

AN ABSTRACT OF THE THESIS OF

Donna G. Kilgore for the Master of Science

in Psychology presented on November 2, 1998

Title: The Effects of Social Support on Psychiatric Patients

Abstract approved: Cooper B Holmes

This study examined how a socially supportive Compeer relationship contributed to sustained, community based living and its impact on psychiatric hospitalization rate and length of stay. Participants were psychiatric patients divided into two groups consisting of patients who had been involved in a supportive Compeer relationship and patients who had not. A therapeutic Compeer relationship was defined as an ongoing Compeer match lasting for a minimum of one year.

Results of two t tests indicated no significant difference in regard to number of incidents of psychiatric hospitalization and the total number of days spent in the hospital for mental health patients who do or do not have a supportive Compeer friendship. A correlation for the data revealed that number of admissions and length of stay were significantly related.

Additional research was suggested to investigate other variables such as previous hospitalizations, managed health care, attendant care, and intensive case management as they pertain to psychiatric hospitalization. Also, further research should focus on the practical aspects of a Compeer relationship investigating perceived quality of life and social support for psychiatric patients.

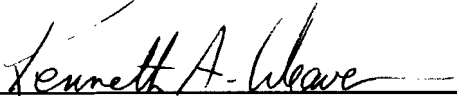
**THE EFFECTS OF SOCIAL SUPPORT
ON PSYCHIATRIC PATIENTS**

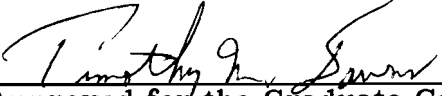
**A Thesis
Presented to
the Division of Psychology and Special Education
EMPORIA STATE UNIVERSITY**

**In Partial Fulfillment
of the Requirements of the Degree
Master of Science**

**by
Donna G. Kilgore
December 1998**

Thesis
1998
K.


Approved for the Division of
Psychology and Special Education


Approved for the Graduate Council

ACKNOWLEDGEMENTS

I would like to thank my parents, Orville and Doris Kilgore, for their encouragement and generous financial support during this endeavor. I would like to express my sincere appreciation to my thesis committee, Dr. Cooper Holmes, Dr. David Dungan, and Dr. Gene Plank for their guidance in this project. A special thank you to Dr. Ken Weaver for graciously serving on my thesis committee following Dr. Plank's retirement. I would also like to thank my supervisor Jayme Collins and Dr. John Randolph for their patience and unconventional methods of motivation. I would like to thank Dr. Jan Wheeler for her assistance in helping me cope with unbearable anxiety. I would like to thank the wonderful June Hubert for her kind spirit and words of inspiration: my dear friend Sharyn Edwards for her continued words of encouragement and anonymous help; Liz Hull for her friendship and continuous encouragement; Jo Mauldin for her early morning, mid morning, early afternoon, mid afternoon, early evening and late night pep talks and really believing this project would see its end; and Leslie Smith and Angela Henderson for gently (depends on how you define gently) prodding me along.

Thank you to Adam Roberts for assisting with analysis of the data. I would like to dedicate this thesis in honor of Don Daniels and his tremendous sense of bone tickling humor and genuinely caring if this thesis project was finished.

Thank you to Gary Gooszen and the Mental Health Center of East Central Kansas for access to the needed data for this study.

Thank you, God, for making a stream in the desert and a road in the wilderness. There is none like you.

TABLE OF CONTENTS

ACKNOWLEDGEMENTSiii
TABLE OF CONTENTS.	iv
CHAPTER 1 INTRODUCTION1
CHAPTER 2 METHOD.13
Participants.13
Procedure.	13
Statistical Analysis	13
CHAPTER 3 RESULTS	15
CHAPTER 4 DISCUSSION.16
REFERENCES	18

CHAPTER 1

INTRODUCTION

The importance of social support in the lives of persons diagnosed with mental illness has been a focal point in the research literature for the past 20 years. Researchers have acknowledged the life enhancing effects social support provides for persons with chronic mental illness (Schoenfeld, Halevy-Martini, Hemley-Van der Velden, & Ruhf, 1985). The past two decades have evidenced a steady deinstitutionalization of the mentally ill and a great need for efforts to establish viable community supports which enable the mentally ill to sustain independent living (Stroul, 1989). Patients once considered as only appropriate for long term inpatient hospitalization, as well as those thought of as never being able to leave the confines of a state mental hospital, are being discharged into the community. It is imperative that community-based supports are in place to promote a successful transition.

Community based supports are those resources enabling the mentally ill person to function in society. These resources include relationships with family, friends, mental health professionals and self help groups. This social network is then available to help with life areas such as housing, income, transportation, recreation, medication management, socialization and legal issues. Inadequate support in any of these life domains would hinder community adjustment (Freddolino, Moxley, & Fleishman, 1989).

For persons with mental illness, a lack of adequate support in any of these crucial areas may create stress, which can contribute to an individual reaching the point of feeling overwhelmed. This sense of

overwhelming stress is a major contributor to mental decompensation leading to psychiatric hospitalization. This precursor of hospitalization can be substantially reduced if the mentally ill persons know about and utilize community supports that are available to meet their needs (Sokolove & Trimble, 1986). Utilizing community resources may lead to reduced incidence of psychiatric hospitalization with fewer days spent in the hospital.

Review of the Literature

Social support refers to a network of individuals who interact within a supportive framework to meet the needs of a mentally ill person. O'Connor (1983) defined a social support network as "the emotional, informational and material support provided by friends, relatives, neighbors, service providers and others with whom one has an ongoing relationship and to whom one can turn in times of need or crisis" (p. 187).

According to Kayloe and Zimpfer (1987) and Stroul (1989), two of the most successful professional mental health services for socially engaging mentally ill persons are case management and psychosocial rehabilitation. Psychosocial rehabilitation is often incorporated in recovery efforts of self-help groups for the mentally ill.

Professional Mental Health Services

Recently discharged mental patients without support, as well as marginally adjusted mentally ill persons already living in the community, are at risk of rehospitalization. In 1977, to combat this problem, the National Institute of Mental Health designed the Community Support Program. Community Support Programs provide a broad range of services for mentally ill persons beyond traditional mental health services (Turner &

Tenhor, 1978). Patients also need community outreach services that provide assistance with such practical matters as finding a place to live, getting a job, applying for and managing entitlements, obtaining health care, and socialization (Biegel, Tracy, & Corvo, 1994).

Deinstitutionalized mental patients are characterized as passive and lacking motivation to seek out and actively utilize community resources (Stein & Test, 1980). Case management links recently discharged psychiatric patients and mentally ill persons living in the community to community based resources (Baker & Weiss, 1984) such as Social Security, the Department of Social and Rehabilitation Services, the Resource Center for Independent Living, ECKAN, Salvation Army, Vocational Rehabilitation, Job Service Centers, and technical schools and colleges.

Baker and Weiss (1984) interviewed patients receiving case management services to determine how case managers assisted clients with their daily functioning. Patients felt at ease with their case managers and attributed this to their case manager's nonthreatening demeanor and peerlike friendliness. Case managers helped patients with such issues as getting involved in social activities, providing transportation, acquiring housing, mediating disputes with landlords, arranging medical services and teaching appropriate hygiene. Knowing their case manager was available to help when needed decreased vulnerable feelings and contributed to the success of community adjustment. These authors suggested the success of case management is due to working with patients on solving practical problems and developing life maintenance skills instead of focusing on symptomatology. Lamb (1980) stated "the goal, then, is to expand the remaining well part of the person and thus his functioning rather than to

remove or cure pathology; the focus should be on the healthy part of the personality and the person's strengths" (p. 763).

Goering, Wasylenki, Farkas, Lancee, and Ballantyne (1988) reported the outcome of a rehabilitation-oriented case management program. Eighty-two patients discharged from an inpatient setting who received case management were compared to a control group of 82 patients discharged from the same institution prior to the implementation of case management services. At a two year follow up, the case management group improved occupational functioning, was less socially isolated, and lived in more independent housing than the control group. There was no difference, however, between the experimental and control group in hospital recidivism. This result was attributed to more attention being given to the improvement of daily functioning instead of crisis intervention. Medication, residential, case management and psychosocial support services must be maintained or relapse is almost certain (Test, 1981).

Timms (1983) stated that recently discharged psychiatric patients lose the social supports of both patients and hospital staff. Mitchell and Birley (1983) addressed the benefits of a 24 hour continuously open hospital ward utilized for social support by psychiatric outpatients. Mentally ill persons at risk of decompensation were encouraged to attend the ward. Nurses kept track of the reasons ex-patients gave for coming to the ward. The need for professional help, material support, social support and acceptance encompassed the reasons given by ex-patients. These researchers identified two types of ex-patient groups. The socially engaged group had a later onset of illness, made fewer visits to the ward and had a larger social network than the socially unengaged group who had an early onset of

illness, made frequent visits to the ward and had an impoverished social network. The behavior of the socially unengaged group made it obvious how their social supports had diminished. Some ex-patients visited the ward to socialize while others used the ward as a social backdrop. This permitted ex-patients to interact according to their comfort level. Ex-patients were permitted to come and go as they pleased which allowed the ward to fit the patient's need for social support.

Mentally ill persons often have social skill deficits which prevent them from initiating or maintaining personal relationships (Mitchell & Trickett, 1980). Another psychosocial rehabilitation program described by Adler (1977) is the Michigan based Traverse City Friendship Center. This walk-in activities center was designed for use by prerelease inpatients as well as those already discharged into the community from the Traverse City State Hospital. It was created with the notion that many chronically mentally ill persons fail in seemingly adequate community placements because they lack social and decision making skills. This walk-in activities center provided a setting where patients could interact with others. Activities included drinking coffee and visiting, working on a craft project, and role-playing.

Patient Driven Self-Help Programs

Chronically mentally ill persons benefit from a variety of treatment options to avoid hospitalization and sustain themselves in the community. Patient run self-help programs are organized and operated by patients for patients. Patient self-help groups can offer a relaxed, less structured alternative or adjunct to traditional professional mental health services (Mowbray, Wellwood, & Chamberlain, 1988). Group members can facilitate the development of coping skills and methods of problem solving through

the sharing of mutual experiences. Wortman and Lehman (1984) suggested that people perceive the most effective support as coming from someone who has the same problem. Mathews, Mathews, and Pittman (1985) noted self esteem increased among patients who were helping other patients.

Mowbray, Chamberlain, Jennings, and Reed (1988) reported on the benefits of the patient self-help networks. In the early 1980s, the Michigan Department of Mental Health allocated funds for patient run demonstration projects. These projects were intended to encourage mutual help among patients in promoting successful daily living. Also, it was thought that mental health professionals might refer their patients to these groups as an adjunct to professional treatment.

Project Ease-Out enlisted four former patients to meet with 25 hospitalized patients and to track them in the community upon discharge. These advocates assisted recently discharged patients in linking them with resources that provided social activities, medication management, transportation, housing, and income. A patient satisfaction survey indicated a positive outcome. There were no drop outs from the program, five patients graduated no longer needing services and only one patient was rehospitalized. Closely related, Project Stay involved ex-patient volunteers who responded to patient requests for assistance with daily living needs. These patients were similar to psychiatric inpatients in regard to level of functioning and were thus prone to hospitalization. A total of 9,560 patient requests were helped by the ex-patient volunteers. It is likely the ex-patient volunteers enhanced their own ability to maintain successful independent living by helping others acquire resources they themselves had once used.

Another pilot project, The Companions Program, matched community volunteers in one-on-one relationships with persons with mental illness to spend time together visiting and incorporating them in normal social activities. The importance of the need for this program was evidenced by few terminations and most matches lasting more than six months.

There are several reasons why patients attend a drop-in center. Mowbray and Tan (1993) reported members' perception and evaluation of patient run drop-in centers. Members indicated that support was the main reason they came to the drop-in centers. The majority of members felt the center belonged to them and that they had input into what went on at the center. Most members went to the center because they made the "choice" to do so and felt accepted by one another. Members claimed the drop-in centers impacted their lives in positive ways. Some members had volunteer or paid jobs; others attended school. Since attending the drop-in centers, many members had fewer instances of psychiatric hospitalization, abused alcohol and drugs less, and did not use professional mental health services as often.

Kurtz and Chambon (1987) examined three psychiatric self-help organizations: Recovery, Inc., Emotions Anonymous, and GROW International. The purpose of Recovery, Inc. is to control tension-producing self-defeating thoughts which accentuate symptoms. Seemingly insurmountable problems are broken down into small, achievable tasks. Recovery, Inc. is open to former mental patients and those who describe themselves as "nervous." Incorporating the philosophy of Alcoholics Anonymous, achieving serenity and peace of mind are the goals for

members of Emotions Anonymous. Emotions Anonymous believes peoples' severe emotional problems can be attributed to their focusing so intently on the negative aspects of life that eventually minor problems are considered devastating. GROW recruits hospitalized or recently discharged mental patients for membership. Members focus on becoming mentally, socially and spiritually mature. These self-help organizations promote cognitive change which helps members reevaluate how they view life's problems.

Another component of a mentally ill person's social network is the family. A family's social resources influence its mentally ill relative's opportunity to develop interpersonal relationships. Brown, Birley, and Wing (1972) found that people with schizophrenia residing with their families experienced a more favorable prognosis when their parents had a sizeable network of their own. Also, families who possess greater external resources may be better suited to manage the stresses and strains and tolerate crises of a mentally disturbed family member living with them (Mitchell, 1982).

Family members should be more than passive bystanders regarding their relative's mental health treatment. This starts with educating family members about their relative's mental illness and incorporating them in assisting the case manager in accessing community resources. Family members should have a part in connecting their relative to services, checking to see how their relative is doing, helping with daily living, intervening when problems arise, and advocating for consumer rights (Biegel, Tracy, & Corvo, 1994).

Family members who provide support to their mentally ill relatives also need support. Family members can be employed to solicit other family

members of persons with mental illness to come to a family support group (Intagliata, Willer, & Egri, 1986). Craig et al. (1987) suggests gathering family members together to discuss ways to support their relative, relatives having a getaway time while another support fills in, and hooking families up with support groups like the National Alliance for the Mentally Ill. Crotty and Kulys (1985) reported that caregivers felt less burdened when they were part of a mentally ill person's supportive network that had many members.

The research literature on persons with mental illness and social support contains a significant number of ways both mental health professionals and patients can enhance the structure and function of patients' social networks. Mentally ill persons have a substantially smaller social network than persons who do not have a mental illness (Hammer, 1963-1964). This small social network is associated with multiple hospitalizations. Members of a small network may not be available during a crisis (Cohen & Sokolovsky, 1978). Repeated hospitalizations decrease the number of social supports for a mentally ill person. Network members may drift away after the patient has been absent from the community for some time (Lipton, Cohen, Fischer & Katz, 1981).

Atkinson (1986) believes it is not so much the size of a person's social network as it is the internal structure of the network which determines its effectiveness. A similar opinion is shared by Baker, Jodrey, Intagliata, and Straus (1993) who found it was not so much the amount of support available that contributed to improved functioning but that the support fit the person's needs at the time support is needed. In a previous study Baker, Jodrey, and Intagliata (1992) used the Bradburn Positive and

Negative Affect Scales and the Satisfaction with Life Domains Scale (SLDS) to assess the adequacy and availability of social support. These authors found a significant correlation ($r = .21$, $p < .001$, $n = 657$) between availability of social support and positive affect. Although there was a significant relationship between adequacy and availability of social support to the SLDS, adequacy of social support was related to a lesser degree than availability of social support. This higher degree of availability of social support was attributed to mentally ill persons having opportunities for socialization wherein they can observe others' behavior to determine appropriate social interactions.

Biegel, Tracy, and Corvo (1994) discussed ways to strengthen social networks through constructing new network ties. Network strategies involved in strengthening social networks include creating a flexible network, adding clusters to an existing network, and connecting network members.

A flexible network contains members who are capable of performing more than one task. A flexible network member may provide emotional and instrumental support. For example, the network member may comfort a mentally ill person during a time of crisis as well as provide transportation to the grocery store. Adding clusters to an existing network increases the size of the network. Clusters are added by introducing the patient to a group of people such as a church, a community group, or volunteer project. Connected network members know and support one another in meeting the needs of the patient. A connected network facilitates communication and enhances service delivery. Reissman's (1965) helper-therapy principle postulates that network size can be increased through

reaching out and helping others .

The Compeer Program is a prime example of network linking. Compeer believes that people recovering from mental illness need the type of social support a friend would provide. Compeer matches persons suffering from mental illness with a non-mentally ill person in a supportive friendship relationship (Tulumello, 1990). The Compeer Program grew out of what was originally known as the "Adopt a Patient" project. After reading a magazine article entitled "Adopting Forgotten Mental Patients," concerned citizens contacted the Mental Health Association, which in turn formed a committee to assess the need for a friendly visitor program (Skirboll & McLaughlin, 1990). Established in 1973 and sponsored by the Rochester-Monroe County chapter of the Mental Health Association, the "Adopt a Patient" project matched 12 community volunteers with 12 psychiatric inpatients at a local state hospital (Skirboll & Pavelsky, 1984). In 1976, under the direction of a progressive leader, the "Adopt a Patient" project was renamed Compeer, which according to Webster's dictionary, means companion, equal, or peer. Promoting a relationship of equality was considered a more effective marketing strategy to recruit volunteers (Skirboll & McLaughlin, 1990).

Mental health professionals have been pleased with the positive ways the Compeer match has benefited their patients. Therapists have noticed a decrease in feelings of loneliness and isolation while self-esteem and confidence in social relationships has improved. Therapists also viewed the Compeer match as a positive supportive relationship which was available for their patient on a regular basis and helped to increase knowledge of community resources (Skirboll & Pavelsky, 1984). A 1991 survey indicated

that out of 152 therapists, 89% viewed their patient's Compeer relationship as helpful. Nearly 33% of therapists remarked that their patients matched with a Compeer evidenced a reduction in psychotic symptoms and two-thirds stated their patients felt more secure due to the relationship. Improved self-esteem was noted for 54% of patients participating in the Compeer Program (Skirboll, 1994).

The purpose for conducting the present study was to determine whether or not rate of hospitalization (number of admissions) and length of stay (number of days in the hospital) are affected by being matched with a Compeer individual in a supportive relationship. The hypothesis was that chronically mentally ill persons who had been matched with a Compeer individual in a supportive relationship would have fewer incidents of psychiatric hospitalization and would spend fewer days in the hospital than chronically mentally ill persons who do not have the socially supportive benefits of a Compeer relationship.

CHAPTER 2

METHOD

Participants

The sample for this study was comprised of 32 chronically mentally ill adult Kansas residents, 8 men and 24 women, aged 35 to 68 who had received mental health outpatient services at the Mental Health Center of East Central Kansas, Emporia, Kansas. Their primary diagnoses, as defined by the DSM-IV, were schizophrenia, personality disorders, schizoaffective disorder, bipolar disorder, and major depressive disorder (American Psychiatric Association, 1994). One group of 16 participants were involved in a Compeer friendship for a minimum of one year during the 1991-1998 time frame. The participants who had a Compeer were identified by information provided by the local Emporia, KS Compeer program. A second group of 16 participants were not involved in the Compeer program. The two groups were matched for age, gender, and diagnosis.

Procedure

Statistical information needed for this study was obtained from two different agencies. A computer-generated printout was obtained from the Mental Health Center of East Central Kansas. This printout contained the age, gender, and diagnosis of all chronically mentally ill persons currently receiving, or who had received, mental health services. The Director of the Emporia Compeer Program provided a computer-generated printout indicating the name of the Compeer volunteer, and the name of the patients who had been matched for a minimum of one year. A review of patient charts, specifically the emergency contact sheets and chart summaries, provided information as to the number of hospital admissions and length of

hospital stay during the year of Compeer involvement. In some cases, it was necessary to contact the social worker at the psychiatric hospital to provide information regarding number of admissions and length of stay that was not recorded in patient charts.

CHAPTER 3

RESULTS

The number of psychiatric hospital admissions and length of hospital stay for mental health patients who did or did not have a Compeer friendship were obtained. These data were used to investigate differences between the two groups.

Since there were two dependent variables, two t tests were conducted to determine if there was a significant difference in regard to number of incidents of psychiatric hospitalization and the total number of days spent in the hospital for mental health patients who did or did not have a supportive Compeer relationship.

The outcome of two t tests revealed no significant difference in regard to number of incidents of psychiatric hospitalization and the total number of days spent in the hospital for mental health patients who did or did not have a supportive Compeer relationship. The Compeer relationship had no effect on number of admissions between patients who had a Compeer ($M = .25$, $SD = .77$) and patients who did not have a Compeer ($M = .69$, $SD = 1.2$); $t(32) = -1.23$, $p > .05$, two-tailed. The Compeer relationship had no effect on number of days spent in the hospital between patients who had a Compeer ($M = 10.88$, $SD = 39.68$) and patients who did not have a Compeer ($M = 16.19$, $SD = 40.12$); $t(32) = -.38$, $p > .05$, two-tailed. A correlation for the number of admissions and length of stay for the Compeer group was significant, $r = +.98$, $n = 16$, $p < .05$. A correlation for the number of admissions and length of stay for the non-Compeer group was significant, $r = +.76$, $n = 16$, $p < .05$.

CHAPTER 4

DISCUSSION

The purpose of this study was to determine whether or not rate of hospitalization (number of admissions) and length of stay (number of days in the hospital) would be affected by being matched with a Compeer. Participants were divided into two groups consisting of patients who had been involved in a Compeer relationship and patients who had not. A Compeer relationship was defined as an ongoing Compeer match lasting for a minimum of at least one year. No significant difference was found regarding number of admissions and length of stay between psychiatric patients who were or were not involved in a Compeer relationship.

One limitation of this study is the size of the sample. Compeer is a relatively new program and the majority of Compeer matches exist less than a year. As a result, the data set was limited to 16 participants who had been matched in a Compeer friendship for a minimum of one year. It is important to note that only limited conclusions can be drawn from such a small sample size. This nonsignificant finding may be related to limited statistical power because of small sample size. Drawing the conclusion that there is no difference with regards to number of psychiatric admissions and length of stay between patients who did or did not have a Compeer may be premature.

Another limitation of this study is examining only one source of social support. Since Compeer is a type of friendship referral service, patients referred for a Compeer may be individuals who are unable to sustain friendships without the structure of a professional agency that monitors

frequency of social contacts and promotes agency sponsored social outings. Patients involved with Compeer may actually have limited social contact. Patients who have additional social supports likely have increased opportunity to further enhance their social networks. More recently, mental health services such as attendant care and intensive case management have offered psychiatric patients additional support.

For some individuals, the severity of mental illness combined with inadequate coping strategies may override even the best support system. Persons with mental illness often have to deal with the cyclical nature of their specific illness. Persons suffering severe mental decompensation, triggered by biochemical abnormalities, are typically stabilized through inpatient hospitalization and medication adjustments. These incidents may be unaffected by any degree of social support.

Another explanation for the results is that Compeer does not work. A Compeer relationship may have no bearing on the number of admissions or length of stay for psychiatric hospitalization.

This study offers suggestions for future research. It would be interesting to look at previous hospitalizations prior to Compeer involvement to determine if Compeer involvement reduced the number of psychiatric admissions as well as length of hospital stay. Other variables to consider with regard to psychiatric hospitalization are the current trend towards managed health care and the recent implementation of attendant care and intensive case management as additional supportive mental health services. Further research could focus on the practical aspects of a Compeer relationship investigating perceived quality of life and social support for psychiatric patients.

REFERENCES

Adler, I. (1977). A walk-in activities center to help prerelease patients improve social functioning. Hospital and Community Psychiatry, 28, 181.

American Psychiatric Association. (1994). Diagnostic and statistical manual of mental disorders (4th ed.). Washington, DC: Author.

Atkinson, D. (1986). Engaging competent others: A study of the support networks of people with mental handicap. British Journal of Social Work, 16, 83-101.

Baker, F., Jodrey, D., & Intagliata, J. (1992). Social support and quality of life of community support clients. Community Mental Health Journal, 28, 397-411.

Baker, F., Jodrey, D., Intagliata, J., & Straus, H. (1993). Community support services and functioning of the seriously mentally ill. Community Mental Health Journal, 29, 321-331.

Baker, F., & Weiss, R. S. (1984). The nature of case manager support. Hospital and Community Psychiatry, 35, 925-928.

Biegel, D. E., Tracy, E. M., & Corvo, K. N. (1994). Strengthening social networks: Intervention strategies for mental health case managers. Health and Social Work, 19, 206-216.

Brown, G. W., Birley, J. T., & Wing, J. K. (1972). Influence of family life on the course of schizophrenic disorders: A replication. British Journal of Psychiatry, 121, 241-248.

Cohen, C. I., & Sokolovsky, J. (1978). Schizophrenia and social networks: Expatients in the inner city. Hospital and Community Psychiatry, 36, 407-410.

Craig, T. J. H., Hussey, P. A., Kaye, D. A., Mackey, K. J., McCreath, J., Trembley, J., & Vedus, M. S. (1987). Family support programs in a regional mental health system. Hospital and Community Psychiatry, 38, 459-460.

Crotty, P., & Kulys, R. (1985). Social support networks: The view of schizophrenic clients and their significant others. Social Work, 30, 301-309.

Freddolino, P. P., Moxley, D. P., & Fleishman, J. A. (1989). An advocacy model for people with long-term psychiatric disabilities. Hospital and Community Psychiatry, 40, 1169-1174.

Goering, R. N., Wasylenki, D. A., Farkas, M., Lancee, W. J., & Ballantyne, R. (1988). What difference does case management make? Hospital and Community Psychiatry, 39, 272-276.

Hammer, M. (1963-1964). Influence of small social networks as factors in mental hospital admission. Human Organization, 22, 243-251.

Intagliata, J., Willer, B., & Egri, G. (1986). Role of the family in case management of the mentally ill. Schizophrenia Bulletin, 12, 699-708.

Kayloe, J. C., & Zimpfer, D. G. (1987). Social Support Groups for Psychiatric Outpatients: Panacea or Pandemonium? Psychosocial Rehabilitation Journal, 10, 41-50.

Kurtz, L. F., & Chambon, A. (1987). Comparison of self-help groups for mental health. Health and Social Work, 12, 275-283.

Lamb, H. R. (1980). Therapist-case managers: More than brokers of services. Hospital and Community Psychiatry, 31, 762-764.

Lipton, R. R., Cohen, C. I., Fischer, E., & Katz, S. E. (1981). Schizophrenia: A network crisis. Schizophrenia Bulletin, 7, 144-151.

Mathews, R. M., Mathews, S. A., & Pittman, J. L. (1985). Peer counseling: Consumer involvement in independent living programs. Rehabilitation Counseling Bulletin, 28, 161-166.

Mitchell, R. E., & Trickett, E. J. (1980). Task force report: Social networks as mediators of social support. Community Mental Health Journal, 16, 27-44.

Mitchell, R. E. (1982). Social networks and psychiatric clients: The personal and environmental context. American Journal of Community Psychology, 10, 387-401.

Mitchell, S. F. & Birley, J. L. T. (1983). The use of ward support by psychiatric patients in the community. British Journal of Psychiatry, 142, 9-15.

Mowbray, C. T., Chamberlain, P., Jennings, M., & Reed, C. (1988). Consumer-run mental health services: Results from five demonstration projects. Community Mental Health Journal, 24, 151-156.

Mowbray, C. T. & Tan, C. (1993). Consumer-operated drop-in centers: Evaluation of operations and impact. The Journal of Mental Health Administration, 20, 8-19.

Mowbray, C. T., Wellwood, R., & Chamberlain, P. (1988). Project Stay: A consumer-run support service. Psychosocial Rehabilitation Journal, 12, 33-42.

O'Connor, G. (1983). Social support of mentally retarded persons. Mental Retardation, 11, 3-10.

Riessman, R. (1965). The "helper therapy" principle. Social Work, 10, 27-32.

Schoenfeld, P., Halevy-Martini, J., Hemley-Van derVelden, E., & Ruhf, L. (1985). Network therapy: An outcome of twelve social networks. Journal of Community Psychology, 13, 281-287.

Skirboll, B. W., & McLaughlin, S. (1990). Marketing a mental health program. Administration and Policy in Mental Health, 18, 131-133.

Skirboll, B. W., & Pavelsky, P. K. (1984). Hospital and Community Psychiatry, 35, 938-939.

Skirboll, B. W. (1994). The compeer model: Client rehabilitation and economic benefits. Psychosocial Rehabilitation Journal, 18, 89-94.

Sokolove, R. L., & Trimble, D. (1986). Assessing support and stress in the social networks of chronic patients. Hospital and Community Psychiatry, 37, 370-372.

Stein, L. I., & Test, M. A. (1980). Alternative to mental hospital treatment, I: Conceptual model, treatment program, and clinical evaluation. Archives of General Psychiatry, 37, 392-397.

Stroul, B. (1989). Community support systems for persons with long-term mental illness: A conceptual framework. Psychosocial Rehabilitation Journal, 12, 9-26.

Test, M. A. (1981). Effective community treatment of the chronically mentally ill: What is necessary? Journal of Social Issues, 37, 71-86.

Timms, E. (1983). On the relevance of informal social networks to social network intervention. British Journal of Social Work, 13, 405-415.

Tulumello, M. (1990, July). Volunteers help others break through the isolation of mental illness. New Choices, 30, 70-72.

Turner, J. C., & Tenhoo, W. J. (1978). The NIMH community support program: Pilot approach to a needed social reform. Schizophrenia Bulletin, 4, 319-349.

I, Norma G. Kilgore, hereby submit this thesis to Emporia State University as partial fulfillment of the requirements for an advanced degree. I agree that the Library of the University may make it available for use in accordance with its regulations governing materials of this type. I further agree that quoting, photocopying, or other reproduction of this document is allowed for private study, scholarship (including teaching) and research purposes of a nonprofit nature. No copying which involves potential financial gain will be allowed without written permission of the author.

Norma G. Kilgore
Signature of Author

12-10-98
Date

**The Effects of Social Support
on Psychiatric Patients**

Title of Thesis

Doug Cooper
Signature of Graduate Office
Staff Member

December 10, 1998
Date Received

original
741