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## Social (Societal) Support

### Overview

People do not live in isolation from one another, and instead we are shaped by, and shape, our social environments. These social environments affect both mental and physical health, and one key aspect of social transactions are instances of giving and receiving social support. The idea that social relationships may be good for health is a not a new one; strains of it flow from the book of Genesis when the Lord says, “*It is not good that man should be alone; I will make him a helper comparable to him*” (Genesis 2:18 NKJV) to the writings of influential thinkers such as Aristotle, Emile Durkheim, Martin Buber, and Sigmund Freud. Social scientific research on the association between social relationships and health proliferated in the 1970s and the topic continues to be widely studied. Social relationships have been found to be important predictors of both mental and physical health outcomes, and in fact, having poor social relationships decreases survival likelihoods as much as traditional health risk behaviors (e.g. smoking, physical activity, obesity) and indicators (blood pressure). Overall, this research suggests that positive relationships are good for both mental and physical health.

When specifically focusing on the relationship between *social support* and *mental health*, the research literature suffers from disagreements about definitions, and also tends to focus on received social support when definitions do converge. However, the day-to-day experiences of social relationships involve both receiving social support, and giving it. Thus, social support can be generally defined as the belief that others will provide practical (e.g. money, errands, childcare) and emotional support when needed (*perceived support*), actually receiving such support (*received support*), and also giving such support (*given support*). In addition, *structural support* can be considered as the frame where such interactions take place (e.g. number of relationships, frequency of contact, strength and quality of bonds). Since both receiving and giving social support are confounded in the context of social relationships, it is unclear whether one or the other is a better predictor of mental health outcomes. Thus each type of social support is summarized separately for clarity.

### Receiving Social Support

The earliest form of received support stems from parental caregiving. Parents help to shape infants’ perceptions and beliefs about the availability and reliability of social partners in providing for their needs. These perceptions and beliefs are the basis of infants’ attachment styles, which have later implications for their ability to bond and form close relationships. Attachment theorists posit that infants who receive timely care that is matched to their level of need will develop secure attachments with their mothers (or other primary caregivers), which in turn will be applied to other future relationships. Those who receive inconsistent care, or whose parents are distant and unavailable, will develop insecure attachments (preoccupied and dismissing, respectively), which will negatively affect later relationships. Attachment styles function like a lens through which children, and later, adults, view their social world such that even in the presence of actual social support, some individuals may have trouble noticing or accepting it, because of formative developmental experiences.

The bulk of research on the mental health effects of received support leans toward positive effects of it. However, these studies are often cross-sectional (correlational) or prospective (longitudinal), and thus it is difficult to know whether and how recipient need plays a role. For example, people who are at risk for mental health issues (e.g. have just experienced a significant loss or trauma) may be more likely to receive social support because their need is obvious. In these cases studies might find that the presence of received social support is “bad” for one’s mental health, but this might be explained by the fact that people who need more support to begin with may actually receive more support. Issues of status and power also complicate the relationship between received support and mental health, such that relatively lower status people (e.g. low socioeconomic status) may be seen as needing more social support by higher status people, regardless of their

actual needs. In those cases offers of social support (or social services) might be spurned, or if they are accepted, they may actually lead to poorer mental health in terms of a lower sense of independence, self-esteem, and self-efficacy or mastery.

In addition, people who are currently mentally ill (e.g. depressed) might report not having much social support, which may lead to the conclusion that low social support causes mental illness (e.g. depression). Or in other words, that the presence of social support protects people from mental illness. For example, some research finds that women who are not in committed relationships have over 9 times the risk of depression than women in committed relationships. However, it could be that people with mental illnesses, such as these women, have become alienated from their family members, partners, and friends because of their illness, but otherwise had strong social networks in the past. Psychosocial rehabilitation approaches to mental illness cannot distinguish between giving and receiving social support because they involve community living and cooperative participation. However, these programs show remarkable effectiveness because they address the social isolation and stigma that people experience while mentally ill (e.g. Clubhouse Model, Fountain House).

There is much research suggesting that simply subjectively *perceiving* the availability of social support is related to good mental health. For example, people who believe that others would be there for them if needed are better at coping with stress and illnesses. However, it is unclear whether mentally and physically healthier people create better social networks, whether they are better at believing that they have social support (i.e. they are more optimistic), or whether such beliefs actually cause better mental and physical functioning.

In terms of *actually receiving* social support, the research literature is mixed. Some studies have found that people who have much available social support feel more depressed, guilty, and dependent. Some research even finds that those who receive more social support are more likely to die several years later, even when controlling for baseline demographic and health variables. So the receipt of social support is not always associated with better mental and physical health, for the reasons already discussed. However, many studies have found the opposite: that being the recipient of social support is associated with better mental (e.g. depression) and physical health (e.g. lower mortality risk).

Overall, meta-analytic integrations of the literature suggest that there are small benefits to receiving social support, but that they depend on a number of factors. Such benefits have even been found in the presence of received social support via video messages. Because individuals do not always benefit from receiving social support it is important for practitioners to consider such factors before recommending that people receive more social support to alleviate their mental health issues. For example, gender norms must be taken into consideration when predicting potential benefits of receiving social support. Males who hold gender-stereotypical or traditionally masculine beliefs are less likely to benefit, and may even be harmed by, overt social support gestures. Other research has confirmed that more overt forms of providing support can be damaging because they undermine recipients' views of themselves as competent and independent. Givers trying to maximize mental health benefits in recipients should be aware of these issues and provide more subtle supportive gestures. One other effective way for support givers to minimize recipient harm is to be willing to receive support in return, and thus equalize the relationship dynamics.

## **Giving Social Support**

Although social support is most often conceptualized of as received support, an emerging literature examines the relationship between *giving support* and mental health. One obvious point to consider is that people who are already mentally healthy might find it easier to give. So it is important to consider people's initial mental health when examining the effects of giving support on later mental health outcomes. As with receiving support, the literature on this topic is mixed.

On the one hand many studies find that giving support is associated with mental health benefits. People who give social support are happier, have higher self-esteem, and are less lonely, results that are found in both cross-sectional and prospective studies. In addition, studies that experimentally examine the effects of giving support have found that it leads to higher well-being and lower depression. However in some circumstances givers feel burdened, frustrated, or exhausted, especially when recipients make too many demands, have unsolvable or difficult problems, or do not give back.

Such negative responses to giving are best documented in two research literatures. First, the literature on caregiving (in older adults or disabled children) generally finds negative effects associated with being primarily

responsible for the daily living activities (e.g. bathing, dressing, eating) of spouses, children, or other family members who have illnesses or functional limitations (e.g. because of a stroke, dementia, or developmental disability). Such caregiving behaviors are qualitatively distinct from other support giving behaviors because they involve seeing loved ones in distress, they are often non-voluntary, and they exist at a higher level of giving intensity in terms of time, energy, and financial resources. In fact, many situations involve 24-hour caregiving and power-of-attorney over financial and medical matters, both of which are difficult and stressful. Thus, researchers must attempt to tease apart actual giving behaviors from other confounding contexts to best unpack potential mental health effects of giving. In the rare studies that have done so, researchers have found that the more caregivers *actually help* the recipient, the more positive emotions they feel. But being “on call” at all times of the day or night is especially toxic for caregivers.

Meta-analytic integrations of the caregiving literature find that caregivers on average suffer from increased physiological and psychological problems related to stress (e.g. high stress hormones). However, there are some factors that seem to be protective when it comes to caregiving. For example, male caregivers function better than female ones, and this might be because they have lower caregiving burdens and more financial resources. Similarly, Caucasians and younger caregivers suffer fewer negative consequences from caregiving compared to ethnic minority groups and middle-aged caregivers. According to such meta-analyses, the fewer hours of care given, the fewer caregiving behaviors, the less impaired the recipient of care, and the more financial resources available, the better the outcomes associated with caregiving. And this is one situation when received social support makes a positive difference. Overall, the best mental health outcomes associated with caregiving occur when caregivers are able to experience some distance from the recipients, whether this means the ability to imagine the recipients’ experiences without getting caught up in emotional distress, or whether this means having time off to talk to others or care for one’s own self.

Research on people who give as part of their full-time occupations (e.g. doctors, psychologists, social workers, corrections professionals) finds parallel results. These individuals often experience “compassion fatigue” while caring for others who are in emotional or physical pain. Compassion fatigue that is chronically experienced without refueling can lead to depression, substance abuse, and post-traumatic stress disorder. Similar principles apply in the caregiving and the compassion fatigue literature, with more intensity being associated with worse outcomes, and with the importance of caring for one’s self being apparent.

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### **See Also:**

Coping Behaviors

Family Support

Marital Status

Social Isolation

Stress

### **Further Readings**

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