SOCIAL SUPPORT AND DEPRESSION

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Abstract: This paper provides a rationale for the importance of social support in mental health. It ties depression in adolescence to chronic depression in adulthood. It discusses the importance of interpersonal skill in the achievement of social support and explains how dysfunctional communication impedes the attainment of social support. It variously defines social support as an act, a resource, a result, an understanding, and a relationship. It describes the six forms of social support and the role of reciprocity in the "exchange" of offered behavior. It describes four typologies of dysfunctional pseudo-support, the typical medication treatment regimen, and emphasizes the importance of social skill for both rehabilitation and quality of life. Key terms: social support, depression, interpersonal communication.

A TWOFOLD RATIONALE: There is a well documented and compelling rationale for understanding social support as an interpersonal variable. In order to understand the importance it is necessary to take into account the logic of the following two ideas. One follows from the other and they function in the lives of some as an endless, hopeless, gloomy, downward spiral. One of the most commonly diagnosed psychiatric disorders in adolescents is depression. Depression is identified as a psychiatric disorder in the American Psychiatric Association DSM-IV Manual (1994). Depression in high school or college-aged young people is not at all uncommon (Flemming and Offord, 1990). The corollary to that first idea is that young people who experience episodes of depression during adolescence are at increasing risk for experiencing recurrences of depression during adulthood (Lewinsohn, Rohde, Seeley, Klein & Gotlib, 2000). So, a depressed young person might think, "I know I feel low and listless and sad much of the time, but I'm only 16 or 19 or 21. This must be temporary. I'll grow up and surely I will grow out of it and feel better." The research indicates that if a young person has recurring bouts of depression, it is more than likely that that same person will continue to experience the same symptoms as an adult (Gotlib & Hammen, 1992). It will simply not go away as time passes. Most likely this is because the same circumstances or influences which evoked it originally are still present. This seems to be sufficient reason for trying to understand what acts on that depression. Even if you are not depressed yourself, it is almost certain that you know someone who is.

The second idea is that "interpersonal difficulties" are a common correlate of depression in both youth and adults (Gotlib & Hammen, 1992; Weisz, Rudolph, Granger & Sweeney, 1992). If you are lacking friends or an intimate or both, it is easy to be depressed. If you don't have much social skill, it is understandable that you might be without friends or an intimate. "Interpersonal difficulties" is a very abstract term at this point, but it will become more explicit in the elaborations which follow. For the time being it is sufficient to say that as these "interpersonal difficulties" increase in either number or intensity, depression also increases. There is a clear and direct relationship between one and the other. For example, studies by a variety of people (Cole, 1990; Patterson & Stoolmiller, 1991; Rudolph, Hammen & Burge, 1994) show that a number of measures of interpersonal competence are linked to depression. These would include low teacher approval ratings, low peer ratings, low peer acceptance, sociometric exclusion, low social

competence observer ratings, and an inability to sustain friendships; all are associated with depression. All of these might be seen as more specific versions of "interpersonal difficulties." A critical variable acting on depression is one's connectedness with others, or social support. Social support and depression covary: the availability of others decreases depression and the absence of that availability is associated with increased depression (Albrecht & Adelman, 1984; Altmann & Gotlib, 1988; Gotlib & Hammen, 1992; Hobfoll & Stokes, 1988; Hokanson, et. al. 1989; Lara, Leader, & Klein, 1997). The unavailability of others is a monumental "interpersonal difficulty."

And finally, adults with chronic interpersonal difficulties are likely to be people who were depressed as youth (Harrington, Fudge, Rutter, Pickles & Hill, 1990; Kandel & Davies, 1986). One can see how these findings link up looking both forward and backward. One can also see how these various constructs might connect and interact and how they might be circular. Depression in young people is a common disorder. Depression does not go away as people grow older. Depression is linked to the presence of interpersonal difficulties. Interpersonal difficulties and depression are associated with a lack of social support. Adults with chronic interpersonal difficulties are likely to have been depressed when they are young. Now as adults they continue to be depressed because they continue to have those same interpersonal difficulties. It is a deep black pit that is difficult to get out of.

INTERPERSONAL SKILL AND SOCIAL SUPPORT: "Interpersonal difficulties" is clearly a critical variable. What is it that got someone into, and what might possibly operate to get a person out of that deep black pit of depression? A central component of successful interpersonal functioning is in the *manner* in which a person engages with and the *extent* to which a person engages with others. It is not one or the other, but both the *manner and the extent* of engagement (Albrecht & Adelman 1984) or, i.e., what is the level of our social skill (ability, competence) and how often (frequency) do we use it (Barbour, 1981). This would be especially true in times of distress, when things aren't going well. When things are difficult, who can you call on, and to what extent can you call on them, and what can you call on them for?

It is simple common sense that being liked by another person to the extent that the person would be willing to be helpful to us would derive from what we have said or done. A person willing to be helpful typically would feel a sense of commonality with or of sympathy toward the help seeker. A willingness to be helpful could be said to be the result of positive feelings engendered by certain kinds of interpersonal communication (Barbour, 1981, 1994; Brown, 1965, p. 84 ff.). Verbal reports of liking and disliking have been very much studied in relational communication, social psychology and sociology. There is a whole specialized literature on interpersonal attraction (See Berscheid & Walster, 1969).

The method for studying interpersonal relations through reports of positive and negative sentiments is called the sociometric method (Moreno, 1934). Sociometry quantifies the positive and negative feelings that people have about one another (Hale, 1985). For the past sixty years, sociometry has provided a way to operationalize social support (See Lindzey & Aronson, 1954, pp. 452-525; Moreno, 1956, 1960). The social support questionnaire instrument (SSQ) of Sarason, Levine, Basham, and Sarason (1983) is actually a sociometric test. This fact should serve to remind us that oftentimes the newest idea around is actually an old idea with a change of

clothes and a new name. Usually positive feelings, such as those which might result in an offer of social support, accompany a recognition of similarities. Conversations which result in liking are usually conversations which search for points of agreement or of like-mindedness. When there is a good match, feelings of friendliness and trust may develop. Sympathy is a feeling which often accompanies liking or mutuality. Sympathy in this context is sharing or at least understanding the other person's feelings (Brown, 1965). A person who sees herself as similar to another and who feels friendly toward that person and who trusts that person and who understands that person's feelings might be willing to offer support when it is asked for.

A significant finding from the social support literature is that contact with others, and more especially supportive contact, is an important predictor of both general emotional well-being and its flip-side, vulnerability to depression. For example, research indicates that an individual's perceptions of social support are strong predictors of general emotional well-being and positive social adjustment (an academic way of saying happiness) in both youth and adults (Cronkite & Moos, 1984; Holahan and Moos, 1982; Lara, Leader & Klein, 1997). A study at the University of Denver by Harter, Marold, and Whitesell (1991) showed a strong link between low perceived social support and depression in youth. If you think you have social support, you are more likely to be happy and if you don't think you have it you are more likely to be miserable.

HOW NOT TO GET HELP: Coping strategies (Cobb, 1976) are ways of dealing with the stresses of negative life events (ways of surviving the deep black pit or even getting out of it). If a person's way of coping with negative life events is withdrawal, (avoidance, being alone, staying away from people) that withdrawal maneuver tends to foster and maintain depression, so it is not helpful. People are not helped, cured, or made better by sitting alone in the dark in a blue funk. If depressed individuals cope by withdrawing, they prolong and deepen their depression. You might say that through their coping strategies, some depressed individuals play a problematic role in their own disorder.

There are a number of explanations for how depressed people often get in their own way or are sometimes their own worst enemies in getting what they need. The first explanation is that depressed individuals do not nurture the opportunity to receive support from others. That is, if you never cultivated a friendship with someone and were not mutually available to him/her, it would be difficult later to call on that person in a time of need. There is a series of studies which say that depressed people underutilize others when they are depressed (Kazdin et al., 1985; Altmann and Gotlib, 1988; Hokanson, Rubert, Weller, Hollander & Hedeen, 1989). They withdraw rather than engage with others.

Secondly, it is possible that that manner in which a depressed individual seeks support is maladaptive, so in a sense the person contributes negatively to his/her own unsuccessful and unsatisfying attempts to get support. He or she does it in such a way as to get rejected. After all, who wants to spend a lot of time with someone who looks and sounds like gloom and doom? Not a lot of people seek out that kind of company. That might be especially true if depression seemed to be that person's typical or habitual mood. Another different version of this idea is that a depressed individual may seem too needy and this might repulse a potential helper. For

example, is the needy person requesting excessive reassurance? Does the needy person expect too much time or help? Will the need be exhausting to the potential helper? Will the potential helper be able to extricate him/herself from the helpee once the help is provided? You might say that some people want help, but do not know how to go about it in such a way as to get it. Still, another maladaptive way of going about getting support is simply to be unable to ask for it. This might be for fear that they will be turned down or for fear that asking will make them look bad in the eyes of others. A great many people are simply unable to ask; they cannot say the words, "Please help me."

Third, it is also possible that a depressed person might be in relationships with people who are unavailable for support for a variety of reasons (Kaslow, Deering & Racusin, 1994). A person who is too busy following his/her own agendas may not have the time for someone who is troubled. A person who is dealing with his/her own crises might not be currently available. Sometimes the timing is not good. What I mean by that is that you have to help people when they need it, not when it is convenient. So if the timing is not good, the helper might not be available when the depressed person needs help. "Get back to me in a couple of weeks," is usually not helpful. We might take these three explanations into account: relationships were not cultivated, the way of seeking help was maladaptive, and the potential support people were unavailable.

On the other hand, if a person experiences negative life events (and we all do sooner or later) and the coping strategy is not isolation but involves seeking support from others, and it does not involve the maladaptive patterns described previously, then that help seeking coping strategy can buffer people against whatever has happened. The quantity and quality of social contact appears to have a direct impact on emotional well-being, and this is especially so in times of personal distress. This is a simple and easily understood rationale for the importance of social support.

WHAT IS SOCIAL SUPPORT? In the world of theory building, social support is a construct. A construct is a variable that cannot be seen or measured directly. That we cannot see a construct does not make it any less real or less useful. Numerous validated theories involve constructs, sometimes several of them. My usual best example of a construct is the calorie. We cannot see calories, but we can operationalize them as a unit of heat and measure them indirectly. We cannot see attitudes, but we can measure them and study them. We know they exist. Social support is similar. It is an umbrella term that covers a variety of phenomena. We can't see social support, but we can see evidence of it in its effects. Following are a number of attempts to conceptualize the construct:

Saranson, Saranson & Pierce (1990) define it as the "…existence or availability of people on whom we can rely, people who let us know that they care about, value, and love us" (p. 127). Saranson et al. claim that direct assistance, advice, encouragement, companionship, and expressions of affection have all been associated with positive outcomes for persons facing life's various strains and dilemmas. Typically support would be expected to come from family, friends, and/or fellow workers.
(Emphasis on the availability of people.)

Kahn (1979) describes social support as interpersonal interactions that include one or more of the following: the expression of positive affect of one person toward another; the endorsement of another person's behaviors, perceptions, or expressed views; and/or the giving of symbolic or material aid to another (p. 85).
(Emphasis on certain kinds of interpersonal interactions.)

House (1981) conceptualized social support as the specific actual transaction which took place between two or more people in which emotional concern, instrumental aid, information, or appraisal occurred. House focused on the actual interaction that took place. The "appraisal" part of the definition was most typically evaluative feedback. We will return to that idea later. House also thought the interaction which took place involved a "provider" attempting to offer support and a "recipient" who might be helped by the attempt.
(Emphasis on a certain kind of transaction.)

Others have provided similar interactional definitions. Dunkel-Shetter and Skokan, (1990) saw it as dyadic interactions in which one person attempts to provide information, assistance, or emotional support (p. 437). Hobfoll & Stokes (1988) said it was "…social interactions or relationships that provide individuals with actual assistance or with a feeling of attachment to a person or group that/who is perceived as caring or loving (p. 499).
(Emphasis on certain kinds of dyadic interactions.)

Hupcey, (1998) described social support as well intentioned action, willingly given to a person with whom one has a personal relationship, which produces a positive response in the recipient (p. 313). In the Hupcey definition, positive intention and willingness are taken into account. Thus, an altruistic act for a stranger would not count as social support. One must already know the person and have a "personal relationship." Normally I would not expect that intention would matter in defining social support, but in some unusual circumstances, it is possible that offered support may be maladaptive. I will return to that idea later when I discuss dysfunctional support.
(This three part definition combines both intention and response with an already existing relationship.)

Cobb presented a paper (1976) which emphasized the highly subjective nature of social support. Cobb said it was information which leads a subject to *believe* that he/she (1) is cared for and loved (2) is esteemed and valued and/or (3) belongs to a network or communication and mutual obligation. So it is not just that assistance is offered in an interaction, it is necessary that the recipient *believe* something about the offer. This idea makes very good sense. If an interaction takes place which offers help, and the receiver of the offer does not believe it, then that individual cannot feel very supported. This is the case with all sorts of communicative messages. No matter what was said, it is what was understood that ends up being communicated and making the difference.
(Here, what the recipient *believes* is what is important.)

Hupcey (1998) summed up all of the theoretical definitions in the following way as including all or part of the previous concerns and emphases: (a.) the act of providing a resource, (b) the result

of which is that the recipient has a sense of well-being or of being cared for, (c.) there is an implied positive outcome, and (d.) there is an existing relationship between the recipient and provider (p. 310).

In identifying those components as essential to the definition, Hupcey leaves out some aspects that others have included and thought important such as (a.) social climate or environment, (b.) personal characteristics of either the provider or recipient, (c.) network resources, (d.) negative support (such as "tough love"), (e.) reciprocity (a kind of "pay back"), and (f.) the costs and benefits of giving and receiving support (p. 310).

THE FORMS OF SOCIAL SUPPORT: Let us say that one person has offered support to another person. What are the various forms which that support may take? Although there are various ways of making offers, some of them with multiple or overlapping purposes, there are only six main categories. These are emotional, instrumental, informational, appraisal, network and companionship. They are all, I would say, easily recognizable.

Emotional support: this consists of comfort and security from others leading the effected person to believe that he/she is cared for by others (Sarason et al., 1990). Emotional support conveys the idea that a person is valued for his or her own worth and is accepted. This kind of support may result in the enhancement of self esteem (Wan, Jaccard & Ramey, 1996, p. 502).

Instrumental support: this refers to acts such as loaning money or giving of one's time. It is also called "tangible support" because it involves the giving of material resources or services (Wan, Jaccard & Ramey, 1996, p. 503).

Informational support: this consists mainly of advice and counsel. While this might be helpful, it is my experience that oftentimes people ask for advice when all they want is for someone to listen to them. If you are a good listener, the person may believe that you have given them good advice, when what is actually the case is that they feel understood.

Appraisal support: this refers to evaluative feedback (Tardy, 1992). We all need feedback whether we want it or not. Sometimes the person who provides this is a "reality check" who confronts rationalizations or other escape mechanisms. Sometimes this takes the form of encouragement. Typically, we need positive as well as negative feedback.

Network support: this refers to being a member of a group or being put in touch with a group with common interests and concerns (Saranson, et al., 1990). These are usually more than casual acquaintanceships or shared recreation. You might view the AA as one of these groups, or a breast cancer survivor group, or a gay/lesbian support group. It is not unusual for people to say that support groups they are members of are extremely important to them, sometimes more important than family.

Companionship support: this is having someone to share life's experiences with. It distracts people from their problems and provides feelings of belongingness (Wan, Jaccard & Ramey,

1996, p. 502). Non-intimates as well as intimates can be companions (Tardy, 1992). I remember a young male student whose girl friend's mother was dying. He asked what he should be saying to her in order to be helpful. I told him that he didn't have to say anything in particular. He just had to be there with her.

SOCIAL SUPPORT AND RECIPROCITY: For the past forty years in social science research, a literature has been evolving about exchange theory (Thibaut and Kelley, 1959). The theory is a combination of some of the principles of field theory and reinforcement psychology. It treats relationships as if they were money. It says that offered behavior (such as support) can be responded to by the other in ways that are satisfying or dissatisfying to the giver. These outcomes are called costs and rewards. A relationship in which the offered behavior repeatedly ends up being costly will be perceived as dissatisfying and will eventually be terminated or "extinguished." This would be a relationship, for example, which took from a provider and gave nothing back. This theory suggests that we may have to invest something of ourselves in order to get something back, that some of our investments in other people end up being bad debts, and that there is no such thing as a "free lunch." So it is with social support. In adulthood, supportive relations, for the most part, imply mutuality. Relationships are often reciprocated (Barbour, 1994). If I am there for you now, then later if the need should arise, you will be there for me. That way, support is "cost effective," or "economical" for both parties and does not become burdensome.

DYSFUNCTIONAL SUPPORTIVE BEHAVIOR: There is a saying, common among psychodramatists, that sometimes one of the worst things you can do for someone is to help them. That seems like a strange comment in this context, but not all help is actually helpful. There are times when links with others become chains. Eileen Berlin Ray (1993) has identified four typologies of pseudo-supportive dysfunctions:

Support as commodity: This sets up an exchange so that the help seeker owes the provider; help creates a debt and obligation, sometimes a very large one; e.g., "What can you ever do to pay me back?" Here intention, as a part of the definition of social support, comes into to play. This typology differs from reciprocity (which has just been described as a good thing) because it is not mutually beneficial; it is unilateral only.

Support as information retrieval: The "provider" listens to gain information not otherwise available, but does not provide any actual assistance. This is simply using the other person as a source of information while seeming to help, but not actually helping. It is exploiting and manipulating the help seeker for whatever information he/she might provide.

Support as hegemony: This term from the Greeks describes a form of government alliance in which one state has a powerful influence over another. As a typology this would be a pseudo-supportive relationship in which one person dominates the goals and aspirations of the other even if they are not in that person's best interest. "No, you don't want that, you want this because this would be best for me."

Support as codependency: Both persons collude in an addictive closed system which is not helpful

or healthy to either one of the two. This might be a series of interactions which maintain dependency, delusion, dishonesty, or helplessness.

PRESCRIPTION FOR DEPRESSION: A case has been advanced here that depression may last for a lifetime and that it covaries with a lack of social support and with the "interpersonal difficulties" associated with a lack of social skills. That is, generally speaking, it is socially rather than organically or biologically determined. But if a person seeks treatment for depression, what can that person typically anticipate as a remedy? What is likely to be the recommended regimen? Most probably it is going to be medication, and that medication is going to be an anti-depressant. The brain communicates with itself through the use of special chemicals called neurotransmitters such as serotonin and norepinephrine. There is a strong correlation between the amount of these chemicals in the brain and a person's mood. If the levels of these chemicals get too low, for whatever reason, perhaps even loneliness, people feel depressed. Physicians regularly elevate the level of these chemicals with medication (See Szegedy-Maszak 2002).

There are four main categories of drugs that are recommended for depression and are often prescribed. The first is SSRIs (Selective Serotonin Reuptake Inhibitors) which increase the brain's level of serotonin, thus improving mood. These would include Celexa, Lexapro, Luvox, Paxi, Prozac, and Zoloff. The side effects for SSRIs are heartburn, drowsiness, loss of appetite and sexual dysfunction (typically an inability to achieve orgasm). It is important to note that SSRIs are also often prescribed for persons with severe shyness, an "interpersonal difficulty." A shy person's social condition is not changed or improved in any way, but the person's brain is medicated and the person's mood improves. A second category of medication is TAs (Tricyclic Antidepressants) such as Amitriptyline, Desipramine, and Nortripline with their side effects of drowsiness, dry mouth, constipation and interactions with other drugs. A third category would be such drugs as Effexor, Nardil, Parnate, Remeron, Serzone, Trazodone, Wellbutrin, and Wellbutrin SR with their occasional serious side effects of life threatening interactions with other drugs or with some foods. And there are also MAOIs (Monoamine Oxidase Inhibitors). All of these prescribed medicines are psychotropic drugs, drugs that alter perception, emotion and behavior, changing that person's sense of reality, and creating a chemically-induced emotional high (See Wingert & Kantrowitz 2002). Nurturing friendships, increasing the person's social support base, or developing the person's social skills are not normally in the treatment regimen. Nor is making the person less drug dependent.

THE GROWTH ASPECT: One final but critical idea should be mentioned. Social support can be valuable to people because it relieves depression and contributes to a general sense of well being. Potentially, it has a therapeutic power (Barbour 1986, 1987a 1987b, 1990). But it can also be valuable because it extends the self and what the self is capable of achieving, because it connects the self with others. Peoples' identities emerge out of this process and they can change and grow because of this process. The self emerges and grows out of interactions with others. From positive interactions come positive identities (Tardy, 1992). If we are at all concerned about interpersonal communication and the possible positive outcomes of our interactions with others, then one way to do that is to look at how satisfying our supportive relations are (Moreno, 1934). Who are we there for? Who is there for us? This is one way of examining the quality of

our relations with others. The quality of communication within the support system is a clue to the quality of our personal life generally (Albrecht & Adelman, 1987). If we go back full circle now, all of the way to the rationale we began with, we can see how the negative cycle develops. It was that depression was tied to the lack of the availability of a support system which is tied to "interpersonal difficulties." The most obvious way to halt or reverse the negative cycle is not to spend a lifetime on medication in a false euphoria, but to gain some social skill (Barbour, 1981) and start making contact with others. However small and seemingly insignificant those initial efforts might be, they are the indispensable requirement for creating that needed support system, a system which not only makes our lives healthier, but can also make them fuller, happier and of better quality (Cobb, 1976).

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Paper presented to Group Research Section of 15th International Congress of the International Association of Group Psychotherapy, Istanbul, Turkey, August 25-29, 2003.
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