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SOCIAL NETWORKS: IMPLICATIONS FOR PROFESSIONAL CAREGIVERS

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ABSTRACT

Social networks have been touted as natural units of social structure because of their ability to heighten practitioners' contextual appreciation of human behavior. They are the broadest system, with which practitioners have worked assessing and treating dysfunction, on a continuum which ranges from individuals to couples to families and so on.

This paper is essentially a review of the literature that has emerged in recent years dealing with social networks. The focus is to present implications, for the caregiving professional, which have arisen out of research and practice experience with social networks.

The social network model is gaining popularity within the caregiving professions and comment is made on the development of the model and its entry into the field of clinical practice. As a prelude to the main theme of the paper various definitions, characteristics and functions of social networks are offered to introduce "network" terminology. Research on social networks in the areas of illness, the life cycle, psychopathology, help-seeking and community is presented. Research in these areas is generally incomplete however results of some interest have been found and practice principles are slowly emerging. Implications for professional caregivers are discussed and some practice forms that have developed out of a social network

perspective are examined. Some ethical considerations are outlined and the emphasis on informal or natural helping is appraised. Generally support is found for the use of the social network model in clinical work both in assessing and treating dysfunction.

Family and friends are not all a person needs to survive in this world but they play a large part in making survival more than just living.

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My network of family and friends is warm and supportive. These people deserve my gratitude and love, for without them this project would not have been written.

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FORWARD

Over the past two decades there has been an increased interest in conceptualizing human behavior in the context of large family and social systems (Erickson et al. 1974). The social network model had emerged as a potentially useful theoretical model for the analysis and description of complex social systems and interaction. Social networks and social support systems have become increasingly popular foci of inquiry for both researchers and practitioners (cf. Hammer et al. 1978; Rueveni 1979). Of particular interest within this orientation is the notion of social support and its importance to physical and psychological well-being.

Mitchell and Trickett (1980) suggest that the increasing popularity of the concepts of social network and social support systems can be understood because of their usefulness in practice.

> First, they offer operational means of learning more about the everyday lives of persons in communities. The richness of this perspective for the development of a community psychology is evident. Second, the linking of social support to various aspects of psychological adaptation offers a theoretical base for developing broad-based preventive interventions. If the determinants of psychological dysfunction and psychological development are multiple and affected by one's "social surround", then initiating programs that help individuals and communities to strengthen their systems of social support may reduce vulnerability and risk and increase competence and sense of community. Third, the notions of networks social support systems suggest a way of developing resources that puts less emphasis on treatment by

> professionals and more emphasis on embeddedness within a naturally occurring network of non-professional supportive relationships. (:27-28)

Social networks are natural units of social structure (Gottlieb 1979). They have the potential to heighten professional caregivers' appreciation of human behavior as it occurs in the natural environment. Social networks are also natural units of intervention (Attneave 1976) and hold promise of being curative groupings (Erickson 1975). Overall social networks represent the latest boundary in the ever broadening social context within which professional caregivers assess and treat dysfunction.

There is presently a heightened interest in social networks and this is reflected in the recent practice and research literature. It is important for professional caregivers to familiarize themselves with this literature in order to understand the benefits of assessing and treating dysfunction from a network perspective. This paper draws together social network literature from diverse sources.

Part One serves as an introduction to the paper and to provide the reader with some preliminary information on social networks. An historical picture of the development of the social network model and how the profession of social work became involved with it is presented.

Part Two is devoted to detailing the current ways of describing and analizing social networks. Definitions of social network as provided by various writers are listed to answer the general question "What is a social network?". Part Two also deals with some of the confusion that exists in the social network terminology. Confusion has arisen partly because practitioners and researchers working from a network perspective have used various terms and concepts interchangeably with little consensus on such matters among themselves. The various functions served by social networks are also presented.

Part Three describes some research done on social networks and support. The role of social support and the influence of social networks are examined in relation to: illness; the life cycle; psychopathology; help-seeking; and community. It is this literature on which practitioners, utilizing a social network perspective, base their interventions.

This literature provides the rationale for the inclusion of the notion of support in social assessment and treatment.

Part Four deals primarily with implications for the helping professions derived from social network literature. Comment about the capacity of various network configurations to meet individual need is made. Some ethical considerations relevant to the role of social networks in the helping professions are discussed. Implications for social service agencies and

programs are elucidated and several research needs are noted. A review of the practice forms which presently utilize network concepts is presented.

PART ONE

INTRODUCTION

The term "social network" is generally taken to mean all the social contacts a person has. The term found its way into the vocabulary of some North American professional care-givers via the profession of anthropology. A British anthopologist (Barnes 1954) first used the term when reporting on research in a Norwegian Parish. Anthropologists, who typically focus on kinship, utilize the term "social network" to account for the families' friends, neighbours, and workmates. Bott (1957) and Mitchell (1969), both anthropologists, recognized that persons other than kin may be as or more important to the family. They conducted their research in England and Africa respectively and their work influenced some American family therapists. The family therapy movement initially saw social networks as resources for promoting mental health and later as resources for resolving nuclear family problems (Turkat 1980).

The writings of clinical psychologists such as Attneave (1976), Speck and Attneave (1973), and Rueveni (1975, 1977, 1979) illustrate the applicability of the concept in practice. Social workers (Collins and Pancoast 1976; Erickson 1975; Erickson, Rachlis and Tobin 1974) began writing about the use of the social network model in practice from both a theoretical and a practice perspective during the past decade.

Social work has typically "borrowed" theory from other professions in order to understand "person-in-situation". The profession has come under the influence of a variety of theoretical perspectives and each has undoubtedly served some purpose and has appeared attractive in some way to practitioners. From its earliest days as a profession the social work vocabulary has included the terms "support" and "supportive treatment" which have been used to describe helping activity.

During the 1940's Freudian theory, with its dynamic intrapsychic factors, temporarily distracted social workers from the "person-in-situation" perspective. With the advent of ego-psychology in social work theorizing, came a return to the notion of supportive treatment in that ego-strengths had to be maintained if problem-solving was to be successful. During the 1960's there was a surge of interest in a wide variety of approaches to helping, and an associated flurry of activity among theoreticians. The general framework for assessment and intervention appeared to be comprised of two major theoretical positions; situational (Germain 1979, Siporin 1975) and systemic (Bertalanffy 1968, Hearn 1969, 1974). Social situation theory's greatest contribution to the profession is that it requires simultaneous consideration of the client and the environment in assessment and treatment. Systems theory, on the other hand provides a way of conceptualizing these elements into distinct groupings interacting with one another. Separately and combined with the other, both are inadequate to

provide specific direction regarding intervention. Social situation theory provides some general direction in that it may point to deficiencies in the environment amenable to practitioner manipulation. There is however insufficient consideration of the social interactions of those persons with whom the client interacts and their interaction with the environment (Swenson 1979). Systems theory, because of its complexity and high level of abstraction proves less than optimally useful in generating specific practice principles for the practitioner (Germain 1978). The ecological perspective, with its emphasis on human adaptation to the environment, is typically defined as situational but can be thought of as a less abstract form of systems theory (Germain 1979).

The 1970's witnessed the introduction of the social network model into the profession of social work (Selby 1979). This approach has focussed largely on the ability of an individual's social network to provide support naturally and with the assistance of professional care-givers. It is hoped that social network theory will prove useful as a unifying framework in clinical practice on its own (Erickson 1975; Turkat 1980) or in combination with situational and systems theory (Driedger 1981). Systems constructs most relevant to network theory are boundary, feedback and steady state (Freeman 1976).

Social network theory as a framework is holistic in its approach to problematic and normative situations. The theory provides for the consideration of the physical environment, all the clients' social interactions, as well as, group and cultural, norms and values. The theory focuses on provision of social support in the social network and the influence this has on the client. The steadily accumulating research on social support and networks holds great promise of providing not only useful social network assessment tools and information but also specific and clear direction for the practitioner with regard to intervention.

Swenson (1979) describes five elements of the social network model which outline its usefulness for practitioners. Firstly, problems are defined as a "poor fit" by specifying the relationship between the clients' ability to cope and the impinging environment and by making explicit the relationships between persons and objects in the environment. Secondly she notes that social network theory is specific in providing direction for the analysis of the environment and its influence on the client (i.e., social network analysis). Thirdly, the worker-client relationship is such that a wide range of persons are considered as helpers (e.g., family, friends, neighbours) rather than just professionals. Fourthly, the goals of helping in a social network model are to increase the competence and coping abilities of the client and the social network through interventions into the network largely through consultation.

Lastly, Swenson notes that service delivery arrangements will emphasize the network rather than the person as client and will be operative in the community rather than offices and institutions.

A major contributing factor in the development of the social network model began with numerous studies investigating the relationship between life stress and the onset of physical and psychiatric illness. Criticism of these studies focussed on the fact that significant findings were a product of large sample sizes and that life stress seldom accounted for more than a small proportion of the variance (Surtees 1980). While this criticism was not wholly valid, it did provide the impetus for many social scientists, particularly during the past decade, to address other factors that may influence the outcome of stress. One other factor that was investigated was social support. It was hypothesized and later documented (Cassel 1974, Cobb 1976) that there is an association between social support and life stress such that the former moderates the effect of the latter.

Investigations to date have produced findings which demonstrate that as the level of social support increases the individual's capacity to maintain mental (Cohen and Sokolovsky 1978) and physical health (Gore 1978) increases, as does ability to recuperate from illness (Finlayson 1976). With these results fairly well known, professional care-givers and social

researchers have become progressively more interested in examining the support that is given freely and naturally in our society (Collins and Pancoast 1976). Natural helping networks, support systems and self-help groups of all kinds have received a great deal of attention at a time when the effectiveness of professional treatment is being questioned (Fischer 1976). Professionals are not only eager to develop assessment tools from a social network model (Attneave 1975) but have addressed the issue of treatment from a network perspective as well (Rueveni 1979).

Network is a nebulous term and definitions vary with writers, settings and populations. In Part Two some definitions are offered to enhance the readers understanding of social networks. Social networks can be analyzed, measured or simply identified by certain characteristics. These as well as network functions are discussed in Part Two.

PART TWO

DEFINITIONS, CHARACTERISTICS AND FUNCTIONS

The term "network" appears in the literature with a variety of adjectives such as, "personal", "social", "support", and "natural". There is a great deal of confusion and lack of consensus with this kind of terminology in the professions of social work, psychology, psychiatry, and public health. Some common ground is reached, regardless of the adjective used, because of the widely held and shared belief in the importance of examining provision of support from a network perspective. So important is the notion of support that the term "support system" is often used synonymously with "network". This is somewhat misleading and incorrect in that support systems are generally thought of as specific groupings with recognizable boundaries (i.e., family, churchgroup, etc.). Most individuals however are likely to receive and offer support within a group of people which are not easily identified by a formal boundary. The concept of "network" allows for the consideration of the individual's total field of relationships within which support is exhanged. Network is the more inclusive term and is therefore potentially more useful.

Social Network Defined

There are two general approaches to the concept of "network" in the social sciences (Craven and Wellman 1973).

"Personal network" is often used to refer to the relationships (linkages or ties) a specific (focal) person has with others in the social environment. "Social network" is used to refer to all linkages, among all individuals within a particular grouping. The former involves a focal person, the analysis of many variables, and if need be, sampling of a population. The latter is used typically where the focus of enquiry is a small grouping with a well defined boundary and allows for the investigation of only a few variables because of the large number of potential relationships in the population. It is becoming increasingly common in the literature to use the term "social network" to refer to both. Usually, unless otherwise specified the term "social network" should be given the definition offered above for "personal network".

There has been a great amount of diversity with respect to setting criteria for network membership. Researchers have asked respondents to report from one (Surtees 1980) to almost all (Tolsdorf 1976) relationships as a method of investigating networks. Membership in a network may depend on the quality of the relationship between the potential member and the focal person, the condition or element of need, or the frequency of contact. Members can be simply those with whom one has interaction and commitment (Henderson et al 1978). A network may also be defined by function as "that set of personal contacts through which the individual maintains his social identity and receives emotional support, material aid and

services, information and new social contacts" (Walker et al 1977:35). Unger and Powell (1980), utilizing specific groupings in their definition, write, "a social network consists of a person's relationships with relatives, friends, neighbours, co-workers, and other acquaintances who interact with the person" (:566). A definition that is used extensively is given by Mitchell (1969) who states that a network is "a specific set of linkages, among a defined set of persons, with the property that the characteristics of these linkages as a whole may be used to interpret the social behavior of the persons involved" (:2). Definitions of networks are often given to suit the enquiry at hand and membership in the network expanded as needed to explain the phenomena under investigation.

More specific definitions of networks with specific emphasis on criteria for network membership are provided by various researchers. Perhaps among the most inclusive definition is Tolsdorf's (1976) who requires only that, "the individual in question and the focal person must know each other by name, they must have an ongoing personal relationship and they must have some contact at least once a year" (:408). Cohen and Sokolovsky's (1978) criteria for membership would include "all links within the preceeding year with a [contact] frequency of at least once a month" (:549). They exclude those relationships developed solely within the context of a formal or institutional relationship such as patient-doctor.

While it is not uncommon to think of networks as whole entities some researchers have found it useful to identify specific sectors or groupings within networks. Henderson et al. (1978) for example, note that the primary group is made up of all kin, nominated friends, work associates and neighbors. Boissevain (1974) describes five concentric zones which comprise a network. The first two, personal and first intimate, consist of close relatives and friends with whom the individual keeps active contact. The third zone, second intimate, consists of friends and relatives who keep infrequent contact. The fourth or effective zone, consists of people who are emotionally involved with the individual but who have economic and political relationships. The fifth zone, nominal, consists of those who have little or no relationship to the individual. Hammer et al (1978) utilize a similar conceptual breakdown. They emphasize the fact that the individual while being the centre of his own network is concommitently a member of several other networks. Their concepts of immediate or personal network, second order network and extended network demonstrate the linkages that exist between, the focal person and his immediate relationships, these persons and their relationships, many of which will be unknown to the focal person. Erickson (1975) provides a useful way of conceptualizing the network as it pertains to the practice scene. He notes that minimally it will consist of a kinship sector, a friendship sector and a service sector. This breakdown emphasizes that networks may contain professional

helpers and/or social agencies.

Definitions of networks often exclude the service sector and emphasize the "kith" and "kin" sectors. Horwitz (1977) has referred to these networks as "informal social networks" (:91). Collins and Pancoast (1976) have referred to "natural helping networks" to describe that group within which informal (non-professional) spontaneous helping activities occur. The distinction between the two types of networks (those with and those without a service sector) is made difficult by Hirsch (1980). Focussing on the provision and importance of support in networks he uses the term "natural support system" to refer to "the set of presently significant others who are either members of one's social network (i.e., family or friends) or affiliated non-mental health professionals (e.g., physician and clergy)" (:160). Apparently in this formulation it is "natural" to have a physician and a minister but "unnatural" to have a psychiatrist or a social worker. It is unclear where the line is to be drawn when some but not all care-givers are either granted or denied membership in the network. Morosan and Pearson (1981) provide a useful breakdown and refer simply to informal and formal support systems. Informal support system refer to relatives, friends, and peer-based assistance groups and formal support system includes these in addition to trained and professional help.

At the present time consensus in the use of network

terminology is far from being realized. From its current usage in the literature one can glean some useful but not always applicable definitions. "Social network" typically refers to those linkages which exist between and among a focal person and others in a social environment bounded by specific criteria for membership. Where "social network" refers to all linkages within a defined boundary with no reference to a focal person, special mention is typically made of this. It is helpful to think of social networks as having three sectors: family or kin, friends or associates, and professional care-givers or social service organizations. "Network" can be used synonymously with "support system" when in definition they are meant to comprise all three sectors. When the service sector is to be excluded, "network" and "support system" should be prefaced by "informal" or "natural".

Social Network Characteristics

Social networks can be described by virtue of their function, or criteria for membership. More specifically various characteristics have been identified which enable more accurate analysis and definition of social networks. Characteristics of social networks fall into two general categories: structural characteristics, which refer to properties of the overall network; and component linkage characteristics, which refer to properties of individual relationships.

Of the structural characteristics the most common are size and density. Network size is dependent on the criteria used to set membership in the network. Size is determined by simply counting the persons, the focal individual comes into contact with or, where a focal individual is not referenced, the number of persons within the defined boundary. Density, which is considered the most important structural feature, measures the relatedness of members of a network. Density is defined as, "the number of dyadic relationships (linkages) in the network, in proportion to the number of linkages possible given the network size. In a network containing 'n' people there are $\frac{n(n-1)}{2}$ possible linkages assumming everyone in the network knows everyone else" (Tolsdorf 1976 : 408). Density is expressed as a proportion calculated by dividing the actual number of linkages (an) by the number possible or $\frac{an}{(n(n-1))/2}$.

Commponent linkage characteristics define the quality or nature of the relationships that exist in the network. These characteristics were developed in response to criticism of the simplistic approach that is necessary when one analyzes social networks with mathematical tools. As Holland and Leinhart (1979) note, certain conceptual richness is lost. For example,

> a typical application of network ideas may require conceptualizing a highly complex relationship such as friendship in terms of a simple binary code that records only whether each of two individuals claims the other as a 'friend'. The acceptability of such a reduction depends on its ultimate practical utility in terms of leading to models that are good at explaining and predicting aggregate or individual behavior. (:4)

Researchers differ with respect to which characteristics they see as most salient. Definitions follow for these most commonly used component linkage characteristics: strength or intensity; multidimensionality or multiplexity; reciprocity or directedness; dispersion; frequency and homogeneity.

Strength refers to the durability of linkages and is determined by consideration of a number of factors. Granovetter (1973) in determining strength considers, "The amount of time, the emotional intensity, the intimacy (mutual confiding), and the reciprocal services which characterize the tie" (:1361). Multidimensionality refers to the number of functions served by a linkage. Where a linkage serves many functions (e.g., support and advice), it is termed multidimensional and where it serves only one (e.g., feedback) it is unidimensional. Relationship functions can be determined prior to an investigation (Tolsdorf, 1976) or categories can be created based on observation during data collection (Sokolovsky et al 1978). Reciprocity is the degree to which the individual gives and receives emotional and material assistance. Reciprocity increases as the ratio of actual to possible functions served by a linkage increases. Dispersion refers to the ease with which members can make face to face contact and is often a function of geographic proximity (Walker et al 1977). Frequency refers to the number of contacts the focal person has with his network members. As noted earlier in the paper frequency of contact will often define

network membership. Homogeneity is the extent to which the members of a network share social attributes including demographic, attitudinal and behavioral characteristics.

Social Network Functions

There is ample epidemiological research demonstrating the role that social support plays in "buffering" individuals from the effects of stress (Cassel 1974, Cobb 1976). It would appear that an individual's capacity to handle stress is dependent on how effective his* social support structures are. While the provision of support appears to be the central function of a social network, this is only one of several functions. Caplan (1974) concludes that,

> The harmful effect of absent or confusing feedback in a general population may be reduced in the case of those individuals who are effectively embedded in their own smaller social networks which provide them with consistent communications of what is expected of them, supports and assistance with tasks, evaluations of their performance and appropriate rewards. (:3-4)

Caplan emphasizes that social networks serve as providers of emotional support, task-oriented assistance and as feedback sources for expectation and evaluation. Erickson (1975) writing from a clinical perspective views networks as curative groupings of individuals, as a location of resources, as interpreters of help-seeking behavior and as mitigators of multiorganizational involvement.

*The masculine pronoun is used throughout this paper only for convenience. Any inequity connoted by this usage is regretted.

Hirsch (1980) lists five functions of a support system: cognitive guidance (i.e., information or advice);social reinforcement (i.e., praise or reward); tangible assistance (i.e., material goods or services); socializing and;emotional support. He notes that cognitive guidance is particularly important in increasing the individual's ability to adapt to stress. Gottlieb (1978a) identifies 26 informal helping behaviors displayed by support systems. He organizes them into four main classes: emotionally sustaining behaviors; problem-solving behaviors; indirect personal influence; and environmental action.

The most succinct, yet inclusive and therefore perhaps most helpful statement respecting network functions is provided by Tolsdorf (1976). He claims that networks serve three functions in relation to the individual - they provide support, advice and feedback. Support is defined as "any action or behavior that functions to assist the focal person in meeting his personal goals or in dealing with the demands of any particular situation" (:410). Tolsdorf defines support, as Craven and Wellman (1973) have elsewhere, to include both tangible (material) and intangible (emotional) support. Advice is defined as the provision of information or guidance on how to achieve a certain goal or complete a certain task. Feedback refers to the provision of evaluative statements regarding how the expectations or requirements of a specific goal are being met or surpassed.

In summary it may be helpful to think of social networks as comprised of those significant individuals with whom one comes into contact. These individuals form a network which can be identified and described by specific structural and component linkage characteristics. The network members collectively or individually may offer to one another material and emotional support, advice and feedback. Networks may be considered either formal or informal depending on whether they have a professional caregiving sector.

Part Three presents some social network research which investigates the relationship between social networks and adaptation.

PART THREE

SOCIAL NETWORK RESEARCH

Social network concepts have been used widely in research. Various methodologies have been employed ranging from exploratory studies to longitudinal ones which have extended over years. Direct observation, self-report and archival data collection have been used to gather information. By and large the research suggests that in a wide variety of situations social support can function to influence a person's behavior, perceptions, adjustment, and general well-being.

Researchers have attempted to locate, describe, and analyze specific network characteristics that are associated with favorable outcomes and dispositions in a wide variety of settings and with diverse populations. One purpose of this is to be able to identify those individuals who are at risk because of their social networks. These individual can then be targeted for special preventive programs, which aim to alter the social network characteristic which is associated with the increased risk. This type of intervention will likely have the goal of increasing the amount and quality of support available to the individual. A more immediate purpose, and one that is perhaps more easily attainable, is to be able to generate specific direction for interventions into situations after the onset of problematic stressors. This is done simply

by comparing the network characteristics of those who appear well adjusted after onset with those who do not.

Following are some examples from the social network research literature which demonstrate the association between the level of social support received by the individual, the social network characteristics, and the individuals' level of functioning. This research is categorized into five main areas of interest. The first category, illness, is comprised of reviews of research which examines the social support provided the individual both before and after the onset of disease. The second category, life cycle, contains reviews of research which addresses social network's ability to mediate social support at times of stress related to: school; family and marriage; parenthood; and aging and death. Psychopathology, the third category, consists of numerous descriptions of the networks of the mentally ill and the support available to them prior to, during and after hospitalization. Social networks affect the behavior of the individual in need of services and this is examined in the fourth category, help-seeking. The final category, community, consists of some research studies which have utilized social network concepts to examine residents' perceptions of, and satisfaction with their neighborhood.

Illness

It is generally acknowledged that psychosocial processes

are important in disease etiology. Cassel (1974) notes that much of the research into the role of social factors in disease etiology may be erroneous in that it has been based on notions derived from stress theory. Stress theory, while significant in its contribution to ideas about the nature and causes of disease has unfortunately been misleading. Strict adherence to stress theory results in the investigator of psychosocial processes formulating, often implicitly, that the relatinnship between a stressor and outcome will be the same as the relationship between a disease agent (microorganism) and disease outcome. There is serious doubt about this formulation as there is little evidence to suggest that a specific stress will lead to a specific disease outcome or even that the more intense the stress the greater the likelihood of disease outcome.

Cassel (1974) reviews both animal and human studies which suggest that certain social environment variables with social support functions, moderate stress and influence illness. Writing prior to significant works investigating the effect of social support on illness, he notes that if a moderating effect were found in further research,

> it would suggest a radical change in the strategies used for preventive action. Recognizing that throughout all history, disease, with rare exceptions, has not been prevented by finding and treating sick individuals, but by modifying those environmental factors facilitating its' occurrence...(:479)

Cassel (1974) suggests that screening and early detection, while useful, may prove less functional over the long term

than would identification and possible modification of various psychosocial factors. Dean and Lin (1977) conclude that it is more immediately feasible to mobilize social support systems than to obviate life stressors.

Cobb (1976) writing a few years after Cassel (1974) summarizes a different set of studies with a focus on the interaction between social support and environmental stress. He reports evidence that social support has two general functions in relation to health. Social support can act to protect the individual in that it can reduce the likelihood of disease onset. It can also act to restore the individual by easing the consequences of existing illness.

Following are summaries drawn from evidence revealing that those members of the social environment who are perceived by the stressed individual as "significant others" do serve health protective and health restorative functions.

There are several studies that document the protective function of social support. Lin et al (1979) investigated the relationship between life stresses and illness in a sample of 170 Chinese-Americans. Their findings support the notion that social support, defined as embeddedness in the community, and interaction and contact with friends and neighbours, is important to health. The results indicated that social support was more significantly (negatively) related to lack of well-

being (presence of psychiatric symptomotology) than were life stressors. These authors comment that certain life stresses are unavoidable and cannot be modified in many cases, therefore preventive programs will focus on enhancing social support.

Gore (1978) studied the impact of enforced job termination on workers' health. She found that men who had the emotional support of wives, friends, and relatives experienced fewer symptoms of illness following termination than those men without support. Haywood and Taylor (1981) provide case examples of two support groups that arose in Sudbury, Ontario out of the social conditions resulting from a lengthy strike. These groups provided resources, encouragement and support through a bitter strike.

These studies suggest that individuals who receive a certain type and level of social support are less likely to suffer disease onset. For those individuals however, who do contract illness, their support system can function to promote restoration. Finlayson (1976), taking a somewhat different approach to examining illness and support, studied 76 women whose husbands had experienced a heart attack. She examined the non-professional assistance (support) the women received from children, either set of extended family, and non-kin. Support was examined as both lay help (e.g., baby-sitting, meal preparation, etc.) and lay consultation (e.g., confiding, problem discussing,

etc.). Of Finlayson's sample, the husbands whose illness was defined as having a favorable outcome (i.e., husband returns to work and wife feels that illness is over) had wives who received support from a wide range of sources. Finlayson emphasizes the importance of social support in influencing disease outcome. Croog et al. (1972) attempt to clarify what type of support is provided by what segment of the network following disease onset. Their sample consisted of 293 previously well males who had experienced a first myocardial infarction. The men were interviewed in the hospital shortly after the infarct and several times within the year following. The majority (94%) of this group had access to extended kin. The authors note that friends and neighbors were reported to have provided almost as much assistance to the patient as did the family members. Immediate family members figured prominently in the provision of financial aid while non-kin provided a disproportionately high level of helpful services.

Life Cycle

Social support appears to protect the individual as he progresses through the passages and crises of the life cycle. Cobb (1976) conceives of social support in terms of the individual receiving information that he is cared for and loved, esteemed and valued, and part of a network of communication and mutual obligation. He writes,

> Social support begins 'in utero', is best recognized at the maternal breast, and is communicated in a variety of ways, but especially in the way the baby is held (supported). As life progresses support is derived increasingly from other member of the family, then from peers at work and in the community, and perhaps, in case of special need, from a member of the helping professions. As life's end approaches, social support, in our culture, but not in all cultures, is again derived mostly from members of the family. (: 301-2)

Cobb does not specifically state that the individual seeks support from others but implies this, as well as the notion of the individual providing support for others (reciprocity).

Boss (1980) discusses stress impacting on the family as a result of progression through the life cycle. She notes, that from a systems perspective one can view the boundary changes occurring in families as a function of normative family stress (e.g., moving, death, marriage). She hypothesizes that network structural adaptations, that is, psychological and/or physiological inclusion or exclusion (presence or absence), are made in an effort to enhance survival of the organism. In this respect the family influences their network by including and excluding members as they see the need to moderate the effects of stressful events. Unger and Powell (1980) who also view the family under stress from a systems perspective claim that the family will seek initial aid from relatives and non-mental health professionals. The authors discuss a study by Eddy et al. (1970) who asked 100 urban adults to list and rank individuals and organizations they felt were valuable sources of aid. Family was cited most frequently,

followed by clergy and physicians. A finding of some interest is that friends and mental health centers were ranked with the same frequency. While this is somewhat surprising the authors account for this by noting the proliferation and promotion of mental health centers and the growing sense of alienation and isolation in large urban populations.

Some stressful events are clearly avoidable while others must be faced by all. Several studies are summarized below respecting social networks and : school; family and marriage; parenthood; aging and death.

School

Entering grade school can be a traumatic experience for the child. Routines are changed and the issue of separation can be difficult. This life stress has both psychological and physiological components. Sandler (1980) investigated the relationship between social support, stress and well-being. His sample consisted of 70 kindergarten through third grade school children. The children were economically deprived (61% welfare mothers) and primarily non-white (51% black, 46% Chicano). Social support was defined by virtue of the resources the child had: older sibling or no older sibling; one or two-parent family; and ethnically congruent or incongruent with the community. Various measures of life stress and child adjustment were obtained. Older siblings and

two-parent families proved their effectiveness as support resources in moderating the effects of stress on the sample. Marginal evidence for the beneficial effects of ethnic congruence was obtained. This study in that it was not longitudinal can make no firm assertion that all children, prior to begining school, were better adjusted. There is however a strong enough association to suggest that the social supports did moderate stress on the sample.

Hirsch (1979) in two independent studies examined the social networks of 16 male and 16 female college students (mean age =22.2). One study was designed to partial out the psychological characteristics of personally satisfying social networks. The second study was designed to examine the extent to which the social network could mediate support during the stress of examinations. Hirsch's studies were somewhat unique in that they did not rely exclusively on retrospective and prospective data as the majority of other studies have. Instead he utilized a number of instruments, one of which (Daily Interaction Rating Form), required subjects to track daily the quality and quantity of support received, their satisfaction with the support, as well as the amount of time spent in contact with others. Hirsch found that students who were satisfied with their multidimensional relationships were more likely to be satisfied with their social networks. Students who perceived themselves as having fixed roles within their networks expressed dissatisfaction with their networks. These findings

indicate that an individual's satisfaction with his social network is dependent on the number of activities or functions that can be engaged through any one relationship (linkage). The students reported no significant differences in the amount of social or emotional support (measured as time spent in certain activity with others) received before and during examination periods. There was however a significant increase after examinations. Satisfaction with emotional support increased significantly across before, during, and after examinations. Not surprisingly, these findings suggest that students had less time to spend in offering support prior to and during examinations than after. The increased satisfaction with emotional support across time, suggests that it may be difficult to offer support in anticipation of a stressful event. An interesting finding is that students in high density networks received more support but were less likely to be satisfied with the emotional aspect. Similarly women spent more time than men in support activity but were not more likely to be satisfied.

Beginning school and writing examinations are difficult life stresses. Returning to school is a stressful event particularly for women entering the competitive university scene after having already begun raising a family. Hirsch (1980) explored the support provided 14 mature women (mean age = 37) who had returned to college to assess its impact on their mental health measured as symptomatology, mood,

and self-esteem. Five categories of support were utilized: cognitive guidance; social reinforcement; tangible assistance; socializing; and emotional support. For these women satisfaction with the support variables was significantly associated with the mental health measures. Cognitive guidance (provision of information, explanation, or advice) was strongly related to less symptomotology and better mood. High self-esteem was associated with satisfied social experiences.

Family and Marriage

Writing almost two decades ago, Bell (1962) discussed the differences between "well" and "disturbed" families. He noted that attempts to conceptualize etiological theories of pathology focussed at first on the individual and then on the family. In a critical fashion he cautioned against what he obviously considered a narrow perspective and suggested the use of broader social units. He wrote,

> ...there appears a danger that the fallacies of oversimplification and reductionism characteristic of the focus on the individual are being repeated at the family level. Family psychiatrists seem, by and large, to view the family as a self-contained invariable unit, existing in a social and cultural vacuum...Systematic consideration of the interdependence of the nuclear family and related families of orientation, or the nuclear family and the surrounding society as a universal structural principle have been lacking. Both on theoretical and empirical grounds it is difficult to find justification for neglecting the frameworks within which families function. (:176)

What is of importance here is that Bell (1962) recognized that families are embedded in broader systems and that to some

extent this provides the family with direction and rationale. He suggests that exploration of these broader systems may explain and predict family behavior. Writing a dozen years later, Sparks (1974) noted that family and systems theoreticians, and clinicians, in their efforts to intervene in dysfunctional families have maintained a nuclear family perspective.

The idea of attending to the broader system (social network), while slow to be accepted by clinicians, is presently finding acceptance by some practitioners (Attneave 1976; Pattison et al. 1975; Rueveni 1979). Therapists, confronted with a dysfunctional family are now more so than in the past, likely to assess the nature of the family's social network.

The English anthropologist, Bott (1971), examined social network characteristics of 20 working class couples to identify characteristics which could determine conjugal role. Bott considered the immediate social environment of an urban family to be a network, rather than an organized group. She wrote,

> Kinship and friendship are the most important types of primary social relationships, neighbours and voluntary associations being important largely in that they provide a pool of potential friends and may overlap with the kinship and friendship categories. (:294)

Bott referred to density and implied that it is an important structural characteristic as a determinant to conjugal role.

She found, in fact, that couples with close-knit (dense) networks tended to have segregated conjugal roles and those whose networks were more loosely-knit tended to have joint roles. Joint roles refer to the couple participating in several activities together and alternating responsibility for household tasks. Bott's (1957, 1971) work has encouraged others to strive to understand individuals and families, by their relationships with others and the relationships among others. Her anthropological works are widely referenced by those from the care-giving professions who write from a social network perspective.

Two studies have directly examined the relationship between networks and marital well-being. Blood (1969) investigated kin interaction and marital satisfaction. A curvilinear relationship was found such that moderate amounts of extended family contact (about one per week) were associated with optimum marital satisfaction. More and less contact were associated with less satisfaction. Lee (1979) linked marital solidarity to social networks. Where there is considerable overlap in each partners social network, that is where many persons are members of both networks, marital stability increases. The more mutually exclusive one's spouse's network is of the other's, the greater the instability.

Parenthood

Parenthood is a major life event which is clearly associated with both physical and psychological stresses. Wandersman et al. (1980), studying first time parents, found an association between mothers who perceived themselves as having sufficient close friends to share with and help out, and mothers' feelings of well-being. Utilizing a sample of 170 first pregnancy army wives, Nuckolls et al. (1972) collected data before and during the pregnancy. The women were similar with respect to age, social class and attendance at the same health facility. Life change scores (life stresses) and psychosocial assets (social supports) were assessed before the 32nd week of the pregnancy. Psychosocial assests were defined as the woman's feelings about the pregnancy, about herself, her relationship with her husband, her extended family, and the immediate community. Each pregnancy (and delivery) was classified, using medical records, as normal (53%) or complicated. The authors found that life change and support were not significantly related to complications when considered alone. They did however interact, such that 91% of the women with high change scores and low support experienced complications. This compared with only 33% of the women in the high life change and high support group experiencing complications.

Support mediated by the social network clearly has some influence with mothers. Fathers however are not immune to

the effects of parenthood. Stueve and Gerson (1977) found that arrival of children was associated with a reduced frequency of contact between fathers and their social network members. There was however no decline in felt intimacy with best friends. The inclusion of children in the network results in social interaction being brought into the home whereas before it occurred in public places.

Parenthood is a life stress which can occur in happy or sad circumstances depending on whether the event is desired or not. Morris et al. (1973) collected considerable data on wantedness of babies. Mothers were asked shortly after delivery whether the baby was wanted (or did not matter) or unwanted (or timing error) at the time it was conceived. When considered together with education those women who had completed high school, wantedness was significantly associated with decrease in frequency of low birth weight. It is difficult to imagine "wantedness" as directly influencing the growth and development of a fetus. Rather, wantedness or unwantedness may influence the amount of social support offerred the woman by her social network. While, it is difficult to partial out the role social support can play in birth weight, as compared to the influence of other factors such as nutrition, substance abuse and history, the authors note that their finding are suggestive of this hypothesis.

Aging and Death

The final stages of the life cycle are often associated with increased dependence on others, particularly family. It is a wide-spread belief that the elderly in our society are isolated from their kin. It is not unreasonable to make this assumption in light of today's unprecedented technological developments and geographic mobility. The elderly appear to be left in the hands of institutions and caregiving strangers. Despite this popular but bleak view there appears to be some evidence that suggests such is not the case.

In a large cross-cultural study of the social networks of the aged (65 years of age or older) in the United States, England, Denmark, Yugoslavia, Poland, and Isreal, Shanas (1973) found the elderly to be well embedded in the primary kin network. She found that the majority of the elderly lived either in the same household or within 10 minutes' distance of one of their children. Seventy to 80% of the sample of older persons had some form of personal contact with one of their children within the week prior to the interview for the study.

Being named as a network member and having frequent contact with other network members does not guarantee well-being. In a study of 280 elderly, aged 63 and over, Lowenthal and Haven (1968) found most (85%) of those with low social

interaction were clinically depressed whereas fewer (42%) with high social interaction were depressed.

In a follow-up to a major longitudinal study of 6928 adult subjects in Alameda County, California, Berkman and Syme (1979) examined the relationship between social and community ties, and mortality. Mortality from all causes was examined in relation to a range of social contacts. Four social support sources were examined as influential: marriage; contacts with close friends and relatives; church membership; and informal and formal group associations. The findings show that people that lacked social and community ties were more likely to die in the follow-up period than those with more extensive contacts. Each source was a good predictor of mortality independent of the others, although marriage and contact with friends and relatives were better predictors than the other two. The longitudinal design of the study permitted the researchers to examine the influence of various confounding factors. The findings however held constant across controls for sex, age, and socioeconomic status. When health practices such as smoking, obesity, alcohol consumption, physical activity, and preventive health service utilization were examined, degree of social connectedness proved the best predictor of mortality. This study was not able to make clear whether social connectedness prevents disease incidence or acts to increase "survival time" after disease onset. The study was able however to show that while people who are ill are less able to establish and

maintain ties, this alone does not account for the strong association between social connectedness and increased mortality rates.

For those who are left behind when a loved one dies there is pain and sorrow because of the loss. Bereavement is a psychosocial crisis in the life cycle whose outcome is probably dependent on a number of factors. The essential tasks relate to loss, acceptance, role shifts, identity and independence (Sudnow 1967).

Walker et al. (1977) note that there is no one specific type of network that is universally most supportive in a crisis situation. The authors note that the bereavement process moves through distinct phases. During the initial and intense grief, the spouse is in need of empathy and strong emotional support. These needs are most likely to be met by a social network characterized by high density, low dispersion, and homogeneity. As the bereavement process proceeds the spouse needs assistance in returning to a social life. During this period a dense network could be disadvantageous if, as in the case of a previously unemployed widow, the spouse seeks new social contacts, a job, or a new life style. At this later stage of the crisis less dense networks with linkages to individuals outside the immediate family and friends may be beneficial.

The bereaved have different needs dependent upon the

circumstances of the death, the relationship between the survivor and the deceased, the survivor's personality strengths and history of problem-solving and coping behavior. Walker et al. (1977) note that working class widows are more likely than their middle class counterparts to experience difficulty in coping. The authors conclude that widows require unique assistance that can be provided best by other widows who can serve as strong support givers during the initial stages of bereavement and later provide assistance in the widow's social transition. Program development along these lines (cf. Silverman 1976) has been in response to the perception that family and friends tend to shy away from the bereaved and encourage "a stiff upper lip" instead of allowing for emotional expression.

In an exploratory study, Hirsch (1980) examined the support systems of 20 recent (3-7 months) younger widows (mean age = 46). He found considerable evidence for his hypothesis that support enhances adaptation to stress. In support of Walker et al. (1977) he found that women whose support systems were dense reported less satisfaction with socializing, social reinforcement, emotional support, and cognitive guidance (four supportive interactions). Hirsch also found that having friendships that were multidimensional was related to self-esteem, more satisfying socializing, and more satisfying tangible assistance. He concluded that low density, multidimensional support systems allow for a smoother

reorganization in the widows' lives and increase the probability that the widows will be satisfied with the support they receive. Networks with these characteristics are likely to facilitate widows' involvement in non-family roles and activities.

Psychopathology

Several researcher and clinicians have taken great interest in the social networks of the mentally ill. Most investigations into networks and psychopathology have focussed on schizophrenia. Patients have been investigated with respect to their network size, their social functioning in relation to network characteristics, and their use of network resources. Psychiatric and medical populations have been compared and social support has been investigated as a determinant in depressive outcome. There are several studies on social networks and post-discharge functioning.

Network Characteristics

From data collected on a normative urban population, Pattison et al. (1975) claimed healthy persons have 20 -30 people in their psychosocial network. Typically four or five people will be found in each sub-group of, family, relatives, friends, neighbors, and work or social contacts. Data from smaller populations indicate that neurotics have 10 - 12 persons in their networks, some of whom may be dead or live

far away, and psychotics have impoverished networks of four to five people. Normals' networks have a moderate density while neurotics and psychotics have low and high density respectively. Tolsdorf (1976) employing broad criteria for network membership, found that psychiatric patients (schizophrenic) had smaller and denser networks than did medical patients. Henderson et al. (1978) found that non-psychotic psychiatric patients had fewer good friends and fewer contacts with persons outside the household than did normal controls. Sokolovsky et al. (1978) found schizophrenics with residual symptoms to have smaller and denser networks than either schizophrenics without residual symptoms or a group with no psychotic history.

Hammer et al. (1978) noted that the following network characteristics are associated with schizophrenia: a restricted range of contacts; relative instability of the network; and relatively low connectedness (density) within or across subsets of the network. She and her colleagues claim that social network concepts and methods will provide a unifying framework for social research on schizophrenia. They describe a theoretical model associating social network functions with the onset and recurrence of schizophrenia. In this model the schizophrenic's network has failed to provide feedback essential to the development and maintenance of culturally appropriate behavior.

General Findings

Tolsdorf (1976) compared psychiatric patients to medical patients in American VA hospitals. The psychiatric group were diagnosed schizophrenics and the medical group consisted of various non-life threatening medical problems. Tolsdorf found that the psychiatric group had fewer intimate relationships, had networks that were dominated by family members, and network members were more likely to give than receive support. Through extensive interviewing, Tolsdorf found that the psychiatric group demonstrated a "negative network orientation" characterized by beliefs that it is inadvisable, impossible, useless, or potentially dangerous to draw on network resources. He found that individuals with negative orientations did not endeavor to maintain their networks. He hypothesized that such individuals are more likely to overutilize and become dependent on social service agencies.

Tolsdorf (1976) laid the groundwork for consideration of the individual and the network influencing one another over time. He writes,

> The adoption of a network approach requires the simultaneous consideration of two interlocking systems: one on the individual level and one on the interpersonal level. It is the rich complexity of interaction between these two systems that provides the data for network analysis. For instance, an individual's expectations and beliefs help determine his behavior but they in turn are partially determined by the characteristics of the network. Conversely an individual's network is shaped and maintained by his use of it and by his attitudes toward it. Thus the individual and the network are in constant interaction, both influencing and being influenced by the other. (:416)

Henderson et al. (1978) compared 50 non-psychotic psychiatric patients with 50 "normal" matched controls. The psychiatric patients spent significantly more hours alone, were more dependent on their primary group, and had fewer contacts outside the household. Support was found for Tolsdorf's (1976) findings with regard to a negative network orientation. Henderson et al's. psychiatric group perceived less support from the primary group and reported the group to be deficient both numerically and qualitatively.

Froland et al. (1979) examined the relationship between social network characteristics and aspects of social adjustment. They utilized four groups consisting of a sample of "normals" and three clinical samples from a state hospital inpatient ward, a day treatment program, and an out-patient clinic. Generally the treatment groups had social networks that were smaller, had fewer ties with kin, less interaction with family and friends, and had fewer long term friends. Treatment group networks experienced a high level of instability and relatively poorer social adjustment (defined as both personal and social functioning). Froland et al. found that treatment groups placed significantly greater emphasis on professional or agency help in time of need than did "normals" who sought out family. Mutuality of exchanges (reciprocity) in relationships was found to be a central feature of social support. To the extent that the client is able to maitain some reciprocity in relationships with kin, the feeling of the client being a

burden on the family may be prevented. This study suggested that professional helpers may be of assistance in promoting reciprocity by identifying possible functions and encouraging participation.

Surtees (1980) investigated the role of social support in relation to patients' recovery from depressive illness. Eighty patients with unipolar depressive illness were assessed, using the Hamilton Rating Scale, at referral, after considerable improvement, and 28 weeks after initial assessment. The six components of social support used were: existence of a confidant; contact with close relatives; a living group (shared housing); work contacts; contact with neighbours; and contacts through attendance at clubs or church meetings. The existence of a confidant and a reciprocal confiding relationship was associated with favourable outcomes. Other investigators (Brown and Harris 1978) have found that women with an available intimate confiding relationship are provided considerable protection from subsequent psychiatric disturbance even in the presence of severe life stress.

Aftercare

Today's emphasis on short-term in-hospital stays for psychiatric patients is concomitant with developments in community mental health. An unfortunate consequence of this is an associated shift away from concern with improvement in patients'

psychosocial functioning toward a measure of success in terms of physical location and fiscal expenditure. Within this framework treatment failures are in hospital and treatment successes are in the community. Mental health professionals are familiar with discharged patients' needs, particularly supportive living arrangements, aftercare programs, and vocational training and employment opportunities.

The plight of the discharged patient is often cruel and his term and success in the community tenuous. Strayer and Kieth (1979) interviewed 53 chronic psychiatric patients four days after discharge from hospital. The authors were interested in the nature of patients' social emotional support systems, patients' time expenditure, and activity in the social environment. They found that 1/3 of these patients lived alone and that 1/4 had not left the home since arrival following discharge from the hospital. Two-thirds of the patients slept 12 or more hours per day, 1/3 spent four or more hours per day watching television, and for most, social interaction occupied less than one hour per day. Although the sample was small, it may well be indicative of the need for more timely and socially stimulating aftercare programs.

Cohen and Sokolovsky (1978) attempted to determine if rehospitalization rates could be predicted on the basis of quantitative and qualitative aspects of social networks. Drawing from the clientele of a downtown Manhatten SRO (single room

occupancy hotel) the authors assessed the social networks of 1/4 of the occupants (n = 44). The subjects were placed into three categories: schizophrenics with moderate to severe chronic residual symptoms; schizophrenics with no or minimal chronic residual symptoms; and those residents with no known psychotic history. Findings relative to network size were consistent with previous reports (Pattison et al. 1975). Of the 29 persons who had been hospitalized previously for psychosis, 17 required readmission during the course of the study. Rehospitalized subjects had on the average one admission every 14 months with stays averaging 18 days. A disproportionate number of those readmitted came from the group with moderate to severe symptoms (9 of 11). The 42% readmitted from the group with no or minimal symptoms, had social networks similar in size (small) and number of multidimensional relationships (few) to the group with more severe symptoms. Overall the results suggest that the network members of non-readmitted residents were more likely to socialize with one another. Of importance to practitioners in the field of aftercare is the finding that although schizophrenics have impoverished networks, they do have an available social network. Community caregivers would do well to assess these networks and intervene to strengthen them and facilitate the provision of support by them. Sokolovsky et al. (1978) reporting on the same study data provide a case illustration demonstrating the therapeutic benefits of a schizophrenic patient expanding his social linkages and thereby creating a healthier and more stable environment.

With minimal assistance from SRO staff this patient created a network which enabled him to withstand the pressures of his illness and the harsh SRO environment.

Patients discharged from inpatient psychiatric care are occassionally provided aftercare services through community-based half-way houses. Berman and Hoppe (1976) surveyed three such facilities to locate those patients who had moved into independent living arrangements. They found that 60% of their sample had moved into housing within one mile of the half-way house they had left. Since few of these people had lived in the area before, Berman and Hoppe concluded that the patient's desire for continued formal and informal supportive relationships was the determining factor. This finding has practical significance to the extent that support can be found for the hypothesis that these patients are trained in social and living skills which are not transferable beyond the immediate community. The authors did not utilize formal network analysis to examine the social networks of the patients. A finding that this group has small and dense networks, consisting primarily of half-way house residents would add support to the authors' conclusion.

Help-Seeking

An individual's behavior impacts on the social units with which he comes in contact. From a social network persepctive,

individual behavior is to some extent, seen as determined by these same social units. During times of crisis, and at other points throughout the life cycle, people seek advice, support, and assistance from friends, relatives, neighbors, and professional helpers.

Social networks, in addition to providing assistance, have received some attention as mediators between stressful events and help-seeking behavior. People generally perceive their natural support systems as a major source of help and turn to professionnal agencies when assistance is not available or problem-solving has failed.

Gourash (1978) notes that young, white, middle class, educated, females are more likely to seek professional assistance than are males, minorities, the aged, and the working or lower class. She hypothesizes that those who turn to professional help may be more satisfied with the help received than those who turn to the natural support system only. She concludes that social networks serve as screening and referral networks in that they encourage or discourage professional resource utilization by transmitting certain norms and values.

Gottlieb (1976) in his review of the help-seeking literature examined the influences on the utilization and provision of health services. He refers to the "lay referral network" as a collection of individuals consulted by a person seeking help in

the community. Through a series of consultations, the help-seeker moves away from the family through select, distant and authoritative laymen until the professional is contacted. Conversely Gottlieb claims that the help-seeker can be referred within the "lay treatment network" and escape formal or professional help. He notes that the lay treatment network consists of at least four areas: self-help or mutual aid groups; the help-seeker's social network (family, friends); community gatekeepers (clergy, teachers, etc.); and neighborhood based support systems (clubs, associations, helpful neighbors, etc.).

Regardless of the source of help, the seeker's resultant level of psychosocial adaptation will encourage seekers to approach the source again or refer others to it. In a sophisticated longitudinal study on the consequences of help-seeking, Lieberman and Mullan (1978) found only minimal differences in adaptation among individuals who: sought help from professionals; sought help from their informal support systems; or sought no outside source of help at all. The lack of evidence that seeking help, from professional or informal sources, reduced stress more than seeking no help at all, was persistent, even after the authors controlled for age, race, sex, initial perception of the stress event, initial access to potential sources of help, and initial personal coping resources. Although the study failed to adequately investigate the type, quality and duration of the help received, the evidence was

sufficiently powerful that professionals have good reason to believe that their assistance can be suspect and at best may be no more valuable than informal help or no help at all. This study and more exhaustive studies examining treatment outcomes (cf. Fischer 1976) remind the professional of the need for continuing evaluation of practice routines. Minimally the professional will have to recognize the beneficial role that informal help can play in treatment. Gottlieb's (1978a) identification of 26 helping behaviors may be a start at identifying helping behaviors that are perceived as useful. Since he finds similarity between professional and lay help, the scheme may prove applicable to both groups.

Hammer (1963-64) investigated the social networks of 55 hospitalized psychiatric patients to examine the processes leading to hospitalization. She found that patients who had critical positions in their social networks (i.e., they were important for its maintenance instrumentally and/or emotionally) were brought into treatment sooner after symptom onset then those who did not hold such positions. She found also that network density influenced the degree to which network members maintained ties with the hospitalized individual.

In a survey of 120 out-patients and short-term inpatients at a community mental health centre, Horwitz (1977) examined the structure of their social networks and the interaction between structure and culture as a crucial determinant of entry into

psychiatric treatment. He used two measures of social support, one he called the strength of the kin network and the other, the strength of the friendship network. The former is measured by counting the number of monthly contacts with kin, and the latter is a measure of density among the individual's closest three friends. Horwitz found that weak kin networks and low density friendships were associated with entry into treatment quickly after detection by self or others. Conversely there was considerable delay in entry into treatment for those with weak kin and high density friendships. This study indicates that size and density are good predictors of entry into treatment. These findings are not affected when social class and, knowing someone else who has been treated previously, are controlled. The findings indicate that low density networks are characterized by greater and more diverse information which may enable participants to make better evaluative statements and provide guidance and direction.

It is clear that during a crisis such as mental illness the patient requires various supports and that outcome may be a function of network structures. Hatfield (1979) examined help-seeking in families of schizophrenics. The stress and strain of attending to the crisis of an ill family member can necessitate the seeking of help from others. Hatfield found that families sought help from lectures and books (80%), friends (63%), and relatives (58%). These sources were seen as being of some or great help (94%, 84%, and 73% respectively). Considerably

fewer families sought professional therapy, and when they did, half found it to be no value. Although less than half sought help from families of other schizophrenics, this source was rated highest (95%) in value. Lectures and books were sought by many (80%) and found to be valuable (94%). This study has significant importance for the mental health professional. It may be important to develop more literature appropriate to lay persons and to seek new ways of disseminating it. Attempts should continue to maintain and develop support groups for families of schizophrenics (cf. Plummer 1981).

McKinlay (1973) studied the social networks of 87 working-class families in Aberdeen, Scotland over the period of one and one-half years. The families were chosen by virtue of a woman in the household with a confirmed pregnancy. The women were categorized as "utilizers" or "underutilizers" of health care based on the frequency and timing of their contact with the medical clinic. Social network characteristics were examined to account for utilization or non-utilization. The women were sampled in a way that controlled for education, age, and social class to eliminate bias based on these variables. The underutilizers were more likely to have relatives living in the same house and also more relatives living close to home. They visited more frequently with relatives than did the utilizers. Overall the underutilizers appeared to be part of an interconnected (dense) network which they relied on for health consultation prior to seeking advice from the clinic.

As McKinlay notes this could be a function of the density of the network exercising control and conformity of norms and values with respect to health care. Utilizers were of relatively loose-knit networks which enabled them to be more independent relative to advice and decisions.

Linn and McGranahan (1980) in a survey of 1423 subjects found similar results to McKinlay's (1973). They conclude that greater contact with close friends diminishes the effects of personal disruptions (i.e., health, employment, etc.) on individual well-being. They found that persons with disruptions, who had greater contact with close friends experienced a reduction in their predisposition to utilize counselling services. These findings suggest that professionals need to interact with the natural system in order to "reach" those who underutilize health and social services.

Obviously there are a great many psychological variables operative in determining help-seeking. Brown (1978) found that non-seekers who felt self-reliant and those who sought assistance from informal sources seemed well prepared to manage crises, transitions, and role related strains. Reluctant non-seekers and seekers who approached professionals only, were comparatively more at risk. Since network structures have been associated with various psychological variables (Hirsch 1980), future studies, inquiring into help-seeking behavior should address the interaction between help-seeking, psychological functioning

and social networks.

Community

The provision of social support through social networks has caught the interest of community organizers and developers. Although social networks are not bounded by specific geographic lines, social support can be derived from specific communities nonetheless. The application of network analysis to the study of communities is appropriate and potentially of great benefit.

Heller et al. (1981) surveyed 233 non-student members of a community surrounding a university. The university had undergone massive increases in the number of students attending, which resulted in a flood of students being housed in the surrounding community. The authors found that for those community members who perceived this as a strain, the single most important factor in mediating the stress was the availability of a supportive network (i.e., friends in neighborhood, belonging to organizations, etc.). Overall satisfaction with the neighborhood was associated with personal and neighborhood ties, and a spouse capable of providing companionship.

In support of Heller et al. (1981), Riger and Lavrakas (1981) found, in their study of 1620 urban residents, that attachment to local community settings was dependent on two

distinct dimensions; social bonding and behavioral rootedness. The authors found that young people, without families and older people, whose families are no longer present, are lacking in links to social networks. Young people because of mobility and sufficient resources may be able to establish links to support systems outside the immediate locality. The elderly however, may lack mobility and resources, and therefore may be more beneficially served by efforts to create support systems locally. These findings have obvious implications for the development of appropriate approaches to support alienated and isolated groups in communities.

From the preceding review it is obvious that social networks play an important role in relation to illness, the life cycle, psychopathology, help-seeking and community. Social networks have demonstrated their utility as objects of enquiry vis-a-vis provision of support and earned their place as bona fide foci for research endeavors. They are useful and natural units of social structure and are deserving of attention by professional caregivers. Part Four highlights some implications for professional caregivers with an emphasis on the practice forms that have developed.

PART FOUR

IMPLICATIONS FOR PROFESSIONAL CAREGIVERS

Having reviewed some of the research on social networks and social support, the question now asked is "What does this mean for the professional caregiver?".

To understand the importance of social networks to well-being and apply it to practice one must understand first the relationship between network characteristics and specific client need. Interventions into social networks can be guided, at least in a general way, by understanding what type of network is useful under what circumstance. These interventions are not necessarily best performed by professional caregivers although they may be initiated by them. Interest in social networks has sharpened the contrast between informal or natural, and formal or professional caregiving, raising some ethical considerations.

Some practitioners have taken the idea of social networks and applied them in their practice. Utilization of social network concepts in practice has focussed primarily on broadening the social context in assessing and intervening. This has involved the inclusion of family, friends and work associates, and at times several other professional caregivers. Network practitioners have assisted their clients in constructing viable social networks and have connected their clients to already

existing networks. Professional and natural helpers have interacted to strengthen a community's capacity to be helpful to clients. Some practitioners have utilized social network assessment tools in their practice.

The importance of social network concepts has also been recognized at the agency level and programs have been developed to strengthen the support provided clients.

There are certain limitations to the application of network concepts to practice. Research has been criticized and suggestions have been made for improvement in designs and areas deserving of special emphasis have been noted.

Implications for professional caregivers are discussed under the following headings and sub-headings:

Network Characteristics and Fit with Need
Ethics, Dilemmas and Social Networks
Network Practice
- Network Assembly
- Network Conference
- Network Construction
- Self-Help
- Natural Caregivers
- Network Assessment

Social Networks and Programs
Social Networks and Research Needs

Network Characteristics and Fit with Need

It would appear that there is no one type of network which is universally beneficial or supportive during normative or crisis situations. Some networks however are more supportive than others in certain situations and these can be identified by specific structural and component linkage characteristics. For the practitioner who wishes to utilize a social network approach this knowledge is prerequisite to intervention. Knowing that certain network characteristics are desirable in specific situations provides the practitioner with the direction and goal of the intervention.

Walker et al. (1977) describe what they consider to be optimal relationships between individual needs and network characteristics. They provide the descriptions of networks which are best able to provide the individual with the following: maintenance of a social identity; emotional support; material aid and services; information; and new social contacts. According to Walker et al. simple unchanging identities are best maintained by networks that are small in size, have strong and dense ties, are homogeneous in makeup and low in dispersion. Complex changing identities are best maintained by large networks characterized by a greater number of weak ties, lower density, greater heterogeneity and greater dispersion. Dense and homogeneous networks are likely to provide greater emotional support because of the close-knit grouping and commonality of experiences. The availability of material aid and services should increase

with network size. The likelihood that material aid and services will be provided during crises is associated with greater density because of better and faster communication within the network. Diversity of information, access to new information, and the availability of new social contacts are more likely to be greater in networks which have "bridging" or weak ties to other networks.

Persons in need of affective resources are best served by dense and small networks (Craven and Wellman 1973) while persons attempting to reorganize their lives or change their social roles are better able to do so if their networks are large and low in density (Walker et al. 1977). Small dense networks, because of strong norms and role expectations, can exert considerable pressure on the individual, effectively trapping the person and ensuring conformity (Hirsch 1979). Large less dense networks on the other hand provide the person with greater opportunity to change roles because of the lack of social control and greater exposure to others (Walker et al. 1977).

Hirsch's (1979) study of 32 college students provides some support for the benefit of high density networks during times of emotional need. The students in high density networks reported receiving more support during final examinations than did students in low density networks. High density however did not guarantee greater satisfaction with emotional support.

Hirsch accounts for this finding by hypothesizing that, "membership in high density social networks is related to a decreased probability of receiving empathetic communications in situations of intranetwork conflict" (:274). He explains that in high density networks there is a good chance that interactions between two individuals will be known to a third person. In an effort to maintain good relationships during periods of stress, communications are often superficial resulting in less satisfaction with emotional support. Hirsch concludes that, "a low density social network characterized by several dense clusters may most effectively promote personal growth and enhance adaptation without sacrificing a sense of community" (:275).

Successful adaptation for recent widows and older women returning to college is associated with low density networks. Hirsch (1980) explains this by noting "that greater access to nonfamily roles and activities... allows for a smoother and less drastic reorganization of their lives" (:170). Both sets of women require social networks which support activities away from the family sphere.

Reorganization of one's life, which may be an essential task following a crisis, requires exposure to new contacts and information if the process is going to be successful. Often reorganization involves seeking employment and here also density can be an important contributing factor. Individuals who have

relatinnships with people who can connect them to other social networks are advantaged by this when seeking work (Granovetter 1973). These linkages effectively increase the number of individuals who may be helpful in the search for employment. Welch (1980) has described attempts to organize women into large networks so that they may take advantage of increased information, personal contacts, advice, and moral support. She describes the process as designed for ambitious women interested in upward mobility in corporations. It is,

> beating the system that isolates women as they move up in male dominated environments. It's asking for help when you need it - knowing when you need it, knowing whom and how to ask for it. It's giving help too, serving as a resource for other women. In sum it's getting together to get ahead. (:15)

Psychiatric populations have social networks characterized by low density and small size when compared to the social networks of either medical patients (Tolsdorf 1976) or normals (Pattison et al. 1975). These findings are associated with the focal person receiving less support (Henderson et al. 1978). Conversely those psychiatric patients who have large networks and high density, in relation to their co-patients, were brought into treatment quicker after symptom onset (Hammer 1963-64) and recovered in a shorter period of time (Surtees 1980). Generally, mental health is associated with having several good friends and contacts both inside and away from the primary group (Henderson et al. 1978).

Density and size appear to be the two most commonly referenced network characteristics when the fit between network structure and need is examined. It is generally acknowledged that both high and low density have beneficial effects on the focal person. High density increases the availability of affective resources and low density provides for increased information and opportunity for change. There are however extremes in density which are clearly associated with less adaptation and lower social functioning. Examples of the negative effects of extremes in density would be the crisis of bereavement in its later stages (Walker et al. 1977) for high density and the ex-mental patient's term in the community (Sokolovsky et al. 1978) for low density. The former provides so much support that the widow cannot alter her social roles easily because of the control that is exerted and the latter provides so little support that the patient is isolated and his term in the community tenuous. Less definitive statements can be made about network size, however it is clear that smaller networks are also associated with decreased adaptation and lower social functioning.

Holohan et al. (1978) studied social interaction among university students living in a high-rise dormitory. They found that students on lower floors, where communal facilities encouraged social interaction, had more extensive friendship patterns. Interventions which hope to improve social network functioning will consider environmental variables which may

influence the development of social networks. Individual characteristics determine network development and use. Tolsdorf (1976) noted that psychiatric patients have a negative view of their networks and therefore underutilize them and do not maintain them. Holohan and Wilcox (1978) have demonstrated that social competence is associated with social network development.

Much of the research into social networks is correlational in nature. Because of this, statements can only be made about some network structures being associated with some phenomena such as personal dysfunction, recovery from illness, or hel-seeking behavior. Attributing causality, to say for example, that deficient networks cause lack of well-being, is not justified at the present time. In fact the opposite, that people deficient in personal attributes cause their social networks to become deficient, has been hypothesized (Henderson et al. 1978).

Knowing how social networks develop would greatly enhance practitioners' interventions into social networks to improve the fit between network structure and need. Rounding out social network theory, Mitchell and Trickett (in press) state that there are both environmental and individual determinants of social networks. They argue that attention should be paid to both of these variables as well as the interaction between the two in seeking determinants of social networks.

Ethics, Dilemmas and Social Networks

The provision of social support is central to most investigations of social networks. Researchers (Dean and Lin 1977, Riger and Lavrakas 1981, Sandler 1980, Surtees (1980) have defined support in vague terms but have nevertheless concluded that it has beneficial effects for the focal person. Attempts to apply research findings to practice must address the question "Who is best able to provide support for individuals in need?". This question is addressed here by way of exploring briefly some ethical considerations and some dilemmas that arise in the provision of support.

Definitions of support and discussions about the provision of support reflect both professional and lay involvement. In the literature, professionals are associated with formal networks and lay persons are associated with informal networks. For the professional, supportive treatment consists of "procedures that selectively encourage some and discourage other client behaviors (and) it relies primarily on subtle interaction between worker and client" (Briar and Miller 1971: 25-26). Cobb (1976) defines support as provided by the lay sector of the person's social network. Social support, to Cobb, is information leading the subject to believe that he is cared for and loved, esteemed and valued, and a member of a network of mutual obligation (:300).

Support from both a professional and lay perspective appears to be a characteristic of the relationship between the helper and the helpee. The quality of support provided and the perception of the support available may well be dependent on the quality and type of the relationship that exists between the helper and the helpee. The provision of support in a helping relationship may fit less well with the current perception of professional helping than with helping with occurs naturally between family members, neighbors, friends, and indigenous populations. Professional helping relationships are contrived and often short-term whereas informal helping is predicated on the helper's natural and on-going participation in the life-space of the helpee. Professional relationships are most often unidimensional and non-reciprocal. Informal or natural relationships, on the other hand, may serve many functions other than help-giving and receiving, and both parties are likely to benefit from the relationship at some point because it continues over time.

Lenrow (1978) provides an interesting perspective on professional helping. He refers to professional helpers as those whose job it is to help strangers. He claims that initially client and worker are strangers to one another because each knows so little about the other and the relationship is strictly utilitarian. The relationship may become more intimate but if the helping is successful (and even if it is not) the two will become strangers once again and the relationship will

dissolve.

Most professional helping occurs in large agencies. These bureaucracies serve to promote the "strangeness" between client and worker by virtue of the strong work norms that exist. Lenrow (1978), who differentiates between helping and caring, claims that bureaucratic work norms actively discourage workers from demonstrating genuine concern for clients. He suggests that the norms are based on the following beliefs: 1) clients increase their demands on workers who demonstrate a caring attitude; 2) nothing can be done to help most clients; and 3) workers who care burnout quickly. The dilemma arising out of this situation, according to Lenrow, is believing that caring is a necessary (if not sufficient) condition for helping, but that caring has no place in a bureaucratic setting. This seriously undermines helping as meaningful work and if the assumption about caring is correct it is at best a disservice to the client. The arrangement is psychologically unpalatable to many workers and they either resign or remain to help but not to care. Those who seek help from large agencies become isolated and alienated - an absurdity in a society characterized by estrangement. Lenrow claims that support can not easily, if at all, be provided by helpers in bureaucracies.

Emphasizing the societal context of formal welfare structures and informal support networks (defined to include kith, kin, mutual aid societies and self-help groups (Lewis (1980) comments on the ethical imperatives that distinguish one from the other.

He notes that as the formal welfare structure developed, those eligible for material goods and services began to perceive them as their right. An unfortunate, but perhaps not unforeseen, consequence of the development of the welfare structure was the resultant emphasis on the rights of the individual. According to Lewis the emphasis on the individual in the welfare structure is similar to the emphasis in the economic distributive system, resulting in a diminished collective mutual concern. He suggests that a welfare recipient, if he thought about other recipients at all, would likely assume that they were well served, particularly if he himself believed he was well served. Recipients who are obviously not well served can be thought of in this individualistic welfare structure as simply not deserving.

While concern for individual rights is a necessary condition for a just welfare system, this should be balanced with concern for the common good which Lewis sees as best served through informal support systems. Recipients in this system are not pressed to put their own interests first as they are in the formal welfare structure. The focus is on the transformation of individual self-interest into collective mutual concern in the informal system whereas individual rights is the focus in the formal welfare structure. Individualization of clients, which Lewis sees as having developed as the profession of social work became more bureaucratized, has results in clients failing to develop a sense of collective concern. Because of this clients lack the power that can be derived from grouping together.

Power is realized in the clients' ability to: 1) influence the formal welfare system as in consumer advocacy groups; 2) provide healthy social treatment milieus for themselves as in self-help groups; and 3) establish control over benefits which can be used to provide for the common good as in mutual aid societies.

Lewis (1980) is suggesting that those associated with the formal welfare structure reexamine the impact the system has on clients. He believes that the welfare structure with its emphasis on individual rights is deleterious to the common good of the clientele.

Lewis (1980) and Lenrow (1978) together paint a rather bleak picture of professional helping. Not only does the formal welfare structure create powerless individuals but it fails to care for them as well.

Social network theory offers the professional helper alternatives other than job termination or remaining to help but not care. Believing that support is important in the lives of those who require help, and realizing that it is difficult for the professional to provide it, other approaches are necessary. Essentially what is required is a rethinking of the professional role in helping. Professionals rather than seeing themselves as having sole responsibility for the provision of support in the lives of their clients, should look to the client's social network to assume this responsibility. Social network theory

suggests that this may be done in a number of ways.

Network Practice

Clinical applications of social network theory began in earnest in the early 1960's (cf. Speck 1964). The focus was to break a therapeutic impasse by assembling a family's extended system of relatives, friends and neighbors. This was done to replenish the family's system with additional energies and support which enhanced the system's ability to problem-solve. Emphasis on wider units of intervention and the use of social network concepts are prevalent in a wide variety of practice situations today.

Unger and Powell (1980) believe in the need for those involved in designing and providing professional services to consider the social context in which clients function. This need is consistent with what they see as an emerging paradigm in the social services.

> The paradigm reflects a socio-ecological perspective of services within a family and community context as contrasted to an individualistic, professional-institutional perspective of services to isolated individuals by a professional in an institutional setting. (:571)

Unger and Powell (1980) believe that three general strategies for helping families under stress arise from consideration of social network concepts. Firstly, complimentary linkages between human service organizations and social networks will maximize coping strategies. Secondly, professionals should

provide services which strengthen family use of social network ties in coping with stress. The focus of the second strategy will be on the development and maintenance of resourceful family social networks rather than attempting to meet family needs directly through professional services. Thirdly, where adequate social networks exist, professionals should assist families to mobilize them. These strategies reflect the perception that the support which can be provided by social networks is crucial to families under stess. Essentially the strategies can be summarized as interventions, where the goals are to: mobilize support systems; connect clients to already existing support systems; and create intentional support systems.

In a paper illustrating the use of network concepts in practice, Erickson et al. (1974) point out that there are essentially two types of network interventions. The first type of network intervention concentrates largely on the extended family as the focus of change. This grouping is often enlarged to include friends, neighbors, and work associates and has been referred to as a "network assembly" (Rueveni 1979). The second type of network intervention focuses on the family and the human service organizations involved with the family. This combined grouping is considered the target for change and problems are typically addressed at meetings or conferences where the whole grouping is present.

While there are similarities between the two approaches they are best differentiated by the emphasis they place on specific sectors of the social network. In Erickson's (1975) terminology the first approach would focus on the kinship and friendship sectors while the second would include the service sector as well.

Two other approaches to practice which utilize social network concepts, involve network construction and informal or natural networks. Often networks are deficient in members and resources or are completely non-existent and therefore need to be constructed. Constructing networks can also involve connecting people to already existing networks such as self-help groups. Informal or natural networks have attracted practitioners interested in primary prevention and lay treatment. In this instance the focus in on strengthening natural caregivers' ability to help.

Five approaches to practice which utilize social network concepts will be reviewed: network assembly; network conference; network construction; self-help; and natural caregivers. Some instruments developed to assist the practitioner in assessing networks are discussed.

Network Assembly

The network assembly approach involves the helper, or more correctly the helpers since many are needed, instructing the

client to invite all significant members of his social network to a series of network assemblies. The assembly is the forum within which problems are addressed. Speck and Attneave (1973) believe that social networks can be mobilized to respond to members in time of need.

> The energies and talents of people can be focussed to provide the essential supports, satisfactions, and controls for one another, and that these potentials are present in the social network of family, friends and associates of the person or family in distress. (:7)

Attneave (1976) provides further rationale for the network assembly approach and emphasizes the logic of working with people who share significant relationships. She claims that the therapist's role is to facilitate problem definition and mobilize network resources and supports in order to solve the problem. The emphasis is clearly on restoring control to the natural system rather than professionals' assuming complete responsibility. Pattison et al. (1975) provide a sketchy theoretical framework and an empirical data base in support of this form of intervention.

The process begins with the selection of suitable clients. Rueveni (1977) notes that this approach is most suited to families whose concerns have been difficult to modify by conventional interventions. He claims also that the client or clients should be in a state of crisis that they cannot or will not solve themselves (Rueveni 1975).

> The criteria for selecting the network approach includes the nature and scope of the crisis, the degree of family desperation, previous efforts to deal with the problem, the availability of a sufficient number of resources such as family and friends to assemble, and the willingness of the family members to call on these resources for help. (Rueveni 1979:31)

Speck and Attneave (1973) encourage the client to convene and assembly of network members. Fifty or more is apparently the optimum number with 20 members being the minimum required. The location is typically the client's home and several assemblies are usually held. It is a rather large scale performance involving three to five therapists who have worked together for some time. The head therapist or "conductor" orchestrates the other therapists who in turn orchestrate the network members. With so many persons involved in the intervention the problem of confidentiality arises. Rueveni (1979) claims that most clients while hesistant at first realize that some benefit can come from discussing their problems with others. Rueveni equates confidentiality with secrecy and believes that it can bind the client and the social network in pathological ways. The client's wishes however are always respected with regard to confidentiality.

The intervention is certainly not a conventional one, in fact some mental health professionals claim that this is the work of dreamers and zealots (cf. Parkes 1979).

> Trimble (1980) points out the network approach,
>
> draws from ancient traditions of public healing which predate medicine and psychiatry. The practice of the

> conductor resembles that of the witch doctor or medicine man far more than that of the psychotherapist. (:10)

Each network assembly can be identified by six distinct phases or stages : retribalization; polarization; mobilization; depression; breakthrough; and exhaustion-elation (Speck and Attneave 1973). Rather than being lineal these phases are cyclical, occurring many times during each assembly. Retribalization is the process of reacquaintance for network members. Dormant connections between people are revived and the assembly as a whole learns of the problems faced by the client. As details of the problem are revealed coalitions form and the situation becomes polarized as people "take sides" on the issues that are raised. The team of therapists discourage dependence on them as professionals and encourage members of the network to participate and contribute to problem exploration. If the network is sufficiently resourceful and the team of therapists skillful enough, "activists" will emerge to initiate efforts at solving the problem. Often small groups are formed around specific problems and issues as the assembly mobilizes to address the problem. As immediate solutions rarely come easily or quickly it is quite common for assemblies to enter a depression phase. Members become frustrated that the process is not leading to any solutions. Intensive efforts are necessary on the therapists' part to encourage further attempts at problem solving. Various psychodramatic-type techniques may be used to mobilize the assembly and reach a breakthrough

of the impasse. The heightened activity and interest results in optimism that workable solutions can be found. Support groups are usually formed with specific tasks related to solving the problems. The final stage, exhaustion-elation, is characterized by assembly members feeling as though their contributions have resulted in relief from the immediate crisis.

The greatest benefit for the client is derived from the support groups. According to Rueveni (1979) they provide, basic psychological needs in times of crisis; security, esteem and feedback, material aid and services. Although no empirical evidence is reported for the efficacy of this approach Rueveni (1977, 1979) and Attneave (1976) claim that at follow-up the recipients of this type of intervention report greater satisfaction with social relations and an improvement in their life situations.

From a network analysis perspective the network assembly approach appears sound. As Trimble (1980) notes it is quite successful at accomplishing its main goal of "tightening the linkages" throughout the network. This is achieved primarily through increased communication. The network assembly provides for small clusters (groups), high in density which encapsulate and protect the client during the crisis. Simultaneously the network assembly, by drawing in or mobilizing the network, increases the amount of resources available for problem solving and can easily facilitate role transitions which often require

large numbers of contacts. Thus, the network assembly appears wholly consistent with empirical findings and theoretical positions relating network characteristics with need (cf. Hirsch 1979, 1980; Walker et al. 1977).

Network Conference

This approach addresses itself to problems in social networks which include family, friends, and human service organizations. Network conferencing is typically employed where a client is involved, or in need of involvement, with several social agencies.

Hoffman and Long (1969) describe how several systems (i.e., agencies, professionals, etc.) involved with a family, inadvertently combine in their day-to-day operations in such a way as to frustrate each other's activities and render it difficult for the family to improve their "lot in life". They view the family in terms of its total life space of "ecology" and illustrate a way of working within this framework. They note that only when the contributions of all systems are made clear, and their interrelationships explored do the origins of this phenomena become clear.

Auerswald (1971) expands on this total life space or ecology and views the family and change from an ecological perspective. He defines ecology broadly as a study of beginings and endings

in the dynamic and changing universe and as "the study of life and death in time and space" (:265). He points out that families can become entrapped in a web of helpers, each operating out of organized helping systems. The combined efforts of several such helping systems, operating to a large extent incommunicado, can and often do harm such families. Auerswald suggests that this is a result of these systems dealing with only a specific "piece" of human need. He outlines a technique he calls an "intersystems conference" which provides a structure for assessing and treating family problems through information exchange and planning for problem-solving.

Erickson et al. (1974) describe a way of working with families who are linked to a number of health, social welfare, and educational agencies. They call their approach a "combined family and service network intervention". Erickson (1975) clearly points out that this approach is quite different from the traditional case conference because the family and all of its care-givers are viewed as a single unit of intervention. Erickson et al's (1974) approach differs from Auerswald's (1971). Auerswald takes Speck and Attneave's (1973) and Rueveni's (1975, 1979) consideration of the extended family and family friends as a curative grouping and conferences them together with all care-givers. Erickson et al. however involve only the immediate or nuclear family and all the care-givers who are connected to them. Whereas Speck, Attneave and Rueveni utilize the extended

kinship group as a curative factor, Erickson et al. operate at the various points where the family interfaces with the wider society. Auerswald seems to suggest a combination of the two.

Cutler and Madore (1980) have recently described what they call "community-family network therapy". Their work closely resembles Auerswald's (1971) in that they attempt to involve as many members of the social network as possible (family, friends and care-givers) in finding solutions to the problem. The assumption is that the problem is as much a function of the context in which it occurs as of the person with the problem behavior. Cutler and Madore (1980) believe that several of the following indicators should be present before their approach is employed.

1. A crisis state exists and is continuing to expand with no indications that spontaneous resolutions will occur.
2. Increasing distress within the family is producing symptoms in more than one member.
3. Multiple contacts with many agencies are yielding little or no results.
4. Temporary or permanent removal of the symptomatic family member is deemed either impossible, not helpful, or contraindicated.
5. Family members and staff view the problem as being potentially dangerous without a major overhaul.
6. Lack of interagency coordination serves to enhance communication problems thus adding to the blaming process.
7. Agencies working with the family feel discouraged or are resigned to the fact that they are dealing with a "hopeless family". (:147)

The team of therapists who may come from a variety of agencies assume five basic roles during the therapy: organizer;

advocate; conductor; consultant; and monitor. The organizer is responsible for ensuring that sessions are well planned and participants informed. The advocates generally facilitate the process during the sessions. The conductor is the group leader who convenes the group and facilitates development of contractual agreements among participants. The consultant, who is usually an experienced mental health professional is responsible for observing the process and commenting in a helpful manner. The consultant usually has no prior involvement with the client. The monitor's responsibility is to ensure that agreements and contracts made in the session are carried out. It is the monitor who will request that the network reconvene should the need arise.

The process, as Cutler and Madore (1980) outline it, is essentially one of problem exploration, definition and contracting, followed by monitoring and evaluation. While coordination of the network, particularly the service sector, is an obvious result, it is really a by-product. Of primary importance is the network's enhanced capacity to problem-solve because of the involvement of all the significant people. Professionals and other network members redefine their role in relation to the client. Lines of communication are opened up between the agencies and the client which facilitate problem resolution.

Garrison (1974) reports a method he calls the "Screening-

Linking-Planning Conference" (SLP). This is a technique designed to mobilize social support systems for psychiatric patients (A similar method has been developed for drug-dependent populations, see Callan et al. 1975). The kinship and friendship sectors of the patient's social network are brought together prior to, during, and following any hospitalization. The network is mobilized to cluster around the patient, reinforce positive expectations and to develop options for managing the crisis. For hospital-dependent patients the primary focus is to encourage the patient to rely more on the willing and supportive network of family and friends.

Network Construction

The network perspective demands that the practitioner assess clients' social networks and further that interventions should consider the whole social network. There are instances however when networks are insufficient to meet the client's needs. Networks can lack sufficient members or resources, or their members may simply be unwilling to assist the client. Believing that a supportive social network is necessary for sustained well-being, practitioners are faced with the task of creating or constructing networks. Trimble (1980) believes,

> Through teaching and more active assistance the network therapist can help the client to enlarge, construct, or reconstruct a personal network which has the capacity to nurture, to heal and to challenge. (:16)

The majority of work in this area has focussed on mental

health. Mental patients are thought to often reject their social networks because of their negative orientation to using them (Tolsdorf 1976) or be rejected by their network because they are considered a burden (Froland et al. 1979). When clients and their networks demonstrate incompatibility or when a natural social network is absent, social network construction is indicated (Turkat 1980). Network construction is an alternative to attempting to mobilize dormant but existing networks.

For those without social networks the conventional approach appears to have been the creation of professional helping networks. This method which may utilize a conferencing approach similar to Erickson et al's (1974) provides the client with a supportive professional network. Reliance on professionals for support not only reflects a specific ideology in support of the formal welfare structure (Lewis 1980) but places considerable burden on professional services. Concern has been expressed that individuals without social networks become easily dependent on professional services (Froland et al. 1979). Where professional helping networks are created the dependence can become immutable.

Cutbacks or limited spending on social services as well as the development of what Turkat (1980) calls the "non-professional movement" have given practitioners reason to look elsewhere when attempting to construct networks. Two areas where there is a great potential for support system development are the ever expanding domain of self-help groups and with

natural caregivers in informal networks.

Self-Help

Self-help groups have been defined as informal support systems (Gottlieb 1976). They are brought into existence or constructed by either lay influence and direction (Lieberman and Borman 1979) or by professional design (see Harris 1981 for a report on establishing a self-help group). Practitioners will usually be involved with self-help groups only in referring or connecting clients to them. In one sense self-help groups are readily available, existing and often well established, homogeneous, supportive groups. For clients who have no social networks or networks that are unable to respond to their needs, self-help groups appear to be good alternatives to the development of professional helping networks.

Practitioners, lay persons and clients need only refer to self-help "pop literature" (cf. Evans 1979) to locate a suitable self-help group. The nonprofessional movement has resulted in the development of self-help groups for most physical, psychological and spiritual crises, as well as for most normative life events. Overviews of the development of self-help and its current usage are widely available (Gartner and Riessman 1977, Katz and Bender 1976, Killilea 1976, Lieberman and Borman 1979).

A popular definition of self-help is provided by Katz and Bender (1976).

> Self-help groups are voluntary, small group structures for multual aid and the accomplishment of a special purpose. They are usually formed by peers who have come together for mutual assistance in satisfying a common need, overcoming a common handicap or life-disrupting problem, and bringing about desired social and/or personal change. The initiators and members of such groups perceive that their needs are not, or cannot be, met by or through existing social institutions. Self-help groups emphasize face-to-face social interactions and the assumption of personal responsibility by members. They often provide material assistance, as well as emotional support; they are frequently "cause"-oriented, and promulgate an ideology or values through which members may attain an enhanced sense of personal identity. (:9)

Their definition clearly reflects many of the same ideas, goals and purposes which writers have ascribed to social networks in general (cf. Cobb 1976, Caplan 1976, Hirsch 1980).

The self-help approach appears consistent with the social network perspective. In self-help there is an emphasis not only on the client but on the family and friends of the client as well. Obvious examples of these groups are those of persons related to alcoholics (e.g., Alateen and Al-Anon). In the area of mental health success has been reported in forming self-help groups comprised of families and patients (Plummer et al. 1981), and family and friends (Torjman 1980). An extended family structure, comprised of unrelated families who care for severely emotionally disturbed children, has proven beneficial and supportive (Rubenstein et al. 1981).

Self-help groups can act as supportive social networks.

For those persons with an already existing social network, a self-help group acts as a small dense cluster the person can move into in times of need. This is consistent with research findings (Hirsch 1980) and supports the notion that group identity is important particularly because of a fragmented social order (Haley 1976).

Although self-help has been criticized particularly for the lack of research (Lieberman and Borman 1979) there is some empirical evidence available. Knight et al. (1980) studied eight self-help groups. They found that most members (83%) reported the effectiveness of their group was due to the supportive, accepting environment provided by the group.

The role of the professional in relation to self-help groups is not clear. As Killilea (1976) has pointed out professionals do have some involvement due to their role as founders or acting as guest speakers or consultants. Ideologically, professional involvement is foreign to self-help and perhaps as Lieberman and Borman (1979) note, professionals should wait to be asked before getting involved.

Natural Caregivers

Natural caregiving refers to the help that is given freely and naturally in our society. The caregivers are usually not attached to any human service organization and will

not necessarily be a part of any recognized self-help or mutual aid group. These caregivers have been referred to as "community caregivers" (Gottlieb 1978a), "natural neighbors" (Collins 1973), "central figures" (Collins and Pancoast 1976), and "socially indigenous helpers" (Mitchell and Trickett, in press). They are helpful neighbors, hairdressers, bartenders, clergy, the elderly, and the recovered or rehabilitated. They are useful members of their own networks.

Collins and Pancoast (1976) have identified what they refer to as a "natural delivery system". This system, which is similar to Gottlieb's (1976) lay treatment and referral networks, involves certain neighborhood individuals which provide informal help (e.g., material aid and services) for their neighbors. These natural caregivers were seen initially as important resources for mental health professionals. This grew into a broad based preventive scheme where professionals through collaboration and consultation with the natural caregivers, assist in strengthening and directing the network by way of a problem-solving process.

Collins and Pancoast (1976) believe professionals can greatly increase their ability to influence the well-being of community members by finding and utilizing natural caregivers. According to these authors the basic interventive approach involves three steps. Firstly, the professional becomes thoroughly acquainted with the target neighborhood, its history,

and the ethnic and social make-up. Secondly the professional locates natural caregivers by a process of informal interviewing. Lastly, a consultative mechanism is established so that natural caregivers will have the benefit of professional expertise.

Seeking out natural caregivers is only one way of attempting to strengthen natural systems of support in the community. Practitioners may simply assume that certain persons, because of their positions in the community are likely to be natural caregivers or minimally, can be trained to be caregivers (Gottlieb 1978). With minimal training bartenders and hairdressers have been found to be successful in supporting clients through crises and/or providing a referral service to professional caregivers (Bissonette 1977). Clergy, because of their trusted position in society, are often involved in crisis intervention and counselling. Organizing and training clergy as support systems has beneficial effects for clients (Richards 1976). Volunteers (Curtis 1973), the elderly (Twente 1970), and widows (Silverman 1976) have been trained as natural caregivers.

The assumption is that natural caregivers can in some instances prevent some pathological state from occurring . . . (Collins and Pancoast 1976) and/or facilitate recovery through lay treatment and referral (Gottlieb 1976). Further, it is assumed that informal networks can be strengthened by professional involvement. Baker (1977) has attempted to list the various roles that professionals and natural caregivers

may assume as they interact to strengthen the network. He notes that professionals may assist in the establishment and coordination of a network of natural caregivers, offer consultation to natural caregivers, provide advice on request only (thus assuming a purely reactive role), and refer clients to natural caregivers. Conversely natural caregivers may assume the role of treating clients and in doing so ease the service demand on professionals, they may refer clients to professional caregivers, and they may assume a leadership role which excludes professional involvement.

Baker (1977) claims that three types of relationships can exist at the interface between professionals amd natural caregivers. Firstly, the two systems may collaborate and share the resources of funds, clients and information, acknowledging each others' contribution to helping clients. Secondly they may actively engage in competition for these same resources, each believing the other has little to offer clients. A third type of relationship that can exist between the two systems is characterized by little direct contact. Each system operates in isolation having little influence on the other. To this typology, Gottlieb (1976) adds a fourth relationship, where the professional trains the natural caregivers.

It cannot be assumed that professional contact with natural caregiving systems will strengthen them. Gottlieb (1976) cautions that this interaction may have the unanticipated

consequence of destroying, over time, the elements of natural helping that attract people to natural caregivers. Sandler (1980) cautions as well that professional involvement in natural systems not disrupt or disperse support resources which help moderate client distress. Gottlieb (1979) believes that there is a case to be made for benign non-intervention. He claims that professional consultation with existing natural systems can have a damaging effect, particularly when it involves the transmission of professional modes of helping and the imposition of clinical diagnostic frameworks. Even in times of crisis, intervention may be unwarranted since symptoms of disequalibrium may abate as the natural system mobilizes its resources.

Gottlieb (1979) calls for more strenuous research efforts which hopefully will describe healthy and functional networks and therefore guide interventions and direct practice. He believes that professionals and natural caregivers can interact such that a problem-solving approach can be delivered through informal social networks. The benefits according to Gottlieb (1979) involve broader social purposes.

> First, it can help to restore people's faith in the fact that difficulties in living can be solved indigenously, without resort (or worse the transfer of responsibility) to experts. Second, the potential end-states of healthy support system-functioning go beyond the improvement of members' individual well-being, to include the development of a sense of collective esteem and aggregate power. (:478)

While admitting that it is not a panacea, Gottlieb points out the significance of working from a network persepective,

where professionals and natural caregivers interact.

> This is the point that many of us have been leading up to in community psychology: the search for a natural unit of social structure which will both heighten our contextual appreciation of community behavior and which may be mobilized to protect personal health, in the epidemiological sense, and to enhance the well-being of the collectivity through community-building activities. (:478)

Network Assessment

Researchers have utilized sophisticated statistical procedures and complex data collection techniques in the study of social networks (see Holland and Leinhart (1979 for examples of complex social network analysis). Practitioners working from a network perspective realized that these same research instruments, if modified, could be used with individaul clients in assessing social networks.

Attneave (1975) has developed an assessment tool she refers to as a "Family Network Map" and utilizes it in practice. Clients are asked to list their network members into four zones or categories: household; emotionally significant people; casual relationships or "ordinary folks"; and distant relationships - people seen only on special occassions. They are drawn as numbered symbols in the appropriate zone. .. .. represented by concentric circles. A line drawn through the middle separates the social network into family and relatives on one side and friends and neighbors on the other. Lines are then drawn between those members who know each other or spend

time with one another to represent relationships. The exercise is repeated but this time the client "draws" the ideal network. The challenge to the client and the therapist is to find ways to rearrange the network to make it more supportive and functional for the client.

Attneave (1976) notes that with a visual presentation of a client's social network the social impact from stresses such as geographical moves, normative life cycle events, promotion in status, illness and death are often obvious. These stresses can result in significant changes in the client's social relationships, upsetting the equalibrium and removing essential supports. Attneave's Family Network Map can point to certain deficiencies in the network but more importanly, strengths can be located and strategies devised to utilize them. The decision as to who should be involved in further therapy is often obvious.

Cohen and Sokolovsky (1979) have utilized an assessment instrument called the Network Analysis Profile (NAP) developed by Sokolovsky et al. (1978). They believe that this instrument (or some other instrument designed to assess client's social network) "should be completed concomitantly with the standard intake data" (:210) when clients approach human service organizations for help. Data from the NAP is not only used for research purposes but is utilized in practice to assess the extent to which the client's informal network can be of

assistance in helping and supporting the client. Cohen and Sokolovsky (1979) report that social network analysis has benefits at the agency level. Agency staff quickly begin to view clients not as isolates but as interacting members of social networks. Staff begin to understand clients' behavior as it relates to a broader social context. Agency resources can be concentrated on those clients who are identified as being at risk due to deficiencies in certain network characteristics. Network analysis allows practitioners to locate natural caregivers and indigenous leaders with whom they may interact.

Another network assessment tool has been developed by Pearson (1980) called the Personal Support System Survey (PSSS). Morosan and Pearson (1981) report that the PSSS has proven useful in assessing the social network's ability to provide support during times of crisis. They note that individuals in counselling, couples in marital conflict and families in crisis can "helped to develop an awareness of their support needs and status and to begin the process of considering actions to improve their situation" (:5). The PSSS lists 13 types of support and asks the client to list those persons who provide the supports and further explores the quality of the relationships.

Other instruments presently used for research purposes such as the Social Network Assessment Questionnaire (Froland et al. 1979) and the Oregon Quality of Life Questionnaire

(Bigelow and Brodsky 1979) hold promise for use as clinical tools.

Social Networks and Programs

The community mental health movement has been criticized because massive numbers of patients have been moved into the community from institutions prior to services being developed (Greenblatt 1978). Lack of proper funding and a reluctance on the part of existing service agencies to serve this population compounds the problem (Barton and Sanborn 1975). As Chu and Trotter (1974) have pointed out, "many [patients] are without families and friends: others are no longer wanted back into their homes" (:35). They continue:

> Unfortunately, the community care ideology developed far faster than actual services and facilities. Most communities lack the social support programs and transitional facilities necessary to properly sustain former state hospital patients in the community. It is therefore important that these people are assured of help in returning to noninstitutional life. (:35)

It is generally acknowledged that there are gaps between the rhetoric and the reality in the movement to deinstitutionalize chronic patients and provide services to them in the community.

The Community Support Program (CSP) implemented by the National Institute of Mental Health (USA) is an example of a program designed as a corrective to a system failing to attain its stated goals. Turner and Ten Hoor (1978), reporting on the CSP, note that its major feature is the concept of the community support system. They define the program as a "network of caring

and responsible people committed to assisting a vulnerable population to meet their needs and develop their potentials without being necessarily isolated or excluded from the community" (:329). Unique to this program is the emphasis placed on the community and family as natural caregivers interacting with the more conventional treatment facilities. The focus is clearly not just on the patient but on the patient embedded in a family (or pseudo-family) in a community. The program is relatively new and no evaluative data have been reported.

Application of network concepts at an agency level is well documented by Sarason et al. (1977). Sarason's (1974) involvement with professional helpers led him to conclude that agency personnel often consider only their own agency's resources in attempting to meet the needs of their clients. He believes this narrow focus is perpetrated by the myth of unlimited resources and results in a reduction of overall benefits for clients.

Sarason et al. (1977) describe their efforts to developed two functioning networks. The provide rationale for the utilization of network concepts and demonstrate practical application in non-crisis agency-level situations. The Essex network began when Sarason and some colleagues began to meet regularly in an effort to exchange resources. The goal was to enhance member agencies' capacity to provide services

to clients by exchanging non-fiscal resources through a system of bartering. As connections between agencies formed solutions to common problems were found and joint programs developed. Those involved in providing human services began to feel like members of a mutually supportive community. The TRI-university network, comprised of faculty from three universities studying network concepts, joined the Essex network with productive results.

The essense of resource exchange is the emphasis on human, not material resources. According to Sarason and Lorentz (1979) professionals should acknowledge that it is dangerous, or minimally unproductive to believe that more material resources will be available and therefore the client need only wait to be served properly. They remark that professionals should consider themselves and others as resources and seek ways of banding together to meet client needs.

Sarason and Lorentz (1979) emphasize that the attractiveness of this concept is related to workers' perception that greater satisfaction can be derived through participation in a voluntary network of helpers, than in involuntary networks. They believe that workers prefer informal networks because of the perceived productiveness, mutuality of goals, and the voluntary exchange or resources, information and shared values. The development of resource exchange networks is necessary at a time when large human service organizations are seen as ineffective at helping

clients and material resources are becoming scarce. Sarason and Lorentz document a variety of successful educational and health networks yet concede problems with coordination of resource exchange and unresolved issues in leadership.

Cutler and Madore (1980) use network concepts to band together community agencies to help serve the needs of multi-problem families. While noting that these families benefit most from this approach they sum up the benefits for the agencies which participate in the helping endeavor.

> [There is]increased understanding of roles, functions, and goals among persons as well as agencies; a reduction of energy wasting; and added respest and common experience among staff of collaborating agencies. (:153)

Social Networks and Research Needs

While the idea of applying network concepts to practice is popular, Mitchell and Trickett (1980) caution against wholesale acceptance. They claim that network concepts can be used only in a general way for two reasons. Firstly, not enough is known about the relationship between social network concepts and specific settings and populations to guide interventions. Secondly, descriptive data from research does not necessarily imply a specific intervention. With some exceptions (cf. Froland et al. 1979) it is generally acknowledged that it would be premature to detail the specific ingredients of interventions into networks (cf. Heller 1979).

Cobb's (1976) review of the research on social networks reveals several negative associations between measures of social support and coping behaviors. He suggests therefore that the mechanism by which social support is brought about needs to be better understood.

The strength of research findings in any area is dependent on the extent to which other plausible explanations of the results can be disproven. Unfortunately most of the available research on social networks is correlational in nature, adding greater difficulty to the interpretation and defense of the findings. As Henderson et al. (1978) have observed, rather than attributing psychological dysfunction to lack of network resources one might just as easily attribute it to lack of personal social skills or incompetence.

In an extensive review of the essential knowledge relative to social support, Dean and Lin (1977) observe the difficulty in sorting out cause-effect relationships. Noting that experimental studies may be difficult they suggest the use of longitudinal designs.

There is little standardization of measures or design from one study to the next making comparison difficult and accumulation of data impossible. Adding to this difficulty is the fact that support is variously defined and measured numerous ways from subjective and retrospective data collection to participant observation. Sample sizes have generally been small making the

use of statistical procedures suspect and generalization to larger groupings difficult. These samples have been comprised of various network members with different relationships to the focal person dependent on the researcher's view of who is most important, or what criteria is used for inclusion in the network.

Heller (1979) claims that knowledge about social support is generally incomplete. He suggests research in the following areas:

1. The relationship between the individual and the supportive others.
2. The behavior of supportive companions and the content of support.
3. Personality, demographic characteristics, and role behavior that influence the receptivity to support.
4. The skills necessary to access and maintain supportive relationships.
5. Environmental structures that are conducive to the establishment and maintenance of supportive systems. (:367)

Of particular interest in future research is the question of social competence. As Heller (1979) points out, individual differences in social competence may account for differences in adjustment between supported and unsupported research subjects. Interventions which aim to alter the environment to better facilitate support will be wasted if the recipients are deficient in the skills needed to access and maintain the necessary relationships.

The familiar call "more research is needed in this area" applies to social networks. There has been a considerable

amount of research into social networks and this will likely continue because of the enthusiasm in the social sciences that social networks hold great promise as natural social units for intervention (cf. Gottlieb 1979). The increasing interest in social network analysis (cf. Holland and Leinhart 1979; Wellman 1979) and the resultant development of network assessment tools for research (cf. Pearson 1980) and for practice (cf. Cohen and Sokolovsky 1979) indicate that deficiencies in research may soon be corrected.

The application of social network concepts in practice appears to be well justified on theoretical and practical grounds. Social networks are both a natural unit of social structure from which the professional may accumulate knowledge about human behavior and an organized grouping into which the professional may intervene.

Research is strongly suggestive that support offered through social networks acts to protect individuals from a wide variety of illnesses and to restore health after disease onset. Social networks also moderate normative stress resulting from transitions across the life cycle. When stress does occur social networks tend to influence the stressed person with respect to help-seeking. Social networks are proving useful as social units within which the plight of the mentally

ill may be examined. Todate, research has encouraged the use of social network concepts in practice.

Various and diverse approaches to the utilization of social network concepts in practice are currently in evidence. Some, such as network conference, have gained a degree of credibility among professional caregivers while others, such as network assembly, have fallen more or less into disuse.

This paper has reviewed social network literature respecting both research and practice. The central message for professionals is one relating to increased emphasis on social networks in assessing and treating problems. More specifically professionals must become aware of ways to utilize the informal supportive caregiving that occurs naturally in social networks. The role of the professional in this endeavor is not clear however the literature is able to provide some direction.

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