A SOCIAL NETWORK INTERVENTION FOR PEOPLE WITH MENTAL HEALTH PROBLEMS

BY

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A SOCIAL NETWORK INTERVENTION FOR PEOPLE WITH MENTAL HEALTH PROBLEMS

BY

DANA JOAN LEWIS

A practicum submitted to the Faculty of Graduate Studies of the University of Manitoba in partial fulfillment of the requirements of the degree of

MASTER OF SOCIAL WORK

Abstract

A review of the literature indicates that social support buffers stress during major life transitions and that individuals with mental health problems tend to have low levels of social support resources. The practicum objective was to investigate the efficacy of a ten session individual intervention to increase social support resources with participants of an employment service for individuals with mental health problems. The writer met with eight participants of the employment service. Interventive methods included education about the function of social support, network mapping, goal setting, social skill coaching, amelioration of attitudinal barriers and increasing access to social opportunities in the community. Complete data sets were available for five of the participants. An increase in the level of reciprocity of relationships was reported by 80% of participants. Some of the participants were able to increase the size and diversity of their networks. Network building interventions may be a valuable addition to programs designed to increase the community integration of people with mental health problems.

Acknowledgements

I would like to thank Eric and my family, my colleagues at the Canadian Mental Health Association, Winnipeg Region, the practicum participants and practicum committee members for their assistance and support.

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INTRODUCTION

The tenets of social network theory complement social work's emphasis on an ecological approach. The application of concepts drawn from social network theory to social work in the mental health field, represents an alternative to the emphasis on inter-individual factors of the medical approach that has dominated the field. Social network literature suggests that programs of formal support increase attention to the building and maintenance of informal support. Garbarino writes that:

> As people concerned about the quality of living in our society, we must understand the limitations of our role and how to complement and augment it by collaborating with informal helping networks (1983:16).

The following is a report of a practicum intervention designed to increase the informal social support available to participants of an employment service for people with mental health problems.[1]

A review of the literature indicates that supportive ties in the social network act as a buffer to stress during life transitions. The literature also suggests that people with

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[1]Although the term "person with a mental health problem" is used throughout this report to refer to a person who has experienced the mental health system, it is acknowledged that language is a very sensitive issue with a range of preferred terms.

mental health problems tend to have reduced levels of social support. While the employment service model specifies on-going support from project staff to participants during and following the transition from unemployment to employment, D'Augelli (1983) cautions that formal services are inadequate in meeting individual support needs. The practicum intervention was designed to address participants' support needs. It was created to facilitate participants' own network building activities with the intention that the increased levels of support would ease their transition to employment and assist them in maintaining employment.

The practicum had two main objectives. The first was to improve the effectiveness of the employment service in maintaining program participants in the workplace by increasing the levels of informal social support available to them. The intervention was designed to increase the reciprocity of participants' network ties and to increase the size and diversity of their networks. The intervention included facilitating participant awareness of the function and importance of social support, assisting participants to improve social skills related to network building and increasing access to social opportunities in their communities to accomplish this end. The second objective of the practicum was to increase the awareness of employment service staff of the theory behind and the utilization of social network

interventions. In their recommendations for training of personnel in supported employment programs, Danley and Mellen (1987) specify the need for professionals to recognize the contribution that family members and peers can make to program success. They argue that supported employment practitioners require not only knowledge of the community support network but must possess the skills to generate support from program participants' significant others.

The practicum comprises a major part of the requirements of the Master of Social Work degree. In accordance, student learning is one of the primary goals of the practicum.
Four learning goals for the practicum were set. First, through the practicum the writer planned to explore the use of social network interventions with people with mental health problems. A second goal was to develop skills in the preparation and delivery of an intervention. Third, the writer hoped to improve interpersonal skills in one to one situations and to increase group facilitation skills. Finally, the practicum provided an opportunity to develop skills in the evaluation of an intervention.

The first chapter of this report contains a review of literature relevant to the practicum intervention. This is divided into three areas: social networks and their relationship to coping, studies that have explored the social

networks of people with mental health problems, and work which has explored the relationship between social support and employment. The second chapter of the report contains a description of the methods employed in the practicum intervention and the evaluation design. The third chapter provides detailed descriptions of the experiences of three of the practicum participants and a thorough reporting and discussion of individual and aggregate data. In the fourth chapter, issues that arose during the execution of the practicum and their implications are explored. The final chapter contains the conclusions that were drawn from the practicum.

CHAPTER 1

LITERATURE REVIEW

1.1 Social networks and coping

A social network is comprised of the people with whom we live, work and interact on a regular basis. "A social network refers to the ties one has with a group of people and the links within the group. It is a way to objectively measure the structure of a person's social resources and examine how structure varies across a range of settings" (Mitchell & Trickett, 1980 in Leavy, 1983:4).

Social support, then, is the help provided to individuals by the members of their social networks. Garbarino (1983) defines social networks as: "...a set of interconnected relationships among a group of people that provides contingent reinforcement for efforts to cope with life on a day-to-day basis" (5). Caplan (1974) states that natural support systems generally consist of three basic elements: they assist the individual to deal with emotional problems and use psychological strengths, they share burdens and tasks and provide tangible resources such as money, tools, living space or advice. House (1981) identifies four types of social support behaviours: emotional support which includes caring, trust and empathy; instrumental support which involves

tangible forms of aid such as lending money; informational support which entails the provision of knowledge or skills; and appraisal support which assists in measuring personal performance (in Leavy, 1983). In both Caplan's and House's conceptualizations the categories of support are not separate entities but rather are interrelated components of social support (Leavy, 1983).

According to Gottlieb (1983) it is incorrect to assume that the social network provides solely positive support. The network may contain un-supportive ties which are themselves a source of stress. Attempts by network members to assist the focal individual may disrupt his or her coping abilities or create feelings of dependency. When a network focuses its efforts on helping an individual that individual may experience a loss of self-esteem and personal control.

Social support is often classified as either formal (support provided by professionals) or informal (support received from friends, family or other natural network members). Many theorists argue that support from informal sources is preferable. Froland, Pancoast, Chapman and Kimboke (1981) found that informal helpers dealt with a broader range of issues and related to clients in terms of mutuality, common experience and equality of status, features that are lacking in professional helping relationships (in Weslowski, 1987).

Analysis of social networks began in the fields of sociology and anthropology to better explain the patterns of relationships between people (Berkman, 1984). Network analysis combines both structural and functional dimensions (Gottlieb, 1983). Structural dimensions like size (the number of network members), density (the connections between network members) and the sources of ties (neighbourhood, work setting) are commonly measured. Functional characteristics such as multiplexity (the extent to which network members fulfil more than one supportive function), reciprocity (the mutuality with which aid is provided), intensity (the strength of the tie) and durability (the duration over time of the tie) allow assessment of the quality of the support supplied by the network.

The health protective effects of social support have been the focus of much recent interest in the social work field. Low levels of social support have been correlated with alcoholism (Hunt & Azrin, 1973), stress (Cobb, 1976), mental illness (Gottlieb, 1981), marital problems (Wilcox, 1981), depression (Reiss & Benson, 1985) and re-entry into mental institutions (Caplan, 1974) (in Weslowski, 1987). Both physical and mental health are believed to be safeguarded by the support provided by social networks (Cassel, 1976; Heller. 1979; Kaplan, Cassel & Gore, 1977 in Tardy, 1985). Social support is believed to have both a stress buffering and health protective effect on

individuals (Gottlieb, 1983). The health protective effects of social support are postulated, according to Gottlieb, in the context of a theory that implicates life stress in the onset of psychological and physical disorders: the accumulation of life stressors triggers changes in the accustomed pattern of social adjustment, these changes in turn have emotional and behaviourial effects that lead, either directly or indirectly through some neurochemical process, to a weakened state and greater vulnerability to illness or disordered functioning. During times of life change or chronic exposure to stress, social support buffers the individual from potential adverse effects on mood and functioning, and facilitates coping and adaptation, reducing the likelihood of illness. Social support may play a role in insulating people from exposure to stressors and in fostering good health and morale (Gottlieb, 1983).

The analysis of an individual's social network is a helpful tool for assessing coping resources and may be useful in predicting adaptation to life transitions (Gottlieb, 1983). Interestingly, however, such life transitions often affect the size, interconnectedness, clustering and geographic dispersion of an individual's social orbits (Gottlieb, 1983). Gottlieb (1985) has pointed out that differences in social network needs exist not only between people but change for an individual over the course of the lifespan. He argues that

different structural configurations (for example, a dense network during times of crisis) are optimal during periods of stress, transition or stability. During times of transition, then, particular attention should be paid to the network to ensure that appropriate supports are in place to aid in the initial transition and to maintain the hoped for changes following the transition.

1.2 The social networks of people with mental health problems

Comparisons of the social networks of individuals diagnosed with a mental illness with matched samples from the general population have appeared in the literature. Evidence suggests that clinical populations have social supports which differ from non-clinical populations in three ways. First, findings have consistently shown that people without mental health problems have more support available to them than do people with psychological disorders (Leavy, 1983). Second, individuals with mental health problems tend to receive more support than they provide (Hammer, 1981). Research has not shown whether this lack of reciprocity is a result of poor social skills, dependency created by network members or from low levels of self-esteem which cause the individual to believe that he or she is incapable of extending support

(Gottlieb, 1983). Sokolovsky and his colleagues have linked low reciprocity of supportive relationships with higher symptomatology and a greater likelihood of hospitalization among people with mental health problems (in Hammer, 1981). Finally, there is evidence of emphasis on non-family ties in the composition of networks of people with mental health problems. Both Silberfield (1978) and Sokolovsky (1979) reported lower family involvement in the support networks of the mentally ill (cited in Leavy, 1983). While Tolsdorf's (1976) findings differed, his study was based on a small sample of young men diagnosed with schizophrenia and may reflect a population who have not lost family ties through death or by having exhausted the resources of family helpers (Leavy, 1983).

The empirical data confirms what clinicians have reported for years, an isolated population with few social supports (Beels, 1981). A study of 505 people discharged from inpatient psychiatric facilities in Toronto reported that:

> [t]he degree of social isolation was reflected dramatically by the finding that one in five subjects had no close friends and two in five had fewer than two social visits a month (Fischer et al., 1981:24).

While inter-individual factors are frequently cited as reasons for the social isolation of people with mental health problems, the formal mental health system often provides

services in a way that exacerbates their seclusion. Many of the current approaches to psychiatric care, housing and employment services limit the opportunities for individuals to develop and maintain supportive social ties. Minuchin and Elizur (1989) describe the re-organization of social systems to exclude the individual while he or she is hospitalized. Psychiatric care continues to be provided outside of the individual's community. Nelson and Earls (1986) and Fisher et al. (1981) describe the lack of social support available to residents of mental health boarding homes. Lugtig (1990) found that community tenure increased the number of supportive ties and Boydell (1993) cites transitional housing models as limiting client's social network building. Yet housing services for people with mental health problems continue to rely on segregated and/or transitional approaches.

Psychiatric care that is not community based, housing that is transitional and non-integrated and a lack of competitive employment opportunities contribute to the shortage of support often experienced by people with mental health problems. Professional characterization of the family as dysfunctional has caused families to distance themselves from members with mental health problems (Birchwood & Smith, 1990). The concept of the "schizophrenogenic family" is an example of this tendency to place blame on families.

Gottlieb describes care-giver support development activities that could replace the family therapy modalities that focus on the dysfunctional aspects of the families of people with mental health problems. The aim of this network intervention is "to strengthen the capacity of social networks or central figures therein to provide ongoing and crisis support" (Gottlieb, 1985:313). An example of this kind of support is the provision of respite care to families who have a member with a mental health problem residing with them. Family support or self-help groups are another way to help families provide services. A third way of supporting community care-givers is through the reduction of the discrimination against people with mental health problems and their families.

Lack of appropriate services may exacerbate difficulties that people with mental health problems experience in gaining satisfying levels of social support. There are difficulties, however, involved in speaking generally about social networks and about the needs of people with mental health problems. The difficulties with generalizing are three-fold. Beels (1981) has pointed out that the circumstances and needs of people may vary depending upon the kind of mental health problem they experience:

> Important variables in depression--presence of a spouse confidant, absence of young children at home, and employment--are not significant variables for schizophrenics because they tend to be unmarried, childless, and unemployed as a group (61).

Second, Gottlieb (1985) has pointed out that differences in social support requirements exist not only between people but change over the course of life. Different network structures are optimum during periods of stress, transition or stability. Finally, the social context of the individual cannot be ignored in attempting to facilitate the development of appropriate social support in the community. Social network formation is related to normative values of ethnicity, gender, social class, and personal belief systems.

1.3 Employment and the social network

According to Anthony and Blanch (1987) "some of the symptoms of chronic unemployment, ie., social withdrawal, passivity, lethargy, and isolation, seem to mirror some of the symptoms of a chronic mental impairment" (5). In Canada, the employment rate for individuals diagnosed with a major mental illness is about half the rate for the general adult population (Fisher et al., 1981:24). This high rate of unemployment is found even though people with mental health problems reflect the range of intelligence, level of education and career goals found in the general population (Anthony & Dion, 1986 in Anthony & Blanch, 1987).

The transition from unemployment to employment is a major life change. Such life transitions often affect the size, interconnectedness and clustering of an individual's social network (Gottlieb, 1983). Employment impacts upon the social field of an individual and creates the potential for higher functioning and greater community integration (Anthony & Blanch, 1987).

Employment has the potential to address the deficits in the social networks of people with mental health problems cited in the literature. The size and diversity of the social network may be augmented by increased social contacts in the workplace. The greater economic resources generated by employment increases the accessibility of recreational and community activities thus further enlarging opportunities for support. In Canadian society, the receipt of social assistance is stigmatized and individuals who rely on this source of income often exist on the periphery of the social system. According to Armitage (1988) "All social welfare programs have a tendency to stigmatize their recipients, principally because welfare support continues to be viewed as an admission of failure on the part of the beneficiary" (48). People with mental health problems who are also recipients of social assistance are thus doubly stigmatized. An important effect of employment is the reduction of stigma, improvement of self-esteem and increased attractiveness to potential

supporters. Reciprocity of relationships may also be enhanced through improved self-esteem due to employment and increased financial resources.

According to Pearson (1990), major life transitions often involve a decrease in social support because the individual's resources are exhausted in coping with the change rather than in generating new sources of support. While employment provides the opportunity for increasing the size, diversity and reciprocity of an individual's social network, the transition from unemployment to employment may decrease the occasion for continuing supportive ties already established. An individual who gains support from a group at an afternoon drop-in centre may lose contact with those individuals if working hours preclude participation in the group. An unemployed individual may render services to friends or relatives that would no longer be possible during a period of employment. The transition to employment presents both an opportunity to increase social support and a threat to the continuation of support from existing sources.

Social skills required in the work setting differ from the skills that are required in other settings. According to Pearson (1990), "the changed situation into which the person in transition moves may have informal rules governing the

formation of relationships of which the individual is unaware" (27). Social skills, the development of which is facilitated by social interaction, play an important role in maintaining employment. A review of the literature of the psychosocial rehabilitation field reveals the impact of social skills on the work performance of people with mental health problems. In Anthony and Jansen's (1984) review of studies of predictors of vocational outcome, the authors found that ratings of work adjustment skills, which include getting along with co-workers, are the best clinical predictors of future work performance. They write that "...it would appear that estimates of the skills of getting along with co-workers and supervisors and being dependable ... are most relevant to future work behaviour" (541). Ratings of more general social functioning have been found to be a significant predictor of future work performance among the psychiatrically disabled (Green et al., 1968; Griggiths, 1974; Gurel & Lorei, 1972; Miskinims et al., 1969; Strauss & Carpenter, 1974; Sturm & Lipton, 1967; in Anthony & Jansen, 1984). According to the authors of this review:

> In spite of the wide range of items used to tap social functioning, the studies are remarkably similar in finding a relationship between social ability and future vocational performance (Anthony & Jansen, 1984:541).

Social skills provide individuals with the tools to tap sources of support in the workplace and to garner social support elsewhere. Since much of work is primarily social,

proficiency with these skills enhances ability to maintain employment. A supportive network in general can bolster individual's coping resources to deal with the transition to employment.

1.4 Summary

Social support provides individuals with assistance in coping with the stress generated by both day to day living and by negotiating major life transitions. Studies of the social networks of people with mental health problems have shown deficits in the amount of support available. Frequently, inter-individual factors such as a lack of social skills have been implicated in the social isolation of people with mental health problems. Systemic barriers such as discrimination and traditional modes of treatment have also played a part in the segregation. Employment offers an opportunity for increasing levels of support available but successful vocational outcomes may be hampered by a lack of support in adjusting to work and a lack of the social skills which are developed through social inclusion.

CHAPTER 2

INTERVENTIVE METHODS AND EVALUATION DESIGN

2.1 Setting

The Canadian Mental Health Association, Winnipeg Region, is a volunteer, non-profit agency. The agency's objective is to promote mental health. In collaboration with the actions of other regions, with the divisional and with the national arms of the Canadian Mental Health Association, the Winnipeg Region engages in various lobbying strategies to advocate the interests of individuals with mental health problems. A primary strategy of the agency is to engage in direct service and educational projects that meet priority mental health needs and demonstrate exemplary methods of meeting those needs. At present, the agency delivers advocacy, public education, information and referral, employment and housing services.

The Canadian Mental Health Association, Winnipeg Region received funding for an employment service designed to enable people with mental health problems to secure employment in the competitive labour market. A three-year demonstration project which began in November 1990, the program offers assistance to individuals with mental health problems who have had difficulty in accessing the competitive labour market.

Using a supported employment approach, the program differs from traditional ways of providing vocational services to people with mental health problems. One of the program's premises is that the potential to work resides in all individuals regardless of diagnosis or history of disability. The program focuses on assisting participants to secure and maintain employment in competitive settings in the community. Employment that enhances financial independence is sought, with attention to factors such as wage level, job security and working conditions. The opportunity for frequent daily contact with co-workers, supervisors and others in the most normalized work setting possible is emphasised. Personal choice in setting career goals and long term support in achieving them are seen as the keys to success. With the assistance of program staff, participants select occupational goals and develop and implement plans for achieving them. A staff-participant ratio of approximately 1 to 10 assures a high level of service.

During the first year of operation, approximately 24 individuals were accepted into the employment program. Referral is from other agencies and by client self-referral. Participants in the employment service are selected to include those with a wide variety of educational and employment backgrounds, a range of the duration and level of disability and of differing ages and vocational goals. The length of

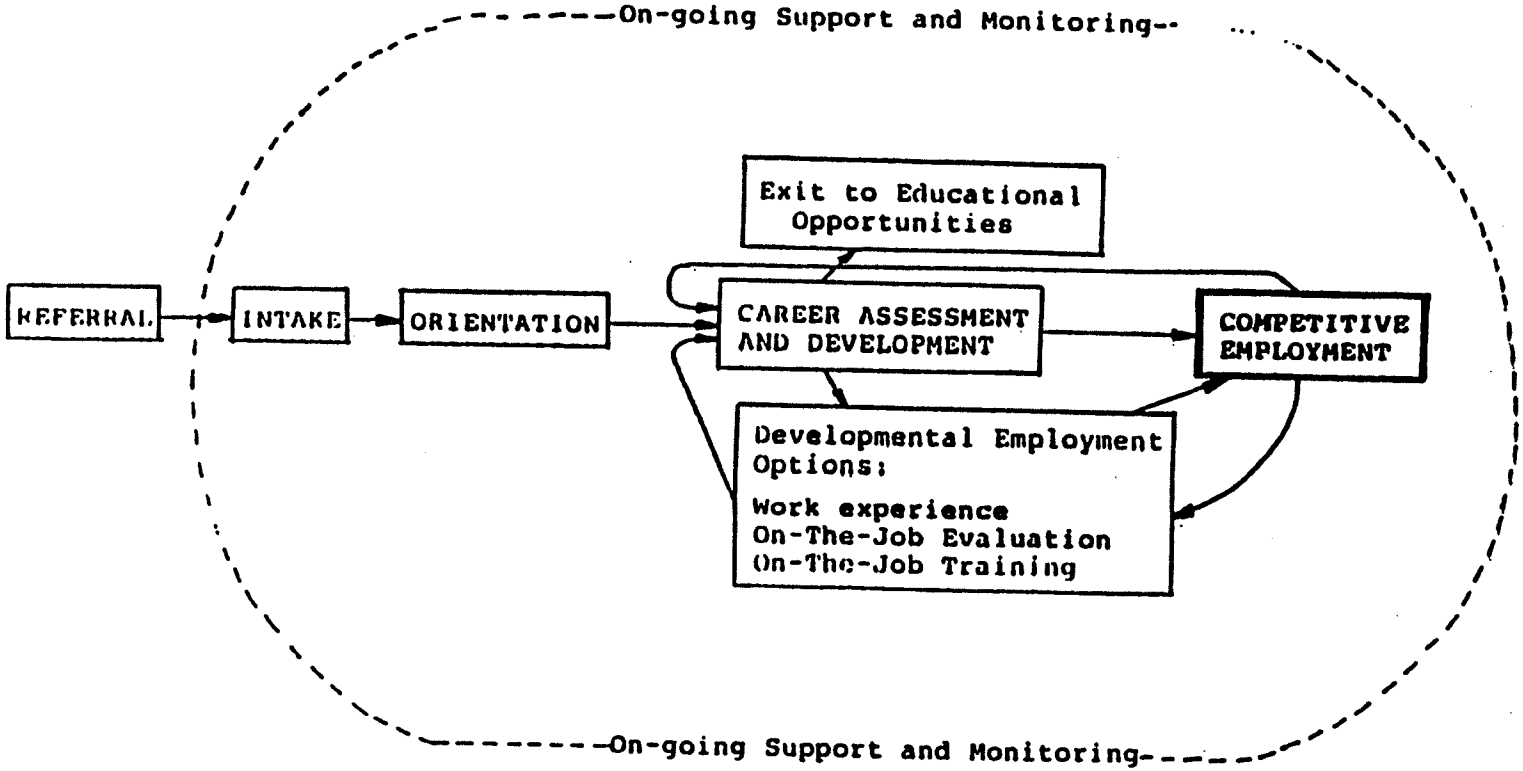
program participation depends upon the individual participant's choice. The program offices are located in downtown Winnipeg.

Eligibility criteria for program access are as follows:

1. Primary psychiatric diagnosis, which includes the following components:
   A. Diagnosis: Evidence of psychiatric diagnosis.
   B. Disability: Evidence of factors which have impeded integration and lifestyle.
   C. Duration: Indication that a person's situation has some historical component.
2. Eighteen years of age or older.
3. Be motivated toward the acquisition of competitive employment in the community.

On the following page is a flow chart of the model upon which the employment service is based.

Figure 1 Employment Service Model



2.2 Practicum inclusion criteria

For inclusion in the practicum, participants were required to meet the following criteria:

1. Be a participant in the employment service;
2. Be willing to participate in the practicum (see voluntary consent, below);
3. Able to identify current or potential difficulties with their social networks and be willing to work toward ameliorating these difficulties;
4. Be available for appointments in addition to those required for participation in the employment service;
5. May be involved at any stage of the program--choosing, seeking or keeping a job;
6. May be working with any of the employment coordinators.

2.3 Recruitment

During the start up phase of the practicum, employment service staff were apprised of the nature and purpose of the intervention. Staff members were provided with both written and presented material on the theoretical and practical aspects of social support. They were asked to speak about the

practicum with the participants with whom they were working and to pass along the names of participants expressing an interest in more information. The writer met with interested participants to further explain the nature and purpose of the practicum intervention and the time commitment required. Participants who were still interested after further explanation were given a written summary of the practicum which included an explanation of the provisions to ensure confidentiality. (The recruitment letter is included in Appendix D.) They were asked to consider their decision and to contact the writer in one week. Attached to this information was a consent to participate form which they were asked to complete if they decided to participate. (The consent to participate form is included in Appendix D.) Participants were recruited initially in July 1991 and then as spaces became available new participants were approached.

There was limited interest expressed by participants of Employment Dimensions in forming a support group and thus this option did not comprise part of the practicum.

2.4 Voluntary Consent

The nature and purpose of the practicum intervention was explained to potential practicum participants, including the

procedures to be used for the evaluation of the practicum. Involvement in the employment program was not dependent upon participation in the practicum intervention, but involvement in the practicum intervention required consent to the collection of data for evaluation. Consent to the audio recording of individual sessions was sought, however participation in the practicum intervention was not contingent upon obtaining consent. A one week period between the explanation of the requirements of practicum involvement and signing of the consent form was given to allow individuals time for consideration of their participation. Each potential participant was given written materials about the practicum intervention and evaluation procedures to review during this time.

2.5 Confidentiality

Members of the practicum committee were required to sign and adhere to the confidentiality policy of the Canadian Mental Health Association, Winnipeg Region. All audio recordings and files related to practicum participants were kept in locked cabinets and were destroyed following the practicum presentation. Throughout the practicum report and during the practicum presentation identifying details of participants were masked to protect confidentiality.

2.6 Supervision

File notes of each session included the session plan or purpose, a description of the session and an analysis. Copies of these notes and audiotapes, where available, were supplied to Don Fuchs and work with each participant was reviewed during meetings between Don Fuchs and the writer throughout the intervention phase of the practicum.

2.7. Overall Strategy

The intervention approach was participant-driven and focused on support, education and skill-building. Lugtig and Fuchs (1992) delineate three activities in the networking process: identification, mapping and linking. Identification is described as:

> the process whereby persons recognize the potential for networking in their social networks. This is an information-gathering phase in which the potential network members are named, their willingness to provide support is discussed, their resources and personal capabilities are listed, and their willingness to provide help or support in different situations is determined (Lugtig and Fuchs, 1992:51).

Mapping is described as a process of charting network ties, including features such as strength of ties, type of relationship and the frequency, duration and intensity of the connections. (Lugtig and Fuchs, 1992:51). Linking is the goal setting step. "Once the network is mapped, a determination

can be made about how it can be changed or altered to provide different or better sources of social support" (Lugtig and Fuchs, 1992:51).

Work began with what Lugtig and Fuchs (1992) refer to as identification. This included use of a standardized measure, the Social Relationships Scale (McFarlane et al., 1981). The Social Relationships Scale is a structured interview which elicits information about network size, types of support provided by each network member, helpfulness of the support provided and the reciprocity of relationships with network members. In addition to assessing the current level of social support, initial interviews with practicum participants were also designed to clarify their support needs. Mapping of the participant's network was done in the second interview. (A procedure for network mapping appears in Appendix F.) The information gleaned from these activities was shared with the participant. According to Gottlieb (1983), a comprehensive approach should give people a clearer understanding of the interplay between their social and personal resources so that they can make better use of both. An educational component was included to help participants to understand the basic tenets of social networks to heighten their awareness of the function and importance of social support. An outline of the information discussed with participants is included in the procedure for network mapping in Appendix F.

The identification and mapping phases provided a basis for the linking or goal setting phase of the practicum intervention. An individual strategy for improving network support was developed through a process of consultation. Sensitivity to normative values of ethnicity, gender, social class, and personal belief systems was observed. Ways of overcoming the barriers to a participant's goals were discussed and an agenda for the remaining sessions negotiated.

Three strategies were employed in assisting participants to meet their networking goals: social skills coaching, amelioration of attitudinal barriers and increasing knowledge of and access to social opportunities.

The development of needed social skills is invaluable in developing and sustaining the relationships that form a web of support. A lack of appropriate social skills has been cited as a barrier to people with mental health problems achieving community integration (Dimirsky, 1982). When a participant identified a social skill deficit as a barrier to goal achievement, exploration of the nature of the skill required, the extent to which it was required and the participant's current performance of the skill followed. Coaching strategies included the polishing of existing skills and the development of new skills to facilitate the formation of new

ties or to maintain or improve existing relationships. Coaching included the discussion of the importance of particular social skills. Role plays during sessions were employed to learn skills and practice their use in a controlled environment. In vivo practice either with the writer or independently was done to ensure that the skill could be used in a natural setting.

Pearson (1990) identifies several attitudes that act as barriers to social support: low self-esteem, fear of criticism, expectation that others won't help, ambivalence toward others, self-centredness, suspicion and insensitivity (78). These attributes when identified as barriers became the target of change efforts. Discussion with participants allowed for exploration of fears related to social situations and provision of information about expectations in social situations assisted them in overcoming their attitudinal barriers.

Where participants identified a deficit in accessing community resources as a barrier to goal achievement, the intervention included linking individuals to appropriate resources and facilitating their usage. Potential settings for interacting with others were explored during sessions. Information about available resources in the community was researched either by the participant, the writer or both. Where barriers to the

use of the community resource was an issue, an access plan was made and facilitated.

Participants met with the writer for ten sessions at intervals of approximately one week. Meetings took place at the Employment Dimensions office in private interview rooms and were usually one to one and a half hours in duration.

2.8 Intervention plan

The following was the plan for the ten sessions of the intervention.

Session #1
Review practicum participation requirements
Overview of the intervention process
Explain measurement strategy, rationale and procedures
Administer Index of Self-Esteem
Give Index of Self-Esteem to do between sessions
Administer Social Relationships Scale
Summary and Debrief

Session #2

Administer Index of Self-Esteem

Score Index of Self-Esteem

Chart Index of Self-Esteem results and discuss relationship to how participant has been feeling to check accuracy of score

Give Index of Self-Esteem to do between sessions

Explain network mapping procedure and draw network map

Summary and Debrief

Session #3

Administer Index of Self-Esteem

Score and chart results of Index of Self-Esteem and check in to check accuracy of score

Give Index of Self-Esteem to do between sessions

Give feedback from Social Relationships Scale and Network Map

Explain basic network concepts like reciprocity, formal and informal helpers, balance across sectors

Begin discussion of possible participant goals for practicum work

Summary and debrief

Session #4

Administer Index of Self-Esteem

Score and chart results of Index of Self-Esteem and check in to check accuracy of score

Give Index of Self Esteem to do between sessions

Goal setting

Establish agenda for remaining sessions

Summary and debrief

Sessions #5-#9

Administer Index of Self-Esteem

Score and chart results of Index of Self-Esteem and check in to check accuracy of score

Give Index of Self-Esteem to do between sessions

Review participant goals and agenda for remaining sessions

Work on topic for the session

Summary and debrief

Session #10

Administer Index of Self-Esteem

Score and chart results of Index of Self-Esteem and check in to check accuracy of score

Administer Social Relationships Scale

Draw Network Map

Administer Service Checklist

Review participant goals, progress toward achievement of goals and future goals for the network

Termination

Follow-up Appointment (at three months following session #10)

Administer Social Relationships Scale

Administer Service Checklist

2.9 Evaluation design

Practicum evaluation used a single subject design. It included the use of a standardized measure, The Social Relationships Scale (McFarlane et al., 1981), to evaluate change in the social networks of the participants over the course of the intervention. Changes over the course of the intervention in the self-esteem of practicum participants were charted through the use of the Index of Self-Esteem (Hudson, 1974). The clinical significance of the intervention was assessed through discussion with participants and the administration of a service checklist for evaluating effectiveness (adapted from Bloom and Fischer, 1982:405). The Social Relationships Scale, Index of Self-Esteem and Service Checklist are included in Appendix B. A file audit was proposed to determine if changes had occurred in the amount of time that employment service staff spent with participants as a result of practicum involvement.

2.9.1 Index of Self-Esteem

The relationship between social support and self-esteem has been discussed in the literature. According to Pearson (1990), "[t]he pervasive belief that one is of little worth is both cause and effect of social isolation" (36). Included in the practicum evaluation, therefore, was ongoing measurement of the level of participant self-esteem. The scale chosen to measure self-esteem was Hudson's Index of Self-Esteem (1974), a 25 item scale designed to measure the respondent's level of self esteem. Scoring of the instrument yields a rating ranging from 0 to 100 with higher scores giving more evidence of the presence of problems with self-esteem. It has a cutting score of 30 (+ or -5), with scores above 30 indicating that the respondent has a clinically significant problem with self-esteem. Norms for the scale were derived from tests of 1745 respondents of varying backgrounds. The Index of Self-Esteem has very good internal consistency, with a mean alpha of .93. A two-hour re-test correlation of .92 demonstrates its stability. It has good known-groups validity and can differentiate between groups identified by clinicians as having difficulty with self-esteem and those not. The Index of Self-Esteem has good construct validity. It correlates well with other measures with which it should correlate highly (depression, happiness, sense of identity) and not with measures that it should not (Corcoran & Fischer, 1987:188).

The Index of Self-Esteem is written in easily understood language and is readily administered and simple to score. It takes approximately five minutes to complete.

The Index of Self-Esteem was administered twice weekly beginning with the initial data gathering session. This yielded approximately six data points to establish a baseline before the beginning of the intervention. Data collection continued throughout the intervention. Results were charted during each session and discussed with participants.

2.9.2 Social Relationships Scale

The Social Relationships Scale (McFarlane et al., 1981) was developed as part of a more extensive home interview carried out by trained interviewers. Respondents are presented with six categories of potential life stress and asked to list those persons with whom they have discussed each of the problem areas and their relationship to that person (spouse, parent, sibling, co-worker). The respondent rates the helpfulness of discussions with each person on a 7-item Likert scale ranging from "makes things a lot worse" to "helps things a lot" and indicates whether the person they have named would discuss similar matters in his or her own life with the respondent. The interviewer probes the respondent to elicit

information about network members who may have been forgotten.

The questionnaire asks with whom the participant discusses changes, both positive and negative, in each of six topic areas. These six sub-scales measure support from network members in the areas of work, money and finances, home and family, personal health, personal and social issues and society in general. Administration of this instrument takes approximately thirty minutes depending upon the number of individuals that a respondent lists.

The psychometric properties of the Social Relationships Scale, as described by McFarlane et al. (1981) recommend its use for evaluation of the practicum intervention. Test-retest reliability was established by administering the same instrument twice to 73 community college students at a one week interval. Network size remained stable with a median correlation over each category of support of .91. The test-retest reliability of the extent of the network was above .90 for spouse, siblings, parents and friends. Lower correlations for the categories "other relatives" (.62) and "physician" (.65) were reported. The lower stability of the latter category was anticipated to be problematic given the impact of the doctor-patient relationship on people with mental health problems observed in clinical practice. It is not expected that the low stability for the "other relatives" category will

have significant impact upon the data given their generally lesser role in support provision. The average helpfulness score across categories had a median correlation of .78, and correlations for each category ranging from .54 to .94. Correlations for helpfulness in the categories of work and personal life were .94. These are expected to be the most important areas for the intervention. Low reliability of helpfulness for health (.60) is a potential problem given the expected concern among practicum participants with health-related matters. The authors explain the low correlation for the category of money and finances (.54) by the wide variation on this score by one individual.

Milardo (1988) identifies response bias as a problem with measures of close associates and significant others. A group of 19 post-graduate students were given the questionnaire on two occasions with two different sets of instructions. The first instructions asked them to complete the form based on their own circumstances and the second instructions asked them to complete it for ideal circumstances. The significant differences in response indicated that a socially desirable response is not elicited by the usual instruction set.

Face, content, criterion and construct validity were established for the Social Relationships Scale. The authors cite the clinically expectable results of the data yielded by

the instrument as indicative of its face validity. In examining the measure it appears to be comprised of questions that would extract the necessary data. An expert panel of four clinicians reviewed the instrument to assess content validity. They concluded that the scale failed to provide information about the existence of key figures who could provide reliable support, and so the instrument was altered to elicit this information. Discriminant validity for this measure was established by administering the instrument to a group of parent-therapists (n=18) and patients referred for marital or family problems (n=15). As hypothesised, the measure was found to discriminate between these groups in ratings of spouse helpfulness in all categories. Results of the application of the instrument to a group of 518 general population subjects were similar to findings of other studies examining social network support with other instruments and thus support the construct validity of the instrument.

Five advantages of using the Social Relationships Scale for this application were found. First, the Social Relationships Scale measures support in various settings and from various sources. The wide range of information generated gives a global picture of support and thus provides an important baseline for clinical assessment in determining appropriate points of intervention for participants. Second, the scale measures qualitative aspects of support. According to

Gottlieb (1983), the social network should not be viewed exclusively as a support system that is unconditionally helpful to its members. For clinical evaluation, an instrument that measures perceived outcome of interactions is important to generate potential areas of intervention and to measure results of an intervention component that aims to strengthen social skills to impact upon the quality of the social network ties. Third, the Social Relationships Scale measures the reciprocity of support. An assumption of equivalence and reciprocity across all close relationships when in fact such relationships among adults tend to be highly specialized and asymmetric has been identified as a weakness of many measures of social support (Milardo, 1988). The non-reciprocal nature of relationships between significant others and people with mental health problems is a target of the proposed change efforts and measurement of this dimension is important to the evaluation. Fourth, although the interview format of the instrument requires somewhat more clinician time for administration than a questionnaire format, it overcomes possible misunderstanding of questions and difficulty due to literacy level or test anxiety. Finally, the Social Relationships Scale is a Canadian measure with norms developed for a Canadian population.

Five limitations were discovered in using the scale. First, information about the application of the Social Relationships

Scale to a sample of people with mental health problems is unavailable thus its accuracy with this population is unknown. Second, although discriminant validity was established between clinical and non-clinical groups, there is no information regarding the instrument's sensitivity to clinical change. Third, by focusing on discussion of potential sources of stressors, the Social Relationships Scale may miss the important aspect of more active forms of aid such as lending money or providing transportation. Gottlieb (1983) suggests that these more active forms of aid may be important in assessing social support. Changes in more active forms of aid may be difficult to assess from the data. Fourth, some social support measurement devices include questions that inquire about affective ties to individuals that a person does not interact with regularly or even necessarily know. According to Pearson:

> While it is rare that an individual will report vicarious supporters (those with whom there is no current contact or there has never been any contact), there are situations in which such support is not only observed, but is an important part of the individual's support resources (1990:67).

According to Pearson, reliance on vicarious supporters is most likely for individuals who are socially isolated, and may be a factor for people with mental health problems who have been found, as a group, to be so (Beels, 1981; Fisher et al., 1981). Finally, the Social Relationships Scale relies upon information provided by the respondent and may be subject to

variation caused by feelings of the respondent. According to Tardy (1985): "Individuals' reports of social support may be a function of how individuals feel when they complete the instrument" (194). Despite the methodological problems accompanying subjective measures of social support, it is important not to dismiss the etiological significance of people's feelings about their social resources (Gottlieb, 1983).

Social scientists reviewing the measurement of social support agree on little except that there is a lack of reliable and well validated instruments available to the practitioner. This has been attributed to the theoretical vagaries of social support and to the relative newness of the area of study (Barrera, 1986). The Social Relationships Scale is one of the few instruments that demonstrates acceptable levels of validity and reliability. This, coupled with the attributes that make it suitable for the evaluation task, recommended its use.

2.9.3 Follow Up

The literature indicates that skill-building and support interventions characteristic of the psychosocial rehabilitation process are shown to have a greater impact on

vocational outcomes when assessed at long term follow-up than when evaluated over shorter time periods (Anthony, Cohen and Farkas, 1990:53). A follow-up period of one to three years is consistent with the employment program model that specifies involvement with program participants over an extended time period.

Such long term follow-up, however is beyond the scope of the proposed project. Comparison of vocational outcomes at a point less than six-months following the intervention is not expected to yield significant findings. Thus it was proposed that follow up evaluation of the practicum intervention focus on assessment of the impact of the intervention on social support and not include a measurement of its effect on vocational outcome.

At three months following the completion of the intervention, an appointment with each of the participants was scheduled. Administration of the Social Relationships Scale to participants was used to determine whether changes in social support observed immediately following the intervention were sustained, increased or decreased. The service checklist was also administered at this interview to allow participants to evaluate the impact of the intervention from the perspective of three months distance.

2.10 Summary

Set in the Canadian Mental Health Association, Winnipeg Region's employment service, the practicum intervention was designed to augment the levels of social support available to participants. The intervention approach was participant driven and focused on education and skill building. Participants' understanding of the function of social support and of the features of their own networks was facilitated. Participants set goals for the practicum which related to deficits which were identified during examination of their networks. Interventive strategies included social skills coaching, amelioration of attitudinal barriers and increasing awareness of and access to social opportunities in the community. A single subject evaluation design was employed to assess the impact on participants of their involvement in the practicum intervention. It included measurement of network features, of participant levels of self-esteem, participants' own evaluation of the impact of the intervention through the employment of a service checklist and a file audit to determine whether there was an impact on the time that employment service staff spent with participants. Measurement occurred throughout the practicum intervention and at a follow up interview three months after the completion of practicum involvement. The data collection schedule is included in the intervention plan which appears above. The following chapter

reviews the experience of participants involved in the practicum and an analysis of the data collected.

CHAPTER 3

THE EXPERIENCE OF THE PRACTICUM PARTICIPANTS

This chapter opens with descriptive data of the practicum participants. Following the descriptive data are vignettes which describe in detail the experiences of three of the practicum participants. The examples were chosen to represent issues which were common to other participants and at the same time to illustrate the different ways in which the practicum process unfolded. Each vignette includes a description of the participant, his or her circumstances at the time of the intervention, the process leading to goal setting and the strategies employed to reach those goals. Changes observed over the course of the intervention and their interpretation accompany each vignette. Network maps, from the beginning and end of the intervention are included in the text. The next two sections of the chapter are devoted to an analysis of the data of the Social Relationships Scale and the Index of Self-Esteem. The clinical or practical significance of the intervention is explored through an analysis of the results of the Service Checklist. Finally, the decision not to employ a file audit in the evaluation of intervention results is examined.

3.1 The participants

There were in total eight practicum participants, four of them men and four women. The average age of participants was 34 years old at the beginning of the practicum work with a range in ages of 29 to 41 years. Two of the participants were diagnosed with bipolar affective disorder or manic depression, two with schizophrenia, two with an anxiety disorder, one with depression and one of the participants had no diagnosis recorded. Two of the participants lived alone, one in a group living situation, one with parents, one with a sibling and the sibling's spouse and children. Three participants were in marital relationships, two lived with a spouse only, and one with a spouse and two children.

Table 1 Practicum Participants

Participant	Gender	Age	Living Situation	Diagnosis
1	M	40	Alone	Schizophrenia
2	F	30	Alone	Manic Depression
3	F	41	Parents	Anxiety Disorder
4	F	40	Spouse/Children	Anxiety Disorder
5	F	30	Spouse	Depression
6	M	32	Spouse	Manic Depression
7	M	29	Group	No Diagnosis
8	M	40	Sibling/Family	Schizophrenia

3.2 Vignettes

3.2.1 Marie

Marie was thirty-two years old at the time of the practicum. She lived in a central neighbourhood in an apartment that she shared with her husband. Her diagnosis was chronic depression. She had an undergraduate degree from a local university. At the time of the practicum she was working in a family-owned business and part-time as an activity worker.

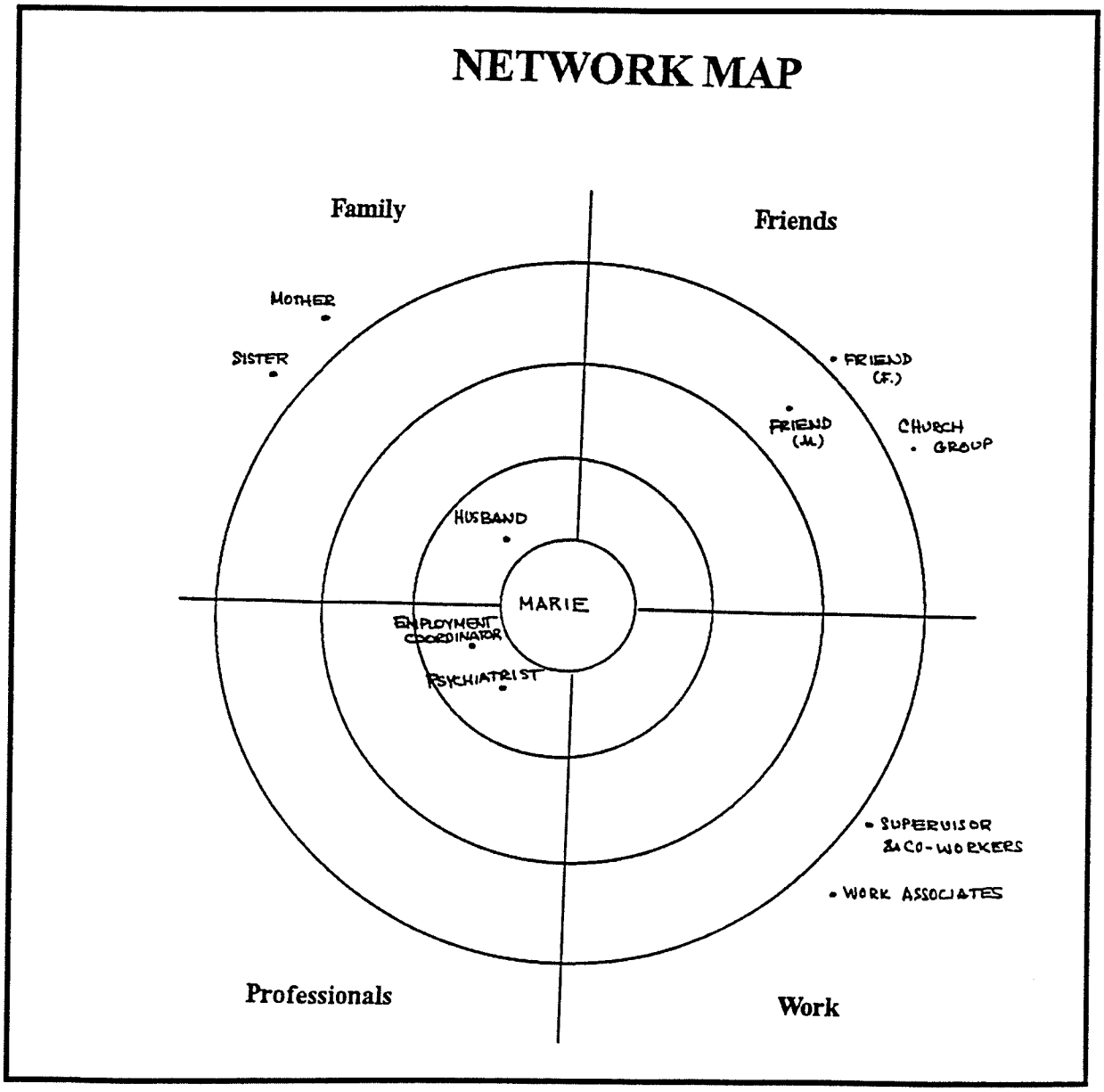
Marie, like others in the group of practicum participants, had good social skills but reservations about getting close to other people. Her concerns, to a lesser extent, were mirrored by other participants who feared being taken advantage of by those close to them. Her heavy reliance on a few ties and her confusion about the rules of friendship were issues relevant to the practicum intervention.

Analysis of Marie's social network showed a small, professionally-dominated network that she perceived as moderately helpful. Marie listed her husband, her psychiatrist and her employment coordinator as the members of her network. Her psychiatrist and husband were both modal figures in her network. She rated the helpfulness of her network (average across topic areas) as moderately helpful

(helps things a bit). She reported that less than half of her discussions were reciprocal.

When drawing her network map, she placed her husband, employment coordinator and psychiatrist near the centre of the map. Outside the farthest circle, in the family sector, she placed her mother and sister. At the farthest circle of the work sector she listed work associates, undifferentiated by name. She placed a friend of her husband's, a woman that she had telephone contact with and the members of a church group (undifferentiated by name) at the outer boundary of the friends sector of the map. Marie seemed upset during and following the administration of the Social Relationships Scale with the small size of her network and expressed feelings of isolation when mapping her network. Her feelings of sadness and loneliness were validated and the potential for change in her network was discussed.

Figure 2 Pre-Intervention Network Map: Marie



Some of the effects of Marie's experience of mental health problems on her social network emerged during our early discussions. She reported losing touch with friends as a result of hospitalization and a fear of rejection if others knew of her mental health problem. She also cited feeling that others could not understand her experiences and living a different sort of life than her peers (ie. not having children, periods of unemployment) as reasons for her isolation.

Marie chose to work on establishing some couple friends and we explored the difficulties with setting a goal the success of which was contingent upon her husband's behaviour. We discussed using the creation of couple friends as a longer-term goal and looking at smaller steps towards this goal. Marie set the following goals:

1. Improving conversational skills;
2. Gaining a better understanding of the expectations of friends;
3. Increasing opportunities for meeting people.

As we began to examine what areas Marie felt she needed to improve in her conversational skills, she began to express apprehensions. Three barriers to increasing social support emerged. First, Marie expressed difficulty trusting people and feeling safe in their company. As a child Marie had been

sexually abused by her father and as a young woman she was sexually abused by her psychiatrist. She attributed much of her mistrust of people to this latter violation of trust. She talked about feeling panicky around people and needing to limit the time that she spent with them as a result of this experience. Another impediment to increasing her network lay in her relationship with her husband. Neither participated in social activities independently. To begin to socialize on her own would mean a re-negotiation of her primary affiliation and Marie seemed reluctant to jeopardize the stability of this important relationship. The third barrier was Marie's perception of how to make friends and the steps involved from acquaintanceship to close friendship. Marie felt unworthy as a friend and felt that friendships happened only to people who were more physically attractive, intelligent and affluent than she.

In overcoming the barriers to increasing social support, the intervention relied heavily upon an educative approach. The strategy of the intervention was to give Marie a sense of control in inter-personal relationships through mastery of boundary maintenance skills. Marie needed to learn the skills of keeping a safe distance before she could begin to pursue relationships with others. Marie also needed to learn the steps in forming a relationship, where increasing degrees of intimacy are reached by mutual consent.

Dialogue allowed Marie an opportunity to vent her anxiety about interacting with others while learning how she could set rules for her relationships. Discussions included characteristics and behaviours that are warnings that a person may not be suitable as a friend, cautions and danger signs in a relationship, when to say no in a relationship, how to say no assertively, steps in forming relationships, expectations that friends have of each other and timing the disclosure of sensitive personal information.

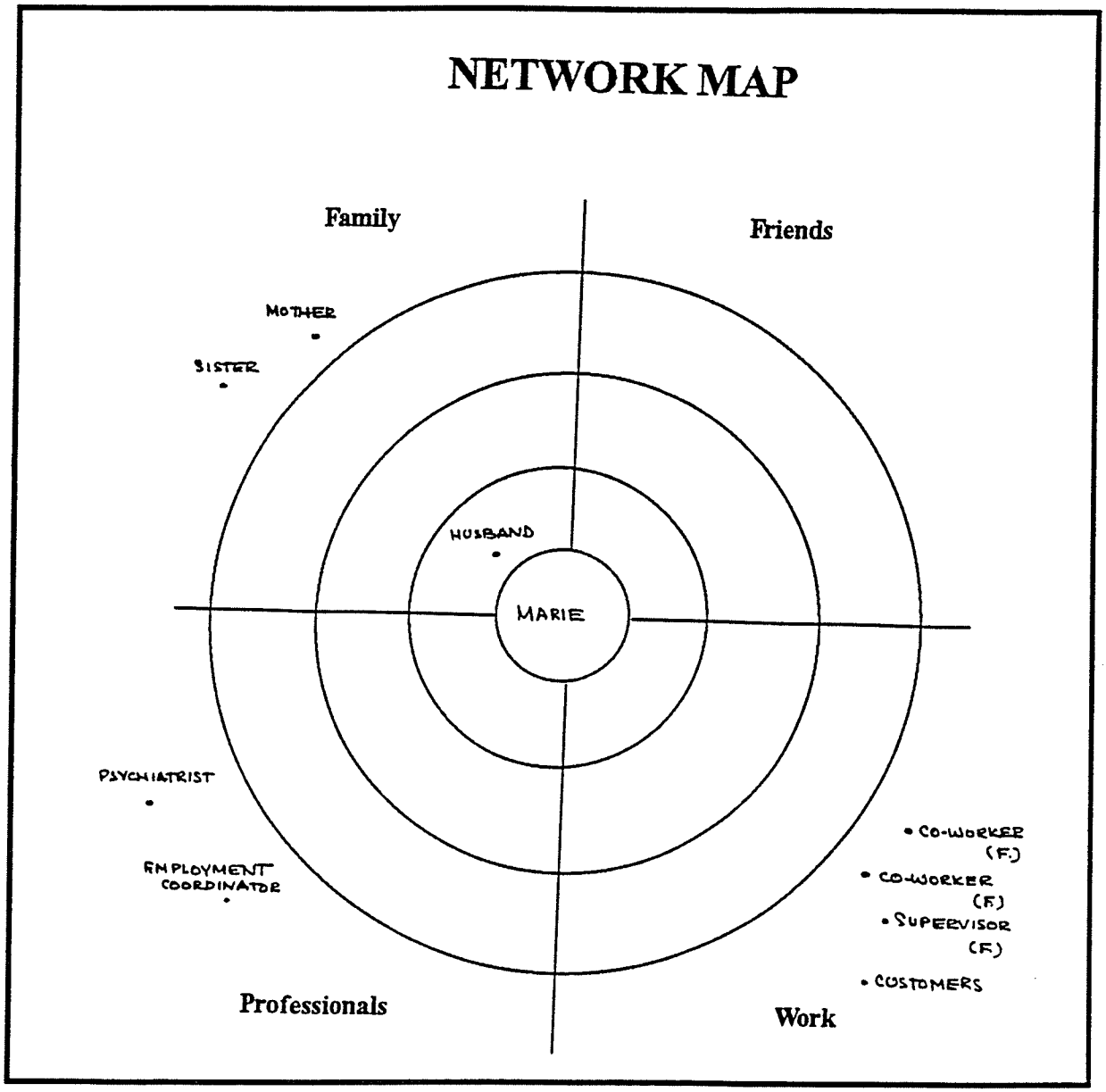
Further discussion centred on how to increase social ties. It was an important revelation to Marie that she could take an active role in making friends and that she had attributes that would make her desirable as a friend. There was little motivation for her to learn or use the skills of making conversation when she felt that this was not actually how people made friends.

In the tenth and final session, Marie set a goal for herself of spending more time with people. This seemed reflective of her improved understanding of the process of increasing network size and her greater sense of safety with people. It also appeared to demonstrate Marie's comfort with her own need for time in the formation of relationships.

The post-intervention and follow-up administrations of the Social Relationships Scale showed mixed results. At both of these administrations Marie added her mother to her network. The original three network members, her husband, employment coordinator and psychiatrist, were also included. The three modal figures in Marie's network, two professionals and her husband were unchanged at post-intervention. At follow-up her modal figures were her husband and her psychiatrist. The perceived helpfulness of her network rose slightly at post-intervention from the original administration and then fell to slightly below the originally reported level at follow-up. The reciprocity of discussions remained constant from pre- to post-intervention and then rose dramatically at the follow-up administration. In summary, the changes included the addition of one network member, the loss of one modal figure and a marked increase in reciprocity with the helpfulness of the network remaining relatively stable.

Network maps were drawn both pre- and post-intervention. There was no change in the number of network members on the maps, however network members in the professional, friends and work sectors were placed at a greater distance on the second map than on the first.

Figure 3 Post-Intervention Network Map: Marie



Marie's reliance on professional helpers and the dominance of this type of support in her network may have impacted on her perception of the constituents of support and of relationships. Marie's feelings of powerlessness in relationships which she attributed to her experience with her psychiatrist may have been perpetuated by her continued reliance on relationships with professionals. The dominance of paid helpers in her network may have also contributed to feelings of unworthiness as a friend since close relationships were occurred as part of the significant other's professional duties and were predicated on Marie's need for help. The professional helper provides a confidante type of relationship but does not provide social opportunities which may serve to take the focus off of problems. This too may have underscored her feelings of undesirability. Marie's involvement with professionals may also have contributed to her confusion about what to appropriately disclose in a social relationship. Marie's exposure to the therapeutic relationship seemed to have left her unsure about what might be expected in a friendship and about her right to privacy and control in relationships.

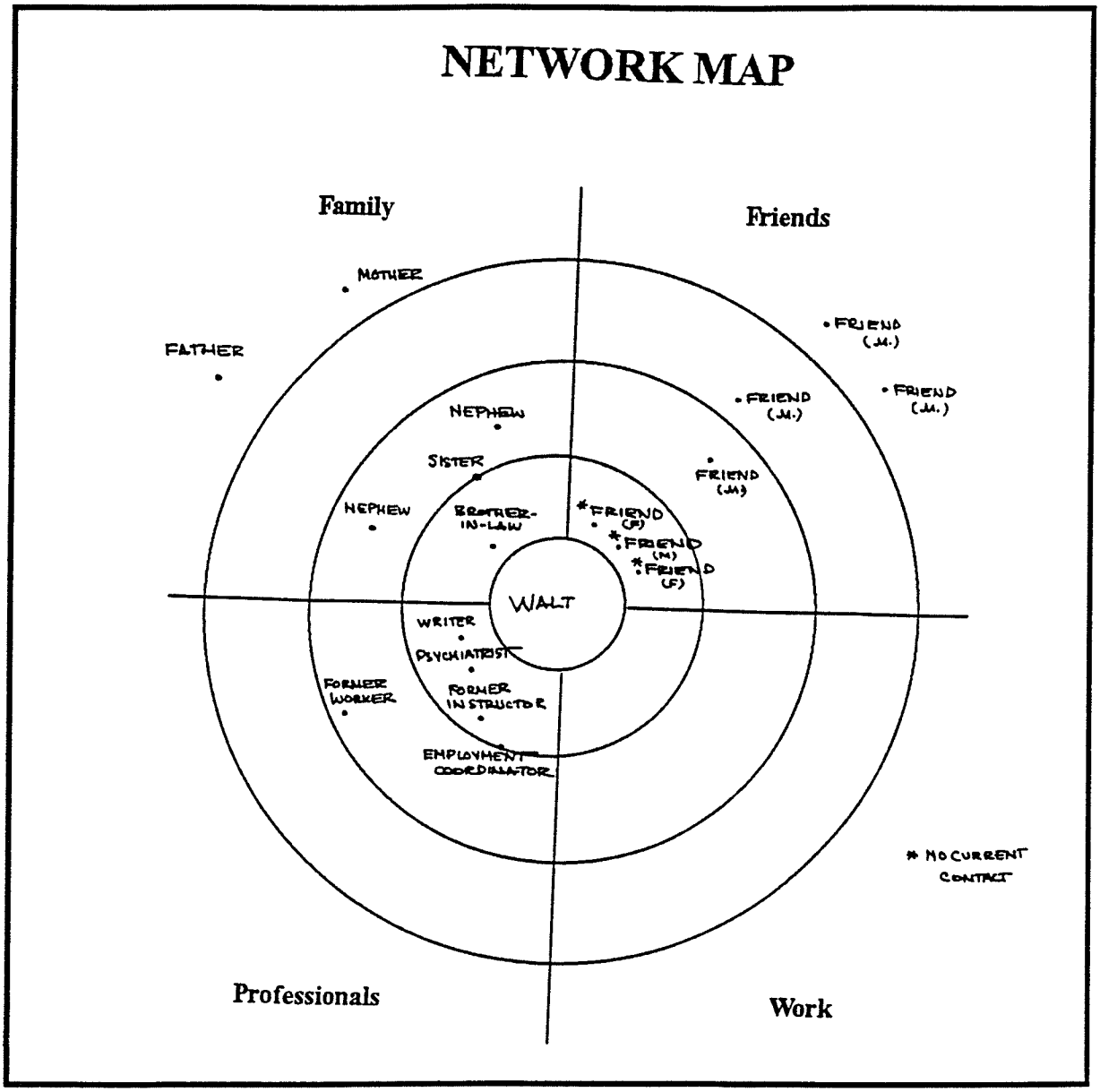
3.2.2 Walt

Walt was thirty years old at the time of his participation in the practicum. He lived in a suburban neighbourhood with his sister, his sister's husband and their young children. Diagnosed with schizophrenia, Walt was unemployed at the time of the intervention.

Analysis of Walt's network revealed a moderately sized network, comprised predominantly of family members and professionals. Walt perceived that his network was fairly helpful and reciprocal. When drawing the network map, Walt included in the closest circle of the friends sector three people with whom he had not had contact for several years. He also included two friends with whom he wanted to sever his ties.

Walt was unhappy with what he perceived as his high level of dependence on his family and chose to work on increasing the level of support from friendship ties. He voiced concern about handling social situations but set a goal of increasing the number of social acquaintances that he had. As we began to discuss the steps towards achieving his goal, Walt was apprehensive about doing more than talking about his situation. With reassurance he was able to include some action steps in his plan.

Figure 4 Pre-Intervention Network Map: Walt



The practicum intervention began with a discussion of the attributes that Walt valued in a friend. Through discussions and role plays we examined interpreting and sending social cues of approachability and the skills of starting, continuing and ending a conversation. During these discussions, Walt raised concern about the impression that he made on others. Walt was worried that he appeared intimidating to those around him. We discussed the aspects of presentation that made an impression on others: grooming, clothing, voice tone, movements and gestures. Walt's fears seemed to arise from his isolation. He did not interact with the people around him and thus did not get feedback from them about himself.

The second part of the intervention focused on assisting Walt to examine his current opportunities to meet people and to explore new opportunities. Walt's personal criteria for outings were listed, including factors such as interest, proximity and expense. We considered the advantages and disadvantages of both existing and potential opportunities. We also discussed how to plan an outing, what information would be required and ways of obtaining it.

Walt chose and planned an outing to a local festival. We met as arranged and over the course of the evening, reviewed topics that we had discussed during sessions as we observed other people at the festival and how they interacted with one

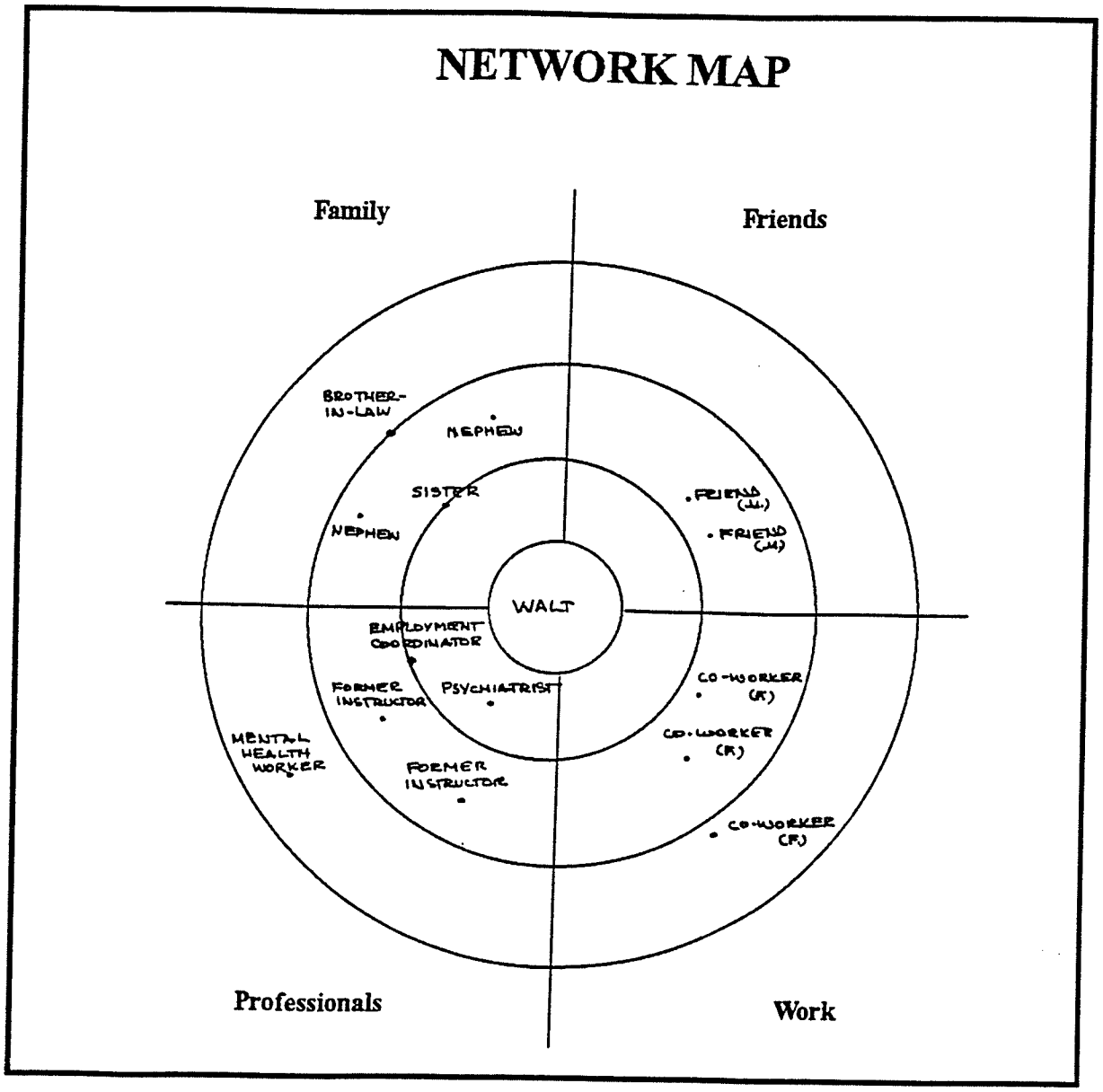
another. Walt noted a number of people attending the event alone and said that he felt that he would be comfortable with doing the same in the future. Walt initiated conversations with several of the festival volunteers. He spoke to people older than himself which for him was less threatening than speaking to age-mates. It did, however, provide him with a chance to practice and gain confidence. The outing served as a chance to observe and to practice skills as well as to reinforce the positive aspects of participating in community activities.

Walt began a work experience just prior to the final session. He reported that the other workers were distant but that he initiated conversations with several of his co-workers and that his overtures were well-received. The intervention was timely, in that the work experience provided Walt with a chance to use the skills that he had rehearsed. Positive reinforcement in real life situations seemed an important factor for practicum participants. Early successes motivated participants like Walt to continue to approach social situations in new ways.

According to Walt the intervention had helped him to realize that people might want to meet him and might enjoy his company. He said that he found the skills of starting conversations useful. He noted his increased awareness of

opportunities for socializing in the community but commented that he had not yet increased the number of his social acquaintances. He was hopeful that this would come in time. At the follow-up appointment, Walt spoke of being more comfortable and motivated to meet people. He described himself as being more outgoing in a variety of social situations but said that lack of money due to his continued unemployment decreased his social opportunities. Walt said that he was looking forward to working as it would give him a chance to meet people at work and also provide him with the financial resources required to engage in social activities.

Figure 5 Post-Intervention Network Map: Walt



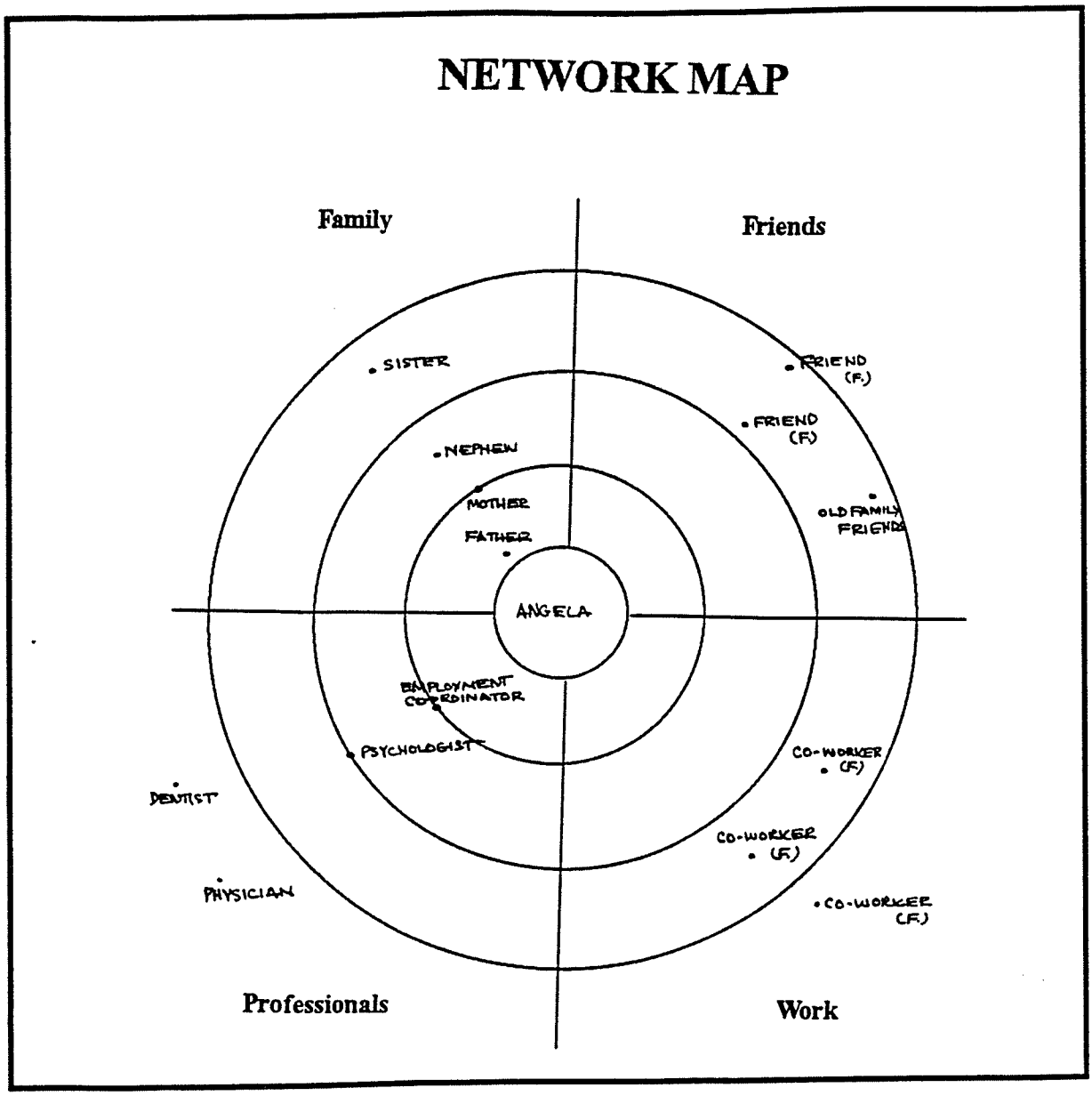
At follow-up, Walt's network was smaller by three members due to the exclusion of three friends with whom he had no recent contact. Walt perceived his network as somewhat more helpful and the level of reciprocity remained relatively stable. Although the Social Relationships Scale data and the network map showed a decrease in members in the friends sector, those individuals excluded in the second administrations were people with whom Walt had no recent contact. Walt, through the course of the intervention, seemed to see friendships as achievable in the present rather than as something from the past.

3.2.3 Angela

At the time of her participation in the practicum, Angela, a woman in her early forties, lived with her elderly parents in suburban Winnipeg. She was diagnosed as having an anxiety disorder, obsessive compulsive disorder and depression. She was on medication and used behaviour modification techniques to control her symptoms. She had done volunteer work on a part-time basis for the year previous but had not held paid employment since the mid-eighties. She became involved in a work experience at a nursing home through the employment program. Angela was involved in two friendship groups and frequently attended social outings with these groups of single people.

Analysis revealed a social network dominated by kin and professionals with a paucity of ties to friends. Angela listed her parents and her nephew, her work supervisor and three professionals as members of her network on the Social Relationships Scale. Angela's modal figures were her parents and two professionals. Angela reported that she found her network fairly helpful with a moderate level of reciprocity. In the closest regions of the network map, Angela included only family members and professionals. Ties to co-workers and social contacts were distant ones.

Figure 6 Pre-Intervention Network Map: Angela



In assessing Angela's barriers to improving social support there seemed to be both attitudinal and skill factors present. Angela expressed anxiety about the level of risk involved in pursuing social contacts. On further exploration, the perception of risk resulted from a lack of understanding of the steps involved in making friends. In thinking about increasing her social ties, Angela contemplated taking large steps with people and then was unable to do so because of the peril involved. Angela also expressed some concern about being rejected by people if they knew that she had a mental health problem. Part of her withdrawal in social situations was a result of wanting to conceal this fact from the people around her. Angela, in social situations, appeared withdrawn and somewhat unfriendly. She said that she saw herself as a naturally unfriendly person. The attitudinal barrier stemmed from fear of rejection and a lack of information.

The strategy of the intervention was to assist Angela in finding ways of minimizing the risk that she felt in approaching people and in improving her use of friendly behaviours in social settings.

Angela expressed apprehension about setting a goal for the practicum work. Her initial suggestion for a goal was that she invite a woman she knew from a friendship group to accompany her on a trip. In exploring this possible goal,

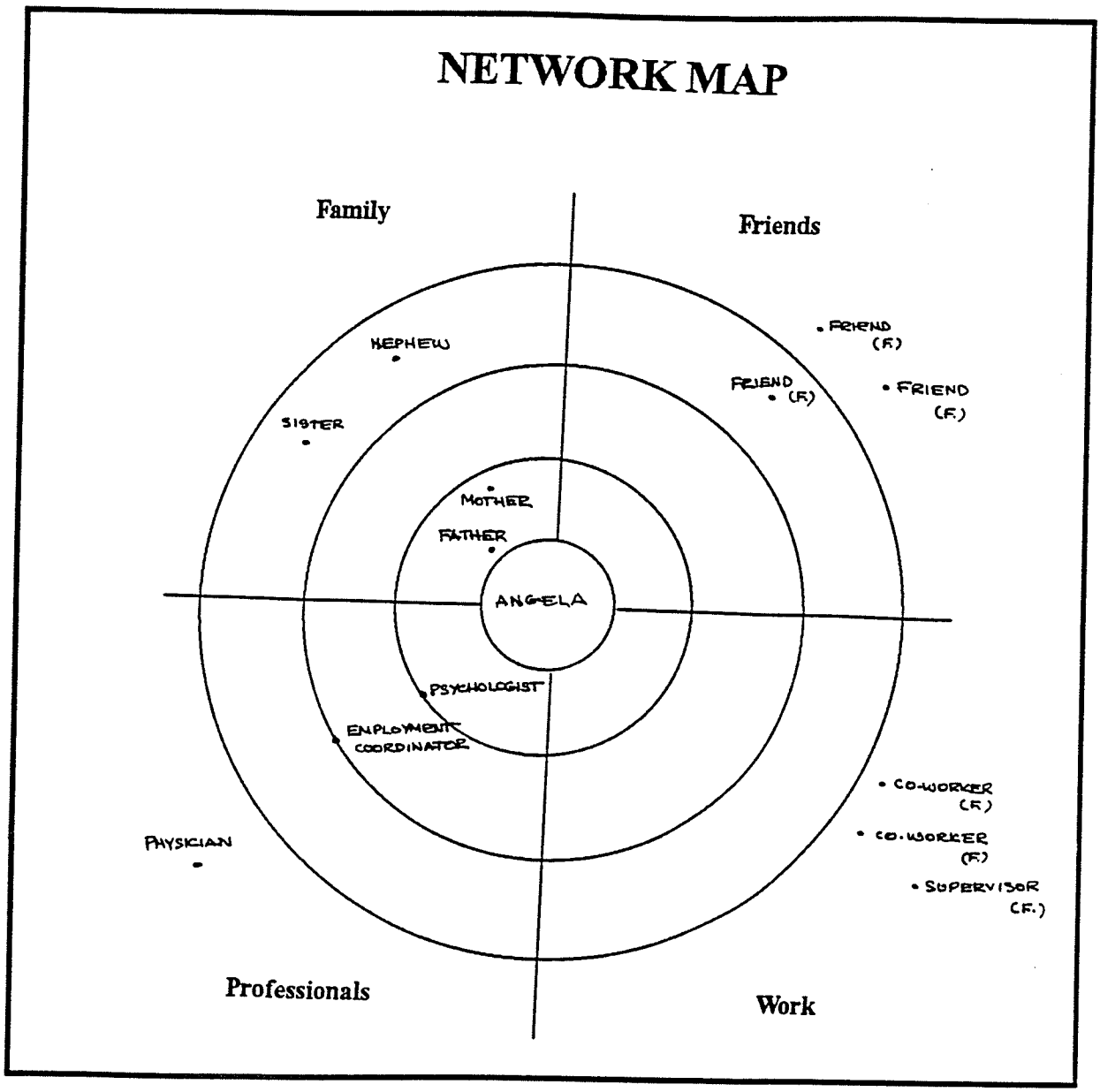
Angela suggested that it was too large a step to take and involved too great a risk. During the analysis of her network, Angela commented on the scarcity of friends in her network. Although she had opportunity to meet people through her involvement in the social groups and in her work experience, she was aloof and remained on the periphery of these groups. Angela seemed to have a limited understanding of social interactions and the skills that were involved in getting to know people. Angela was able to generate a list of behaviours that would convey to other people her interest in them. Angela said that she was not able to consistently use these behaviours in social situations and so we used this as the goal for our work. Angela's goal was to improve performance of the behaviours involved in being friendly: smiling, talking to people, listening to people, having a relaxed posture and making eye contact.

The educative component of the intervention included helping Angela to understand the progression of a relationship from acquaintanceship through to close friendship and the importance of being friendly to acquaintances in order to increase the pool of individuals from which closer friends might be developed. The skill development component of the intervention involved the writer modelling the use of the skills, followed by role plays during sessions in which Angela used the skills in simulated social situations. Angela,

accompanied by the writer, practised the skills in natural settings in the community. In vivo practice as part of the intervention provided Angela with support to practice these behaviours. Once she was able to improve her performance of the targeted behaviours and convey an attitude of friendliness during practice sessions, Angela was encouraged to use these behaviours in the social settings to which she was exposed as part of her everyday life, predominantly at work and during meetings with one of the friendship groups. In later sessions Angela reported being more involved in the social aspects of work and described a greater level of enjoyment and participation in her friendship group outings.

During the ninth session, Angela described an upsetting incident with a family member which had occurred on the weekend. She spoke with a woman from her friendship group about the incident and felt better about it. While we had previously discussed the value of social support in problem-solving and the importance of feeling part of a group that experiences similar problems and concerns, this was the first time that Angela had used this way of coping with a family dispute.

Figure 7 Post-Intervention Network Map: Angela



In discussing the effects of the intervention at our final session, Angela stated that she was somewhat more comfortable and involved in the friendship group to which she belongs, though not yet as comfortable as she would like to be. Angela said that as a result of the intervention she had become more conscious of friendly behaviours and that when she was feeling comfortable she was able to use them. She said that when her anxiety level was high in social situations her ability to concentrate and to use the skills diminished.

The overall size and the closeness of ties in Angela's network remained relatively stable. There seemed to be a slight shift from family ties with the exclusion of a relative from the close network and the inclusion of a friend. Old family friends were excluded from the network and included were two new acquaintances. At follow-up, Angela included two work-mates and a friend as modal figures. Although Angela's network continued to have a large professional involvement, this indicated less reliance on the formal system for support. At follow-up she reported a rise in reciprocity. There was a decline in the average helpfulness of discussions with network members from pre-test to follow-up. This suggested that Angela found informal support less helpful than formal support. An interesting finding, it may represent a transitional phase while Angela's expectations adjust to new types of relationships. Professional and kin relationships

provide different types of support, and their helpfulness may be experienced as different than the support provided by friendship ties. The newness of the experience of friendship for Angela may have effected her assessment of the helpfulness of her network.

The three vignettes illustrate the differences and the commonalities of participants experiences with their social networks. All were able to gain a greater sense of efficacy in their networks and all experienced changes in their networks over the course of the practicum intervention.

3.3 Analysis of Social Relationships Scale Data

The Social Relationships Scale, used as a pre- and post-intervention measure and also at follow-up, was acceptable to participants. It occasionally evoked negative feelings when participants expressed discomfort with the size of their network. It also created discomfort for participants when they had included the writer or employment program colleagues in their network and were asked to rate the helpfulness of discussions with these individuals. When this occurred, participants were offered the option of not rating the helpfulness of these discussions. When participants chose not to rate the helpfulness of these discussions, this score was

not included in the average for the category or in the average rating across topic areas.

The mean network size of practicum participants was 7.9 members with a range of from 3 to 12 members reported. The mean number of modal figures, network members with whom the participant discussed at least three content areas, was 3.9 with a range of 2 to 5 modal figures reported. The mean average helpfulness, a score derived by averaging ratings of helpfulness of discussions with network members, was +1.43 (on a scale from -3 to +3). The mean level of reciprocity, the extent to which participants provided support to those who supported them, was 65.5%, expressed as a percentage of the total number of discussions.

Table 2
Social Relationships Scale Pre-Test Administration

Participant	Network Members	Modal Figures	Average Helpfulness	Reciprocity
1	8	5	+1.06	59%
2	10	4	+0.85	57%
3	7	4	+1.77	61%
4	6	5	+1.73	90%
5	3	2	+1.03	40%
6	8	4	+2.08	88%
7	12	4	+1.84	54%
8	9	3	+1.06	75%

McFarlane et al. (1981) established norms for the instrument using a sample of 518 general population subjects. A comparison of the practicum group to the general population yielded differences that were foreseen by the literature on the social networks of people with mental health problems. The mean size of McFarlane's subjects' networks is 8.69 members. On average, practicum participants reported a network smaller by roughly 1 member than the general population. The average number of modal figures for the McFarlane group was 2.59, compared to 3.9 for practicum participants. The practicum group had more modal figures in a smaller overall network, indicating greater multiplexity of ties than among the general population. Mean average helpfulness across content areas for the general population group is reported at +1.86, somewhat higher than for the practicum group indicating that practicum participants find their networks less helpful than do members of the general population. McFarlane reports that on average his subjects had 1.14 professionals in their networks in contrast to the 2.63 professionals that the practicum group listed. This may to some degree account for the difference in the levels of reciprocity for the two groups: practicum participants reported a mean level of reciprocity of 65.5% compared to 86.6% for the general population group.

As a group, then, the practicum participants tended to have networks that had fewer members, included more multiplex relationships, contained more professionals, and were perceived as less helpful and less reciprocal than the norms established for the Social Relationships Scale. Although these findings mirror those reported in the literature that indicate deficits in the social support of people with mental health problems, the results must be interpreted cautiously. The practicum group was not randomly selected but chose to participate in an intervention that was designed to improve the level of support that they received. The recruitment process may have resulted in a sample that was biased as participation would appeal more strongly to individuals that were unsatisfied with the level of support that they were receiving. The findings do suggest, however, that there are individuals currently receiving services in the mental health system who could benefit from a social network intervention.

Table 3
Social Relationships Scale Comparison of Pre-Test and Post-Test Administration

Participant	Network Members		Modal Figures		Average Helpfulness		Reciprocity	
	Pre-Test	Post-Test	Pre-Test	Post-Test	Pre-Test	Post-Test	Pre-Test	Post-Test
1	8	9	5	6	+1.06	+.76	59%	76%
3	7	6	4	4	+1.77	+.39	61%	77%
4	6	4	5	4	+1.73	+1.71	90%	88%
5	3	4	2	3	+1.03	+1.20	40%	43%
8	9	6	3	4	+1.06	+1.94	75%	56%
Average	6.6	5.8	3.8	4.2	+1.33	+1.20	65%	68%

Social Relationships Scale post-test data was available for five of the original eight participants. One participant withdrew and two were unable to complete the practicum due to health problems.

The mean network size of participants at the end of the intervention was 5.8 with a range in size of 4 to 9 members. For this same group of participants, those who completed the intervention, the mean network size at the beginning of the intervention was 6.6 with a range of from 3 to 9 members. There was a decrease from pre-test to post-test in the average network size by .8 members. Two of the practicum participants reported a net increase in their network size by one member. The three other participants reported a net decrease in the size of their networks of one, two and three members.

The mean number of modal figures at post-test was 4.2 with a range of from 3 to 6 individuals. At pre-test, participants reported a mean number of modal figures of 3.8 with a range of from 2 to 5 individuals. The average number of modal figures in the networks of participants increased by .4. Four of the five participants for which data is available reported changes in the number of modal figures over the course of the intervention. Three reported the addition of one modal figure to their network and one reported the loss of one modal figure.

The mean average helpfulness across content areas reported at post-test was +1.2 with a range of +.39 to +1.94. At pre-test this same group had a mean average helpfulness of +1.45 with a range of from +1.03 to +1.77. There was a slight decrease in the perceived average helpfulness of discussions with network members from pre-test to post-test administration of the Social Relationships Scale. This result was in part due to a large decrease in helpfulness reported by one of the participants.

The mean level of reciprocity was 68 % with a range of 43% to 88% at the end of the intervention. At the beginning of the intervention the mean level of reciprocity was 65% with a range of from 40% to 90%. The average level of reciprocity remained almost unchanged from pre-test to post-test. Reciprocity levels of two of the participants were stable, while larger changes were reported by three other participants. Two participants reported an increased level of reciprocity (17% and 16%) and one reported a decrease (19%).

None of the changes from pre-test to post-test reached a level of statistical significance, due to the magnitude of the changes and the small sample size. The average level of reciprocity, helpfulness of the network and number of modal figures remained relatively constant, though the average masks larger changes for individual participants. The change in the

average network size, a decrease of nearly one member, was not in the direction expected. It is a finding that is difficult to analyze because the changes are net changes and include the addition as well as the deletion of network members. The slight increase in the average number of modal figures in participants' networks when coupled with the finding of a decrease in overall network size suggests a denser network configuration, in which the focal individual relies more intensely on fewer network ties.

The findings indicate that changes did occur over time in the social networks of the participants. Reported changes may be in part attributable to an altered perception of networks and support by the participants following the educative component of the intervention. It was not anticipated that measurable changes in network indicators would occur over the course of the intervention. Given the skill building approach employed in the practicum intervention, the results of which were expected to be measurable only over the longer term, changes in network indicators are more likely attributable to a change in participant perception than to networking activity.

At the follow-up administration of the Social Relationships Scale, three months after the end of the intervention, participants reported a mean network size of 8.2 members with a range of from 3 to 18 individuals. The mean number of modal

figures was 4.0 with a range of from 2 to 6. The mean average helpfulness across content areas was +1.25 with a range of from +.64 to +2.45. The average level of reciprocity reported at follow-up was 78.6% with a range of from 62% to 100%.

On the following pages are tables comparing the data and the mean scores obtained from the pre-test, post-test and follow up administrations of the Social Relationships Scale.

Table 4
Social Relationships Scale Comparison of Pre-Test, Post-Test and Follow Up Administration

Participant	Network Members			Modal Figures			Average Helpfulness			Reciprocity		
	Pre-Test	Post-Test	Follow Up	Pre-Test	Post-Test	Follow Up	Pre-Test	Post-Test	Follow Up	Pre-Test	Post-Test	Follow Up
1	8	9	18	5	6	6	+1.06	+.76	+.64	59%	76%	85%
3	7	6	10	4	4	6	+1.77	+.39	+.67	61%	77%	75%
4	6	4	3	5	4	3	+1.73	+1.71	+2.06	90%	88%	100%
5	3	4	4	2	3	2	+1.03	+1.20	+.45	40%	43%	62%
8	9	6	6	3	4	3	+1.06	+1.94	+2.45	75%	56%	71%

Table 5 Social Relationships Scale Comparison of Means

	Pre-Test	Post-Test	Pre- to Post-Test t-Statistic	Follow Up	Pre-Test to Follow Up t-Statistic
Mean Number of Network Members	6.6	5.8	1.000 not significant	8.2	0.667 not significant
Mean Number of Modal Figures	3.8	4.2	-1.000 not significant	4.0	-0.302 not significant
Mean Average Helpfulness	+1.45	+1.20	0.854 not significant	+1.25	0.600 not significant
Mean Level of Reciprocity	65.0%	68.0%	-0.310 not significant	78.6%	-2.575 not significant
Mean Number of Professionals in Network	2.2	2.0	0.302 not significant	1.8	0.784 not significant

t.05(4)=+/-2.776

In comparing the results of the three administrations of the Social Relationships Scale, there appeared to be an increase in the mean number of network members from 6.6 at first administration to 8.2 at the follow-up administration. This was an average increase of 1.6 network members. Two participants reported a decrease in network size by three members each. Three participants reported an increase in the number of members in their networks. One participant reported an increase of one member, one reported an increase of three members and one participant reported an increase of ten network members. The dramatic rise in network membership reported by one of the participants skewed the results of the analysis and thus the increase in the mean number of network members may not accurately represent the experience of the participants. Closer inspection of the data, therefore, tempers optimism in interpreting this result as suggestive of the efficacy of the intervention in assisting participants to increase the size of their networks.

The mean number of professionals in the networks of participants shows a decrease from 2.2 at first administration to 1.8 at follow-up administration. Three participants reported the same number of formal ties in their networks at follow-up as they did at the pre-test. The remaining two participants reported a decreased level of professional involvement. Although not at a statistically significant

level, this finding indicates that any increase in network members was not attributable to the addition of professionals to the network and that participants were able to increase the number of informal ties in their networks.

The mean number of modal figures in the network remained relatively stable across data collection points with a slight change from 3.8 at pre-test to 4.0 at follow-up administration. Again, though not statistically significant, this finding implies that the increase in network size did not correspond to an increase in the number of modal figures which suggests that new ties established tended to be looser rather than closer ties.

The mean average helpfulness score declined slightly from pre-test to follow-up, though not significantly. This suggests that although participants may have increased the size of their networks, they did not find their networks more helpful.

The mean level of reciprocity of discussions reported by participants increased from 65.0% at first administration to 78.6% at follow-up administration. Four of the participants for which full data sets were obtained reported an increase in the level of reciprocity of discussions with network members. The remaining participant noted a decrease of 4% at follow-up from the pre-test level. This enhanced reciprocity, though

not of statistical significance, may be in part attributable to an overall decline in the number of professionals in participants' networks relative to total network size. It may also suggest a change in participants' perception of their own ability to provide support to network members and may indicate a change in their orientation towards their networks.

While none of the changes reached statistical significance, the data suggests that changes in participant's networks occurred over the time period from pre-test to follow-up. Participants tended to experience their networks as more reciprocal following the intervention. That is, they saw themselves as not only the recipients of support, but able to provide support to the members of their networks. Professional involvement in the networks of participants declined slightly while the level of helpfulness and the number of modal figures remained relatively stable. The presence of an outlier made the data difficult to interpret with regards to changes in the overall network size.

At three months following the end of the intervention the networks of practicum participants continued to differ from the networks of the general population in several important ways. When compared to the norms established for the Social Relationships Scale, the networks of participants were smaller, the number of modal figures and the levels of

professional involvement were greater, the mean average helpfulness was lower as was the reciprocity level.

3.4. Analysis of Data from Index of Self-Esteem

The Index of Self-Esteem was completed by participants at the beginning of each practicum session and once during the time elapsed between sessions, yielding approximately 20 data points per participant. Administration of the Index of Self-Esteem was acceptable to participants. They reported finding it interesting to chart changes in their self-image and generally found that it accurately represented fluctuations in their moods. The writer found charting and discussing the results of the Index of Self-Esteem a helpful starting point with participants. It facilitated discussion of the participant's feelings that day and over the course of the previous week. Administration occasionally provoked feelings of anxiety in participants by asking them to consider sensitive areas of their ideas about themselves. This generally subsided with repeated administration.

Below are reproductions of the graphs of the Index of Self-Esteem scores for the participants for whom complete data sets were available. Higher scores on the Index of Self-Esteem indicate lower levels of self-esteem. To make reading of the graphs easier, the scale has been inverted.

Figure 8 Index of Self-Esteem Graph: Participant 1

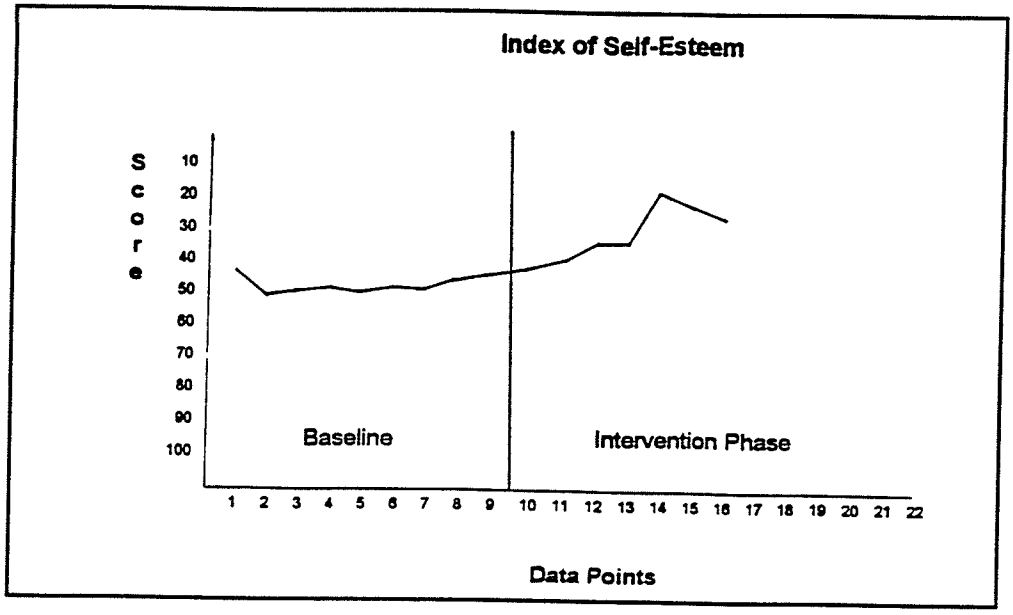


Figure 9 Index of Self-Esteem Graph: Participant 3

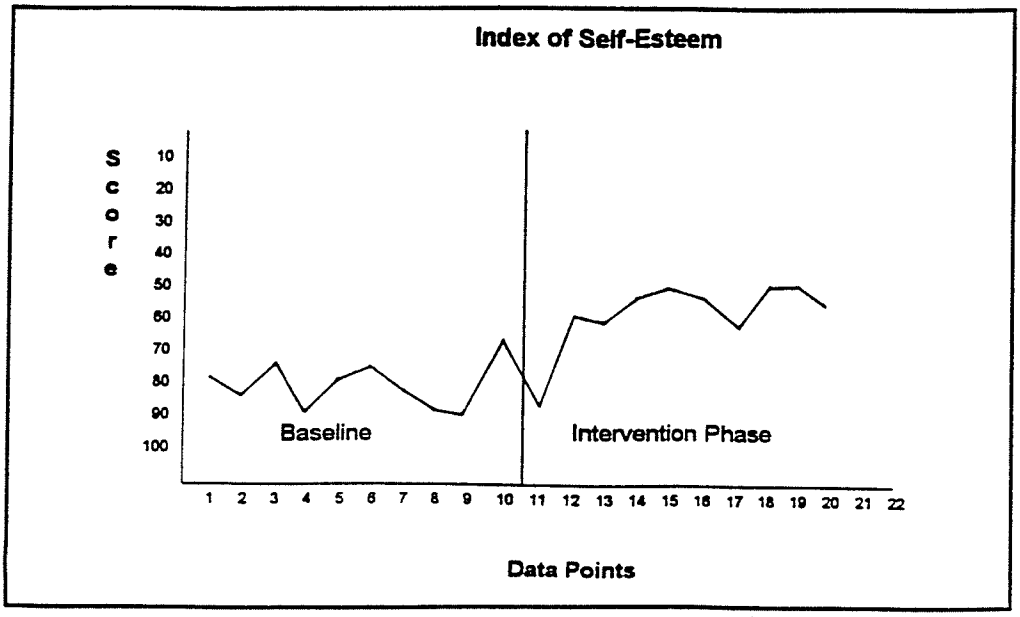


Figure 10 Index of Self-Esteem Graph: Participant 4

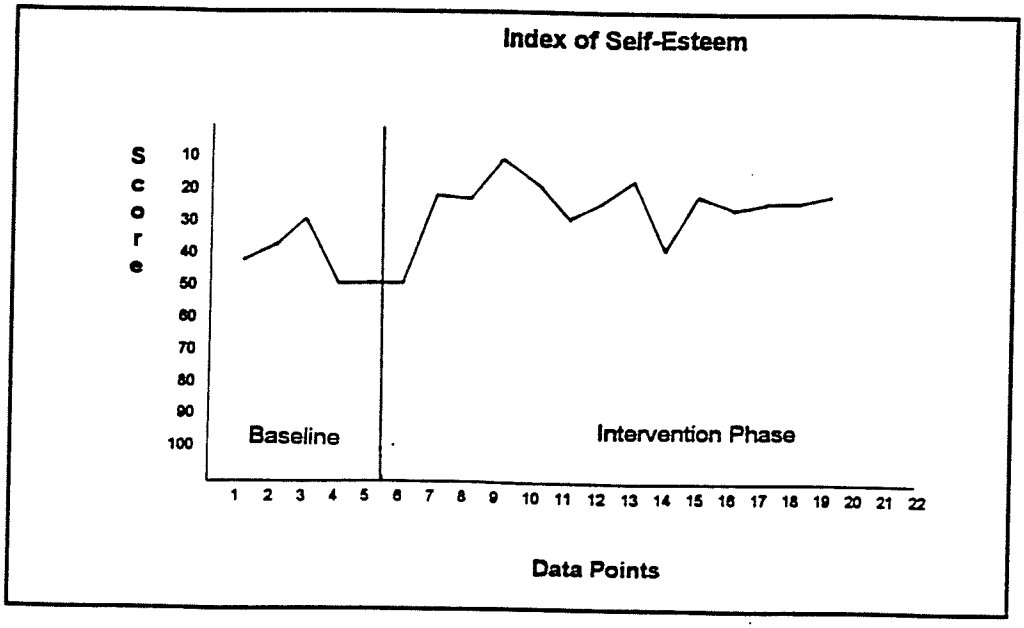


Figure 11 Index of Self-Esteem Graph: Participant 5

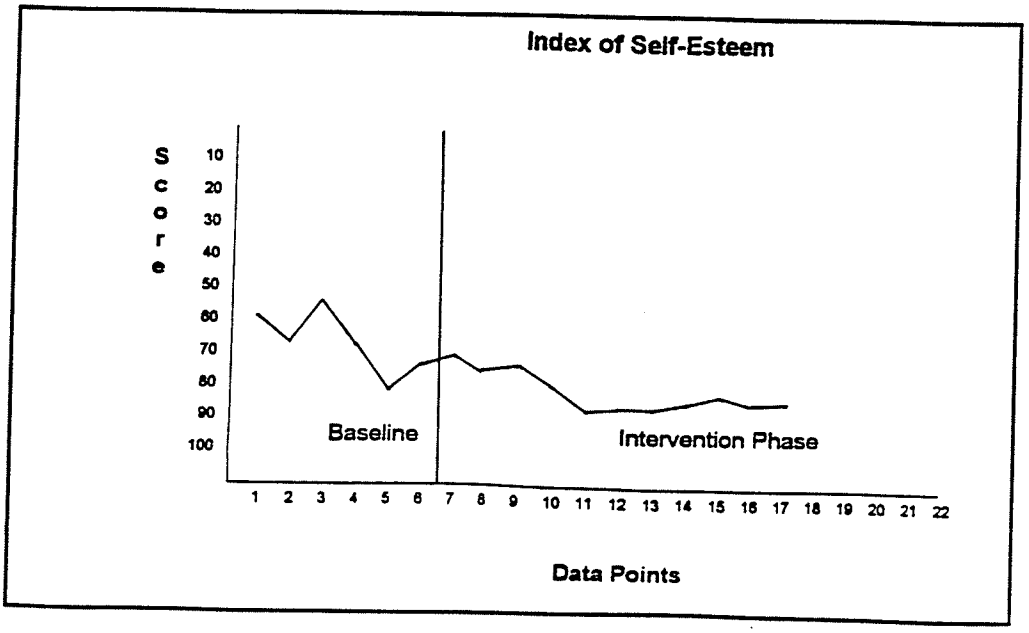
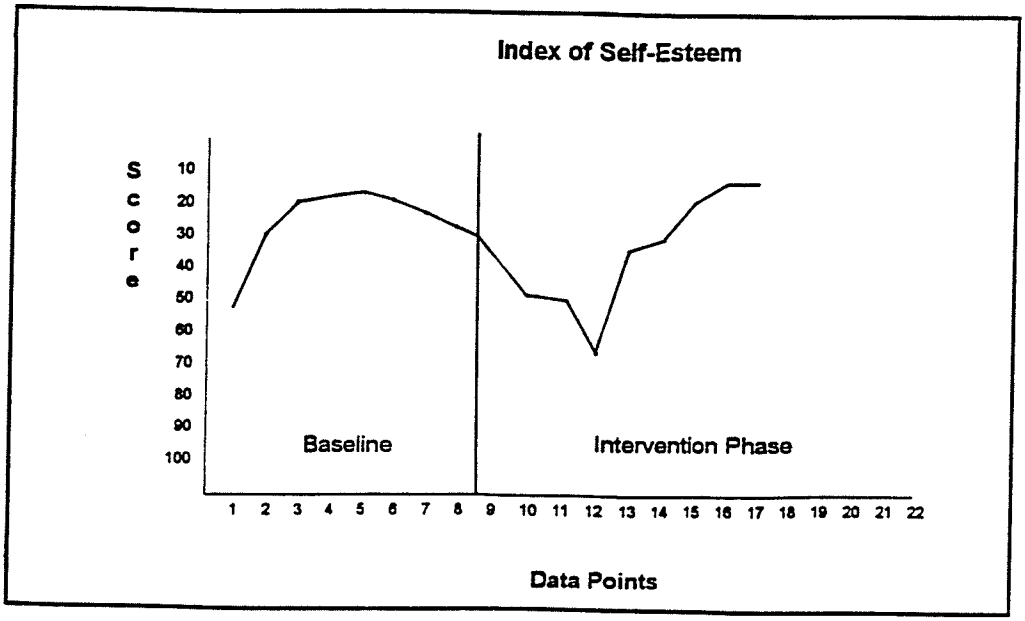


Figure 12 Index of Self-Esteem Graph: Participant 8



The graphs made by charting the Index of Self-Esteem results were difficult to interpret by visual inspection due a lack of stability in the baselines. Though a minimum of five data points was collected for the baselines, bimodal or irregular patterns appeared in four of the graphs. The fifth graph showed baseline data increasing in the desired trend which Bloom and Fischer (1982) caution could be an effect of response bias or repeated administration. Due to these patterns, the results of the Index of Self-Esteem could not be interpreted with a sufficient degree of confidence.

Table 6 Index of Self-Esteem Comparison of Mean Scores

Participant	Mean Score Baseline Phase	Mean Score Intervention Phase
1	47.8	31.7
3	80.4	58.7
4	41.8	23.9
5	67.6	80.4
8	26.6	33.8

NOTE: Higher scores on the Index of Self-Esteem indicate lower levels of self-esteem.

In comparing the average of the scores for points during the baseline to the average of the scores for points during the intervention phase it would appear that for one of the participants the level of self-esteem declined, for one participant it was relatively stable and for three participants levels of self-esteem rose.

Participant 8 said during the intervention that he found it difficult to be honest in his completion of the instrument and that he had increased the level of his responses because of this. Rather than accurately reporting his feelings on the Index of Self-Esteem, the participant was responding to what he perceived as an expectation that his scores improve. This participant's reactivity to the demand characteristics of the practicum setting were not reported by other participants but may have been an issue for them.

The clinical cutting point for this measure is set at 30 (+ or -5). According to the creator of the Index of Self-Esteem, individuals who score above 30 on this measure are likely to be experiencing difficulties with self-esteem. The scores during the baseline phase indicate that all but one of the participants are experiencing difficulties with self image. The scores during the intervention phase suggest that three of the participants had healthy levels of self-esteem. For two of the participants, levels of self-esteem were elevated to a

non-clinical level during the intervention phase of the practicum. An examination of the changes in the social networks of these two participants did not yield a corresponding increase of network activity that could account for these changes. The changes in self-esteem could not be correlated with changes in the networks of participants and could be a result of intervening factors.

Due to the difficulty establishing a stable baseline for the measure and because of response bias reported by one of the participants, the results of the Index of Self-Esteem are not reliable enough to be used to interpret the results of the intervention.

3.5. Clinical Significance

A service checklist was administered at post-test and follow-up to assess the clinical or practical significance of the intervention. Participants were given a list of the areas that they had targeted for work during the intervention and asked to rate the level of improvement in this area on a five point scale that ranged from much worse to much improved. (The Service Checklist appears in Appendix B.)

In assessing the level of clinical significance of the intervention using the Service Checklist, all but one of the participants noted an improvement on one or more of the targets for work. At follow-up all of the participants were able to note an improvement in at least one of the problem areas. The average mean level of improvement increased slightly at follow-up from the post-test measure, indicating that the improvements that participants observed as a result of the intervention were stable after three months. This data indicates that participants found the practicum intervention helpful in achieving their goals. Tables 7 and 8 summarize the results of the administration of the Service Checklist.

Table 7 Service Checklist Results

Participant	Number of Targets	Post-Test	Follow-Up
1	3	3-same	2-same 1-improved
3	5	1-same 4-improved	1-same 3-improved 1-much improved
4	4	3-improved 1-much improved	3-improved 1-much improved
5	4	4-improved	1-same 3-improved
8	3	1-same 2-improved	1-same 1-improved 1-much improved

Table 8 Service Checklist Mean Level of Improvement

Participant	Post-Test	Follow-Up
1	0	+0.33
3	+0.80	+1.00
4	+1.25	+1.25
5	+1.00	+0.75
8	+0.67	+1.00
Average Mean Level of Improvement	+0.74	+0.87

3.6. File Audit

As it was expected that an increase in informal social support as a result of the intervention would affect the level of social support required from professional sources, a file audit to ascertain whether participants required less time from the employment service staff in the months following the intervention was proposed. This was expected to yield results that would indicate the utility of including the intervention in the program in terms of effective use of program resources. This audit was not performed as intervening factors for several of the participants, leave of absence, program exit and change in employment situation, were expected to skew the results.

3.7 Summary

As can be seen by the various ways in which data was collected to explore the results of the practicum intervention, the effect on each of the participants was unique. The vignettes provided examples of how the practicum intervention unfolded with three of the participants.

As a result of the small sample size and the magnitude of the changes experienced by the participants, none of the findings

reached a level of statistical significance. Although discriminant validity between clinical and non-clinical groups was established for the Social Relationships Scale, no information was available regarding its sensitivity to clinical change. The scale may not have been sufficiently sensitive to discern changes experienced by participants as a result of the intervention. A second feature of the measurement strategy that may have limited the ability to detect changes was the brevity of the follow up period. A follow up period of one year may have yielded changes that reached statistical significance. The small sample size and the likelihood of unavailability of participants made a longer term follow up impractical. Due to difficulties with achieving a stable baseline and the effect of response bias reported by one of the participants, results from the Index of Self-Esteem were not helpful in the evaluation process. The results of the administration of the scale could not be used to explore the possibility of a link between changes in self-esteem and changes in network features. The proposed file audit was not performed due to intervening factors which were expected to make accurate interpretation of the data unlikely. This limits the ability to predict whether the work of the practicum would reduce reliance by participants on the support from employment service staff.

The strongest finding was the increased level of reciprocity of relationships between participants and their network members. This change was experienced by four of the five participants for which a full data set was obtained. The remaining participant reported a slight decrease (4%) in the reciprocity level. This enhanced reciprocity, although not of statistical significance, may be in part attributable to a change in participants' perception of their own ability to provide support to network members and may indicate a change in their orientation towards their networks.

In assessing the level of clinical or practical significance, participants responded favourably to the intervention, generally expressing the opinion that changes in the areas that they targeted for work had occurred in the desired direction at the post intervention point and continued to be improved at three months following the end of their practicum involvement.

CHAPTER 4

ISSUES AND IMPLICATIONS

The application of the practicum intervention and the analysis of the findings suggested four major issues. First the experience of the practicum suggests that the inclusion of network building interventions in mental health programming would be both helpful and meaningful to program participants. Second, some of the tools used in the intervention may be helpful in social work practice in the field. Third, a sub-group of practicum participants who identified themselves as survivors of abuse differed from other participants in the networking issues that they raised. Finally, the context which contributes to the need for social support interventions with people with mental health problems is an issue which cannot be addressed solely on an individual level but has wider implications for practice. In the following chapter, these issues are discussed and their implications for further study and for practice in the mental health field are highlighted.

As a group, practicum participants tended to have networks that had fewer members, included more multiplex relationships, contained more professionals, and were perceived as less helpful and less reciprocal than the general population. Although this finding was not generalizable to the

participants of the employment service because random selection was not used, this finding in addition to more general research in the area indicates that a lack of social support may be a problem shared by other employment service participants. This suggests then that there is reason to include network building interventions as part of the employment service. Employment service participants were willing to participate in the practicum study and were able to identify goals to improve their social network support. Participants reported finding the intervention helpful in reaching and sustaining their goals. This indicates that inclusion of a network building component in programming would be meaningful to clients.

Due to the small sample size of the study none of the observed changes reached a level of statistical significance but arguably there were changes of practical significance to the participants involved. That a brief intervention had results that were stable after three months indicates the efficacy of network building interventions for people with mental health problems. Further research is required in this field to develop better interventions and to generate a larger sample size that would be more amenable to statistical methods of evaluation.

Some of the tools used in the intervention could be helpful for general assessment in the mental health field. Network mapping provided a good visual tool for practitioner and participant to better understand the network, to illustrate basic network concepts as they applied to an individual's experience, to target areas for work and to chart changes as they occurred. A procedure for network mapping with participants appears in Appendix F. It includes an orientation to the task, a form to list network members and a map format that may be used. The Social Relationships Scale provided a structured way of discussing network ties that was helpful both clinically and in the evaluation process. It is helpful in eliciting information about the person's level of satisfaction with his or her network, the multiplexity of ties and the level of reciprocity of relationships.

There was a sub-group of practicum participants who had experienced abusive relationships who required additional support during the intervention. Two of the four women in the practicum group identified themselves as having experienced physically and/or sexually abusive relationships as children and/or adults. Although the information at this stage is anecdotal, they expressed difficulties with trust and boundary issues to a greater extent than did other participants. For survivors of abuse, learning to establish boundaries with potential network members was an important first step to

beginning to increase the number of network ties. Further study in this area could produce findings helpful in work with survivors of abuse.

During practicum sessions, participants identified many issues that have contributed to their need to improve their level of social support. In addition to citing skill and attitudinal barriers, they recognized several features of their social situations which led to reduced levels of support. Participants experienced a fear of rejection if others knew of their mental health problems and expressed a fear of others discounting their feelings and opinions because of their history of mental health problems. They frequently spoke of the fear of and discrimination against people with mental health problems and how this impacted on them socially. One participant reported having lost touch with friends as a result of a psychiatric hospitalization that kept her out of the community for several months. People living with family or in group living situations reported a decrease in the range of options for socializing due to a lack of privacy. Others reported that being unemployed as a result of a psychiatric disability impacted upon the support available from family and friends who expressed the opinion that they should be working. Many cited the constraints imposed by a lack of financial resources that limited mobility and access to recreational facilities.

Current approaches to psychiatric care, high levels of unemployment, the widespread prejudice against people with mental health problems and poverty limit the opportunities for individuals to develop and maintain supportive social networks. Inclusion of network building interventions in a context of segregation and devaluation will have at best limited effect. Low levels of social assistance that restrict the use of public transit and make rental of a telephone difficult might be a more appropriate focus of change efforts in any attempt to increase levels of social support.

Participants involved in work or work experience situations, at the time of or immediately following their practicum involvement, reported finding that what they had learned in the practicum sessions was helpful in building relationships in the work setting. The intervention described in this report will be most effective as part of a larger strategy to further community integration and most appropriately remains as part of an employment or housing program that helps alleviate some of the systemic barriers and can provide an opportunity for people to use the knowledge and skills that they develop.

CHAPTER 5

CONCLUSION

The application of concepts drawn from social network theory to social work in the mental health field represents an alternative to the emphasis on inter-individual factors that has dominated practice. Social network theory suggests that programs of formal support increase attention to the building and maintenance of informal support (Garbarino, 1983; Weslowski, 1987). Inattention to informal support has been faulted for the failure of interventions with people with mental health problems:

> The inability of our mental health systems to design circumstances that would remove symptomatology can be seen as the consequence of the mistaken belief that artificial social networks can be instrumental in producing change in everyday life (D'Augelli, 1983:95).

The practicum intervention is an illustration of one of the ways that attention to informal social support can be included in a program providing formal support.

In contemplating the completion of the practicum, it is helpful to return to the objectives for the practicum set out in the original proposal. The data collected suggests some success in increasing the awareness of participants of the function and importance of social networks and social support, an increased level of reciprocity in their networks, an

increase in the size and diversity of the networks of some of the participants and for some an increase in social skills. Whether these changes will improve the effectiveness of the employment service in maintaining program participants in the workplace remains unanswered. Those participants involved in work or work experience situations, at the time or following their practicum involvement, reported that they found what they had learned in the practicum sessions to be helpful in their work situations. The second practicum objective was to increase the awareness of employment service staff of the theory behind and the utilization of social network interventions. There was already a high level of awareness of social networks and social support among the staff. Availability for discussion and provision of resources were the ways utilized to further this awareness.

The practicum proved a rich opportunity for the achievement of the learning goals set out in the proposal. With the exception of improving group facilitation skills, all learning goals were met. Reviewing audio-tapes of sessions both independently and with the supervisor allowed for reflection on and improvement of direct service skills. The evaluation component of the practicum allowed an opportunity to develop skills in single subject design and to appreciate the contribution that such measurement can have in an intervention.

Working with participants on social support issues offered a chance to better comprehend the dynamics of support and contributed to the writer's understanding of the forces at play in the lives of people with mental health problems. Finally, the experience of the practicum confirmed for the writer the complexity of the inter-play between personal and social spheres. For the participants of the practicum, improvement of individual skill in accessing support, given the context of their lives, remained only part of the answer to achieving optimal levels of social support.

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APPENDIX A. LETTER FROM ETHICS COMMITTEE

SCHOOL OF SOCIAL WORK
UNIVERSITY OF MANITOBA

SCHOOL OF SOCIAL WORK COMMITTEE ON THE USE OF HUMAN SUBJECTS IN RESEARCH

NAME: Dana Lewis DATE: 12.8.91

YOUR PROJECT ENTITLED: Social Support and the Transition to Employment of Individuals with Mental Health Problems.

HAS BEEN APPROVED BY THE COMMITTEE

COMMITTEE PROVISOS OR LIMITATIONS:

Nil

You will be asked at intervals for a status report. Any significant changes of the protocol should be reported to the Chairman for the Committee's consideration, in advance of implementation of such changes.

** This approval is for the ethics of human use only. For the logistics of performing the study, approval should be sought from the relevant institution, if required.

Sincerely yours,

Ranjan Roy
Professor & Chairman,
School Committee on the Use of
Human Subjects in Research

RR/km

TELEPHONE ENQUIRIES:

APPENDIX B. MEASUREMENT INSTRUMENTS

INDEX OF SELF ESTEEM (ISE) Today's Date _____

NAME: _____

This questionnaire is designed to measure how you see yourself. It is not a test, so there are no right or wrong answers. Please answer each item as carefully and accurately as you can by placing a number by each one as follows:

1 Rarely or none of the time
2 A little of the time
3 Some of the time
4 A good part of the time
5 Most or all of the time

Please begin.

1. I feel that people would not like me if they really knew me well _____
2. I feel that others get along much better than I do _____
3. I feel that I am a beautiful person _____
4. When I am with other people I feel they are glad I am with them _____
5. I feel that people really like to talk with me _____
6. I feel that I am a very competent person _____
7. I think I make a good impression on others _____
8. I feel that I need more self-confidence _____
9. When I am with strangers I am very nervous _____
10. I think that I am a dull person _____
11. I feel ugly _____
12. I feel that others have more fun than I do _____
13. I feel that I bore people _____
14. I think my friends find me interesting _____
15. I think I have a good sense of humor _____
16. I feel very self-conscious when I am with strangers _____
17. I feel that if I could be more like other people I would have it made _____
18. I feel that people have a good time when they are with me _____
19. I feel like a wallflower when I go out _____
20. I feel I get pushed around more than others _____
21. I think I am a rather nice person _____
22. I feel that people really like me very much _____
23. I feel that I am a likeable person _____
24. I am afraid I will appear foolish to others _____
25. My friends think very highly of me _____

3,4,5,6,7,14,15,18,21,22,23,25

Social Relationships Scale

SOCIAL RELATIONSHIPS SCALE (SRS)

This questionnaire concerns who you talk to when things happen to you for better or worse in your daily life. For convenience, we have categorized these things as follows:

First, **work**, that is: change in job, retirement, troubles on the job, change in workload, strike, promotion, etc.

Second, **money and finances**, that is: income increase or decrease, bill payments, investments, taxes, loans, making ends meet, etc.

Third, **home and family**, that is: change in residence, home improvements, neighbourhood decline, death in the family, birth, marriage, persons moving in or out of the home, separation/divorce, etc.

Fourth, **personal health**, that is: change in amount of recreation, sickness, diet, allergies, pregnancy, impairment of sight or hearing, etc.

Fifth, **personal and social**, that is: making new friends, furthering education, changes in religious or political beliefs, "falling out" of a relationship, loneliness, achievement, boredom, etc.

and lastly, **society in general**, that is: politics, economy, pollution, violence, housing, inflation, education, etc.

A.H. McFarlane
McMaster University
Hamilton, Ontario CANADA

☐ Check here if this category does not apply to you.

WORK
(See Page 1 for Examples)

Please list the people whom you generally discuss work, using the first name or initials only. After each name or set of initials fill in the one or two word description of the relation each person has to you.

Then go on to check the circle which indicates the degree of helpfulness or unhelpfulness of your discussions with each person, and lastly, check off YES or NO if you feel this person would come to you to discuss work.

Don't feel you have to fill up all the spaces provided. If you find you need more spaces, inform the interviewer.

I discuss work with:

Name or Initials	Relation	Helpfulness of discussion (check one circle)				Would this person come to you to discuss work YES	NO
_____	_____	makes things a lot worse	makes things a bit worse	helps things a bit	helps things a lot	( )1	( )2
_____	_____	makes things a lot worse	makes things a bit worse	helps things a bit	helps things a lot	( )1	( )
_____	_____	makes things a lot worse	makes things a bit worse	helps things a bit	helps things a lot	( )1	( )
_____	_____	makes things a lot worse	makes things a bit worse	helps things a bit	helps things a lot	( )1	( )
_____	_____	makes things a lot worse	makes things a bit worse	helps things a bit	helps things a lot	( )1	( )
_____	_____	makes things a lot worse	makes things a bit worse	helps things a bit	helps things a lot	( )1	( )

☐ Check here if this category does not apply to you.

MONEY AND FINANCES
(See Page 1 for Examples)

Please list the people whom you generally discuss money and finances, using the first name or initials only. After each name or set of initials fill in the one or two word description of the relation each person has to you.

Then go on to check the circle which indicates the degree of helpfulness or unhelpfulness of your discussions with each person, and lastly, check off YES or NO if you feel this person would come to you to discuss money and finances.

Don't feel you have to fill up all the spaces provided. If you find you need more spaces, inform the interviewer.

I discuss money and finances with:

Name or Initials	Relation	Helpfulness of discussion (check one circle)				Would this person come to you to discuss mone and finances YES	NO
_____	_____	makes things a lot worse	makes things a bit worse	helps things a bit	helps things a lot	( )1	( )2
_____	_____	makes things a lot worse	makes things a bit worse	helps things a bit	helps things a lot	( )1	( )
_____	_____	makes things a lot worse	makes things a bit worse	helps things a bit	helps things a lot	( )1	( )
_____	_____	makes things a lot worse	makes things a bit worse	helps things a bit	helps things a lot	( )1	( )
_____	_____	makes things a lot worse	makes things a bit worse	helps things a bit	helps things a lot	( )1	( )
_____	_____	makes things a lot worse	makes things a bit worse	helps things a bit	helps things a lot	( )1	( )

☐ Check here if this category <u>does not</u> apply to you.

HOME AND FAMILY
(See Page 1 for Examples)

Please list the people whom you generally discuss home and family, using the first name or initials only. After each name or set of initials fill in the one or two word description of the relation each person has to you.

Then go on to check the circle which indicates the degree of helpfulness or unhelpfulness of your discussions with each person, and lastly, check off YES or NO if you feel this person would come to you to discuss home and family.

Don't feel you have to fill up all the spaces provided. If you find you need more spaces, inform the interviewer.

I discuss home and family with:

Name or Initials	Relation	Helpfulness of discussion (check one circle): makes things a lot worse	makes things a bit worse	helps things a bit	helps things a lot	Would this person come to you to discuss home and family? YES	NO
______	______	O	O	O	O	( )1	( )2
______	______	O	O	O	O	( )1	( )2
______	______	O	O	O	O	( )1	( )2
______	______	O	O	O	O	( )1	( )2
______	______	O	O	O	O	( )1	( )2
______	______	O	O	O	O	( )1	( )2

☐ Check here if this category does not apply to you.

PERSONAL HEALTH
(See Page 1 for Examples)

Please list the people whom you generally discuss personal health, using the first name or initials only. After each name or set of initials fill in the one or two word description of the relation each person has to you.

Then go on to check the circle which indicates the degree of helpfulness or unhelpfulness of your discussions with each person, and lastly, check off YES or NO if you feel this person would come to you to discuss personal health.

Don't feel you have to fill up all the spaces provided. If you find you need more spaces, inform the interviewer.

I discuss personal health with:

Name or Initials	Relation	Helpfulness of discussion (check one circle)				Would this person come t you to discus personal health? YES	NO
		makes things a lot worse	makes things a bit worse	helps things a bit	helps things a lot	( )1	( )2
		makes things a lot worse	makes things a bit worse	helps things a bit	helps things a lot	( )1	( )2
		makes things a lot worse	makes things a bit worse	helps things a bit	helps things a lot	( )1	( )2
		makes things a lot worse	makes things a bit worse	helps things a bit	helps things a lot	( )1	( )2
		makes things a lot worse	makes things a bit worse	helps things a bit	helps things a lot	( )1	( )2
		makes things a lot worse	makes things a bit worse	helps things a bit	helps things a lot	( )1	( )2

☐ Check here if this category does not apply to you.

PERSONAL AND SOCIAL
(See Page 1 for Examples)

Please list the people whom you generally discuss personal and social things, using the first name or initials only. After each name or set of initials fill in the one or two word description of the relation each person has to you.

Then go on to check the circle which indicates the degree of helpfulness or unhelpfulness of your discussions with each person, and lastly, check off YES or NO if you feel this person would come to you to discuss personal and social things.

Don't feel you have to fill up all the spaces provided. If you find you need more spaces, inform the interviewer.

I discuss personal and social things with:

Name or Initials	Relation	Helpfulness of discussion (check one circle)				Would this person come you to discu: personal and social thing: YES	NO
______	______	makes things a lot worse o	makes things a bit worse o	helps things a bit o	helps things a lot o	( )1	( )2
______	______	makes things a lot worse o	makes things a bit worse o	helps things a bit o	helps things a lot o	( )1	( )2
______	______	makes things a lot worse o	makes things a bit worse o	helps things a bit o	helps things a lot o	( )1	( )2
______	______	makes things a lot worse o	makes things a bit worse o	helps things a bit o	helps things a lot o	( )1	( )2
______	______	makes things a lot worse o	makes things a bit worse o	helps things a bit o	helps things a lot o	( )1	( )2
______	______	makes things a lot worse o	makes things a bit worse o	helps things a bit o	helps things a lot o	( )1	( )2

☐ Check here if this category does not apply to you.

SOCIETY IN GENERAL
(See Page 1 for Examples)

Please list the people whom you generally discuss society in general, using the first name or initials only. After each name or set of initials fill in the one or two word description of the relation each person has to you.

Then go on to check the circle which indicates the degree of helpfulness or unhelpfulness of your discussions with each person, and lastly, check off YES or NO if you feel this person would come to you to discuss society in general.

Don't feel you have to fill up all the spaces provided. If you find you need more spaces, inform the interviewer.

I discuss society in general with:

Name or Initials	Relation	Helpfulness of discussion (check one circle)				Would this person come you to discu: society in general? YES	NO
_____	_____	makes things a lot worse ○	makes things a bit worse ○	helps things a bit ○	helps things a lot ○	( )1	( )2
_____	_____	makes things a lot worse ○	makes things a bit worse ○	helps things a bit ○	helps things a lot ○	( )1	( ):
_____	_____	makes things a lot worse ○	makes things a bit worse ○	helps things a bit ○	helps things a lot ○	( )1	( ):
_____	_____	makes things a lot worse ○	makes things a bit worse ○	helps things a bit ○	helps things a lot ○	( )1	( ):
_____	_____	makes things a lot worse ○	makes things a bit worse ○	helps things a bit ○	helps things a lot ○	( )1	( ):
_____	_____	makes things a lot worse ○	makes things a bit ○	helps things a bit ○	helps things a lot ○	( )1	( ):

Service Checklist

Name_____

Date_____

Level of Improvement

The Problem Is:

Target Problem	Much Worse	Worse	Same	Improved	Much Improved
1._____	___	___	___	___	___
2._____	___	___	___	___	___
3._____	___	___	___	___	___
4._____	___	___	___	___	___
5._____	___	___	___	___	___

APPENDIX C: PERMISSION FOR USE OF STANDARDIZED MEASURES

Statement of Permission for Use of Index of Self-Esteem

"Dr. Walter Hudson has granted permission to reproduce and use any or all of these scales presented in Figures 6.2 through 6.10 in any quantity needed provided that the following three conditions are met: the format and wording of each scale must not be altered, the copyright notation at the bottom of each scale must be retained, and none of the scales may be reproduced for commercial purposes."

Bloom, Martin and Joel Fischer. Evaluating Practice: Guidelines for the Accountable Professional. (1982) Englewood Cliffs, N. J. Prentice-Hall, Inc. Page 162.

McMASTER UNIVERSITY
Faculty of Health Sciences
Department of Psychiatry
1200 Main Street West, Hamilton, Ontario L8N 3Z5
Telephone 525-9140

November 25, 1992

Dana Lewis

Dear Ms. Lewis,

I hereby give you permission to use the Social Relationship Scale.

I will give all Rights

Allan H. McFarlane, M.D.,F.R.C.P.(C)

AHM:ab

APPENDIX D. RECRUITMENT LETTER AND CONSENT TO PARTICIPATE

Employment Dimensions

Dear Participant:

Social support is the help that a person gets from the people that he or she knows (family, friends, workers). The purpose of this study is to look at the types of relationships with other people that participants in Employment Dimensions have. This study is designed to find ways that social support can be improved and how this may affect an individual's transition to employment. As a participant in Employment Dimensions, you are expecting to begin a new job in the near future and may wish to participate in the study.

The idea behind the study is that increased social support will improve an individual's ability to be successful at work. Although there is evidence to support the idea that involvement in the practicum will be helpful, this cannot be guaranteed. As with any such study, there is the risk of negative effects. These may include feeling unsettled by taking a look at difficult relationships in your life or affecting those around you by behaving in a different way.

Participation is voluntary. Your decision will in no way affect your involvement with Employment Dimensions. If you wish to withdraw from the study at any point you may do so, again, without affecting your involvement in Employment Dimensions.

As a participant in the study, you would receive approximately ten one hour sessions of individual counselling. Sessions could take place at the Employment Dimensions office, in your home or at a place convenient to you. You may decide to become involved in a weekly group meeting instead of or in addition to the individual sessions. Information will be collected during interviews at the beginning and end of the study and the results analyzed. These results will be shared with you. Participants are also requested to be available for a three month follow-up interview.

3 - 1000 Notre Dame Ave., Winnipeg, MB. R3E 0N3 • Telephone. (204) 786-6684 Fax (204) 788-[illegible]

A Project of the Canadian Mental Health Association, Winnipeg Region Inc.

If you wish to become involved in the study, you may decide to allow individual counselling sessions to be audio-taped. You may participate in the study without allowing the sessions to be taped. If you permit the taping to occur, the tapes will be reviewed by me and my clinical supervisor at the University of Manitoba. We are both bound by the policy of the Canadian Mental Health Association to maintain such information in the strictest confidence. Tapes will be kept in a locked cabinet and erased after the study.

Information collected from the study will be kept strictly confidential. Staff of Employment Dimensions and members of the University of Manitoba faculty involved in the study are bound by a policy that prohibits the sharing of information without prior consent from clients.

A final report of the study will be written including data collected from the study. Names will not be used and identifying details will be masked to assure your anonymity. A copy of the final report will be kept at Employment Dimensions office if you wish to view it.

Please take a week to consider your decision about participating in the study. If you wish, review your decision with someone that you trust. If you have any questions, please do not hesitate to contact me at .

Yours truly,

Dana Lewis

I would like to participate in the study and understand the following:

1. My decision about participating in the study will in no way affect my involvement in Employment Dimensions.

2. If I wish to withdraw from the study, I may do so at any time, without affecting my involvement in Employment Dimensions.

3. Information collected as a result of the study will be kept confidential.

4. My involvement would require that I participate in approximately ten individual counselling sessions. This would be in addition to time regularly spent in the Employment Dimensions program.

PLEASE CHECK:

_____ I would like to participate in individual sessions.

_____ I would be interested in participating in a support group.

_____ You have my permission to audiotape sessions.

_____ I prefer that you do not audiotape sessions.

_____ I prefer not to participate in the study.

Signature _____

Date_____

APPENDIX E: PARTICIPANT BIOGRAPHIES

Participant 1.

The participant was a 39 year old man with a diagnosis of paranoid schizophrenia and an anxiety disorder. He sustained a head injury in his late teens and reports that from this time he has had slurred speech. Initial network measurement revealed a close network of eight members, predominantly close family members and professional contacts. He reported the network to be helpful with a reciprocity level of 59%. During the course of the practicum intervention he moved from a suburban boarding home to a bachelor apartment in a central neighbourhood. He also began a work experience through the employment program during this time.

The participant set three goals for the practicum work: to improve conversation skills; to explore recreational opportunities in the community; and to connect with others with a shared interest. During the practicum sessions social support needs and expectations of different relationships were discussed. General conversational rules such as not interrupting when others are speaking, listening attentively, staying on topic, speaking slowly and clearly were examined in addition to practising probing questions and exploring

different topics for conversation. Recreational activities in the community that the participant enjoyed and strategies for meeting others with a shared interest were explored. Ways of optimizing the social opportunities created through the work experience were also examined.

The post-intervention measurement of the participant's network showed some changes with an increase in the close network by one member and a shift in the network composition to include a friend and reduce the level of professional involvement. At follow-up, the network size increased dramatically with the addition of nine people from the work setting. The level of reciprocity increased at this measure to 85% while the level of helpfulness declined slightly from initial and post-intervention standing. The most striking changes shown in the network are in the sectors of work and friends are attributable to three factors. First, the participant's work experience allowed him daily contact with a large group of co-workers. Second, he moved to a neighbourhood where he had previously resided and was able to renew old social contacts. Third, his living situation, an apartment rather than a boarding home, was more conducive to inviting friends and acquaintances over.

Participant 2.

The participant was a thirty year old woman who lived alone in a suburban apartment. She worked casual shifts at a day care and had not worked full-time for the four years following the onset of her mental health problem, manic depression. Initial assessment of her social network showed a moderately sized network with a large professional involvement. The participant reported some close relationships among her neighbours. She perceived her network as helpful with a 57% rate of reciprocity.

Much of the initial work focused on defining the parameters of the practicum and on setting an appropriate goal for the work. The participant identified difficulty in staying calm during social situations. Her nervousness during social situations caused her to misinterpret social cues and to be overly friendly and boisterous. She set improving her ability to relax in social situations as her goal.

Development of a greater awareness of her anxiety level and use of relaxation techniques were practised. Discussion centred on reading social cues accurately and sending cues that would make her intentions in relationships more clear.

Following several sessions the participant decided not to pursue the goal that she had set and withdrew before the end of the practicum. Due to this post-intervention measures were not obtained.

Participant 4.

The participant was a woman in her early forties with an anxiety disorder. She worked part time as a home-maker and attended evening classes to upgrade skills related to her employment goal. At the time of her practicum involvement she was doing a work experience through the employment program. She lived with her husband and two children in a Winnipeg suburb. Assessment of her network indicated a small, fairly helpful network with a predominance of modal figures and a high degree of reciprocity.

The participant set three goals for the practicum work: to increase the intensity of her ties with two friends currently in her network; to alter existing relationships to include outings rather than exclusively phone or at-home visits; and to include some couples as friends in her network.
The educative component included social network theory, the role of social support and the constituents of a balanced network.

Discussions included what is valued in a friend, her husband's role in bringing people into the network and an exploration of opportunities to socialize.

Most features of the network remained unchanged following the practicum intervention. At post-test, the participant's network remained a small, fairly helpful network with a predominance of modal figures and a high degree of reciprocity. A smaller close network following the intervention was reported with the loss of one professional member as a modal figure. There was an apparent decrease in the level of involvement of professionals in the network overall. The changes targeted as goals of the intervention, to increase the number of close friends and the number of couple friends, appeared on the network map. The second map showed an increase in the number of friends and the inclusion of two friends in the inner circle of the map. At follow-up the network remained relatively unchanged from the post-intervention measure with some increase in the levels of reciprocity and helpfulness. The loss of one relationship was reported.

Participant 6.

The participant was thirty years old at the time of the practicum intervention. He grew up in rural Manitoba and was diagnosed with manic depression during his teens. He lived in a central neighbourhood with his partner and was unemployed at the time of the intervention. Network analysis showed a medium sized network which included his partner, a close family member, three friends and three professionals in the close network. Modal figures were drawn from each of these groups. He perceived his network as helpful and reported a high degree of reciprocity.

As a goal for the practicum, the participant chose to work to improve his ability to communicate assertively and clearly. In addition to the educative component of the work which provided the participant with an understanding of the role and function of social support and social networks, discussions and role plays centred on assertive communication.

The participant was hospitalized and was unavailable to complete work in the practicum beyond the sixth session.

Participant 7.

The participant was thirty years old at the time of the practicum intervention. He lived in a central neighbourhood in a co-operative housing program for people with mental health problems. He was involved in a work experience through the employment program.

Initial assessment showed a fairly extensive network which included five friends, three family members, three professionals and one work associate. Modal figures in the network were two friends and two family members. Professionals were not among the modal figures. The network was perceived as helpful with a relatively low level of reciprocity (54%). The participant was involved in two groups related to his hobby, a church group and a self-help group at the time of the practicum. One of the notable features of his network was the lack of ties with women outside of his immediate family. His friends also tended to be considerably older than he.

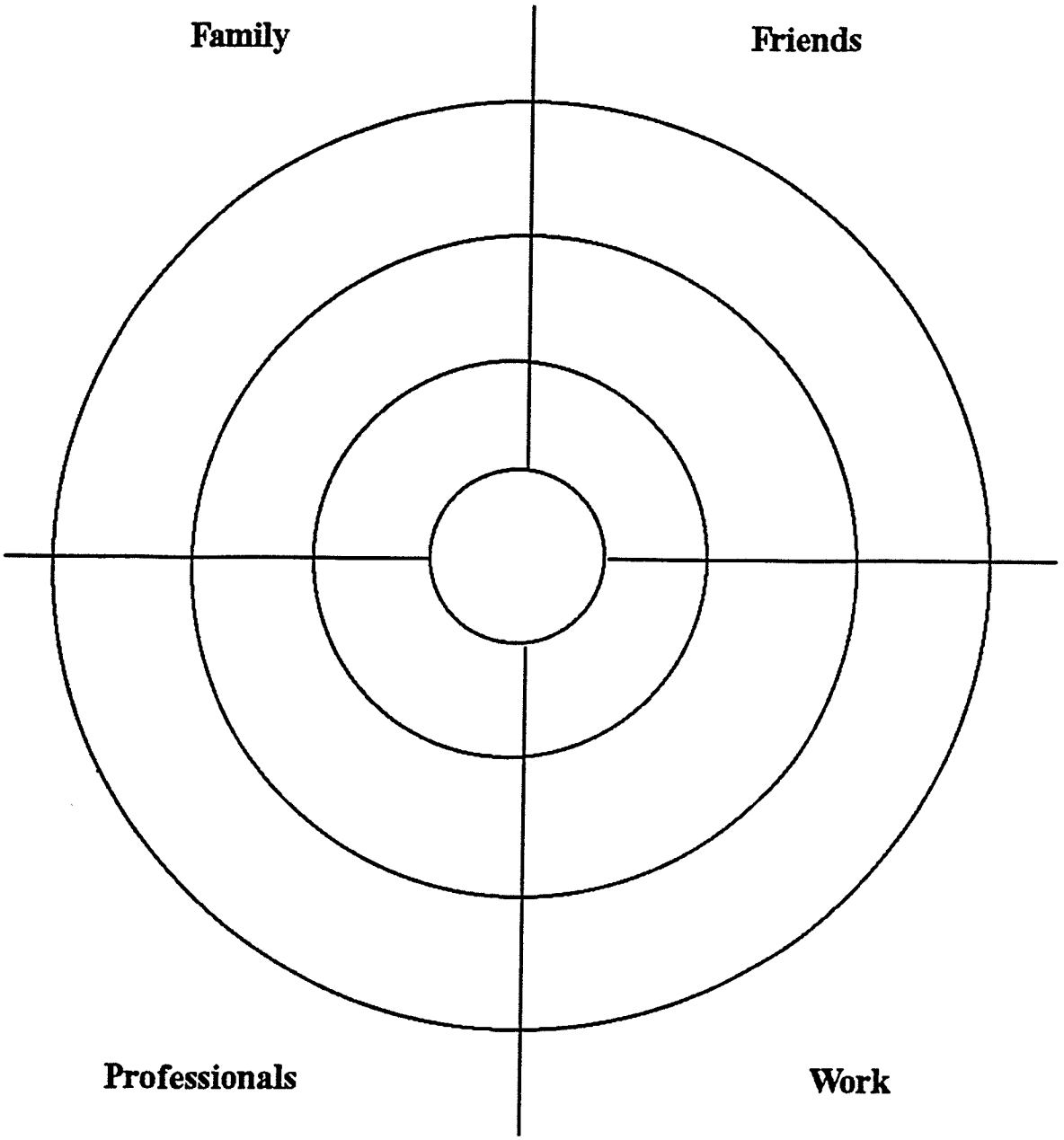
The participant set a practicum goal of increasing his social ties with men and women of his own age. In addition to the basic tenets of network theory, sessions included discussion of what the participant sought in friendships, opportunities to meet people, and conversational skills.

The participant became unavailable to continue practicum work beyond the seventh session.

APPENDIX F. PROCEDURE FOR NETWORK MAPPING

The network map is a way of organizing network members according to type of relationship (example: family, friend) and intensity or closeness of relationship. The participant's name goes at the centre of the map. Network members are placed on the map in the appropriate sector. The work sector may contain ties from volunteer work, school or other activities besides paid employment. Network members are placed on the map according to the intensity of the participant's relationship with them: the more intense the tie, the closer to the centre of the map it is placed. Remember that an unsupportive tie may be intense.

NETWORK MAP



SOCIAL NETWORKS: BACKGROUND INFORMATION

1. A social network is comprised of all of the individuals in a person's life. A network may include both supportive and unsupportive ties.

2. Social support is the help provided by network members that helps an individual cope with daily life. Types of social support may be categorized as follows:

    a) Informational support: provision of information or advice
    b) Appraisal support: provision of feedback about performance
    c) Instrumental support: provision of goods or services
    d) Emotional support: caring, trust, empathy

    Categories are not separate entities but components of support. Emotional support may be conveyed to someone through another form of support, for example a ride to work.

3. A social network will likely include members that are professionals (formal supports) and non-professionals (informal or natural supports). Formal and informal ties vary in the expectations of the relationship, especially reciprocity.

4. Modal figures in the network are members, in close relationship with the person, who usually provide different types of support. (Example: someone you can talk to about work and borrow money from).

5. Many dimensions of a network may be measured. Among the most common are:

    a) Size: How many members are there?
    b) Composition: Are network members family, friends, co-workers, professionals?
    c) Density: To what extent do network members know each other?
    d) Reciprocity: Are relationships mutually supportive?
    e) Multiplexity: How many support functions does each tie fulfil? (Modal figures)

6. An "ideal" network?

    - Networks will vary depending on things like cultural norms, gender, life stage and personal preferences. During times of crisis, for example, a small, dense network is thought to provide optimal support. This type of network may be experienced negatively during times of stability.
    - It is generally helpful to have members from different sectors (friends, family, co-workers). In a family crisis, network members from outside the family may be better

able to provide support than family members who are also experiencing stress from the crisis. Members from different sectors can also allow an individual the opportunity to take different roles.

- Reciprocity can be an issue with networks dominated by professionals and/or family of origin ties.