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PSYCHIC COPING BEHAVIOUR AND THE ROLE OF SOCIAL SUPPORT

T.I. OEI

SUMMARY

After defining the social support concept this article discusses some studies of its significance in relation to psychic functioning. Correct conception and operationalisation of social support is urged. Only then can some aspects of social support be studied in the clinical and the epidemiological perspective.

INTRODUCTION

Since in the late Fifties and late Sixties systematic attention was focused on the significance of forming relationships and social interactions (Bott, 1957; Hodge & Treiman, 1968; Litwak & Szelenyi, 1969; Lowenthal & Haven, 1968), the interest taken in social support as a pathogenetic factor has really been on the increase in the past decade. One of the reasons for this was the growing conviction that social support can exert both a direct effect on health and indirectly enhance the individual's ability to cope with stress influences such as life events (so-called buffer function). In the Seventies it was pointed out by Brown & Harris, (1978), Caplan (1974), Cassel (1974 & 1976), Cobb (1976) and Kaplan *et al.* (1977) that psychiatric disorders correlate with such matters as marital status, geographical mobility and social (dis)integration. A striking feature in the above-mentioned studies is the shortage or virtual absence of systems providing social care. This article takes a closer look at the relational aspects of social support and behaviour disorders on the basis of studies presenting clinical and epidemiological (case)histories and with reference to review articles.

THE SOCIAL SUPPORT CONCEPT

Although (or because?) many studies (Caplan, 1974; Cobb, 1976; Schaeffer, 1981) are not too careful in their definition of, and arguments about, social support, the flow of publications continues.

With increasing insight into the relative influence of social commitment and support on psychic functioning, critical considerations about its significance for individual health evidently increase as well (Broadhead *et al.* 1983; Cohen & McKay, 1984; Eisemann, 1984; Heller, 1979; House, 1981; House & Kahn, 1984; Kobasa & Puccetti, 1983; Thoits, 1982; Wortman & Conway, 1984).

Meanwhile the literature continues to reveal a marked lack of consensus about the nature

and significance of social support, and even more so about how the phenomenon could best be objectified with the aid of manageable measuring methods.

Apart from this paucity of methods, the primary need is of course to define the concept more precisely (Blalock, 1982). Several approaches have been developed for further analysis of the social support concept (Wortman, 1984).

Structural aspects

- a) How does the individual live: isolated or together with others?
- b) How frequent are his social contacts?
- c) Participation in social activities in a club or other kind of association?
- d) Participation in a social network, i.e. a group of persons whose contacts may be more or less frequent and who may or may not gather around the person in question (the "set") (Barnes, 1954).

Functional aspects

- a) Being able to utter positive sounds (emotional support).
- b) Being able or willing to agree with another person's views.
- c) Being able to defend oneself; able to ventilate one's own feelings.
- d) Giving advice or information.
- e) Offering material help.

The above mentioned aspects of social support are of course not complete. Other aspects required in the course of the further operationalisation of the concept should include awareness of contacts intended as support and satisfaction with these contacts (Ormel *et al.* 1985; Sarason *et al.* 1983).

Many studies relevant to the relationship between social support and coping behaviour have opted in favour of the so-called buffer function (Brown *et al.* 1975; Caplan, 1974; Cassel, 1976; Cobb, 1976; Dean & Lin, 1977).

Very recently, good (longitudinal, controlled) studies have been devoted to the significance of the supportive interventions (Broadhead *et al.* 1983; Kessler & McLeod, 1984). Research of this type, however, has failed to elucidate possible causal relationships between (the lack of) social support and psychopathological behaviour (Broadhead *et al.* 1983; Heller, 1979; House, 1981; Thoits, 1982).

METHODS

The (possible) correlation between social relationships and susceptibility to psychiatric disorders can be studied in several different ways, which will be briefly discussed here.

Studies of patient populations

Are there differences in social support perceptions and relationships between healthy persons and hospitalised (psychiatric) patients? Mueller (1980) and Levy (1983) published reports on this question and found that psychotics show firm(er) family relationships and neurotics have

rather loose(r) contacts as compared with a control group. The extent to which these differences are the result or the cause of the disorders involved, remains to be established. In imitation of the pioneer work of Brown *et al.* (1982), the Leff group (1985, 1976) and the Goldstein group (1981, 1982, 1983) offered some relevant information (see also Dingemans & Van Engeland, 1986).

The essential concept used in this research is covered by the term "expressed emotion" (EE). This is a collective term referring to an initial situation in which hostile feelings as well as meddlesomeness and quarrelsomeness of family members can significantly affect the prognosis of the (often schizophrenic) patient recently discharged from hospital. The relapse risk of such patients may be reduced by helping the family members reduce their EE (Boyd *et al.* 1981. Similar research has been carried out in the field of depression (Surtees, 1980) but the results still lag behind the knowledge already acquired concerning schizophrenic psychoses (Coyne *et al.* 1984).

Studies of healthy populations

Rather than studying the (direct) correlation between social support and disease (course), the literature has focused for the most part on the so-called indirect (or buffer) effect, i.e. the ability of available support systems to protect the individual from negative effects of stress of life events on his health (Aneshensel & Frerichs, 1982; Garsen *et al.* 1985; Heller & Swindle, 1983; Lin & Ensel, 1984; Thoits, 1982). In a group of working-class and middle-class women from Camberwell (South London), Brown & Harris (1978) demonstrated that having a steady partner (friend or spouse) had a preventive effect against depression. Depression developed in about 40% of those without a steady partner, versus only 4% of the women with a steady partner. The interpretation of such results, it should be borne in mind, poses some methodological difficulties, even though they were corroborated in similar studies by Miller & Ingham (1976) and Slater & Depue (1981). How, for example, to evaluate when the life events directly influence social contacts (Mueller, 1980), e.g. dismissal after a quarrel with one's superior, as a result of which the supportive climate among colleagues may be abruptly disrupted?

In such a situation development of a depression need not be purely a result of 1) the dismissal and/or 2) loneliness due to lack of contact with colleagues. It is also conceivable that a depressive process led to the dismissal with the resulting farewell to colleagues etc. On the other hand it is conceivable, and known from actual practice, that depressive patients in general are unable to give positive attention to persons and things surrounding them (Beck, 1967). In response to what seems a lack of appreciation in the immediate environment (children, colleagues, etc.) they may withdraw even further. As a result the patient may be even more inclined to regard herself/himself as incompetent mother/incompetent worker and this may facilitate aggravation of symptoms (and corresponding functional level (Hendrickx & Oei, 1984; Oei, 1986).

The abovementioned complications, which it is methodologically difficult to interpret, have caused quite a number of investigators to focus largely on studies in which normal populations are questioned on two different occasions (Henderson *et al.* 1981; Lin & Ensel, 1984; Turner & Noh, 1983). Although evidence in support of the stress-buffer hypothesis of social support is still far from unequivocal, there are some positive indications in this direction. They include the insight that some types of support—especially emotional support and the conviction that help is available if one asks for it—can reduce the effect of life-stress on disturbed behaviour. It is

likewise evident that emotional support has stronger stress-preventing effect than so-called structural support such as social activity or club membership (Kessler & Mcleod, 1984).

Studies of crisis reactions

It is possible to study the role of social support in the case of adaptation to special life events such as the loss of a steady partner (Vachon *et al.* 1982a), unemployment (Gore, 1978) and being the victim of a crime (Burgess & Holstrom, 1979). Many of these studies are longitudinal and the presence or absence of social support is often found to be a predictor of emotional (re) adaptation. An example is the study published by Vachon *et al.* (1982b). He found that, in the case of recent partner loss, dissatisfaction about the social support (received) one month after the event was a predictor of disturbed behaviour within two years of the event.

In addition there is the fact that these studies have significantly increased our knowledge of the specific role of certain types of support in relation to certain behaviour problems. For example in a situation where life events force an individual to obtain new information or learn other patterns of behaviour, the availability of an unstructured network is more likely to raise the adaptive target level than the availability of a well-balanced network of social relations (Hirsch, 1980; Hirsch, 1981; Wellman, 1979).

The study of life crises gives the investigator more opportunities to analyse short-term and long-term effects. In this way changes in the supportive system—when the individual tries to overcome the crisis—can be followed more closely and systematically than a purely epidemiological survey would permit. Moreover, in these studies the phenomenon of social support can be related more accurately to other aspects of the stress process—cognitions, self-feeling and self-esteem, coping mechanisms, etc.—and thus a better insight may be gained into the effects which make social support so important in maintaining psychic stability (Brown, 1984).

In the study of consequences of crises for the individual, the term “successful adaptation” arises repeatedly. The definition of this term is by no means certain (Haan, 1982; Wortman, 1983). The following definitions of this concept have been considered:

- 1) Controlling a crisis situation within certain limits:
 - a) keeping one's distress manageable (Friedman *et al.* 1963),
 - b) realistic assessment of the situation in question (Hamburg & Adams, 1967),
 - c) being able adequately to play important “life roles” (Gersons, 1981; Haan, 1977; Visser *et al.* 1983; Vliert, 1983).
- 2) Emotional reactions do not by definition imply failure of adaptation. On the contrary. Goldsmith (1955) demonstrated that severe paraplegics, although very much aware of their handicap emotionally, are able in principle to adopt an acceptable attitude to life via rehabilitation.

Another problem in coping effectively with the demands of manifest crisis phases in a person's life, is that some people's reactions may minimise damage to themselves, but often at the expense of others (partner, friends, acquaintances).

At present most diagnostic aids such as rating scales are unable either to trace or to predict such serious social implications of certain coping mechanisms (Coyne *et al.* 1984).

CONCLUSION

The findings would seem to warrant the conclusion that there are indications of a relationship between (lack of) social support and the development and/or maintenance of disturbed behaviour (Gottlieb & Green, 1984; Parry & Shapiro, 1986). It remains a task for the near future to achieve proper conceptualisation and then operationalisation of the term social support (Barrera & Ainlay, 1983; House & Kahn, 1984; Starker, 1986; Wortman, 1984).

Henderson (1984) stresses that various aspects of social support should be so operationalised that they can be studied apart from existing personality variables. In his view research should focus on the null hypothesis that lack of social support—as a concept, entirely stripped of the illness effect and not mixed with personality attributes—has neither a direct nor a buffer effect against the development of disturbed behaviour.

Henderson thus adopts what Medawar (1969) called the hypothetico-deductive model, meaning that the initiative for the kind of activity that “is distinctively scientific is held to come not from apprehension of ‘facts’, but from an imaginative preconception of what might be true” (p.7). But in the same publication Henderson admits that in fact this cannot be achieved because social support is precisely a result of or acquired by social intercourse.

Brown (1985) in a similar way corroborates Medawar’s views in that he states (p.8) “....., I have come to believe that too strict an adherence to a hypothetico-deductive view will be bound to weaken the chance of new ideas emerging”.

Henderson (1984) therefore advises to focus especially on effects of social interventions with a view to their implications for prevention and therapy.

Whether or not hypothesis-testing research should be given priority over inductive-intuitive research models, the various aspects of the central social support concept have to be further analysed (Ullah *et al.* 1985). It seems evident that each of them separately may exert its own influence on (disturbed) behaviour (Cohen & McKay, 1984; House & Kahn, 1984; Lin *et al.* 1985; Wortman, 1984). One recent research finding has indicated that help and support from just anyone is not as effective as the help of an equally affected person, e.g. cancer patients supporting one another (Dunkel-Schetter & Wortman, 1982; Wortman & Lehman, 1984). A finding of epidemiological research (Hirsch, 1980; Kobasa *et al.* 1985; Rowledge, 1984) is that personal characteristics as well as the developmental phase (adolescence, senescence, etc.) may be of great importance in the appreciation of social support.

Data obtained from epidemiological studies can be important for studies of (clinical) psychiatric populations (Billings & Moos, 1985; Brown, 1984; Eisemann, 1984; Klerk *et al.* 1985; Weissman & Klerman, 1978). In this way it may be possible to correlate social support with other psychosocial or biological variables in order ultimately to achieve a better understanding of human behaviour (Bruhn & Philips, 1984; McFarlane *et al.* 1983; McKay *et al.* 1985; Schwartz, 1984).

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