People commonly rely on the support of others in everyday circumstances. Friends and family offer emotional encouragement in times of stress. Coworkers and neighbors provide information and material assistance as it is needed. We turn to trusted friends and colleagues for helpful advice. Marital and romantic partners monitor the well-being of those they care for. Social support is among the most important features of the relationships that support healthy psychological functioning.

At times, social support is also offered in formal helping relationships. Physicians, religious advisors, social workers, and other professionals provide social support as part of their role responsibilities. Social support is a critical function of many approaches to psychological therapy, of course, whether the support is received from an individual mental health professional, a therapy group, or a special preschool, classroom, or adult education program designed to assist troubled individuals. In many respects, the efforts of formal helpers are meant to emulate the kinds of social support obtained from the most helpful individuals in natural support networks.

The relevance of social support to developmental psychopathology derives from its relationship to the etiology, maintenance, and treatment of childhood psychological disorders. First, inadequate social support, often in the context of social isolation or dysfunctional social relationships, can contribute to the development of psychological problems in children. Children who face social adversity without the buffering assistance of supportive relationships are at a higher risk of developing clinical problems, especially if they encounter adversity in the home. This is why many preventive interventions for at-risk children and families emphasize strengthening formal and informal forms of social support, such as through home visitation programs. Second, for children with psychological disturbances, social support may help to diminish their problems, and lack of support can exacerbate their difficulties. Social support can assist in coping, increase children’s social skills, and help them and their families access needed services. Conversely, many clinical conditions in childhood, including depression, conduct disorders, and child maltreatment, cause children to alienate or resist social support and to become further isolated within their families, peer groups, and communities. Enhancing existing avenues of social support and creating new ones thus becomes central to effective intervention. For this reason, most approaches to therapy for children enlist social support, whether in the context of group therapy, peer mentoring, parent education
or parent support groups, social skills training, therapeutic preschool programs, mother-child psychotherapeutic intervention, or other avenues. Understanding the nature of social support and its relevance to psychological well-being and restoration improves understanding of the development and treatment of child clinical disorders.

Because social support is so often a part of everyday experience, it is easy to expect that social support can be straightforwardly provided to troubled children and families, and that there will be direct benefits from doing so. It is surprising, therefore, when socially isolated families actively resist efforts from supportive social networks, or home visitors quickly become exhausted by their efforts to provide assistance to at-risk families, or children in emotional turmoil continue to alienate those attempting to assist them. The same conditions that contribute to social isolation, in other words, make the enlistment of social support especially difficult. Social support is thus easy to conceptualize but difficult to implement in the lives of troubled children and their families. This has been the hard lesson of recent years of efforts to enlist social support into preventive and therapeutic efforts on behalf of children at risk. As a result, although clinicians and researchers remain convinced that social support is beneficial, they have become more aware that formal efforts to provide social support can be frustrated even when they are designed to emulate or build on the natural sources of support on which people commonly rely. Further, enlisting natural sources of support for therapeutic purposes can be challenging and, at times, problematic. Researchers and practitioners are only at the beginning of understanding and overcoming the obstacles that exist to providing social support as a component of preventive and treatment efforts.

Our goal is to profile the multifaceted ways that social support is relevant to developmental psychopathology. In the section that follows, we consider how to define social support and its functions in the lives of children and adults, drawing on the importance of social networks to developmental adaptation. Next we consider social support within the broader social context of development and psychopathology. This requires considering the independent and overlapping social networks of children and parents, developmental changes in support needs and capacities to elicit support, and the importance of peers and the community. We then examine social support in relation to psychopathology, discussing the role of support—or its absence—in the onset of clinical problems, their maintenance over time, and their remediation. Social support is relevant to etiological, maintenance, and treatment concerns in different and complex ways, in other words, and distinguishing among them emphasizes how social support and the absence of support has diverse applications to the problems of troubled children and families. In the next section, we try to understand the influences that can enhance or frustrate the efficacy of social support efforts, whether they occur in natural social networks or in formal interventions. These include clarity (or lack of it) concerning the intended goals of support, the needs of providers of support, and the complex reactions to receiving assistance from another. We also consider the cultural and community context of social support. From these considerations, we then proceed to profile the implications of these contingencies for interventions that have the goal of providing or enhancing social support, and consider the lessons learned for future efforts. We integrate these ideas in a concluding section in which we consider future directions for research and intervention.

WHAT IS SOCIAL SUPPORT? WHY IS IT IMPORTANT?

Because social support is such a familiar feature of everyday life, it is easy to assume that it is readily understood and that most people experience social support in comparable ways. Yet, a thoughtful analysis of what social support is and does reveals that it is both more multidimensional and more complexly offered and received than we often assume. Consider, for example, the following definition: “Social support consists of social relationships that provide (or can potentially provide) material and interpersonal resources that are of value to the recipient, such as counseling, access to information and services, sharing of tasks and responsibilities, and skill acquisition” (Thompson, 1995, p. 43). Embedded in this definition are several features of social support that underscore its complexity.

First, social support is given and received in the context of relationships, and relationships are psychologically complex (Badr, Acitelli, Duck, & Carl, 2001). Support may be obtained from relationships within natural social networks—such as with parents or offspring, extended kin, coworkers, teachers, peers, neighbors—or formal helping relationships, such as with a religious advisor, mentor, physician, mental health professional, social worker, or other professional.1 The nature of the relationship deter-

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1To be sure, social support usually but does not always occur in the context of relationships. For example, crisis hotline (and “warm-line”) services can provide advice, support, and referrals for individuals who need immediate assistance, including children (see Peterson, 1990). For people who would otherwise resist the risks of discussing personal problems with a friend or counselor, the anonymous self-disclosure offered by services like these can be of benefit.
mines what kinds of support are possible and the limitations that may exist in receiving social support. On the broadest level, for example, some individuals are support generalists who provide many kinds of assistance, whereas others (especially people in formal helping relationships) are support specialists who have one particular form of social support to offer (Bogat, Caldwell, Rogosch, & Kriegler, 1985). The kind of assistance received from each person—and the circumstances in which one would seek their help—are likely to differ considerably.

The roles of relational partners also shape the support they can offer and limitations in that support. Extended family members, for example, can offer emotional guidance and understanding based on long-standing, close relationships. But the assistance of a relative may be colored by family traditions or a legacy of family conflict, and multi-generational assistance is often complicated by conflicting responsibilities to different generational networks (e.g., one’s obligations to adult siblings may conflict with providing assistance to their offspring, especially when the latter are troubled by family problems). Neighbors can provide referrals to local help givers, material aid, emergency assistance, and respite child care. But in communities at risk, neighbors may experience the same economic and ecological problems as do the families who need their assistance, and neighbors may thus have little to offer because of their own needs. Neighbors may also be as concerned with distancing themselves from a family in turmoil as they are with providing aid. Peer friendships and group acceptance may buffer loneliness for a shy child and work in concert with other protective factors to prevent depression. But if the child’s shyness leads to withdrawal that discourages age-mates from interacting with the child, the peer response may increase the child’s vulnerability and enhance, rather than diminish, loneliness and vulnerability to depression.

The same “situation specificity” of relationships (Unger & Powell, 1980) is also true of formal support agents. A social worker may offer valuable assistance by connecting families to community resources and providing informal counseling. But an overwhelming caseload may diminish the caseworker’s reliability or limit the other kinds of assistance that can be provided. A doctor or minister may be a source of professional guidance and can offer an expert and dispassionate perspective on family problems, but professional training and role definitions may shape the kind of support that is offered. Problems may be viewed through the prism of a professional’s specialized expertise or background, for example, such that the kind of assistance that is offered (e.g., medication, counseling, referral) may or may not be what is really needed by the recipient. In other circumstances, the role responsibilities of professional helpers may curb the involvement of other potential helpers. It is well-known, for example, that professionals who are legally mandated reporters of suspected child maltreatment are typically aware of many more child abuse cases than they formally report. This owes, in part, to the complications introduced into their professional relationships with families once a child abuse investigation has been inaugurated and the preference of many helping professionals to address family problems on their own (Zellman, 1990; Zellman & Anter, 1990). But their failure to enlist legal authorities means that additional sources of support are unavailable to families who might need them, and the clinician assumes a heavy burden of responsibility. Social support is thus mediated by the relationships through which it is offered and the other roles and responsibilities of those relationships.

Other features of relationships are also important to offering and receiving social support. In natural social networks, for example, assistance is usually provided in two-way relationships of mutual aid, where individuals can be providers as well as recipients of help. This helps to ensure feelings of mutual respect that contribute to relational satisfaction. When help giving is unidirectional, or when it occurs at considerable cost to the helper, it can make the recipient feel indebted and, as a consequence, inferior and vulnerable, and this can quickly undermine a helping relationship (Fisher, Nadler, & Witcher-Alagna, 1982; Shumaker & Brownell, 1984). When children are the recipients of social support from adults, the mutual obligations of help giving are less compelling because children are commonly recipients of one-way assistance. Nevertheless, their parents may feel indebted and vulnerable, especially if help giving is perceived as deriving from parental inadequacy. When children receive help from peers, mutuality may be especially important to the maintenance of the relationship and its positive influence. In formal helping relationships (such as with a counselor, therapist, or social worker), unidirectional assistance is part of the relationship and feelings of vulnerability are less likely. But formal relationships may be limited in the extent to which they influence the facets of a child’s (or family’s) private life in which assistance is truly needed. Thus, one of the significant challenges of offering social support in the context of relationships is understanding how support can be offered without the negative reactions that support can engender, especially when assistance is not bidirectional.

More generally, relationships are also complex constellations of mutual obligations that can offer support and affirmation but also create stress and difficulty, sometimes at the same time (Berscheid & Reis, 1998; W. A. Collins & Laursen, 1999). Belle’s (1982) study of lower-income single mothers provocatively illustrates how their relationships...
with extended kin, neighbors, and boyfriends afforded support but at the same time the risks of rejection, criticism, privacy violations, and entrapping demands that relationships with family and romantic partners often entail. Likewise, although peer relationships can offer considerable social support to children, association with deviant peers, especially in adolescence, has been associated with antisocial behavior (Dishion, Andrews, & Crosby, 1995; Laird, Jordan, Dodge, Pettit, & Bates, 2001). The relationships affording the greatest support often entail a complex calculus of assistance and demand in which risks accompany receipt of support. Thus, it is not always wise to assume that integrating needy individuals, or isolated families, into broader social networks will necessarily increase social support or ameliorate psychopathological processes. Deriving social support from social networks depends on characteristics of needy recipients and of others with whom they have relationships.

A second feature of this definition of social support is that it is multifaceted. It includes emotional encouragement but can also incorporate access to information and services, counseling and guidance, material assistance, sharing of tasks and responsibilities, and skill acquisition. The importance of each of these facets of social supports depends on what is needed and is of value to the recipient. For adults under stress, for example, one of the most important benefits of supportive relationships is the sense that one is not alone and that others are emotionally “on your side” with compassionate encouragement. For others, however, assistance is best provided when people are also brokers of information or services, such as when friends and neighbors are consulted for childrearing advice, referrals to child care providers or counselors, or access to community agencies where further information or resources can be obtained. For individuals in economic difficulty, material assistance (such as lending money or a car) and services (such as respite child care) is an important form of social support. For others, help in acquiring vocational or personal skills (such as financial management skills) is especially valuable. For many people in difficulty, social support is received as counseling, advice, and guidance about troublesome issues, whether related to marital difficulty, parenting problems, or managing emotional stress. Even in children’s peer relationships, social support is multifaceted. Parker and Asher (1993) found that the friendships of children who were highly accepted among their peers provided greater validation and caring, more help and guidance, greater conflict resolution, and more intimate exchange than friendships of children with lower peer acceptance. The friendships of children who were not well accepted were characterized by higher levels of conflict and betrayal compared to the friendships of highly accepted children.

Of course, supportive relationships do not necessarily incorporate each of these facets of support, and, indeed, these features of support are not always complementary within relationships. Individuals who provide emotional encouragement to friends or neighbors may find it difficult, for example, to offer critical advice and still be perceived as supportive. This is the difficulty faced by those who urge family members or friends to reduce their smoking, drinking, or substance abuse as a way of improving family life or personal well-being. Their efforts to create more healthy practices in another may be perceived by the recipient as meddlesome and intrusive. In other circumstances, material assistance is deeply appreciated when it is freely offered, but if it becomes conditional on the recipient’s compliance with behavioral expectations (which can occur in families, religious groups, and adolescent peer groups), it loses its emotionally supportive qualities. A young adult may appreciate the financial assistance that derives from moving back to the parent’s home, for example, but the more limited freedom and parental monitoring that this entails may be experienced as demeaning and unsupportive.

When social support is viewed in the context of developmental psychopathology, there are additional potential facets of socially supportive relationships. Social support can be enlisted to monitor the well-being of at-risk children, such as when extended kin or a social worker regularly check in on a family member who is suspected of child neglect. In these instances, social support is enlisted for preventing harm. Social support can also be offered to improve parental conduct, such as through the guidance of a home visitor or the advice of a grandparent. By contrast with other forms of skill acquisition, its purpose is not only to enhance parental competency but also to indirectly benefit children by creating more positive, constructive parent-child relationships. Finally, social support can be enlisted for purposes of developmental remediation. As we shall explore further, supportive relationships contribute to psychological healing in children, whether via therapeutic child care programs that provide young children with secure attachments to caregivers, social skills training or peer mentors that help children experience more successful peer relationships, or individual therapy that focuses on the impact of problems on significant relationships. In these cases, supportive relationships are oriented toward treating troubled children and strengthening developing capacities that have been undermined by such problems as depression, conduct disorders, or parental abuse.
Taken together, these multifaceted qualities of social support have diverse applications to developmental psychopathology. Consider, for example, the challenges of preventing child maltreatment (Thompson, 1995). Families prone to child abuse are typically multiproblem families in economic difficulty, living in poor neighborhoods, and socially isolated from others in the community (Daro, 1988; Polansky, Chalmers, Buttenwieser, & Williams, 1981; Straus, Gelles, & Steinmetz, 1980). Child protection strategies often begin with integrating social support into family life, which can occur through a program of professional home visitation, efforts to strengthen neighborhood connections, enrolling parents in parenting classes, or through other community services. The general goals of such efforts are to reduce parenting stress through emotional support, strengthen parenting skills by providing developmental guidance and models of effective parenting practices, and monitor children’s well-being through regular home visits or agency consultations. More ambitious efforts to prevent child maltreatment through social support sometimes include crisis counseling, material aid to families in economic distress, and programs to strengthen job skills or household competencies. When social support is enlisted to reduce abuse recidivism, interventions are typically more intensive, enduring, and focused than when social support strategies are part of a broader effort to prevent abuse in at-risk populations. The most intensive treatment programs, for example, can involve daily visits by a specially trained therapeutic social worker who works to reconstitute healthy family relationships (Thompson, 1995).

Social support alone is unlikely to be an effective answer to the complex problems faced by families at risk for child abuse or neglect or children facing the challenges of clinical disorders. But social support is probably an essential component of any multifaceted effort to prevent psychological difficulties in at-risk families and children or to provide therapeutic assistance when family problems have resulted in a troubled or harmed child. The challenge is to craft well-designed interventions that improve the support afforded by natural helpers and enlist the assistance of formal helpers, based on a careful assessment of the needs of the child or family at risk (Thompson & Ontai, 2000). Accomplishing this requires a thoughtful appreciation of the nature of social support, as well as the social context of development and psychopathology.

THE SOCIAL CONTEXT OF DEVELOPMENT AND PSYCHOPATHOLOGY

Whether the focus is on children’s typical or atypical psychological growth, developmental psychopathologists are concerned with how early patterns of individual adaptation evolve into later adaptations as developmental transformations occur in thinking, behavior, and emotion (Cicchetti & Cohen, 1995; Dodge & Pettit, 2003; Sroufe & Rutter, 1984). Among the many influences on psychological growth, relationships are central to how children adapt to the opportunities and challenges of each period of life. Understanding the relevance of social support to developmental psychopathology thus requires appreciating the social context of development and psychopathology, as well as developmental changes in children’s access to broadening networks of social support in their natural environments.

From the beginning of life, infants depend on the solicitude of others for protection, nurturance, and well-being. A well-functioning parent-child relationship provides a supportive context for development despite variations in external resources (such as the family’s economic status) or internal characteristics (such as the child’s temperament) because it can buffer the effects of disadvantage and provide significant psychological resources for healthy growth. Indeed, this relationship can be regarded as being socially supportive in all the facets just described (e.g., emotional encouragement, providing material and interpersonal resources, sharing activity, fostering skill acquisition), and this is why infants and young children rely so significantly on the assistance and nurturance of their caregivers. Early in infancy, for example, babies become quiet in anticipation of the mother’s arrival when they are distressed (Lamb & Malkin, 1986), enlist the emotional information in the mother’s face when encountering uncertain or perplexing situations (Baldwin & Moses, 1996), and turn to the caregiver for assistance when they are fearful or distressed.

Variations in the quality of parental nurturance or sensitivity are important in young children’s reliance on the support of their caregivers. An extensive literature on the security of attachment documents how young children develop secure relationships with caregivers who respond sensitively and appropriately to their signals and, conversely, develop insecure attachments when caregivers are inconsistently responsive (for reviews, see Cassidy & Shaver, 1999; Thompson, 1998). These variations in attachment security may be regarded as significant early differences in perceived support from caregivers on whom an infant must rely for emotional and physical well-being. These variations in security are apparent not only when young children are distressed but also in nonstressful circumstances, such as in the quality of emotional sharing between a toddler and an adult during play or social interaction. Differences in the security of attachment are,
not surprisingly, developmentally significant. Attachment security is associated with many features of psychosocial growth, including the quality of children’s relationships with other people, their capacities to interact sociably with unfamiliar adults, emotion understanding and emotion regulation, self-understanding, and even conscience development (see Thompson, 1999, for a review). These findings are consistent with the theoretical view that from the security of their relationships with caregivers, young children derive broader representations of relationships, themselves, and other people that guide their subsequent social encounters and their expectations for future relationships (Bretherton & Munholland, 1999; Thompson, 1998, 2000).

Moreover, the support entailed in a secure or insecure attachment foreshadows continuing support in later years as children encounter later developmental challenges. In one study, children’s perceptions of emotional support from the mother at age 8 were predicted by the security of mother-child attachment at age 4 (Booth, Rubin, & Rose-Krasnor, 1998). Bost and her colleagues (1998) found that secure preschoolers had more extensive and supportive social networks and were also higher on sociometric assessments of peer competence (see Booth, Rubin, & Rose-Krasnor, 1998; DeMulder, Denham, Schmidt, & Mitchell, 2000, for similar results). Anan and Barnett (1999) also found, in a sample of lower-income African American 6½-year-olds, that secure attachment (assessed 2 years earlier) was associated with children’s perceptions of greater social support, and social support mediated the association between secure attachment and lower scores on externalizing and internalizing problems. Viewed in the context of social support, therefore, young children derive foundational support from the parent-child relationship and are creating provisional representations from this relationship about the quality of support they can expect from others they encounter.

Responsive, warm parenting may thus be regarded as a protective factor in early psychological growth because of its positive psychological correlates and the confidence it inspires in parental responsiveness and because it creates more positive expectations of the support of others that may cause children to more competently elicit assistance when it is needed (Colman & Thompson, 2002). By contrast, parental harshness and unresponsiveness may be a risk factor for psychosocial problems, especially if parental behavior creates stress as well as being unsupportive. Consider, for example, the experience of young children living with a depressed parent (Cicchetti & Toth, 1998; Goodman & Gotlib, 1999; Zahn-Waxler & Kochanska, 1990). In these circumstances, children are emotionally attached to a mother who manifests a great deal of sad emotion, together with irritability, helplessness, and blame of others, including offspring. In the context of this emotional climate, moreover, depressed caregivers act in ways that enhance children’s sense of guilt and responsibility for the adult’s depression. Depressed parents have high expectations for the behavior of offspring, and thus they can also be demanding and critical, using love withdrawal and other techniques to enforce compliance with their demands. It is easy to see how children living with a depressed parent are themselves at risk for psychological problems (Cummings & Davies, 1994, 1996). Their vulnerability to a parent’s depression begins as early as infancy (Zeanah, Boris, & Larrieu, 1997). Young children are especially prone to becoming enmeshed in the parent’s affective difficulties because their emotional attachments to these caregivers, even if they are insecure, makes their emotional well-being contingent on that of their parents.

Parents are primary sources of social support for children or, in the words of Cauce, Reid, Landesman, and Gonzales (1990), “support generalists.” Parents also mediate children’s access to other sources of social support, both formal and informal (Cochran & Brassard, 1979; Parke & Bhavnagri, 1989). Most generally, parents’ choices of housing, neighborhoods, and schools affect the range of children’s options for forming social connections with others outside the family, and frequent residential mobility limits the breadth of a child’s social network (Ladd, Hart, Wadsworth, & Golter, 1988). Children growing up in troubled schools or dangerous neighborhoods simply have fewer options for creating and maintaining supportive social relationships with peers and adults than do children living in more constructive settings. Parents also commonly arrange, facilitate, and monitor their children’s contact with others as gatekeepers of children’s access to them. Parents schedule activities, provide transportation, and supervise offspring during social and recreational activities with friends and neighbors, especially when children are young (Ladd & Le Sieur, 1995). O’Donnell and Steuve (1983) reported that lower-income and middle-class mothers differed significantly in the access they provided their school-age children to community activities, with middle-class mothers participating extensively with their offspring in these programs (often as volunteers and aides) and lower-income mothers declining to commit themselves in these ways and instead permitting their children greater unscheduled freedom for “just being with friends.” As children become capable of bicycling, using public transportation, and later driving independently to their activities, parents still retain an important monitoring role. They do so less directly, such as by granting permission to participate in activities, providing
funding, and consulting with offspring about their plans, but this supervision is developmentally appropriate by enlisting the adult’s guidance in the increasingly independent social lives of their children. Parents also mediate children’s contact with extended kin networks by facilitating opportunities to see grandparents and other extended family members or restricting access to them (Thompson, Scalora, Castrianno, & Limber, 1992).

In therapeutic contexts, of course, parents mediate children’s access to clinical assistance not only by providing transportation but also by giving consent, paying for therapy, and supporting the clinician’s efforts. When children are young, nearly all evidence-based treatments rely heavily on parental participation. Parental involvement is integral to therapies that decrease disruptive behavior problems, such as those experienced by children with Attention-Deficit/Hyperactivity Disorder (ADHD), Oppositional Defiant Disorder, or Conduct Disorder (e.g., Hembree-Kigin & McNeil, 1995; McMahon & Forehand, 2003; Webster-Stratton, 1998). Therapeutic interventions addressing internalizing disorders, such as anxiety (Kendall, Aschenbrand, & Hudson, 2003) or depression (Stark et al., 1996), require parental support to ensure that children complete therapeutic tasks in home, school, and neighborhood settings. This means that therapeutic assistance to children will be nearly impossible without the parent’s cooperation (or tacit cooperation, in the case of adolescents). When children’s difficulties arise from family problems or are maintained by family responses, parents may limit the effectiveness of treatment by denying that problems exist or resisting assistance. When parents experience their own mental health difficulties, obtaining therapeutic support for children can be challenging. This means that therapeutic efforts for children often require a two-generation approach in which the parent’s needs receive attention as well as the child’s, and this is especially true when social support is a central feature of the therapeutic effort.

The social networks of parents and offspring overlap in other ways. Parental networks have important consequences for children because they influence parents’ well-being, offer opportunities to children for new experiences and relationships, and directly socialize parental behavior (Cochran, 1990; Cochran & Niego, 1995). Social support to parents has been found to improve parenting and, in doing so, to enhance many features of the psychological well-being of offspring, including attachment security, social competence, and emotional adjustment (see review by Thompson, 1995). Parents with many close friendships have offspring with better social skills and peer acceptance because, in part, of the peer relationships afforded by parents’ social contacts (Parke, 2002; Parke et al., 2002). However, parental social networks can be sources of stress as well as support, and children’s well-being can be undermined by the difficulties that parents experience in their relationships with coworkers, neighbors, or extended kin. Relatives can be critical and demanding as well as supportive, and coworkers can offer helpful advice but also heighten workplace strain. Thus, the nature of parents’ social networks can have helpful or unhelpful implications for family functioning and children’s well-being.

The shared social networks of parents and offspring, and their potentially helpful and hurtful consequences for psychological well-being, are also illustrated by the associations of socioeconomic status (SES) with social support. For many reasons related to the impact of financial and job stress, neighborhood disorganization and danger, and lack of community resources, the social networks of families in poverty are likely to be less supportive and, at times, more stressful than those of families living in economically more advantaged conditions (e.g., Belle, 1982; Ceballo & McLoyd, 2002). Socioeconomic stress and community problems can have direct impacts on children. Lynch and Cicchetti (2002) noted, for example, that children who reported that they had been exposed to high levels of community violence also reported feeling less secure with their mothers.

The stresses associated with socioeconomic difficulty can also moderate the influence of social support on parenting, but relevant studies offer contrary portrayals of how this occurs. In a study of low-SES African American women, for example, Ceballo and McLoyd (2002) found that for women in more difficult circumstances (i.e., poorer and more dangerous neighborhoods), the positive associations between emotional support and nurturant parenting decreased, as did relations between instrumental support and diminished reliance on punishment. In short, the positive connection between social support and constructive parenting was strained and attenuated in poorer, more dangerous neighborhoods even though social support needs were greater. However, studying a large, nationally representative sample, Hashima and Amato (1994) reported that the negative association between maternal perceptions of social support and reports of punitive behavior were strongest in lower-income families. In other words, social support appeared to have the greatest benefits for mothers when socioeconomic stresses were greatest. Although more research is needed to clarify these differences in conclusions, each study confirms that the stress-buffering effects of social support may vary according to income and neighborhood quality. This is important because children and parents share the economic
conditions of the family, and thus the effects of income and neighborhood quality not only have direct effects on children (through the impact of neighborhood crime, poor schools, financial need, and related influences) but also indirect effects through the influence of stress and social support on parenting quality.

Research on the interaction of income with social support and stress is important also as a reminder that the social networks in which children and families live are not always potential sources of social support. At times, they are greater sources of stress and difficulty than of support. Indeed, one of the challenges of providing assistance to multiproblem families is that their living circumstances often do not provide avenues of informal social support because extended family members are in turmoil, neighbors and friends suffer from the same stress as do the targets of intervention, and communities are drained of potentially helpful social resources. This can make it difficult to find sources of support for needy families in difficult living conditions.

The intersection of parent and child social networks therefore has important implications for the association between developmental psychopathology and social support. When children’s difficulties are associated with family problems, parents’ social networks often do not provide meaningful support to the children. One of the characteristics of families at risk for child maltreatment is their social isolation, which significantly reduces potential sources of assistance for children (Limber & Hashima, 2002; Thompson, 1995). Within their more limited social networks, moreover, extended family and neighbors often fail to intervene when children are maltreated and may actually reinforce harsh parental attitudes and conduct that lead to abuse or neglect (Korbin, 1989, 1991). Thus, parents’ social networks can exacerbate rather than help to remediate children’s problems through their influences on parental conduct and family functioning. This is one reason child clinical problems must often be conceptualized as family problems when questions of etiology and treatment are concerned.

The overlap of social support networks for children and parents highlights the value of two-generation interventions for troubled children. Two-generation interventions are founded on the realization that treating a troubled child requires addressing the needs of the parent (and the family system) because a child’s psychopathology and the remediation of clinical problems are typically associated with broader family difficulties and strengths. With respect to social support, two-generation interventions can include efforts to enlist the support of parents’ social networks when network members can provide assistance—and reduce the influence of network associates when they contribute to children’s difficulties—as a means of enlisting supportive assistance for the child. Two-generation interventions are the basis for many preventive and therapeutic programs for at-risk children, such as home visitation programs that are discussed subsequently in this chapter. The importance of thinking multigenerationally emphasizes how problems in developmental psychopathology must be addressed in ways that are distinct from conventional adult therapeutic approaches because of the reliance of children on their parents and families and the overlap of their social support networks.

With increasing age, children depend less exclusively on their parents for their emotional well-being, yet parents’ continuing importance as social support agents should not be underestimated. In adolescence, for example, striving for autonomy and independence is not inconsistent with continuing needs for parental support (Allen & Land, 1999). Even as peers become more important consultants on issues like appearance, style, and taste, parents remain preferred advisors on core moral values, political and religious beliefs, and planning and achieving life goals (Coleman & Hendry, 1990). This suggests that in adolescence, parents and peers are each support agents with influence that differs in a domain-specific fashion, with young people relying on each in relation to specific issues and concerns. One of the important changes with increasing age, however, concerns children’s attitudes toward help seeking. Seeking emotional reassurance or instrumental aid is natural and encouraged in young children, but adolescents are likely to resist help seeking if doing so is regarded as a threat to self-efficacy or perceived competence (Robinson & Garber, 1995). The combination of teenagers’ reliance on their parents for support and the need to perceive themselves as self-reliant helps to account for the mixed signals that parents (and, to a lesser extent, peers) receive during this period of life and the ease with which adolescents’ support needs within the family can be misunderstood.

With increasing age, children not only experience changes in their help-seeking attitudes but also achieve access to a greater variety of sources of social support outside the family. Infants and young children are influenced by the supportive or nonsupportive social environments of out-of-home care, of course, from an early age (Cochran & Brassard, 1979; Feiring & Lewis, 1988, 1989; Votruba-Drzal, Coley, & Chase-Lansdale, 2004). Child care experiences affect young children directly through the security of the relationships they develop with providers, the quality of
the child care environment, and the developmental guidance providers offer. Child care affects young children indirectly as providers monitor the child’s well-being, offer support and information to parents, and provide referrals (such as to mental health services or community agencies) from which children and parents can benefit (Thompson, Laible, & Robbennolt, 1997). In these ways, child care can be a significant source of social support early in life, contingent to a great extent on the quality of care. Entry into school further widens children’s extrafamilial natural support networks through both curricular opportunities (such as relationships with teachers, counselors, and peers) and extracurricular activities (such as in sports, clubs, and service programs; Asp & Garbarino, 1983; Lynch & Cicchetti, 1997; Rose et al., 2003). Teachers can be especially important sources of social support because they, like child care providers, may be the first to identify problems that emerge in a child and can create a bridge between children and their parents with professionals who can offer assistance. Moreover, well-trained teachers can sensitively assess the constellation of difficulties a child exhibits by realizing, for example, that classroom behavior problems and emotional difficulties may be an indication of child maltreatment at home (Meehan, Hughes, & Cavell, 2003; Thompson & Wyatt, 1999). In adolescence, workplace and community associations further broaden potential sources of social support as young people achieve greater independence from family networks.

In all of these contexts, the emergence of extrafamilial sources of social support offers avenues of potential aid that are not entirely contingent on parental cooperation. Equally important, children and youth actively construct and maintain these networks. With increasing age, for example, they choose many of the activities in which they participate and the adults and peers with whom they affiliate. There are also significant developmental changes in the social skills that enable children to maintain affiliations that they experience as supportive. With increasing age, for example, children become more skilled at taking active initiative in maintaining the relationships that matter to them, and they develop the social skills required to make these relationships mutually rewarding. Furthermore, children of all ages are also active construers of the support likely to be provided by different partners in their social settings (Furman & Buhrmester, 1985, 1992; M. Reid, Landesman, Treder, & Jaccard, 1989). They readily distinguish the partners who are likely to offer aid and the situations in which these partners are likely to be most helpful, and this helps them to enlist assistance when it is needed.

The role of children as constructors, maintainers, and construers of their natural networks of social support is crucial to understanding the role of social support in developmental psychopathology. Children who experience psychological difficulty have considerable need for supportive relationships, but their clinical problems may also undermine the skills required to constructively maintain those associations. Indeed, children with conduct disorders, ADHD, and other clinical problems may, because of their behavioral difficulties, repel or drain potential support providers of helpful solicitude. Furthermore, children who are depressed, traumatized, or experience other affective disorders may have difficulty perceiving potential help providers as being genuinely supportive and, for this reason, may reject assistance that is offered. Thus, somewhat ironically, at the same time that they are in greatest need of natural sources of social support, children with clinical problems may be least capable of creating or maintaining the relationships that will provide them with aid or of perceiving assistance from the interpersonal sources from whom it may be most readily available. This constitutes a formidable challenge for those who seek to ally natural support networks in therapeutic efforts and is a challenge to formal helpers (e.g., counselors and therapists) who must also overcome these difficulties in their efforts to offer aid.

**SOCIAL SUPPORT AND PSYCHOLOGICAL WELL-BEING**

At its best, social support provides recipients with emotional understanding, instrumental aid, counseling and guidance, material resources, and/or referrals to other sources of assistance. Viewed in this light, there are at least two ways that social support mediates the impact of stress for individuals at risk (Barrera, 1986; Cohen & Wills, 1985; House, Umberson, & Landis, 1988; Vaux, 1988).

First, social support can be *stress-preventive*. Social support invests its recipients with the material and psychological resources that foster positive development and thus prevent many stresses from occurring. These resources include healthy practices (e.g., exercise, diet, socializing), self-esteem and a sense of belonging, social competencies and coping strategies, access to emergency aid, social monitoring, specific skills, and other benefits that arise from the examples, encouragement, and/or material aid of social partners. Having these resources reduces the likelihood that recipients will experience...
The stress-preventive functions of social support are especially important to children who rely so significantly on others for their well-being; they highlight how the material and psychological resources of parents are instrumental to preventing many of the difficulties that their offspring might encounter. Parents who are warm and nurturant, support the positive self-esteem of offspring, encourage constructive social competencies, and foster academic success help to reduce stress in children by strengthening socioemotional competencies and self-confidence. Moreover, partly through parents’ social networks, children have access to other support agents (e.g., teachers, extended family, neighbors, coaches, mentors, and peers) who also reduce stress by promoting skills and resiliency. In this respect, especially for children at risk, social support is one of the most important protective factors within the broader constellation of risks and vulnerabilities that children experience.

Second, when stress occurs, social support can be stress-buffering. In other words, the material and psychological resources available through supportive relationships diminishes the impact of stressful events by enhancing coping. Clinical studies have shown that social support is associated with a reduction of the effects of disease pathology and psychological distress on stressed individuals, contributing to less severe symptomatology, quicker recovery, enhanced coping, and diminished long-term sequelae (e.g., Cassel, 1974; Cobb, 1976; Cohen & Wills, 1985). This can occur by altering (e.g., by making more constructive or realistic) recipients’ appraisals of stressful events, enhancing knowledge of coping strategies, providing useful information or instrumental aid, and supporting self-esteem and perceptions of self-efficacy. Social support as a stress buffer is important to children who lack the more sophisticated knowledge, appraisal skills, and coping capacities of adults and who are thus more vulnerable to the psychological challenges posed by negative life events. In this sense, it is even more important to children to have someone who is psychologically alongside them when encountering stressful events because of the assistance that an older individual can provide in effective coping.

There is recent evidence from molecular genetics research that social support can buffer the impact of stress and biological risk on children’s vulnerability to psychopathology. A recent study by Kaufman and colleagues (2004) showed that among children with a history of maltreatment and with a genetic vulnerability to depression, those without social support had the highest depression ratings, whereas those with access to positive social supports exhibited only minimal increases in their depression scores. These findings illustrate the interaction of genes and environment in the development of vulnerability to psychopathology and the influence of social support as a potential moderator of the genetic vulnerability to clinical problems (see Cicchetti & Blender, 2004).

Quite often, the stress-preventive and stress-buffering functions of social support have simultaneously protective effects on psychological well-being. One important example is peer support in childhood. Developmental and clinical theorists, such as Sullivan (1953), have long emphasized how peer support shares the stress-preventive and stress-buffering characteristics of adult social support; this is reflected in current views of the association between peer relationships and developmental psychopathology. In their 1995 review, for example, Parker, Rubin, Price, and DeRosier described how children’s and adolescents’ friendships can contribute to enhancing self-esteem and positive self-evaluation, provide emotional security, offer a nonfamilial context for intimacy and affection, give informational and instrumental assistance, and provide companionship and stimulation. These benefits accrue through the influence of at least three features of peer relationships: peer acceptance (or popularity), number of reciprocal friendships, and friendship quality. Each of these features independently and collectively improves children’s and adolescents’ concurrent life satisfaction and feelings of self-worth (Parker & Asher, 1993). In these respects, then, peer relationships appear to have social support features similar to those noted earlier for adult relationships. Moreover, peer social support can have enduring influences. A longitudinal investigation of preadolescent friendship and adult adjustment found, for example, that peer group acceptance and friendships in the fifth and sixth grades were significantly predictive of adult life status, perceived competence, and psychopathology 12 years later. Peer group acceptance and friendship made unique contributions to psychological well-being: Having a reciprocal friendship in fifth or sixth grade showed a moderately strong association with general self-worth 12 years later, even when preadolescent levels of self-competence were controlled (Bagwell, Newcomb, & Bukowski, 1998).

In light of these influences of social support on stress, the absence or deterioration of social support can be associated with enhanced stress and poorer coping: Individuals who are isolated or rejected, or who experience the withdrawal of others’ support, are more prone to difficulty. As
we shall see in the section that follows, the absence of social support is, at times, implicated in the etiology of child psychopathology and the maintenance of children’s problems over time. The enhancement of social support (especially the dimensions of support most relevant to a child’s problems) is also associated with the remediation of symptomatology. Each of these processes underscores the stress-preventive and stress-buffering influences of natural sources of social support in everyday life.

The association between social support, stress, and psychological well-being is complicated, however, because enhanced stress can sometimes provoke the deterioration of social support for troubled individuals. Unfortunately, this is what often occurs when adults and children encounter difficulty. Although people often seek supportive partners when they are stressed, it is also true that stressors diminish social support as they cause individuals to withdraw from others because of their circumstances (e.g., job loss, divorce), their incapacity (e.g., hospitalization, emotional turmoil), or their humiliation and feelings of vulnerability arising from stressful events (Shinn, Lehman, & Wong, 1984; Vaux, 1988). Moreover, potential sources of support may withdraw from individuals under stress because the behavior of the recipient is disturbing (e.g., psychological disorders, domestic violence, sexual abuse of children), the problems of the recipient are emotionally challenging or overwhelming (e.g., terminal diagnosis; loss of a family member), or potential support providers are undermined by the same circumstances as the recipient (e.g., poverty, single parenting; Belle, 1982; Fischer, 1982; Wortman & Lehman, 1985). More generally, potential support providers may withdraw from troubled individuals because of the sheer emotional drain of providing one-way assistance to very needy individuals (Fisher et al., 1982; Shumaker & Brownell, 1984). The self-protective withdrawal of potential helpers derives from the difficulties of providing assistance to individuals who need so much. Stress may be associated with diminished (rather than enhanced) social support, therefore, because the circumstances associated with stress may cause potential recipients to be unable or unwilling to receive aid and potential help providers to withdraw. Children who have been abused may lose access to potential support agents, for example, because of their anguish withdrawal from social interaction with familiar people, a parent’s efforts to isolate them from others, the deterioration of social relationships owing to the emotional impact of their abuse on social competence, or others’ sense that something is very wrong with the family (Cicchetti & Bukowski, 1995; Rogosch & Cicchetti, 1994; Salzinger, Feldman, Hammer, & Rosario, 1993). Emotional engagement itself can offer less positive support than might be expected. As the literature on expressed emotion suggests, high levels of emotional concern can too easily become intrusive or critical and thus damaging, especially when the emotional intensity interacts with an individual’s temperament or biological vulnerabilities (Brown, Birley, & Wing, 1972; Caspi et al., 2004; Hooley, Orley, & Teasdale, 1986; Miklowitz, Goldstein, Nuechterlein, Snyder, & Mintz, 1988; Rogosch, Cicchetti, & Toth, 2004). One study reported that toddlers’ behavior problems were predicted by differences in the expressed emotion of mothers and fathers in families where maternal depression had characterized family life since the child’s birth (Rogosch et al., 2004). Ironically, the individuals most in need of social support may find it least available within their natural social networks.

Childhood and adult depression also illustrates how social support may be least available to individuals who urgently need it, owing to the reactions of potential benefactors and recipients of support (see reviews by Cohen & Wills, 1985; Coyne & Downey, 1991; Robinson & Garber, 1995). The anhedonia of depressive symptomatology is typically accompanied by social withdrawal together with irritability and hostility, passivity, self-denigration, dependency, and a sense of helplessness and hopelessness. Not surprisingly, the demands these symptoms impose on close relationships can cause others to withdraw and avoid contact, which, in turn, confirms the depressed person’s perceptions of being rejected by others and of relationships being unreliable (Coyne, Burchill, & Stiles, 1991; Coyne & Downey, 1991). Depression is thus associated with smaller social networks, fewer close relationships, and diminished perceptions of others’ support by the depressed adult, and the same associations have been found for children and youth. DuBois, Felner, Brand, Adan, and Evans (1992), for example, found a negative association between social support and psychological distress 2 years later in young adolescents, with initial levels of distress as well as other sources of stress controlled. They also found evidence that distressed youth acted in ways that inadvertently reduced their access to social support and increased the stress of daily experiences.

In short, the association between social support and stress is complex. Support may be related to the prevention of stress, so that individuals in supportive networks encounter difficult circumstances less often than do those in small or disconnected networks. Support may also be a stress buffer such that heightened social support
is associated with reduced levels of stress. However, although stress may lead to a mobilization of support networks and thus a reduction of stress, social support and stress may also be negatively associated because of the impact of stressful events on a person’s access to and willingness to enlist supportive assistance. These complexities in the association between social support and stress suggest caution in studying the empirical relations between them and emphasize the importance of studying their relations over time in prospective longitudinal research designs.

Dimensions of Social Support and Psychological Well-Being

As a predictor of psychological functioning, social support can aid adaptive coping (Barrera, 1986; Robinson & Garber, 1995; Thompson, 1995). It is common to think of social support as a function of social embeddedness, which indexes the frequency of contact with social network members. Individuals who see others often, especially in large social networks, would be expected to derive many benefits from social contact, whereas social isolation would limit access to the personal and material resources that others can offer to assist in coping with difficulty. Consistent with this view, abusive and neglectful parents have been described as socially isolated and thus lacking the personal guidance, material aid, emotional support, and social monitoring that more typically occurs in well-integrated social networks (e.g., Daro, 1988; Polansky et al., 1981; Seagull, 1987). But social embeddedness is not, in itself, a strong index of the amount of social support that individuals expect, or receive, from their network associates (Barrera, 1986; Cohen & Wills, 1985). Social partners can be helpful or hurtful, and conflict often accompanies support in people’s relationships with family members, neighbors, coworkers, and others in the social network. This means that straightforward efforts to increase the size of an individual’s social network or enhance the frequency of social contact is unlikely to be an effective enlistment of social networks (e.g., anonymous benefaction). Furthermore, many acts of social support are not perceived as being supportive by troubled recipients.

Clinicians and researchers often focus on two other dimensions of social support: enacted support and perceived support. The first indexes the frequency of actual help giving in relationships, and the second assesses the individual’s expectations of support from relational partners. Enacted support and perceived support are not, surprisingly, highly associated with each other, and this derives from their complex mutual association and the relation of each to the stressful circumstances in which social support is valuable (Barrera, 1986). People can have confidence in the assistance that is potentially available from others without actually utilizing their aid, which is one reason enacted support and perceived support are not necessarily strongly associated. In addition, social support can be given without the recipient’s awareness (e.g., anonymous benefaction). Furthermore, many acts of social support are not perceived as being supportive by troubled recipients.

Counseling that causes a person to critically reexamine aspects of his or her behavior, material aid that causes recipients to feel indebted or humiliated, and efforts to reduce another’s drinking or other destructive habits may be motivated by genuine supportive concern but are likely to be regarded by recipients as painful, intrusive, or unnecessary.

This is important because it illustrates how recipient reactions to aid, and their effects on providers of social support, can complicate and sometimes undermine helpful assistance to needy individuals and families. It illustrates also how individuals may experience support without perceiving others as supportive or, conversely, may expect little support from network members who are actually striving to provide assistance. It all depends, in part, on individuals’ expectations of social support.

Enacted support and perceived support may also be relevant to different features of coping with stress. If individuals are capable of mobilizing their social networks, enacted support may follow the onset of stressful or distressing circumstances, especially if potential helpers are available and willing to provide aid. Perceived support may, in turn, be especially important to subsequent coping, and to stress prevention, because of a sense that others are reliably “on your side.” Each are likely to be predictive of

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2 Although it can be argued that genuinely supportive assistance will be offered in a manner that reduces negative reactions by recipients, it is nevertheless true that obtaining benefits from another—especially when it cannot be reciprocated, is undeserved, or derives from personal need—almost inevitably heightens feelings of indebtedness, failure, and vulnerability in recipients. As we discuss further, recognizing this not only helps to create more realistic expectations concerning the consequences of providing social support (such as in the context of a home visitation program), but also makes more comprehensible the apparently inexplicable rejection of further aid by the recipient that often occurs.
more successful adaptation in difficult circumstances, although further research is needed to clarify the relations between enacted support, perceived support, and coping for children and adults.

Perceived support is the dimension of social support that is most strongly related to psychological well-being in adults and children (Barrera, 1986; Cohen & Wills, 1985; Jackson & Warren, 2000; Sarason, Shearon, Pierce, & Sarason, 1987). This is so because regardless of network size or social embeddedness, confidence in the availability and helpfulness of social partners is crucial to maintaining a sense that assistance is available and the hope that can ensue even in difficulty (this is, in a sense, what is meant by a secure attachment relationship early in life). Moreover, assessments of perceived support are inherently subjective of measures of social support, relying on how individuals appraise the reliability of their social networks, and thus measures of perceived support tap an important feature of emotional coping for individuals under stress. The significance of perceived support as a psychological resource for coping is important, moreover, for intervention strategies. It suggests that rather than seeking to engage troubled individuals in a broader social network or more frequent social interaction as a means of enhancing social support, it is sometimes more important to focus on the person’s subjective experience of supportiveness from network associates, perhaps by carefully examining their expectations of support in relation to what they perceive to be provided by others around them.

There are developmental differences in perceived support from different network associates (Furman & Buhrmester, 1985, 1992; Levitt, Guacci-Franco, & Levitt, 1993; M. Reid et al., 1989). In self-report studies, adolescents report expecting less support from their parents than do younger children, and there are similar decreases in perceived support from other family members, such as siblings and grandparents. Expectations of support from peers in-crease from childhood to early adolescence, but then stabilize or decline in later years. Teachers, by contrast, are rarely regarded as sources of social support. Individual differences in prior social experiences also contribute to differences in perceived support. In a study with African American 4½-year-olds, for example, Anan and Barnett (1999) reported that secure attachment predicted height-enened perceived support in these preschoolers and that each variable predicted children’s subsequent adjustment, with perceived support mediating the association between attachment and adjustment.

As these developmental and individual differences suggest, perceived support depends, in part, on one’s expectations of support from different network associates. Thus, individual differences in perceived support derive, in part, from the quality of assistance that people expect from family members, neighbors, peers, coworkers, and others. There is considerable need for greater understanding of the factors contributing to individual differences in expectations of support because of its relevance to perceptions of support by troubled individuals. Besides the developmental differences noted earlier, for example, how do experiences of stress and the turmoil of psychopathology alter expectations of social support? Do the overwhelming emotional needs of depression and anxiety disorders heighten expectations of support or increase dissatisfaction with perceived support—or both (as studies reviewed earlier seem to suggest)? Or are individuals in turmoil grateful for whatever assistance they can find from their exhausted social networks, as is suggested by Belle’s (1982) evocative study of socioeconomically distressed single mothers? Studying questions such as these is important to understanding the social support needs of at-risk children and adults.

As valuable as is perceived support, it is important to note that it does not encompass all of the important features of social support, especially those most relevant to assisting troubled individuals and families. This is because individuals may perceive support from network associates who are otherwise acting in a nonsupportive manner. This is tragically illustrated by Jill Korbin’s (1989, 1991, 1995) interviews with mothers convicted of fatal child abuse. These mothers were surrounded by family, friends, and neighbors who were often painfully aware of the bruises, neglect, and other harms inflicted by the mothers on their offspring. But in their efforts to be emotionally supportive, these network associates failed to challenge abusive practices and instead overlooked signs of parental dysfunction, minimized the seriousness of abuse, and offered reassurance about the mothers’ good intentions while providing noncritical emotional affirmation. In so doing, of course, they contributed
little to curbing abusive practices or protecting the children, and were thus ineffective in preventing the death of these children. As Korbin (1991, p. 23) noted, “A high level of perceived support sustained, probably unintentionally, these women in their pattern of abusive behavior.”

In short, the quantity of social relationships should not be mistaken for the quality of social support. People can be surrounded by a large network of social partners who offer little support or who are emotionally affirming while providing little other assistance to troubled individuals. This is one reason efforts to improve social support by increasing social network size or improving social embeddedness are unlikely to increase enacted or perceived support. In addition, a focus on perceived support highlights the importance of how children and adults with psychological disorders perceive—accurately or inaccurately—the supportiveness of their natural networks and the potential value of interventions that target these social perceptions.

Because social support is not the same thing as network size, it is noteworthy that in some cases, access to only one or a few confidants is sufficient to significantly aid coping under stress (Cohen & Wills, 1985; Gottlieb, 1985). With adults (Brown, 1987; Brown, Adler, & Bifulco, 1988) and children (Pellegrini et al., 1986), the absence of a confiding relationship has been found to significantly distinguish whether individuals under stress developed affective problems or not. For adults, supportive intimacy can be found with a romantic partner or spouse; in the study by Pellegrini and colleagues, it was the absence of a best friend that predicted risk for affective disorders in middle childhood. Taken together, these findings contribute to the conclusion that it is not number but quality of relationships that shapes perceptions of support and, in turn, the benefits of social support for coping with stress.

**SOCIAL SUPPORT AND DEVELOPMENTAL PSYCHOPATHOLOGY**

It is clear that social support is associated in complex ways with stress and coping. Support can be stress-preventive and it can be a stress buffer when difficulty ensues. Support can be mobilized when stress occurs, but stressful events can also reduce access to support networks and an individual’s capacity to receive aid that is offered by others. The importance of perceived support adds further complexity to the association between social support and stress because of how stress can alter a person’s awareness of supportive access to helpers.

It follows, therefore, that the association between social support and developmental psychopathology is also complex. In this section, we explore this complexity by distinguishing three phases in the course of psychological disorders. First, we consider how social support, especially its absence, is relevant to the initial development of psychological disorders. This is especially relevant to portrayals of social support as a preventive and buffering agent in stressful circumstances. Second, we examine the role of social support (and its absence) in the maintenance of psychopathology over time, underscoring the importance of social factors in the persistence of psychiatric symptomatology. Finally, we consider social support and the treatment of psychopathology and the alternative avenues that exist for enhancing support as a therapeutic aid.

**Social Support and the Origins of Developmental Psychopathology**

In light of the stress-preventive functions of social support, it is reasonable to expect that individuals who are socially isolated or are in social adversity in the context of stress would be at enhanced risk of psychological problems. Such people are, in a sense, denied the emotional, material, informational, and other kinds of assistance that companions can potentially provide. The important challenge is to understand the extent to which the lack of social support is crucial, independent of other risk factors, in contributing to risk for developmental psychopathology, and why.

The complexity of developmental processes, the diverse etiological contributions to clinical symptomatology, and the methodological challenges of research in developmental psychopathology together make it difficult to construct causal models linking social support to either healthy or unhealthy functioning. Current theoretical views posit complicated, reciprocal associations among biological, cognitive and emotional, and sociocultural processes that are mutually influential in a dynamic, nonlinear fashion to predict most developmental outcomes (see Cicchetti & Toth, 2003; Cicchetti, Toth, & Maughan, 2000; Dodge & Pettit, 2003; Sameroff & Chandler, 1975; Shonkoff & Phillips, 2000). In such models, both parent-child and peer relationships are typically regarded as primary social influences on development that have both direct and indirect effects on risk for psychopathology. Dodge and Pettit propose, for example, that parenting and peer experiences each mediate between biological predispositions or the sociocultural context and children’s vulnerability to chronic antisocial conduct problems. A recent molecular genetics study by Kaufman and
colleagues (2004) indicates that social support may moderate the effects of biological vulnerability and a history of maltreatment on children’s proneness to depressive symptomatology. In short, social support is likely not only to have a direct relationship to the development of psychopathology but also to mediate the effects of other risk factors in complex ways.

The social isolation of families who have abused or neglected their offspring, or who are at significant risk of doing so, is the most extensively studied condition in which the absence of social support is believed to contribute to the development of psychopathology. In this case, children’s risk of pathological development is mediated through their parents’ social support. Many researchers have concluded that parents who abuse or neglect their offspring lack significant social connections to others in the extended family, neighborhood, and broader community and to social agencies that can provide assistance (e.g., Daro, 1988; Garbarino & Sherman, 1980a; Polansky et al., 1981; Seagull, 1987; Straus et al., 1980; see Thompson, 1995, for a review). As a consequence, their treatment of offspring is likely to remain undetected, there are few interpersonal resources to which parents can turn when they are stressed, and the ways that social connections with potential helpers can buffer the effects of stress, promote healthy behavior, and socialize positive parenting are less influential.

An extensive review of this research by Thompson (1995) yields a fairly complex picture of the association between social isolation and child maltreatment. Three conclusions from his review are important to this discussion of social support and developmental psychopathology. First, in most studies, the social isolation distinguishing abusive or high-risk parents consists of their smaller social networks or their more limited social contacts with network members (i.e., limited social embeddedness). Parents at risk of child abuse know fewer people and see them less often, compared to other parents in similar circumstances. But research findings are inconsistent about whether at-risk or abusive parents experience significant deficits in enacted support or perceived support from their network associates. A study by Lovell and Hawkins (1988) is typical, in which abusive mothers reported that very few of their network associates provided practical help with child care or parenting responsibilities, but mothers reported enjoying seeing nearly 80% of these companions very much and reported that they could “share their thoughts and feelings frequently” with nearly 50% of them. Like the fatally abusive mothers studied by Korbin (1989, 1991), perceived support from network associates was often satisfactory even though the social support mothers received did not significantly reduce abuse potential. Thus, on the most important dimension of social support for psychological well-being—perceived support—there are often negligible differences between maltreating parents and those who are nonabusive, even though the social networks of maltreating parents are smaller and less supportive in other ways.

Second, there are subgroups of maltreating parents who experience significant social isolation for specific reasons. Polansky and his colleagues (Polansky, Ammons, & Gaudin, 1985; Polansky et al., 1981; Polansky, Gaudin, Ammons, & David, 1985) have studied neglectful mothers who consistently reported feeling greater loneliness and lack of neighborhood support compared with socioeconomically comparable nonneglectful mothers. Polansky has described an “apathy-futility syndrome” consisting of a passive, withdrawn demeanor coupled with emotional “numbness,” limited competence, distrust of others, retreat from social contact, and verbal “inaccessibility” to others that also makes them hard to reach socially (Gaudin & Polansky, 1986; Polansky & Gaudin, 1983). In Polansky’s view, the social isolation of these mothers derives from their inability to develop and maintain supportive social ties owing to character disorders, deficient social skills, and difficulties in coping adaptively with life stress. In a sense, their neglect of offspring is part of a general syndrome associated with their broader neglect of social connections. By contrast, Garbarino has described a different kind of “social impoverishment” of families in neighborhoods that experience heightened rates of child maltreatment (Garbarino & Kostelny, 1992). By comparing neighborhoods with higher-than-expected child maltreatment rates (based on sociodemographic predictors) with neighborhoods with lower-than-expected maltreatment rates and using informants in each community, Garbarino has sought to characterize the neighborhood conditions associated with child abuse and neglect (Garbarino & Sherman, 1980a, 1980b). He found that mothers in higher-risk neighborhoods reported receiving less assistance from neighbors, finding fewer options for child care, and generally perceiving the neighborhood as a poorer place for raising children. On other assessments related to social support, such as perceptions of sources of potential assistance, the friendliness of neighborhoods, and recreational opportunities, however, mothers of higher-risk and lower-risk neighborhoods did not differ. By contrast with the characterological problems of the neglectful mothers studied by Polansky and his colleagues, therefore, the mothers
of higher-risk neighborhoods studied by Garbarino lacked important features of social support owing to the diminished social resources of their neighborhoods and the diminished human capital of their communities.

Third, studies like these and others indicate that social isolation is not a homogeneous phenomenon, and consequently the reasons for social isolation are diverse in families at risk for child maltreatment (Thompson, 1995). For some, such as Polansky’s neglectful mothers, isolation may derive from social marginality attributable to limited social and coping skills in the context of stressful life circumstances (see also Seagull, 1987). For others, such as Garbarino’s higher-risk neighborhood residents, it arises from the impoverishment of social capital in difficult neighborhoods that may also be dangerous settings for children and that breed social insularity and distrust (see also Lynch & Cicchetti, 1998). For some, social isolation may be actively sought as a means of concealing abusive practices. For others, isolation may result from difficult circumstances that rob adults of the time or energy required to maintain social networks, or create feelings of humiliation and vulnerability and a desire to be left alone. And a significant proportion of high-risk families do not feel socially isolated at all, but are instead satisfied with their social interactions with a small network of close associates who provide emotional support but do not seem to constrain abusive or neglectful practices. “Social isolation,” when it is apparent, can have diverse causes.

The multifaceted causes of social isolation in families at risk for child maltreatment is important for at least two reasons. First, these studies indicate that social insularity may be a significant factor in the origins of child maltreatment for some families, especially when the causes of social isolation derive from psychological problems in parents, difficult or dangerous neighborhood conditions, or active efforts to conceal abusive practices. In these circumstances, the absence of significant social connections increases risk for child maltreatment because there are few from outside the family who can provide emotional support or material aid or monitor parental conduct, especially in the context of life stress. However, it is unwarranted to inclusively generalize this portrayal of abusive families. For many other families, social isolation does not appear to be etiologically relevant because abusive practices occur in the context of active social networks from which parents derive emotional support. Social isolation is not necessarily implicated in child maltreatment—and perceived support is not necessarily a buffer against abusive parenting. Second, the multifaceted causes of social isolation are relevant to intervention. Strategies for enhancing social support for at-risk families who are socially isolated must also be multifaceted. They may require, for example, social skills training (Gaudin, Wodarski, Arkinson, & Avery, 1990–1991), improving recipient reactions to receiving assistance (Tracy, Whittaker, Boylan, Neitman, & Overstreet, 1995), incorporating new support agents into natural social networks, or other approaches depending on the causes of social insularity. As we discuss in a later section, when enlisting social support in clinical treatment, one size does not fit all.

Social support and social isolation are experienced not only by families, but within families as well. In particular, children may be deprived of social support in families characterized by marital conflict, domestic violence, parental affective disturbances, child maltreatment, or other problems. Extensive research literature documents the risks for the development of internalizing and externalizing problems for children growing up in disturbed family environments (Thompson & Calkins, 1996; Thompson, Flood, & Lundquist, 1995). Children in homes characterized by marital conflict, for example, seek to reestablish the emotional security they have lost by intervening in parental arguments, monitoring parental moods, and otherwise striving to manage their emotions in a conflicted home environment (Cummings & Davies, 1994, 1996; Davies & Forman, 2002; Grych & Fincham, 1990; Katz & Gottman, 1991). As a consequence, they show heightened sensitivity to distress and anger, tend to become involved in their parents’ emotional conflicts, have difficulty regulating the strong emotions that conflict arouses in them (in a manner resembling “emotional flooding”), and exhibit other indications of internalizing problems. The work of Shaw and his colleagues has shown how the early development of conduct problems in young children derives from the interaction of the child’s temperament with maternal rejection and depression, parental conflict, and other indicators of family difficulty (Owens & Shaw, 2003; Shaw, Miles, Ingoldsby, & Nagin, 2003). Research on maternal depression shows, as earlier indicated, how the family environment presents children with overwhelming emotional demands deriving from the caregiver’s sadness, irritability, helplessness, and guilt-inducing behavior, which contributes to children’s enmeshment in the emotional problems of the adult and their own vulnerability to internalizing problems (Ashman & Dawson, 2002; Cummings & Davies, 1994, 1996; Zahn-Waxler & Kochanska, 1990).

These troubled family environments are deficient in much more than social support, of course. Children are also subjected to heightened parental negative affect, fami-
ily conflict, and other challenges to their emotional well-being. The relevance of social support is highlighted, however, in interventions in which children are offered the assistance of adults outside the family to aid in their emotional coping (Sandler, Miller, Short, & Wolchick, 1989). In a study by Blanchard, Molloy, and Brown (1992; cited by Beeman, 2001), for example, children living in violent homes reported that the best support was from a caring adult located nearby with whom the child could talk about family conflict. Although considerably more research is needed to examine the effects of extrafamilial social support on children’s coping with family problems, studies like these suggest that access to social support can help to buffer the effects of family difficulty. 

As children mature, social support may be obtained from peer relationships as well as family networks, and, conversely, vulnerability to problems may be enhanced by peers as well as family members. Positive peer relationships are likely to be protective influences, therefore, in preventing and buffering stress, and peer rejection and relationships with deviant peers may contribute to the development of childhood and adolescent depression and conduct problems. Although peer experiences are more likely a mediator or moderator of other risk factors than a direct causal agent for most forms of childhood psychopathology, there is evidence that peer relationships can assume a significant role in their development. One large, prospective longitudinal study that followed more than 500 randomly selected children from preschool through early adulthood found that, as early as preschool, exposure to aggressive peers predicted later aggressive behavior (Sinclair, Pettit, Harris, Dodge, & Bates, 1994). In another longitudinal study, Gazelle and Ladd (2003) found that the combination of anxious solitude (an index of individual vulnerability) and peer exclusion predicted levels of depressive symptoms in a sample of 388 children studied from kindergarten to fourth grade. There is evidence for the stress-buffering effects of positive peer relationships as well. In the prospective longitudinal study by Dodge, Pettit, Bates, and their colleagues, peer acceptance moderated the effects of low SES, high family stress, single-parent status, and violent marital conflict on the development of externalizing behavior in early grade school (Criss, Pettit, Bates, Dodge, & Lapp, 2002). In the same study, peer acceptance and friendship overlapped in their moderation of the effects of harsh discipline on the same outcomes. These positive effects of peer relationships remained even when the researchers controlled for child temperament and social information-processing skills. Of course, the influence of peer relationships on risk for psychopathology is as complex as is the influence of parental social networks. Indeed, in some cases, the same friendships that protect children from internalizing problems, such as depression, may enhance antisocial behavior (Nangle, Erdley, Newman, Mason, & Carpenter, 2003).

Social Support and the Maintenance of Developmental Psychopathology

Psychological disorders have multifaceted origins, of course, arising from the interaction of biological vulnerability, ecological demands and stresses, cognitive constructions, and other influences. The absence of social support, especially in the context of conflict in close relationships, adds further risk to the development of internalizing and externalizing disorders, and the availability of social support can, in turn, help to buffer the onset of clinical symptomatology. Social support and its absence are relevant also to the persistence of symptomatology over time. In other words, once clinical problems have developed, their maintenance may be associated with continuing social adversity and social isolation. Several research fields suggest how this may be true.

Children with anxiety disorders are highly vigilant for and hyperresponsive to situations associated with fearful stimuli. They interpret everyday situations in ways that exaggerate potential threat, are acutely sensitive to their own visceral signs of fear arousal, and become preoccupied with their negative emotion (Vasey & Ollendick, 2000). Not surprisingly, they are challenging for caregivers to help, but research indicates that the efforts of parents to be supportive may exacerbate rather than remedy anxious symptomatology (Thompson, 2001; Vasey & Dadds, 2001). Many parents of anxious children respond sympathetically and protectively to the fear expressed by their offspring, assisting the child in avoiding the fear-provoking event but, as a consequence, offering few opportunities to master the anxiety (Dadds, Barrett, Rapee, & Ryan, 1996; Gerlsma, Emmelkamp, & Arrindell, 1990). This is more understandable in light of studies showing an intergenerational family history for anxiety disorders, suggesting that anxiety is learned in families as part of the shared environment and that parents may thus become anxious in situations in which their offspring are also fearful (Eley, 2001). Thus, a child who responds to an anticipated encounter with a fear-evoking event with screaming, tantrums, hiding, and aggressive resistance offers powerful incentives for adults to accede, and if the adult does so and the child subsequently calms down, each partner is negatively reinforced for behavior that helps to perpetuate anxious symptomatology.
Thus, childhood anxiety disorders are likely to be accompanied by troubled family relationships. They are troubled by aversive interactions focused on the child’s efforts to avoid fear-provoking events that are inadvertently reinforced by parents’ efforts to be supportive and helpful. They are troubled also by the parent’s mixed response to the child’s behavior—overprotective but also critical—that contributes to parent-child relationships of insecurity and uncertainty. It is important to note that parental behavior in these instances is well-intentioned: Adults are striving to provide social support, even though their efforts inadvertently reinforce anxious symptomatology in their children (Thompson, 2001). One reason for family difficulty is that the emotional support offered by parents does not contribute to alleviating anxious fear or symptomatology.

The development of antisocial behavior is another example of how family processes and child characteristics combine to create a social context that contributes to the maintenance of psychopathology. The well-known work on coercive family processes of Patterson and his colleagues (Patterson, 1982, 1986; J. B. Reid, Patterson, & Snyder, 2002) illustrates specific pathways by which parents may inadvertently foster difficult relationships between themselves and their children or adolescents. As Patterson has evocatively shown, antisocial behavior in children is maintained by parents through their responses to child misconduct. By initially resisting the bad behavior of offspring and then acceding when children escalate their aversive conduct, parents provide powerful negative reinforcement for bad behavior. Patterson’s longitudinal studies have shown how such coercive interpersonal processes become generalized by children beyond the family and contribute to the development of antisocial behavior. Although parental practices within these families are not motivated by socially supportive intentions, this work illustrates the ways that aversive parent-child interactions contribute to the development and maintenance of psychopathological conduct through relational influences that victimize the entire family.

Another illustration of the influence of social support in the maintenance of clinical problems is the well-developed research literature linking peer relationship problems and childhood loneliness (see Asher, Parkhurst, Hymel, & Williams, 1990, for a review). Several recent studies have explored the associations between peer relationships and depressive symptoms in children (e.g., Boivin, Hymel, & Bukowski, 1995; Boivin, Poulin, & Vitaro, 1994; Burks, Dodge, & Price, 1995; Nangle et al., 2003; Oldenburg & Kerns, 1997). Nangle and his colleagues, for example, found that a fully mediational model of the influence of peer relationships on children’s loneliness and depression was warranted in their study of 193 third- through fourth-grade boys and girls. In this study, loneliness was the gateway through which peer relationships influenced the development of depression. However, friendships also buffered children from depressive symptomatology. The influence of popularity, or peer acceptance, was completely accounted for by the fact that peer acceptance temporally preceded friendship, suggesting that more popular children were likely to have both larger friendship networks and better relative quality of peer relationships. The researchers concluded that before adolescence, “the mutuality that is unique to friendships appears to be critical” (p. 552). Peer rejection is important not only to the development of depressive symptomatology but also to its maintenance over time, as children without friendships are likely to continue to feel lonely, self-deprecating, and isolated in their peer networks.

Social Support and the Treatment of Psychopathology

Social support is important to developmental psychopathology not only because of its contribution to understanding the etiology or maintenance of pathological symptomatology, but also because of its promise for pioneering avenues for therapeutic assistance. The core features of social support—counseling and guidance, emotional nurturance, information, skill acquisition, and sometimes material aid—are components of successful therapeutic efforts in all theoretical modalities. Whether in the context of individual therapy sessions, peer counseling, group therapy, parent education or parent support groups, therapeutic preschool programs, crisis counseling, or other therapeutic avenues, social support is an almost inescapable element of successful clinical intervention. Thus, understanding the nature of social support as well as obstacles to its efficacy in promoting psychological well-being and conditions that foster perceptions of support in troubled individuals are each important to successfully enlisting social support in therapeutic efforts. In addition, just as social support is incorporated into most forms of psychological treatment, it is
also a central feature of prevention efforts to avert psychological problems or their recurrence. Social support is a contributor to long-term adaptive functioning as well as immediate assistance to individuals and families in need.

Despite its ubiquitous contribution to therapeutic endeavors, incorporating social support in prevention and intervention strategies presents significant challenges. The forms of social support that are most helpful to individuals experiencing psychological distress are not self-evident, and, as we have seen, not all social support efforts are effective in achieving therapeutic or preventive goals. These are crucial considerations because of the many ways that well-intentioned supportive efforts can be rendered ineffective in changing destructive behaviors, fostering psychological well-being, or accomplishing therapeutic goals. Earlier in this chapter, we considered examples of how the emotional support of family and friends did not prevent troubled mothers from committing fatal child abuse, and how parental efforts to respond sympathetically and protectively does not enable offspring with anxiety disorders to master their fears. To be effective, in other words, the purposes and functions of social support must be strategically considered within a broader array of therapeutic efforts, keeping in mind that social support should include not only emotional sustenance and counseling but also reeducation, behavioral change, and monitoring the well-being of those it is intended to assist. In the following section, we consider three distinct interventions that purposefully incorporate aspects of social support to achieve particular treatment goals. First, we describe a treatment for depression that focuses almost exclusively on the social aspects of the disorder. Originally developed for adults, interpersonal psychotherapy has been adapted for adolescents because of the salience of relationships in adolescent development as well as the time-limited nature of this intervention (Mellin & Beamish, 2002; Mufson & Moreau, 1999). Next, we look at approaches that attempt to teach children to help each other in social situations as a means of enlisting social support from peers in developmental therapy. Finally, we briefly discuss a family support program that helps families whose children have Bipolar Disorder and that directly addresses a dimension of iatrogenic emotional engagement, expressed emotion (EE).

As we have noted, nearly all psychotherapy approaches rely on social support in the relationship between the therapist and the patient, and much of therapeutic content focuses on improving personal relationships. Interpersonal psychotherapy (IPT) is based on the premise that problems in relationships are important components of the maintenance of depressive symptoms. Interpersonal psychotherapy for adolescents (IPT-A) uses a three-phase, time-limited approach to help adolescents explore the impact of the interpersonal aspects of one or two problem areas on significant relationships (Mellin & Beamish, 2002; Mufson & Moreau, 1999; Mufson, Moreau, Weissman, & Klerman, 1993). Adolescents with Major Depressive Disorder or Dysthymia identify one or two problem areas from a group of five interpersonal concerns (i.e., grief, role disputes, role transitions, interpersonal deficits, or single-parent families). Specific strategies are recommended for each problem area to help adolescents express feelings, use the therapeutic relationship to increase awareness and understanding, and, ultimately, change their behavior in interpersonal situations. For example, the interpersonal deficits in adolescents between the ages of 13 and 17 who were diagnosed with Major Depressive Disorder, Dysthymia, or both disorders, interpersonal psychotherapy and cognitive behavioral therapy were both more effective in reducing symptoms of depression when compared with a wait-list control group, and 82% of the IPT participants were able to function in an adequate range at posttreatment, as measured by scores on a depression inventory (Rossello & Bernal, 1999).

Another approach to enlisting social support to remediate clinical problems is to engage natural helpers. For children and adolescents, this usually means providing training and supervision to peers who are then expected to help classmates or friends with needs. The goals of such strategies may be to increase the total number of peers who interact with the target child or to teach the target child social skills that will help her or him to attract more friends. Enlisting healthy, socially skilled peers to help children or adolescents who have behavioral or emotional disorders or who are at risk for the development of such disorders has intuitive appeal because of the potential to address both of those goals. However, as we have learned throughout this discussion, what appears simple and straightforward is often deceptively so. Lewis and Lewis (1996) identified several concerns with involving peers in helping each other. Most notably, in programs without careful role definitions and professional supervision, young people who are motivated by a desire to help others may
find themselves in situations that require significantly more training, expertise, and maturity than they have. Lewis and Lewis focused their analysis on risks to peer helpers in programs enlisting peer support for children at suicidal risk, and they reported findings from a descriptive study of Washington schools indicating that suicide rates were higher at schools where peer helpers were not supervised by professional counselors. As we note later with respect to home visitors, the potential advantages of enlisting natural supporters to aid troubled children or families must be balanced by their limitations in expertise and capability.

Behavioral theory suggests that designing interventions with carefully defined target behaviors and narrowly focused strategies is likely to avoid some of the ambiguity of more general supportive or mentoring approaches and provide more precise guidance about what works and what does not work. Consistent with this view, one group of researchers (Christopher, Hansen, & MacMillan, 1991; Guevremont, MacMillan, Shawchuck, & Hansen, 1989) trained 7- to 9-year-old children in specific social skills and rewarded them for playing with identified classmates. Same-sex peers were trained in initiating, responding to refusals, maintaining interactions, and responding to negative behavior. Each was then paired with a socially isolated, dysphoric child, and rewarded for playing with that child during one daily recess. The intervention resulted in an impressive increase in positive social interactions. The improvement in peer interactions for the target children occurred with both the designated helpers and also with other classmates, and the levels of positive interactions were comparable to those of social comparison children in the same setting. The treatment gains increased at a 4-month follow-up (Guevremont et al., 1989). In a similar study that targeted three socially isolated, dysphoric children, the researchers increased the training for peer helpers and achieved similarly promising results. Gains in positive interactions were maintained at the 4-month follow-up, and the positive effects generalized to situations when the intervention was not used. In addition, there was no evidence of negative impact of social support on the helpers (Christopher et al., 1991).

Interventions designed particularly for family members, especially parents, are often part of the therapeutic endeavor when children and adolescents experience psychopathology. Families are the primary source of support for children, and the quality and effectiveness of the support family members provide to children with clinical problems is crucial to the child’s healthy adjustment. As we have seen, however, not all efforts to enhance social support are helpful; indeed, emotional support may not be effective in remediating children’s problems in some situations. In fact, the parent’s emotional engagement may have negative effects in certain circumstances. For example, children’s emotional or behavioral difficulties may lead to heightened criticism and hostility toward the child (Hooley & Richters, 1995). Expressed emotion (Hirshfeld, Biederman, Brody, Farone, & Rosenbaum, 1997a) is an index of parental attitudes of criticism or emotional overinvolvement in the child’s problems that has been studied as a contributor to the onset, maintenance, or relapse of a number of clinical problems, including Schizophrenia (Brown et al., 1972), depression (Hooley, Orley, & Teasdale, 1986), Bipolar Disorder (Miklowitz & Goldstein, 1997), behavioral inhibition (Hirshfeld et al., 1997a, 1997b), and Conduct Disorder (Calam, Bolton, & Roberts, 2002; Caspi et al., 2004; Rogosch et al., 2004). Family support or treatment components have been designed to include a specific focus on EE as a way of improving the quality of social support for young people with clinical problems. The RAINBOW treatment protocol, for example, is a child- and family-focused cognitive behavioral therapy for children with Bipolar Disorder that addresses the intense personal demands of raising a child with this disorder in an effort to decrease the potentially harmful effects of EE (Pavuluri et al., 2004). Elements of this program include encouraging family members to distinguish helpful from unhelpful reactions in their efforts to cope with a child who can be difficult to live with, helping parents model appropriate strategies for affect regulation, fostering shared effective problem-solving strategies in which parents and target children jointly participate, assisting children in their efforts to develop successful peer relationships, and identifying other sources of social support. Preliminary conclusions from a study of 34 families participating in this program indicated that symptom severity for children decreased significantly following therapy and parents reported strong satisfaction with the treatment, although there were no family-based measures of the emotional environment (Pavuluri et al., 2004).

Taken together, conclusions from these and other therapeutic interventions that explicitly attend to the social support needs of troubled children and families indicate that when carefully designed and thoughtfully implemented, social support can be an important contribution to therapeutic success. But because social support needs are multifaceted, one feature of the preventive or therapeutic enlistment of social support is that supportive interventions are multifaceted. They should include not only emotional aid and counseling but also information or educational guidance, help with everyday stresses and practical life
skills (such as parenting), economic assistance or job training when it is warranted, and, when children are concerned, counseling and educational assistance. Although services must always be tailored to the needs of recipient families, a broad array of socially supportive interventions is most likely to address the salient needs of multiproblem individuals and families.

There are many examples of intervention programs with blended forms of social support. Gaudin’s (Gaudin et al., 1990–1991) Social Network Intervention Project, for example, combines strategies to enhance informal social network support for families identified as neglectful with the assistance of regular volunteer aides, the enlistment of neighborhood helpers, and social skills training to enable family members to better create and maintain supportive relationships. Yoshikawa’s (1994, p. 28) review of programs to prevent chronic juvenile delinquency concludes that “interventions combining comprehensive family support with early education may bring about long-term prevention through short-term protective effects on multiple risks.” Programs like Childhaven combine quasi-therapeutic full-time day care services with practical parent education, casework support, parent support, family therapy groups, and social agency referrals for troubled families (Durkin, 1986; Miller & Whittaker, 1988). The Committee on Integrating the Science of Early Childhood Development of the National Academy of Sciences concluded an extensive review of the prevention research by finding:

Model early childhood programs that deliver carefully designed interventions with well-defined objectives and that include well-defined evaluations have been shown to influence the developmental trajectories of children whose life course is threatened by socioeconomic disadvantage, family disruption, and diagnosed disabilities. Programs that combine child-focused educational activities with explicit attention to parent-child interaction patterns and relationship building appear to have the greatest impacts. In contrast, services that are based on generic family support, often without a clear delineation of intervention strategies matched directly to measurable objectives, and that are funded by more modest budgets, appear to be less effective. (Shonkoff & Phillips, 2000, p. 11)

To be sure, characterizing the variety of intervention strategies encompassed within these preventive efforts as consistently “socially supportive” threatens to overstretch the boundaries of the social support construct. But these reviews underscore that social support efforts must be multifaceted to effectively address the complex needs of troubled children and families, and that social support interventions must be undertaken in an individualized manner that is responsive to the specific needs of recipients and the specific goals of the intervention effort.

THE CONTINGENCIES OF SOCIAL SUPPORT EFFORTS

In a recent review article, Hogan, Linden, and Najarian (2002) asked, “Social support interventions: Do they work?” Their answer was that current research provides support for the general usefulness of social support interventions, but there is insufficient evidence to conclude which kinds of interventions work best for what problems. Likewise, Heller and Rook (2001) noted in their review of social support interventions that the effective ingredients of supportive interventions are still unknown. The problem in designing the most effective interventions to improve social support and increase healthy functioning in troubled individuals may be even broader. Robinson and Garber (1995) noted that there is currently no coherent theory of how social support should guide intervention efforts. Absent a well-developed and empirically based theoretical portrayal of social support, interventions are often guided by a general expectation that greater social support, usually indexed by increased social ties, is a good thing and will have broadly positive benefits. Unfortunately, this often means that social support interventions are vague and ill-defined and, without specific outcome expectations, sometimes fail to accomplish measurable improvement in the lives of their recipients.

In addition to problems in specifying the most effective ingredients of effective supportive interventions and identifying what interventions work best for what psychological problems (and for individuals of what ages), it is also important to understand the contingencies of social support efforts. In other words, what influences can enhance or hinder the efficacy of social support interventions? At times, thoughtfully designed social support efforts founder because of challenges concerning the needs of support providers, the complex recipient reactions to obtaining assistance from another, cultural factors associated with giving and receiving social support, and the goals of intervention. We consider these contingencies next.

Sources of Support and the Needs of Support Providers

Social support may be obtained from informal helpers (such as friends, neighbors, family members, coworkers, teachers, or classmates) or formal helpers (such as counselors or therapists, home visitors, social workers, or
also have difficulty engaging the consistent cooperation
instances affecting their well-being. Formal helpers can
cipient families, they may be unaware of many circum-
cumstances and values of recipients, they may also share
their stresses and difficulties and may be less sensitive to,
or unwilling to challenge, unhealthy or inappropriate con-
duct if it is typical for their reference group (such as harsh
parenting or substance abuse). Formal helpers do not have
these disadvantages because of their professional training,
and their helping relationships with recipients are well-
defined by their professional role responsibilities. But
because they are less well integrated into the lives of re-
cipient families, they may be unaware of many circum-
stances affecting their well-being. Formal helpers can also have difficulty engaging the consistent cooperation
of their clients.

These distinctions between formal and informal sources of support are important for defining the capabilities and needs of support providers. Enlisting natural social networks into social support interventions can be valuable but is constrained by the limitations in expertise and skills of informal helpers. As illustrated earlier when describing efforts to enlist peers to support adolescents at risk of suicide, the ethical responsibility of program designers is to ensure that natural helpers like these are not put into situations that exceed their capabilities and skills, which can easily occur if they are striving to help others who have serious psychological problems (Lewis & Lewis, 1996). Likewise, volunteer home visitors have much to offer social support programs because they often share the backgrounds and orientations of recipient families, but most are inadequately prepared to address serious family problems arising from depression, domestic violence, or substance abuse, and they may have difficulty engaging challenging families or following a consistent curriculum (Margie & Phillips, 1999). Although informal helpers are convenient, inexpensive, and often highly motivated, it is unreasonable to expect that their efforts can accomplish as much as professionally trained formal helpers might achieve in similar circumstances, and it is ethically irresponsible to expect them to provide long-term help or to assist individuals with serious problems without training and support. In short, the source of social support enlisted into an intervention de-
fines, in part, the scope of results that might be reasonably expected from the effort.

The source of social support is an important consideration also because offering assistance to troubled individu-
als can be draining and demoralizing (A. H. Collins & Pancoast, 1976; Shumaker & Brownell, 1984). Recipients are needy but may also be demanding and critical for rea-
sons described in the next section, and providing help in re-
lationships of one-way assistance can be exhausting
because support is not reciprocated. Moreover, the relation-
ship between support providers and recipients can be diffi-
cult because each may have different goals, with recipients
seeking noncritical emotional affirmation and providers
also striving for changes in the recipient’s behavior and at-
titudes. They may differ in their views of the recipient’s
problems and the best solutions to them. Crises may force
support providers to focus on immediate needs (urged to do
so by recipients) and neglect attention to long-term strate-
gies for building healthy practices. For these reasons, it is
common for providers and recipients each to feel frustrated
by their relationship and sometimes to experience conflict.
The professional training of formal helpers prepares them
to cope with these challenges, but informal helpers may be
surprised to discover how difficult it is to provide social
support, especially if they began doing so with little train-
ing or guidance. It is common, therefore, that social sup-
port interventions enlisting natural helpers must address
the frequent turnover and burnout of their staff, which is
reduced but not eliminated when informal helpers are pro-
vided with appropriate training, guided supervision, fre-
quent affirmation of the value and importance of what they
are doing, and other forms of social support. In designing
successful social support interventions involving natural
support agents, in other words, it is as essential to train and
support the helpers as it is to ensure that appropriate forms
of social support are also offered to targeted recipients.

For this reason, integrating the efforts of formal helpers
with those of informal helpers in recipients’ natural social
networks may offer the best opportunities for creating en-
during preventive or therapeutic benefits (Froland, Pan-
coast, Chapman, & Kimboko, 1981; Miller & Whittaker,
1988). The teamwork of formal helpers with members of
informal social networks can enable natural helpers to be
supported in their efforts while ensuring the skill and ex-
pertise that formal helpers can provide. Their integrated
efforts can occur in many ways. Formal and informal assis-
tance is harmonized, for example, when a parent support
group is organized around a local school or child care pro-
gram, a perinatal home visitor encourages the company of
extended kin during home visits, or a group therapy pro-
gram for adolescents has connections to the school or to the peer group. The effective coordination of formal and informal support networks is not easy, however, because of the differences in background, values, goals, and definition of the problem that may provoke mutual distrust between formal and informal helpers. All too commonly, extended family members or neighbors reinforce a parent’s skepticism of the potential helpfulness of a counselor or paraprofessional home visitor. Sometimes social workers undermine informal helpers by criticizing them or trying to assume their roles. But the integration of formal and informal helping is essential to promote the engagement of recipients in social support interventions and to provide a foundation for enduring assistance. Many well-meaning social support interventions fail because they do not sufficiently incorporate the natural helping networks of family members, resulting in assistance that is limited in time, scope, and impact.

Recipient Reactions to Assistance

Receiving assistance from another evokes surprisingly mixed reactions from most recipients. In addition to the feelings of pleasure and gratitude that helping naturally inspires, recipients may also experience various negative feelings (Fisher et al., 1982; Shumaker & Brownell, 1984). Receiving assistance can be humiliating and stigmatizing, especially when the need for assistance derives from inadequacies in the recipient (such as poor parenting, substance abuse, or inadequate personal or financial management) rather than from broader, impersonal circumstances (such as an economic recession or a natural disaster; Heller & Rook, 2001). Receiving help can also create feelings of failure, indebtedness, and inferiority, especially when assistance cannot be repaid, because of cultural norms of equity and reciprocity (Greenberg & Westcott, 1983). Moreover, if assistance cannot be reciprocated or compensated, the recipient may experience feelings of vulnerability or dependency because obtaining assistance from another violates norms of self-reliance and autonomy. There can also be sensitivity to privacy violations if helpers become intimately acquainted with aspects of the recipient’s life that are not normally disclosed to others.

As a consequence of these reactions, recipients may rather paradoxically begin to resent the assistance they receive and the person providing it. This is especially likely when assistance is received from voluntary benefactors (whom one cannot reciprocate or otherwise compensate, enhancing the violation of equity and reciprocity norms) or strangers (with whom one does not share an ongoing relationship of mutual aid), and when the helper and the recipient are from similar backgrounds and circumstances (enhancing the inequity of the helping relationship). When recipients experience assistance as humiliating, demeaning, or intrusive, they are less likely to seek help in the future and are more likely to abridge or terminate a helping relationship if they are capable of doing so. This can explain why the recipients of assistance, to the surprise of their benefactors, may be ungrateful, fail to become engaged in the helping relationship, are often inexplicably absent from scheduled meetings, do not return phone calls, and progressively make the relationship unworkable or unsatisfying.

This analysis has surprising implications for providing social support to troubled individuals or families. It suggests that assistance is more easily accepted when recipients have opportunities to reciprocate or repay the aid they receive, perhaps in service to other individuals. It suggests that support is more readily received in circumstances that minimize the potential for humiliation or stigmatization, such as when support services are broadly available or universal (rather than specifically targeted to those in greatest need) and accessed in everyday settings (at home, for example, rather than at an agency office). This analysis suggests also that social support is more easily received when the recipient and the helper agree about the need for assistance and the reasons for the need. By contrast, assistance from another may be resented when the recipient perceives that it derives from unshared judgments of the recipient’s inadequacy or incompetence. Provider efforts to preserve the dignity and the privacy of recipients are also important.

Other characteristics of the recipient can mediate the provision of social support. Because social support is given and received in relationships, many of the personal qualities necessary to creating and maintaining relationships are important also to the success of social support interventions (Cochran, 1990). When these capacities are deficient in troubled individuals owing to mental health or substance abuse problems, intellectual challenges, or the effects of stress itself, it can also complicate the receipt of social support (Heller & Swindle, 1983; Shinn et al., 1984). As earlier noted, for example, one portrayal of child neglect emphasizes the personal disorganization of neglectful parents, which becomes manifested as an inability to effectively organize home life, ensure children’s physical well-being, and keep appointments with a help provider (Polansky et al., 1981; Seagull, 1987). These qualities, which are certainly not unique to child neglect, make it difficult for parents to create and maintain supportive helping relationships with other adults. For children and adults with emotional disorders, clinical symptomatology may
undermine the willingness or ability to maintain formal or informal supportive relationships. Stress can cause individuals to feel overwhelmed by life difficulties and to lack the time, energy, or hope to seek support from others. This can be especially true when families at risk live in dangerous neighborhoods that undermine access to neighbors, extended family members, and formal help providers (Eckenrode, 1983; Eckenrode & Wethington, 1990).

Because social support is not passively received, these recipient characteristics can pose formidable barriers to interventions based on supportive social relationships. Indeed, one of the most intractable obstacles to the success of social support interventions is the limited engagement and participation of recipient families. This suggests that a careful analysis of recipient reactions to assistance is necessary. When resistance to obtaining assistance derives from feelings of indebtedness, humiliation, or dependency, the conditions of support can be altered to reduce these perceptions and enhance participation in supportive relationships. This can occur by involving recipients in activities that help others, or that assist the intervention program, or that mobilize the recipient’s special skills or capabilities. When supportive relationships are undermined by characteristics of the recipient, these problems must often also be addressed in the context of the intervention, such as in a substance abuse treatment or a social skills training program. This is not an easy task, however, because the personal characteristics of recipients that undermine their acceptance of help are often deeply rooted.

Cultural and Contextual Considerations

Among the most important personal characteristics of the providers and recipients of social support is their cultural and ethnic identity (Tietjen, 1989; Vaux, 1985). Cultural norms affect many of the central influences on giving and receiving social support and its psychological effects, including understandings of relationships, the nature of informal social networks, reciprocity and equity expectations in giving and receiving help, values concerning the relation between the individual and the group, attitudes toward assistance from formal helpers (such as therapists), and how help itself is evaluated (Dilworth-Andersen & Marshall, 1996; Jacobson, 1987). An appreciation of cultural and contextual factors related to social support is essential for understanding its associations with psychological well-being and developmental psychopathology. Cultural understanding is also critical to designing interventions in which social support is offered in a culturally aware manner to ensure that potentially beneficial intervention strategies do not founder on delivery approaches that render them ineffective or even harmful.

A broad, well-known dimension by which concepts of the self in relation to others vary interculturally is that of individualism and collectivism (Triandis, 1989), or independence and interdependence (Markus & Kitayama, 1991). In cultures with an interdependent view of self, there is greater emphasis on connectedness with others and on deriving important features of identity and esteem from those associations; in cultures with a more independent view of self, there is a greater emphasis on the autonomy of personal thoughts and feelings, self-reliance, and privacy. These cultural views of the self are developed quite early and influence how children perceive themselves and their relationships from early childhood (e.g., Greenfield, Keller, Fuligni, & Maynard, 2003; Han, Leichtman, & Wang, 1998; Wang, 2004). By later childhood and adolescence, youth with backgrounds from interdependent cultures (such as Hispanic and Asian societies) acknowledge the expectation that they will assist and support family members more than do adolescents from European backgrounds (Fuligni & Pedersen, 2002; Fuligni, Tseng, & Lam, 1999). One study of Chinese American teenagers reported that such intergenerational expectations had neither positive nor negative consequences for psychological well-being (Fuligni, Yip, & Tseng, 2002). But the association between cultural values and social support is complex. A cultural emphasis on interdependence may facilitate help giving and help receiving through normative practices, but cultural values may make receiving help more difficult in many circumstances. One illustration is a study of older Japanese American adults living in New York City for whom norms of reciprocating support made receiving assistance difficult. Adults who held strong reciprocity norms and who received material support from their families were more depressed and were less satisfied with their lives than those who did not embrace strong reciprocity norms (Nemoto, 1998).

Cultural values and practices are related to a number of features of social networks and social support. Specifically, there is significant intercultural variability in the United States in (1) the nature and functioning of informal social networks, (2) the association between social support and psychological well-being, and (3) attitudes toward receiving assistance from formal helpers. Each of these sources of variability is relevant to designing culturally competent interventions involving social support and linking formal and informal sources of support to troubled children and their families.

Although the constituents of social networks are similar for families in different ethnic and cultural groups (e.g., in-
including immediate and extended family, friends, neighbors, and the like), the relative importance of each of these network members for social support is likely to vary. MacPhee, Fritz, and Miller-Heyl (1996) compared lower-income Native American, Hispanic, and European American parents living in the United States on their self-reported sources of support. They found that Native Americans reported more interconnected social systems, more frequent contact with extended kin (but not friends), more members who knew one another, and greater closeness with members of their support networks. Hispanic parents reported having the largest social networks, and, although these networks were close-knit, Hispanics were in general most likely to rely primarily on kinship networks for emotional support. Although they reported the lowest proportion of network members who could offer emotional support, they also reported the highest proportion of network members who could provide instrumental support (e.g., material assistance). European American parents had more diffuse social networks but also reported having a higher proportion of members available for instrumental support. Unlike parents in the other two groups, they reported that friends were the primary providers of emotional support rather than family members. Children also exhibit intercultural variability in the network members on whom they rely for support. In a study of fourth and sixth graders, DeRosier and Kupersmidt (1991) reported that children from Costa Rica rated their parents as the most important providers of support, and children in the United States rated their best friend as the most important source. These intercultural differences are important for understanding the network members who are likely to provide the most helpful forms of informal social support to children and families in need, as well as the avenues by which such support can be offered. It is a much different task to enlist the assistance of other family members in close-knit extended kinships than to call on the help of friends or other extrafamilial associates to provide social support.

Understanding cultural variability in social networks is especially important when children are the targets of social support interventions. For example, children and youth report receiving greater support from their extended families than do children from European families (Cauce, Felner, & Primavera, 1982; Dressler, 1985; Taylor, Casten, & Flickinger, 1993). Likewise, Hispanic values of familialism, involving strong feelings of support and reciprocity with family members, expand the social support networks of children to include adults beyond the immediate family unit (Sagobal, Marin, Otero-Sabogal, Van OSS Marin, & Perez-Stable, 1987). These conclusions are important not only for widening conceptions of the social networks of children and youth from culturally diverse families, but also for cautioning that problems in parent-child relationships, such as those arising from parental stress, substance abuse, or psychopathology, may not leave these children bereft of social support from other sources.

Likewise, parents may not act consistently as monitors, supervisors, and gatekeepers of children’s access to other sources of social support. In recent immigrant families, for example, children and their parents may quickly differ in their familiarity with the environment, facility with the majority language, and access to social networks outside the family owing to different acculturation experiences at school and in the workplace. Although this may cause some parents to seek to restrict the access of children to extrafamilial social partners (Nanj, 1993), intergenerational differences in acculturative status mean that as children and youth become increasingly comfortable in the majority culture, parental restrictions are likely to become less effective and add stress to the parent-child relationship (Garcia Coll & Pachter, 2002). These influences may make it difficult for parents to function adequately as gatekeepers of children’s access to extrafamilial sources of support.

Although social support comes from potentially diverse sources and is experienced in the context of cultural values, there is good evidence that social support contributes to psychological well-being for different cultural groups in the United States. Coatsworth and colleagues (2002) recently examined family, school, and friend support in relation to externalizing and internalizing behavior in Hispanic girls in middle school, and found that controlling for age, SES, and years in the United States, youth reports of greater perceived family support and teacher support (but not friend support) predicted fewer externalizing problems, and greater perceived family support and friend support (but not teacher support) predicted fewer internalizing problems. Support within the family was the strongest predictor of externalizing and internalizing symptomatology (Coatsworth et al., 2002). Likewise, in a short-term longitudinal study of African American male adolescents,
Zimmerman and colleagues (Zimmerman, Ramirez-Valles, Zapert, & Maton, 2000) found that although support from friends did not predict later outcomes, support from parents predicted diminished depression and anxiety. Rodriguez and colleagues examined perceptions of family and friend support in relation to stress and psychological adjustment in Hispanic college students (Rodriguez, Bingham Mira, Myers, Morris, & Cardoza, 2003). They found that higher support from family and friends predicted increased psychological well-being, although only friend support was a unique predictor of lower psychological distress.

However, cultural values may significantly mediate whether members of different ethnic and cultural minorities access formal—rather than informal—supports when facing psychological distress. This can occur for various reasons, including lack of awareness of formal services, distrust of providers (or providers who cannot speak their language), cultural beliefs that assistance from nonfamilial helpers is unnecessary or inappropriate, resistance to formal helpers from within the family or cultural group, or service delivery practices that are culturally uninformed. In the study of lower-income families described earlier, MacPhee and colleagues (1996) found that European American parents were significantly more likely to have sought professional therapy than were Native American or Hispanic parents, and they also tended more to seek professional help with parenting issues. Similar findings have been reported by Stevens (1988).

Findings such as these underscore the need for cultural awareness in designing interventions to enhance social support to children and families of culturally diverse groups. A culturally competent service delivery system will (1) identify groups that are underserved and seek to reduce cultural barriers that may interfere with service delivery by understanding their characteristics, resources, and needs; (2) orient program planning, staff training, and community involvement to ensure that the development, implementation, and evaluation of services are respectful of the values and practices of recipient families; (3) evaluate assessment and outcome procedures and instruments to ensure their appropriateness and validity for the children and families who are served; (4) build cross-cultural communication skills with program staff, including the appropriate use of interpreters and an ethnographic understanding of communication approaches within cultural groups; and (5) seek to develop an appreciation of cultural diversity as a facilitator rather than impediment to service delivery (Shonkoff & Phillips, 2000). These practices are especially important in services that seek to strengthen the benefits of social support interventions by linking formal support to informal support networks, especially in light of how “outside” helpers can be regarded with distrust or resentment by members of close-knit families or communities. In the end, cultural beliefs and practices are among the most significant personal characteristics mediating the needs of potential recipients and the providers of social support.

Clarity of Goals

Each of these contingencies in the efficacy of social support interventions underscores why clarity concerning the goals and purposes of intervention efforts is essential. Without clear goals, it is difficult to carefully design interventions that will accomplish specific goals for recipients that address their particular needs and living conditions and that result in measurable goals (Gottlieb, 2000; Heller & Rook, 2001).

Achieving clarity in goals means answering a series of questions. First, in what ways do recipients lack social support that an intervention is expected to address? Answering this question requires a thoughtful understanding of potential recipients and their living circumstances and cultural background, including their personal needs and the resources as well as deficits that exist in their informal social networks and access to formal helpers. It is especially important to comprehend how stress is affecting potential recipients and their capacity to receive assistance from within or outside their natural social connections, and how shared stresses may affect the capacities of network associates to offer social support. Second, what are the specific goals that a social support intervention is meant to address? Multiple goals might be envisioned—providing emotional affirmation, offering instrumental or material aid, social support as a bridge to other forms of assistance, curbing inappropriate or dangerous conduct, preventing problematic behavior from occurring, promoting healing or developmental remediation, integrating formal with informal sources of support—but they should be related to the needs of recipients and identify outcome expectations that will enable an evaluation of the success of the effort. Third, who will offer support and how will they be identified, trained, and enabled to undertake this challenging task successfully? In what specific ways will they offer support, in what contexts, for how long and with what frequency and intensity, and in what social circumstances (e.g., working in teams or individually)? There are also trade-offs between the cost of an intervention and the training and professionalism of formal helpers, and the design of a social support intervention should approach these considerations thoughtfully, keeping in mind that volunteer helpers cannot
be expected to undertake the challenges or provide the long-term assistance that professional helpers may be better prepared to provide.

Taken together, questions such as these that focus on the needs of potential recipients, the capabilities of support providers, and the purposes of intervention help to ensure that efforts involving social support are well-designed to address the ways that social support can support psychological well-being for specific families and individuals in need, and that the resources of support providers will be equal to addressing these challenges. Moreover, addressing such questions also identifies the specific outcomes that the social support intervention is intended to affect, making it easier to conduct later evaluations of intervention effectiveness that are carefully tailored to the goals of the program.

Implications

Because the availability of social support will not in itself ensure benefits to recipients, considering the contingencies of social support is essential to planning interventions that will have greatest beneficial impact (see Thompson, 1995). In general, social support efforts are likely to be most effective in the following circumstances:

- The contributions of formal helpers are integrated and coordinated with the efforts of informal helpers in natural social networks and the latter are provided affirmative support for their efforts.
- There are clear, well-defined goals in mobilizing social support that are based on a careful analysis of the needs of target individuals or families and their social networks, the specific purposes for intervention, and the capabilities of support providers, and that identify outcome expectations that can constitute the basis for subsequent evaluation studies.
- Program planners understand how stress may impact the capacity of recipients to receive assistance and the functioning of informal networks of social support.
- Cultural beliefs and practices receive careful consideration and interventions are designed to respond sensitively to cultural diversity.
- Social support interventions provide bridges to broader community resources or other resources that can offer recipients long-term assistance.
- Help providers are supported through continuing supervision, training, and other forms of assistance, especially if they are volunteers or paraprofessional helpers.
- There are efforts to improve recipient reactions to accepting aid, which may include reducing feelings of vulnerability, failure, or inferiority by providing opportunities to reciprocate aid, promoting recipients’ voluntary participation in efforts to help other individuals, and developing an environment of mutual respect.
- The need for social support is normalized in the community, so that receiving assistance is not stigmatizing or humiliating.
- Social support interventions are coordinated with other services that address other needs of troubled individuals or families or help recipients to function more successfully in socially supportive relationships (such as through social skills or substance abuse programs).
- When children are the targets of intervention, considerable attention is devoted to the needs of their parents and families in the context of potential two-generation interventions and the impact of family processes on the child’s capacity to benefit from social support efforts.

Although these conclusions may seem straightforward and intuitively sensible, there are many reasons that intervention practitioners ignore them (Gottlieb, 2000). One reason is that owing to resource limitations, program philosophy, or tradition, most agencies or programs have only a limited range of support services to offer needy recipients and are thus constrained in their capacity to tailor services to specific client needs (Thompson & Flood, 2002). Another reason is that a detailed needs assessment takes time and, in the absence of validated, readily implemented assessment tools, this process may be abridged or ignored in the rush to provide services. Finally, because the budgets of most intervention efforts are limited, providing support to helpers assumes a lower priority than providing direct services to clients, even though this often results in high turnover and burnout among staff, especially when they are volunteers or paraprofessionals. On the other hand, the same resource limitations make investment in well-trained or formal helpers an impossibility.

Nevertheless, the importance of these contingencies to program success is reflected in the costs of ignoring them when potentially helpful intervention approaches encounter difficulty. One illustration is home visitation. During the past several decades, home visitation has become the most enthusiastically supported and widely recognized approach to providing social support for needy families. The fundamental strategy unifying diverse home visitation programs is the delivery of information, guidance, and emotional support to family members in their homes, often in the context
of two-generation efforts in which improving the well-being of the child is the basic goal. Doing so provides an avenue for offering diverse forms of social support, overcomes some of the barriers these families otherwise face when obtaining needed assistance (such as lack of transportation or health insurance) and establishes a relationship of trust with a home visitor who can provide individualized assistance and bridge connections to broader resources (Thompson, 1995; Wasik & Bryant, 2000). Home visitation has provided the foundation for a number of intervention efforts throughout the country, most notably the Healthy Families initiative, developed by the National Committee to Prevent Child Abuse, which has established a nationwide consortium of hundreds of home visitation programs throughout the country serving families at risk (Daro, 2000; Daro & Harding, 1999). A large number of home visitation programs are funded by direct legislative appropriation in many states, or by project grants from federal agencies, as central features of statewide efforts to strengthen child health and development, prevent child maltreatment, and improve parent-child relationships.

There have been a number of reviews and evaluations of home visitation initiatives (see, e.g., General Accounting Office [GAO], 1990; Olds & Kitzman, 1993), but the most recent and large-scale evaluation efforts have yielded the most startling conclusions. Based on sophisticated evaluation studies of six of the most well-known home visitation models that have been implemented nationally, Gomby, Culross, and Behrman (1999) concluded that program benefits were modest and inconsistent across program sites, benefits were enjoyed by only a subset of the families who participated in the program, and programs failed to accomplish most, if not all, of the goals of the home visitation effort. The recent results of a meta-analysis of 60 home visitation programs provided evidence that families in home visitation programs benefit from their participation, but these effects are modest and studies do not offer insight into what kinds of home visitation initiatives benefit what kind of participants. These reviewers concluded that “the utility of home visiting programs cannot be clearly stated” (Sweet & Appelbaum, 2004, p. 1448), and Gomby and colleagues recommended

Several problems of program implementation were identified by these reviewers and by other evaluations of family support programs emphasizing social support (e.g., Halpern, 2000; Larner, Halpern, & Harkavy, 1992) as helping to account for these discouraging conclusions. They include the inconsistent participation of recipients, the importance of supporting help providers, the need to develop community connections, and the problem of lack of clarity in program goals and expectations.

The failure to fully engage families in the program and the high attrition rates of participants have been identified as significant challenges for virtually all home visitation programs. According to Gomby and colleagues (1999), between 10% and 25% of families invited to participate in home visitation programs decline, and between 20% and 67% of the families who enroll fail to complete the program. Moreover, even when families enroll and remain in home visitation programs, they tend to receive only about half or fewer of the planned number of contacts with the home visitor. The reasons for problems in participant engagement are unclear but are likely related to residential relocation, busy or disorganized family schedules, and other typical characteristics of recipients. But lack of engagement may also be related to the mixed recipient reactions to obtaining assistance discussed earlier, especially if family members do not perceive that home visitation addresses their needs and concerns, or feel embarrassed, indebted, or vulnerable because of the services they receive (Margie & Phillips, 1999).

A second problem in successfully implementing home visitation programs is the lack of training, supervision, and support for home visitors, which contributes to the high turnover rates that are observed in most home visitation programs (GAO, 1990; Gomby et al., 1999). It is common for home visitors to report shorter visits than planned, broken appointments that are not rescheduled, and becoming preoccupied with immediate family crises rather than the delivery of intended education or guidance during home visits. Home visitors are further challenged when working with culturally or linguistically diverse families, at-risk populations, or parents who suffer from depression, domestic violence, or substance abuse (Margie & Phillips, 1999). Moreover, several studies have found that how the intended curriculum of a home visitation intervention is implemented varies significantly depending on the values and orientation of the home visitor (Baker, Piotrowski, & Brooks-Gunn, 1999; Wagner & Clayton, 1999). At times, in other words, what actually occurs during home visitation may be much different from what program designers had intended. Furthermore, the high turnover of home visitors
undermines the relationship between participants and the program, and this may be one contributor to the lack of family engagement. Turnover can be especially difficult for adults in the highest-risk families, who may have fewer alternative sources of support on which to rely and who often have histories of abandonment and relational dysfunction. These challenges to program implementation are directly related to the training, supervision, and support provided to home visitors, especially those who are volunteers or paraprofessionals. However, personnel, training, and supervision account for most of the costs of a home visitation program, and thus poorly or inconsistently funded programs are likely to scrimp on these essential features of service delivery.

Another challenge to effective program implementation is the failure of many home visitation programs to explicitly establish the development of community supports as a central goal for recipient families. This is unfortunate because, by contrast with the traditional social work model, the social support approach incorporated into home visitation recognizes that a home visitor cannot provide all that recipients need, and consequently one of the significant goals of intervention must be to help families forge associations within their communities to individuals and agencies that can offer longer-term support. Moreover, community connections and visibility can also enhance the positive regard for a home visitation program in the neighborhood, and this can contribute to improving family engagement and strengthening the connections between family members and community services.

Finally, the reviews by Gomby and colleagues (1999) and Sweet and Appelbaum (2004) each identified program goals as problematic because they were unclear, unduly ambitious, and/or were not carefully translated into intervention strategies. Gomby and colleagues emphasized, in particular, a renewed appreciation that home visitation programs must have modest expectations for what social support alone can accomplish for needy families. They suggest that home visitation efforts be combined with other services that can address other family needs. This is an additional reason for consolidating stronger connections between family members and community resources so that home visitors do not seek to do it all. Home visitation programs that focus on limited, clear, well-defined, and realistic objectives have the greatest chance of success by enabling program staff to sustain program focus and to use limited resources to achieve realistic expectations (GAO, 1990).

These concerns with the effective implementation of home visitation programs are familiar in light of the foregoing analysis of the contingencies of social support interventions. They do not indicate that efforts to improve social support in the lives of troubled children and their families are inappropriate or worthless. They do, however, suggest that it is crucial to move beyond a general expectation that providing social support in itself will yield many benefits to recipients. Programs must recognize that (1) social support is multifaceted; (2) potential recipients have diverse needs, expectations, and personal and cultural backgrounds; (3) their natural social networks have unique resources and difficulties; (4) their communities likewise have unique constellations of material and human capital; (5) support providers have needs for training and support that are central to an effective intervention; and (6) social support alone cannot address the complex needs of recipients. The importance of clear thinking concerning the purposes of social support interventions, how these objectives should be translated into program strategies, and how the outcomes of these efforts should be evaluated is warranted.

**CONCLUSIONS AND FUTURE DIRECTIONS**

One of the central conclusions from the research on social support and developmental psychopathology is how complicated the provision of social support in everyday circumstances is, yet how beneficial it is for psychological functioning. When people are surrounded by natural networks of family, friends, neighbors, coworkers, and others who offer emotional guidance and instrumental aid and monitor well-being, the odds in favor of psychological health and healing are meaningfully improved. However, another central conclusion of this research is how difficult it is to create the benefits of natural forms of social support in preventive or therapeutic interventions. This not only owes to the challenges of instituting formal helping relationships that can offer social support, but also because when natural social networks are not functioning supportively (because they are drained or stressed, for example), it is difficult to reconstitute them in healthy and helpful ways. Added to these challenges is the neediness of support recipients and how their personal and ecological characteristics can pose obstacles to the success of social support interventions. In short, the benefits of social support are easy to envision but difficult to implement. This poses a fundamental challenge for researchers, theorists, clinicians, and practitioners who, after the initial wave of enthusiasm for the preventive and therapeutic benefits of social support interventions 2 decades ago, must now confront the host of practical challenges to effectively implement social support in the lives of needy families. As the evaluation studies of home visitation programs are familiar in light of the foregoing analysis of the contingencies of social support interventions. They do not indicate that efforts to improve social support in the lives of troubled children and their families are inappropriate or worthless. They do, however, suggest that it is crucial to move beyond a general expectation that providing social support in itself will yield many benefits to recipients. Programs must recognize that (1) social support is multifaceted; (2) potential recipients have diverse needs, expectations, and personal and cultural backgrounds; (3) their natural social networks have unique resources and difficulties; (4) their communities likewise have unique constellations of material and human capital; (5) support providers have needs for training and support that are central to an effective intervention; and (6) social support alone cannot address the complex needs of recipients. The importance of clear thinking concerning the purposes of social support interventions, how these objectives should be translated into program strategies, and how the outcomes of these efforts should be evaluated is warranted.

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From the varieties of programs that have documented measurable and predictable benefits for recipients—and from those that have failed to do so—there is now a wealth of good ideas for crafting more carefully conceived, thoughtfully designed social support interventions that have greater promise of success. It remains to be seen if the enthusiasm for the psychological benefits of social support interventions can be sustained in the current environment of conceptual rethinking, more careful and modest goal setting and, as always, limited budgets.

There are many ways an examination of social support and developmental psychopathology illustrates the principles of a developmental psychopathology perspective (Cicchetti & Cohen, 1995). Most fundamentally, there appears to be considerable consistency in the processes and outcomes of social support in diverse developing populations, both those that face atypical challenges and clinical difficulties and those that do not. Although at-risk children and families encounter unique problems in obtaining or receiving social support, and particular forms of support may be especially important to different recipient populations, the potential benefits of well-designed social support interventions are consistently clear in our review of diverse clinical and developmental literatures. The continuity in developmental processes between atypically and typically developing populations is, of course, a hallmark of the developmental psychopathology view and appears to be supported by the benefits that well-crafted social support interventions can offer needy individuals of all kinds. However, our review of research on social networks has shown that contrary to the simplified views of social support of several decades ago, there are both risk factors as well as protective factors in the everyday social relationships from which it is derived. The continuity in developmental processes between atypically and typically developing populations is, of course, a hallmark of the developmental psychopathology view and appears to be supported by the benefits that well-crafted social support interventions can offer needy individuals of all kinds. However, our review of research on social networks has shown that contrary to the simplified views of social support of several decades ago, there are both risk factors as well as protective factors in the everyday social relationships from which informal social support is constituted. Especially for troubled families and children, these relationships may be sources of stress and difficulty in neighborhoods that may be dangerous or deprived, and thus simply enfolding individuals into broader social networks will not ensure access to social support. Instead, thoughtfully designed social support interventions must carefully determine the resources as well as the liabilities that exist in natural social networks in order to evaluate whether these networks can be strengthened to increase support to target individuals, or whether new sources of social support must be identified. The need to consider both risk factors and protective factors as contributors to psychological health or dysfunction is an important feature of a developmental psychopathology analysis, as is the concept of multifinality, which is also illustrated in the social support research. Multifinality suggests that any component of a developmental system may function differently depending on the organization of the system in which it operates. In our review, we have indicated many instances in which social support can have benefits but also create liabilities for well-being depending on the form of social support and other features of the social ecology of the child and family. These include situations in which individuals offer emotional support but, in doing so, condone or excuse psychologically unhealthy practices (such as child maltreatment or pathological forms of child anxiety) and circumstances in which social support is offered at a price (of engaging in relationships that also cause stress) that significantly alters its benefits for the recipient. This affirms the conclusion that social support is not in itself a panacea, but its benefits avail only when it is thoughtfully incorporated into the lives of its recipients.

The research literature on social support is broad and expansive, yet there remain significant gaps in knowledge that future research must address, especially with respect to issues of developmental psychopathology. First, there is a critical need for better understanding of the social support process, especially when children and families are concerned. What are the specific ways that social support is given, experienced, and received in the everyday social relationships from which it is derived? What specific things do network associates do to make recipients feel supported? How is the process of social support experienced differently by young children, older children, and adolescents in relation to their relative understanding of the complexity of relationships and their own social support needs? In what ways is the experience of social support significantly altered by clinical psychopathology, whether children or parents are depressed, abusive (or abused), or troubled in other ways? In a similar fashion to an earlier generation of studies of the clinical process that helped to identify some of the important features of the therapeutic process related to clinical outcomes, understanding of social support would benefit from finer-grained investigations that examine the process of social support as it is experienced by helper and recipient (Barker & Pistrang, 2002). Such studies, which should include field studies as well as experimental probes, could meaningfully inform the design of social support interventions by promoting more effective intervention design and enabling better training of social support providers.

A related, and significant, concern for future research concerns determinants of the perception of social support. As we have noted, an individual’s perception that social support is available and accessible is the most important dimension of social support predictive of psychological well-being, but it is not directly and strongly linked to enacted support (see also Hogan et al., 2002). This raises new questions concerning the other determinants of perceptions of social sup-
port and, more broadly, how individuals make judgments of social support. Lakey and his colleagues (e.g., Lakey & Lutz, 1996; G. L. Rhodes & Lakey, 1999) have argued that perceptions of social support derive from (1) personality characteristics of the recipient (e.g., a secure or insecure attachment history, interpretive biases, extraversion), (2) characteristics of the helper (e.g., personality factors such as empathy, enacted support), and, most important, (3) the interaction between helper and recipient (e.g., their similarity in background and outlook). This is a heuristically powerful analysis and invites both broader inquiry into the determinants of perceptions of social support and a thoroughgoing developmental analysis of these determinants (e.g., How do developmental changes in support needs, understanding of relationships, and other factors contribute to changing perceptions of social support with increasing age?). One important implication of research on this topic concerns intervention. If perceptions of social support are central to the preventive and therapeutic benefits of social support, then perhaps support interventions could be effectively oriented toward changing perceptions of social support in the minds of needy recipients. If needy individuals begin to perceive their existing social networks as offering greater opportunities for social support, is their own sense of well-being enhanced (even if there have been no significant changes in the behavior of network associates) and, more important, do they become more willing and capable of fostering social support on their own?

We also urge greater, and more systematic, examination of the nature and efficacy of interventions incorporating social support. As Barrera and Prelov (2000) have noted, there is very little research examining whether changes in social support are directly linked to changes in psychological well-being, despite a wealth of suggestive research findings. Moreover, there is relatively little inquiry into the long-term effects of social support interventions: Most evaluation studies examine immediate or short-term outcomes with little inquiry into enduring influences. Furthermore, much remains to be learned about the recipients of social support and, in particular, what kinds of families and children are likely to benefit most from social support interventions, and for whom such efforts are likely to prove ineffective. As the work of Polansky and his colleagues (1981) on neglectful families exemplifies, the research reviewed in this chapter shows that potential recipients differ significantly in their capacity to receive social support and to benefit from it, and further inquiry into individual and developmental differences will inform intervention design.

There is also considerable need for further study of developmental considerations related to giving and receiving social support within families. The intersection of the social networks of parents and offspring offers a start to understanding the direct and indirect avenues by which parents’ experience of social support influences offspring, and the roles of parents as gatekeepers to children’s access to social networks outside the home affirms the importance of two-generational thinking in providing social support to children. Beyond these, however, developmental inquiry into how children’s social networks change with age, the manner in which these networks become increasingly self-regulated and independently accessed, how children’s perceptions of social support and capacities to access support from others change with age, and related issues would contribute to a more fully developed understanding of social support in its normative and clinical dimensions.

Beyond these, there are a number of basic questions that continue to merit attention:

• How do natural networks of social support function in everyday life? How is their functioning affected by aspects of neighborhood and community life that may inhibit or encourage contact with others. How are they affected by cultural values?
• How do individuals experience support from informal and formal helpers in everyday life? How do they identify particular persons as sources of reliable assistance, and what are the characteristics of these people?
• How do stress, family turmoil, and the psychological problems of a family member affect social support processes within families? What causes some families to seek and gratefully accept assistance and other families to become withdrawn and isolated? What are the characteristics of potential help providers that may affect how families respond to offered aid?

Although inquiry into social support and its psychological benefits has been ongoing for several decades, this essential component of preventive and therapeutic success is current and vital. For children in psychological turmoil and families in distress, the work of developmental psychopathologists on social support remains essential.

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