Social support: the concept and the evidence

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The notion that social support may protect mental health has some intuitive appeal. It has fuelled a considerable literature for at least two decades. Among health workers and the public alike, there is a strong belief that social support is a good thing, that many people with common mental disorders lack it, and that it should be supplied where it is deficient. As a broad construct, social support fits well into a broader paradigm concerning the aetiology of mental disorders. Earlier this century, the focus was on happenings in infancy and childhood. Then it was life events, whereby experiences arising externally and impinging on the individual were thought to be powerfully pathogenic. And now there is social support which, like life events, has its origin in the person's social environment. But here it is the positive or beneficial components of that environment that are being singled out. It is timely to ask ourselves what lies in the term, how adequately it can be measured, and what the current evidence is for its place in psychiatry (Henderson, 1991, page 89).

There is abundant testimony in general literature that the presence of friendly others is favourable for mental health. The idea seems to be part of human existence, probably because our species typically congregates in groups. The sixteenth century essayist, Francis Bacon, put it concisely in his essay «On Friendship»: «... *this communicating of a man's self to his friend works two contrary effects: for it redoubleth joys, and cutteth griefs in halfs. For there is no man that imparteth his joys to his friends, but he joyeth the more: and no man that imparteth his griefs to his friends, but he grieveth the less*». Bacon was referring to the ventilation of strong affect in a small group in which relationships have already been established. A similar theme is expressed in the work of human and primate ethologists on attachment behaviour. In the course of his celebrated 3-volume work on attachment. John Bowlby (1973, page 359) wrote: «*For not only young children, it is now clear, but human beings of all ages are found to be at their happiest and to be able to deploy their talents to best advantage when they are confident that, standing behind them, there are one or more trusted persons who will come to their aid should difficulties arise*».

A further pointer to the relevance of social support for mental health has come from sociology. Social scientists have long been aware of the integrative function of human groups, as in the contribution of Durkheim (1897) and the later propositions of Leighton *et al.* (1963) on social disorganization and psychiatric morbidity. From such a confluence of ideas, it can readily be understood how Cassel (1976) came to put forward the stress-buffering hypothesis in his paper. «The contribution of the social environment to host resistance». By the 1980s, five distinct hypotheses had emerged, though the important distinctions between them have not always been made clearly explicit. They are: 1) that social support (variably defined) may act as a buffer against stressors or adversity, protecting against the development of psychological morbidity; 2) that the lack of social support may be pathogenic in its own right, independent of the load of adversity; 3) that social support promotes well-being, without any claim to reduce psychological symptoms; 4) that social support may be therapeutic for persons who have already developed symptoms; or 5) that low levels of support are associated with increased mortality. To its detriment, the field of enquiry has not always made it clear which of these hypotheses is being proposed. In reading publications and in the course of scientific discussion about social support, the reader is strongly advised to bear this in mind, and to determine which of the several hypotheses is being considered.

Testing the hypotheses is dependent on having ap-

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propriate methods for measurement, yet until only a few years ago none existed. Some enquiries have been based on simple demographic variables, such as marital status or living arrangements, or on a small number of items concerning the respondent's current involvement with friends, neighbours and social groups. More detailed instruments have attempted to determine the respondent's interaction with both the immediate family and more diffuse relationships. Examples are the Interview Schedule for Social Interaction (Henderson *et al.*, 1981), which has been widely used in Europe, North America and Australasia, the Social Support Questionnaire of Sarason *et al.* (1983), and the Mannheim Interview on Social Support by Veiel (1990). Construction of an instrument to measure social support has to start with some notion of the field to be covered. Here, the contribution of Robert Weiss has been most useful, in his setting out the main ingredients or «provisions of social relationships». These are: attachment or affectional relationships, social integration, an opportunity for nurturing others, reasurrance of personal worth, a sense of reliable alliance, and obtaining help and guidance from others in facing difficulties. An overview of the measurement of support has been recently assembled by Veiel and Baumann (1992) in their edited volume.

In any instrument, there are certain limitations to validity that should be borne in mind. First, the information typically is derived from the subject him or herself, the same person whose mental health is being assessed. So both dependent and independent variables are based on verbal information from the one source. Jorm and Henderson (1992) have drawn attention to the information bias that this inevitably introduces. The individual's mood state may influence reports of the social relationships being assessed. Second, it is difficult to avoid confounding by personality variables. That is, the social support reported by the individual, or indeed the amount and quality of social relationships, is likely to be determined in part by that person's capacity to establish and maintain mutually satisfying personal relationships. So what is measured is the product of both the actual social environment and the individual's behaviour within it, recent and more distant in time. People are to a large extent the architects of their social environment and the support it affords. This is rarely recognised in the literature.

The findings about social support are best considered in relation to the hypotheses being tested. There is overwhelming evidence that support is lower in the current lives of persons with common mental disorders, such as anxiety or depression. It is far less clear what this means. In a review of the evidence concerning depression, Henderson (1992) examined 34 studies, concluding that 1) there was indeed an inverse association between social support and affective symptoms; and 2) there was a buffering effect in the presence of severe stressors. Some authors are persuaded by their data that the deficiency they so commonly find is a significant causal factor. Others, including the present writer, would hold that it has yet to be demonstrated that lack of social support is wholly independent of the individual's personality and interpersonal behaviour. These differences in view have been set out, though not resolved, by Henderson and Brown (1988). To resolve the problem, it would be necessary to identify situations where the lack of support was independent of the person's recent behaviour. Bereavement is one example, but that has attributes which go rather further than the lack of support. No research design has been proposed that would yield a conclusive test of the first or second of the hypotheses outlined above. For social support and well-being, it would likewise be plausible that both plentiful support and high well-being arise from a common set of personality traits. For the fourth hypothesis concerning a therapeutic effect, there is obviously a major body of literature in favour of this, particularly for the common mental disorders. This is, after all, the essence of supportive psychotherapy. The fifth hypothesis concerning mortality is most intriguing. Schwarzer and Leppin (1992) have given a penetrating analysis of the evidence and its interpretation. If the association exists, and if it is net of health-related behaviour, the implications would be profound: it would mean that the presence of harmonious social relationships has a physiological effect conferring resistance to disease, and this must be mediated through the brain.

For clinical research workers or social scientists contemplating a study on social support, the therapeutic effect of intervention in groups at risk makes an attractive prospect, because it is methodologically practicable, and allows the use of controls in the design. By deliberately selecting different provisions of social relationships, such studies would also have an opportunity to identify more precisely what the effective ingredients are in the complex so disarmingly called «social support».

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