Abstract

This essay is an introduction to a review of the literature on measurement of social support in schizophrenia. It proposes a natural history for the development of the career of the schizophrenic in his social network. The dimensions of social support in this illness are shown to be specific to it, and different from what has been described for other illnesses such as depression. Certain qualitative and quantitative characteristics of the clusters which make up the social network are suggested for study.

This essay provides a conceptual introduction to the problem of measuring social support in schizophrenia. It is background for a critical review of the literature and instruments of measurement in this area, which is being prepared by a group of colleagues at Columbia University under the direction of the NIMH Center for Schizophrenia Studies (to be published separately).

The principal purpose of the present article is to make a connection between several areas:

- Clinical and phenomenological experience with the schizophrenia syndrome.
- Studies of the social context of the illness.
- Sociological and anthropological studies of normal social network formation.
- A small but growing body of specific epidemiological investigations of social supports in schizophrenia.

If these areas can be connected to make a coherent structure, we will have the beginnings of a theoretical basis for the design of new studies.

Clinical Significance

The Community Mental Health Center movement of the early 1960s and the policy of deinstitutionalization of chronic mental patients which began in the 1950s had a common goal: to make possible a better life for chronic schizophrenics in some place or surrounding natural and convenient for them. The legal reforms which have appeared more recently, especially those concerned with the "least restrictive alternative" to hospitalization, have had the same end in view. But all these reforms in psychiatric administration have come about with very little development of systematic knowledge about the social lives of chronic schizophrenics and others with serious mental disorders. Gerald Caplan, an early theorist of the community psychiatry movement, wrote originally, and hopefully, of the possibility of prevention through early identification of cases and early treatment of those which are known. More recently, after the movement has experienced some disillusionment with "treatment" of patients in the community, his writings have emphasized the "natural social supports" of mental patients (Caplan 1974, 1976). We have begun to realize there is something about the environment of actual helping...
and supporting people surrounding patients which requires our attention and understanding—and our strategic support.

Most recently the President’s Commission on Mental Health (1978) has declared in its leading section:

Personal and community supports, when they emphasize the strengths of individuals and families and not their weaknesses, and when they focus on health rather than sickness, may be able to help reduce the stigma often associated with seeking mental health care. These largely untapped community resources contain a great potential in innovation and creative commitment in maintaining health and providing needed human services. (p. 15)

The Report recommends that:

A major effort be developed in the area of personal and community supports which will

- Recognize and strengthen the natural networks to which people belong and on which they depend.
- Identify the potential social support that formal institutions within communities can provide.
- Improve the linkages between community support networks and formal mental health services.
- Initiate research to increase our knowledge of informal and formal community support systems and networks.

The first three points emphasize our conviction about the clinical wisdom of involving natural networks in treatment, and the fourth acknowledges our scientific ignorance about what is involved. It is not clear, beyond the invocation of clinical experience, how a therapist would recognize a social support if he saw one among the collection of facts that make up a clinical record. We do not really know, for example:

- Which patients have supports that are helping them as much as possible and should be left alone. Some of the “successes” of social treatment may be with attractive people who will do well enough without us.
- Which patients have no access to support and need to have it constructed for them by professional sponsors.
- Which patients have potential social supports to which for some reason they have not become connected. These may need to have only a few connections supplied by professionals—support for the supports, so to speak.
- Which patients will return for long stays in a hospital or some other total institution no matter how well-connected they are or what professional effort is expended on them.

The practical importance of these questions, especially with limited treatment resources, is obvious. But they can only be approached if we have a way of defining and describing the structures that already exist in the lives of patients and relating them to the success and failure of treatment. They are necessary questions to ask if we are to avoid wholesale expenditure of yet more money on a treatment that should not be the same for everyone. Social therapies, like drug treatment or hospitalization, should be applied with judgment, and for this, we need a parsimonious and scientific set of indications.

Background

This essay is built upon the ideas in a previous issue of *Schizophrenia Bulletin*, which I edited (Beels 1978). The first article in that issue (Hammer, Makiesky-Barrow, and Gutwirth 1978) reviewed recent research in this field. Hammer, Makiesky-Barrow, and Gutwirth (1978) noted that the “social network”—an empirically defined group of family, neighbors, and friends—is the subject of much recent social science research. It appears to be one conceptual tool that will help us to arrive at a workable definition of social support to be used by scientists and clinicians. The network concept is related to several others in psychiatric epidemiology (e.g., migration, social marginality, isolation, social class, marital status, employment, sex, age, and ethnic group) and is also related to recent ideas about treatment for this population (e.g., crisis intervention, resocialization, work rehabilitation, and partial hospitalization).

Five quantitative studies have connected the course of schizophrenia with network measurement. Pattison (1975) found the networks of psychotic patients to be smaller and denser than those of normals and neurotics. Tolsdorf (1976) found that changes in network size and function began at or before the time of first hospitalization. Cohen and Sokolovsky (1978), working with chronic patients, demonstrated a relationship between network size, and the direction of exchange of helping network relations, on the one hand, with community tenure, on the other. Hammer (1963–64) investigated important links in the social network before and after
hospitalization, and found that patients whose close relations were with individuals not connected with each other were more likely to have their connections severed following hospitalization. And finally Garrison (1978) studied the natural groups of nonkin supports on which migrant Puerto Rican women in New York depend. She demonstrated that these groups differed systemically across a spectrum of illness from no psychiatric illness to least functional schizophrenia. Garrison’s findings emphasize the importance of the patient’s sex, ethnicity, and stage of the life cycle as keys to understanding the natural history of types of groups available to the patient and norms of behavior governing connections with people in those groups.

These studies demonstrate that the investigation of the social supports of schizophrenic patients, and the connection between their available networks and the course of their illness, is a promising area for research, but that the investigation of this area is just beginning. It is important at this point to consider the development of methods for the definition of important variables in the measurement of social support.

Definitions

I take “social support” to be whatever factors there are in the environment that promote a favorable course of the illness: I assume that we do not know exactly what those factors are, but, depending on certain definitions of a favorable course—fewer or shorter hospitalizations, more independent social function, less symptomatic distress—we can discover what social support is through natural history studies, analysis of correlations, and, eventually, clinical experiments. Although we do not know with any great clarity what social support is, we have seen evidence for it in some cases. There are patients who appear to survive crises with the help of friends, relatives, and therapists; and there are patients who deteriorate when certain social connections disappear. On the other hand, Bleuler has observed that some patients who have been in the hospital for years will pull themselves together and start to live independent lives when a key relative dies. Clearly the responsiveness of schizophrenics to their environmental supports is not simply a matter of “the more the better.” Some patients are overwhelmed instead of supported by their social connections, in ways that are not easy to define.

The “social network” as used here is simply one of several ways to define social life in relatively objective terms. Many of these terms have been discussed in detail by Hammer, Makiesky-Barrow, and Gutwirth (1978) and Hammer (1981). What I want to recall here is that the social network is not a priori good or bad for a given purpose. It is, rather, large or small, dense or sparse, old or new, and may be based to varying extents on family, friends, neighbors, workmates, fellow patients, members of a church, etc. Everyone has a social network, and different aspects of that network may be important at different times or for different purposes. A recent widow may find herself most supported by old and close friends in the early days of her bereavement, but may find that new friends—perhaps other widows and single women—are most important to her in building her new life a year later.

Outline

In this essay on social networks and schizophrenia, I will focus on the following questions.

- What variety of social support measures have been used in the study of health and mental health, and are they likely to be of use in research on schizophrenia?
- Considering what we know of the subjective experience, symptomatology, and life history of schizophrenia, can we deduce some theoretical expectations concerning the relevance of social supports? An excursion into the natural history of network-building in our culture will be helpful here, as well as some comparisons with the course of schizophrenia in other cultures.
- How are social supports in schizophrenia likely to be different even from those in serious mental illnesses such as psychotic depression, which are similar to it in severity?
- What are the effects of ethnicity and social class on network structure, and do these effects have consequences for the course of schizophrenia?
- Finally, what are the measures of networks and of other aspects of social support which have the most relevance for schizophrenia research?

Social Support and Health

A review of the literature of social support and health reveals a vari-
ety of measures of support: intimacy with spouse, availability of family help in crisis, majority representation of one’s ethnic group in the community, favorable atmosphere in the home or the workplace, presence of a confidant, general good feeling about extended family relations—these measures and many more have been applied to problems surveyed in the general population and in clinic populations such as heart patients and pregnant women. The mental health variables measured by survey have included cases of depression defined by psychiatric diagnosis or by screening test, neuroticism defined by self-report of symptoms, and general level of disturbance or anxiety defined by symptom checklists. The assumption behind many of these studies is that social support is a positive presence rather than an absence (an absence of burdensome dependents, for example) and, in an intuitively obvious way, the more support the better.

On the other hand, a look at the very important work of George Brown (Brown and Harris 1978) and his colleagues on depression and on schizophrenia reveals that when you start with such specific diagnostic categories, you find that different aspects of social support are important in different diagnoses. In their study of depression among the women of Camberwell, for example, Brown and Harris found that presence of a confidant in the form of spouse, boyfriend, or close friend protected women in the community from developing depression as measured by their field interview criteria, but did not do so for women who developed depression treated by a psychiatrist. That is, in spite of many similarities of symptoms, something about the severity of depression that led to psychiatric treatment in a London suburb made it different from depression encountered by survey. One difference was that treated depression was less sensitive to social support.

Using the same instruments, Brown and Harris (1978) surveyed women on a Scottish island, and found that a local type of strongly integrated social support system of family and church membership appeared to protect against depression, but such a support system was also strongly associated with symptoms of anxiety, which the depressed, less supported, women tended not to have. That is, a support that protects against depression may be a contributor to anxiety, and vice versa.

When one turns to Brown, Birley, and Wing’s (1972) work on the social supports of schizophrenic men discharged home to their families, it is useful to compare the important variables in that study with those in the depression studies. Important variables in depression—presence of a spouse confidant, absence of young children at home, and employment—are not significant variables for schizophrenics because they tend to be unmarried, childless, and unemployed as a group.

What was important for their prognosis was a particular kind of tolerant, even-tempered family attitude, called “low expressed emotion” (to which we will return). The small minority of schizophrenics who achieve either stable marriage or competitive employment are mostly in a separate favorable group with a later onset of illness (Huffine and Clausen 1979). We can see here an example of a recurring problem: in schizophrenia research, measures of the availability of social supports are confounded with measures of social competence, and of general prognosis. We can also see from this brief look at the social support field as a whole that there is not much point in talking about social support in general as being related to mental health in general.

To see how difficult it may be to apply otherwise useful concepts of social support to schizophrenia, consider the idea of the "confidant." A confiding relationship, especially with a spouse, has been shown to be a protective social support in a variety of conditions, from depression (Brown and Harris 1978) to heart disease (Medalie and Goldbourt 1976). But a confidant may be a very problematic person for a schizophrenic.

Vaughn and Leff (1981) have shown that an important correlate of an intrusive, negative family attitude, which is specifically unfavorable for schizophrenics, is disappointment in the patient’s refusal to confide. What is important here is not that the patient acquire a confidant but that the parent stop trying to be one: It may be better for some patients to keep their confidences to themselves.

Social Support and the Phenomenology and Natural History of Schizophrenia

We need a descriptive account of the social context of schizophrenia which will connect clinical observations of social events on the one hand to the phenomenology and natural history of the illness on the other. In this way, we will have an ordered set of theoretical expecta-
A social supports consequence of these ideas is that schizophrenics should optimally have several different social spaces in their lives through which they can move easily and freely, so that they are not trapped in one environment at one level of stimulation. This is, of course, related to the observation that patients do best if they have home and parents available to them, but are not confined by habits or expectations to either home with family or the isolation of a single room.

The next theoretical point requires that we make a few observations about the dynamics of social relations in our society—in particular concerning the way in which we normally develop social connections. I am relying here on ideas suggested in Boissevain and Mitchell (1973).

The roles we all play in the formal social structures of classical sociology (e.g., family, work, and church) are only one part of social life. Our networks are built up from the exchange of goods and services through informal connections as well. These informal connections, which may be unsupported by role membership, are made on the basis of mutual attraction and interest. The creative working margin of network formation is in the development of informal connections. That is, one important way in which people in complex societies like towns and cities overcome the limitations of their formal memberships is by developing informal ones. In practice, of course, the two are not by any means mutually exclusive, but the analytic distinction, as I will show presently, has particular importance in the lives of schizophrenics.

A second preliminary idea, for which I am indebted to Conrad Arensberg, is that in these social exchanges, the perception of initiative is very important. Who makes the move, or the offer; who makes the response, or receives; how turns are taken; and what is the balance of initiative over time, are all important to how the developing relationship is viewed by the participants.

To put these ideas together, then, the natural history of network formation in our society could be thought of as operating through a range of institutions from more formal (family, workplace, school, church) groups to more informal groups (eating and drinking parties, weekend leisure activities, hobbies and interest groups). Oversimplifying to make a point, one could say that membership in formal groups has a routinized or regulated quality to it. Home and work are examples. "Home is where they have to take you in." Work is supposed to be run by rules of competence and productivity—at least there is some line of work one can get without depending on social grace or influence. The two types of organizations overlap. Of course, having gotten even the most menial kind of work (formal organization), one is then faced with informal groups and factions inside the workplace: who has coffee or lunch together, who gossips with whom.

Informal organizations, more than formal organizations, depend on the graceful making and receiving of social initiatives. It is in informal groups that the manners and tastes involved in the offering of social goods, such as interest or entertainment or influence, are most obvious, because they are unsupported by formal reasons for
the exchange. Another way of putting this is that the dues which have to be paid as the price of membership in the two kinds of groups are different. You can make a low, routine, and in terms of initiative, reactive contribution to church, family, or workplace, and still be considered a member, albeit perhaps a devalued one. You cannot go on being a member of a gossip clique for long without contributing something interesting and inviting the group, occasionally, to meet at your house.

If we say then that membership in informal groups depends on fluctuations of taste, advantage, and initiative (one could also say graceful manipulation or social resourcefulness), then the connection of network formation and schizophrenia becomes clear. Grace and resourcefulness in social initiatives are precisely the qualities schizophrenics do not have.

Especially, in the acutely psychotic state, and to some extent after it has subsided, the schizophrenic's experience of initiative, distance, and exchange is radically altered. Schizophrenics often feel great anxiety at the simplest initiatives. Their difficulty in carrying out greetings and negotiations with strangers is famous, and is the reason why evidences of thought disorder are especially present in the psychiatric interview. There is difficulty in controlling over social distance. Feelings of pursuits, fusion, and rejection may overwhelm the patient in situations where, for most of us, there is simply the problem of encouraging someone or putting someone off.

The schizophrenic in mid-crisis cannot evaluate a social exchange. He either feels he has nothing to offer or, by compensation, that he has so much to offer, is so important, that others are stupefied by his social potential (delusions of grandeur).

Because of defects in their ability to perceive how social exchange is organized, then, schizophrenics are at a loss in the process of ordinary network formation, which proceeds for most of us by low-risk experimental offerings and invitations, mostly within informal groups.

Most of the time, for most people, the process of making new connections and breaking old ones can be almost imperceptible. On the other hand, there are certain periods of life which are marked by more definite passage from one configuration of formal organization to another: adolescence, entering and leaving college, marriage, divorce, getting a job, moving, retirement. And although the more obvious upheaval in these transitions is in the shift of formal memberships, the accompanying reorganization of informal memberships is also crucial. The ability to develop new informal connections is put to a severe test during these periods. Granovetter (1973) has noted, for example, that getting a job usually requires the mobilization of weak, informal ties.

Adolescence is the passage in which schizophrenia usually makes its first appearance. During adolescence, the transition from dependence on family to a more or less formally recognized peer group of friends (school or college group, gang, workmates), a great strain is placed on the adolescent's ability to make new informal connections in order to explore which peer group he/she will join. The adolescent is out on a social limb, having broken somewhat with his family, having not quite made it into one group, thinking about joining another. In this stage the ability to obtain tokens of acceptance of one's social initiative is very important.

Sullivan (1962) was especially interested in this phase of adolescence and schizophrenia. He pointed out that the experience before or during adolescence of having a "chum"—a companion whose presence assured one of the possibility of being accepted by at least one peer—was essential to passing through this developmental crisis. He also noted that the prodrome of a first schizophrenic episode often contained a rebuff of the young person's social initiative—could be anything from an invitation to go bowling to a proposal of marriage. Such a rebuff may come to signify the whole failure to negotiate the passage, the collapse of confidence in the effect of one's initiatives with new people.

It is congruent with our theory, then, that first and recurring episodes of schizophrenia seem to coincide with the early passages of life. What is such a passage like for the patient who finds himself graduating, not into college, let us say, but instead into a day hospital? I described this in a recent article:

It is the regular experience of patients after an acute schizophrenic episode that they leave the network they were in, where they were regarded as ordinary citizens—and so regarded themselves—and enter a network of people the structure and ideology of which is determined to a large extent by a new label. They lose many old friends, and the support of some relatives, and acquire some new friends almost all of whom are fellow patients, their relatives, and friends. For
some, this means a drop in social class, a distressing change of taste and interest, a crisis in social confidence and competence. Now since disability is such a dominant defining characteristic of the schizophrenic and his network, it follows that the ideology and morale which he, or they, compose in the face of his, or their disability, is crucial. [Beels 1979.]

There are several different possible responses to this network crisis, all familiar to clinicians. One is to deny that the whole thing has happened and substitute a paranoid or other fantastical explanation for why this particular person finds himself in this situation. Another is to retreat into a state of withdrawal where nothing social is happening at all. Another is to accept the same definition of the situation as family and others have, and begin to compose an approach to it. This last response is accompanied by the best prognosis. It has been called "insightful" by students who like to locate such things inside the patient's head. Scott and Montanez (1972) and others have demonstrated that this insightful attitude with its favorable prognosis is strongly related to a particular kind of congruence of view between patient and family, and to certain attitudes which the family members have toward their own participation in the situation. Goldstein et al. (1978), Leff (1979), and Anderson, Hogarty, and Reiss (1980) have all emphasized the importance of common understanding between staff, patient, and family on the nature of the illness and treatment. "Insight," then, is a social phenomenon, requiring the consensus of the group that is participating in the treatment. Such insight, or ideology, is the essential ingredient of morale.

If you consider what goes on between members of organizations such as Soteria House, as described by Mosher et al., of the most effective half-way houses, of the Fountain House rehabilitation program in New York, and Fairweather lodges, you can see that they are networks which have had a certain intense common experience together, and which take pride as a group in their competence in dealing with this affliction. Members find each other jobs, room with each other, come to help one another in crises, and collectively apply skills which they learned together, as a result of their special experience. [Beels 1979, p. 214]

From this point of view, it makes sense that the various self-help groups which have arisen in the mental health field (Alcoholics Anonymous, Mental Patients Liberation, Recovery, Inc., American Schizophrenia Association, and others) are so intensely ideological in their approach to the problem. We who have accomplished our transitions into a high-morale group, such as a psychotherapy guild, tend to forget how confusing the transition was, and how much it helped to have a common (perhaps oversimplified) idea of what it was all about which we shared with the other initiates.

To summarize the foregoing description in terms which could be used in network research, I would say that the schizophrenic crisis is accompanied by a loss of the ability to advance one's career by the development of new relationships. It produces, at least temporarily, a more or less complete reliance on relatively dense formal clusters such as family and hospital or clinic which require little initiative or exchange ("social dues") to maintain membership. This disability of initiative persists to various degrees after the crisis, and the further social career of the patient (development of independence from family and clinic) depends on the availability of other clusters, generally based in other social spaces, where disability and lack of initiative are not a bar to membership (church, self-help group, sheltered work). Indeed, in a positive sense, the ideology—the attitude which such groups have toward disability—may be more important than their structure and organization, formal or informal. Outside of such clusters, as Hammer (1963–64) has demonstrated, single unsupported friendships will tend to be lost as a result of the schizophrenic episode, whereas supported ones (in which a third party is also a friend of the friend) have a better chance of being retained. The third party may be able to moderate the failure of initiative by fostering the connection for the patient.

Cultural Relativity of This Formulation. The description we have just given is culture-bound in the sense that it implies the "healthy" ideal of a relatively independent personal career which has developed to its greatest extent in urban industrial societies and is rather less important in village agrarian societies, where kinship, economic career, and the village society are all closely and formally linked. I want to mention briefly two consequences of this.

One is the confounding of the mobilization of social support with other indicators of major mental illness in our society. That is, in
our urban society, the recruitment and mobilization of social support from a more or less open market of potential supporters is seen by all of us as a life task. Failure in this recruitment is very much bound up with the whole concept of psychiatric illness itself. The proposition can be put this way:

Serious psychiatric illness (especially schizophrenia) occurs together with a relative failure to develop types of social supports which are expected in the life cycle in this culture—that is, movement from family dependency in childhood and early adolescence to (1) steady and gainful employment in the competitive market, (2) intimate and stable relationships in a household independent of original family (what used to be called marriage and children), and (3) a developing circle of friends with whom various social goods are exchanged. The association between defective social supports and schizophrenic illness is thus a clinical commonplace in our society.

Now the causal direction of this association—that is, whether defects of social support produce mental illness or vice versa—is a question which has been raised. I want to emphasize that it should be raised, not to be settled one way or the other, in favor of a nature or nurture model of schizophrenia, but rather to emphasize that the two factors interact with each other to produce better or worse courses of development of the illness. Committed environmentalists can design studies to show the impact of social supports, and constitutionalists can show that neurophysiological vulnerability is important, but neither of them will have provided much help for patients or clinicians.

What we really want to know is, given a certain disposition to the illness, what kind of social supports produce better adaptation? Under what conditions do social factors make more or less difference? As Henderson et al. (1980) have stated, the ultimate approach to this kind of problem will be the experimental manipulation of social supports. Eventually we will try supplying particular kinds of support to well-defined subgroups of schizophrenics (first breaks, good and poor premorbid, etc.). But before doing that we need natural history research, using multiple correlations to discover what we want to manipulate.

The second point is this: Some enlightenment about the interaction of the illness and its social factors is being provided by the natural experiments of cross-cultural comparisons. We may learn more about the nature of social supports in schizophrenia by examining cultures in which the definition of a normal career does not require the recruitment of new connections.

Waxler (1979) has shown, for example, that in Sri Lanka, although the lifetime incidence of schizophrenia is the same as in other countries, both the rate of recurrence of episodes and the subsequent course are, in general, much more benign than in urban societies. She suggests a labeling-theory explanation of this. I would rather emphasize that in such village societies there is no structure outside the family into which deviants can be extruded, so that their failure to label people as deviant is not so surprising. It is more a question of structure. There is evidence (Murphy 1976) that such societies know perfectly well that the person is psychotic and therefore unmistakably deviant. But since the career consequences of this and the consequences for group membership are different in that society than in ours, the course of the illness is different. If our theory of the illness is correct, the course of schizophrenia will be different in a society where a person has to take initiative to find new connections in launching a career, from a society where there is already an acceptable or indeed unavoidable career with its connections provided by family and village structure. The development of informal connections in the latter society may not be so important to a viable career.

### Schizophrenia as a Special Social Experience

Most schizophrenic patients experience a crisis of identity different from that experienced by other “mental patients” such as neurotics, character disorders, etc. Their experience is different even from that of depressives, who may sometimes have a similar decrease of function. Depressives experience considerable pain, lowering of mood, and devaluation of themselves as persons, but especially with modern treatment, they retain the same place and identity in their network, even though they may regard their contribution to the exchange of social goods as strongly on the debit side. They do not experience themselves as radically transformed. Depressives or manic depressives, especially if they have good interval function between episodes, may come to see their periods of illness as absences like the exacerbations of
other kinds of recurrent illness, such as chronic lung or heart disease. The expectation of their network is that when they have recovered, they will be able to regain their old place. An episode of affective illness generally does not, like schizophrenia, leave its stamp upon the whole life and personality.

Some schizophrenic illnesses appear before the patient has been able to have a try at late adolescent independence, or acquire a certain level of school or work experience. These disorders of early onset lead to a more radical sense of incompetence, both in the patient’s expectations of self and in the expectations others have of him. Huffine and Clausen (1979) have documented this for work and career, and Strauss and Carpenter (1974) have pointed out that previous experience in the areas of work and sociability independently predict prognosis in each of these areas.

A schizophrenic episode is also more frightening for the others—the friends and family—than is the case with affective illness. Affective disorder, whatever it is like for the sufferer, is for the others more on a continuum with familiar lesser invalidism such as grief, demoralization, discouragement, fatigue, or physical illness.

For all these reasons, which have to do with the phenomenology of the illness—the persistence of the thought disorder, the difficulty of communication, the altered perceptual world, the need to reorganize experience along paranoid or other uncanny lines of explanation—a person suffering from schizophrenia has a need greater than that of other sufferers from mental illness to reorganize his social life around the specific requirements of his illness or situation. That is why we need to investigate the varieties of reorganizations which have been undertaken by patients who manage to stay relatively free and happy for more of the time than their fellows.

Now consider that the argument I have gone through may be inverted in the following way: We are beginning to discover that some people, whom we used to classify as schizophrenic because in the pre-DSM-III days we singled out their thought disorder as the main sign of their illness, are, on careful examination of their heredity and their responses to drugs, more likely cases of affective disorder (Pope and Lipinski 1978). Like manics and depressives, they had good previous adjustment, later onset, better interval function, and more of a tendency toward episodic illness. But during periods of illness, their behavior and subjective experiences are indistinguishable from those of "true" schizophrenics with a more persistent and malignant course.

Could it be that these patients with atypical affective disorders learned from the way in which their family, friends, and therapists, perhaps especially their hospitals, treated their first episodes? Could it be that they learned to emphasize and pay attention to some more psychotic features of their experience rather than others, so that they develop more schizophrenia-like symptomatology when they fall ill again from time to time? This is a speculation of mine based on some experience. If it is so, the manner of handling first episodes is crucial, and we should begin to see a different phenomenology of psychosis appearing in patients whose first episodes were dealt with in experimental programs such as Soteria House (Mosher, Menn, and Matthews 1975). Further, there may be features of network organization and attitude at the time of first illness which are fateful for the aspects of the experience which the patient and others learn to identify as the essential, and therefore expectable and recurrent, features of going crazy.

This hypothesis could be investigated by a retrospective study of the circumstances of the first episode in different groups of patients, and confirmed by prospective studies of cohorts from very different institutions.

Clusters and the Social Support of Schizophrenia

Hammer (1980) notes that a person’s typical network of about 40–50 people frequently seen is made up of five or six clusters—groups of people richly connected to each other. There are very few members of the network who are connected only to the informant and not to anyone else (unsupported connections), and there are several connections between clusters (spans). She also notes that schizophrenic individuals, by comparison with normals, appear...
to have not only smaller networks, but are also characterized by:

- Few clusters.
- More unsupported connections.
- Few spans.

These facts and their relation to schizophrenia are important because, as Hammer (1963–64) has also demonstrated, after an admission to a psychiatric hospital, the chances of losing an unsupported connection are greater than those of losing a supported one. A cluster can thus be seen as a collection of mutually supported connections which are unlikely to be severed in a crisis.

Clusters can be further classified by whether or not they are supported by a formal group, in which a person does not have to exert his initiative or pay his dues. Drop-in centers, day hospitals, and keep-in-touch clubs are organizations of relatively effortless sociability which professionals have set up for schizophrenics. We want to be able to identify other such groupings which arise naturally in the community to see whether they can substitute for professionally sponsored ones. Does a bar or a lunch counter function this way, for example? What are the qualities of atmosphere or sponsorship that promote this kind of cluster formation? One way to identify such groupings in the community is to take note of the kinds of social spaces—the actual buildings or rooms—that they occupy. We need to examine the ways in which chronic or recurrently schizophrenic persons find alternative clusters to those offered by their ethnic group for the normal pursuit of a career, the extent to which those clusters are supported by formally located organizations, the ideology and atmospheres of those organizations and places, and the extent to which, in some ethnicities (as Garrison, 1978, has pointed out for Puerto Rican women) these clusters occur naturally, independent of formal organizations.

**Social Supports, Social Class, and Ethnicity**

Different lives, as defined by social class or ethnicity, imply different network characteristics. This is most dramatically illustrated by Poole and Kochen’s (1978) data on personal networks of blue-collar workers, white-collar workers, and professionals. Blue-collar workers see almost half their network more often than twice a week, and less than a quarter more rarely than once a month. Professionals, on the other hand, have networks which are more than twice as large in total as those of blue-collar workers, and more than half of those contacts are rarer than once a month. (White-collar networks are intermediate on most of these measures.) Thus, blue-collar workers inhabit small, compact worlds of considerable stability, but, as Hammer notes, they are more vulnerable to change, such as job change or migration. Professionals, on the other hand, maintain far-flung networks with a small core of frequent contacts and a large perimeter of rare contacts, and those many rare contacts are used for making connections needed for new information or movement. It is a network adapted to a changing career.

These observations may be related to the fact that upper- and middle-class schizophrenics often move downward in the class structure (“downward drift”). They cannot maintain the large periphery that supports professional and middle-class position. And whether they drifted down or were born into the lowest class, people with a predisposition to schizophrenia will hardly be supported there without professional intervention. Studies of social networks by Stack (1974) and Liebow (1967) in Black inner-city Class V society show that constant attention to informal social connections is a condition of survival in that class. The high rate of treated schizophrenia in Class V is probably due in part to the demands of daily life. Hustling and swapping are not things schizophrenics are good at, and their friends and family have too little left over from their own scramble to be able to maintain them without strong institutional support.

To give just a few examples of how ethnicity dictates the organization of networks in ways which are important to the course of schizophrenic illness:

1. White, middle-class, unmarried patients have difficulty negotiating the “independence” phase of their development in which they are supposed to live apart from families of origin and choose friends and a career. The halfway house movement has provided a substitute transition period with social supports (Budson and Jolley 1978; Beels 1978). More recent immigrant groups (Italians and Hispanics, for example) do not expect unmarried young people to go through such a phase of independence from family, but rather to go directly to marriage. This presents other problems for
schizophrenic offspring who need some acceptable exit from the family other than marriage.

2. Flexibility of child-rearing arrangements in the extended American Black family provides face-saving relief for mothers going through periods of crisis and an acceptable definition of the relationship between women in the family during the mother's incapacity (Stack 1974). Thus, unlike her isolated suburban counterpart, a Black woman in an urban lower-class extended family can fit into the flexible child-rearing network by helping to care for children even while she is quite disabled in other respects, and if she is herself a mother, she can get help taking care of her children from such a network, without having any of these arrangements labeled as deviant by the family, and sometimes without creating excessive strain for the others.

3. A small group of Albanians in a Bronx catchment area faced special problems of language, immigration barriers, and family attitudes toward psychosis which were insoluble without the intervention of the priests of their church. Psychiatrists at the local clinic worked with the priests as co-therapists in crisis intervention and achieved synergies of religious and medical authority which provided relief and avoided hospitalization in otherwise unmanageable situations (Weiser 1974).

4. Garrison (1978) has shown that Puerto Rican schizophrenic women, who would otherwise have difficulty locating social supports, acquire self-definition, purpose, and support from being members of spiritist cult groups. She described seven patterns of nonkin network organization among Puerto Rican women in the Bronx, and showed how patients of different symptomatology and histories of hospitalization fitted into each of these available ecological systems. From a network standpoint, Garrison's classification defines a variety of nonkin clusters with different membership requirements and patterns of initiative.

What is needed is detailed attention to the modal and variant forms of organization of social networks in different ethnic groups so that the strengths and weaknesses of these forms can be related to the problems faced by patients of particular age, sex, and diagnosis. Garrison provides a model of field work and ethnography by which this can be done.

Application of These Concepts to the Literature and to the Design of Further Investigation

There are two directions in which this discussion should go. One is toward a review of the existing instruments for the measurement of social support in schizophrenia, and we are undertaking such a review for publication elsewhere. Some of the considerations we will take up will be the evaluation of:

- Network structure, size, density, balance of exchange with the respondent, multiplexity of ties, frequency, and range of sources from which connections are developed—all measures familiar from other reviews.
- Definition of clusters and spans.
- Ease of access and "dues"—formal or informal—that need to be paid for membership.
- Attitudes or atmospheres of clusters with respect to disability.

For reasons I have developed here, these are matters of concern in approaching schizophrenia in general.

A second direction would be to see whether these ideas are consistent with findings of studies that have distinguished between subgroups of schizophrenics with different courses of illness. I will conclude by giving just three examples of how these ideas can be applied to clinical studies which I find particularly interesting.

The Expressed Emotion (EE) Studies. Probably the most quoted and best replicated measure of the quality of social supports in schizophrenia is Brown, Birley, and Wing's (1972) "expressed emotion" (EE) rating—a count of critical or rejecting remarks recorded during an interview with the relatives of patients shortly after the patient is hospitalized. The interrater reliability of this rating (made on sound recordings of the interview with the relative—usually a parent) is generally around 0.8. It predictsrehospitalization if the patient returns home to that family. The numbers are impressive: In a sample of 101 patients returning home, 58 percent of the high EE group relapsed as compared with 16 percent of the low EE group. The development of the EE measure is well reviewed by L. Kuipers (1979).

What is of interest for our purpose is Vaughn and Leff's (1981) work, described in this issue, on the correlates of high EE in such families, and the use of these concepts in treatment described by Leff (1979). Brown et al. (1972) noted in their earlier work several
features of high and low EE families.

1. Patients in low EE families needed less medication than those in high EE families; that is, failure to take medication was related to early relapse in high but not in low EE families. Thus, medication buffers the effect of EE.

2. The effect of high EE could be reduced by reducing the amount of contact between parents and patient: arranging a day program for the patient, having a work schedule such that the parents were asleep when the patient was up and vice versa. Thus, space and distance buffer high EE.

3. Parents with low rates of contact with friends and relatives outside the house, with no one else besides the patient at home, and single parents with no one else but the patient at home were all more likely to register high EE. Thus, EE may be partly a function of social space.

The connection of the last two points to network characteristics—household composition and number of social spaces or clusters available—is interesting. Before relating them to our discussion, however, some additional points should be made:

1. The EE measure may not hold up across cultures. It has failed to predict relapse in a New Delhi sample which registered a very low rate of EE altogether (Day 1979). In the samples where it is a very strong predictor of relapse, it may be an indicator of attitudes which can be measured in another way.

2. Vaughn and Leff’s (1981) work suggests what some of these attitudes might be. They found a high correlation of EE with

- Intrusiveness.
- Feeling the patient’s illness status was unjustified.
- Disappointment.
- Pressure on the patient to act normally.

This somewhat contradictory set of attitudes is recognizable from clinical experience with adverse family atmosphere in schizophrenia, and it is easy to see how such a set could coincide with social isolation and a sense of patient and parent being “trapped” with each other. If in addition there is no other space for either to move in, the only “out” is to send the patient back to the hospital.

3. Leff (1979) has had therapeutic success with an essentially network-oriented intervention for the treatment of high-EE families. He puts them into parent groups with low-EE families and notes that they learn other ways of dealing with their patient—offspring in the course of the treatment. The meeting with the other families provides a new social connection, not for the patients, but for the parents primarily.

Similarly, Anderson, Hogarty, and Reiss (1980) have designed a program of family treatment which includes an all-day seminar and discussion group with other families, the effect of which is to focus common definitions of the problem and acquaint them with other people who have had the same experience, in order to enhance their social network in the face of the challenge to understanding and morale.

Evaluations of these treatment programs are now underway, and include measurement of change in social structure surrounding the family. This whole line of thinking recognizes that the family as a context for the patient is most strongly influenced by the family’s own context, its structure, and attitudes.

Scott and Montanez (1972). These English investigators contribute another way of looking at morale and problem definition in the family. They divided a sample of schizophrenics who had families into (1) those who in the previous 2 years had been mostly in the hospital, and (2) those who had been mostly out with families. One striking finding at the outset is that this is a population with a strongly bimodal distribution: if “out” is defined as 40 percent of the time hospitalized and “in” as 90 percent of the time hospitalized, only 15 percent of the population falls between those two groups.

When the patients and parents were given an adjective checklist describing self and others, the two groups differed strongly in this way: The “out” patients and parents were congruent with each other, defining the problem as being with the patient, and there was fair agreement on attributions of “sick” or “well” characteristics to family members. The “in” patients, on the other hand, regarded their parents as sick, and whereas there was much greater incongruence of attributions in the “in” families, the parents tended to rate their own strengths lower than did the “out” parents. This study again suggests the importance of congruence and coherence of definition of the problem (shared “insight”) and attitudes toward disability within the important cluster of the family.
The study also brings to mind a possible negative aspect of what appears to be positive social support. That is, only two alternative social spaces appear to be available to the patient: family or hospital. If the congruent attitudes of patient and family keep the patient from returning to hospital, they may keep him from going anywhere else either. (It is perhaps in the same sense that, for the prostitute whose alternative is jail, the congruent attitudes of the pimp and madam may lead to a very stable life.) What would happen to the patients in Scott and Montanez's study if patients in each of these groups, "in" and "out," were skillfully introduced to other social spaces? Would their responses be different one from another, and in what way?

Lehmann's (1980) Studies of Hotels. Turning finally to the study of other clusters besides family, we find an outstanding example of the combination of attitude survey and social structure analysis in Lehmann's (1980) work on Manhattan single-room-occupancy (SRO) hotels. Lehmann and his colleagues, in a series of progressively refined surveys of hotels where psychiatric patients predominate, found that measures of life satisfaction and high social function among patients were strongly associated with casual rather than intimate or nurturing contacts within the hotel. "The more intense (intimate or affective) social relationships either make small negative contributions to the criteria, or none at all." The other, nonpatient residents seem to value the hotel's social life for itself, but the patients experience it as a background condition for their relativley quiet and isolated experience of satisfaction and activity. Also, contacts with relatives and others outside the hotel are negatively associated with patients' satisfaction and well-being. My guess would be that these contacts are single visits not associated with some other social space or cluster and experienced by the patient as a demand more than a support—but that would be a question for further research. The important thing here is that the hotel, as a social space with a certain perceived atmosphere, is more associated with positive outcome for ex-patients than are some of the expressive or involving types of contact which nonpatients need, and in which they participate.

Lehmann notes that we do not know the direction of cause in these relationships, and argues, as I have done, that trying to resolve it is inappropriate: "Specific forms of social relationships are associated with specific kinds of effects." A study like this does, however, suggest the design of experimental programs in which certain kinds of social atmosphere, tolerance of deviance, optimal distance, and background activity are promoted. We can only promote them if we learn more about how to describe them.

Summary

This essay connects the phenomenology and natural history of schizophrenia with studies of its social contexts, especially studies of "social support" and the course of the illness. Precision about what is meant by support and what is meant by schizophrenia yields important distinctions concerning the relevance of social factors in different diagnoses. The normal development of social networks in stages of the adult career in our culture is suggested as a key to the analysis. The demands of this task vary with sex, social class and ethnicity. This may affect variations in the course of schizophrenia. A particularly important dimension of the networks of schizophrenics is the way in which they are divided into clusters. Some relevant characteristics of clusters are proposed in the light of recent research.

References


Brown, G.W., and Harris, T. Social Origins of Depression: A Study Of


World Congress of Biological Psychiatry

The World Federation of the Societies of Biological Psychiatry and the Swedish Society of Biological Psychiatry announce the Third World Congress of Biological Psychiatry, to be held in Stockholm, Sweden, June 28–July 3, 1981. Each day a plenary session will be followed by two or three symposia suggested by the various societies. Participants are invited to structure reports either as oral presentations or as posters. Abstracts will be made available.

Preliminary deadline for papers: February 1, 1981.

English, French, and Spanish will be official languages. Simultaneous translations from and into these languages will be arranged.

Exhibitions will display new equipment in experimental disciplines relevant to biological psychiatry, as well as drugs used in treatment and research.

An attractive social program, as well as pre- and postcongress tours will be offered by the Congress Committee to participants and all accompanying persons. Weather in Sweden is generally at its best in June, with an average temperature of 20–23°C, light evenings, and short nights.

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