Social Network and Social Support at a Clubhouse Program

Thesis

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Abstract

Recovery is an increasingly important concept in severe and persistent mental illness (SPMI). In the context of SPMI, Clubhouses are self-help programs that foster recovery-oriented attitudes of their members. To date, there is no study describing the manner in which Clubhouses do this. Two possible mechanisms include member affiliation to the Clubhouse and a willingness of members to offer emotional social support to other members. In this exploratory study, researchers tested these mechanisms by administering a pencil-and-paper social network survey, a Clubhouse affiliation scale, and the Maryland Assessment of Recovery in People with Severe Mental Illness (MARS) to Clubhouse members (n=46). Preliminary results indicated that member affiliation with the Clubhouse and the number of members' positive comments directed at other members predict scores on the MARS ($t=2.888$, $p=0.00617$; $t=2.288$, $p=0.02738$, respectively) regardless of Clubhouse attendance, which did not predict MARS scores. While this is an exploratory study, it supports the possibility that both member affiliation with the Clubhouse and a willingness of members to offer emotional social support to other members might contribute to recovery-oriented attitudes in people with SPMI.

Curriculum Vitae

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List of Tables and Figures

Chapter 1: Introduction

Recovery is an increasingly important concept in severe and persistent mental illness (SPMI). In the context of SPMI, Clubhouses are self-help programs that foster recovery-oriented attitudes of its members. Two possible mechanisms include member affiliation with the Clubhouse and a willingness of members to offer emotional social support to other members. To date, there is no study that describes these socially supportive mechanisms.

While the affiliation that members feel with other members and staff could be a valuable piece to the Clubhouse program and mental health in general, literature on the construct is sparse. Conversely, literature abounds for emotional social support. However, little research explains how social support is given and received in a Clubhouse. In addition, traditional conceptualizations of emotional social support may not capture the beneficial relationships between members of a Clubhouse program. A new conceptualization of emotional support with Clubhouse members' relationships in mind could shed light on the role of the construct in the recovery process. This exploratory study provides insight on affiliation and an alternative conceptualization of emotional social support for a Clubhouse program.

Chapter 2: Literature Review

Social Support

Social support has been historically related to positive physical, mental, and social health (Cohen & Willis, 1985; Cohen & Syme, 1985). This connection holds true in the SPMI population. Specific to this particular project, social support will be discussed as being a pervasive and important concept for people with SPMI. However, there are multiple definitions of social support and hypothesizes for the construct as a mechanism for positive outcomes.

Social support literature outlines four distinct forms of social support (House, 1981). The first is emotional social support. This form of social support is defined as sharing life experiences. This can take the form of empathy, love, trust, and caring. In the mental health field, emotional support becomes more relevant in crisis situations (Cohen & Willis, 1985). The result is a form of social support demonstrated by interactions of seriousness and gravity. To date, there are few instances in this literature that focus on other aspects of emotional social support.

Returning to the Clubhouse model, the second form of social support is instrumental social support, or provision of tangible aid and services that directly affect a person in need. The third form of social support is information social support, or information. Clearly, it involves the provision of information that a person can use to address problems. In mental health, informational social support can be thought of as advice, guidance, and suggestions. House's final form of social support, called appraisal support, is the provision of information that is useful for self-evaluative purposes. Cohen and McKay, whose research on social support will be later discussed, described an additional form of social support as sense of social belonging (1984). It is sometimes referred to as affilational social support or affiliation. Affiliation is ill-defined in the social support literature on people with severe and persistent mental illness.

Although commonly appearing in literature of fields outside of the social sciences as the manifestation of the biological "tend-and-befriend" natural response to stress there is no formal definition relevant the mental health field (Taylor, 2002).

So while social support as a broad construct that is frequently referenced and used in research, nuances of social support are less understood. Even social support in the broadest terms raises questions at the most basic level. The exact nature of the relationship between social support and mental health is not yet fully understood (Corrigan & Phelan, 2004). This is, in part, is due to issues of establishing causality between social support and mental health. While social support may lead to positive mental health outcomes, it could also be that people with better mental health outcomes are better able to maintain sources of social support.

Another source of confusion is differential explanations for the positive effects of social support. Two separate explanations argue whether or not social support is inherently beneficial at all times or that social support acts as a buffer during times of stress (Cohen & Willis, 1985). The latter definition is consistent with the traditional mental health conceptualization of social support being most relevant in crisis situations. The buffering hypothesis cites several seminal studies finding inverse correlations between perceived social support and depressive symptoms (Andrews, Tennant, Hewson, & Vaillant, 1978; Cohen & Hoberman, 1983).

Finally, there is debate whether giver or receiving social support is more beneficial. Studies suggest that providing others with help is therapeutic, citing the effectiveness of self help groups (Roberts, Salem, Rappaport, Toro, Luke, & Seidman, 1999). While this "helper therapy" does not discredit potential benefits of receiving social support, it raises questions about how the construct is traditionally viewed in clinical settings (Reissman, 1965).

The basic conceptualization of social support as assistance from other people or face-to-face interactions with other people can serve as a functional definition when perusing most of the literature on the construct and related outcomes. Social support is also sometimes viewed as the size of the collection of an individual's relationships and their structure. This is called a social network (Carrington & Scott, 2011). The larger an individual's social network, the more potential sources of social support for him or her. Studies have indicated that all kinds of social support *can* be predictive of outcomes for people with SPMI, in and out of crisis. As previously stated, these outcomes can be found across physical, mental, and social health domains of functionality.

While research concerning people with SPMI, social support, and the physical health domain is sparse, numerous studies implicate social support as a mediating factor of mortality and morbidity (Berkman, 1984). However, it is uncertain whether social support is causal for physical health outcomes or negative physical health outcomes impede social support. Physical health conditions could simply alter an individual's perception of received social support as well. Despite this, social support has established relevancy in a variety of conditions, including but not limited to cardiovascular, neuroendocrine, and immune system problems (Uchino, 2004). While this is not specific to the SPMI populations, poorer health outcomes compared to those of the general public have often been observed. It stands to reason that people with SPMI are especially vulnerable to physical health conditions when lacking social support. Recent studies have emerged suggesting that social support can play a role in health behaviors with people with SPMI, such as diet and exercise (Aschbrenner, Mueser, & Pratt, 2013).

Social support is also relevant on the mental health domain. SPMI is associated with smaller social network sizes (Lipton, Cohen, Fischer & Katz, 1981). Therefore, as previously

mentioned, there are fewer potential sources of social support. Low social support is predictive of greater depression and anxiety symptomology (Cohen & Willis, 1985). More recently, it has been associated with suicidal ideation as well (Casey, Dunn, Kelly, Birkbeck, Dalgard, Lehtinen, Britta, Ayuso-Mateos, & Dowrick, 2006). A recent study suggests that social support can be adjunctive to professional help (Davis & Brekke, 2012).

Perhaps the most obvious domain affected by social support with SPMI is the social domain. On the macro level, interplay between social support and stigma exists. The World Health organization cites stigma as a barrier to treatment of mental illness. While social support may mediate the effects of stigma, stigma may cause individuals to withdraw from those around them and minimize the amount of received social support (Chronister, Chou, & Liao, 2013). In other words, social support can beneficial for people experiencing stigma from SPMI. On the other hand, stigma hinders social support. In 2006, Mueller, Nordt, Lauber, Rueesch, Meyer, and Roessler found that social support even played a role in perceived stigmatization within the first year of onset of mental illness.

On an individual level, the smaller network sizes of people with schizophrenia puts the population at risk for social isolation. Social isolation has been connected with symptomology of schizophrenia in the past—so much so that it was once thought to be a cause of the mental illness (Jaco, 1954). In a 2009 study, Hendryx, Green, & Perrin found that people with SPMI were less likely to participate in activities (e.g. go for a walk, play a sport, ride in a bus or car) when social support was low. Other studies have gone farther, demonstrating that diminished social support may affect coping skills and social functioning (Davis & Brekke, 2013). It should be noted, however, that causality between social support and outcomes cannot be conclusively established.

Even so, social support consistently proves to be important when discussing mental illness. In a 2007 study, McCorkle, Rogers, Dunn, Lyass, and Wan implemented an intervention to increase social support for participants with serious mental illness. Results of the study showed improvement in symptoms and wellbeing for the participants. This study indicates that social support can play a role in mental health programs. Clubhouse programs have shown to be conducive to social support development among its members (Carolan, Onaga, Pernice-Duca, & Jimenez, 2011). However, how Clubhouse programs do this is still unclear.

The Clubhouse

In the context of mental health, a Clubhouse is a self-help program for people with SPMI that consists of voluntary membership and participation, a work-ordered day, a weekend and evening social program, supported employment in mainstream businesses and industries, and case management and community support (Clubhouse International, 2013). Within the Clubhouse model, there are four central principles: (1) the clubhouse belongs to its members, (2) the presence of members is expected, (3) each member is a valuable contributor to the clubhouse, and (4) all efforts are essential to the functioning of the Clubhouse (Beard, Propst, & Malamund, 1982). The result is a recovery-oriented psychosocial rehabilitation-type program that fosters a unique community of individuals.

The effectiveness of Clubhouses has been evidenced in several studies (Macias, Rodican, Hargraves, Jones, Barreira, & Wang, 2006; Schonebaum Boyd, & Dudek, 2006; Mowbray, Woodward, Holter, MacFarlane, & Bybee, 2009). Research has shown that the Clubhouse serves as a community for its members (Jackson, 2001; Herman, Onaga, Pernice-Duca, Oh, & Ferguson, 2005). Consequently, the Clubhouse program is recognized as anevidence based practice (Substance Abuse and Mental Health Services Administration, 2014). At the most basic

level, it provides opportunity to people with SPMI to participate in meaningful activity, which, per the aforementioned Hendryx et al. study, is less likely to happen without social support.

Perhaps most salient about Clubhouse programs is the way in which members relate to one another. Participants in a Clubhouse program are emphatically referred to as "members." In his famous experiment in 1973, Rosenhan asked participants without mental illness to feign auditory hallucinations to gain admission into psychiatric hospitals (Rosenhan, 1973). The participants were admitted, diagnosed with schizophrenia or bipolar disorder and, despite feigning no other symptoms, and not released for up to almost two months. The study illustrates the power of labeling of mental illness. While the study is decades old, results of a study indicated mental illness labels extinguish a sense of humanity toward people with mental illness on the part of people without mental illness (Martinez, Piff, Mendoza-Denton, & Hinshaw, 2011).

The "member" designation strays from more typical words such as "patient," "client," or even most recently, "consumer." The terminology minimizes the power differential between the members and the staff members that oversee the program. This noteworthy quality markedly differentiates the Clubhouse program from other mental health programs (Jackson, 2001). For this reason, the way in which members relate to one another in the Clubhouse should be unique as well. However, the Clubhouse does share similarities with other evidenced-based practices in community mental health. The recovery orientation is one such similarity.

Recovery

The Clubhouse model shares an approach to mental illness with a paradigm shift that occurred in the mental health field during the 1980s called the recovery movement (Deegan, 1988). This movement emphasized recovery from mental illness, defined as "the establishment

of a fulfilling, meaningful life and a positive sense of identity" (Andresen, Oades, & Caputi, 2003). The literature related to the recovery movement is extensive, although how the shift will play out in terms of goals of mental healthcare remains unclear (Clarke, Oads, & Crow, 2012). The recovery orientation of mental health care promotes empowerment for people with mental illness (Barrett, Young, Teague, Winarski, Moore, & Ochshorn, 2010). In addition, recovery has been found to be related to higher levels of social support (Rogers, 2004).

Chapter 3: Conceptual Framework

Theoretical Framework and Purpose of Study

As previously discussed, there is no study that adequately describes the manner in which affiliation and social support function in a Clubhouse program. In a related study, researchers looked at the social support in a Clubhouse in terms of whom a member talked with regarding a concerning personal matter (Pernice-Duca, 2008). The traditional conceptualization of emotional social support did not appear to manifest in the member-to-member social network of the Clubhouse. In addition, the study did not address affiliation.

As previously discussed, emotional social support is often conceptualized in the context of crisis in the mental health literature. The buffer hypothesis of social support exemplifies this notion (Cohen & Willis, 1985). While having sources of emotional support during crisis has been shown to be beneficial, whether positive effects of social support exist outside of crisis is less clear. All people with SPMI experience or have experienced stress throughout the course of their illness. Therefore, emotional social support is relevant regardless of whether it buffers the individuals from stress or is inherently beneficial for this population. This study does, however, look to clarify the construct of emotional social support.

This study posits that emotional social support could also be beneficial with a nontraditional conceptualization. Brief, day-to-day interactions might also serve as a buffer for stress or be inherently beneficial. These interactions, while seemingly natural to people without SPMI, may be less commonly experienced for people with SPMI due to social isolation associated with the severity of the mental illness. So while people with SPMI do not get emotional social support in the traditional sense because of the social isolation, they also do not receive the alternative conceptualization of emotional social support.

The alternative conceptualization might also prove relevant considering the Clubhouse setting. As per the Clubhouse model, the Clubhouse environment is deliberately non-clinical. Therefore, it stands to reason that Clubhouse members would not seek traditional emotional social support in times of crisis from other Clubhouse members. This may explain why, in a previous study, Clubhouse members did not name other members as sources of social support (Pernice-Duca, 2008). However, daily positive interactions with other members may serve a purpose in the recovery process. Since this alternative view of emotional social support has not been employed in a study with a Clubhouse, this relationship is unknown. The aforementioned lack of research on affiliation also renders the relationship between this form of social support and the Clubhouse program uncertain. Since the Clubhouse model emphasizes the facilitation of teamwork and the group setting, affiliation to the Clubhouse and other members might function in terms of recovery from SPMI.

A better understanding of social support in Clubhouses and SPMI, in general, could contribute to the improvement of interventions. Earlier studies, similar to the previously referenced McCorkle et al. study, tested the efficacy of social network-based interventions seeking to improve emotional social support. While outcomes are generally positive, a review of social support interventions posits that the mechanisms for their successes are not well understood, and that simply receiving social support may not be as beneficial (Hogan, Linden, & Najarian, 2002). Perhaps if interventions target the alternative conceptualization of emotional social support or affiliation and in a different manner, social network-based interventions could more definitively demonstrate effectiveness.

Relevance and Contributions to Social Work

This study is especially relevant to social work. In terms of theoretical perspective, the underpinnings of the recovery movement of SPMI, social support, and the Clubhouse model overlap with several core professional values outlined by the National Association of Social Workers (2014). These values include service, social justice, dignity and worth of the person, importance of human relationships, integrity, and competence.

In terms of service, the treatment of people with SPMI has been traditionally poor. Even in clinical settings, people with SPMI were often mistreated. This project seeks to improve the care for people with SPMI by expanding the literature on Clubhouse programs and social support. By doing the latter, the project also brings issues related to the population to attention. Therefore, it is similarly related to the professional value of social justice.

Both the recovery movement and subsequent Clubhouse model emphasis the dignity and worth of people with SPMI. The focus on self-determination and strengths of individuals are especially intrinsic to the field of social work. This strengths-based approach emphasized the ability of an individual to have agency in his or her life. Lastly, a goal of the project is to enhance competence of the mental health field—competence being the final social work value. By gaining a better understand of social support, Clubhouse programs, and the recovery process, the field will better be able to serve people with mental illness. Involving topics that share the values of the field of social work, this thesis will benefit the field by raising awareness in literature.

Research Questions

The primary purpose of the study was to explore the manner in which social support flows through the social network of the Clubhouse and the implications for the recovery of its members. The goals of the project can be summarized in the following questions:

1. How is the emotional social support that Clubhouse members receive from other members, staff, and nonmembers related, if at all, to the recovery process?
2. How does an alternative conceptualization of emotional social support compare to a traditional conceptualization?
3. How is affiliation to the Clubhouse program related, if at all to the recovery process?

Chapter 4: Methodology

Research Design

The research design utilizes a full network approach to codify demonstrations of various forms of social support between participating members in the Clubhouse. The participants nominated members, staff, and nonmembers of the Clubhouse for given socially supportive interactions in a self-report survey. The survey also measured the demographics, place in recovery, and affiliation with the Clubhouse for every participant. The participants received a compensation of $5 for approximately 30 minutes of time.

The researchers distributed, assisted with, and collected surveys at the Clubhouse over a 5-day period to attempt to capture the core network of the Clubhouse. In addition, the Clubhouse provided the researchers with archival data. This information was limited to attendance, work crew assignment, and involvement in transitional employment.

Participants

The clubhouse that is the focus of this study is located ina large Midwestern city and has 365 members.According to clubhouse records, 23% of the members visit nearly every day, 15% visit 11 to 15 times a month, 17% visit 6 to 10 times a month, and 45% visit 1 to 5 times a month. As with other Clubhouses, members are adults with SPMI. The principal investigator and key personnel recruited participants over a period of 5 days to ensure that the frequent attendees that make up the core network of the Clubhouse would be accounted for in the data analysis. The principal investigator and key personnel explained the purpose of the study, expectations of participation, and answered questions related to the survey. The 13% of Clubhouse members who had legal guardians were required to obtain consent from their guardian before participating.

Data Collection Methods

One week before the first day of data collection at the Clubhouse, the principal investigator and key personnel announced the project to the members. Recruitment flyers were posted throughout the Clubhouse. On the first day of data collection, the key personnel attended the daily morning meeting for the Clubhouse to reintroduce and thoroughly explain the project, as well as answer the members' questions.

Following the morning meeting, the key personnel distributed consent forms to interested members. There were no eligibility requirements for the study beyond membership to the Clubhouse. Members that returned the completed consent forms will receive the survey. Participants returned the surveys (completed or not completed) to the principal investigator or key personnel in exchange for $5. The principal investigator or key personnel was always available for assistance, including clarification of the survey questions.

Instrumentation

Social Support. The full network approach warrants particular attention to the way in which data is collected in terms of social support. The social network and social support questionnaire measured the received social support. Since the researchers attempted to gather this information from as much of the core social network of the Clubhouse as possible, outgoing social support was extrapolated from the received social support of other members. Because we asked participants for the specific names of individuals who had given them social support, we were able to reconstruct a social network of those who gave and received social support. Affiliation, however, was measured differently due to the nature of and limited literature on the construct.

Affiliation. Due to the lack of literature on affiliation, there is no scale that directly measures this construct. Therefore, the researchers developed a scale utilizing 3 different domains of affiliation. The 3 domains of the scale were the affiliation that members felt to other members, the affiliation that members felt to the staff, and the affiliation that members felt to the Clubhouse as an abstract whole. Each domain contained 5 questions totaling 15 questions for the entire scale. The member-member and member-staff subsections mirrored one another and included 1 negatively worded question each. All questions were presented as statements to which participants rated their agreement on a scale of 1 to 10.

Emotional Social Support. The social support questionnaire asked participants to nominate individuals with which they shared 2 different interactions. The first interaction was designed to guage the casual, day to day interactions that are frequently ignored in measures of social support. The question was phrased, "In the last week, which Clubhouse member said something that brightened your day?" he second interaction was related to the traditional conceptualization of emotional social support, and specifically attempted to tap into the therapeutic mechanism of universalization (Yalom, 1983; Neff, 2003), on the assumption that the clubhouse milieu should provide plentiful opportunities to universalize. The question was phrased, "When you were down, which Clubhouse member have helped you by sharing how they felt in a similar situation?"

Other Social Support. In order to capture the network of informational social support of the Clubhouse members as it might relate to recovery, a third question was added to the questionnaire. The question was phrased, "In the last month, which Clubhouse members have shared ideas for improving your mental health?" One final question was added to the questionnaire to assess the number of peers that participants considered being friends. The

question was phrased, “In the last month, which Clubhouse members have you socialized with outside of the Clubhouse?” The members were also asked to name both members of the clubhouse staff and individuals who were not affiliated with the clubhouse as sources of social support. These questions were identical to those above except that the phrase “Clubhouse members” was replaced by “Clubhouse staff” and “people outside the Clubhouse” respectively.

Recovery. Recovery was measured by the Maryland Assessment of Recovery in Persons with Serious Mental Illness (MARS) (Drapalski, Medoff, Unick, Velligan, Dixon, & Bellack, 2012). The MARS is a 25-item self-report scale. While there are no standardized norms, it can be used as a comparative instrument for people with SPMI. All items were presented as statements related to their recovery from mental illness to which participants rated their agreement on a scale of 1 to 5. Researchers chose this instrument for its consideration of input from consumers. Given the nature and approach of the project, the MARS was appropriate not only in terms of measuring recovery but for use in the member-driven Clubhouse program. In addition, the MARS has demonstrated internal and test-retest reliability (Cronbach’s α=0.95, r=0.898, respectively). The length, paradigm, and psychometrics of the measure suited the objectives for the project.

Data Analysis

Following completion, surveys were collected and responses were coded. Using the MARS as the dependent variable, scores on the affiliation scale, select demographic information (i.e. race, age, and gender), and member attendance were evaluated as predictors using multiple linear regression analysis. Race and gender were dummy coded (0=European American, 1=African American, Asian American, Native American or Other and 0=Male, 1=Female, respectively). Attendance was coded as number of visits to the Clubhouse during the previous

year. Received social support for the social support questionnaire was coded as the number of individuals the Clubhouse member nominated for each question. While 60 Clubhouse members participated in the study, 14 participants were excluded from data analysis due to incompleteness of survey. For the purposes of the study, informational support, socialization, and member work crew assignment were not evaluated as independent variables.

Chapter 5: Results

Demographics of Sample

The demographic information (i.e. race, age, gender, and mental illness diagnosis) of the study is displayed in the following table. The participants were disproportionately African-American adult males with schizophrenia.

TABLE 1. Demographics of Sample

Variable	Frequency	%
Mental Illness Diagnosis		
Schizophrenia	27	48
Depression	10	18
Anxiety	4	7
Bipolar Disorder	2	4
Schizoaffective Disorder	2	4
Post-Traumatic Stress Disorder	2	4
Autism	2	4
Mental Retardation	1	2
Borderline Personality Disorder	1	2
Obsessive Compulsive Disorder	1	2
Attention Deficit Hyperactivity Disorder	1	2
Other	2	4
Gender		
Male	30	65
Female	16	35
Race		
African American	29	63
Asian American	1	2
European American	12	26
Native American	1	2
Other	4	9
Age		
25-29 years	5	11
30-39 years	3	7
40-49 years	11	24
50-59 years	21	46
60-66 years	6	13

MARS

The lowest score reported on the MARS was 45 while the highest was 125, which is the highest score possible. The median and mean were 100 and 97.89, respectively.

Affiliation

The lowest score reported on the affiliation scale was 40 while the highest was 141. The median and mean were 127.2 and 136, respectively.

Social Support

Results of the social support questionnaire (i.e. number of people nominated by the participant) can be found in the following table.

TABLE 2. Results of Social Support Questionnaire

Variable	Min.	Max.	Mean
Member—Member			
Received Alternative Emotional Social Support	0	7	1.37
Outgoing Alternative Emotional Social Support	0	4	0.8696
Received Traditional Social Support	0	2	0.5
Outgoing Traditional Social Support	0	2	2.391
Member—Staff			
Received Alternative Emotional Social Support	0	8	1.196
Received Traditional Emotional Social Support	0	3	0.7174
Member—Outside of the Clubhouse			
Received Alternative Emotional Social Support	0	6	1.326
Recieved Traditional Emotional Social Support	0	4	0.6087

Linear Regression Analysis

The relationship between MARS scores and independent variables is displayed in the following table.

TABLE 3. Linear Regression of MARS Scores and Dependent Variables

Variable	Estimate	Std. Error	Prob.
Member—Member Social Support			
Received Alternative Emotional Social Support	2.208	2.192	0.319
Outgoing Alternative Emotional Social Support	7.850	2.732	0.00623*
Received Traditional Social Support	0.09677	5.30538	0.986
Outgoing Traditional Social Support	2.118	5.930	0.723
Member—Staff Social Support			
Received Alternative Emotional Social Support	2.831	1.991	0.162
Received Traditional Emotional Social Support	5.239	3.531	0.145
Member—Outside the Clubhouse Social Support			
Received Alternative Emotional Social Support	4.287	2.007	0.0383*
Recieved Traditional Emotional Social Support	1.368	3.257	0.676
Affiliation	0.4027	0.1396	0.00606*

Outgoing alternative emotional social support, or outgoing positive comments, from one member to another, received alternative emotional social support, or received positive comments, from staff to members, and affiliation were predictive of MARS scores. The relationship between MARS scores and these significant predictors as a linear regression model controlling for attendance, race, age, and gender can be found in the following table.

TABLE 4. Linear Regression Results Controlling for Attendance, Race, Age, and Gender

Variable	Estimate	Std. Error	Prob.
(Intercept)	57.67574	27.88271	0.0456*
Member—Member			
Outgoing Alternative Emotional Social Support	6.07204	2.85029	0.0399*
Member—Staff			
Received Alternative Emotional Social Support	0.48490	1.94353	0.8044
Affiliation	0.38402	0.16025	0.0217*
Attendance	-0.00853	0.04113	0.8368
Race	3.57102	0.27351	0.5853
Age	-0.26597	0.27351	0.3371
Gender	-1.10255	5.99529	0.8551

Controlling for demographic variables and attendance, only outgoing positive comments from one member to another and affiliation were predictive of MARS scores. The final linear regression model with controlling for demographics and attendance is displayed below.

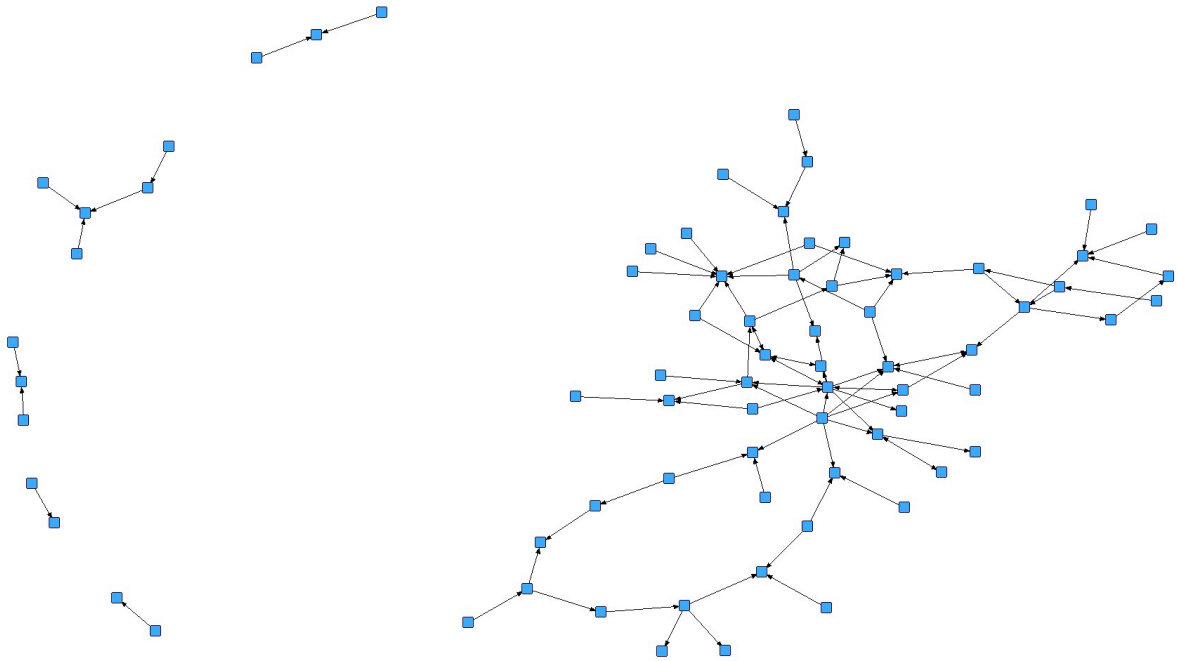
TABLE 5. Final Linear Regression Model with Controls

Variable	Estimate	Std. Error	Prob.
(Intercept)	58.10789	27.48333	0.0411*
Member—Member			
Outgoing Alternative Emotional Social Support	6.29441	2.67373	0.0238*
Affiliation	0.38750	0.15766	0.0187*

The adjusted r^2 value for the model was 0.2421, considered a moderate effect size.

A representation of the network of alternative emotional social support can be found below.

FIGURE 1. Alternative Emotional Social Support Between Members



Chapter 6: Discussion

Summary of Results

Preliminary analysis indicated that outgoing positive comments form one member to another, positive comments received from outside of the Clubhouse, and affiliation were predictive of MARS. Positive comments received outside of the Clubhouse, however, was not predictive when controlling for demographic information and attendance. Even though adding additional variables to the control model increased the risk for over-fitting, this would increase the likelihood of type I, and not type II error. Therefore, the researchers could validly exclude positive comments received from outside of the Clubhouse from the model. The final model accounted for 24.21% of the variance. Interestingly, traditional emotional social support and all forms of incoming social support were not predictive of MARS.

Implications and Limitations

While this is an exploratory study, it suggests that both affiliation to the Clubhouse and a willingness to offer social support to other Clubhouse members might contribute to recovery-oriented attitudes in people with SPMI. The latter finding is consistent with Riessman's "Helper Therapy Principle," which proposes that giving—rather than receiving—help is the impetus for mental health improvement (1965). This is in contrast to the traditional view of social support as something that is received in order to be beneficial. The novel conceptualization of emotional social support as positive comments (i.e. saying something that "brightened your day") implies that common exchanges may have therapeutic value for people with SPMI.

A limitation of the study was the nonresponse rate, which reduced the sample size. In addition, the study was conducted at a single Clubhouse; it is not certain that the results would generalize to others. While the study establishes a relationship between the alternative

conceptualization of emotional social support and affiliation and recovery, the direction causality for the relationship is impossible to determine. It could be that giving positive comments to other Clubhouse members and feeling affiliated to the Clubhouse facilitate the recovery process. It could also be that people further in the recovery process give more positive comments and feel more affiliated. However, the results of this study warrant further investigation of traditional views of emotional social support. Future directions include longitudinal studies to establish causality between the alternative emotional social support and affiliation and recovery, as well as if the alternative emotional social support and affiliation is relevant in other mental health settings.

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Appendices

APPENDIX A: LETTER OF SUPPORT

MAGNOLIA
clubhouse

July 19, 2013

Keith Warren, Ph.D.
Associate Professor
The Ohio State University
College of Social Work
1947 College Rd.
Columbus OH, 43210

Dear Professor Warren:

This letter is to notify you that the Magnolia Clubhouse intends to participate in the project, "Social Networks and Social Support at a Clubhouse program."

We understand that the project requests that consenting Clubhouse members complete a pencil-and-paper survey consisting of demographic, social network, recovery, and member affiliation questions. We also understand that the project will involve access to archival data kept by Magnolia Clubhouse on member attendance, unit work and transitional employment placement.

We look forward to working with you on this study.

Sincerely,

Lori D'Angelo, Ph.D.

Lori D'Angelo, Ph.D.
Executive Director
Magnolia Clubhouse

Magnolia Clubhouse • 11101 Magnolia Drive • Cleveland, Ohio 44106 • P 216.721.3030 • F 216.721.0105 • www.MagnoliaClubhouse.org
A Member of the International Center for Clubhouse Development

APPENDIX B: RECRUITMENT FLYER

Participate in a Clubhouse Research Study

Researchers at The Ohio State University are studying the social networks of clubhouse members. If you are a member of Magnolia Clubhouse and would like to be a part of this study, you can earn $5 for approximately 30 minutes of your time.

Researchers will be at Magnolia Clubhouse on **Monday, October 14th** through **Friday, October 18th** to hand out consent forms and surveys for the study.

Principal Investigator: Professor Keith Warren
College of Social Work

APPENDIX C: RECRUITMENT SCRIPT

We are doing a research project for The Ohio State University about the social networks of clubhouse members. We hope to…

- Learn more about clubhouse social networks
- Learn how people feel about the clubhouse
- Learn how people feel about their own recovery

For our project, we would like you to complete a 59-question survey. It will last about 30 minutes. The questions will be about yourself (for instance, we will ask about your age and mental health diagnosis), about help that you may have received from clubhouse members and staff or people outside of the clubhouse, about how you feel about the clubhouse, and how you feel about your own recovery. You can skip any question that you do not feel comfortable answering.

If you participant, you will receive $5. You will receive $5 even if you do not complete the entire survey, and you can stop taking the survey at any time.

We will try to assure that all information that you give us is kept confidential.

APPENDIX D: CONSENT FORM

The Ohio State University Consent to Participate in Research

Study Title:	**Social Networks and Social Support at a Clubhouse Program**
Researcher:	**Keith L. Warren**
Sponsor:	The Ohio State University

This is a consent form for research participation. It contains important information about this study and what to expect if you decide to participate.

Your participation is voluntary.

Please consider the information carefully. Feel free to ask questions before making your decision whether or not to participate. If you decide to participate, you will be asked to sign this form and will receive a copy of the form.

Purpose:

The study is looking at the social networks of clubhouse members. We hope to learn more about clubhouse social networks, how people feel about the clubhouse, and how people feel about their own recovery.

Procedures/Tasks:

We will ask you to complete a 59-question survey. Some of these questions will be about yourself, for instance we will ask about your age and any mental health diagnosis you might have. Some of these questions will be about help that you may have received from clubhouse members and staff or people outside of the clubhouse. Some of these questions will be about how you feel about the clubhouse. Some of these questions will be about how you feel about your own recovery. If there is any question that you do not want to answer, you do not have to answer it.

Duration:

The study will take approximately 30 minutes. You may leave the study at any time. If you decide to stop participating in the study, there will be no penalty to you, and you will not lose any benefits to which you are otherwise entitled. Your decision will not affect your future relationship with The Ohio State University.

Risks and Benefits:

The risk in the study is minimal. It is limited to a breach of confidentiality. We will try to assure that such a breach does not happen by keeping completed surveys in a locked drawer in a locked office and keeping any electronic data on password-protected computers.

You may benefit by gaining additional appreciation for your own role at the clubhouse by participating in the study.

We hope that this study will help us understand how the clubhouse program works. A better understanding, in turn, could improve similar programs and offer evidence to support all clubhouse programs.

Confidentiality:

Efforts will be made to keep your study-related information confidential. Completed surveys will be taken to The Ohio State University and kept in a locked drawer inside of a locked office for 5 years before they are destroyed. The data will be entered into a spreadsheet located on a server accessible only to research team members.

However, there may be circumstances where this information must be released. For example, personal information regarding your participation in this study may be disclosed if required by state law. Also, your records may be reviewed by the following groups (as applicable to the research):

- Office for Human Research Protections or other federal, state, or international regulatory agencies;
- The Ohio State University Institutional Review Board or Office of Responsible Research Practices;
- The sponsor, if any, or agency (including the Food and Drug Administration for FDA-regulated research) supporting the study.

Incentives:

You will receive $5 for participating in the study. You will still receive $5 even if you do not complete the study.

Participant Rights:

You may refuse to participate in this study without penalty or loss of benefits to which you are otherwise entitled. If you are a student or employee at Ohio State, your decision will not affect your grades or employment status.

If you choose to participate in the study, you may discontinue participation at any time without penalty or loss of benefits. By signing this form, you do not give up any personal legal rights you may have as a participant in this study.

An Institutional Review Board responsible for human subjects research at The Ohio State University reviewed this research project and found it to be acceptable, according to applicable state and federal regulations and University policies designed to protect the rights and welfare of participants in research.

Contacts and Questions:

For questions, concerns, or complaints about the study, or if you feel you have been harmed as a result of study participation, you may contact Keith Warren at 619-292-9187.

For questions about your rights as a participant in this study or to discuss other study-related concerns or complaints with someone who is not part of the research team, you may contact Ms. Sandra Meadows in the Office of Responsible Research Practices at 1-800-678-6251.

Signing the consent form

I have read (or someone has read to me) this form and I am aware that I am being asked to participate in a research study. I have had the opportunity to ask questions and have had them answered to my satisfaction. I voluntarily agree to participate in this study.

I am not giving up any legal rights by signing this form. I will be given a copy of this form.

Printed name of subject		Signature of subject	
		Date and time	AM/PM
Printed name of person authorized to consent for subject (when applicable)		Signature of person authorized to consent for subject (when applicable)	
Relationship to the subject		Date and time	AM/PM

Investigator/Research Staff

I have explained the research to the participant or his/her representative before requesting the signature(s) above. There are no blanks in this document. A copy of this form has been given to the participant or his/her representative.

Printed name of person obtaining consent		Signature of person obtaining consent	
		Date and time	AM/PM

APPENDI
SOCIAL
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DATE:

Please provide the following information.	
Name (First and last)	
Age	
Gender (Please Check √)	☐ Male ☐ Female
Race (Check all that apply)	☐ African American ☐ Asian American ☐ European American ☐ Latino/Latina ☐ Native American ☐ Other
Mental illness diagnosis	

For each of the following the questions, please write the *first and last* names of as many people as you can remember.
In the last week, which Magnolia Clubhouse members have said something that brightened your day?
In the last month, which Magnolia Clubhouse members have you socialized with outside of the clubhouse?
Which Magnolia Clubhouse members have shared ideas for improving your mental health?
When you were down, which Magnolia Clubhouse members have helped you by sharing how they felt in a similar situation?
Which Magnolia Clubhouse staff members have said something that brightened your day?

In the last month, which Magnolia Clubhouse staff members have shared ideas for improving your mental health?
When you were down, which Magnolia staff Clubhouse members have helped you by sharing how they felt in your situation?
In the last week, which people outside of Magnolia Clubhouse have said something that brightened your day?
In the last month, which people outside of Magnolia Clubhouse have you socialized with outside of the clubhouse?
Which people outside of Magnolia Clubhouse have shared ideas for improving your mental health?
When you were down, which people outside of Magnolia Clubhouse have helped you by sharing how they felt in your situation?

This scale contains a list of statements about your attitudes and beliefs about your health and wellness. There are no right or wrong answers; we just want to know what you think about these things. Read each statement and then decide how much you agree with it, from **Not at All** to **Very Much**. Then circle the number that best reflects how much you agree with each statement using the following scale:

Not at All	A Little Bit	Somewhat	Quite a Bit	Very Much
1	2	3	4	5

	How much do you agree with the statement?				
	Not at All	**A Little Bit**	**Somewhat**	**Quite a Bit**	**Very Much**
1. I can influence important issues in my life.	1	2	3	4	5
2. I have abilities that can help me reach my goals	1	2	3	4	5
3. I believe that getting better is possible.	1	2	3	4	5
4. When I have a relapse, I am sure that I can get back on track.	1	2	3	4	5
5. I have skills that help me to be successful.	1	2	3	4	5
6. My strengths are more important than my weaknesses.	1	2	3	4	5
7. Overcoming challenges helps me to learn and grow.	1	2	3	4	5
8. I can have a fulfilling and satisfying life.	1	2	3	4	5
9. It is up to me to set my own goals.	1	2	3	4	5
10. I believe I make good choices in my life.	1	2	3	4	5
11. I am responsible for making changes in my life.	1	2	3	4	5
12. I feel good about myself even when others look down on my illness.	1	2	3	4	5
13. I am confident that I can make positive changes in my life.	1	2	3	4	5
14. I am responsible for taking care of my physical health.	1	2	3	4	5
15. I work hard to find ways to cope with problems in my life.	1	2	3	4	5
16. I believe that I am a strong person.	1	2	3	4	5
17. I am hopeful about the future.	1	2	3	4	5
18. I feel loved.	1	2	3	4	5
19. I usually know what is best for me.	1	2	3	4	5
20. I know that I can make changes in my life even though I have a mental illness.	1	2	3	4	5
21. I am able to set my own goals in life.	1	2	3	4	5
22. I am optimistic that I can solve problems that I will face in the future.	1	2	3	4	5
23. I can bounce back from my problems.	1	2	3	4	5
24. I feel accepted as who I am.	1	2	3	4	5
25. I want to make choices for myself, even if I sometimes make mistakes.	1	2	3	4	5

Please read the following statements and indicate the degree to which you agree or disagree with each statement.										
	Strongly Disagree				**Neutral**					**Strongly Agree**
I feel comfortable with the other members of Magnolia Clubhouse.	1	2	3	4	5	6	7	8	9	10
I feel accepted by other members of Magnolia Clubhouse.	1	2	3	4	5	6	7	8	9	10
I feel that the other members of Magnolia Clubhouse understand me.	1	2	3	4	5	6	7	8	9	10
I look forward to seeing the other members of Magnolia Clubhouse.	1	2	3	4	5	6	7	8	9	10
I do **NOT** feel welcomed by the members of Magnolia Clubhouse.	1	2	3	4	5	6	7	8	9	10
I feel comfortable with the staff of Magnolia Clubhouse.	1	2	3	4	5	6	7	8	9	10
I feel accepted by the staff of Magnolia Clubhouse.	1	2	3	4	5	6	7	8	9	10
I feel that the staff of Magnolia Clubhouse understands me.	1	2	3	4	5	6	7	8	9	10
I look forward to seeing the staff of Magnolia Clubhouse.	1	2	3	4	5	6	7	8	9	10
I do **NOT** feel welcomed by the staff of Magnolia Clubhouse.	1	2	3	4	5	6	7	8	9	10
Magnolia Clubhouse is an important part of my life.	1	2	3	4	5	6	7	8	9	10
I feel that I am important to Magnolia Clubhouse.	1	2	3	4	5	6	7	8	9	10
I enjoy welcoming other people to Magnolia Clubhouse.	1	2	3	4	5	6	7	8	9	10
I am proud of Magnolia Clubhouse.	1	2	3	4	5	6	7	8	9	10
I like telling I am a member of Magnolia Clubhouse.	1	2	3	4	5	6	7	8	9	10