
<th>Beta</th>
<th>T</th>
<th>Sig T</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication</td>
<td>1.43</td>
<td>.52</td>
<td>.46</td>
<td>2.74</td>
<td>.01</td>
</tr>
<tr>
<td>(Constant)</td>
<td>12.54</td>
<td>6.00</td>
<td>.46</td>
<td>2.09</td>
<td>.05</td>
</tr>
</tbody>
</table>

**Time 2**
Variables Entered on Steps 1, 2 and 3: Adequacy of Finances, Control of Demands, Network Multiplexity

| Multiple R | .81 |
| R Square   | .66 |
| Adjusted R Square | .62 |
| Standard Error   | 5.51 |

Analysis of Variance

<table>
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<tr>
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<th>DF</th>
<th>Sum of Squares</th>
<th>Mean Square</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regression</td>
<td>3</td>
<td>1380.66</td>
<td>460.22</td>
</tr>
<tr>
<td>Residual</td>
<td>23</td>
<td>698.06</td>
<td>30.35</td>
</tr>
</tbody>
</table>

F = 15.16  Significance of F = .00 (N=27)

Variables in the Equation

<table>
<thead>
<tr>
<th>Variable</th>
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<th>SE B</th>
<th>Beta</th>
<th>T</th>
<th>Sig T</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adequacy of Finances</td>
<td>1.25</td>
<td>.34</td>
<td>.47</td>
<td>3.68</td>
<td>.00</td>
</tr>
<tr>
<td>Control of Demands</td>
<td>1.53</td>
<td>.37</td>
<td>.55</td>
<td>4.11</td>
<td>.00</td>
</tr>
<tr>
<td>Network Multiplexity</td>
<td>9.24</td>
<td>3.85</td>
<td>.30</td>
<td>2.40</td>
<td>.02</td>
</tr>
</tbody>
</table>
Control of Demands, and Number of multiplex relations in one's social network. These three variables are related to psychological well-being with a multiple correlation coefficient of .82 (p=.00). They explain 62% (adjusted) of the variance in psychological well-being. The issues related to psychological well-being differ from time 1. A focus on communication at entrance to therapy changed to a focus on instrumental support and the number of close friends at time 2.

Many of the individuals enter therapy in crisis. Many are recently separated from husbands, family or friends. Others have experienced losses to their social network of significant others and they were in need of someone to hear their concerns and issues. They needed emotional support.

After some time in therapy, the needs of the patient sample changed. Their psychological health is related more to instrumental support—help with money and help with the demands and responsibilities of daily living. An important source of help with instrumental support is the number of close friends in one's network who are very familiar with their personal issues.

Variations In Social Support And Psychological Well-Being Over Time

The literature on social support presents conflicting evidence on the relationship between social support and psychological health. The stress buffering hypothesis states that support is indirectly related to health. When stress is
high, support and health are related. When stress is low, there is no relationship between support and health.

A competing hypothesis, the main effects hypothesis states that support and health are directly related regardless of stress levels. If social support and health are directly related, they should vary together over time. For example, patients coming in to a community mental health center for treatment are expected to have lower levels of health at the beginning of treatment than at the completion of treatment. Likewise, the social support of patients is also expected to be lower than for nonpatients at the beginning of treatment. As the psychological health of patients improves, their social support should also improve.

To investigate this relationship, the difference scores (time 2 scores minus time 1 scores) were calculated for all social support variables and for psychological well being. The difference scores for each social support variable were then correlated with the difference score for psychological well-being. Table 5.3 lists the correlations between social support change scores and changes in psychological well-being. When the difference scores for the social integration variables were correlated with the differences in psychological well-being, social contacts and overall social well-being had little relation to changes in psychological health status. However, in the model of support provision hypothesized in Chapter 4, social integration variables are more important for creating the
### TABLE 5-3 CHANGES IN PSYCHOLOGICAL WELL-BEING AND SOCIAL SUPPORT: DIFFERENCE SCORE CORRELATIONS

<table>
<thead>
<tr>
<th>Social Support Variable</th>
<th>Psychological Well-Being</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Social contacts</td>
<td>-.02</td>
</tr>
<tr>
<td></td>
<td>(25)</td>
</tr>
<tr>
<td></td>
<td>p = .45</td>
</tr>
<tr>
<td>Group Participation</td>
<td>-.22</td>
</tr>
<tr>
<td></td>
<td>(26)</td>
</tr>
<tr>
<td></td>
<td>p = .14</td>
</tr>
<tr>
<td>Social well-being</td>
<td>-.08</td>
</tr>
<tr>
<td></td>
<td>(25)</td>
</tr>
<tr>
<td></td>
<td>p = .34</td>
</tr>
<tr>
<td>LNetwork Extent</td>
<td>.13</td>
</tr>
<tr>
<td></td>
<td>(26)</td>
</tr>
<tr>
<td></td>
<td>p = .26</td>
</tr>
<tr>
<td>Network Helpfulness</td>
<td>.31</td>
</tr>
<tr>
<td></td>
<td>(26)</td>
</tr>
<tr>
<td></td>
<td>p = .06</td>
</tr>
<tr>
<td>LNetwork Multiplexity</td>
<td>.43</td>
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<tr>
<td></td>
<td>(23)</td>
</tr>
<tr>
<td></td>
<td>p = .02</td>
</tr>
<tr>
<td>LProportion of Reciprocal Network Contacts</td>
<td>.08</td>
</tr>
<tr>
<td></td>
<td>(26)</td>
</tr>
<tr>
<td></td>
<td>p = .36</td>
</tr>
<tr>
<td>Adequacy of Finances</td>
<td>-.02</td>
</tr>
<tr>
<td></td>
<td>(26)</td>
</tr>
<tr>
<td></td>
<td>p = .46</td>
</tr>
<tr>
<td>Control of Demands</td>
<td>.57</td>
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<td></td>
<td>(26)</td>
</tr>
<tr>
<td></td>
<td>p = .00</td>
</tr>
<tr>
<td>Communication with Others</td>
<td>.57</td>
</tr>
<tr>
<td></td>
<td>(26)</td>
</tr>
<tr>
<td></td>
<td>p = .00</td>
</tr>
<tr>
<td>Companionship</td>
<td>.48</td>
</tr>
<tr>
<td></td>
<td>(26)</td>
</tr>
<tr>
<td></td>
<td>p = .00</td>
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<tr>
<td>Perception of Social Support</td>
<td>-.28</td>
</tr>
<tr>
<td></td>
<td>(26)</td>
</tr>
<tr>
<td></td>
<td>p = .08</td>
</tr>
</tbody>
</table>

*Notes: Two tailed test of significance.*
context in which social support is provided to a patient by others. It is the support received from close friends that should have a bearing on psychological health status.

The helpfulness of one’s social network and the multiplexity of the network members are significantly related to changes in psychological health. The relationship between the extent of the network and psychological health, although positive, was not significant. Thus, the size of the network was of less consequence than its qualities.

It was argued earlier that small, cohesive networks are important for the provision of social support. Larger networks are more likely to have members who are not supportive. The actual numbers of network members are not as crucial as the multiplexity or the number of close friends and relatives and the feelings of helpfulness of the network.

All components of received support vary significantly with changes in psychological well-being except for adequacy of finances. Changes in adequacy of finances are unrelated to changes in psychological health status. In Chapter 3, adequacy of finances was strongly related ($r=.62$) with psychological health at time 2. At time 1, adequacy of finances is not significantly related to psychological health ($r=.18$, $p=.14$). Adequacy of finances, an instrumental support measure does not vary with changes in mental health over time. However, adequacy of finances does impact psychological health at time 2.
The final correlation represents the relationship of changes in the perception of social support to changes in psychological well-being. Changes in perception of social support are inversely related to changes in health \((r=-.29, p=.08)\). In other words, the smaller the improvement in perception of support, the more the improvement in one’s psychological health.

**Changes In Support Or Changes In Psychological Health: Causal Relations**

The data in table 5.3 show that particular measures of social support and psychological health vary together. What is not shown is the causal relationships between changes in support and changes in health. To investigate the causal relationships, a causal model was constructed for each social support variable. The object of each model was to determine if there was any statistical support for the notion that social support is responsible for improved psychological health. A diagram was drawn for each dimension of social support similar to the diagram in Figure 5.3. Two multiple regression equations were then calculated. The first equation had as the dependent variable, psychological health status at time 2. The independent variables were psychological health status time 1, a social support measure at time 1 and a control variable, socioeconomic status. The second equation had as the dependent variable, a social support measure at time 2. The independent variables were psychological health status at time 1, the social support
measure at time 1 and socioeconomic status. These same two equations were calculated for each social support measure. In all, 24 equations were performed.

Only one of the 24 equations had a significant beta weight between time 1 social support and time 2 psychological health status (or vice versa). This equation shows an impact of social support (financial support) at time 1 on psychological health status at time 2. (see figure 5.1).

It is expected that previous psychological health is correlated with later psychological health. But if earlier social support is equally or more strongly related to psychological health at time 2, then there is a suggestion that social support may be causally related to improved psychological health.

While only one relationship had a significant beta weight coefficient between either psychological health and social support or vice versa, this relationship is very interesting. It was shown earlier that on entering therapy, having a job, or having enough money to meet one’s needs is not significantly related to psychological health (if one is upset over a breakup with a spouse or loved one, having a job will not be as effective as having someone to talk to for psychological status). However, those who had a job or adequate financial help at the beginning of therapy experienced better outcomes after time in therapy.
Figure 5-1. The Impact of Adequacy of Finances On Psychological Health: A Path Model (non significant paths omitted).
SUMMARY

We found that perception of social support, demands and communication with others are related to psychological well-being at time 1. The extent of one’s network and an index of social integration also had influence (or were influenced by) on psychological health. Three months after intake to therapy, the support received from others, the qualities of one’s social network, and the perception that one is supported by others have some bearing on psychological health.

In Chapter 4, a model of social support provision was presented. In this model, the structural variables of social integration and social network were presented as providing the context and opportunities for developing close friendships. Close friendships provide an availability of support and lead to a perception that one is loved and cared for. These perceptions influence the strategy one uses to request support. If the support seekers feel that their close friends accept and support them, they will be open about their needs. The support received will be more helpful with such a strategy, and as the data described above indicate, will be related to improved psychological health.

The proportion of reciprocal contacts was negatively correlated with psychological health at time 1 and weakly correlated at time 2. For the patients coming to therapy, social support is a strong need. In Chapter 3, an analogy was made between reciprocity and a bank. Social support
between friends can be thought of as making deposits to the bank. Withdrawals are made by friends when needed. In times of great stress, like the stress precipitating entrance to therapy, large withdrawals need to be made to restore one's equilibrium. If the withdrawals are greater than what has been deposited, then the support available will not be very helpful.

The types of social support that are related to psychological status differed at time 1 and time 2. At time 1, psychological status is related to the amount of communication the patient had with others.

At time 2, instrumental supports like adequate financial support and control over stresses were significant for improved psychological health outcomes.

In fact, adequacy of finances turned out to be causally related to psychological outcome. Those individuals who enter therapy with fewer financial problems have better psychological outcomes. This raises the question of priority of treatment. Should patients be helped to find jobs and financial assistance, or should they be treated with therapeutic intervention? It seems that help with jobs and finances should be the recommended treatment option.
CHAPTER 6

CLIENT AND THERAPISTS' DESCRIPTIONS OF PROBLEMS, IMPROVEMENTS AND HELPFULNESS OF THERAPY

Introduction

Chapter 5 examined the relationship between social support and psychological distress. Supports received from others were found to be significantly correlated with psychological well-being, and changes in received social support was found to vary over time with changes in psychological well-being. This chapter reports on the changes in relationships that may have contributed to the improved support from others. The data were collected by interviewing clients before and after therapeutic intervention. Examining client reports of the changes in relationships over the course of therapy may provide some insight into the kinds of changes that occurred, their personal meaning for the clients and their consequences as the clients saw them.

Not only is it important to understand the client’s view of changes in the support system, it is equally important to understand the therapist’s view of the client’s problems. The therapist’s assessment of the client’s difficulties will determine the treatment strategy employed by the therapist, as well as the differences and
similarities in the views of the therapists and clients around therapeutic intervention.

Clients were asked to present their opinions of the effectiveness of the therapeutic intervention they received. Therapists, during their interviews, reported on the progress or lack of progress the client made during the course of treatment. Comparisons of the client’s and therapist’s comments about the reasons for entering therapy were analyzed. In addition, the changes that took place over the course of therapy as reported by therapists and clients were also examined. These comparisons provide some insight into the workings of the formal and informal systems of support around patients. To further understand the workings of the formal system of support, therapists were asked two questions. The first question asked, "How do strategies of psychotherapists implicitly or explicitly impact on the social support of the patient?" The second question focused more directly on the therapist’s strategy. It asks, "Are changes in patient’s social support during psychotherapy the result of a planned psychotherapeutic intervention strategy?"

To answer these questions, therapists were asked to describe their theoretical orientation. Their orientation could presumably will provide an understanding of the framework guiding the therapist’s intervention strategy. The answers to the orientation question were coded. Orientations included approaches dealing with traditional
psychiatric concepts of transference, motivations, and effects of one’s developmental history on current relationships and problems. Other orientations focused on substance abuse treatment. Substance abuse orientations were concerned with abstinence, support groups like Alcoholics Anonymous, and/or full disclosure of addictive behaviors.

Another class of treatment reported was Systems therapy. Systems therapy was described as treating the individual as part of a larger whole. In systems therapy, there is a focus on couples and marital therapy and the interaction with significant others. It also focuses on how those interactions affect the client and how the client affects others. Once the different orientations were coded, the orientations were ordered on a scale. Orientations that focused on intrapsychic issues of motivations, transference and developmental history were at one end of the scale. Orientations that focused on relationships with others were at the opposite end of the scale. A number was attached to each orientation. This allowed some statistical comparisons to be made using ordinal level statistics. For example, at the end of the scale focusing on intrapsychic orientations was the orientation "psychodynamic-developmentalist". This orientation was coded (-3). At the opposite end of the scale focusing on relationship changes was "family systems" which was coded (+2).

After therapists explained their orientation, they were asked to report on the specific strategy they used in
treating the client. Three general strategies seemed to emerge. The first strategy focuses on psychological approaches concerned with issues arising during childhood. Again, therapist strategies were numbered on an a scale ranging from -1 to +1. Psychological approaches were numbered -1. A second approach targeted relationship changes as the focus of therapy. Relationship change strategies were numbered +1. The final category was described as engagement. Engagement is the process of helping the client determine why he or she is in therapy and if therapy is the right place for the client. Engagement was numbered (0).

Understanding which therapeutic orientations and approaches have a greater impact is important not only for treatment considerations, but also for social policy considerations. If an orientation or strategy of a therapist affects social support, then understanding how a particular approach differs from other strategies will improve our understanding of the social support process.

The chapter begins by describing changes in relationships reported by clients prior to entering therapy. The changes reported by clients were compared with therapist’s assessments of the issues facing clients upon entering therapy.

Client reports of changes in relationships that occur over the course of therapy were examined. Their descriptions of relationship changes were then followed by a series of tables that were developed from coded interview data. These
tables reflect 1) differences in client and therapist assessment of outcome, 2) client reports of the affect of therapy on changes in supports 3) therapists reports of orientations and strategies and how the orientations and strategies are related to changes in social support and psychological well-being.

**Entering Therapy Or Purchasing Friendship**

There are many reasons for seeking mental health care. Researchers have reported class differences in help seeking. For example, Myers and Roberts (1967) report that individuals in lower classes seek medical attention only when they are seriously ill or injured. These individuals saw little value in treatment for minor sicknesses and had little understanding about psychotherapy. For many, "mental illness was 'craziness', or 'insanity' or the like, not sickness" (Myers and Roberts 1967:204). The patients from higher social classes showed a more favorable attitude toward medicine and psychiatry than the lower class patient.

Patients who had a strong support group were quicker to enter mental hospital care than those with more limited support (Perucci and Targ 1988). The high support group was also more quickly discharged because they had family and friends to return to who could provide care.

Individuals who are in distress have to make choices about how to cope with their problems. Fisher et al. (1988) discuss three alternatives: self help, seek social support from friends and relatives or seek professional help or help
from individuals in self help groups. Self help involves solitary effort. It also precludes the actual receipt of instrumental and emotional supports that are the benefits of a supportive network. Network members can provide help and give emotional and instrumental assistance, but do not have the specialized professional training often needed (Fisher et al. 1988).

Many of the individuals coming to the mental health center experienced recent disruptions in their social supports. Eighty-two percent of the admissions to the mental health center revealed the loss of spouse, loss of job or family problems occurred just before their intake interview.

Veroff et al. (1981) found that friends and neighbors are chosen for support only when the issue is not particularly serious and is related to everyday problems. Family members are chosen more when the issues are considered serious and especially if they include financial issues. Croog et al. (1981) report that individuals outside of family and in formal organizations are only considered supplements to family rather than substitutes for family in matters of social support. Other individuals and groups are only sought after family members are found not to be accessible.

Professional resources are much different than network and peer supports. Professionals remain in nonreciprocal relationships with the patient. They are not peers and seldom become members of the help seeker’s support network
Professionals tend to espouse values that represent society at large due their position in their communities. Licensing of these professionals, which includes certain minimums regarding credentials, tends to align the professional's values and philosophy with the licensing agency which is usually a professional discipline or state. As a result, professionals are more often likely to engage in controlling deviant behavior rather than providing acceptance and autonomy.

**Changes In Relationships**

Many of the clients coming to treatment at the mental health center have pressing personal problems. Most have difficulty in their interpersonal relationships. They seemed to draw away from group activity to more isolated activity. Table 6.1 presents the changes in relationships listed by patients at intake to outpatient therapy.

As indicated in Table 6.1, 35% of the respondents indicate that just prior to entering therapy they have experienced divorce, separation, or the death of a close friend or relative. Job loss and changes in close relationships such as estrangement from a close friend or family member accounted for 47% of the changes reported by respondents. Fifteen percent reveal they have a chronic illness or previous diagnosed mental illness that affects their relationships with others. Eighty-five percent report their marital status as divorced, separated or single. In
Table 6.1  Patient Problems At Beginning Of Therapy: The Client And The Therapist View

<table>
<thead>
<tr>
<th>Loss/Change Category</th>
<th>Percent Therapist</th>
<th>Percent Client</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Change</td>
<td>0.0</td>
<td>2.5</td>
</tr>
<tr>
<td>Divorce/Death/Separation</td>
<td>9.7</td>
<td>35.0</td>
</tr>
<tr>
<td>Job Loss</td>
<td>12.9</td>
<td>10.0</td>
</tr>
<tr>
<td>Relationship Changes</td>
<td>25.8</td>
<td>37.5</td>
</tr>
<tr>
<td>Chronic Conditions</td>
<td>35.5</td>
<td>10.0</td>
</tr>
<tr>
<td>Psychiatric Problem</td>
<td>16.1</td>
<td>5.0</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>100.0</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>
all, 82% of the respondents report significant changes in their relationships with others prior to therapy.

**Divorce, Separation, Breakup or Death**

Changes in relationships for new psychiatric outpatients vary from recent separation from a spouse or the breakup with a girlfriend or boyfriend to multiple relationship changes. For example, one individual explained that "My brother moved to Nevada. I separated from Susan. I separated from my mother who has control issues especially enabling issues." Another patient explained that "Yes, my wife and I are separated. The divorce is pending. I lost my brother-in-law, grandmother and uncle through death. All in the past month."

A number of respondents answered the question about changes in relationships with direct presentations about breakups or divorces or separations. When the therapists and family members of patients could be interviewed, they added more details to some of the responses made by patients. Some examples are 1) A young college student stated she had broken up with her boyfriend. She felt her parents were not supportive because they did not like her boyfriend and did not understand how she felt. However, her therapist added "Her primary problem is bulimia. She may have (a) substance abuse (problem)... several years ago she was in treatment for family problems. She was eating and purging (then) but didn’t tell her therapist....After the first time in therapy she came back and was drinking, but she didn’t want to deal
with the bulimia... (she's coming to therapy now) because she's scared. She vomited blood during the summer. Her doctor told her that it is very bad when that happens. However, she did not do anything until the intake date. Her fear of daily bulimia, her ex boyfriend's threatening to kill himself and her school work was very difficult to keep up with." In addition the therapist added "mother is very controlling. Father is very critical. Mother paid her rent recently. Mother balances her check book. She can't ever please her father."  2) Another participant stated flatly that there were no changes in relationships prior to entering therapy. However, her sister reported that she was concerned about her sister's safety. The patient's sister explained "she goes to violent family members (previous boyfriends or husband) then to another and back to the first violent family member. She won't tell me about going back to a violent family member... violent relationships make her leave town and then she needs to break off therapy... She was seeing a psychiatrist to deal with anxiety, bulimia and alcoholism."

**Relationship Changes**

Divorce, separations, breakups and death point to actual physical separations or loss of contact with a member of one's family or friend or coworker. A second category, Relationship Changes refers to a weakening of relationships or estrangement between family members or very close friends, but not an actual separation.
An example of an estrangement is given by a woman who was pregnant and who had recently placed her daughter in a group home. The client described changes with family and friends before entering therapy by saying "I will (have changes), (but with) close friends, no. I will have a change in my family. I'm expecting a baby." She added, "I was in family counseling for six months. I was at the mental health center for 2 or 3 months (she attended another agency for the initial three months of her therapy). I left family counseling because it was court ordered. I left when the order was up. Then I came to (the mental health center used for this study)... My parents are not speaking to me because when I had trouble with my oldest daughter and I placed her in a group home, they thought I made the wrong decision.

Similarly, an elderly mother described how her daughter "wrote a note that (has) been distressing me terribly. She seems much happier. We are still not talking. I'm going to mental health to try to resolve the note she wrote. She won't talk with me. The conversation is one sided. She won't talk."

A young man was unable to discuss the changes in his family relationships. His therapist divulged that his wife was mentally ill. He was seeking custody of his children and wanted to present to the court his ability to care for them.

For many people, relationship problems involved more than one network member. An older mother living in a housing project explained to me that "one boy (her son) can't see
his son due to his drinking problem. I can’t see the
grandchild. I take care of my mother and there has been a
change over time. I’ve been hard with her. I think I’ve
mistreated her. I need her money. We use it to live off."

Job Change

Job changes caused disruptions for 10% of the
respondents. One man described his experience as follows:
"I separated from my wife and left my job. I relocated to
the North Country. I was fired in a dispute after 13 years.
I don’t see a lot of friends I’ve known for a long time. I
see the kids once a week and every other weekend. I’m about
130 miles away."

A house mother at a University stated "I moved
recently. I’ve changed the proximity to people I feel close
to. I came from another state for a job and personal
choice.... There has been a weakening with friends (recently
as a result) but not relatives."

Chronic Conditions

Chronic illnesses are reported by 10% of those seen at
the mental health center. The illness itself was considered
a problem for some of the patients. For others it was an
underlying cause of other problems. Alcoholism was a chief
problem reported by many patients.

Physical Illnesses. As one business owner explained,
"Yes, I sort of divorced my family. I’m no longer involved
with them. It started a couple of years ago. I’ve finalized
it.... I’m backing off. I’m focusing on (me). I was always
there for them before. Sometimes I can’t give a piece of me.” Her therapist added “She admitted problems with too many people when I was treating her. She has chronic scleraderma. It’s a fatal disease. (It has to do with the shrinking of the skin. She uses substances (drugs)).

Alcoholism. A number of individuals sought treatment for alcoholism. For many of these individuals, family and friends were extremely important. At the beginning of treatment one alcoholic stated “It’s very important to have family and friends. I don’t have anyone to relate to. It’s an empty world. I just need people. They are important to the structure of your life.” In another case, a therapist described his encounter with a young alcoholic as originating via a call from the client’s mother. The young man was abusing drugs and alcohol. The mother wanted him to go to a treatment center. The therapist explained, “He had had a stroke at 13. He’s a people pleaser. The strategy was rehab education and support through groups. He went to (rehab facility) for supportive insight therapy. They couldn’t figure out the effects of the stroke on his hypersexuality and conversation ability. They don’t know where he was (on hypersexuality and conversation ability) before the stroke. They need reference points. He needed to learn about how to carry on conversations. I saw the mother also. He left therapy. He needs AA (Alcoholics Anonymous) therapy and rejoining the community. He has a strong relationship with a sponsor. He came back to see the
psychiatrist for deeper therapy. I also would send him around to talk with people about how to talk with other people. He was into sex. He did well with not drinking. Resocialization is very important in alcohol treatment. The trick is to find a way to reorganize his personality rather than focus on not drinking."

Two other individuals being treated for alcoholism initially explained how their social relationships had improved at the time they entered therapy. Both were residents of halfway houses for recovering alcoholics. Both had been hospitalized for detoxification or other serious problems. The social atmosphere of the group home was important to these individuals. They had a sense that others care about them. "Bob, my roommate and I are good together. We’re ‘stuffers. We keep things in. We can draw out from each other." I "moved in with 12 guys in a group home for alcoholics. We work as a family." "In the house just about anybody will sit down and talk...." If I had a problem at 2:00 A.M. they would stay up and talk." Therapy at the mental health center was an additional source of help for the client to deal with other issues. One individual explained how he was reunited with his mother after 10 years. Due to his alcoholism, the mother chose not to see him. Now that he was recovering, she was willing to meet with him, but he needed help from the therapist to have the courage to meet with her.

Chronic Strains. Demographic data indicated that the
majority of individuals participating in the study had economic problems. The strains of daily living manifested in serious anxiety. A women living in a rural town presented that there had been a number of accidents in her neighborhood recently. A young girl was hit by a car. Her son and nephew were in an automobile accident and were in serious condition. Her husband was involved in an accident with his truck and the expense to repair the truck was beyond their budget. As a result, they were financially strapped. She entered therapy because she was having panic attacks. As she explained, "I started being afraid of everything. I have panic attacks... (the therapy is helpful by) just talking to someone. No one else understands it. I'm still working through my fears."

**Psychiatric Problems**

Some of those interviewed had much experience with the mental health system. They suffer from a chronic mental illness. When asked if her family and friends encouraged her to enter therapy, one woman answered, "No. I diagnosed myself. I thought people were doing porno pictures of my family (from out in my yard through the windows). I had guns. I was listening to a CB (radio). I shut it off and I could still hear voices (I checked the plugs and knew it was off). Then they put me in New Hampshire Hospital and then Hampstead Hospital. My mother is up here. I was going through a divorce. I moved this way because people said there was work this way... I need pills to maintain. I'm a
The Therapists' View

Therapists were interviewed three months following a patient's intake to therapy. During the course of the interview, the therapists explained the difficulties clients were experiencing at the beginning of therapy. Table 6-1 lists client issues at the beginning of therapy as described by therapists.

The categories of divorce, death or separation were listed by 35% of the clients coming to therapy as a change in their network just before therapy. Therapist indicated this same category as an issue for therapy for 9.7% of the clients. Similarly, clients expressed psychiatric problems as difficulties prior to therapy 5% of the time as opposed to 16% by therapist description. As an illustration, one elderly woman stated she had come to therapy as a result of a note written to her by her daughter. The note from the daughter accused the mother of not protecting her from an abusing father when she was a child. This note plus the refusal of the daughter to talk (at times) with the mother upset the mother. With her husband's encouragement, the mother sought therapy. The therapist described the situation thus: "Elizabeth had a major depression. She was treated with Prozac. The major focus is her personality. She has a conflict with her daughter. Her daughter accused her (client) of not protecting her from abuse (sexual molestation). She (client) accused her mother of verbal and
physical abuse. Since the client has been in therapy, she has talked about this experience with her husband, close friends and pastor. Others are more open to her. She has an odd personality. She went to the hospital. She brought with her some puppets and talked to the nurse using the puppets. She has a major personality disorder as well as obesity and arthritis. She has a compulsive eating disorder. She will eat an entire stick of butter at a sitting even though her doctor has told her of the very grave result. The Prozac has helped her with her depression, but hasn’t helped her with her eating. She’s now becoming very tired during the day."

A second client indicated that she had recently broken up with her boyfriend. Her therapist explained that she has, "an eating disorder - bulimia is her primary problem. She may have substance abuse. She has a personality disorder. I approached her to try to get her to engage in therapy. She was in treatment several years ago for family problems. She was eating and purging but didn’t tell her therapist. After the first time in therapy, She came back a second time and was drinking, but she didn’t want to deal with the bulimia. She has a new boyfriend but is not telling me... (she continues to come to therapy because) she’s scared. She vomited blood during the summer. Her doctor told her that it is very bad when that happens. However, she did not do anything about it until the intake date. Her fear of daily bulimia, her ex boyfriend threatening to kill himself, and her school work was difficult to keep up with (keeps her
coming to therapy).

Therapist presentations of the reason for therapy and client descriptions of changes in relationships were coded for: losses, changes in relationships and other (psychiatric problems, legal problems or other chronic conditions). When client and therapist descriptions were compared, it was found that clients stated 52% of the time that they had experienced a loss in relationships before therapy. Other problems were evidenced only by 10% of the client population at intake. On the other hand, Therapists list 52% of the time that client's presenting problems were "other" (psychiatric in nature of chronic conditions) or due to losses 23% of the time.

The characterization of problems by professionals and laymen differ. This is to be expected, but there are costs for the difference in terms. One of the costs is the way society thinks about problems and interventions (Vaux 1988). The medicalization of psychology requires that mental illness be found in each individual and insists on one to one therapy and psychotropic medication (Vaux 1988). This approach opposes a competence and well-being model that has as its focus preventive intervention rather than treatment of a developed disorder (Vaux 1988). This focus on a medical view also discourages the use of informal, natural systems. As the previous chapters show, the use of informal systems is related to changes in well-being. Approaches that use supports will enhance the effectiveness of intervention.
**Relationship Changes After Therapy**

Most clients reported changes in close relationships prior to approaching the mental health center. Many of these changes reflect losses of contact with significant others, and most of these changes are termed by stress researchers as life event changes. Life events have been construed as life transitions by Felner et al. (1983) that require adaptations. Transitions disrupt old patterns of behavior and new expectations are developed. Members of one's support network are used to adapt to new task demands (Heller, Price and Hogg 1990). Ability to adapt, then, depends on support available from one's network. For many coming to therapy, the loss of a significant other affected the support available from their network, and their therapist was utilized to help deal with the client's current transition.

In Table 6.1, more than 82% of the clients reported divorces, losses or relationship changes at the beginning of therapy. If intervention is important for helping the client deal with transitions, how does therapy help with relationship changes or losses? What impact is there on client relationships after therapy? Client interview responses were coded to reflect categories of changes in relationships. Table 6-2 lists resultant coded responses of changes in relationships that occurred after three months in therapy.

Table 6.2 shows that 43% of the respondents state that there is an improvement in their social relationships.
Table 6.2 Reported Changes In Relationships Three Months Following Intake To Therapy.

<table>
<thead>
<tr>
<th>Loss/Change Category</th>
<th>Percent of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improved Relationships</td>
<td>20.0</td>
</tr>
<tr>
<td>Found a Job</td>
<td>20.0</td>
</tr>
<tr>
<td>Strains Alleviated</td>
<td>3.3 43% improved</td>
</tr>
<tr>
<td>No Change</td>
<td>30.0 30% no change</td>
</tr>
<tr>
<td>Relationship Loss</td>
<td>13.3</td>
</tr>
<tr>
<td>Lost a Job</td>
<td>3.3</td>
</tr>
<tr>
<td>Divorce or Separation</td>
<td>10.0 26.6% decrease</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>
between the first and second interviews. Thirty percent noted that there is no change in their relationships and 26% stated that their relationships deteriorated even further between time 1 and time 2.

**Mending Broken Ties**

Social support improvement for most people was described as reconnecting to family or friends. One client placed her daughter in a group home. Her parents disagreed with that course of action and refused to speak to her. This was most disturbing to the client. After therapy commenced, she gave birth to a baby girl. This was a positive experience for the client. In addition, she made new contacts with her family. As she explains, "Some things got worse (like) between my parents and me. (Some) things got better between me and my second daughter and my sister-in-law and my brother. They started listening and standing by me. I can call them when I need them." Another individual going through a divorce explained, "With my oldest son it has gotten a lot stronger. I don’t know how. We are connecting a lot more. Before I’d have to ask questions."

Similarly, one elderly woman described herself as unwilling to make friends because three of her best friends died of cancer, announced, "Lot of it is just the need to have contact. I enjoy people and love to talk with them to share ideas and thoughts.... In July I have a grandchild coming. We still have problems with one daughter (the reason given for entering therapy) still. We are trying to succeed
but haven't yet. I have gotten stronger relationships with my friends. I precipitated that change. I have been more open. I call people to see how they are. We have a lot of people who live alone (a small town in northern New Hampshire). One woman in particular I call to see if she is all right."

A number of clients were part of substance abuse treatment programs. At the beginning of therapy, one individual had just moved into a halfway house. While at the halfway house, he had recontacted his mother. As he described, "Well my mom and I, we hadn't seen each other in 8 years. It was great and was like starting up all over like we had years ago." (Recently I experienced the ) death of my uncle who I was close to. It was a loss. But mom and I got together. I moved from the halfway house and my best friend went to Saudi, but I got friends at work and in my apartment complex. There have been lots of tradeoffs. My relationship with Joanne (girlfriend) is stronger overall. We have our ups and downs. She's happy I'm staying sober and I'm not so self-centered... Joanne used to ask me to do things that I now do automatically. Like I help out, give money for gas. We used to fight over it. I wash dishes without being asked. (I) do her laundry with mine... I clean the sink after shaving... I do little things and she appreciates it."

A woman suffering from agoraphobia (panic attacks) explained the changes in her support network as follows, "My
roommate moved out. Her lifestyle didn't mesh with mine. I confronted her and she made the decision to leave. There have been a big changes in relationships. I joined a group for stress management and I learned a lot and built my self-esteem. How I handle things is very different. The group ended. I've gotten a lot closer and more personal. Instead of acquaintances, we've become friends. I have contact with my children. My panic attacks are not as severe and I can control them."

Another case was that of a young woman who broke up with her boyfriend and was without a place to stay described the improvement in her relationships when she described her current living arrangements by very proudly exclaiming, "I'm not living with that family I was living with the first time we talked. I was homeless then. I don't see some friends as much anymore because they live away. I do see other people more. I see Melody and Maria. I have a job now. Before I did not have a job or a place to live. Now I have my own apartment and Melody lives with me."

**Some Improvement**

A few individuals indicated that their support system was beginning to improve, but did not yet reached a point that would generate the enthusiasm described above. Presentations from this group were subdued when asked what changes in relationships or support they had experienced over the past three months. For example, "No, not really. I'm reemployed about three weeks. I was unemployed about
three months. I was laid off at a factory." Or, "a couple of friendships got stronger...by talking to them and they talking with me made us more comfortable with each other.

**Broken Relationships**

Twenty-seven percent of the respondents stated that their social relationships had actually become worse. One unemployed woman who had moved to New Hampshire for a job stated, "My relationships with Peter and Merle have gotten weaker. My...uhm.. Pete calls the same but I have different feelings and I back off and keep conversation on subjects that don’t bother. Merle... I’m in touch with less frequently. We had a lot of parallels. He is talented and he had got his life together. He’s doing well. This makes a strain for me, I’m not happy. I’m envious. I’m not able to get there. He’s well educated, a Ph.D. physicist. He’s beginning to use it. I understand it and I know I won’t (get there).

A young man in trouble with the law offered, "I get with my drinking group and stuff like that. My friends have never been helpful... (my relations with my cousins have grown weaker) they ran their mouth then we get to fighting. Then it ain’t the same. Same with my best friend. People will run their mouth".

A woman currently suffering from a fatal disease and using drugs presented an example of her current difficulties with friends. At her first interview she explained she was stepping away from her family as she could give no more to
them. At the second interview, she presented, "some relationships have waned. Some long term relationships, 20 years. Jan, a 20 year friend, is involved with another friend. When she comes up from Epsom she doesn't visit. She doesn't trust me any more. I find out through the grape vine. We'll work it out. Our lives and relationships are opposite. Now she's unhappy. Maybe she's having a problem with that.

**Broken But On The Mend**

Thirty percent of the respondents explained that as of the second interview, there were no changes in their relationships with others. About one half of this group indicated that improvements had not occurred. Their therapists, on the other hand, believed some changes were about to happen. For example, one female patient described herself as being very lonely and in the process of separating from her husband. "The therapy worked on the separation. Even if we decide to get back together its made both of us realize that there were problems. When you try to commit suicide and you tell him (her husband) about it and have him tell you its ridiculous. If he can't see it, then there's something wrong with him." This patient wanted her husband to go to therapy. "John said he'd go. Its hard for John to express himself. He's 65 and (its) very difficult for people in that era". The therapist explained that this patient was also an alcoholic. She had begun attending Alcoholics Anonymous meetings and had a "wonderful woman"
who is her "peer supporter." When the difficulties in the relationship with her husband did not improve, the patient separated from her husband. Prior to the separation, the patient's stepdaughter moved out. Following the separation, the patient's husband began attending therapy and the patient was attending AA meetings.

Similarly, a young professional woman who was described by her boss and therapist as having trouble asking for help was having difficulties around the breakup of a long term relationship with her boyfriend. After therapy began, the boyfriend actually moved out. The client presented, "My breakup with Norman (brought me to therapy)...Norman goes to therapy too. Its couple therapy. We talk about what's going on presently—to work on our relationship. Therapy is needed to work on this issue." Again the actual breakup occurred after therapy began. However, the couple attends therapy together to help with problem resolution.

The friend of one client had a daughter who the client considered very special. The child died. The client sought help from the mental health center when she began experiencing nightmares. She attended only a few sessions, and the nightmare seemed to subside. When asked in her second interview, about changes in social support, the client offered, I broke up with my boyfriend and he seemed like he didn't want to see me. I asked Angie to talk with him. I shouldn't have done it because she made things worse. Angie and I are not as close (because) of the way
she's decided to lead her life." The client revealed that she stopped going to therapy because she did not have enough money to pay the weekly fee. She stated she wanted to continue in therapy "around my boyfriend and Angie. I can do them without therapy. Its easier to talk with someone who is not involved and have him help me work through it. Its just harder without the therapist."

Previous chapters reported that there were positive changes in support and psychological well-being over time. In the 43% of the cases where data were available, clients did report improvements in relationships from time 1 to time 2. Many of the initial relationship changes (prior to therapy) were due to divorces or separations or estrangements or job losses. Relationships were considered improved when jobs were found or patients moved back to locations where their family and friends lived. A number of clients explained that they were helped with re-establishing relationships. This help was provided during therapy by participation in group activities related to their therapeutic intervention such as group therapy or Alcoholics Anonymous. Changes such as moving, job finding or group participation or skill development helped re-establish ties to a social group. Within those groups, new network members were found. These individuals were able to provide support to the client. In addition to support improvement, there was a improvement in psychological well-being.
**Assessments Of Outcome**

Patients were asked if the therapy they received was helpful. Therapists were not asked this question directly, but their comments about the therapy were revealing. Responses by both clients and therapists were coded as unhelpful, somewhat helpful or helpful. As reported in table 30, the responses from the two group differed markedly. Therapists were more likely to report that the therapy was unhelpful. Patients, on the other hand, were more prone to indicate that the therapy was helpful. Both client and therapist’s assessments of outcome were related to relationship changes (.29 and .34 respectively). Clients were asked if the therapeutic intervention had any impact on changes that occurred in their relationships. Forty percent of the clients reported that the therapy did have an impact. Sixty percent reported no impact. Assessments of therapy outcome by clients and therapists were correlated with client reports of improvements in relationships as a result of therapy (r=.32 clients and .39 for therapists).

**Therapist’s Theoretical Orientation And Strategies**

Therapists have different theoretical orientations. These orientations help provide a general framework for the intervention or strategy they choose for each patient. Here we were interested in whether changes in social support were the result of a planned intervention strategy perhaps emanating from a particular theoretical orientation. If there was not a planned strategy to effect change in the
patient's social support, did the therapist implicitly affect the patient's social support in other ways. Finally, how do clients and therapists report the effectiveness of their therapeutic intervention? Was there a relationship between changes in social support and patient and therapist reports of therapeutic effectiveness?

**Types of Therapist Orientations**

Tables 6.3 and 6.4 list the therapist orientations and strategies respectively. The orientations and strategies were coded. The orientation codes were taken directly from responses made by therapists to a question asking for their orientation. The strategies focused on three areas, an individual focus on needs, wants and transference; a focus on engagement or attempting to help the individual decide why he or she is in therapy; and finally a focus on relationship building.

Those therapists describing their orientations as developmental or psychodynamic account for 44.8 percent of all therapists interviewed. Over 40% of the strategies focused on individual issues and not on relationship issues. Another twenty-five percent of the strategies concentrated on helping the patient decide to participate in the therapeutic process or terminate therapy.

**Eclectic.** For example, one therapist described his orientation as eclectic and defined it by stating, "Eclectic. Object relations base. I build with systematic,
### Table 6.3 Therapist Orientations

<table>
<thead>
<tr>
<th>Orientation</th>
<th>Percent of therapists classified</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychodynamic</td>
<td>20.7%</td>
</tr>
<tr>
<td>Developmentalist</td>
<td></td>
</tr>
<tr>
<td>Psychodynamic</td>
<td>10.3</td>
</tr>
<tr>
<td>Constructive</td>
<td>13.8</td>
</tr>
<tr>
<td>Developmentalist</td>
<td></td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>27.6</td>
</tr>
<tr>
<td>Eclectic</td>
<td>13.8</td>
</tr>
<tr>
<td>Systems</td>
<td>13.8</td>
</tr>
<tr>
<td>TOTAL</td>
<td>100.0</td>
</tr>
</tbody>
</table>

### Table 6.4 Therapist's Intervention Strategy

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Percent Therapist Reporting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychological/individual</td>
<td>41.4</td>
</tr>
<tr>
<td>Engagement</td>
<td>24.1</td>
</tr>
<tr>
<td>Relationship Improvement</td>
<td>34.5</td>
</tr>
<tr>
<td>TOTAL</td>
<td>100.0</td>
</tr>
</tbody>
</table>
cognitive and behavioral." When asked what he meant by "object relations base", he replied, "psychodynamic object relations. Ego psychology or how clients related to objects, people. I guess to work through with parental objects/transference. I see people for long periods of time". The therapist was then asked, in the case of a particular client, to describe his intervention strategy. He explained that, "(the client) was fairly narcissistic. He lost his job and a conflict relationship propelled him into a depression. I look for ways to help increase self-esteem and try to help him seem more successful in relationships and as an individual. When asked about the outcome of the therapy, the therapist offered, "He was feeling better. His depression was completely lifted. His situation did not change. His relationship did not change. His being able to sit with someone who listened and witnessed his pain and let him know that he is okay and these are things you can do to get back on track".

This account differed somewhat from the matter of fact response provided by the patient who reported he left therapy because "I had no money. I felt they were acrimonious about it." He explained that he currently needed therapy but had no money to attend further.

Psychodynamic. A second therapist who described her orientation as "psychodynamic" explained, "(she) paid attention to drives, needs and other things not true to that relationship but from some other relationship. The
strategy employed was the use of the therapeutic relationship for healthy and safe relationships and allowing the patient to be in a kind of accepting manner to experience the relationship. The patient brings other things and (she) doesn’t fall into those (maybe bad ways of relating) same problems he has with others. His experience of therapy will help him understand safe relationships. The girl friend of the client being discussed above was asked what relationship changes occurred for this patient since his therapy had started. She replied, "He saw his mother for the first time in ten years. His uncle died last month. He lost contact with friends from the old days. There is a reluctance to see friends who were supportive when he was drinking in Concord. He doesn’t want to see any of them.

When asked if the therapy was helping, the girl friend replied at time 1, "Yes, it just began. He went a year ago and it was not helpful. (He) was lying and he’s not interested in doing that anymore". At time 2, the girl friend explained why the patient was more successful with this attempt at sobriety than the attempt one year ago (described above): "because this time he’s had family and friends to get him through and its made a big difference".

"What difference?"

"I heard him say that he no longer felt alone and it has helped him to stay sober and has lifted him out of the depression. It has given him courage, and he is not alone. It has improved his self-esteem. If people care then he
should care about himself. I’m not sure this is the way. But first he started to care about himself. Others would care for him and then he could help himself. I helped when he didn’t care. (His) mother would not risk when when he did not care (his mother was unwilling to become involved with him when he was drinking and not seeking help).

This client was asked why he went to therapy. He stated, "It was aftercare follow up from rehab therapy. It was suggested".

"What benefit did you get from therapy?" It opened up things I had not talked about before. I got things out. It makes it easier. Things were eating away. Also, it helps one around people. I’m less self centered. I’m not the king anymore and they are the servants".

"Did the therapy help your relationship with your mom?"

It worked itself out on its own. My therapist gave advice on how to work with my mom. She said to let mom steer the ship. If she brings up something, then talk. The reconciliation was due to circumstances not the therapist. The therapist helps with (the girl friend). She gets me to think about (the girl friend).

When the girl friend was asked if the therapy helped the client’s relationship with his mother, she replied, "No, the uncle dying brought them together. But therapy gave him the courage. (His therapist) called him before the trip to see his mom. She gave him courage. He mentioned it. Her call kept him sober".

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Family Systems. A family systems therapist described his orientation thus, "Systems means not seeing the individual but seeing the individual as part of a whole. It is seeing the client in their context. I work with couples. I don’t identify a patient but work with both. I’m looking at circular causality. I think it can play a factor - like abuse and compulsion. One partner, through abuse causes compulsions in the other. Causality plays some role. I don’t look at causality usually. I’m ahistorical because insurance limits one’s visits. I focus on circular causality and how different people affect each other.

With the patient in question, this therapist’s strategy was described as "...a cognitive behavioral approach following Michebaum. I taught her deep breathing. I helped her notice when she ‘awfulized.’ I taught her progressive relaxation. I helped her control her sympathetic nervous system. She came from an alcoholic family with an agoraphobic mother. I showed her autohypnosis focusing on specific strategies. I gave her a stress management tape Tai Chi.

"What do you mean by ‘awfulized’?"

"It follows Albert Ellis ... exaggerated, negative consequences."

"(The patient) talked recently with her husband. Did you encourage her?" (This patient, at time 1 described changes in her life prior to therapy as "I went through a divorce after 18 years of marriage. My youngest son left home and my
oldest daughter and three grandchildren went to Virginia. All of this happened within six months. Plus I moved.

The therapist responded to my question by stating, "She needed to talk to her husband who was a batterer. I encouraged her to be assertive with her support system. I wanted her to move away from her mother. I encouraged her to be in group therapy. At the end of treatment, she needed no further therapy and the group helped her wean from individual therapy."

The patient being discussed above was asked at time 2 what relationship changes had occurred since the beginning of therapy. She replied, "There has been a big change in relationships. I joined a group for stress management and I learned a lot and built my self esteem. How I handle things is very different. The group ended. I’ve gotten closer and more personal. Instead of acquaintances we’ve become friends."

"Did you seek them out (your friends)?"

"They had tried but I was withdrawn. My ex-husband and I have become friends. I have contact with my children. My panic attacks are not as severe and I can control them."

"Did the individual or group counseling help?"

"Definitely both. I give all the credit to the counselor. He was like a teacher. The counselor conducted both (individual and group therapy). I’ve gone before (to therapy) and it had not been helpful."

"Did your family and friends encourage you to go to
therapy?"

"No, they didn't."

"Do they notice any change?"

"They are eating crow now."

"What kept you going?"

"I could see the change. I physically felt better and that gave me the determination to change. (The therapist) is fantastic. My husband and I have been seeing each other. We've become friends which is something we've never become before".

"What precipitated the change with your husband?"

"He made the first phone call. My attitude - I put my hatred in the past on the shelf. And I tried to understand him more and communicate more. We don't have much time to talk so we've made the best of the time".

"Putting the hatred on shelf - did you do this on your own or did this occur as a result of therapy?"

"Both. I started it before therapy. It would have worked out without therapy. Therapy helped because I enjoy myself and I don't want to be in a situation I was in before".

The patients responding above explain that some significant relationships were reconnected primarily on their own with some help from the therapist. The therapist seems to be playing the role of the supporter. Those individuals connected to groups were able to make connections with others. With helpful hints, actually instruction and guidance in how to proceed with certain
relationships, the patients were able to re-establish ties to individuals important to them. A net effect of the psychological treatment for these patients has been a increase in their support network. The treatment strategy has not been strategically planned to focus on improving social relationships, but that has been the outcome.

The interview data presented above indicates that the orientation and strategy of the therapist has some affect on social support. The effect is not the result of a planned strategy for most therapists, but there is an implicit affect on the client’s social support. Table 6-5 presents correlations (Somer’s D for ordinal level measurement) between social support variables discussed in Chapters 3 and 5 and the orientation and strategy of the therapist.

As table 6.5 illustrates, therapist orientation is related to improvements in social contacts and overall social well-being (two of the three variables depicting social integration). Therapist orientation is also related to improvements in the multiplexity of patient’s networks and to improved companionship (an expressive support variable). The positive relationship between the variables indicates that improvements in social support are related to orientations focusing on improving patient relationships. These findings are consistent with the view that if one changes the social supports around a patient, their mental health will improve.

On the other hand, the therapist’s strategies are not
Table 6.5 Correlations Of Therapist Orientation And Strategy With Client Social Support Variables.

<table>
<thead>
<tr>
<th>Social Support Variables</th>
<th>Orientation</th>
<th>Strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Changes in Companionship</td>
<td>.27</td>
<td></td>
</tr>
<tr>
<td>Changes in H.I.E. Social Support</td>
<td>.35</td>
<td></td>
</tr>
<tr>
<td>Changes in Multiplexity</td>
<td>.34</td>
<td></td>
</tr>
<tr>
<td>Changes in H.I.E. Social Contacts</td>
<td>.29</td>
<td></td>
</tr>
<tr>
<td>Network Extent Time 2</td>
<td>.26</td>
<td></td>
</tr>
<tr>
<td>H.I.E. Social Support Time 2</td>
<td>.31</td>
<td></td>
</tr>
<tr>
<td>H.I.E. Social Contacts Time 2</td>
<td>.24</td>
<td></td>
</tr>
<tr>
<td>Adequacy of Finances Time 2</td>
<td>-.33</td>
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</tr>
<tr>
<td>Control of Demands Time 2</td>
<td>-.20</td>
<td></td>
</tr>
<tr>
<td>Communication with Others Time 2</td>
<td>-.29</td>
<td></td>
</tr>
<tr>
<td>Changes in Finances</td>
<td>-.25</td>
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</tbody>
</table>
related to improvements over time in any of the social support measures with the exception of improvements in financial support. More importantly, therapist strategies are not related to the same social support measures their orientations are related to. It seems that a therapist's orientation dictates some particular approaches like group therapy or some involvement in a support group like AA (for substance abuse therapists). However, the intervention strategy presented by the therapist seems to focus more on how the intrapsychic changes the therapist feels are occurring. Thus, it is not the foremost intent of the therapist to improve relationships. It is their intent to correct an intrapsychic deficit.

**Summary**

It is the contention of this research that patients come to therapy suffering from major stresses in their life. Many of these stressors involve the loss of relationships with significant others.

Patients seek support from a professional when the losses they have suffered impact their social support in such a way that the support is either no longer available or unsatisfactory. The losses suffered by patients resulted in patients feeling unhappy, sad or dissatisfied with their current life situation. The therapist evaluates the client's presenting problem differently. Therapists use terms like "personality disorder" or "depressive". They describe the patient's problems in terms of a malfunctioning
of some intrapsychic process. While this is expected, the medicalization of therapy focuses away from a competence model that has as its focus preventive intervention. Instead, the medical model focuses instead on therapy and psychotropic medication (Vaux 1988). Informal or natural systems are not encouraged even though there is evidence that these informal systems promote psychological health. The difference in the interpretation of the reason for entering therapy between the therapist and client usually results in differences in focus of solutions to the patient's problem. Patients under strain from a job loss and mounting bills feel they no longer have the strength to go on. However, they show marked improvement when they are reemployed. The therapist helps by being available as a supporter. Once the patients are reemployed, they leave therapy because they are feeling better and they are reconnected to important others. The stresses they were experiencing are now less problematic.

Patients consistently feel that the therapy is more helpful than the therapists. This too is expected if there are differences in the labeling of the reason for coming to therapy. If patients come to therapy as a result of breakdowns in their relationships with others, then re-establishment of supportive connections to others will improve one's psychological health. Therapists are trying to correct deficits that their patients do not recognize.
Finally, therapists do impact the support surrounding their patients. They do not do so explicitly. Therapist's orientations provide certain mechanisms that improve patient's social support. Therapists describe what they are attempting to do by intra-individual deficit correction.

Are the informal support system and the mental health system irreconcilable? Certainly not. In fact they are operating together without much awareness of each other. The data in this chapter show that therapists help clients reconnect with important family members by offering support, role playing, giving them exercises or helping put problems and issues into a different perspective. The informal support system helps client's psychological health by providing visitors, encouraging clients to go to therapy, giving them shelter or loaning them money until they can get back on their feet. A change in the orientation of the formal system from therapy and medicine to competence in daily living and prevention has significant implications for mental health.
Chapter 7

CONCLUSIONS

Introduction

This research was designed to investigate four major questions. Those questions are:

1) Do social supports vary directly with mental health status over time?

2) How do different measures of social support interrelate with each other before and after therapy?

3) How are social support resources, social support behaviors and perceptions of social support related to each other and to psychological health status?

4) Do the orientations and strategies of therapists affect the social support of their patients or does the support of patients affect their therapeutic outcomes?

These questions were examined by first studying how strongly the four measures of social support were interrelated. Once the interrelationships among the social support measures were found, we studied the relationships of social support to psychological health status. In addition, we examined how supports and psychological health were causally related. We also calculated change scores for the different social support measures and psychological health
status. Once the change scores were calculated we could then determine if supports and psychological health varied over time.

Patient and therapists descriptions of events related to social support and therapy were essential in providing clues to the reasons for coming to therapy. The descriptions revealed the changes that took place over the course of therapy and how helpful the supports and therapy were to the patient. Interviews with clients were used to develop a model outlining some of the key transactional components necessary for providing social support.

Sample size. To study the four questions, 40 community mental health center patients and their therapists (31) were interviewed. Patients were interviewed at entrance to therapy and again at three months following entrance to therapy. Therapists were contacted when the second interview with patients was completed.

Data analysis. We examined the questions by first measuring patient’s social support. Four distinct measures of social support were used: social integration, social networks, received social support and perceived social support. Once patient’s social support was measured, patients were asked open ended questions. They were questioned about their views of social support, how they wanted to be supported and how they provided social support. Patients were also asked about changes in their relationships with others before therapy and over the course
of therapy. Finally, therapists were asked about their general orientation and specific strategy in treating each patient. These interviews were used to supplement the quantitative measures of social support. Our sample size was small and made certain statistical treatments of the data unavailable. The interview data enriched the findings found using the quantitative measures of social support and helped compensate for the small sample size.

Limitations. There are several limitations that limit the application of the findings of this study to other outpatient populations. The first limitation is the restricted sample. The sample was small and nonrandom. The representativeness of the sample being studied is questionable. Second, this study focused on treated mental disorders. It cannot be determined if these results can be applied to persons who were not receiving psychiatric treatment but were in need of it.

A third limitation is the lack of a control group. Such a limitation does not allow one to rule out that social support or psychological well being score changes could be the result of statistical regression effects.

Data And Method Triangulation. Clearly, our study has limitations. On the other hand, there are some strengths in the design that improve the validity of our findings. Several of the elements of data and method triangulation discussed by Denzin (1970a 1970b) are incorporated into the design and analysis of this research. In fact, it employs a
high degree of triangulation. For example:

a) Panel data collected at two time points.

b) Multiple indicators of social support.

c) Systematic comparisons between the patient sample studied in this research and nonpatients studied in other research.

d) Use of multiple informants on the same cases.

e) Quantitative, standardized measures of the main variable with detailed qualitative interview material.

This degree of triangulation will hopefully offset some of the limitations discussed above.

**Summary and Interpretation Of Findings**

Variations in health and support. Our findings show that changes in certain measures of social support do vary with changes in psychological health status over the course of treatment. Not all measures of support do vary with changes in psychological health status. However, changes in network multiplexity and received support in the form of companionship (someone to talk to and help with day to day stresses) vary with changes in psychological health status.

The relationships of four measures of social support. The findings related to the second question (the changes and interrelationships of the different measures of social support) show that at least one dimension of each measure of social support significantly increased from the first administration of the measure to the second. More dimensions of the four social support measures are interrelated at time 1 than at time 2. The perception of social support is the
social support measure most consistently related to the other social support measures at both time points. Neither social integration measures nor social network measures are related to received support at time 2. This is not surprising since only the quality of the network was related to received social support at time 1. In addition, Social integration variables at time 1 are thought to be functioning as stress buffers rather than as direct supports. The fact that the social integration variables are unrelated to received support at time 2 lends some support to this argument.

A transactional model of providing social support. Combining the lack of relationship between integration and network support variables with received support and client interviews leads to the development of a model of a transactional process of supporting others. The model proposes that social integration (the existence of relationships) is necessary to the development of a social network and to the closeness of the relationships in that network. The availability of close relationships with others who will be available for support is directly related to positive perceptions of support. Perceptions of support influence the strategies for eliciting support from others. As the perception of support becomes more positive, the strategy of eliciting support will be more open. Open strategies increase the amount of received support from others primarily because the support provider directly asks
for the type of support that is the most helpful. The type of support patients requested most frequently was communication with others.

**Causal implications of supports on psychological health.**

In studying the third question (the relationship of support variables to psychological health status) we found that at time 1, at least one dimension of each support measure is significantly related to mental health status. At time 2, all of the dimensions of received support, and the perception of support are related to psychological health. These relationships are consistent with our model of social support provision.

To understand the connections between received support and psychological health, the relationship between health status and social support was examined closely. We found that at time 1, emotional support is most related to psychological health status. At time 2, instrumental aid is most important. We also found support for a model that expressed a causal relation between social support (financial help provided) at time 1 and psychological health status at time 2. The implication of the model is that financial support provided at time 1 is an important factor in determining psychological health status at time 2.

**Therapist orientation and strategy.** The final question examined in this research was the affect of the therapist's orientation and intervention strategy on patient's social support. We found that improvements in a number of measures
of social support are related to therapist’s theoretical orientations. Orientations that focused on improving patient support networks were related to improvements in social support. Therapist’s intervention strategy is unrelated to improvements in social support with the exception of improvements in financial support. The theoretical orientation of the therapist, such as a substance abuse therapist, directs the types of activities that the therapist engages in. Substance abuse therapists have a tendency to use support groups like Alcoholics Anonymous. Family systems therapists focus on improving the dynamics within family groups. Orientations such as these are related more to changes in social support than orientations focused on intrapsychic aspects of patient’s personalities. The strategies of therapists’ are unrelated to changes in social support because the strategies are coded based on therapist’s descriptions of what was occurring. The therapist’s descriptions of their strategy tends to be more focused on changing intrapsychic components of patient’s personalities. The conclusion is that therapists are not explicitly seeking to change patient’s social support though there is a relationship between the theoretical orientation of the therapist and changes in patient social support.

The therapist’s focus on intrapsychic variables versus social support variables is highlighted by comparing patient’s descriptions of changes that recently preceded they’re coming to therapy with therapist’s views of the same
question. More than 80% of the clients reported experiencing a recent divorce, separation or relationship change just before entering therapy. These presentations are in stark contrast to therapist’s descriptions. Therapist’s categorize only 48% of patient’s presenting problems as relationship related. As a result, sixty percent of the patients report that the therapy had no affect on improvements in relationships that occurred between entrance to therapy and three months after intake to therapy.

Reciprocity of support. Relationships with significant others are necessary for support to be available. More than 80% of the patients coming to the mental health center had experienced some relationship loss prior to coming to therapy. For mental health patients, lack of close, intimate relationships with others means that their social support is unhelpful. For example, all of the patients who categorize their social support networks as unhelpful are unmarried. But in McFarlane et al.’s (1984) study of nonpatients, 78% of those categorizing their social network as unhelpful are married.

McFarlane et al. (1984) also found that the average network size of nonpatients decreases with increasing helpfulness. The average network size of an unhelpful network for McFarlane’s nonpatients was 9.4 members. For our patients, the average size of an unhelpful network is 4.7 members. However, for our patients, increasing network size is related to increasing helpfulness.
The differences in network size and composition (married versus unmarried) in the unhelpful category reported by the patient and nonpatient samples point to an issue raised by Vaux (1988). He argues that those individuals who have high personal and social assets have support resources that can routinely handle their support needs. Those with limited social and personal assets are unable to have their support needs fulfilled. As Vaux (1988:298) states, "That is, needs often exceed the sustainable yield of the network. As a result, not only is support often inadequate and inept, but stressors arise both from the poor quality of the network and from efforts to elicit support from it".

Our patients need unreciprocated support from others. It is argued that unreciprocated support is evidence of long term, strong relationships. Patients can borrow support from their close friends when in need. At a later time, they can pay back that support. For the supporter, providing unreciprocated support is similar to making deposits in a bank. When they have a need, they receive support. For a number of our patients (28% who listed their networks as unhelpful) there are not enough members in the network to meet their support needs. Our patients reach out for support, but there was no one to provide unreciprocated support.

Sex differences and support. We found some support for the notion that men and women differ in their support preferences. Women in crisis seek emotional support. Men
tend to seek instrumental support when in crisis. As a result, there are implications for the kind of support that will be found to be effective by men and women.

**Implications**

Vaux (1988) presents that social support is too complex an idea to be considered a single concept. In Vaux’s (1988) view social support is a metaconstruct. He argues for three constructs of social support: social resources, supportive behavior and appraisals of support. Our findings support the notion of social support as a metaconstruct. Supportive resources affect appraisals of support. Appraisals of support are important in determining strategies of seeking support. Strategies in which the support seeker can be open about his or her needs will increase the likelihood that the support received will be effective. For many patients, the support resources are just not available.

In times of crisis, the kind of support requested by patients is having close friends and family who will accept them in spite of their problems. Patients want support givers to respect their autonomy in choosing what course of action they take to solve their difficulties. Primarily, patients in crisis want people to listen to them and not give advice unless asked.

The emotional turmoil at the time of intake to therapy is only the symptom of a much more difficult problem. Once the crisis subsides, the variables important to psychological health are stress reduction and financial
support. In fact, availability of financial support is important for improving psychological health.

For many patients coming to therapy, a precipitant is a disturbance in their supportive resources. Divorce, separations, moving from friends and family or job loss resulted in changes in the ability of many patients just to meet basic minimum needs of shelter, food and clothing. For others, chronic strains are a fact of life. Some of the changes that occurred prior to therapy pushed the patient to therapy. What these individuals really need are close friends who can help them with the day to day struggles of living. Therapy is a temporary fix until patients are able to find a new job, stop drinking or using drugs, recover from serious illnesses find help with child care, or not have to worry that they are alone.

Changes in therapeutic intervention seems warranted. If social supports do have an impact on mental health outcomes, then therapists need, as part of their assessment and treatment strategy, to understand the social support needs of patients and explicitly work to affect positive change in the support resources. In some cases, the therapy may be job finding instead of psychotherapy, or overcoming a problem that affects one’s ability to maintain relationships with others. These findings, point to the need for change in the type of interventions used to alleviate psychological distress. Specifically, the focus of these interventions needs to incorporate competence enhancing interventions.
Suggestions For Further Research

There are important relationships between the different dimensions of social support depicted in this study. Some of these dimensions may be buffers against stressful life events while others are an innoculant against stress. This study would have been enhanced had there been a measure of life events included. The life events measure would have allowed an examination of the stress buffering potential of some of the support measures (or at least to rule out the possibility).

Different dimensions of social support and psychological health vary together over time. This lends support to a direct relationship between the two variables. What is missing is the causal order. Does social support affect one’s psychological health or vice versa. Studies using different measures of social support and different measures of psychological well-being with more than two time points need to be done to help determine causal order and the relationship between different measures of social support and psychological health. Random samples of patients with sufficient numbers of subjects are needed for this kind of analysis.

Prospective studies that allow comparisons between psychologically impaired individuals who go and do not go to the mental health center are needed. They should provide meaningful insights about the relationship of social support and therapy on psychological well-being.
Finally, this study needs to be replicated. There are several interesting findings presented in this research. A larger study with a randomized sample will, hopefully, help validate and expand the findings of this research. Obtaining such a sample is difficult because of the protected status of the mentally ill, but a more representative sample can be obtained.
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