

**DISABILITY AMONG WOMEN WORKERS  
AND THE ROLE OF SOCIAL SUPPORT SYSTEMS**

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## **ABSTRACT**

### **DISABILITY AMONG WOMEN WORKERS AND THE ROLE OF SOCIAL SUPPORT SYSTEMS**

**Nabila El-Bassel**

The study examined factors affecting return to work following a short-term disability and measured the relationship between social support and the subject's well-being status, emphasizing the role of the social support system.

Subjects are 185 female city workers, members of District Council 37, AFSCME, AFL-CIO, and recently either physically or mentally disabled. They are entitled to a maximum of six-months short-term disability benefits.

Data, collected through a structured telephone interview, included the Arizona Social Support Interview Schedule (ASSIS), modified to the type of event (short-term disability), population (female), to measure perceived social support, and the General Well-Being Schedule to measure subjects' well-being. Univariate and multivariate statistical techniques were utilized.

Six variables predicted length of unemployment: (1) severity of illness; (2) general well-being; (3) type of disability (physical or mental); (4) quality of support from immediate family; (5) job tenure; and (6) perceived financial stress. None of the work social support variables were statistically significant in predicting length of unemployment.

A relationship between social support and well-being was found. Four variables predicted the subject's well-being status: (1) perceived financial stress; (2) job satisfaction; (3) quality of support from family; and (4) quality of support from friends.

Mentally disabled subjects remained longer on short-term disability than the physically disabled and a higher percentage were unemployed at the end of the six-month short-term disability, implying that they are at a greater risk of leaving the labor force.

Findings are consistent with existing research on the role of social support in promoting well-being and return to work, as well as identification of critical risk factors for leaving the labor force. These have critical implications for social work practice and policy, in general, and in union settings.

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## **DEDICATION**

**This dissertation is dedicated to my father, who passed away three months ago. He was an extremely supportive and loving person.**

**SECTION 1**  
**INTRODUCTION**

## INTRODUCTION

In modern society, particularly in the United States, the notion that work is important is inculcated at an early stage; young people generally grow up with the expectation that they will become earners and will be responsible for their own support and/or that of others. As a result, having a career or holding a job is a daily reminder that one is responsibly meeting his/her obligations. Furthermore, because "the job" is at the center of adult life, an individual's self-image and status are partially determined by how his or her living is earned. It is also true that self-support and sensible management of financial resources confer a kind of morality upon an individual. Therefore, work is a vital element in establishing a sense of worth, and the very act of working and earning often overrides, in importance an individual's satisfaction with his or her work. Because of work's importance, the moderate rate of unemployment that we are witnessing among the normal population and a higher percentage among disabled people, particularly women, are matters of concern. Of special concern is the fact that a high percentage of workers, principally disabled women, do not return to work after they become disabled.

Statistical evidence of this problem abounds. Unemployment is estimated at approximately 7.3% in the national total population in the United States; 6.9% among males and 7.8% among females. The unemployment rate among disabled individuals who have pre-disability work history is 47% (Statistical Abstract of United States, 1988). About 8.5 million women reported work disability, and such disability has more negative effects on women's employment than it does on that of men. After becoming disabled, only 52.2% of women return to work, whereas 56.8% of



men do return (Rehab Group, Digest of Data on Persons with Disabilities, 1980). While non-disabled women have become an increasingly larger percentage of the labor force, the pace of change has been slower for disabled women (Brooks & Deagan, 1981).

The return to work after an illness or a disability is a phenomenon that has some complexity which has been studied in the context of different illnesses and populations.

A literature review reveals that a series of variables have been consistently related to return to work after disability. Some of these variables identified the nature and the severity of the illness, socio-economic status, demography, type of work, health care and type of health insurance (Valasco, 1983; Hyman, 1975; Garrity, 1973; Cay et al., 1973; Yelin, 1986). Others identified psychological and social factors. The social factors included the role of the social support network at work and at home (Haltky, Hanly, Barfoot, Clif, Mark, Pryor, Williams, 1986).

However, no one has examined the role of social support in predicting return to work after controlling for the severity of the illness and the individual's demographic and socio-economic characteristics. This phenomenon is one of the main concerns of the present study.

The present study focused on a random sample of 185 female employees who are newly disabled members of District Council 37, American Federation of State, County and Municipal Employees, AFL-CIO (D.C. 37, AFSCME).

Documents of the Health and Security Plan of the District Council 37, AFSCME revealed that approximately 20% of members who go out on short-term disability stay out longer than the six-month period of insured short-term disability. Some entirely leave the labor force. Absence from work, due to illness, is higher among females than males. A large number of females who go out on short-term disability are single parents, and some of them caregivers of other dependents as well. These dual responsibilities coupled with the illness itself characterize many in this population as representing a high degree of vulnerability and in need of special attention.

Return to work after the onset of a disability among these women is a matter of concern of the Investigator. As a social worker, the Investigator has counseled this population for three years and closely studied this phenomenon as both a clinician and a researcher. This phenomenon is also the concern of the Health and Security Plan of D.C. 37 (AFSCME).

The present study examined the factors affecting the return to work after short-term disability (demographic, socio-economic, health, job) with an emphasis on the role of work and non-work social support systems. The study aimed to identify members at high risk of leaving the labor force.

The present study addresses the following research questions: (1) Does the person (worker) return to work following the onset of disability? (2) Who provides what support during short-term disability? (3) Do social support domains vary across several demographic and employment status variables (marital status, age, ethnicity)? (4) What is the relationship between well-being and social support domains? (5) What are the best predictor variables for well-being? In addition, the study seeks to determine

the best predictor variables of the subject's length of unemployment as a result of the disability.

The study consists of eight sections. The first section is the study's introduction. Section two is devoted to exploring the theoretical and empirical basis of social support system theory and to presenting factors affecting return to work after an illness or a disability. This section emphasizes: 1) the relationship between social support and health status; 2) the relationship between social support and well-being; and 3) the factors affecting an early return to work after an illness or disability. Section three explains the research design in detail. Section four provides a description of the characteristics of the study population (demographic, socio-economic, health and job related variables). Comparisons between mentally and physically disabled persons and between those who went back to work and those who did not (in relation to several critical variables) are provided. Sections five and six are devoted to social support systems: section five focuses on the research question pertaining to whether or not social support domains (size, source, quality and type) vary across several variables (age, ethnicity, marital status and employment status) and section six is devoted to the research question as to what constitutes the best predictors for the subjects' well-being. Section seven then deals with factors affecting the return to work and the role of the social support systems in predicting an early return to work. Section eight discusses the main research findings and explores the implications of the findings for social work practice and policy. It also presents directions for future research and conclusions.

## **SECTION 2**

### **REVIEW OF THE LITERATURE**

- 2.1 CONCEPTUAL DEFINITION OF SOCIAL SUPPORT**
- 2.2 MEASUREMENT OF SOCIAL SUPPORT**
- 2.3 DETERMINANTS OF SOCIAL SUPPORT**
- 2.4 MODELS OF SOCIAL SUPPORT PROCESS**
- 2.5 SOCIAL SUPPORT AND WELL-BEING**
- 2.6 ILLNESS OR INJURY AND SOCIAL SUPPORT**
- 2.7 SOCIAL SUPPORT AND WORK**
- 2.8 RETURN TO WORK AFTER AN ILLNESS**
- 2.9 CONCLUSION**

## **SECTION 2 -- REVIEW OF THE LITERATURE**

### **SOCIAL SUPPORT**

#### **2.1 CONCEPTUAL DEFINITION OF SOCIAL SUPPORT**

A review of the literature reveals that social support has been defined in varied ways, leading to misunderstanding and inaccurate generalization. However, it is important to note that the various definitions and operationalizations do share a common assumption. In this section, I review the different conceptual definitions of social support that appear in the literature and attempt to highlight the common assumption.

Social support has been described in the literature both in terms of its presence and its absence. Durkheim (1939) referred to an absence of social support as social isolation. The absence of social support is predominant in most ecological studies of support and diminished health status.

What is social support? Some authors have defined it as the extent to which an individual's basic social needs (e.g., approval, esteem) are met through interaction with others (French et al, 1974; Caplan et al, 1977; Thoits, 1982). Others have defined social support as it relates to goal or task achievement. For instance, Tolsdorf (1976) states that social support is any action or behavior that assists the person in meeting personal goals or situational demands. Caplan and Killilea (1976) view social support as attachment among individuals or groups that improves their competence in dealing with personal challenges and life transitions through: a) promoting mastery; b) offering guidance in problem solving; c) providing behavior feedback that validates individual self concept and fosters improved performance.

Cobb (1979) has conceived of social support as information leading the person to believe that he/she is cared for and loved, esteemed and valued, and belonging to a network of communication and mutual obligation. He refers to these three aspects of social support as emotional, esteem, and network support. Furthermore, he distinguishes social support from instrumental support or goods and services. (Tuner 1981; Pearlin, Menaghan, Lieberman and Mullen, 1981).

In contrast, Kahn and Antonucci (1980) have defined social support as interpersonal transactions that include one or more of the following key elements: 1) affection -- expressions of caring, admiration, respect; 2) affirmation -- agreement with appropriateness of some behavior of another person; and 3) aid -- direct aid or assistance the form of which includes things, money, information, advice, time and entitlement. Thus, Kahn and Antonucci identify aid as a key element of social support, whereas Cobb labels aid as material, action, or instrumental (rather than social support).

Pinneau (1975) has distinguished among tangible, appraisal (or information), and emotional support. He defines tangible support as intervention in the person's objective environment or circumstances, (e.g., loan of money or other resources); appraisal or information support as that which enhances the individual's body of knowledge or cognitions (e.g., new job opportunity); and emotional support as information that directly meets basic social-emotional needs (e.g., listening).

Robert Caplan (1979) has specified two dimensions of social support that form four variations of support patterns: objective/subjective and

tangible/psychological. Objective is the provision of resources to benefit one's mental or physical well-being. Objective psychological support is the provision of cognitions (e.g., values, attitudes, beliefs) to promote well-being (1979). Subjective support (tangible and psychological support) are analogous to their objective "counterparts" but they are determined by the target person's perception that supportive conditions exist. Caplan's distinction between objective and subjective social support is critical. Social support can be measured from the frame of reference of the target person -- the subjective or from an outside observer. House (1981) has elaborated subjective supports (tangible and psychological) as analogous to their objective counterparts, but whose type is determined by the perception of the target person that supportive conditions exist. Thus, social support can be measured from the frame of reference of the target person (subjective) or from an observer (objective).

House (1981) has suggested that social support be examined within the context of "who gives what to whom regarding which problems." Such an examination would likely reveal that some resources are more important than others, depending on the nature of the person and problem. Informal sources of support can include the work supervisor/manager, co-worker, family, friends, neighbors. House delineated four types of supportive social behavior: a) emotional support involving empathy, love and trust; b) instrumental support involving physical assistance with one's work to meet their daily needs; c) information support facilitating problem-solving; and d) appraisal support involving information that is relevant to self-evaluation.

Sandler and Barrera (1980), Caplan (1974), and Hirsch (1979, 1980) define social support as a set of behavioral interactions between individuals that restore their emotional and instrumental equilibrium during a stressful event. Barrera (1980) organized the various social support operationalizations into three distinct approaches: 1) social network analysis, in which the characteristics of the supportive network are described; 2) behavioral operationalizations, in which supportive expressions are recorded; and 3) qualitative judgments of support (e.g., satisfaction). Caplan and Killilea (1976) and Gottlieb (1971) view support systems as including spontaneous and organized caregiving efforts by individuals, natural systems (e.g., family), mutual aid groups, formal community institutions, and the professions.

The various definitions of social support indicate a wide range of conceptualizations. Some authors have defined social support in terms of its structural components, others from its functional components or combinations of both. For these reasons, much of the social support research has been criticized for its failure to formulate a precise conceptual definition of support (Thoits, 1982) or to agree to the utility of distinguishing among sources (Carvett and Gottlieb, 1979).

However, the varied definitions of support do share common threads -- all address in varying degrees, emotional, communicative, need for support, and relational aspects. Social support is a significant aspect of a social network.

The conceptual definition of social support of Sandler and Barrera (1980), Caplan (1974), and Hirsch (1979, 1980) is utilized in the present



study. As mentioned previously, they define social support as a set of behavioral interactions between individuals that restore their emotional and instrumental equilibrium during a stressful event.

## 2.2 MEASUREMENT OF SOCIAL SUPPORT

Despite a large body of empirical literature on social support, the field has been marked by confused measures (Deal and Lin, 1977; Heller and Swindler, 1983; Leavy, 1983; Thoits, 1982). Leavy (1984) stated that most social support measures are of questionable reliability and unknown validity. Tardy (1985) suggested that of the few rigorous studies of measurement, social support instruments do not build systematically on previous methodologies; rather, authors frequently develop a new instrument with each study, which is costly and inefficient.

The literature reveals that the social support concept is measured by different domains. It is a metaconstruct (Cook and Campbell, 1979), comprising several constructs. The following constructs are utilized most frequently: 1) support network structure (e.g., size, density); 2) function or type of support (e.g., listening, advising); 3) perceived (available) social support; 4) enacted (utilization of) support; and 5) subjective appraisals (e.g., satisfaction) (Barrera, 1981; Sarason, Levine, Basham and Sarason, 1983; Barrera, Sandler and Ransay, 1981; Caveth and Gottlieb, 1979). Each of these constructs is discussed in the paragraphs that follow.

There are a number of variables that are used to describe the structure of a network. The most commonly used one is size, which in turn depends on how the network is defined. Most research defines the network

to include people who are significant to the respondents and with whom the respondent interacts regularly.

Network density (the extent to which all members of a network are linked with each other) is another structural variable that has received attention in the literature. Hirsch (1979, 1980) has found that denser networks offer greater quantities of support, but less dense networks provide more satisfying support and enhance mental health. Other researchers have suggested that smaller, dense networks with strong ties provide effective and instrumental support, as well as foster a positive social identity.. However larger, less dense networks are more likely to provide new information and access to new social ties and roles during periods of psychosocial transition (Wilcox, 1981; Waeker et al., 1982; Hamburg and Killilea, 1976). Therefore, the importance of network size and density in social support appears related to the type of problem experienced and support needed.

Many researchers have measured social support in terms of its functions. For instance, Barrera and Ainlay (1983) have suggested that there are six major functions: 1) material aid; 2) behavior assistance; 3) intimate interaction; 4) guidance; 5) feedback; and 6) positive social interaction. However, researchers have given little attention to specifying which social groups are likely to provide which type of assistance under what conditions. A notable exception is the work Litwak et al., who have developed the "shared function" perspective. It provides a means of categorizing the particular types of assistance that are likely to be provided by different types of informal groups (Litwak and Figuerra, 1968; Litwak et al., 1979).

A third construct of the social support concept is perceived social support, defined by Barrera (1980) as a set of intervening perceptions that precedes supportive interactions between an individual and the support network in which she or he is embedded. These perceptions are based on recollection of past support-seeking behaviors and their outcomes. Two variables that are typically studied here are perceived network size and network conflict. Perceived network size is defined as the number of network members that the person believes is available during time of stress.

Several researchers have recently developed measures to appraise social support (Barrera, 1981; Henderson, Duncann Jones, Bryne and Scott, 1980; Hirsch, 1990; Holahan and Moos, 1982; Sarason et al., 1983; Neal, Norman, Roy and Strener, 1991; Turner et al., 1983).

In this study, Barrera's (1981) work has been used. He has developed a measure for enacted support based on the work of Caplan and Hirsch, the Inventory of Socially Supportive Behavior. This measure focuses strictly on the receipt of social support. It describes the enactment of various content type of support with a high degree of internal consistency (0.93). The modified Arizona Social Support Interview Schedule, which was also developed by Barrera, captures the actual and perceived supportive behavior and two other domains that the Inventory of Social Supportive Behavior does not capture (satisfaction and need of support). These scales were used in this study because they capture the conceptual framework of which the study is concerned: actual and perceived supportive behavior, as well as quality of support.

Although some reliability and validity data are available on all measures of social support, in most cases they differ markedly from the support appraisals concept proposed by Cobb (1976) or Kaplan et al. (1977). In many cases, for instance, the focus is primarily on satisfaction with support as a complement to network resources or other measures (Barrera, 1981; Hirsch, 1980; Sarason et al., 1983).

Support satisfaction appears to be especially important in predicting psychological well-being. In several studies, for instance, satisfaction with support or perceived adequacy of support has shown a stronger relationship to distress or well-being than did social support measures, such as network size (Barrera, 1981; Hirsch, 1980; Procidano and Heller, 1983; Sarason, Levine, Basham and Sarason, 1983). However, support satisfaction has shown a positive association with the size of support network (Sarason, Levin, Basham and Sarason, 1983), number of reported confidants (Stokes, 1983), availability of friendship, family, and confidants, social involvement and neighborhood resources (Turner et al., 1983). Support satisfaction does not show an association with the number of significant others. In addition to confirming the associations mentioned, Vaux and Harrison (1985) found support satisfaction to be associated with the closeness of network relationships and presence of spousal, acquaintances and friends.

In summary, the above paragraphs reveal that there is a lack of consensus regarding the measurements of social support and what actually constitutes "social support". Nonetheless, social support is viewed as a metaconstruct with at least three facets: resources, behaviors and subjective appraisal.

## 2.3 DETERMINANTS OF SOCIAL SUPPORT

Despite considerable interest in social support over the past decade, relatively little is known about its variance across demographic groups (Vaux, 1985). Many studies have focused on specific groups (e.g., low-income mothers) and yet few have actually compared domains and levels of support across various groups. This section presents a discussion of the literature regarding support variance across four determinants: gender, ethnicity, marital status, and age. The present study, which builds on the existing literature, addresses the research question of whether social support varies across demographic determinants and how these domains are associated to well-being.

### 2.3.1 Gender

Social support may be more complex for women than men (Schilling, 1987). Most studies have found that females draw on social support more often than males (Lauri, 1984). Women also tend to report more psychological disturbance and lower levels of well-being than men (Ameshesel, 1981). Women have consistently been shown to have larger networks than men (Babchuk, 1978; Harris, 1975; Longino and Lipman, 1982; Campbell, 1980; Veroff et al., 1981). They are also more likely to have larger supportive networks than men (Vaux et al., 1984). One explanation for these findings is that women tend toward an external locus of control, which fosters a sense of helplessness and dependency (Sandler and Lakey, 1982).

In the role of mother, spouse, and child of aging parents, women provide social support to others, but may not receive the same amount of

support given. Men tend to develop social supports that serve them well in the workplace, and they invest relatively less than women in more intimate networks (Gronenwell et al., 1981). Women, who are often excluded from certain support in the workplace, may invest in a close supportive network composed of family and friends (Billings and Moos, 1981). Bell (1981) has concluded that women have more close friends than men and emphasize intimacy and disclosure in their friendships. In contrast, sociability is emphasized in male friendships. The emergence of more intimate friendships among men would require changes in sex role behaviors that permit expressiveness and disclosure and reduce competitiveness and avoidance of intimacy. In addition, wives were mentioned most often by husbands as confidants, but husbands were mentioned least often by wives (Lowenthal and Haven, 1968). Tolsdorf (1979) has found that men are twice as likely as women to exhibit a negative network orientation (e.g., an unwillingness to utilize support resources because of mistrust, independence, or the belief that others cannot help).

Hirsch (1979) in measuring social interaction and satisfaction found that women report receiving significantly more emotional support than men. However, the women were less satisfied with the level of support received than men. Vaux and Stewart (1982) have found that among black and white college students, women report significantly more supportive behaviors from friends than men, including more emotional support, advice/guidance, and socialization. Stokes and Wilson (1984) compared support behavior of male and female college students on the Inventory of Socially Supportive Behavior (Barerra et al., 1981). Men and women did not

report different amounts of supportive behavior, but females reported receiving more emotional support.

Holahan and Moos (1982) compared social support across gender for employed and unemployed persons. With the employed sample, support resources were associated with lower levels of depression, but not with fewer psychosomatic symptoms for both men and women. For men, both distress measures -- depression and psychosomatic symptoms -- were inversely related to family and to work support. For women, depression was negatively related to family support but not to work support. Among the unemployed of either gender, neither distress measure was negatively related to support resources. Depression, but not psychosomatic complaints, were inversely related to family support for men; whereas both distress measures were negatively related to family support among women. The associations suggest that support in the work environment is considerably more important for men than women.

Butler et al. (1985) found that women more than men reported requesting and receiving more support during personal stress. Depner and Ingersoll-Dayton (1985) examined spousal support for married people 50 years of age and over. Women reported receiving and providing less support than their husbands reported. Bachuk (1979) found no differences in the number of primary relations reported by men and women, but there were differences in the relationship between network characteristics and mental health for men and women. This latter finding was contradicted by Griffith (1985) who found no significant differences in the relationship of network characteristics and mental health for women and men.

In summary, research findings concerning social support systems reveal variations in social support across gender. This may be due to biological sex differences, differences in sex role or social role expectation, or differences in the definition of social support and sampling measurement of support.

### 2.3.2 Marital Status

A series of studies have examined how social support varies with marital status. McFarlane et al. (1981) found that married individuals have more work-related individuals in their network than singles. Single adults have a larger number of friends than marrieds; widowed and divorced more often feel that their network is not adequately helpful or supportive. Stephens et al. (1978) found that married individuals receive the most informal support, followed by single, widowed, and then divorced individuals.

Most of the studies have revealed that there is a relationship between marital status and well-being, with marrieds having a higher state of well-being than other marital groups. Also the structural and functional characteristics of support vary across marital groups.

Lynch (1971) found that death due to heart disease was significantly higher among single, divorced and widowed than married individuals. Data from the U.S. Third National Cancer Survey was used to explore whether "marital status contributes to or protects against cancer of various sites". For all sites, regardless of race or gender, married people had significant lower incidences of cancer than did unmarrieds (Ernster, Sacks, Sevin and Petrakis, 1979). Marital status was also found to be a



significant predictor of mortality for men (House et al., 1982; Berkman and Syme, 1979) and for whites (Schoenbach, et al., 1983).

Brown and Harris (1978) found that an intimate relationship with a husband or a boyfriend protects women from depression. However, intimate relationships with a mother, sister, or girlfriend did not appear to offer the same protection. Liberman (1982) has found that when women experience maternal distress, there is no replacement for husband support.

### 2.3.3 Age

Studies have focused on specific developmental stages including childhood (Sandler, 180), adolescence (Barrera, 1981; Hotalin, et al., 1978), and adulthood (Gore, 1978; Wilcox, 1981). However, few studies have compared social support across age or stage of life cycle. In this section, a few studies are reviewed that examine this relationship. On the basis of the studies reviewed here, it would appear that some aspects of support networks decrease across the adult life cycle.

Ingersoll (1980) and Stephens (1978) found that age is associated with a decrease in both network size and amount of informal support for persons over age 55. For women, the decrease seems to be steady. The bulk of the decrease occurs about the time of retirement, and is partially recovered by age 75 or above. Nevertheless, the older an individual is, the less he/she expresses a desire for a larger network. Heller and Mansbach (1985) found that older women (median age 73) report smaller social networks, less contact with confidants, and less contact with relatives. Other characteristics of the network (e.g., density) were not strongly linked with age.

Vaux et al. (1983) examining support characteristics found that age is inversely correlated with the size of networks providing emotional support, instrumental assistance, financial assistance, and advice/guidance, but not socialization. There was also an inverse association between age and perceived support from friends. Age was unrelated to relationship characteristics (e.g., closeness, complexity) or source (e.g., family, friends), to perceived family or marital support. In contrast to these findings, Dean et al. (1981) found that younger adults reported lower instrumental or expressive support and lower durability of a confidant relationship. Age was unrelated to support satisfaction .

#### 2.3.4 Ethnicity

Studies comparing support characteristics across various ethnic groups have found that support varies with ethnicity. Ball et al. (1979, 1980) in a study involving White and Black low-income women, found larger family networks among Black respondents, but similar friendship networks between the two groups. Compared to their White counterparts, Black women were less willing to request help from family. Raymond et al. (1980) compared support satisfaction among Anglos, Hispanics, and Blacks. Hispanics and Blacks attributed significantly more importance to family than Anglos. Blacks attributed more importance to friends than Anglos or Hispanics. Support satisfaction did not vary by ethnicity.

Several studies examined the relationship between ethnicity and social support among college students. It was found that Asian-American college students report fewer supportive behaviors from family and friends, and perceive their families to be less supportive (Stewart and Vaux, 1983;

Moos, 1974). Uomoto (1983) found that black and white college students have similar support network resources (e.g., size, composition, relationship characteristics) and perceived family and friend support. However, black women report friends as less supportive than do white women college students.

In sum, the present study focuses on three determinants of social support (age, ethnicity, and marital status). These determinants were used in order to answer the following research question: Do social support domains (size, source, type, quality) vary across the three variables (age, ethnicity, marital status)?

#### 2.4 MODELS OF SOCIAL SUPPORT PROCESS

During recent years, interest in the role of social support in health maintenance and disease etiology has increased (G. Caplan, 1974; Cassel, 1976; Cobb, 1976; Dean & Lin, 1977; Gottlieb, 1981, 1983; Kaplan, et al., 1977; Sarason & Sarason, 1985). Numerous studies indicate that people who receive psychological and material support from informal systems (e.g., spouses, friends, and family) are in better health than those with fewer supportive contacts (Broadhead et al., Leavy, 1983; Mitchell, Billing & Moos, 1992). Although the many correlational results do not permit causal interpretation, these data in combination with results from animal research, social-psychological analogue experiments, and prospective surveys suggest that social support is a causal contribution to well-being (S. Cohen & Syme, 1985; House, 1981; Kessler & Mcleod, 1985; Tuner, 1983; Wallston et al., 1983).

Although numerous studies have shown a positive correlation between support and well-being, this result could have occurred through two very different processes. One model, called the "main effect" model, proposes that social resources have a beneficial effect regardless of whether persons are under stress or not. The second model, called the "buffering" model, proposes that support is related to well-being primarily for persons under stress. The support "buffers" model suggests that supports protect persons from the potentially pathogenic influence of stressful events.

In the following sections, studies are reviewed in which different conclusions are drawn as to whether social support operates via the buffering or main effects processes. However, the review is limited to studies involving informal rather than professional support.

#### 2.4.1 Main Effects Model

There has been an ongoing debate in the literature for the past decade as to whether the observed relationships between social support networks and health is due to a main effect or a buffering one. Much of the debate has been atheoretical, taking the form of constantly developing new research designs. According to one group, "Surprisingly . . . the literature provides almost no theoretical explanation as to why social support should play a [negative] role in the etiology of illness." (Lin et al., 1979, p. 109). Much of the work centers around a search for buffering effects; much less has been done to to "examine the theoretically pertinent and practically significant main effect." (Thoits, 1982, p. 146).

A main effect would, by definition, show that social supports either have a direct beneficial effect on health; or precede other variables which

directly effect health status in a causal model. Two sociological traditions would support this kind of effect--symbolic interactionism and anomie theory. (Thoits, 1982; Graham and Reeder, 1979).

Symbolic interactionism, as developed by Cooley and Mead, proposes that social interactions form the basis for self-evaluation and social identities. People learn what others expect of them through social interactions. At times, though, incongruencies develop between goals and norms and the individual's capacity to achieve them, which may lead to stress and illness (Graham and Reeder, 1979).

Similarly, the absence of such interaction may deprive the individual of the feedback necessary for normal growth, development and self-maintenance. This is consistent with the social isolation hypothesis developed by Faris and Dunham (1939). Cassel (1974) proposes that when people get insufficient social feedback they become susceptible to disease, while increased feedback strengthens them. Using this base, Hammer (1983) then theorizes that people with large and diverse (kin and non-kin) extended social networks can benefit from multiple sources of feedback, in addition to being able to replace parts of their core network when a member is lost.

The second major sociological tradition which would provide support for a main effect theory is Durkheim's (1951) anomie theory. Dealing primarily with psychological well-being, he emphasized the impact of external forces in maintaining social integration, a necessary condition of well-being. Accordingly, membership in a cohesive group gives a purpose to life and "protects against uncertainty and despair that may lead to

disordered functioning . . . [The] implication is that social support as an aspect of social integration should have a main effect upon psychological state." (Thoits, 1982, p. 147).

#### 2.4.2 Buffering Effects

Much as the "main effect" school has its roots in traditional sociology, the buffering hypotheses relies heavily on concepts of ego-psychology, particularly in as much as the buffers most often referred to are working against the deleterious effects of stress and life changes upon health. (See Dohrenwend and Dohrenwend, 1974.) The hypothesis, however, has been highly criticized by some, such as Hammer (1983), who see it as a phenomenon in search of a theory. She argues that "the 'buffer' model of social support arose in part as a metaphorical rationale for the apparent impact of social relationships upon health and in part from findings . . . which showed these effects only under high stress." (p. 406). This ties in to another criticism: "failure of researchers to define clearly what is meant by buffering or modifying effects . . . of social support." (Williams, Ware, and Donald, 1981, p. 326). The latter criticism has been set in part (1) by consistent operationalization of buffering as an interaction effect, and (2) by attempts to formulate a theory of social network utilization as a coping strategy.

The buffering hypothesis per se was first proposed by John Cassel (1974), who derived it from the works of Dubos and Wolff. Dubos (1965) describes disease potential in humans as ubiquitous and omnipresent, but "exert[ing] pathological effects only when the infected person is under conditions of psychological stress." (p. 165). Wolff differentiates between

physiochemical disease agents and psychosocial ones, saying that the former act directly upon the body "while the latter acted indirectly by virtue of their capacity to act as signals or symbols." (In Cassel, 1974, p. 473). Thus social support systems are conceived of as intervening in the ability of a disease-causing agent to adversely affect the individual. As Cassel states, "These might be envisioned as the protective factors buffering or cushioning the individual from the physiologic or psychologic consequences of exposure to the stress or situation." (Cassell, 1974, p. 478).

In order for this theory to be borne out, there is a need to demonstrate an interaction between social supports and a disease-producing agent in its effect on health. Research around this phenomenon has centered on ongoing life strain and stressful life events as those agents. (See, for example, Lin et al., 1979; Miller and Ingham, 1976; Turner.) Thus, "the occurrence of events in the presence of social support should produce less distress than should the occurrence of events in the absence of the social supports." (Thoits, 1982, p. 146).

According to Cobb (1976), "The most attractive theory about the nature of this phenomenon involves pathways through coping and adaptation." (p. 311). Such an approach requires a broad conceptualization of coping which includes both "cognitive and behavioral responses that seek to avoid the problem." (Billings and Moos, 1981, pp. 140-41). It also requires (1) seeing coping as both problem-focused and emotion-focused, the former aimed at modifying or eliminating stress or change; the latter at managing its consequences; and (2) recognizing the importance of the source of stress.

Within such a framework, then, there are several ways in which coping can be protective: (1) by eliminating or modifying conditions causing problems; (2) by changing one's perception of problematic situations; and (3) by containing the consequences of problems (Pearlin and Schooler, 1978, p. 2). Viewed in this way, the buffering hypothesis would be a restatement of numbers one and two above. What Cobb calls "esteem support" could enhance one's mastery--using one's own resources to cope. Tangible and information support could provide the climate for self-identity change, particularly as it involves abandoning (or failure to adopt) the sick role (Cobb, 1976, p. 311; Wilcox, 1981, p. 372. See also, Hirsch, 1981).

## 2.5 SOCIAL SUPPORT AND WELL-BEING

A considerable body of research has shown that social support is related to increased psychological well-being and to a lower probability of physical illness (Cohen and Wills, 1984; Wallston, et al., 1983; Broadhead, et al., 1983). In examining the relationship between well-being and social support, some studies have focused on the structural domains of support, and others, the functional domains or both, using different measures of psychological and physical indicators to capture health and well-being. Psychological symptoms are usually measured with standard epidemiological instruments and brief self-report items, in which subjects report the occurrence of depression, anxiety, physical fatigue and a variety of psychosomatic symptoms. Measures of physical health typically focus on the presence of serious illness or chronic conditions. Some investigators have used fairly extensive checklists of physical symptoms. In this section, some studies examining the relationship between social support and well-



being are reviewed, beginning with those that have used structural domains.

### 2.5.1 Structural Domains of Support

Persons having a confidant are far less likely to become depressed after a severely stressful life event than those without a confidant (Brolchain and Harris, 1975; Brown et al., 1975). House (1984) found that marital status, frequency of social contact, and group leisure activities are related to mortality among a sample of men and women aged 35 to 69.

Pearlin and Johnson (1977) found that longer neighborhood residence, having friends close by, and participation in voluntary organizations were all related to lowered depression scores among women. Harris (1979), surveying women on a Scottish island, found that a strong integrated support system of family and church membership is protective against depression. Brown et al. (1984) found that number and proximity of ties and church attendance are related to depressive symptoms. Persons who live alone or have few friends have lower well-being and increased psychiatric symptomatology (Miller and Ingham, 1976; Eaton, 1970).

Sarason et al. (1983) found that for college men, size of social support network was inversely related to depression complaints. Ware and Donald (1980) found that well-being increases as the number of friends and relatives in a community increase. Wilcox (1981) examined the relationship of psychiatric symptoms and network size among adults and found that network size mediates the relationship between stress and psychiatric symptoms. This was found also among an elderly population. Larger social networks were significantly related to higher levels of

psychological well-being (Levitt and Antonucci, 1985). Henderson, Bryne, and Duncan-Jones (1981) examined the relationship between neurotic symptoms and social support. They found there is no relation between neurotic symptoms and objective measures of the availability of social support. What predicts symptoms is the perceived adequacy of social relationships when an individual is facing adversity. The most vulnerable people are those who are habitually dissatisfied with their personal relationships. Dressler (1985) found that among blacks, the number of extended kin are unrelated to depression. However, persons who perceive their extended kin to be more supportive report fewer symptoms of depression.

### 2.5.2 Functional Domains of Support

Having close ties with intimates, friends, and acquaintances is related to a lowered incidence of psychological and physical symptomatology (Miller and Ingham, 1976, 1979; Henderson et al., 1976). Brown and his colleagues (1975) found that intimate emotional support was an effective buffer against depression for women who had experienced difficult life circumstances and suffered important losses. In a community survey of 2,271 subjects, Kessler and Essex (1982) discovered an inverse relationship between the ability to talk about problems with spouse for marrieds (or significant other for non-marrieds) and depressive symptoms. Henderson and Henderson (1980) examined the relationship between the availability of relationships that provide esteem support (i.e., someone close to whom one can express one's most private feelings) and depressive symptoms. Cross-sectional analyses indicate significant buffer effects for women and main effects for men. Cohen and Hoberman (1983) found

buffering effects when they examined the perceived availability of appraisal (confidant/informational) support, tangible (instrumental) support, self esteem (esteem) support and belonging (social companionship) support and depressive and physical symptomatology. Paykel et al. (1980) found a buffering effect for husband (instrumental) help and depressive and physical symptoms.

Barrera and Antonucci (1987) examined the relationship between psychological well-being and social support network (size, density, frequency, proximity, dispersion and reciprocity) and function of support (affective/instrumental support) among 104 women between the ages of 60 and 68. They found that there was not a relationship between the well-being and the structural social support variables. Nonetheless, there was a positive relationship between the well-being and affective support and instrumental support. Using Cobb's conceptualization of support (information that one is loved, valued and part of a network), Turner (1981) found that social support had a direct effect on well-being for new mothers, maladaptive parents, the deaf and the mentally ill, in four separate but ongoing studies.

The present study examined the relationship between subjects' well-being status and three domains of social support: functional, structural and quality of support.

## 2.6 ILLNESS OR INJURY AND SOCIAL SUPPORT

Garrity (1973) was one of the first to suggest a negative relationship between social supports and adjustment to illness. Looking at 85 men who survived heart attacks, he found that for those who were working before the

attacks, the greater the degree of family concern, the fewer the number of returnees to work. In another study of adjustment, Reveson et al. (1983) examined various kinds of social support and coping with cancers of the blood. They found that social support was positively correlated to feelings of personal growth, but negatively related to a sense of mastery and adjustment. They concluded that support may threaten autonomy and self-worth especially where chronic conditions are involved. Nanjundappa and Frye (1983) examined the potential of social support to moderate depression in diabetes. They found that for the control group, support was negatively correlated with depression. However, for diabetics, support made little difference. Litan (1963) studied 100 orthopedically-disabled patients to see if social support was important in rehabilitation. He found that family reinforcement during rehabilitation and social involvement prior to the disability were both significant predictors of a positive response to treatment. Porritt (1979) in a study of road accident victims found that the quality rather than the availability of support was a significant determinant of physical and emotional health status.

McLeroy et al. (1984), in a longitudinal study of stroke survivors, examined the relationship among types of social support, social network, and health status (activities of daily living). Instrumental support from professionals was negatively related to self-functioning (i.e., the development of daily living skills). Funch and Marchell (1982) followed 283 women with breast cancer until their deaths. Examining three measures of social networks (marital status, network size, organizational involvement), they found only organizational involvement to be important in predicting length of survival. Its effect, even when controlling for prior

health status, was most important for the oldest and youngest group of survivors. In a study of hemodialysis patients, Boyer and Friend (1984) found that perceived support and religion are positively related to perceived quality of life and to a number of physiological indicators.

## 2.7 SOCIAL SUPPORT AND WORK

The role of social support at the workplace has been investigated only during the last decade. Support from friends, family, and co-workers is viewed as powerful. Empirical studies of how social support operates at the workplace have focused almost exclusively on the two models of social support process, the main and buffering (buffers) effect. The vast majority of these studies have examined how support mediates stressors at work and have utilized primarily male samples.

In longitudinal analysis, Gore (1978) explored the effects of pending and actual unemployment and reemployment on workers awaiting a plant closing. The study period began six weeks before the scheduled shutdown and ended two years after the closing. Measures were obtained of stress (stage of job change and search experience); health status (indices of depression, illness symptoms and cholesterol level); and social support (ties, frequency of contact, and support satisfaction). Unsupported men who became unemployed showed significantly higher levels of cholesterol, illness symptoms, and depression than those who were unemployed but supported. However, the results were not consistent over the course of the study. Gore argues that support does not buffer the effects of stress, but rather that low support exacerbated the effect of stress.

LaRocco et al. (1980) examined the role of perceived social support in buffering the effect of perceived job stress and strain on mental and physical health. An occupational stratified random sample of 636 men in 23 occupational groups was drawn from several organizations. In a secondary analysis, using 225 regression analyses, LaRocco et al. found that social support buffered the effect of stress or strain. They also noted that work-related support buffered work-related stress and strain better than did other supports. LaRocco examined support from co-workers, supervisors, wives, work friends and non-work friends and found co-worker support to be more important than support from supervisor. However, Wells (1978) found that supervisory support moderated job distress more than co-worker support.

Pearlin et al. (1981) examined the rate of support as a mediator of job disruption (e.g., firing, demotion). A causal model was developed with stress (job disruption) and strain (economic strain) moderated by mastery and self-esteem, leading to mental status (depression). Emotional support from friends, relatives, and spouse was then examined to test their effect on depression. Social support helped job losers by preventing lowered self-esteem. The effect was stronger for the unemployed than the stably employed, thus supporting the buffering hypothesis.

All three studies support the hypothesis that social support buffers the stress of job-related problems on health. However, the relationship is more important for persons with job-related problems (stress) than those without such problems, consistent with the buffer model.

House (1982) examined the relationship between work and non-work support, perceived occupational stress and health outcomes. He found that home support had little effect on job stress, while supervisory support and co-worker support had a potent effect on a variety of stress measures. Men with high support from either supervisor or co-workers generally reported low role conflict, low role ambiguity, high participation, and good utilization of their skills. Social support predicted significantly low levels of psychological strain in a number of instances. Home support was less associated with job satisfaction measures than supervisor and co-worker support. Caplan et al. (1975) found that social support from supervisor and co-worker was negatively related to poor health outcomes, whereas support from family and friends was not.

Blau (1981) examined the different sources of support and found evidence of direct effects for both supervisory and co-worker support, which were negatively related to job dissatisfaction. However, the buffering hypothesis was not supported, as only one of 19 possible interaction effects in a hierarchical regression analysis was significant and in the predicted direction. In contrast to Blau's findings, Abdel-Halim (1982) observed consistent buffering effects in his study of job stress and social support among managerial personnel. In addition, social support from supervisors and co-workers reduced work-related strains (e.g., anxiety), about half of the time. Thus, only limited support for direct effect model was observed. Billings and Moos (1982) in their study of the effects of social support on psychological and physical health found no significant buffering effects for women, but significant direct effects of work-related and family support were found for men. Only family support was directly related to

health among women. Orpen (1982) surveyed black and white clerical workers in South Africa and tested for buffering effects within each group. Buffering effects were consistently observed for black employees but not for white employees.

An analysis of the U.S. Quality of Employment survey data by Karasek et al. (1982) involved several aspects of supervisory support (tolerant, instrumental, and demanding-authoritarian) and co-worker support (instrumental). The job stressor variable was an additive combination of high job demands and low decision latitude. The findings were that lower levels of stress were associated with higher social support.

Diagram (1988) examined six theoretical models of social support in relation to perceived occupational stress, burnout and health, cross-sectionally and longitudinally, among state correctional officers. Participants were tested twice within three months. Five models were derived from a general model of causal relationships between job stress, job-related strain, and health originally proposed by LaRocco, House and French (1980). The direct (a) model is a form of the direct effects hypothesis in that social support on the job is hypothesized to have a direct negative influence on the experience of burnout independently of job stress. Burnout, in turn, theoretically increases the likelihood of poor health. The direct (b) model is another derivative of the direct effects hypothesis. In this model, workplace social support exerts a direct negative influence on poor health symptoms; in addition, burnout has a direct negative influence on health. Job stress is expected to affect only burnout directly; it should have no direct effect on health. The final three models are all based on the buffering hypothesis in that outcomes are presumed to be influenced by



social support on the job, but only in interaction with other variables. The buffering (a) model suggests that social support on the job weakens the direct positive relationship between job stress and burnout. In the buffering (b) model, it is proposed that social support on the job weakens the direct effect of burnout on health. Finally, the buffering (c) model assumes that the direct positive relationship between job stress and poor health is weakened if social support is present on the job. None of the six models was supported by the longitudinal results. However, cross-sectional results were consistent with the direct effects model, in which social support reduces the effect of burnout symptoms. The absence of support for the direct model in the longitudinal analyses could have resulted from the length of the time lag between measurements (three months).

In summary, the direct effects model has been supported fairly consistently in studies of workplace support, but much of this is in the form of simple correlational results that are vulnerable to alternative explanations. The buffering hypothesis has received less consistent support in many studies. Several studies that focused on the gender and ethnicity differences have shown that support effects at the workplace varied with sex and race of the subjects. Also the findings revealed contradictions. This may be related to both the lack of consensus on operational definition, and to the fact that different measures were used in various studies.

In the present study, work and non-work social support domains (size, source, quality) were used in order to examine whether or not work and non-work social support domains predict subjects' well-being status, and whether or not they predict length of time of unemployment following onset of disability.

## 2.8 RETURN TO WORK AFTER AN ILLNESS

The return to work after an illness has some complexity that has been studied in the context of different illnesses and populations. The literature review reveals a series of variables which have been found consistently to relate to return to work after an illness. Some of these reflect the nature and severity of the illness and general health status. Other variables have been identified as socio-economic, demographic, work-related, vocational, psychological, sociological variables, difference in health care, type of health insurance, and labor market conditions, etc. Health status and severity of the illness were found in many studies to be the most important predictor variables for return to work (Mulcahy, 1976; Velasco, 1983; Hyman, 1975; Garrity, 1973; Cay et al., 1973; Yelin, 1986).

A number of studies have focused on psychological determinants such as depression, anxiety, self-perception of the illness, self-esteem (Robinson and Froelicher, 1984) and psychological reactions to the illness (Cohen, Lazarus, 1980; Garrity, 1981; Hyman, 1975; Cay et al., 1973). Other studies have been concerned with the effects of personality traits or coping styles, such as denial, repression-sensitization, and health locus of control (Shaw, Cohen, Doyle, Paleshy, 1985). Some studies investigated the relationship between social and religious participation, family relationships and motivation (Barry and Malinovsky, 1963; Lane and Barry, 1970; Salmone, 1972; Westerheide and Wright, 1968). Some of the most extensive studies have taken place among those experiencing disability as a result of cardiac disease.

Fisher (1970) found that educational level is related to return to work. Shapiro et al. (1972) examined return to work after first myocardial infarction and found that white collar workers return to work more frequently than non-white collar workers. Garrity (1973) examined the same phenomenon and found that the person's perception of his/her health status, social class, and sense of control over his fate predicted his return to work. Croog and Levine (1977) found that over two-thirds of the myocardial infarction patients who initially expected future work problems, in fact reported such difficulties to have occurred one year later as compared to one third of those who had no such expectation. Mayou (1977) reported early expectations about work to be related to return to work one year after myocardial infarction. Stanto et al. (1983) found patients' preoperative expectation to return to work after cardiac surgery to be the single most important predictor for post-operative employment status among the large number of demographic, occupational, medical and psychological factors examined.

Medical, psychological and social factors were used to examine their relationship to return to work among 815 men younger than 60 years of age with coronary artery disease (CAD) (Hlatky, et al., 1986). Clinical factors studied included measures of symptom severity, prior myocardial infarction, coronary anatomy and left ventricular function. Psychosocial factors studied included the Multiphasic Personality Inventory (MMPI), Zung Depression and Anxiety scales, a type-A structured interview, Jenkins Activity Survey and measure of education and social support. The social support variables were measured by the Social Support Networks questionnaire. This questionnaire measures the perceived level of social

support available to the patient from family and friends. The independent predictors of work disability were, in decreasing order of importance, low education level, history of myocardial infarction, high levels of depression and high levels of hypochondriasis. Social and psychological factors are strongly related to work status in patients with CAD, and may be more important than medical factors.

The literature on cardiovascular patients demonstrated that white collar workers returned to work more than blue collar workers (Reeder, 1965; Pell and D'Alonzo, 1964; Weinblatt et al., 1966; Garrity, 1973; Guttman et al., 1982). Gohlke et al. (1982) examined return to work after bypass surgery with a five-year follow-up study and found that the ability to return to work was related to the severity of the illness. A number of studies have been concerned with the effects of personality traits or coping styles (such as denial), and health locus of control (Shaw, Cohen, Doyle, Paleshy, 1985).

The relationship between a return to work six months after a myocardial infarction and selected personality traits, such as emotional reactions, health knowledge and beliefs, expectations and global health perceptions have been examined in the prospective study of 249 patients below 67 years of age. Patients' expectations of their future of anxiety and depression during hospitalization and their level of cardiac lifestyle knowledge were independently associated with return to work. These effects could not be explained by demographic, work-related, or medical factors (Mealand, Odd, Havik, 1987).

The literature has shown various factors related to employment of individuals with multiple sclerosis. These can be categorized as two types:

disease and demographic characteristics. The disease characteristics which have been shown to be significant are: degree of physical impairment (LaRocca et al., 1982; Mitchell, 1981) and age at diagnosis (Mitchell, 1981). In a national survey of employment in the chronically impaired (Schechter, 1981) and survey of patients with MS, males were more likely to be employed than females (LaRocca et al., 1982). Data from the National Multiple Sclerosis Survey revealed a significant drop in employment status, from the time of the first symptom through the first four years of the disease. At the time of disease onset, 58% of individuals with MS were employed, while after five years, only 37.5% of initially employed MS individuals remained employed. Multiple sclerosis is a disease marked by exacerbations and remissions in the great majority of cases (McAlpine et al., 1972). A number of surveys indicated that from 70-80% of the population with Multiple Sclerosis are unemployed (Scheinberg et al., 1980). Education was related to employment in patients with Multiple Sclerosis (LaRocca et al., 1982) and spinal cord injuries (Ghatti and Hanson, 1978), but not with patients with rheumatoid arthritis (Yelin et al., 1980).

The employment of multiple sclerosis patients was examined on a national level, to identify factors which might influence an MS individual's employment status. Data was restricted to a subset of a sample who had worked at one time in their lives. Of 949 persons, 79.7% were currently employed. In this study a path analysis was constructed to explain variation in employment status. Employment status was defined as whether or not an individual was employed part-time or full-time in a paying job at the time of the interview. Because the employment rate for

women was 12.5% lower than that for men, the data was analyzed separately for males and females. Mobility was the major determinant of employment status in both, while age and duration were minor influences. The effect of mobility was greater in males than females, with mobility dysfunction being the only variable showing substantial influence upon employment in males. For males, duration of illness has a small indirect effect on employment status mediated through mobility, with no direct effect. Age was found the second most important predictor of employment, largely through indirect effects. Other factors likely to influence employment are occupation, illness and psychological characteristics.

Data regarding 3,100 persons with limitations in activities and chronic diseases who were respondents to the 1978 Social Security Administration Survey of Disabled and Non-Disabled Adults were used to distinguish persons with muscular-skeletal disease who continued working after the onset of illness from those who did not. Persons with musculo-skeletal diseases who stopped working had poorer overall health status and physical function, different work attitudes and working conditions than did those who continued to work.

The employment experience of 266 individuals one year after traumatic injury (thoracic and abdominal injuries as well as head and spinal cord injuries) were studied. Of those working full-time prior to their injury, 56% were working part-time. Those sustaining a severe head or spinal cord injury were at highest risk of not returning to work (only 43% and 21%, respectively) had returned to work within the year. Low one year employment rates (58%) were also noted for individuals whose most severe injury involved one or more extremities. The extent and rate of return to

work was examined in relation to selected socio-economic and personal characteristics. Findings indicate that after controlling for type and severity, personal income, and level of education of the injured persons, as well as the identification of a strong social network as defined by the presence of one or more confidants, were important correlates of post injury employment status (Mackenzie, Shapiro, Smith, Siegel, Moody, Pitt, 1987). A "confidant" was operationally defined as any person with whom the respondent could discuss serious and personal problems, and expect the other significant person to reciprocate if the need arose, found it very easy to contact, and was in contact with at least twice a month.

## 2.9 CONCLUSION

In reviewing the recent literature concerning return to work after an illness the following critical findings were revealed. First, there are factors affecting return to work which are interrelated. Those factors are the nature and severity of the illness, health status, socio-economic, demographic, work-related, vocational, psychological, sociological, socially-related variables, differences in health care, type of health insurance, and market. However, in many studies, severity of the illness was found to be the most important predictor variable for return to work. Second, only a few studies have examined the relationship of social support systems and employment status, and fewer yet have assessed the unique contribution of work and non-work support, controlling for medical factors. Third, most of the studies were concerned with male populations, and those that encompassed female populations did not take into consideration the specific factors and needs of the female working population. Fourth, only a few studies have examined union members.

The present study focused on a random sample of 185 females who were newly disabled, city workers, and members of District Council 37, AFSCME. The study sought to determine what are the best predictor variables of the subjects' well-being status. An emphasis was given to the relationship between work and non-work social support domains (size, function, structure and quality of support) and well-being status. The study also examined factors affecting return to work after a disability, e.g., socio-economic, demographic, job, health and social support. Particular attention was given to the role of work and non-work social support systems when other variables were controlled.



## **SECTION 3**

### **RESEARCH DESIGN AND METHODOLOGY**

- 3.1 RESEARCH SETTING**
- 3.2 SAMPLE SELECTION**
- 3.3 DATA COLLECTION**
- 3.4 INTERVIEW TRAINING**
- 3.5 SURVEY INSTRUMENT**
- 3.6 RESEARCH QUESTIONS  
AND HYPOTHESES**
- 3.7 DATA ANALYSIS**

### **SECTION 3. RESEARCH DESIGN AND METHODOLOGY**

#### **3.1 RESEARCH SETTING**

The study took place at the Health and Security Plan at District Council 37, American Federation of State, County and Municipal Employees AFL-CIO (D.C. 37, AFSCME). District Council 37 has 61 locals that represents New York City's civil service employees, except teachers, uniformed employees and management staff. There are 114,000 members in D.C. 37. Approximately 70% of them are female. D.C. 37 is organized into divisions that represent different "trades": 1) blue collar; 2) white collar; 3) professional; 4) clerical; 5) school; and 6) hospital.

D.C. 37 Benefits Fund Trust is comprised of the Health and Security Plan, the Municipal Employees' Legal Service Plan and the Education Fund. The Benefits Funds focuses on the provision of benefits for health care, education opportunities, and legal protection. Each of these benefits were won in collective bargaining at the negotiating table along with the salary and working conditions.

Union members are entitled to a short-term disability benefit which is provided by the Health and Security Plan. Every member who is unable to work for a short period of time (up to a maximum of six months) as a result of the onset of non-work connected illness or an accident is entitled to short-term benefits. Workers who remain unemployed for more than six months are defined as long-term disabled and are usually entitled to social security disability benefits.

Health and Security Plan documents reveal that the number of days utilized by a person on short-term disability varies. Absence from work due to illness is higher among females than males; 20% stay unemployed longer than six months, and some entirely leave the labor force. Unfortunately, there is no data about those who leave the labor force.

The Health and Security Plan, through a Personal Service Unit, provides social services for members including those who go on short-term disability. One of the primary concerns of the Personal Service Unit is to try to reach the workers who go on short-term disability as early as possible in order to promote an early return to work and maintenance of their labor force participation. This is based on the philosophy that the longer the persons stays out of work, the more difficult the adjustment to return to work, and the higher the probability that the person will leave the labor force.

Subjects were selected to the study when they filed for short-term disability as described in the sample selection section which follows.

### 3.2 SAMPLE SELECTION

A proportional stratified random sample is utilized in the study to secure a representative sample of subjects for the study.

The following is a description of the procedures that were developed by the investigator to obtain the study sample. Those procedures were used on a weekly basis until a sample of 210 was selected. The response rate is very high, 88.1% (185 cases).

During the period of the study (December 1987 to September 1988) the investigator had access to every new disability claim by union members who stopped work because of the onset of physical or mental illness or disability resulting from an accident (short-term disability). Subjects were selected for the study on the basis of the information obtained from the disability claims. The disability claim form contains the name of the subject, telephone number, sex, age, length of time on the job, job status, medical diagnosis, type of disability and expected duration of unemployment because of the current disability as projected by a physician.

1. On a weekly basis, all new disability claim forms were gathered by the investigator from the disability unit at The Health and Security Plan at D.C. 37.

2. Those subjects who fell into one or more of the following categories were excluded from the study.

1-Male

2-Provisional worker

3-Working less than one year at a city job

4-Above age of 55

5-Alcohol or drug related diagnosis and/or

6-Mental diagnosis but not depression (depression diagnoses are included in the study).

3. All the claims remaining after the second step were classified according to type of the following illness categories.

1-Fracture

2-Neoplasma

**3-Circulatory**

**4-Respiratory**

**5-Muscular/Skeletal**

**6-Multiple physical diagnosis**

**7-Depression**

4. On a weekly basis a proportional random sample of a total of 20 subjects was selected from the total number of subjects after they were stratified into the seven disability categories. The last year's Health and Security Plan reports (1987) contained a breakdown of all disability claims by diagnosis. This was used to establish the proportion of the sample that should be drawn from each disability category. These proportions were used as a guide for both weekly and total sample composition. The number is limited to 20 because that is the number of interviews that could be conducted during one week by the interviewers.

In sum, the study includes only females under the age of 55, who are permanent workers, who are employed for more than one year by the City of New York, and who fall into one of the above-mentioned diagnostic categories, and have a telephone.

The study is limited to females because they represent the majority of municipal workers (70%) and because women are the focus of considerable recent scholarship dealing with status in contemporary American society. Age is limited because of the possibility that age itself may constitute a factor that prevents the worker from returning to work (retirement benefits may be a disincentive). Diagnosis categories were selected because of an

expected variability in the distribution of those returning and those not returning to work by diagnosis.

### 3.3 DATA COLLECTION

Data was collected by telephone interview scheduled at two points in time. The first interview was conducted one month after the subject stopped working because of physical or mental illness, whereas the second interview took place six months after the day the person stopped working.

Data was collected between December 1987 and September 1988. Most of the interviews were administered during the day; for those who were working at the time of the interview, evening interviews were conducted.

### 3.4 INTERVIEW TRAINING

In addition to the investigator, three other individuals were hired to conduct the interviews. Two were social workers accustomed to working with this population and the third was a social work Master's student, also used to working with this population in her field of practice. The three interviewers participated in a three-day training program in which they were taught general interviewing skills as well as skills specific to the telephone interview.

#### Subject Respondents

A positive quality of collaboration and participation was shown by the subjects. Only 25 did not participate in the study (11.9%). Fifteen subjects refused to participate and 10 had their phones disconnected or did not have a telephone where they could be reached. Among them, four subjects were

diagnosed as having depression and the others had different physical illnesses.

All subjects were reached at the second interview and were very collaborative and responsive. This high rate of initial response and absence of attrition is likely explained by the nature of the setting in which the study was carried out, and the utilization of the telephone procedure. The Union, serving as the site of the study, is known to command strong loyalty among its members.

It is known that telephone interviews secure the highest rate of responses compared to the other data collection techniques. It should be noted that data in the telephone interview format has been demonstrated to be valid, reliable, and comparable to data gathered in face-to-face interviews (Combotos, 1964; Hochstin, 1967). Sampling bias is still a potential problem since people must have a telephone to participate, although the literature suggests that this type of sampling bias is reduced because most people have telephones (Leuthold & Schule, 19871). This study has revealed that only ten people did not have telephones (4.7%).

### 3.5 SURVEY INSTRUMENT

A telephone interview schedule was developed by the investigator. It contains individual items that measure different domains (covering demographic variables, job related issues, perceived health status) and multi-item scales that measure social support, general well-being and depression status. A pilot study was carried out with a random sample of 15 subjects selected from the disability claims roster of the Union. The purposes were to assess the length of time of the telephone interview, to

probe the face validity of the questions, and to provide an opportunity for the interviewers to practice interviewing skills prior to the actual study.

During the pilot phase, the interview schedule went through several modifications. Some items were deleted and item wordings were revised to maximize the smooth flow of the interview between and within sections. After modifications were made, the revised interview schedule was then tested with another random sample of 10 subjects. The final schedule includes a mix of open-ended, fixed-choice and items composing established indices or scales. The interview takes an hour to administer.

### **3.5.1 The Telephone Interview Schedule**

The following are the main areas included in the interview schedule (See Appendix for a complete questionnaire):

- 1-Demographic related variables
- 2-Job related variables
- 3-Physical Health related variables
- 4-General well being status
- 5-Social support

### **3.5.2 Variables (Dependent and Independent)**

The study focuses on three dependent variables and several independent variables.

#### **Dependent Variables:**

- 1-Number of days the subjects were unemployed because of the illness
- 2-Employment status (returnees vs. non-returnees)



### **3-General well-being status**

#### **Independent Variables:**

The independent variables are divided into the five following domains:

- 1-Demographic
- 2-Socio-economic
- 3-Job descriptions
- 4-Health descriptions
- 5-Social support

#### **3.5.3 The Demographic Related Variables**

Age, ethnicity, marital status, economic status, educational status, household composition, length of time the subject has lived in the same place, and number of places the person has lived during the last two years are included in the demographic data.

The economic status was measured by the utilization of different objective and subjective indicators that were developed by the investigator. The purpose for the inclusion of a diversity of economic status measures is to be able to capture this domain, which may be a critical predictor variable for return to work.

**The following financial indicators were utilized:**

- 1-The bi-weekly salary**
- 2-Annual salary as recorded on W-2 form**
- 3-Number of people contributing financially to the family income**
- 4-Number of dependants for whom subject income is a major source of income**
- 5-Whether or not a person in her family started working more hours as a result of the disability income loss**
- 6-The subject's perception about how financially pressed she feels during the period of short-term disability (the subject was asked to express her perception about how pressed financially she felt during the short-term disability with six different payments on a scale of 1 to 7 in which 1 is not financially pressed and 7 is pressed very much). The six different payments were selected by the investigator based upon a content analysis of 100 financial problems of clients selected randomly from the Personal Service Unit at D.C. 37, Members Assistance Program.**

- 1-Mortgage payment**
- 2-Rent payments**
- 3-Food expenses**
- 4-Medical expenses**
- 5-Car payments**
- 6-Other**

### **3.5.4 Job Related Variables**

Job title, division, date of employment at the current job, number of jobs the person held during the last three years, work shift, type of job the person performs, number of people the person works with, number of expected days of unemployment because of the current illness were included under this ruberic.

#### **Job Classification**

For research purposes the different types of jobs were divided into two separate job classifications:

- 1-Service workers
- 2-Administrative workers

The work classifications are as follows:

- 1-Custodial assistant
- 2-Housekeeping aide
- 3-Nurse's aide
- 4-Health service aide
- 5-School workers
  - a-School helper
  - b-Kitchen helper
  - c-School neighbor
  - d-Lunch room helper
- 6-Administrative workers
  - a-Office aide
  - b-Office associate
  - c-Secretary

**d-Eligibility specialist**

**e-Computer aide**

One item was asked about the perceived degree of the job routines.

The item is:

Which of the following statements describes you?

1-On the job I do many new things

2-Some of my job is varied and some is routine

3-My job involves doing the same thing over and over again

Four items were developed to measure the degree of physical effort the job requires. Subjects were asked whether or not their job requires:

a-Physical effort

b-Travelling from one location to another

c-Mobility around the office

4-Standing around

### Job Satisfaction

Job satisfaction is measured by several items developed by the investigator. Subjects were asked about to what degree they were satisfied with the following three domains on a scale of one to five, with one being the least satisfaction and five reflecting the greatest satisfaction:

1-Satisfaction from the money the subject makes

2-Satisfaction from the type of work the subject performs

3-Subject's overall satisfaction from the job

### **3.5.5 Health Related Variables**

#### **Disability Diagnosis Categories Among the Study Sample**

The study utilized the Health and Security Plan illness classification focusing on seven categories, six of which are physical and one psychiatric (depression). Listed below are the different types of illnesses encompassed among the study sample:

- 1-Trauma: Fractured ankle of foot, burns, auto accident, etc.  
(excluding the work related accidents which are workers compensation cases);
- 2-Neoplasma: benign, malignant, cancer such as breast cancer, pneumonia;
- 3-Circulatory: ASCVD, M.I., hypertension, etc.
- 4-Respiratory: bronchitis, asthma, chronic obst, etc.
- 5-Muscular-skeletal: acute low back syndrome, rheumatoid arthritis, etc.
- 6-Multiple physical diagnosis: encompassed more than one of the above physical disability categories
- 7-Depression

For research purposes and statistical analyses, the above illness categories are used in the study and not the type of the particular illness within each category.

Among the different mental disorders categories, only depression diagnosis is included in the study. This is because during the pilot study it was very difficult to gain the attention and trust of an individual who had been diagnosed as schizophrenic and/or with other mental disorder with

the exception of depression. Those with a primary diagnosis of substance or alcohol abuse were also eliminated because of the unique issues these problems present.

### Severity of the Illness

Severity of the illness was measured by the expected days of unemployment because of the illness. This was determined by the physician at the time the person applied for the disability benefit.

### Health Status Variable

The health status variables were collected from two resources:

- 1-The subject
- 2-The disability claim

The health status variables are:

- 1-Disability diagnosis
- 2-Date of current disability
- 3-Number of days of hospitalization because of the current illness
- 4-Perceived health status
- 5-Whether or not the person is on medication
- 6-Length of time the person is/was on medication
- 7-Severity of the disability

Disability diagnosis, date of current disability and number of days of hospitalization because of the current illness were collected from the disability claim forms; whereas, the perceived health status, whether or not the person was on medication and the length of time the person was on

medication were collected through the telephone interview. The number of days of hospitalization was collected through the telephone interview as well, for validity purposes.

Severity of the illness was measured by the expected duration on short-term disability that was determined by the subject's physician. This variable was identified as the best indicator for the severity of the illness.

### General Well-Being Status

This variable was measured by the utilization of the General Well-Being Schedule.

The General Well-Being Schedule (GWB) was developed by Dr. Harold Dupy (1970) for the National Center for Health Statistics, as part of a national health survey (1971-75) of adults ranging in age from 25 to 74. It is a 33-item instrument of six subscales. The six subscales measure health worry, energy level, satisfying-interesting life, depressed-cheerful mood, emotional-behavioral control, and relaxed versus tense-anxious. The first 14 items are six response options; the next 4 items are 0-10 rating bars; and the last 15 are criterion-type behavioral and self-evaluation items.

The ratings can be obtained as overall total scale score. The GWB is scored in a positive direction in that a high score reflects a self-representation of well-being. Though originally designed for a national sample, it was subsequently used with a clinical sample of mental health patients. Testing the GWB with a group of undergraduate students, Fazio (1977) reports that it is highly reliable with a test-retest correlation of .85 for the total scores. Internal consistency coefficients were .91 for males and .94

for females, indicating the GWB is a unidimensional scale that measures one's general psychological state. Internal consistency of GWB in this study is high (.85). Overall, Fazio notes that the GWB is brief, well-designed, easy to comprehend, and distinguishes distressed from non-distressed individuals. It can be used in a variety of research and applied settings, such as a quality of life index, a mental health status appraisal, a measure of psychotherapy outcome evaluation, and a social indicator for measuring population change in the sense of well-being over time.

The major weakness of the GWB scale seems to be that the subscales have too few items to provide content-homogeneous and reliable subscales for individual assessment on these aspects of well-being or distress. (Fazio, 1973). Since subscales were not analyzed in this study, this potential weakness was eliminated.

### 3.5.6 Social Supportive Behavior

This variable is measured by the utilization of The Modified Inventory Socially Supportive Behaviors (ISSB) and The Arizona Social Support Interview Schedule (ASSIS) (Barrera, 1982). Both scales were modified for the research purposes and context.

Barrera (1983) has employed a definition of support that is based on the work of Caplan (1976) and Hirsch (1979) to develop a behavioral measure of social support, the Inventory of Socially Supportive Behavior (SSB) and the Arizona Social Support Schedule (ASSIS). Social support provisions are thought to include activities directed toward emotional distress, sharing tasks, giving advice, offering appraisal, feedback and providing tangible assistance. In addition, Barrera has introduced Social Participation as



another form of support, which he defines as "engaging in social interaction for fun, relaxation, and diversion from demanding conditions". His Arizona Social Support Interview Schedule (ASSIS) measures network size and support satisfaction and need.

Inventory Socially Supportive Behaviors (ISSB) and the Arizona Social Support Interview Schedule (ASSIS)

The Inventory Socially Supportive Behaviors (ISSB) and the Arizona Social Support Interview Schedule (ASSIS) were developed by Manuel Barrera (1983) as a multimethod assessment of support. The 40 items permit a specification of support functions and the identification of which best predicts health.

The ASSIS comprises six behavior functions:

- 1-Material aid: providing material aid in the form of money and other objects
- 2-Physical assistance: sharing a task
- 3-Intimate interaction: feelings and personal concerns are expressed
- 4-Guidance: offering advice and guidance
- 5-Feedback: providing individual with information about his or her self
- 6-Social participation: engaging in social interaction for fun, relaxation or diversion from demanding conditions

The ISSB has been evaluated for test-retest and internal consistency. Test-retest correlations coefficient for individual items ranged from .44 to .91. Internal consistency as measured by Cronbach's alpha coefficient was

.93 and .94. Such high values imply that the ISSB score is based on items that cohere well together and permits the computation of a total ISSB score for each participant, by simply summing frequency ratings across all scale items. The usefulness of the ISSB as a global measure of social support has been confirmed by Stoes et al. (1984) with their sample of college students. The ISSB also had strong internal consistency in measuring social participation. For the ASSIS it was found the test-retest coefficient is .88 (internal consistency was not reported). The internal consistency of ASSIS in this study is .85.

The study presented in this dissertation focuses at the structural and functional aspects of the social support at the workplace and outside it with specifications of size, sources, quality and type of support.

Structure of Support refers to the extent to which individuals are linked to and interact with others (Berrera, 1983; Stokes, 1984).

Size of Non-Work Social Network refers to the social network subjects reported (number of family members, friends, relatives, and neighbors).

Size of Perceived Non-Work Supportive Network refers to number of individuals the subjects reported that they could turn to for help/support (immediate family, relatives, friends, neighbors).

Size of Work Social Network refers to number of people at work that the subjects reported as friends or acquaintances (co-workers, supervisors, etc.).

**Size of Perceived Work Supportive Network** refers to number of people at the workplace that the subjects reported they could turn to for help (co-workers, supervisors, etc.).

**Function Support** refers to the behavioral activities that are involved in the expression of supportive assistance (Barrera, 1983). There are six behavior functions included in the study:

- 1-Material aid: providing material aid in the form of money and other objects;
- 2-Physical assistance: sharing a task;
- 3-Intimate interaction: feelings and personal concerns are expressed;
- 4-Guidance: offering advice and guidance;
- 5-Feedback: providing individual with information about him or her self; and
- 6-Social participation: engaging in social interaction for fun, relaxation or diversion from demanding conditions.

**Source of Support** refers to the helping person(s) who provide the assistance. This includes work and non-work sources.

**Quality of Support (Support Satisfaction)** refers to the individual's subjective appraisal of the assistance provided (Barrera, 1983). In addition, the subjects were asked to rank order the most helpful person during the short-term disability.

### **3.6 RESEARCH QUESTIONS AND HYPOTHESES**

**This study includes six research questions and eight hypotheses.**

#### **Research Questions**

- 1. Does the person return to work?**
- 2. Who provides what type of support during short-term disability (emotional, instrumental, material aid, feedback, advice, companionship)?**
- 3. Do support dimensions (size, quality, type) vary across socio-economic and demographic groups (ethnicity, age, marital status, work status)?**
- 4. What is the relationship between subjects' well-being status and social support domains?**
- 5. What are the best predictor variables for general subjects' well-being status (demographic, socio-economic, job, health, and social support domains)?**
- 6. What are the best predictor variables for number of days of unemployment (demographic, socio-economic, job, health, and social support domains)?**

## Hypotheses

1. There is a relationship between type of disability and size of non-work perceived supportive network. Mentally disabled subjects have a smaller non-work perceived supportive network than those who are physically disabled.

2. There is a relationship between employment status and size of non-work perceived supportive network. Those subjects who return to work have a larger non-work perceived supportive network than those who do not.

3. There is a relationship between type of disability and size of perceived work supportive network. The size of work perceived supportive network is larger among the physically disabled than the mentally disabled.

4. There is a relationship between size of perceived work supportive network and employment status. The size of work perceived supportive network is larger among subject who return to work than those who do not.

5. There is a relationship between the size of the non-work supportive network (co-workers, supervisors, union representatives, shop stewards) and well-being -- as the size of the work supportive network increases, general well-being increases.

6. There is a relationship between general well-being and quality of non-work support (spouse, immediate family, relatives and friends) -- as the quality of non-work support increases, general well-being increases.

7. There is a relationship between general well-being and workplace quality of support from co-workers, supervisors, shop stewards, and union representatives -- as the quality of work support increases, general well-being increases.

8. There is a relationship between the size of the workplace supportive network and general well-being -- as the size of the workplace supportive network increases, general well-being increases.

### 3.7 DATA ANALYSIS

Descriptive statistics (e.g., mean, mode, median, etc.) were conducted to provide univariate descriptions concerning the study sample. T-TEST and CHI SQUARE statistics were used to look at significant differences between groups (returnees vs. non-returnees; mentally disabled vs. physically disabled) and other groups.

Correlation analyses using zero-order correlations were conducted to examine the relationship between well-being and social support.

Hierarchical multiple regression (HMR) analyses were used to determine the best predictor variables to well-being and number of days of unemployment because of the illness. In addition, HMR was used to test the amount of variance explained by the social support when other variables were controlled. These analyses were carried out by several steps, with R, R<sup>2</sup>, and R<sup>2</sup> adjusted reported in each step.

Three levels of data were collected in this study -- interval, ordinal and nominal. Both interval and ordinal levels were treated as interval level for purposes of multiple regression. This has been debated in the literature

with arguments for both sides (see for example, Lewis and Beck, 1980). For the purposes of this study, in order to avoid overloading equations with numerous variables and to simplify interpretations, the ordinal level data is treated as continuous.

## **SECTION 4**

### **RESULTS: SAMPLE CHARACTERISTICS**

- 4.1 DEMOGRAPHIC AND SOCIO-ECONOMIC FINDINGS**
- 4.2 JOB CHARACTERISTICS**
- 4.3 DISABILITY DIAGNOSIS CATEGORIES AMONG THE SAMPLE STUDY**
- 4.4 COMPARISON OF SOCIO-ECONOMIC, JOB AND HEALTH-RELATED VARIABLES BY TYPE OF ILLNESS**
- 4.5 COMPARISON OF BOTH GROUPS (RETURNEES VS. NON-RETURNEES)**
- 4.6 COMPARISON OF BOTH GROUPS (MENTAL VS. PHYSICAL DISABILITY)**



## **SECTION 4. RESULTS: SAMPLE CHARACTERISTICS**

The purpose of this section is to describe the study, focusing on socio-economic, demographic, job, health, and disability variables. Each domain will be presented separately. As mentioned in the methodology section, variables that are encompassed in each one of the four domains are critical and utilized across the remaining chapters. Most of those variables are used to predict length of time of unemployment because of the disability.

In Section 4.1, demographic and socio-economic information is presented. Section 4.2 concerns job related variables and Section 4.3, health and disability variables. Section 4.5 is a description and comparison of relevant characteristics of subjects who returned to work or did not return to work. Section 4.6 is a description and comparison between the mentally ill and physically disabled subjects.

### **4.1 DEMOGRAPHIC AND SOCIO-ECONOMIC FINDINGS**

#### **4.1.1 Age**

The mean age is 42.5 with range of 23-55 (mode=55; median=43). These findings are consistent with District Council 37 Health and Security Plan's documents which show that the average age of females who go out on long-term disability is 39.

#### **4.1.2 Marital Status**

Twenty-one point six percent (40) of the respondents are single never married, 36.2% (67) are married, 17.8% (33) are separated, 18.4% (34) were

divorced, 4.3% (8) are widowed and 1.6% (3) are living with a significant other (see Table 4-1).

When the marital status was collapsed into the following three groups: 1) single; 2) married (including living with significant other); and 3) divorced, separated and widowed; it appeared that the third group was the largest. Forty point six percent (75) of the entire sample were divorced/separated/ widowed (see Table 4-2).

**TABLE 4-1. SUMMARY TABLE OF MARITAL STATUS**

<u>MARITAL STATUS</u>	<u>FREQUENCY</u>	<u>PERCENT</u>
Single never married	40	21.6%
Married	67	36.2%
Separated/Divorced	67	36.3%
Widowed	8	4.3%
Living with Significant Other	<u>3</u>	<u>1.6%</u>
	185	100.0%

**TABLE 4-2. SUMMARY TABLE OF COLLAPSED MARITAL STATUS**

<u>MARITAL STATUS</u>	<u>FREQUENCY</u>	<u>PERCENT</u>
Single never married	40	21.6%
Married/Living with Significant Other	70	37.8%
Separated/Divorced/Widowed	<u>75</u>	<u>40.6%</u>
	185	100.0%

Thirty-two point five percent (13) of the single never married are single parents, and 25% (10) are care givers of an elderly parent who lives in the household.

Among the married, 71% (48) have children, and 9% (6) of the married are taking care of elderly parents.

Sixty-five point seven percent (44) of the separated/divorced/widowed subjects have children and 16.4% (11) of them are taking care of elderly parents.

Comparing these findings with the general population characteristics of New York City's census (1980), it was found that the separated group in the study is overrepresentative. In the general population in New York, 7.03% are separated, 14.4% are widowed, 9.29% are divorced, 31% are married, and 38.1% are single.

#### 4.1.3 Household Composition

The mean household composition is 2.8 with range between 1-9 (mode=3; median=3; SD=1.35). In collapsing the household composition into three groups (see Table 4-3), only a few subjects fell into the 7-9 range, 1.1% (2).

**TABLE 4-3. SUMMARY TABLE OF HOUSEHOLD COMPOSITION**

<u>HOUSEHOLD COMPOSITION</u>	<u>FREQUENCY</u>	<u>PERCENT</u>
1-2	79	42.7%
3-4	87	47.0%
5-6	17	9.0%
7-9	<u>2</u>	<u>1.1%</u>
	185	100.0%

**4.1.4 Level of Education**

The mode and median level of education falls into "finished high school" (SD=.892). The least number of subjects fell into the lower and highest levels of education: 2.2% (4) at grade school and 1.1% (2) at graduate level. However, 41% (76) finished high school (see Table 4-4).

**TABLE 4-4. LEVEL OF EDUCATION AMONG THE SAMPLE STUDY**

<u>LEVEL OF EDUCATION</u>	<u>FREQUENCY</u>	<u>PERCENT</u>
Grade School	4	2.2%
Some High School	31	16.8%
Finished High School (including G.E.D.)	76	41.1%
Finished College	65	35.1%
Some Graduate Work	7	3.8%
Graduate Degree	<u>2</u>	<u>1.1%</u>
	185	100.0%

**4.1.5 Ethnicity**

The percentage distribution of ethnicity is as follows: 26.5% (49) white; 56.3% (103) are Black; 14.2% (26) are Hispanics, and 2.7% (5) fell into other ethnic groups (see Table 4-5). This result is consistent with the ethnic distribution among D.C. 37 union members.

**TABLE 4-5. DISTRIBUTION OF ETHNICITY AMONG THE SAMPLE STUDY**

<u>ETHNICITY</u>	<u>FREQUENCY</u>	<u>PERCENT</u>
White	49	26.8%
Black	103	56.3%
Hispanic	26	14.2%
Other	<u>5</u>	<u>2.7%</u>
	185	100.0%

Blacks are overrepresented in the study as compared to the general population in the New York City Census (1980). In New York City, 64% are white, 25% are Black, 8% are Hispanics, 3% are Asian, 0.9% are American Indian (New York Census 1980).

#### 4.1.6 Economic Status

Economic status of the respondents was measured by utilizing different objective and subjective indicators developed by the investigator. The purpose for including a diversity of economic measures was to capture the domain of economic status. This may appear as a critical predictor variable for an early return to work.

#### Bi-Weekly Salary

The findings show that the bi-weekly salary for a full-time worker was \$460 (mode=\$500; median=\$451; SD=\$103.292). However, the mean bi-weekly salary for the part-time workers was \$263.5 (mode=\$247; median=\$245; SD=\$70.829).

**W-2 Form**

The mean W-2 Form for full-time workers was \$16,948.766 (mode=\$16,000; median=\$17,000; SD=3744,660); whereas, for part-time workers the mean was \$9,084.778 (mean=\$10,000; median=\$8,000; SD=2818,150).

**Number of People Contributing to the Family Income**

It was determined that 68.1% (126) reported that no one else contributed to the family income, 26.5% (49) reported one person, and 5.4% (10) reported that two people contributed.

Among the never married, 82% (33) reported that no other household or family member is contributing to the family income, compared to 41% (22) among the married, and 85.3% among the divorced/separated/widowed.

**Number of People Dependent Upon the Person as a Major Source of Income**

It was found that 68.6% reported that they have at least one person dependent upon their income (see following table).

**TABLE 4-6. NUMBER OF PEOPLE DEPENDENT UPON RESPONDENT'S INCOME**

<b><u>NUMBER OF PEOPLE DEPENDENT UPON RESPONDENT'S INCOME</u></b>	<b><u>FREQUENCY</u></b>	<b><u>PERCENT</u></b>
0	59	31.4%
1	40	21.6%
2	43	23.2%
3	33	17.8%
4	9	4.9%
5	<u>2</u>	<u>1.1%</u>
	185	100.0%

### Number of Family Members Who Started Working As Result of Economic Stress

A surprisingly low 5.4% (10) reported that one person in their family household began working more hours as a result of the economic stress of the disability.

### Financial Stress

The following are the means and the total scores of each of six types of payments. Each mean reflects the degree to which the subject felt financially stressed in making a particular payment. The total score reflects the degree to which the subject felt stressed in paying each bill (see Table 4-7).

**TABLE 4-7. REPORTED PERCEIVED FINANCIAL STRESS OF THE SAMPLE STUDY BY DIFFERENT PAYMENTS <sup>a</sup>**

<u>TYPE OF PAYMENT</u>	<u>FREQUENCY</u>	<u>MEAN OF PERCEIVED FINANCIAL STRESS</u>	<u>SD</u>
Mortgage	185	.79	.133
Rent	185	3.73	.214
Food	185	3.71	.183
Medical	185	2.27	.163
Car Loan	185	.61	.115

<sup>a</sup> The score represents the degree in which the subject felt stressed in making the particular payment on a scale of 1 to 7, where 1 is not financially pressed and 7 is financially very pressed.

The mean degree of perceived financial stress because of mortgage payment is .79 (SD=1.807); 74% (137) reported that they did not have mortgage payments.

The mean degree of perceived financial stress because of rent payment is 3.73, with 20% (37) of the subjects not paying rent.

The mean degree of perceived financial stress because of food expenses payment is 3.71, with 34.6% (64) reporting they were not financially pressed in terms of food expenses.

The mean degree of perceived financial stress because of medical payment is 2.2, with 60.3% (111) reporting that they were not financially pressed in terms of medical expenses.

The mean degree of perceived financial stress because of car expenses is .61, with 75% (140) reporting that they did not have cars.

The results indicate that this population was under financial pressure mostly because of rent payments. It is important to note that they did not report a high degree of medical financial pressure, clearly because of the different and extensive medical coverage to which members of D.C. 37 are entitled. Loss of employment could be expected to have a significant change on that situation.

A total score of the degree of perceived financial pressure was computed by marital status group. It was found that the mean financial stress of the never married single parents is the highest among the five groups. Single never married parents felt their economic status to be more stressful than other groups (see Table 4-8). This variable later emerged as a



significant predictor variable for number of days of unemployment because of the disability.

**TABLE 4-8. TOTAL SCORE OF PERCEIVED FINANCIAL STRESS BY MARITAL STATUS<sup>a</sup>**

<u>MARITAL STATUS</u>	<u>FREQUENCY</u>	<u>AGGREGATE MEAN SCORE OF PERCEIVED FINANCIAL STRESS</u>	<u>SD</u>
Single Never Married	40	17.42	1.21
Married	70	11.07	.99
Separated/Divorced/Widowed	75	14.44	1.28

<sup>a</sup> The score represents the degree of perceived financial stress in making all the payments; the higher the score the greater the stress.

Conclusively, the data revealed that the single never married group were the most vulnerable group. Among them 32% were single parents, and 25% were care givers of elderly parents. This group's level of economic stress was higher than other marital status groups.

#### **4.2 JOB CHARACTERISTICS**

For research purposes, the different types of jobs were divided into two major job classifications: service workers and administrative workers. The data revealed that 73% (136) are administrative workers; whereas 26.5% (49) are service workers and 9.7% (18) are part-time workers compared to 90.3% (167) full-time workers.

The study reveals that 70% (130) of the subjects were administrative workers, 11.9% (22) were nurses aides, 11.4% (21) were school workers, 3.2% (6) were custodial workers and 3.2% (6) were police administrators. All the school workers (21) were part-time and constituted 85% of the part-

time workers in the sample. This phenomenon is common for women in the United States. Clerical jobs are the most common occupation for American women, involving one third of currently employed females (Bureau of Labor Statistics 1980).

**TABLE 4-9. DISTRIBUTION OF JOB CLASSIFICATIONS AMONG THE SAMPLE STUDY**

<u>JOB CLASSIFICATION</u>	<u>FREQUENCY</u>	<u>PERCENT</u>
Custodial workers	6	3.2%
Nurse's aides	22	11.9%
School workers	21	11.4%
Clerical	130	70.3%
Police administrator	<u>6</u>	<u>3.2%</u>
	185	100.0%

Previous to the disability, 85.4% (158) worked a day shift, 5.9% (11) an evening shift, 5.9% (11) a night shift, and 2.7% (4) worked a rotating shift. Among the administrative workers, 10.3% (14) worked night and evening shifts compared to 26.5% (13) among the service workers (see Table 4-10).

**TABLE 4-10. WORK SHIFT OF SAMPLE STUDY BY JOB CLASSIFICATION**

<u>SHIFT</u>	<u>SERVICE WORKER</u>	<u>ADMINISTRATIVE WORKER</u>
Morning	73.5% (36)	89.7% (122)
Evening/night	26.5% (13)	10.3% ( 14)

The findings above indicate that more service workers worked evening/night shifts than did administrative workers with 26.5% of the service workers reporting that they worked an evening/night shift as compared to administrative workers.

The mean number of jobs held during the last three years is 1.18 (SD=.480) with a range of 1-5. Eighty-three point four percent (154) held the same job during the last three years, 15.5% (29) held two jobs, .5% (1) held three jobs, and .5% (1) held five jobs.

Mean tenure (length of time a person was on the job) is 8.3 years, ranging from 1-26 years (mode=2; median=7; SD=.369). Forty-one percent (76) were in the same job between one and five years, 28% (53) between six and ten years, 14.6% (27) between 11 and 15 years, 12.4% (23) between 16 and 20 years, and 3.2% (6) between 20 and 26 years (see Table 4-11).

**TABLE 4-11. TENURE (YEARS) ON JOB OF SAMPLE**

<u>TENURE (YEARS)</u>	<u>FREQUENCY</u>	<u>PERCENT</u>
1-5	76	41.0%
1-10	53	28.6%
11-15	27	14.6%
16-20	23	13.4%
20-26	<u>6</u>	<u>3.2%</u>
	185	100.0%

Of the total sample, 34.6% (64) reported that their job was routine, and they were doing the same thing over and over, 55% (102) said that some of their job tasks are varied and some are routine, and only 9.8% (18) reported that their job involved doing new things over and over again, and therefore they did not perceive it as a routine job.

Table 4-12 below presents the degree to which the subjects perceived their jobs as requiring routine activities and compares both administrative and service workers.

**TABLE 4-12. JOB PERCEPTION BY JOB CLASSIFICATION OF SAMPLE STUDY**

<u>PERCEPTION OF JOB</u>	<u>SERVICE</u>		<u>ADMINISTRATIVE</u>	
	<u>FREQ.</u>	<u>PERCENT</u>	<u>FREQ.</u>	<u>PERCENT</u>
In my job I do many things	1	2.0%	17	12.5%
Some of my work is varied and some involves doing the same thing over and over	24	49.0%	77	57.5%
In my job I am doing the same thing over and over	24	49.0%	40	29.9%

The data in the above table indicates that service workers perceived their jobs to involve routine activities more than the administrative workers. Forty-nine percent of the service workers reported that they were doing the same thing over and over as compared to 29.6% of the administrative workers.

The following are means of job satisfaction in each one of the different items that were developed by the investigator. Each subject was asked how satisfied she was with what she earns, the type of work she performs, and her overall satisfaction on a scale of 1 to 5, in which 1 is not at all satisfied and 5 is very satisfied.

**TABLE 4-13. THREE DOMAINS OF JOB SATISFACTION (MONEY, TYPE OF WORK, AND OVERALL SATISFACTION)<sup>a</sup>**

<u>JOB SATISFACTION</u>	<u>FREQUENCY</u>	<u>MEAN</u>	<u>SD</u>
1-satisfaction from the money	185	2.57	1.12
2-satisfaction from the type of work	185	3.77	1.23
3-overall satisfaction from the job	185	2.07	0.40

<sup>a</sup> The score represents the degree in which the subject was satisfied in the job in each one of the three domains.

These three variables will be used as predictor variables for return to work.

#### 4.3 DISABILITY DIAGNOSIS CATEGORIES AMONG THE SAMPLE STUDY

The study utilized the Health and Security Plan's illness classification focusing on seven categories, six of which are physical and one psychiatric (depression). Table 4-14 describes the distribution of illness categories among the study sample.

**TABLE 4-14. DISTRIBUTION OF ILLNESS CATEGORIES OF THE SAMPLE STUDY**

<u>TYPE OF ILLNESS</u>	<u>FREQUENCY</u>	<u>PERCENT</u>
1-Trauma	37	20.0%
2-Neoplasma	25	13.0%
3-Circulatory	31	16.8%
4-Respiratory	17	9.2%
5-Muscular-skeletal	34	18.4%
6- Depression	29	15.7%
7-Multiple physical	<u>12</u>	<u>6.4%</u>
	185	100.0%

The data in the above table indicates that the largest group fell within the trauma category, and that the smallest group was among the multiple physical illness category, 6.4% (12).

Muscular-skeletal appeared to be the second highest disability group. It constitutes 18.4% of the total sample (34). These results are consistent with the Health and Security Plan at D.C. 37, which shows that a high percent of female union members go on short-term disability because of muscular-skeletal illness.

The percentage of subjects that fell into the mental disorders category compared to other groups of illnesses is slightly higher than the Health and Security Plan documents. It is possible to explain this evidence by the fact that data for the study was collected during a period around Christmas time. This may have created a financial stressor to single parents that led to emotional crisis. This phenomenon is observed and anecdotally reported by the disability unit. The disability examiners and their supervisors reported to the investigator that they observed more mental disorder claims during holiday periods, such as Christmas. However, this phenomenon needs further study.

#### 4.4 COMPARISON OF SOCIO-ECONOMIC, JOB AND HEALTH-RELATED VARIABLES BY TYPE OF ILLNESS

Table 4-15 presents means of age, anticipated number of days of unemployment due to illness, actual number of days of unemployment due to illness, number of years on the job (seniority) and perceived financial stress by type of illness.

**TABLE 4-15. DIAGNOSIS OF ILLNESS BY SEVERAL CHARACTERISTICS (AGE, ANTICIPATED DAYS OF UNEMPLOYMENT, NUMBER OF YEARS ON THE JOB AND PERCEIVED ECONOMIC STRESS)**

<b>Variable</b>	<b>Trauma</b>	<b>Neoplasma</b>	<b>Circulatory</b>	<b>Respiratory</b>	<b>Muscular-Skeletal</b>	<b>Depression</b>	<b>Multiple Physical</b>
<b>Age</b>	(Mean=43) (SD=9.6) (N=37)	(Mean=44) (SD=7.1) (N=25)	(Mean=44) (SD=7.8) (N=31)	(Mean=42) (SD=6.8) (N=17)	(Mean=43) (SD=7.9) (N=34)	(Mean=37) (SD=8.3) (N=29)	(Mean=40) (SD=4.9) (N=12)
<b>Perceived economic stress</b>	(Mean=11) (SD=7.44) (N=37)	(Mean=11.8) (SD=8.40) (N=25)	(Mean=14) (SD=10) (N=31)	(Mean=15) (SD=0.9) (N=17)	(Mean=15) (SD=6.7) (N=34)	(Mean=17) (SD=1.0) (N=29)	(Mean=16) (SD=6.6) (N=37)
<b>Anticipated # of days of unemployment due to illness</b>	(Mean=51) (SD=27.8) (N=37)	(Mean=61) (SD=34.6) (N=25)	(Mean=36) (SD=22.0) (N=31)	(Mean=31) (SD=30.0) (N=17)	(Mean=58) (SD=43.9) (N=34)	(Mean=81) (SD=55.3) (N=29)	(Mean=57) (SD=33.3) (N=31)
<b>Actual # of days of unemployment due to illness</b>	(Mean=87) (SD=8.45) (N=37)	(Mean=75) (SD=33.1) (N=25)	(Mean=73) (SD=43.9) (N=31)	(Mean=66) (SD=49.6) (N=17)	(Mean=95) (SD=37.9) (N=34)	(Mean=144) (SD=3.0) (N=29)	(Mean=86) (SD=31.4) (N=37)
<b>Number of years on the job (seniority)</b>	(Mean=8) (SD=6.6) (N=37)	(Mean=9) (SD=5.6) (N=25)	(Mean=10) (SD=7.0) (N=31)	(Mean=8) (SD=5.22) (N=17)	(Mean=7) (SD=6.7) (N=34)	(Mean=7) (SD=5.3) (N=29)	(Mean=5.8) (SD=6.8) (N=37)

Table 4-15 shows that the respondents who fell in the depression category appeared to differ in several variables.

The mean age of the depression category is lower than other groups, and their anticipated date of returning to work is later, as well as their perceived financial stress being higher than all other diagnostic categories.

Respondents who fell into the depression category stayed unemployed longer than the other six groups. The muscular-skeletal group comes second, trauma third, multiple illness fourth, neoplasma fifth, circulatory sixth, and the respiratory group stayed unemployed for the least amount of time out of the seven groups.

The mean number of days of unemployment for the total sample is 92. (It should be noted that for those who were still unemployed at the end of the six month period, 180 days (six months) was substituted for actual number of days until return to work.)

#### 4.5 COMPARISON OF BOTH GROUPS (RETURNEES VS. NON- RETURNEES)

Of the total study 77.3% (144) went back to work within six months; whereas 23.7% (44) were unemployed at the end of six months. Of those unemployed, 45% (20) fell into the mental disorder illness category (depression), and 54.5% (23) in the physical illness categories. Of these, one subject died, and five resigned. (See Table 4-16.)

**TABLE 4-16. DISTRIBUTION OF EMPLOYMENT STATUS AMONG THE TOTAL SAMPLE STUDY**

<u>SUBJECT</u>	<u>FREQUENCY</u>	<u>PERCENT</u>
Back to work	144	77.3%
Not back to work	38	20.0%
Died	1	0.5%
Resigned	<u>5</u>	<u>2.7%</u>
	185	100.0%

T-tests and CHI SQUARE were computed to look at several significant differences between both groups (those who returned to work and those who did not). The T-test was used for the continuous variables and the CHI SQUARE for the categorical variables.

The data in Table 4-17 reveal that there were significant differences between groups in terms of anticipated date of return to work, overall satisfaction from work, tenure, type of disability, perceived financial stress and general well-being status.



**TABLE 4-17. COMPARISON OF RETURNEES VS. NON-RETURNEES ACROSS SEVERAL DEMOGRAPHIC, SOCIO-ECONOMIC, JOB AND HEALTH-RELATED VARIABLES**

<u>VARIABLES</u>	<u>T VALUE</u>	<u>CHI SQUARE</u>	<u>D.F.</u>	<u>PROBABILITY</u>
<u>Demographic and Socio-economic:</u>				
Age	1.42		183	.157
Marital status		3.88811	2	.1431
Ethnicity		.67084	2	.7150
Level of education		2.40780	4	.7903
Perceived economic stress	2.23		182	.020
Bi-weekly salary	-0.37		183	.737
W-2 Form	-0.02		183	.985
Total persons contributing to income	-1.30		183	.195
Total dependent upon the person's income	1.30		183	.196
Number of children	0.88		183	.378
Number of care takers	0.77		183	.430
Household composition	-0.33		183	.745
<u>Job-Related:</u>				
Overall satisfaction from work	2.75		182	.006*
Satisfaction from the type of work the person does	0.85		183	.404
Tenure	2.21		183	.029*
Job classification (administrative vs. service)		1.83048	1	.1761
Work full- or part-time		1.84408	1	.1745
Job routine		1.14102	3	.7672
Shift the person works		0.88340	1	.3473
<u>Health-Related:</u>				
Severity of the illness	-5.08		183	.001*
Number of days of hospitalization	-1.41		183	.159
General well-being	4.21		183	.001*
Type of disability (mental vs. physical)		35.92409	1	.0001*

#### **4.6 COMPARISON OF BOTH GROUPS (MENTALLY VS. PHYSICALLY DISABLED)**

As mentioned previously, of the 44 subjects (23.8% of the total sample) that had not gone back to work during the six month period, 20 (45.5%) were diagnosed as mentally disabled and the remaining 24 (54.5%) with different physical illnesses.

For descriptive purposes, T-tests and CHI SQUARE were computed to examine the significant relationship between the two types of illnesses (depression compared to physical) and several demographic, socio-economic, job and health-related variables (see Table 4-18).

**TABLE 4-18. COMPARISON OF MENTALLY VS. PHYSICALLY DISABLED  
ACROSS SEVERAL DEMOGRAPHIC, SOCIO-ECONOMIC,  
JOB AND HEALTH-RELATED VARIABLES**

<u>VARIABLES</u>	<u>T VALUE</u>	<u>CHI SQUARE</u>	<u>D.F.</u>	<u>PROBABILITY</u>
<u>Demographic and Socio-economic:</u>				
Age	3.70		183	.001*
Marital status		1.06235	2	.001*
Ethnicity		0.04095	2	.839
Level of education		2.70238	4	.608
Perceived economic stress	3.70		182	.017*
Bi-weekly salary	-1.53		183	.127
W-2 Form	-0.96		183	.338
Total persons contributing to income	-1.10		183	.273
Total dependents upon the person's income	-0.24		183	.812
Number of children in family household composition	-0.08		183	.934
Number of care takers	0.34		183	.731
Household composition		35.85745	42	.736
<u>Job-Related:</u>				
Overall satisfaction	2.09		183	.038*
Satisfaction from type of work the persons does	1.67		182	.097
Tenure	1.14		183	.257
Job classification (administrative vs service)		5.13450	1	.023*
Work full or part-time		3.16757		.075
Job routine		0.80932	3	.667
Shift the person works		0.17600	1	.674
Back to work		35.83010	1	.002*
<u>Health-Related:</u>				
Severity of the illness	-4.50		183	.001*
Number of days of hospitalization	-0.20		183	.842
General well being	7.30		183	0.000

The data in the Table 4-18 indicate that there was significant association between employment status and the nature of the disability (depression compared to physical). It also reveals that there was a significant association between the type of illness and marital status. This is also true for job classification (service workers vs. administrative). It should be noted that 89.7% of the depression respondents fell in the administrative job classification, whereas only 10.3% fell in the service category. This phenomenon needs further investigation in future research.

The T-tests reveal that there was a significant difference between mental and physical disability groups in relation to age, anticipated date of return to work after short-term disability, length of unemployment because of the short-term disability, perceived financial stress, satisfaction with the type of work and employment status and general well-being status.

Mentally disabled subjects were younger, primarily single, and reported a higher level of perceived financial stress than the physically disabled respondents.

Among job related variables, job classification and overall job satisfaction were significantly different between both groups (mental vs. physical).

The demographic, socio-economic, job and health related variables will be used in the multivariate analyses to test the best predictor variables for the length of time of unemployment because of the illness.

**In sum, subjects who fell into the mental disorder (depression) category stayed longer on short-term disability and a higher percentage of them had not gone back to work during the six-month period.**

## **SECTION 5**

### **RESULTS: SOCIAL SUPPORT**

- 5.1 INTRODUCTION**
- 5.2 NON-WORK SUPPORT**
- 5.3 WORK SUPPORT**
- 5.4 TYPE OF SUPPORT**
- 5.5 SUMMARY**

## **SECTION 5. RESULTS: SOCIAL SUPPORT**

### **5.1 INTRODUCTION**

This section is divided into four subsections. Section 5.2 presents a description of two different aspects of non-work support, structural and functional. For structural domains, size, quality and source are the focus of analyses; the functional is defined by the type of support. These four domains are analyzed across demographic variables (age, ethnicity, marital status, type of disability, and return to work status) to examine the research question that concerns whether non-work support varies across the demographic variables.

Two hypotheses are then tested. The first hypothesis states that the mentally disabled have a smaller perceived non-work supportive network than subjects who are physically disabled. The second hypothesis is that returnees (to work) have a larger non-work supportive network than the non-returnees.

Section 5.3 focuses on social support at the work place examining the same four domains (size, quality, sources and type). Size and quality are analyzed across the following variables: type of disability, return to work status, job classification, and tenure (length of time on the job).

Two main hypotheses are tested here. The first concerns the relationship of size of the supportive network at work and type of disability. The second hypothesis is that the size of the supportive network at work is larger among returnees than non returnees.

Section 5.4 focuses on the six types of support (emotional, material aid, physical, advice, companionship and feedback). This section examines the research question about who provides what support.

Subjects were asked two questions related to the size of their non-work network. The first question addresses the size of respondent's social network: the number of friends (non-work), relatives, immediate family members, neighbors and significant others. The second question examines how many of these individuals the subjects perceive can be turned to for support. The focus is upon five non-work support resources: 1) immediate family; 2) relatives; 3) friends (non work); 4) neighbors; and 5) significant others (significant others include lovers and boy friends).

"Perceived support network" refers to the number of individuals the subjects can turn to for help/support compared to the size of the social network. The "perceived support network" will be used in the analysis.

## 5.2 NON-WORK SUPPORT

### 5.2.1 Size of Non-Work Support Network

The results reveal that the mean sizes of the non-work network and perceived non-work supportive network were different (see Table 5-1). The social network is larger than the perceived supportive network. Whereas the mean number of relatives is 12, the mean number of supportive relatives is 5. This is also true for friends, neighbors and significant others. It should be noted that immediate family in this section is included in the relative category.



**TABLE 5-1. SIZE OF NON-WORK SOCIAL NETWORK AND PERCEIVED SOCIAL SUPPORT NETWORK BY EACH SOURCE OF SUPPORT**

	MEAN SIZE OF NON-WORK SOCIAL SUPPORT NETWORK*			MEAN SIZE OF PERCEIVED NON-WORK SOCIAL SUPPORT NETWORK**		
	FREQ.	MEAN	SD	FREQ.	MEAN	SD
Relative	185	12	18	185	5	10.2
Friends	185	5	7	185	3	5.4
Neighbors	185	4	10	185	1	4.5
Significant Others	185	0.4	1.03	185	0.3	.112

\* Size of non-work social support network refers to the social network subjects reported (number of family members, relatives, friends and neighbors).

\*\* Size of perceived non-work social support network refers to the number of individuals the subjects reported that they could turn to for help/support (immediate family, relatives, friends, neighbors).

Eight point six percent (16) reported that they do not have relatives, whereas 91.45% (169) reported they have at least one relative (spouses and children are included in this category).

The mean number of relatives was 12.0 with mode=4; median=5. However, the mean number of supportive relatives was 5.0 with (mode=0, median=3). The size of the supportive relatives appears to be smaller than the size of the network of relatives.

Eighteen point four percent (34) workers reported that they had no friends at all; whereas 81.6% (151) reported that they had at least one friend. The mean number of friends was 5.0 with (mode=1; median=3). On the other hand, the mean number of the perceived supportive friends was 3.0

with (mode=2; median=0). The size of the perceived supportive friend network is smaller than the size of the social network of friends.

Thirty-seven point eight percent (70) reported that they do not know their neighbors and 56.8% (105) reported they never turn to their neighbor for any help/support, and of those remaining the mean number is 1.0 with (mode=0, median=0).

Twenty-four percent (45) of the respondents reported that they have significant others they can turn to during short-term disability. The mean number of supportive significant others is 0.3 with (mode=0, median=0).

#### Total Size of Non-Work Perceived Network of Support

The total size of the perceived non-work supportive network was computed by adding the number of individuals that subjects could turn to for support among relatives, friends, neighbors, and significant others, as well as the total size of the non-work social network. The total size of the non-work supportive network was compared across the following variables: type of disability (mental vs. physical), age, marital status, and ethnicity.

The mean size of the total perceived non-work supportive network was 10 with (mode=4, median=6) and the range is from 0-28, whereas the mean of the total social network is 22 with (mode=21; median=13) and the range was 0-100.

#### Size of Perceived Non-Work Support By Type of Disability

The mean size of the perceived support network among physically disabled subjects is higher (N=156; mean=7.9; SD=14.68) than that of

mentally disabled subjects (N=28; mean=3.9; SD=5.40). T-test computation showed that size of perceived supportive network is significantly different between both groups (T-value=2.60; DF=75.69; Prob=0.03).

This result supports the hypothesis that there is a relationship between the size of supportive network and type of disability. Physically disabled subjects have a larger supportive network than the mentally disabled.

#### Size of Perceived Non-Work Support By Age

For statistical analysis age was collapsed into three groups: 1) 23-30; 2) 31-40; and 3) 41-55.

Subjects in the third group (41-55) had the highest mean (N=18; mean=10; SD=6.5) size of perceived support network. The middle age grouping (31-40) had the second highest, (N=52; mean=9; SD=10.8) and the first age group had (N=115; mean=8; SD=6.60). The older the subjects the larger the perceived non-work supportive network. However, after controlling for type of disability and marital status, size of the non-work perceived supportive network was smaller among the older group. Nonetheless these differences are not statistically significant (F value=0.047; DF=1; Prob=0.954). Another explanation is the small sample size.

#### Size of Perceived Non-Work Support Network Among Returnees vs Non-Returnees

The results revealed that respondents who returned to work during the six months' period reported a larger size of perceived supportive

network (N=141; mean=10; SD=15.6) than those who did not (N=44; mean=7; SD=7.5). T-test revealed that this difference was statistically significant (T=1.85; DF=167; Prob=0.05). This result supports the second hypothesis that concerns the relationship between return to work and size of supportive network. Those respondents who returned to work have a larger non-work supportive network than those who did not.

#### Size of Perceived Non-Work Support Network By Marital Status

Table 5-2 reveals that widows have the largest mean size of perceived non-work supportive network among the four marital groups. Married subjects have the second largest, followed by the divorced, and finally, single never married and separated respondents.

**TABLE 5-2. SIZE OF SUPPORTIVE NETWORK BY MARITAL STATUS**

<u>MARITAL STATUS</u>	<u>N</u>	<u>MEAN</u>	<u>SD</u>
Single Never Married	40	8	10.7
Married/Significant Other	70	11	15.2
Separated	33	7	5.3
Divorced	34	8	9.1
Widowed	8	18	10.1

#### Mean Size of Perceived Non-Work Support Network By Ethnicity

The data in Table 5-3 shows that whites had the largest mean size of perceived non-work supportive network (N=49; mean=13; SD=18.83). However, the size of the non-work social network was largest among Blacks, followed by Hispanics, then among whites. Blacks and Hispanics

have larger informal social networks, but smaller perceived supportive networks.

**TABLE 5-3. SIZE OF PERCEIVED SUPPORTIVE NETWORK BY ETHNICITY**

<b>ETHNICITY</b>	<b>PERCEIVED NON-WORK SUPPORTIVE NETWORK</b>			<b>NON-WORK SUPPORTIVE NETWORK</b>		
	<b>N</b>	<b>MEAN</b>	<b>SD</b>	<b>N</b>	<b>MEAN</b>	<b>SD</b>
White	49	13	18.83	49	21	23.7
Black	103	9	12.69	103	26	28.5
Hispanic	26	5	5.2	26	22	23.2

### 5.2.2 Quality (Satisfaction) of Non-Work Support

The quality of non-work support was measured by asking the subjects these questions: 1) the degree to which they were satisfied with the support they received from their social network on a scale of 1 to 6, with 1 being the least satisfaction and 6 reflecting the greatest satisfaction; and 2) who was the most helpful person during short-term disability. The quality of support is analyzed across the following variables: marital status, age, type of disability, return to work status.

#### Quality of Support By Marital Status

##### Married

Married subjects reported the highest quality of support. The spouse obtained the highest mean score of support satisfaction (mean=5.05; SD=0.96). Immediate family (i.e., children, siblings) had the second highest (mean=4.11; SD=0.44); friends, the third (mean=4.0; SD=0.96); relatives, the fourth (mean=3.65; SD=0.33) and neighbors, the lowest mean

scores (mean=3.00; SD=0.33). In answering who is the most helpful person, married respondents ranked spouses as the most helpful person. Children were ranked second, and non-work friends, third.

#### Single Never Married

Among single never married respondents, friends received the highest mean of perceived support satisfaction (mean=4.50; SD=0.98); immediate family the second highest (mean=4.20; SD=1.26); and relatives the third (mean=3.85; SD=1.27). Among these subjects only three people reported that they receive support from neighbors. In terms of the most helpful person, single never married respondents ranked an immediate family member (child, parent) and friends the highest.

#### Separated/Widowed/Divorced

The separated, widowed, divorced subjects rated family as providing the highest quality of support (mean=4.36; SD=0.92); friends had the second highest (mean=4.00; SD=0.93); relatives, third (mean=3.37; SD=1.29); and neighbors, fourth (mean=3.57; SD=1.20). This group ranked an immediate family member as the most helpful source of support.

Similar results were obtained when ethnicity was ruled out. Nonetheless, in controlling statistically for ethnicity, one difference appeared: spouses of Black and Hispanic respondents did not receive the highest mean score of satisfaction as did their white counterparts. Also, Blacks and Hispanics did not rank the spouse as the most helpful person, as did whites. Instead they ranked a family member (children or sibling) as the most helpful support source.

### Quality of Support By Age

Examining the quality of support across the three age groups (24-30; 31-40; and 41-55), the third age group (41-55) reported a slightly higher support satisfaction with their network (spouse, family, friends, relatives, neighbors) compared to the other two age groups (see Table 5-4). However, age could be confounding with marital status and type of disability, because there are more subjects with mental illness in the younger age group, as there are in the single never married category.

**TABLE 5-4. QUALITY OF SUPPORT ACROSS THREE AGE GROUPS**

<u>AGE</u>	<u>SPOUSE</u>	<u>IMMEDIATE FAMILY</u>	<u>RELATIVE</u>	<u>FRIENDS</u>	<u>NEIGHBORS</u>
24-30	(Mean=4.60) (SD=0.57) (N=4)	(Mean=4.00) (SD=0.95) (N=10)	(Mean=2.50) (SD=1.11) (N=9)	(Mean=3.73) (SD=1.09) (N=15)	(Mean=2.00) (SD=0.98) (N=6)
31-40	(Mean=4.80) (SD=0.74) (N=15)	(Mean=4.30) (SD=1.18) (N=50)	(Mean=3.00) (SD=1.35) (N=31)	(Mean=4.05) (SD=1.21) (N=40)	(Mean=2.50) (SD=1.27) (N=24)
41-55	(Mean=5.50) (SD=0.53) (N=46)	(Mean=4.50) (SD=0.90) (N=107)	(Mean=3.81) (SD=1.29) (N=53)	(Mean=4.50) (SD=0.75) (N=88)	(Mean=3.00) (SD=1.04) (N=24)

### Quality of Support By Type of Disability (Mental vs. Physical)

The physically disabled reported a slightly higher satisfaction from non-work support than the mentally disabled (see Table 5-5).

**TABLE 5-5. QUALITY OF SUPPORT BY TYPE OF DISABILITY**

TYPE	IMMEDIATE				
	SPOUSE	FAMILY	RELATIVE	FRIENDS	NEIGHBORS
Physical	(Mean=5.20) (SD=1.04) (N=63)	(Mean=4.50) (SD=0.88) (N=149)	(Mean=3.68) (SD=1.28) (N=80)	(Mean=4.29) (SD=0.88) (N=122)	(Mean=3.80) (SD=1.09) (N=77)
Mental	(Mean=4.25) (SD=0.88) (N=8)	(Mean=3.70) (SD=0.83) (N=24)	(Mean=3.00) (SD=0.84) (N=21)	(Mean=3.90) (SD=0.49) (N=21)	(Mean=2.00) (SD=0.44) (N=9)

Quality of Support Among Both Groups Controlling for Marital Status (Physical vs Mental)

The married physically disabled reported greater satisfaction with non-work support than their mentally disabled counterparts. (See Table 5-6.) The quality of friends' support was significantly different between the two groups (T value=2.09; DF=64.74; Prob=0.041).

**TABLE 5-6. QUALITY OF SUPPORT BY TYPE OF DISABILITY AND MARITAL STATUS**

	MARRIED		NON-MARRIED	
	PHYSICAL	MENTAL	PHYSICAL	MENTAL
Spouse	(Mean=5.50) (SD=1.04) (N=57)	(Mean=4.20) (SD=0.89) (N=8)	N/A N/A N/A	N/A N/A N/A
Immediate Family	(Mean=4.70) (SD=0.94) (N=61)	(Mean=3.70) (SD=0.85) (N=8)	(Mean=4.40) (SD=0.95) (N=88)	(Mean=3.60) (SD=0.85) (N=16)
Relative	(Mean=3.70) (SD=1.10) (N=28)	(Mean=2.50) (SD=0.86) (N=5)	(Mean=3.50) (SD=1.01) (N=52)	(Mean=2.40) (SD=0.87) (N=8)
Friends	(Mean=4.50) (SD=1.09) (N=48)	(Mean=3.60) (SD=0.05) (N=6)	(Mean=4.65) (SD=1.08) (N=74)	(Mean=3.20) (SD=1.08) (N=15)
Neighbors	(Mean=3.20) (SD=1.04) (N=27)	(Mean=0.0) (SD=0.0) (N=0)	(Mean=3.60) (SD=1.05) (N=40)	(Mean=2.50) (SD=0.85) (N=50)



**Quality of Support Among Returnees vs Non-Returnees**

Respondents who returned to work reported a slightly higher mean of support satisfaction from their network than those who did not. (See Table 5-7.)

**TABLE 5-7. QUALITY OF SUPPORT AMONG RETURNEES VS NON-RETURNEES**

	<u>SPOUSE</u>	<u>IMMEDIATE FAMILY</u>	<u>RELATIVE</u>	<u>FRIENDS</u>	<u>NEIGHBORS</u>
Returnees	(Mean=5.00) (SD=0.99) (N=58)	(Mean=4.60) (SD=0.99) (N=139)	(Mean=3.52) (SD=1.24) (N=140)	(Mean=4.50) (SD=0.99) (N=112)	(Mean=3.00) (SD=1.49) (N=68)
Non-Returnees	(Mean=4.00) (SD=1.23) (N=13)	(Mean=3.00) (SD=1.05) (N=29)	(Mean=3.00) (SD=1.30) (N=21)	(Mean=3.50) (SD=0.90) (N=31)	(Mean=2.50) (SD=1.04) (N=18)

Controlling for marital status, the mean quality of support was slightly higher among married returnees than non-married returnees. (See Table 5-8).

**TABLE 5-8. QUALITY OF SUPPORT BY MARITAL STATUS (RETURNEES VS NON-RETURNEES)**

	<u>MARRIED</u>		<u>NON-MARRIED</u>	
	<u>RETURNEES</u>	<u>NON-RETURNEES</u>	<u>RETURNEES</u>	<u>NON-RETURNEES</u>
Spouse	5.50 (SD=0.99) (N=54)	4.20 (SD=0.2) (N=11)	N/A N/A N/A	N/A N/A N/A
Relative	4.00 (SD=0.88) (N=28)	3.22 (SD=1.35) (N=5)	3.60 (SD=1.22) (N=44)	3.00 (SD=1.2) (N=16)
Immediate Family	4.80 (SD=0.90) (N=57)	4.00 (SD=0.95) (N=12)	4.50 (SD=0.96) (N=75)	3.51 (SD=1.05) (N=29)
Friends	4.60 (SD=0.83) (N=47)	3.51 (SD=0.83) (N=7)	4.50 (SD=0.85) (N=65)	3.70 (SD=0.87) (N=24)
Neighbors	2.50 (SD=0.44) (N=39)	2.00 (SD=0.59) (N=14)	2.20 (SD=0.59) (N=29)	2.00 (SD=0.57) (N=4)

### **5.3 WORK SUPPORT**

**This section focuses on the functional and structural aspects of work support. The structural aspects are size, quality and sources of support; and the functional aspect is the type of support provided.**

**The size of work support was measured by the following two items:**

- 1) The number of people at work including subordinates and superiors who are considered to be friends.**
- 2) The number of people at work that the respondents could turn to for any kind of help/support, such as physical assistance, emotional, advice, social participation, feedback.**

**The overall quality (satisfaction) of work support was measured by asking the subjects the following question:**

**On a scale of 1 to 6, with 1 being the least satisfactory and six being the most satisfactory, how satisfied are you with the help/support you received from, co-workers, supervisor, shop steward, or union representative?**

**The type of support focuses on six different functions of support (emotional, physical assistance, advice, material aids, social participation, feedback) using the modified Barrera scale (Modified Arizona Interview Schedule 1983).**

**The size and quality of support were analyzed across the following variables: type of disability, return to work status, job classification, and tenure (length of time on the job).**

The following hypotheses are discussed at the end of this section:

- 1) The size of the perceived support network is larger among the physically disabled than the mentally disabled.
- 2) The size of the perceived work support network is larger among returnees than non-returnees.

### 5.3.1 Size of Network

The mean size of the perceived work supportive network was smaller (N=184, mean=3.79, SD=1.6) than the mean number of co-workers or other people at the work place who were considered as friends (N=184; mean=6.4; SD=10.4).

This was also true for the non-work support network in which the number of persons in the perceived availability of a supportive network was smaller than the total support network.

It should be noted that for research purposes only, the size of the perceived work supportive network was used and not the actual size of the workplace social-network.

### The Size of Work Support by Type of Disability (Mental vs. Physical)

The mean size of the perceived work support network for the physically disabled (mean=6.93; N=156; SD=11.0) was greater than that of the mentally disabled (mean=3.96; N=28; SD=5.4).

A T-test was computed to test the hypothesis about the relationship between size of the perceived work support network among the physically

and mentally disabled. The T-test revealed a statistically significant difference. (T-value 2.20; DF=75.69; Prob=0.03). This implies that the workers with physical disabilities reported a significantly larger perceived supportive network than those with mental disabilities.

#### Size of Work Support Networks by Returnees vs. Non-Returnees

Returnees reported a larger work support network (mean=7.19; N=141; SD=11.66) than non-returnees (mean=4.13; N=44; SD=4.40).

A T-test was computed to test the hypothesis about the relationship between the size of the perceived work support network and return to work status. This hypothesis was supported -- returnees reported a larger support network than non-returnees (T-value=2.57; DF=137.92; Prob=0.01). However, when the type of disability was controlled, the mean number of returnees remained higher but not statistically significantly different (T-test=1.70; DF=77.74; Prob=0.09). That was also true for the mentally ill.

#### Size of Work Support by Ethnicity

The mean size of the perceived work support network was greater among whites (N=49; mean=8.48; SD=13.32) than among blacks (N=102; mean=5.73; SD=9.69) and Hispanics (N=26; mean=5.73; SD=7.66). However, this difference was not found to be statistically significantly different (F value=1.2013; Prob=0.30). This result held true when the type of disability was ruled out. Among the physically disabled, whites had a higher mean (mean=6.68; N=19; SD=10.42) than blacks (mean=5.89; N=76; SD=10.53) and Hispanics (mean=5.76; N=17; SD=9.06) but not statistically significantly different (F value=0.078; DF= ; Prob=0.924).

### Size of Perceived Work Support Networks by Marital Status

Married respondents had the largest mean size of perceived work support network (mean=8.4; N=39; SD=14.21). Single never married respondents had the second highest mean (mean=7.2; N=70; SD=10.99). Divorced (mean=6.3; N=34; SD=9.11) and widowed subjects (mean=6; N=8; SD=9.11) had the third highest size of support network, the same as single never married. The separated group had the smallest perceived support network (mean=4.4; N=33; SD=5.19). However, these differences were not statistically significant ( $F$  value=0.614; Prob=0.606). Controlling for the type of disability, the same results were obtained among the physically disabled. The married subjects had the highest mean (mean=9.6; N=28; SD=16.36). The single never married had the second highest mean (mean=7.4; N=62; SD=11.46), while the widowed (mean=6.3; N=30; SD=9.29) and divorced (mean=6.3; N=8; SD=5.22) had the next highest size support networks. The separated had the lowest mean size of support network. Those with non-work support networks also appear to have support networks at work.

Among the mentally disabled, the married respondents had the largest mean size of network (mean=7.3; N=11; SD=1.19). The single never married (mean=1.7; N=8; SD=6.37) and the separated (mean=1.2; N=5; SD=1.30) had the smallest mean size of support network in the workplace. Divorced women had a greater mean size of support network (mean=6.4; N=4; SD=8.81) than both the separated and single never married groups. It should be noted that there were no widowed subjects among the mentally disabled.

### Size of Work Support Networks by Age of the Subjects

Respondents in the 41-55 age group reported a larger work support network (mean=7.42; N=114; SD=10.68) than the other two age groups. The 23-30 age group had mean=3.94; N=18; SD=4.39 whereas the 31-40 age group had mean=5.28; N=52; SD=11.31. This implies that the older the subjects, the greater the perceived support network at work. Controlling for type of disability, once again among the physically disabled, the oldest had the largest mean size of support network (mean=7.56; N=104; SD=11.01) and the youngest age group has the smallest network (mean=3.45; N=11; SD=2.01). The middle age group has mean of mean=6.26; N=41; SD=12.57.

These findings held true for the mentally ill disabled. The 41-55 age group reported the largest mean size of support network (mean=6; N=10; SD=6.50). However, age could be confounding with tenure, with support networks developing the longer one is on the job (see below).

### Size of Networks by Job Classification (Administrative vs. Service Workers)

Service workers reported a larger size (mean=7.63; N=129; SD=11.41) of perceived supportive network than administrative workers (mean=6.41; N=55; SD=7.9).

### Size of Networks by Tenure

The length of time on the job was divided into the following four groups: 1) 1-3; 2) 4-6; 3) 7-10; 4) 11 or more. The results showed that the longer the respondent was on the job the higher the size of the perceived work social supportive network. First group reported (N=45) mean=5.62;

SD=11.93, the second (N=39) mean=5.2051; SD=5.51, the third (N=45) mean=7.26; SD=7.66 and the last group (N=55) mean=8.44; SD=13.53.

### 5.3.2 The Quality of Work Support at the Work Place

The mean quality of support was examined across the four sources of supervisors, co-workers, shop steward and union representative. Then the mean quality of support for each source was analyzed across the following variables: 1) job classification; 2) type of disability; 3) return to work status; and 4) tenure.

The following table presents the means and SDs of the perceived quality of work support:

**TABLE 5-9. PERCEIVED QUALITY OF WORK SUPPORT**

<u>SOURCE</u>	<u>FREQUENCY</u>	<u>MEAN</u>	<u>SD</u>
Co-workers	185	4.05	1.00
Supervisors	185	3.73	1.35
Shop steward	185	2.49	2.10
Union representative	185	2.08	2.06

The above table reveals that the quality of support from co-workers is higher than that provided by the other sources.

**TABLE 5-10. QUALITY OF WORK SUPPORT BY TYPE OF DISABILITY**

<u>SOURCE</u>	<u>PHYSICAL</u>	<u>MENTAL</u>
Co-workers	(Mean=4.50) (SD=0.97) (N=156)	(Mean=3.51) (SD=0.51) (N=29)
Supervisors	(Mean=3.85) (SD=1.31) (N=156)	(Mean=3.00) (SD=1.40) (N=29)
Shop steward	(Mean=2.58) (SD=2.08) (N=156)	(Mean=1.96) (SD=2.12) (N=29)
Union representative	(Mean=2.00) (SD=2.09) (N=156)	(Mean=1.48) (SD=1.86) (N=29)

The data in the above table reveals that, once again, the physically disabled respondents had a higher quality of support than the mentally disabled subjects. Among both groups, co-workers received the highest satisfaction rating. A lower mean of quality of support was reported for both shop steward and union representative.

**TABLE 5-11. QUALITY OF WORK SUPPORT BY EMPLOYMENT STATUS**

<u>SOURCE</u>	<u>RETURNEES</u>	<u>NON-RETURNEES</u>
Co-workers	(Mean=4.50) (SD=0.96) (N=141)	(Mean=3.80) (SD=1.06) (N=44)
Supervisors	(Mean=3.77) (SD=1.31) (N=144)	(Mean=3.00) (SD=1.48) (N=44)
Shop steward	(Mean=2.53) (SD=2.08) (N=141)	(Mean=2.01) (SD=2.17) (N=44)
Union representative	(Mean=2.10) (SD=2.03) (N=141)	(Mean=2.00) (SD=2.18) (N=44)



Returnees reported a higher level of satisfaction from the support they received from their work colleagues when compared with non-returnees. Among the four groups, co-workers received the highest mean level of quality of support. This implies that respondents are satisfied the most with the support they receive from their co-workers and the least satisfied from shop stewards and union representatives.

**TABLE 5-12. QUALITY OF WORK SUPPORT BY JOB CLASSIFICATION**

<u>SOURCE</u>	<u>ADMINISTRATIVE</u>	<u>SERVICE</u>
Co-workers	(Mean=4.00) (SD=0.98) (N=136)	(Mean=4.50) (SD=1.03) (N=55)
Supervisors	(Mean=3.60) (SD=1.40) (N=130)	(Mean=4.20) (SD=2.08) (N=55)
Shop steward	(Mean=2.00) (SD=2.08) (N=130)	(Mean=2.50) (SD=2.12) (N=55)
Union representative	(Mean=2.00) (SD=2.10) (N=130)	(Mean=2.50) (SD=1.98) (N=55)

Service workers have a slightly higher mean satisfaction from the four support sources than do administrative workers; co-workers have the highest mean scores among the four groups for both administrative and service workers.

#### 5.4 TYPE OF SUPPORT

The Arizona Social Support Interview Schedule (ASSIS) was used to measure six perceived social support functions: 1) private feelings; 2) material aid; 3) physical assistance; 4) advice; 5) positive feedback; and 6) social participation. This scale was modified for the particular context and the study population (female workers on short-term disability).

This section addresses the research question concerning the type and source of the support utilized (work and non-work). In this section the analyses are carried out separately for each marital status group (married vs. non-married). First, the total number and percentages of people the subjects reported they turned to for a particular type of support is presented and discussed in this section. Second, the number of people available for each type of support is presented and compared across different variables (type of disability, return to work status, marital status).

Data in Tables 5-13 and 5-14 reveal that respondents reported that they turn to their total social network for all the six types of support: emotional, physical, material, advice, companionship, and feedback. On the other hand, there is a trend that indicates a differentiation concerning which persons subject turns to the most for a particular type of support.

Results revealed that married and non-married respondents utilize their social network only slightly differently.

**TABLE 5-13. PERCENTAGE AND NUMBER OF AVAILABLE SOURCES BY TYPE OF SUPPORT AND MARITAL STATUS**

Question	MARRIED					
	Spouse	Immediate Family	Relatives	Friends	Co-Workers	Neighbors
If you want to talk to someone about things that are very personal, who would you go to?	82.1% (55)	65.7% (44)	13.4% (9)	64.2% (43)	29.9% (20)	11.9% (8)
If you feel depressed or frustrated because of your illness, to whom would you go to talk?	80.6% (54)	71.6% (48)	14.9% (10)	64.2% (43)	28.4% (19)	10.4% (7)
If you need to borrow \$25 or more, to whom would you go to?	76.1% (51)	68.7% (46)	17.9% (12)	37.9% (25)	16.4% (11)	6.0% (4)
If you could not do your shopping because of your illness, to whom would you go to?	92.5% (7.5)	73.1% (49)	16.4% (11)	50.7% (34)	19.9% (13)	30.0% (20)
If you need a ride to the doctor or other places (work, etc.), to whom would you go to?	83.6% (56)	52.2% (35)	13.4% (9)	30.8% (26)	19.4% (13)	25.4% (17)
If you need advice related to your job, to whom would you go to?	59.7% (40)	29.9% (20)	7.5% (5)	26.9% (18)	73.1% (49)	3.0% (2)
If you need advice related to your personal life or matters, to whom would you go to?	77.6% (52)	61.2% (41)	11.9% (8)	55.2% (37)	16.4% (11)	3.0% (2)
If you would like to have some fun or visit someone or have company, to whom would you go to?	91.0% (61)	71.6% (48)	26.9% (18)	73.1% (49)	43.3% (29)	20.9% (14)
Who are the people you could expect to let you know they like your ideas?	90% (72)	50.7% (34)	20.9% (14)	73.1% (49)	43.3% (29)	3.0% (2)

**TABLE 5-14. PERCENTAGE AND NUMBER OF AVAILABLE SOURCES BY TYPE OF SUPPORT AND MARITAL STATUS**

<u>Question</u>	<b>NON-MARRIED</b>				
	<u>Immediate Family</u>	<u>Relatives</u>	<u>Friends</u>	<u>Co-Workers</u>	<u>Neighbors</u>
If you want to talk to someone about things that are very personal, who would you go to?	72.0% (85)	23.7% (28)	61.0% (72)	42.4% (50)	9.3% (11)
If you feel depressed or frustrated because of your illness, to whom would you go to talk?	68.5% (82)	23.7% (28)	61.0% (72)	42.4% (50)	11.0% (13)
If you need to borrow \$25 or more, to whom would you go to?	63.6% (75)	21.2% (25)	44.1% (52)	26.3% (24)	6.8% (8)
If you could not do your shopping because of your illness, to whom would you go to?	72.0% (85)	26.3% (31)	52.5% (62)	22.9% (27)	33.0% (39)
If you need a ride to the doctor or other places (work, etc.), to whom would you go to?	55.1% (65)	18.6% (22)	45.8% (54)	22.0% (26)	22.0% (26)
If you need advice related to your job, to whom would you go to?	44.1% (52)	13.6% (16)	35.6% (42)	78.8% (93)	2.5% (3)
If you need advice related to your personal life or matters, to whom would you go to?	66.9% (79)	24.6% (29)	63.6% (75)	66.9% (79)	8.5% (10)
If you would like to have some fun or visit someone or have company, to whom would you go to?	60.2% (71)	34.7% (41)	65.3% (77)	48.3% (57)	19.5% (23)
Who are the people you could expect to let you know they like your ideas?	56.8% (67)	22.0% (26)	42.4% (50)	46.6% (55)	12.7% (15)

#### **5.4.1 Married Respondents**

##### **Spouse**

Married respondents reported they utilized their spouses for all types of support. However, there is a variation in terms of the type of support sought by subjects from their spouses. Results revealed that married subjects turned to their spouses most for emotional, instrumental and companionship support and less for job-related advice.

##### **Immediate Family**

Married respondents turned for help to their immediate family primarily for physical assistance, material aid, and companionship. A small percentage of the married subjects turned to immediate family for job-related advice, whereas more subjects turned to their immediate family for personal advice.

##### **Relative**

Married respondents do not utilize their relatives as much as spouse and immediate families. They turned to relatives primarily for companionship and material aid.

##### **Friends**

Married respondents turned to friends more than relatives. They turned to friends primarily for emotional support, companionship and personal advice, but not for job-related advice.

### Co-Workers

Married respondents turned to co-workers primarily for job-related advice and emotional support.

### Neighbors

A small number of married respondents turned to neighbors. These subjects reported that they turned primarily for instrumental help (e.g., shopping, a ride).

## 5.4.2 Non-Married Respondents

### Immediate Family

Non-married respondents utilized their immediate families more than the married group. The non-marrieds turned to immediate family primarily for physical assistance, material aid and companionship. A small percentage of these respondents reported that they turned to immediate family for job-related advice.

### Relative

Non-married respondents utilize their relatives less than immediate families and friends. They turn to relatives primarily for companionship and less for physical assistance.

### Friends

Non-married respondents utilized their friends more than the married. Non-married respondents turned to friends primarily for

emotional support, companionship and feedback and less for instrumental help.

### Co-Workers

Non-married respondents utilized co-workers primarily for job-related advice and feedback.

### Neighbors

As in the married group, a small number of subjects turned to neighbors. They turned to neighbors primarily for physical assistance (rides, shopping).

### 5.4.3 Number of Individuals Available for Each Type of Support by Type of Disability, Marital Status and Employment Status

In the following analyses, the six types of support (emotional, instrumental, companionship, advice, material and feedback) were analysed by groups. The groups were: physical v. mental; married v. non-married; and returnees v. non-returnees. The purpose was to assess the availability of each type of support by groups.

**TABLE 5-15. PERCENTAGE AND NUMBER OF PEOPLE RESPONDENTS TURNED TO BY TYPE OF SUPPORT AND TYPE OF DISABILITY (PHYSICAL VS. NON-PHYSICAL)**

<u>Type of Support</u>	<b>PHYSICAL</b>			
	Number of Persons Available of Each Type of Support			
	<u>0</u>	<u>1-2</u>	<u>3-5</u>	<u>5 or more</u>
Emotional support (talks about personal matters)	4.5% (7)	47.4% (74)	43.6% (68)	4.5% (7)
Emotional support (talks about illness)	8.3% (13)	49.0% (76)	36.0% (57)	6.5% (10)
Instrumental support (shopping)	1.3% (2)	55.1% (86)	34.6% (54)	9% (14)
Instrumental support (rides)	14.7% (23)	54.5% (85)	21.8% (34)	9% (14)
Companionship	9% (14)	37.2% (58)	39.1% (61)	14.7% (23)
Advice related to personal matters	8.3% (13)	55.8% (87)	32.0% (50)	3.9% (6)
Advice related to job	10.3% (16)	57.7% (90)	31.4% (49)	0.4% (1)
Material aid	9.6% (15)	61.6% (96)	24.4% (38)	4.5% (7)
Feedback	10.3% (16)	31.4% (49)	57.7% (90)	0.4% (1)



### MENTAL (DEPRESSION)

<u>Type of Support</u>	<u>Number of Persons Available of Each Type of Support</u>			
	<u>0</u>	<u>1-2</u>	<u>3-5</u>	<u>5 or more</u>
Emotional support (talks about personal matters)	17.2% (5)	51.7% (15)	31.1% (9)	0.0% (0)
Emotional support (talks about illness)	17.2% (5)	62.2% (18)	17.2% (5)	3.4% (1)
Instrumental support (shopping)	10.3% (3)	58.6% (17)	31.1% (9)	0.0% (0)
Instrumental support (rides)	41.4% (12)	44.8% (13)	13.8% (4)	0.0% (0)
Companionship	31.1% (9)	48.2% (14)	21.1% (6)	0.0% (0)
Advice related to personal matters	17.2% (5)	58.6% (17)	17.2% (5)	6.9% (2)
Advice related to job	13.8% (4)	58.6% (17)	27.6% (8)	0.0% (0)
Material aid	24.1% (7)	69.0% (20)	6.9% (2)	0.0% (0)
Feedback	24.1% (7)	48.3% (14)	24.1% (7)	3.4% (1)

The number of individuals who were perceived by the subjects as available to provide support varied across the six types of support. It also varied between the two groups of disability (physical vs. mental). Tables 5-16 and 5-17 revealed that 17.2% (5) of the mentally disabled respondents reported that they did not have any one to turn to for emotional support as compared to 4.5% (7) in the physically disabled group. Forty one percent (12) of the mentally disabled respondents reported that they did not have anyone to turn to for instrumental support, such as shopping or a ride, whereas only 1.3% (12) of the subjects in the physically disabled group had no source of such support. 31.1% (9) among the subjects in the mentally

disabled category reported that they did not have any one to turn to for companionship compared to 9% (14) among the physically disabled subjects. This was also true for job-related or personal advice and material aid in which there is a large number of respondents in the mentally disabled category who reported that they had no one to whom they could turn.

Physically disabled subjects reported a greater number of people they can turn to for each of the six types of support. Fewer mentally disabled subjects (depression) reported more than three people that they could turn to for any type of support. However, the physically disabled subjects reported five or more people they could turn to for several types of support.

**TABLE 5-16. PERCENTAGE AND NUMBER OF PEOPLE RESPONDENTS TURNED TO BY TYPE OF SUPPORT AND MARITAL STATUS (MARRIED VS. NON-MARRIED)**

<u>Type of Support</u>	<u>MARRIED</u>			
	<u>Number of Persons Available of Each Type of Support</u>			
	<u>0</u>	<u>1-2</u>	<u>3-5</u>	<u>5 or more</u>
Emotional support (talks about personal matters)	5.7% (4)	35.0% (25)	52.0% (37)	7.1% (5)
Emotional support (talks about illness)	8.6% (6)	42.9% (30)	38.6% (27)	10.0% (7)
Instrumental support (shopping)	1.4% (1)	41.4% (29)	50.0% (35)	7.1% (5)
Instrumental support (rides)	8.6% (6)	58.6% (41)	22.9% (16)	10.0% (7)
Companionship	2.9% (2)	28.6% (20)	47.1% (33)	21.4% (15)
Advice related to personal matters	7.1% (5)	54.3% (38)	34.3% (24)	4.3% (4)
Advice related to job	11.4% (8)	48.6% (34)	38.6% (27)	1.4% (1)
Material aid	7.1% (5)	57.6% (40)	21.0% (30)	14.3% (10)
Feedback	35.7% (25)	15.7% (11)	34.3% (24)	14.3% (10)

## NON-MARRIED

<u>Type of Support</u>	Number of Persons Available of Each Type of Support			
	<u>0</u>	<u>1-2</u>	<u>3-5</u>	<u>5 or more</u>
Emotional support (talks about personal matters)	7.0% (8)	55.7% (64)	34.8% (40)	2.6% (3)
Emotional support (talks about illness)	10.4% (12)	55.7% (64)	30.4% (35)	3.5% (4)
Instrumental support (shopping)	3.5% (4)	63.4% (73)	24.3% (28)	9.0% (10)
Instrumental support (rides)	25.2% (29)	49.6% (57)	19.0% (22)	6.1% (7)
Companionship	13.9% (16)	45.2% (52)	29.6% (34)	11.3% (13)
Advice related to personal matters	11.3% (13)	57.3% (66)	27.0% (31)	4.3% (5)
Advice related to job	10.4% (12)	63.4% (73)	26.0% (30)	0.0% (0)
Material aid	14.8% (17)	66.1% (76)	16.5% (19)	2.6% (3)
Feedback	30.5% (35)	45.2% (52)	24.3% (28)	0.0% (0)

**TABLE 5-17. PERCENTAGE AND NUMBER OF PEOPLE RESPONDENTS TURNED TO BY TYPE OF SUPPORT AND WORK STATUS (RETURNEES VS. NON-RETURNEES)**

## RETURNEES

<u>Type of Support</u>	Number of Persons Available of Each Type of Support			
	<u>0</u>	<u>1-2</u>	<u>3-5</u>	<u>5 or more</u>
Emotional support (talks about personal matters)	7.5% (11)	44.2% (65)	43.5% (64)	4.8% (7)
Emotional support (talks about illness)	10.6% (15)	47.5% (67)	35.4% (50)	6.4% (9)
Instrumental support (shopping)	3.4% (5)	52.4% (78)	35.4% (50)	8.8% (13)
Instrumental support (rides)	17.7% (26)	52.4% (77)	21.0% (31)	8.8% (13)
Companionship	10.2% (15)	36.7% (54)	37.4% (55)	15.6% (23)
Advice related to personal matters	4.8% (7)	51.0% (75)	39.4% (43)	4.8% (7)
Advice related to job	11.6% (17)	44.2% (65)	36.6% (48)	7.6% (11)
Material aid	10.9% (16)	62.6% (92)	22.4% (32)	4.1% (6)
Feedback	34.0% (48)	27.0% (38)	31.4% (44)	7.6% (11)

## NON-RETURNEES

<u>Type of Support</u>	<u>Number of Persons Available of Each Type of Support</u>			
	<u>0</u>	<u>1-2</u>	<u>3-5</u>	<u>5 or more</u>
Emotional support (talks about personal matters)	34.1% (15)	5.8% (3)	54.3% (23)	5.8% (3)
Emotional support (talks about illness)	34.1% (15)	5.8% (3)	54.3% (23)	5.8% (3)
Instrumental support (shopping)	26.5% (9)	43.2% (19)	31.9% (14)	4.5% (2)
Instrumental support (rides)	26.5% (9)	59.1% (26)	18.2% (8)	2.3% (1)
Companionship	32.8% (14)	6.8% (3)	44.3% (20)	15.9% (7)
Advice related to personal matters	38.6% (17)	9.1% (4)	47.7% (21)	4.5% (2)
Advice related to job	34.1% (15)	47.8% (21)	12.3% (5)	5.8% (3)
Material aid	13.6% (3)	45.5% (20)	38.5% (17)	4.5% (2)
Feedback	34.1% (15)	18.1% (8)	47.8% (21)	0.0% (0)

Married subjects reported a greater number of people primarily for emotional, instrumental (shopping, a ride), and material aid than non-married respondents. Seven percent (8) of the non-married subjects reported that they had no one to turn to for emotional support compared with 5.7% (4) for married. Three point five percent (4) of the non-married reported that they had no one for instrumental support compared with 1.4% (1) for marrieds. Thirteen point three percent (13) of the non-married reported they had no one for companionship compared with 2.9% (2) for the married respondents. Fourteen point eight percent (17) of the non-married reported they had no one for material aid compared with 7.1% (5) for the

married subjects. For job-related advice, there was no difference among both groups 11.0% (13) of the non-married reported that they had no one for job-related advice, and 11.4% (8) of the married so reported. Among the married only 1.4% reported five or more people for advice related to job and none (0.0%) for the non-married.

In general, married respondents had a larger number of people to turn to for the different types of support than the non-married respondents.

This phenomenon is also true among the two groups, those who returned to work and those who did not. Returnees reported a larger number of people available for each type of support than non-returnees. This is also true primarily for emotional support in which 34.1% (15) of those who did not go back to work reported that they had no one to turn to for emotional support compared with 7.5% (11) among those who returned. These findings are supportive of the previous results concerning the relationship of the size of social network and type of disability, and the size of social network and the employment status.

## 5.5 SUMMARY

Results in this section show that respondents differentiated somewhat to whom they turn for a particular type of support. Among marrieds, their spouses, immediate family and friends are utilized the most. In both groups (married and non-married), co-workers are utilized primarily for job-related advice, friends for emotional support, companionship and advice related to personal problems. However, friends and co-workers are more utilized by the non-married subjects than the married. Neighbors are utilized the least among both groups. Among the married group, none of the respondents turn to neighbors for advice related to their personal matters or jobs. That is also true among non-married subjects in which only a few subjects reported that they turn to neighbors for advice. Neighbors are utilized mainly for physical assistance (shopping, a ride).

Emotional support is provided primarily by spouses, immediate family and friends. Material aid is provided primarily by spouses and immediate family; physical assistance by spouse, immediate family and friends; job-related advice by co-workers. Companionship is provided primarily by spouses, immediate family, relatives and friends, and, for non-marrieds, co-workers as well.

### 5.5.1 Non-Work Support

In conclusion, the size of non-work perceived supportive network varies across different demographic variables. Black respondents have a larger social network than whites and Hispanics, but they have a smaller supportive network. Mentally disabled have a smaller size of non-work

perceived support network than the physically disabled. Single, divorced and separated respondents have a smaller non-work perceived supportive network than married or widowed subjects.

Married respondents reported the greatest support satisfaction with their spouse. Single never-married respondents reported the greatest support satisfaction with the support received with their friends, and separated, divorced, and widowed subjects reported that the immediate family was their source of quality support. The married respondents ranked their spouses as most helpful, single never married ranked friends and immediate family best, and the separated, divorced, widowed respondents ranked immediate family as the most helpful source.

Physically disabled subjects reported a slightly higher level of support satisfaction from their network than the mentally disabled. The level of the perceived quality of support among returnees was slightly higher than non-returnees when marital status is ruled out. However the difference was not statistically significant, possibly due to a small sample size (when other variables were controlled for).

Two hypotheses were supported. One concerns the relationship between size of non-work supportive network and type of disability (mental vs. physical). The second concerns the relationship between return to work and size of non-work supportive network. It was found that the physically disabled respondents reported a larger supportive network than the mentally disabled subjects. This was also the case for subjects who returned to work compared with those who did not. Those who returned to work reported larger non-work supportive networks.

### 5.5.2 Work Support

The results revealed that the older the subjects, the larger the size of the perceived supportive network at work and more satisfaction felt with the support they received. However, it was also found that the longer the subjects were on the job, the larger the size of network and the higher the level of satisfaction from the support they received from the social network at work.

Two hypotheses were supported: the first revealed that there is a relationship between size of perceived supportive network at work and the type of disability (physical vs. non-physical). Physically disabled subjects had a larger perceived supportive network at work than the mentally disabled. The second hypothesis concerns the relationship between size of the supportive network and return to work status. It was found that those who returned to work had a larger supportive network at work than non-returnees even when type of disability was ruled out.



## **SECTION 6**

### **RESULTS: GENERAL WELL-BEING AND SOCIAL SUPPORT**

#### **6.1 INTRODUCTION**

#### **6.2 CORRELATION ANALYSIS OF WELL- BEING WITH DEMOGRAPHIC, SOCIO-ECONOMIC, JOB AND SOCIAL SUPPORT VARIABLES**

#### **6.3 HIERARCHICAL MULTIPLE REGRESSION ANAYLSIS FOR THE BEST PREDICTOR VARIABLES FOR WELL-BEING**

#### **6.4 SUMMARY**

## **SECTION 6. RESULTS: GENERAL WELL-BEING AND SOCIAL SUPPORT**

### **6.1 INTRODUCTION**

There are two purposes for this section. One purpose is to test four hypotheses concerning the relationship of general well-being and the social support domains. The second purpose is to determine which are the best predictor variables for the general well-being of this study population. In addition, the third purpose is to assess the amount of variance that social support adds to the models of return to work when other variables are ruled out.

The first hypothesis states that there is a relationship between size of non-work supportive network and general well-being. The larger the size of the perceived non-work supportive network, the greater the general well-being. The second hypothesis states that there is a relationship between quality of support from the non-work social network (spouses, immediate family, relatives, friends and neighbors) and general well-being. The higher the level of satisfaction from the support received from each group of non-work social network, the greater the general well-being. These two hypotheses are also tested for work support; one concerns the size of work supportive network and well-being, while the second concerns the relationship between the quality of non-work support (co-workers, supervisors, union representatives and shop steward) and well-being. Each one of the four hypotheses will be discussed separately in this section.

General well-being was used as an outcome measure and social support domains as independent variables. The social support variables

that were included in this section were those which were tested in section 5 (size, source and quality of work and non-work support).

As mentioned in the methodology section, the general well-being scale consists of 33 items in six subscales. The six subscales measure health worry, energy level, satisfying interesting life, depressed-cheerful, emotional behavior, and relaxed versus tense-anxious. For research purposes, all the items that are tapping the social support domains were excluded from the scale and only fifteen items were used in the study. The purpose of excluding those items was to prevent multicollinearity and redundancy. The total score was used and not the sub-scale. General well-being was scored in a positive direction in that a high score reflects a self representation of well-being. This scale is unidimensional and measures one's general psychological state.

In Section 6.2 the results are reported of a correlational analysis that was conducted to assess the relationship of the well-being with the following domains:

- a) socio-economic and demographic variables
- b) job related variables
- c) non-work social support variables
- d) work social support variables

It tests the above mentioned hypotheses.

Section 6.3 reports on several hierarchical regression analyses that were utilized.

First, eleven work and non-work social support variables were entered simultaneously in the regression analysis to predict the amount of total variance explained by those variables, and assess the increment to  $R^2$  of each one of the social support variables. Second, the social support, socio-economic, demographic, job, and health related variables were entered in one regression equation to predict general well-being and assess the increment to  $R^2$  of each variable when other variables are controlled. Third, all those variables that became statistically significant in the second regression equation were included in the final regression equation model to predict well-being.

## 6.2 CORRELATION ANALYSIS OF WELL-BEING WITH DEMOGRAPHIC, SOCIO-ECONOMIC, JOB AND SOCIAL SUPPORT VARIABLES

In this section the relationship of general well-being with the following domains are presented: a) background; b) job; c) non-work social support; and d) work social support. Their relationship will be expressed in terms of the correlation coefficient, Pearson's R (for interval level) or correlation ratio, Eta square (for nominal level). Pearson's R represents the degree of relationship between two interval level variables, whereas Eta<sup>2</sup> represents the extent to which differences in the mean of a dependent variable are explained by variance in the independent variable.

**TABLE 6-1. CORRELATION BETWEEN BACKGROUND, SOCIO-ECONOMIC VARIABLES AND GENERAL WELL-BEING**

<u>VARIABLE</u>	<u>ETA</u>	<u>ETA<sup>2</sup></u>	<u>R</u>	<u>R<sup>2</sup></u>
Age			0.2176*	0.05
Ethnicity	0.19798	0.04		
Marital Status	0.21699*	0.05		
Economic Stress			-0.3265**	0.11
Level of Education			0.1013	0.01
Bi-weekly Salary			0.1708	0.03

\* P < 0.05      \*\* P < 0.01

The data in the above table reveals that age is positively correlated with well-being, (R=.2176; P<0.05), as age increases the general well-being also increases. This finding contradicts other studies that have shown that age is inversely correlated to well-being. It could be explained that age in this study is confounding with the type of disability (mental v. physical). A

high percentage of younger subjects fell into the mental disability category (depression). Also, older subject have a larger social support network and social support is related to well-being. Finally, the oldest workers in the study are younger than the age group for whom well-being usually drops off.

$\eta^2$  showed that the general well-being status was associated with marital status ( $\eta^2=.2199$ ;  $P<0.05$ ). Single never married subjects had the lowest general well-being scores compared with other marital status groups.

Perceived economic stress was negatively significantly correlated with well-being ( $R=-.3265$ ;  $P<0.05$ ). As the perceived economic stress decreased, general well-being increased.

Bi-weekly salary and ethnicity were not significantly correlated with well-being. It was interesting to note that general well-being was significantly correlated with the perceived economic stress and not with the actual bi-weekly salary. As mentioned in the methodology section, the perceived economic stress reflected the degree to which the subjects felt stressed economically in five different payments (car, medical care, rent, mortgage payments). This variable was used in the regression analyses as a predictor variable for well-being and as an independent variable in predicting factors that affect early return to work.

Perceived economic stress had the highest significant correlation with well-being among the other background variables.

**TABLE 6-2. CORRELATION BETWEEN JOB-RELATED VARIABLES AND GENERAL WELL-BEING**

<u>VARIABLE</u>	<u>ETA</u>	<u>ETA<sup>2</sup></u>	<u>R</u>	<u>R<sup>2</sup></u>
Tenure			0.1087	0.01
Satisfaction with salary			0.0927	0.008
Satisfaction with type of work			0.2882**	0.08
Overall job satisfaction			0.2315*	0.05
Workshift	0.1110	0.01		
Job Classification	0.1376*	0.02		

\* P < 0.05      \*\* P < 0.01

Satisfaction from the type of work, and overall job satisfaction were positively significantly correlated with general well-being. This implied that as satisfaction from the type of work increased, general well-being increased. Also, as the overall satisfaction increases, the well-being increases. It is interesting to note that there was no significant relationship between the satisfaction with the money the person makes and general well-being.

Job classification was significantly correlated with well-being; the mean for general well-being was different among the two groups. Administrative workers had a lower mean of well-being than service workers. One explanation is that the result could be confounding with the fact that in the study there was a higher number of mentally disabled subjects in the administrative workers than in the service, or the administrative workers had more stressful jobs than the service workers. This phenomenon needs further investigation in another study.

The shift subjects worked, tenure and the level of education were not significantly correlated with well-being.

Interestingly, despite the fact that job satisfaction was measured by individual items, they appeared to be significantly correlated with well-being. Satisfaction from work has the highest correlation with well-being among the job related variables.

**TABLE 6-3. CORRELATION BETWEEN HEALTH-RELATED VARIABLES AND GENERAL WELL-BEING**

<u>VARIABLE</u>	<u>ETA</u>	<u>ETA<sup>2</sup></u>	<u>R</u>	<u>R<sup>2</sup></u>
Type of disability	0.5270**	0.27		
Number of days of hospitalization			0.1328	0.02
Anticipated date of return to work			-0.3098**	0.10

\* P < 0.05      \*\* P < 0.01

Type of disability was highly positively correlated with well-being ( $R^2=.5270$ ;  $P<0.01$ ). The mentally disabled subjects reported lower well-being than the physically disabled.

Anticipated date of return to work was inversely correlated with well-being, ( $R=-.3098$ ;  $P<0.01$ ) as the number of anticipated sick days decreased, the general well-being increased. As mentioned in the methodology section this variable was used as an indicator for the severity of the illness. The number of days of hospitalization was not significantly correlated with well-being.



**TABLE 6-4. CORRELATION BETWEEN NON-WORK SOCIAL SUPPORT AND GENERAL WELL-BEING**

<b>VARIABLE</b>	<b>ETA</b>	<b>ETA<sup>2</sup></b>	<b>R</b>	<b>R<sup>2</sup></b>
Size of non-work support network	-	-	0.0429	0.001
Size of non-work supportive network	-	-	0.1724*	0.020
Quality of support from spouse	-	-	0.2697**	0.070
Quality of support from immediate family	-	-	0.1840**	0.030
Quality of support from relatives	-	-	0.1568	0.020
Quality of support from friends	-	-	0.1418*	0.020
Quality of support from neighbors	-	-	0.1254	0.020

\* P < 0.05      \*\* P < 0.01

The quality of support from one's spouse is more highly correlated with well-being than other social non-work support variables (R=.2697; P<0.05). This implies that as the satisfaction with the spouse's support increases, well-being increases. It is also true for size of supportive network, quality of support from friends (R=.1418; P<0.05), relatives (R=.1568; P<0.05), and immediate family (R=.1840; P<0.05). This implies that as the quality of support from immediate family increases, well-being increases. This was also the case with the quality of support from relatives and friends. However, the quality of support from neighbors was not significantly correlated with well-being. (There was very little support from neighbors among the study sample.)

**TABLE 6-5. CORRELATION BETWEEN WORK SOCIAL SUPPORT AND GENERAL WELL-BEING**

<u>VARIABLE</u>	<u>ETA</u>	<u>ETA<sup>2</sup></u>	<u>R</u>	<u>R<sup>2</sup></u>
Size of work support network	-	-	0.1226	0.020
Size of work supportive network	-	-	0.1724**	0.030
Quality of support from co-workers	-	-	0.2094*	0.040
Quality of support from supervisors	-	-	0.1917*	0.040
Quality of support from shop stewards	-	-	0.1236	0.020
Quality of support from union representatives	-	-	0.0094	0.000

\* P < 0.05

\*\* P < 0.01

Among all the work support variables, the quality of support from co-workers was the most significantly correlated with well-being (R=.2094; P<0.05). The quality of support from supervisors came second (R=.1917; P<0.05). This implies that as quality of support from co-workers and supervisors increases, well-being increases. This was also true for the size of work supportive network (R=.1724; P<0.05). As the size of work supportive network increases, general well-being increases. The quality of support from union representatives and shop steward was not significantly correlated with well-being.

The four hypotheses that are stated in the introductory section were supported. Well-being is significantly correlated with the size of one's support network and the perceived quality of support.

The following hypotheses are related to non-work place social support and well-being.

Hypothesis 1: There is a relationship between the size of the non-work supportive network and well-being. That is, as the size of non-work supportive network increases, general well-being increases.

This hypothesis was supported where results revealed that the size of the non-work supportive network was significantly correlated with well-being. As the size of the non-work supportive network increases, general well-being increases.

Hypothesis 2: There is a relationship between non-work support and well-being. That is, as the quality of non-work support from spouse, immediate family, relatives or neighbors increases, general well-being increases. (The relationship between well-being and each one of the five sources of support was tested separately.)

The results revealed that the quality of support from spouses, relatives and immediate families was significantly correlated with well-being, but this was not true with regard to the quality of neighbors' support.

**The following hypotheses are concerned with the work place social support and well-being:**

**Hypothesis 1: There is a relationship between the size of work supportive network and well-being. That is, as the size of work supportive network increases, general well-being increases.**

**This hypothesis was supported. The results revealed that the size of work supportive network is statistically correlated with well-being. As the size of the work supportive network increases, general well-being increases.**

**Hypothesis 2: There is a relationship between work support and well-being. That is, as the quality of work support (co-workers, supervisors, union representatives, and shop stewards) increases, the general well-being increases. The relationship between well-being and each of the four sources was tested separately.**

**The results revealed that general well-being was significantly correlated with the quality of support from co-workers and supervisors, but not with the quality of union representatives and shop steward's support. The results showed that as the quality of support from supervisors and co-workers increases, well-being increases.**

### 6.3 HIERARCHICAL MULTIPLE REGRESSION ANALYSES FOR THE BEST PREDICTOR VARIABLES FOR WELL-BEING

Several hierarchical multiple regression analyses were conducted to select the best predictor variables for general well-being and to assess the amount of variance explained by the social support domains when other variables were controlled statistically. These analyses were carried out by several steps. In each step R,  $R^2$ ,  $R^2$  adjusted and Beta, its significance and the  $R^2$  increment are reported. In the first step, all the non-work and work support network variables are entered in one equation simultaneously. In the second step, the background, job and health related variables that were significantly correlated with well-being and all the non-work and work social support variables are entered in one equation simultaneously. In the third and last step, those variables that became statistically significant in the second step were selected to be included in the final regression equation as the best predictor variables.

#### First Step:

All the eleven work and non-work support variables were entered simultaneously in one equation to predict general well-being. The results revealed that the eleven support variables together explained 22% of the variance in the dependent variable ( $R=0.4657$ ;  $R^2=0.2160$ ;  $R^2$  adjusted= $0.166$ ;  $DF=4.330$ ;  $P<0.001$ ) (see Table 6-6).

**TABLE 6-6. HIERARCHICAL MULTIPLE REGRESSION WITH THE ELEVEN WORK AND NON-WORK SUPPORT VARIABLES -- FIRST EQUATION**

<u>VARIABLE</u>	<u>PART CORR.</u>	<u>SQUARE PART CORR.</u>	<u>BETA</u>	<u>T-SIG</u>
Size of non-work supportive network	0.0675	0.004	0.0072	0.3186
Size of work supportive network	0.0647	0.004	0.0696	0.3385
Quality of support from spouse	0.1379	0.020	0.1429	0.0424*
Quality of support from immediate family	0.2458	0.060	0.2566	0.0424*
Quality of support from friends	0.1431	0.020	0.1455	0.0004**
Quality of support from relatives	0.0791	0.006	0.0894	0.2426
Quality of support from neighbors	0.0769	0.006	0.0870	0.2557
Quality of support from co-workers	0.0889	0.007	0.0515	0.1894
Quality of support from supervisors	0.0781	0.006	0.0860	0.2484
Quality of support from shop stewards	0.0737	0.005	0.0829	0.2763
Quality of support from union representatives	0.0461	0.002	0.0515	0.4948

\* P < 0.05      \*\* P < 0.01

The data in the above table shows that quality of support from immediate family has the highest Beta coefficient (Beta=0.2566; P<0.05) and was the most important predictor variable among the eleven social support variables. Quality of support from friends was the second most important

variable (Beta=0.1455;  $P<0.01$ ); quality of support from spouse was the third most important variable (Beta=0.1429;  $P<0.01$ ). One explanation as to why the Beta coefficient for quality of support from spouse did not appear to be as high as that of immediate family and friends was the smaller number of subjects (70) that are married or living with significant others in the total sample.

Examining the square semi partial correlation, it is found that quality of support from immediate family added the highest amount of variance to well-being (6%) when other variables are controlled. Quality of support from spouses (2%) was next, followed by the quality of support from friends (2%).

Neighbors' and relatives' quality of support did not contribute to well-being as much as the family quality of support and that of spouse and friends, and they were not statistically significant. This finding was consistent with previous findings concerning social support. In the previous sections, the mean quality of support from neighbors was lower compared to others. Subjects reported lower satisfaction from the support received from their neighbors. It is interesting to note that although the size of work and non-work supportive network appeared to be significantly correlated with well-being, this relationship disappeared in the regression analysis.

#### Second Step:

The background, job, health and social support variables are entered simultaneously in one equation (see Table 6.7). The equation included 18 variables: eleven social support variables, those that were presented above;

three background variables (perceived economic stress, age, and marital status); three job-related variables (the shift the subject works, job classification, and satisfaction from the type of work the person does); and one health-related variable (length of time that the person is expected by her physician to be unemployed because of illness). It should be noted that the health-related variable was used in this study as a measure of the severity of the illness. The hierarchical regression analysis showed that the 18 variables explained 32.1% of the variance in well-being when they were entered simultaneously ( $R=0.6548$ ;  $R^2=0.31904$ ;  $R^2$  adjusted= $0.24430$ ;  $F=4.26862$ ;  $P<0.01$ ).



**TABLE 6-7. HIERARCHICAL MULTIPLE REGRESSION WITH THE EIGHTEEN VARIABLES -- SECOND EQUATION**

VARIABLE	SQUARE		BETA	T-SIG
	PART CORR.	PART CORR.		
Marital status	0.1640	0.030	0.2180	0.1591
Age	0.0060	0.000	0.0007	0.9203
Perceived economic stress	0.2118	0.044	0.2383	0.0001**
Size of non-work supportive network	0.0369	0.001	0.0404	0.5427
Size of work supportive network	0.0636	0.004	0.0700	0.2942
Quality of support from spouse	0.0475	0.002	0.1225	0.4330
Quality of support from immediate family	0.1235	0.013	0.1345	0.0427*
Quality of support from friends	0.1006	0.010	0.1051	0.0045**
Quality of support from relatives	0.0955	0.005	0.0834	0.1364
Quality of support from neighbors	0.0728	0.005	0.0834	0.2302
Quality of support from co-workers	0.0648	0.004	0.0737	0.9143
Quality of support from supervisors	0.0781	0.006	0.0982	0.1986
Quality of support from shop stewards	0.0663	0.006	0.0768	0.2747
Quality of support from union representatives	0.0149		0.0176	0.8052
Job satisfaction	0.1581	0.024	0.1925	0.0150*
Work shift	0.0484	0.002	0.0512	0.4241
Job classification	0.1109	0.012	0.1196	0.8548
Anticipated days of unemployment	0.1072	0.011	0.1162	0.9580

\* P < 0.05

\*\* P < 0.01

Examining the most important variables in the regression equation, the perceived economic stress was found to be the most important variable in relation to the other 18 variables (Beta=0.2118;  $P<0.01$ ); job satisfaction the second most important variable (Beta=0.1581;  $P<0.01$ ); quality of support from immediate family the third (Beta=0.1345;  $P<0.01$ ); and quality of support from friends the fourth (Beta=0.1050;  $P<0.01$ ). These four variables had significant Beta coefficients (see Table 6.7).

Examining the square semi partial correlation, it was found that quality of support from immediate family accounted for 1% of the variance when other variables are controlled, as did the support from friends (1%). Job satisfaction added 2% and perceived economic stress added 4%. It should be noted that among all the 18 variables, the perceived economic stress adds the highest explained variance to well-being, followed by job satisfaction, in turn followed by the quality of support from family and friends (see Table 6.7).

### Third Step:

Satisfaction from one's job, perceived economic stress and quality of family and friends' support were selected to be included in the final regression equation to predict general well-being. This was based on the fact that those variables had significant Beta coefficients (see Table 6.8).

The four variables together explained 24% of the variance in well-being ( $R=.4923$ ;  $R^2=.24238$ ;  $R^2$  adjusted=.1980;  $P<0.01$ ).

**TABLE 6-8. HIERARCHICAL MULTIPLE REGRESSION WITH BEST PREDICTOR VARIABLES FOR WELL-BEING -- THIRD EQUATION**

<u>VARIABLE</u>	<u>PART CORR.</u>	<u>SQUARE PART CORR.</u>	<u>BETA</u>	<u>T-SIG</u>
Job satisfaction	0.1997	0.040	0.2044	0.025*
Quality of support from friends	0.1209	0.010	0.1213	0.050*
Quality of support from immediate family	0.2319	0.050	0.2398	0.001**
Perceived economic stress	0.2658	0.070	-0.2699	0.001**

\* P < 0.05      \*\* P < 0.01

The above four were the best predictor variables for well-being. All four have statistically significant Beta coefficients. Among the four, perceived economic stress was the best predictor variable for well-being. It is interesting to find that job satisfaction, which was measured by one single item, appeared to be a relevant variable in predicting general well-being. It confirms the significance of work in well-being. Among all the non-work and work social support domains, only two became statistically significant in predicting well-being -- quality of friends and immediate family support. Those two variables are non-work support variables. It should also be noted that neither one of the work support variables became statistically significant in the second regression equation when other variables were ruled out. Nonetheless, looking at the bivariate correlation between work support and general well-being, supervisors and co-workers quality of support became statistically significant but this relationship disappeared in the hierarchical multiple regression when other variables

are controlled. This implies that the quality of non-work support offers stronger predictor variables for well-being than the work support for this sample population in this life crisis.

Interestingly, it is perceived economic stress that is the most powerful predictor variable for general well-being in relation to the other variables (support, demographic and job-related variables); it is more powerful than the income level measured by bi-weekly salary.

#### 6.4 SUMMARY

Bivariate and multivariate analyses were conducted to assess the relationship between general well-being and work and non-work social support domains (size and quality of supportive network).

First, a correlational analysis was conducted to examine the relationship between well-being, social support, background and job-related variables. The results revealed that well-being is significantly correlated with several work and non-work support variables, such as quality of support of spouse, immediate family, friends, relatives, co-workers and supervisors, and the size of work and non-work supportive networks.

In terms of the background variables, general well-being was found to be significantly correlated to age, marital status and perceived economic stress. In relation to work-related variables, it was found that general well-being is significantly correlated to job satisfaction and job classification.

Four hypotheses were tested and supported: two of which concern work support and two non-work support.

**Hypotheses:**

1. There is a positive significant relationship between general well-being and quality of non-work support (spouse, immediate family, relatives and friends) -- as the quality of support increases, general well-being increases.

The results showed that there was a substantial significant relationship between general well-being and quality of support from spouse, immediate family, relatives and friends but not with the quality of support from neighbors.

2. There is a relationship between the size of the non-work supportive network and well-being -- as the size of the non-work supportive network increases, general well-being increases.

The results revealed that there was a significant relationship between the size of the non-work supportive network and well-being -- as the size of the supportive network increases, general well-being increases.

3. There is a relationship between general well-being and work place quality of support from co-workers, supervisors, shop stewards, and union representatives -- as the quality of work support increases, general well-being increases.

The results revealed that there was a relationship between well-being and co-workers' quality of support. This was also the case for supervisors', but not shop stewards' and union representatives' quality of support.

4. There is a relationship between the size of the work place supportive network and general well-being -- as the size of the work place supportive network increases, general well-being increases.

The results revealed that as the size of supportive network increases general well-being increases.

A multivariate analysis was utilized to select the best predictor variables for general well-being and assess the amount of variance contributed by the social support variables to general well-being when other variables are controlled.

A hierarchical multiple regression was carried out, first using all the support variables, then all the support variables with background and job-related variables, and finally selecting those variables that became statistically significant in the second equation to predict well-being. It was found that the best predictor variables for well-being were perceived economic stress, job satisfaction, and quality of support from immediate family and from friends. These four variables predicted 24% of the variance in well-being. Perceived economic stress was the most powerful variable among the four, followed by job satisfaction and then quality of family and friends' support.

This implies that the quality of non-work support was a stronger predictor variable for well-being for this sample population in this life crisis than workplace support.

Interestingly, it is perceived economic stress that was the most powerful predictor variable for general well-being from among all variables (social support, demographic, job-related).

## **SECTION 7**

### **RESULTS: FACTORS PREDICTING RETURN TO WORK**

#### **7.1 INTRODUCTION**

#### **7.2 FIRST STEP. HIERARCHICAL MULTIPLE REGRESSION ANALYSIS FOR THE BEST PREDICTOR VARIABLES OF NUMBER OF DAYS OF UNEMPLOYMENT (MODEL 1)**

#### **7.3 SECOND STEP. HIERARCHICAL MULTIPLE REGRESSION ANALYSIS FOR THE BEST PREDICTOR VARIABLES OF NUMBER OF DAYS OF UNEMPLOYMENT (MODEL 2)**

#### **7.4 THIRD STEP. HIERARCHICAL MULTIPLE REGRESSION ANALYSIS FOR THE BEST PREDICTOR VARIABLES OF NUMBER OF DAYS OF UNEMPLOYMENT (MODEL 3)**

#### **7.5 SUMMARY**

## **SECTION 7. RESULTS: FACTORS PREDICTING RETURN TO WORK**

### **7.1 INTRODUCTION**

As mentioned in previous sections, one's recovery from an illness and his or her ability to return to work is influenced not only by one's physical and emotional well-being, but also by non-health-related factors, such as support from friends and family, although no study has formally examined the influence of this support after controlling the factors of illness severity and the socio-economic status of the individual.

This section examines the best predictor variables for number of days of unemployment and the amount of variance that is explained by social support when controlling for demographic, socio-economic, job-related, and health-related variables.

Length (days) of unemployment was the dependent variable. The independent variables consisted of demographic, socio-economic, job, health, and social support variables, as follows:

#### **Demographic Variables**

- 1-Age
- 2-Ethnicity
- 3-Marital status
- 4-Household composition

#### **Socio-economic Variables**

- 1-Bi-weekly salary
- 2-W-2 Form
- 3-Perceived economic stress



**4-Whether or not a family member started working  
as a result of the illness**

**5-Number of dependents (on subjects' income)**

**Job-Related Variables**

**1-Full- versus part-time employment**

**2-Work shift**

**3-Tenure (length of time on the job)**

**4-Satisfaction from the income earned**

**5-Satisfaction from the type of work**

**6-Overall job satisfaction**

**7-Job classification (i.e., administrative versus service)**

**Health-Related Variables**

**1-Severity of the disability (i.e., expected duration of subject's  
unemployment as determined by the subject's physician)**

**2-Type of disability (i.e., mental versus physical disability)**

**3-Number of days of hospitalization because of the recent  
illness**

**4-General well-being**

**Social Support Variables**

**1-Size of non-work supportive network (i.e., number of  
family, relatives, friends or significant others subject  
can turn to for help)**

**2-Size of work supportive network (i.e., number of people  
at the work place subjects can turn to for help)**

**3-Quality of support received from non-work social network,  
which includes spouse, immediate family, relatives and  
neighbors**

**4-Quality of support received from work support network,  
which includes co-workers, supervisors, union  
representatives, shop stewards**

Hierarchical multiple regression was used to determine the best predictor variables length of time (days) of unemployment. The analyses were carried out in the following steps: first, all the demographic, socio-economic, job and health-related variables were entered simultaneously; second, those variables with statistically significant Beta coefficients were selected for inclusion in the second regression equation with the social support variables; and third, those variables which became statistically significant in the second step were included in the final regression equation. In each step, R, R<sup>2</sup>, R<sup>2</sup> Adjusted, Beta and its significant and semi-part correlation were calculated.

**7.2 FIRST STEP. HIERARCHICAL MULTIPLE REGRESSION ANALYSIS FOR THE BEST PREDICTOR VARIABLES OF NUMBER OF DAYS OF UNEMPLOYMENT (MODEL 1)**

Demographic, socio-economic, job and health-related variables were simultaneously entered. The results revealed that 40% of the variance in the dependent variable were explained by those variables ( $R=.63$ ;  $R^2=40\%$ ;  $R^2$  Adjusted=32%;  $F=5.2006$ ;  $P<0.01$ ). Table 7-1 presents the part correlation, square semi-partial correlation, and standardized Beta coefficients, as well as its level of significance. The standardized Beta coefficient indicates the relative importance of each independent variable in relation to each other in predicting the dependent variable. The square semi-part correlation indicates the amount of variance contributed by the individual independent variable when other independent variables in the regression equation are controlled.

**TABLE 7-1. HIERARCHICAL MULTIPLE REGRESSION OF NUMBER OF DAYS OF UNEMPLOYMENT WITH DEMOGRAPHIC, SOCIO-ECONOMIC, JOB AND HEALTH-RELATED VARIABLES**

<u>VARIABLES</u>	<u>PART CORR.</u>	<u>SQUARE PART CORR.</u>	<u>BETA</u>	<u>T-SIG</u>
<b><u>Demographic</u></b>				
Age	0.0964	0.009	0.1146	0.1228
Marital Status	0.0974	0.009	0.0445	0.5884
Ethnicity	0.0060	0.003	0.0030	0.9202
Household	0.0768	0.006	0.0997	0.2189
<b><u>Socio-economic</u></b>				
Perceived economic stress	0.1176	0.013	0.1310	0.0500*
Whether a family member starting working because of the illness	0.0203	0.000	0.0234	0.7430
W-2 Form	0.0592	0.000	0.0884	0.3418
Bi-weekly salary	0.0651	0.004	0.0930	0.2959
Number of dependents	0.0833	0.006	0.1026	0.1816
Number of people contributing to the family income	0.0076	0.000	0.0997	0.2189
<b><u>Job-Related</u></b>				
Part-time/Full-time	0.0848	0.007	0.0781	0.1748
Work shift	0.1066	0.011	0.1164	0.0887
Tenure	0.1914	0.040	0.2127	0.0030**
Job classificaton (service versus administrative)	0.0043	0.000	0.0040	0.9446
Satisfaction from income	0.0328	0.001	0.0397	0.5987
Satisfaction from type of work	0.0027	0.000	0.0030	0.9654
Overall job satisfaction	0.0363	0.001	0.0544	0.5601
<b><u>Health-Related</u></b>				
Type of disability	0.1463	0.020	0.1802	0.0200*
Severity of disability	0.4380	0.200	0.3984	0.0001**
General well-being	0.1470	0.020	0.1867	0.0010**
Hospitalization	0.0167	0.000	0.0177	0.7988

\* P < 0.05 \*\* P < 0.01

Examination of the standardized Beta coefficients revealed that age and marital status are the most important variables relative to other demographic variables and that household composition is the second most important variable. None of the standardized regression coefficients Beta of the demographic variables are statistically significant. This indicates that the demographic variables were not powerful in predicting length of unemployment because of the illness. Square semi-part correlations of the demographic variables revealed that each variable does not add a significant amount of variance to the outcome measure when other variables in the equation were controlled.

In other studies, age was found to be statistically significant in predicting return to work. One possible explanation as to why age is not statistically significant in this study is that age was controlled by design (subjects over 55 years were excluded from the study). Furthermore, most past studies have primarily examined the male labor force. This may have some bearing on the role of age in predicting the length of time of unemployment due to illness. This phenomenon needs further investigation.

Among the socio-economic variables, perceived economic stress is the most important variable in predicting length of unemployment. Other important variables were: 1) number of dependent family members; 2) number of family members contributing to the family income; 3) the bi-weekly salary; and 4) whether or not a person started working as a result of economic stress.

Interestingly, among the socio-economic variables, the perceived economic stress is the only variable that has a statistically significant Beta coefficient. The W-2 Form and bi-weekly salary were not statistically significant in predicting length of unemployment.

Among the job-related variables, tenure was the most important variable in predicting length of unemployment, followed by type of shift, full-/part-time status, and job satisfaction. Among the job-related variables, tenure was the only variable that had a statistically significant Beta coefficient. The attachment of long-term service appears to exert a pull back to work.

Controlling for socio-economic, demographic and health-related factors, perceived economic stress added 1% to the total variance of the length of unemployment.

Among the health-related variables, severity of the disability was the most important variable in predicting length of unemployment because of illness. Type of disability (mental or physical) was the second most important, and general well-being was the third. These three health-related variables had statistically significant Beta coefficients. Number of days of hospitalization was not significant.

Controlling for other variables in the equation, tenure added 4% to the variance in the dependent variable. Type of disability added 2%; severity of the disability added 20%; general well-being added 2%. Clearly, severity of disability was the most powerful variable among the independent variables that were included in the first regression model.

### **7.3 SECOND STEP. HIERARCHICAL MULTIPLE REGRESSION ANALYSIS FOR THE BEST PREDICTOR VARIABLES OF NUMBER OF DAYS OF UNEMPLOYMENT (MODEL 2)**

In addition to the social support variables, those variables that had significant standardized Beta coefficients in the first model were selected for use in the second model. This means that tenure, severity of the illness, perceived economic stress, type of disability, general well-being and social support variables were included in the second regression model. The social support variables were size of non-work supportive network (number of family members, relatives, friends or significant others subjects could turn to for help/support), size of work supportive network (number of people at the work place subjects could turn to for help), quality of non-work support (from spouse, immediate family, relatives and neighbors), and quality of work support (from co-workers, supervisors, union representatives, and shop stewards). It was revealed that 42% of the variance in the dependent variables are explained by those variables ( $R=0.65$ ;  $R^2=42\%$ ;  $R^2$  Adjusted=34%) ( $F=5.2006$ ;  $P<0.01$ ) (see Table 7-1). This indicates that tenure, perceived economic stress, severity of the illness, type of disability, general well-being, and social support are predicting 42% of the variance in the outcome measure. Adding the social support variables to the statistically significant variables of demographic, socio-economic, job, and health-related domains, the explained variance increased by only 2%. Table 7-2 presents the part correlations, square semi-part correlations, standardized Beta coefficients and their levels of significance.

**TABLE 7-2. HIERARCHICAL MULTIPLE REGRESSION ANALYSIS OF SOCIAL SUPPORT VARIABLES WITH DEMOGRAPHIC, SOCIO-ECONOMIC JOB AND HEALTH-RELATED VARIABLES**

<u>VARIABLES</u>	<u>PART CORR.</u>	<u>SQUARE PART CORR.</u>	<u>BETA</u>	<u>T-SIG</u>
Tenure	0.1393	0.020	0.1157	0.050*
Perceived economic stress	0.1104	0.010	0.1157	0.050*
Severity of disability	0.4077	0.170	0.4458	0.000*
Type of disability	0.1205	0.010	0.1511	0.040*
General well-being	0.1885	0.040	0.2321	0.002*
Size of non-work supportive network	0.0276	0.000	0.0300	0.646
Size of work supportive network	0.0374	0.001	0.0401	0.539
Quality of support from spouse	0.0346	0.001	0.0370	0.564
Quality of support from immediate family	0.1334	0.020	0.1475	0.020**
Quality of support from relatives	0.0374	0.001	0.0401	0.549
Quality of support from neighbors	0.0039	0.000	0.0004	0.994
Quality of support from co-workers	0.0097	0.000	0.0107	0.872
Quality of support from friends	0.0712	0.005	0.0738	0.241
Quality of support from supervisors				
Quality of support from union representatives	0.0195	0.000	0.0003	0.984
Quality of support from shop stewards	0.0712	0.005	0.0003	0.824

\* P < 0.05 \*\* P < 0.01

Severity of the disability was the primary variable in the equation that predicted the outcome measure (Beta=0.4458; P<0.01). The second most important was general well-being (Beta=0.2321; P<0.05), and the third most



important variables were tenure (Beta=0.1157;  $P<0.05$ ) and economic stress. However, among the social support variables, two were relatively important. Quality of support from immediate family was the most important variable (Beta=0.1473;  $P<0.05$ ), followed by quality of support from friends not at work (Beta=0.0738;  $P<0.05$ ). And yet, quality of support from immediate family is the only variable among all the social support variables that had a statistically significant Beta coefficient. Among the fifteen variables that were entered in the second equation, severity of the illness was of primary importance, general well-being was the second most important, type of disability was third, the quality of support from immediate family was fourth, tenure was fifth, and the sixth most important variable was perceived economic stress. All six variables had statistically significant standardized coefficients.

Examining the square semi partial correlation, and controlling for other variables in the equation, the severity of the disability adds 17% to the explained variance of the length of unemployment. General well-being added 4%; type of disability, 1%; tenure, 2%; perceived economic stress, 1%; and quality of support from immediate family, 2%.

Summarily, severity of disability added the highest amount of variance to the outcome measure. It is interesting to note that only one variable among all the social support variables was statistically significant. However, it explains a greater percentage of variance in the outcome measure than perceived economic stress.

**7.4 THIRD STEP. HIERARCHICAL MULTIPLE REGRESSION ANALYSIS FOR THE BEST PREDICTOR VARIABLES OF NUMBER OF DAYS OF UNEMPLOYMENT (MODEL 3)**

All six variables that had statistically significant Beta coefficients were selected in the final regression equation to predict the length (days) of unemployment. The number of variables was reduced from twenty-one to six. Three variables among the six were health-related variables (severity of disability, general well-being, and type of disability), one job-related (tenure), one socio-economic variable (perceived economic stress), and one social support variable (quality of support from immediate family). All these six variables explained 39% of the outcome measure ( $R=0.6246$ ;  $R^2=0.3945$ ;  $R^2$  Adjusted= $0.37359$ ). It is interesting to note that by reducing the number of predictor variables from twenty to six, the explained variance of the outcome measure (number of days of unemployment) was reduced by only 2%.

**TABLE 7-3. FINAL HIERARCHICAL MULTIPLE REGRESSION OF SIX VARIABLES WITH STATISTICALLY SIGNIFICANT BETA COEFFICIENTS**

<u>VARIABLES</u>	<u>PART CORR.</u>	<u>SQUARE PART CORR.</u>	<u>BETA</u>	<u>T-SIG</u>
Perceived economic stress	-0.0979	0.009	0.0988	0.050*
Quality of support from immediate family	0.1164	0.013	0.1264	0.040*
Tenure	-0.1181	0.018	0.1191	0.040*
Severity of disability	0.4650	0.216	0.4411	0.000**
General well-being	-0.1868	0.034	0.2183	0.001**
Type of disability	0.1375	0.018	0.1681	0.020*

\*  $P < 0.05$  \*\*  $P < 0.01$

Health-related variables are the most powerful variables in predicting the length of unemployment. Severity of illness is the most important variable among the six that were utilized in the final regression model (Beta=0.4411;  $P<0.01$ ). General well-being was the second most important variable (Beta=0.2183;  $P<0.01$ ). The third most important variable was the type of disability (Beta=0.1681;  $P<0.05$ ); fourth was quality of support from immediate family (Beta=0.1264;  $P<0.05$ ); fifth was tenure (Beta=0.1194;  $P<0.05$ ), and sixth was perceived economic stress (Beta=0.1191;  $P<0.05$ ).

After examining the amount of variance that each variable added when other variables in the equation were controlled, the findings were as follows: Severity of disability added the largest percentage of variance in predicting the outcome measure 22%; general well-being added 3%; type of disability added 2%; tenure added 2%; quality of support from immediate family added 1%; and 0.09% was added by perceived economic stress.

Several critical findings were shown by the three models of the hierarchical multiple regression procedures. One of these findings is that health-related variables are the most powerful variables for predicting number of days of unemployment. Also discovered after controlling for other variables (demographic, socio-economic, job and health-related), is that social support variables add a small amount of variance in predicting return to work. Among the social support variables, the quality of support from immediate family is the most important one in predicting return to work, and this variable adds 1% to the total variance. Work support does not appear to be powerful in predicting return to work. Length of time at the job, however, is an important predictor variable.

After controlling for other variables, it is predicted that those who have been on their job longer, as well as those who have the greatest economic stress, possess a higher sense of well-being, and suffer a less severe illness, return to work earlier than their counterparts. In addition those subjects who have a physical disability returned to work sooner than those who are mentally disabled. These results are consistent with findings in previous sections that showed that the mentally disabled stayed longer on short-term disability and that a large percentage of such individuals did not return to work during the six months.

## 7.5 SUMMARY

The research question as to which are the best predictor variables for return to work was discussed in this section. A hierarchical multiple regression procedure was used to examine the research question and to reduce the data set. This section showed the following results:

Six variables are the best predictor variables for length of time the person was unemployed as a result of illness.

Among the variables that were used in the regression analysis, severity of the illness is the most powerful variable in predicting the outcome measure, followed by general well-being, type of disability, the quality of support from immediate family, tenure and perceived economic stress.

None of the work social support variables were statistically significant in predicting length of unemployment. Nonetheless, in previous sections when univariate, simple descriptive statistics were used, social support variables were significantly different between both groups, those who returned to work and those who did not. Also social support domains have been shown to vary across demographic variables.

Clearly, there are other factors which, although not considered in the present analysis, may directly influence the length of unemployment because of the illness. These factors include other indicators of social support, personality traits, behavior, financial disincentives that may be created through receipt of disability payments, and availability of service resources (medical and non-medical).

**SECTION 8**

**DISCUSSION AND PRESENTATION OF**

**THE MAIN FINDINGS**

- 8.1 INTRODUCTION**
- 8.2 MAJOR FINDINGS OF THE STUDY**
- 8.3 IMPLICATIONS OF THE STUDY FINDINGS  
FOR SOCIAL WORK AND LABOR UNIONS**
- 8.4 PROGRAM PLANNING AND DEVELOPMENT**
- 8.5 LIMITATIONS OF THE STUDY**
- 8.6 FUTURE RESEARCH**
- 8.7 CONCLUSION**

## **SECTION 8. DISCUSSION AND PRESENTATION OF THE MAIN FINDINGS**

### **8.1 INTRODUCTION**

The study focused on a random sample of 185 females, who were newly disabled, city workers, and members of District Council 37, who have protected jobs under civil service regulations.

The study sought to determine what are the best predictor variables of the subjects' well-being status. An emphasis was given to the relationship between work and non-work social support domains and well-being.

The study also examined factors affecting return to work after a disability including socio-economic, demographic, job, health and social support. Under the latter rubric were included immediate family, relatives, neighbors, friends, co-workers, supervisors, shop steward and union representatives. Particular attention was given to the role of work and non-work social support systems when other variables were controlled.

The following are the main research questions: 1) Does the person return to work following the onset of disability? 2) Who provides what support during short-term disability? 3) Do social support domains vary across several demographic (marital status, age, ethnicity) and employment status categories? 4) What is the relationship between subjects' well-being status and social support domains? 5) What are the best predictor variables for subjects' well-being status? And 6) What are the best predictor variables for number of days of unemployment.

## 8.2 MAJOR FINDINGS OF THE STUDY

The correlational analysis carried out here reveals that quality of support from spouses, relatives, immediate family, co-workers and supervisors at work are significantly associated with well-being but this is not the case with respect to the quality of support attributed to neighbors, union representatives and shop stewards. The results demonstrate that as the quality of a person's social support increases, so does the well-being score. These findings are in accord with the relevant literature. A large body of research has shown that there is a significant association between social support and psychological and physical well-being especially in times of stress (Cobb, 1976). In many life events in which individuals are under duress social support was found to promote human well-being and prevent psychological disorders. Social support also enhances the adjustment process with stressful life events as measured by other psychosocial measures (Cassel, 1976; Cobb, 1976; Dean & Lin, 1978; Kaplan, Cassel & Gore, 1977; and Rabkin & Stuening, 1976).

As mentioned in previous chapters, there are two models for characterizing how the social support system operates. One model conceives of social support as a basic human need that must be satisfied in order for an individual to enjoy a sense of well-being (Henderson, 1977). A second model emphasizes the role played by support to moderate or act as a "buffer" of stress (Cobb, 1976). In this case social support is a key resource for overcoming life crisis (Caplan, 1974). It has acquired a prominent place in the development of epidemiological models of stress and maladjustment (Cassel, 1976, Johnson & Sears, 1977). In this study of newly disabled



workers there is exploration of social support operating as a buffer effect in terms or moderating the effects of the stress of the onset of disability on well-being.

In utilizing multiple hierarchical regression we are able to report that the best predictor variables for well-being are absence of perceived financial stress, presence of job satisfaction, and high perceived quality of support from immediate family and friends. These four variables predicted 24% of the variance in well-being. Perceived financial stress was the most powerful variable among the four, followed by job satisfaction and then quality of family and friends' support. This implies that the quality of non-work support is a stronger predictor variable for well-being for this population in this life event than workplace support. When controlling statistically for quality of support from family, job satisfaction, perceived financial stress adds 7% in the total variance in the well-being status. Using the same principle, quality of support from family adds 5%, job satisfaction adds 4%, available support from friends adds 1%.

It comes as no surprise that financial stress is the most powerful variable in predicting the human well-being status. Income is a basic survival phenomenon. Beyond that, financial status can enhance the quality of life of people. Those who have ample income have greater access to better health care, therapy, social activities, etc. Thus in this case financial stress influences well-being in an indirect manner.

Several other findings were demonstrated in the present study that warrant reporting. The following findings deal with the research question concerning whether or not social support varies across demographic

information, and the identification of respondents to whom subjects turn for support of various kinds.

Single, divorced and separated respondents show a smaller non-work perceived supportive network than married or widowed subjects. White married respondents reported the greatest support from their spouses. Spouses of Blacks and Hispanics did not receive as high mean support satisfaction as their white counterparts. Also married Blacks and Hispanics did not rank their spouse as the most helpful person, as was the case for whites. Instead they rank a family member or siblings as the most helpful source. These findings are supported by other studies, Raymond et al. (1980) found that Blacks attributed greater importance to family support than did whites or Hispanics. McFarane et al. (1981) found that married individuals have more work related individuals in their network. Our results confirm that finding. Single adults have a larger number of friends, and widowed and divorced adults feel more often that their network is not being adequately helpful or supportive. Stephens et al. (1978) similarly found that married individuals received the most informal support, followed by the never married, then the widowed.

The results provide information about the people who are primary providers of support during short-term disability experienced by a female working population. As a group, respondents differentiate somewhat in identifying the kinds of persons they turn to for a particular type of support. Emotional support is primarily provided by spouse, immediate family and friends. Material aid is provided mainly by spouse and immediate family. Physical assistance is provided by spouse, immediate family and friends. Co-workers are called upon to offer job related advice. Companionship is

derived from associations with spouse, family members, relatives and friends. This supports the match group theory (Litwak, 1964) which postulates that there is a differentiation among types of people that subjects go to for particular types of support.

Findings concerning return to work have shown that 23% (44) of the total sample did not go back to work during the six month interval covered by the research interviews. Of those, 45.5% (20) were diagnosed as mentally disabled (depression), and 54.5% (23) with different physical disabilities.

Those who went back to work reported a higher sense of well-being, less degree of severity of illness, larger work and non-work supportive network, a higher level of quality of work and non-work support than those who did not. It was also found that from the onset of disability those who return to work have been longer on the job and reported a higher satisfaction with their job than the non-returnees.

The mentally disabled respondents (depression) stayed unemployed longer than the physically disabled. They were younger, mainly single (never married), with children, and less satisfied from their job than the physically disabled. They reported a higher sense of financial stress. On the national level the unemployment rate of the mentally ill is greater than the physically disabled. This is proved by the fact that there is a higher rate of mentally disabled persons among the recipients of social security benefits (DSSI and SSDI) than the physically disabled (Ashbaugh, Mandershcheid, 1985).

Mentally disabled subjects reported a smaller size of non-work perceived support network than the physically disabled. This is in accord

with previous findings. Hammer (1980) found that mentally disabled subjects have a smaller support network in comparison to normal individuals.

Using the univariate statistical analyses, social support variables were significantly different between both groups, i.e., those who returned to work and those who did not (size of supportive network and quality of support). Using hierarchical multiple regression, six variables were found to be the best predictors for the length of time the person was unemployed as a result of disability. Severity of the illness is the most powerful variable in predicting the length of time of unemployment. This is followed by the measure of general well-being. Significant predictors also include type of disability (mental vs. physical), tenure on the job, the quality of support from immediate family, and perceived financial stress. These variables combined predict 39% of the variance in the outcome measure. Controlling statistically for demographic socio-economic and job related variables, social support adds 1% to the total variance in the outcome measure. Using the same statistical procedure the severity of the illness adds 22% to the total variance in the outcome measure. None of the work social support variables were statistically significant. It stands to reason that severity of the illness is the most powerful predictor variable for the length of time of unemployment because of the illness. This finding is supported by previous studies (Muccahy, 1976; Velasco, 1983; Hyman, 1975; Garrity, 1973; Cay et al., 1973; and Yelin, 1986).

Akabas (1987) in her study concerning early intervention among one hundred newly disabled employees at D.C. 37 found that several factors affected the person's decisions regarding when to go back to work. Of the

total sample 47% reported health factors, 43% job related and 42% financial stress. Those three factors were found to be the most powerful predictor variables in the present study.

The quality of support from family predicted length of time of unemployment. This finding can be understood by different sources of explanation. One of the explanations is grounded in the buffer effect model. As mentioned previously, this model poses the view that a subject's social support network buffers the effect of stress on health and is a key resource for overcoming life crises (Caplan, 1974). In the present study the quality of support may serve as buffer against the negative impact of the illness on well-being. Thus, this will enhance the person's health status that may lead to early return to work. This speculation demands further investigation in future research.

Those who have family members that support them emotionally or instrumentally may feel a greater obligation and responsibility for supporting their family than those who lack such support. Thus, this factor may be the base of their motivation to go back to work earlier.

Social support for women during this life event (short-term disability) can be very crucial. Women are typically cast in the role of providing support to others and it is often experienced that those who benefit do not feel compelled to return the same amount of support. As mothers, spouses and children of aging parents, women have traditionally been called upon to fulfill the role of caregivers. Thus, the availability of supportive networks for this population during this life event is meaningful. Availability of supportive network (emotional, instrumental encouragement, etc.) may

enhance well-being and the return to work status. Those who lack adequate social support are in greater need for assistance than other groups. Social workers and other service providers need to intervene in developing self help groups as an alternative for the primary groups or strengthen the weak ones. Social workers and service providers can more effectively assist their clients by learning systematically to identify the types of persons in the social network they need to turn for specific sources of support.

Being a female and disabled in this society can take on the aspect of a double handicap which gives rise to special problems and needs. The situation of disabled women requires sensitive handling and knowledge on the part of the practitioners and policy makers.

In sum, the study showed that there are six variables that predicted number of days of unemployment among newly disabled. Those six variables can be utilized to identify the population at risk for leaving the labor force. Clearly, there are other factors which, although not considered in the present study, may directly influence the length of unemployment due to the illness and might help explain the variance not yet accounted for. Candidate variables include other indicators of social support, personality traits, financial disincentives that may be created through receipt of disability payments, availability of service resources (medical and non-medical), accommodation at the work place, and attitudes of employers towards workers with disabilities.

### **8.3 IMPLICATIONS OF THE STUDY FINDINGS FOR SOCIAL WORK AND LABOR UNIONS**

The findings of the study have implications for social work practice, policy and for the leadership of labor unions in particular. They provide systematic knowledge concerning factors affecting the return to work and the role of the social support system in promoting well-being and an early return to work.

This knowledge can be useful in assessment, intervention and program planning.

#### **8.3.1 Assessment and Intervention**

The study findings can be utilized by social workers in assessment and intervention activities. In the assessment sphere, the employee's existing social support systems and his/her ability to go back to work should be assessed as early as possible. Also, it is suggested that social workers utilize the six factors (severity of the illness, general well-being status, perceived financial stress, tenure at job, type of disability, and quality of support from family) discovered in this study as the best predictor factors for the return to work in assessment and intervention activities. These factors will assist social workers in identifying which clients are at risk of leaving the labor force, and will help them to determine what type of support is needed (emotional, instrumental, advice, etc.) to enhance the client's well-being and promote an early return to work.

#### **8.4 PROGRAM PLANNING AND DEVELOPMENT**

The findings of this study also have implications for the development and implementation of social policy. Both primary and secondary prevention require addressing larger processes and phenomena, and not only on an individual basis.

Primary prevention consists of establishing broad-based programs for all employees. These programs can be designed to promote healthy attitudes, to encourage proper understanding of how to maintain health and the role of stress in disease. Such programs can also include self help groups. Properly designed and implemented, these programs may significantly reduce the incidence of short-term disability.

Social workers and other service providers who work with this population need to strengthen the person's own existing primary groups and to develop self help groups for clients in need.

However, once the individual goes on short-term disability, other kinds of interventions are needed to impact favorably on the subject's well-being, thereby promoting an early return to work. These interventions can include, for example, self help groups that address such issues as illness-related stress and how to manage on a reduced income. Although all persons on disability can benefit from self help groups, those who lack or have weak social support systems will benefit even more substantially.

In sum, the study findings revealed that social support is related to subjects' well-being, and thus, the engagement of social support systems (family, friends, co-workers, self help groups, etc.) in assessment and



intervention activities are crucial for this population. The study's findings as to the best predictor variables for an early return to work can assist the social workers in identifying the population at risk of leaving the labor force and to determine what type of support is needed.

The study findings indicated that subjects who suffered from depression remained longer on short-term disability, that a higher percentage of them did not return to work, and that they reported a smaller supportive network compared to the physically disabled. These findings imply that subjects who suffered from depression are at a higher risk than the physically disabled for leaving the labor force. Self help groups can be extremely useful for employees who are experiencing depression.

The study suggested that social support intervention should be utilized as a treatment tool in a systematic mode by professionals. The message the study offers is that social support is complimentary to the financial organization: both are needed to support this population.

The findings of the study concerning the significant role of the social support systems are particularly attractive as it is consonant with the ideology of the union and the trends of union policy. The study sheds light on areas of philosophical interest to the union leadership as they guide their organization to better serve its members.

#### 8.5 LIMITATIONS OF THE STUDY

The study entails several limitations; some of these are concerned with issues of measurement and others with design questions. Clearly, the

study has several threats to internal validity which are generic to the cross-sectional design.

### 8.5.1 Construct Validity

#### 1. Social Support

The central issue is whether the operational definition of social support actually measures the constructs as defined. As mentioned in the literature review, social support is a complex phenomenon. There are many measures and no agreement about the operational definition of the concept.

#### 2. Severity of the Illness

Severity of the illness was measured by the expected number of days of unemployment as it is determined by the subject's physician. The question that is raised by this study is whether or not this measure tapped the intended concept (severity of the illness).

### 8.5.2 Threat to Internal Validity

Social support was measured only once, during the first interview. This interview took place one month after the person had stopped working as a result of the disability. In the first interview, subjects were asked about their social support during the last month. In the second interview (which took place six months after the person stopped working) subjects were asked one item only. This item was concerned with the actual date of return to work. This raised a question concerning the threat to internal validity. Responses pertaining to social support could be confounded by

other factors (e.g., mood status or personality traits) prevailing at the time well-being was measured which might be temporary phenomena. It is true that in the multiple regression analysis the mood status was ruled out statistically using the well-being scale. Nonetheless a better design could be to measure the social support over time, longitudinally.

### 8.5.3 External Validity

The study includes only the subjects suffering from depression, excluding all other mental disability categories. The rationale for excluding the other mentally disabled groups is based on results from the pilot study. This result demonstrated that it is difficult to obtain the attention and trust of this group in a telephone interview. Thus, due to the fact that the other mentally disabled groups were excluded from the study the generalization in the area of mental disability is limited to depression only. The differential findings between workers suffering physical disability as compared with those experiencing mental disabilities would probably be even more marked if a fuller range of mental diagnoses had been used.

## 8.6 FUTURE RESEARCH

The current study stresses the fact that the role of social support is related to the well-being of women. Therefore, duplication of the study for the male population will be critical in expanding theoretical understanding and in serving practical aims of service delivery.

The study revealed that social support varies according to the type of disability (physical vs. mental). The mentally disabled (depression) stayed

longer on short-term disability and a higher percentage did not go back to work. Therefore the writer suggests for inclusion, in future studies of subjects who suffer from other mental illnesses (e.g. schizophrenia), chemical dependency and alcohol. In such studies face-to-face interviewing is recommended. The study further suggests the utilization of a longitudinal design. This design is more powerful in the perspectives offered than those provided by the cross-sectional approach. Examination of a large random sample of workers prior to their disability is suggested for future research in order to assess social support network over time. This design will yield valid information about the role of the social support and factors affecting early return to work. In addition, it provides systematic knowledge about factors affecting reasons behind going out on short-term disability.

The present study did not examine the negative role of the social network. Therefore, it will be interesting to look at this domain in future studies.

## 8.7 CONCLUSION

In conclusion, I would like to highlight two major points that have emerged from this study.

First, the study demonstrated that the population at risk has excess representation of mentally disabled persons suffering from depression. They are younger than those with physical illnesses, mainly single with children, less satisfied with their jobs and reported a higher perceived level of financial stress. They lack adequate work and non-work supportive networks. These findings raise a question concerning factors contributing

to depression. Whether or not this phenomenon (depression) is a result of stress or other factors. This is a crucial question that requires an investigation in further studies. It is to be expected that being single parents, caregivers, characterized by financial stress and lacking social support, these members are more prone to depression. The study suggests that members who go out on short-term disability due to depression are at risk of staying longer on short-term disability. This emotional state might contribute to the person's leaving the labor force. This phenomenon of depression requires a primary and secondary prevention thrust, primarily to enhance the role of social support.

Second, work and non-work social support domains such as size and quality of support were significantly related to well-being. Thus, it is important to enhance the role of the social network for this population especially during short-term disability.

None of the work support variables predicted when the person goes back to work. A caution should be taken in making a conclusion and generalization about the role of social support at work in predicting return to work. The utilization of different domains of work social support may lead to a different conclusion and this study suggests inclusion of other indicators of social support. For example, it is important to admit that human behavior is complex and interconnected with many factors which makes it harder to look at the individual contribution of a unique factor.

As noted before, the social support literature suggests that measures of perceived availability or occurrence of specific types of supportive behaviors is still in a fairly elementary stage. Behavioral scientists are still

in the process of developing measures of the generic concept of support, including social relationships, their network structure, and specific supportive functions or content of relationship. Social support is a complex concept that is not easy to measure. In addition there is no consensus on its definition among theorists and researchers. Therefore utilizing different definitions may lead to different results and conclusions about the role of work social support network.

The study suggested that the social support intervention should be utilized as a treatment tool in a systematic mode by professionals. The message the study offers is that social support is complimentary to the formal organization: both are needed to support this population.

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**APPENDIX 1**

**DISTRICT COUNCIL 37  
HEALTH AND SECURITY PLAN  
SHORT-TERM DISABILITY CLAIM FORM**



DISTRICT COUNCIL 37 HEALTH & SECURITY PLAN

190

125 BARCLAY STREET  
NEW YORK, N.Y. 10007

HS:DIS 013  
(212)

Phone: 815-1234

Please Type or Print

**SHORT-TERM DISABILITY BENEFIT CLAIM**

TO BE FULLY COMPLETED BY EMPLOYEE AND FILED WITHIN 15 DAYS FROM THE DAY YOU BECOME DISABLED REGARDLESS OF DISCONTINUATION OR ANNUAL TIME.

Name \_\_\_\_\_ Soc. Sec. No. \_\_\_\_\_

Home Address \_\_\_\_\_  
No. & Street City State Zip

Date of Birth \_\_\_\_\_ Male  Female  Home Phone \_\_\_\_\_

Name of your work place \_\_\_\_\_ Date of Employment \_\_\_\_\_

Work Address \_\_\_\_\_ Timekeeper \_\_\_\_\_

Department \_\_\_\_\_ Personnel Phone No. \_\_\_\_\_

Job Title \_\_\_\_\_ If school worker, District Office No. \_\_\_\_\_

Annual Salary \_\_\_\_\_ Hours worked per day \_\_\_\_\_

How many sick days did you have on the date you become disabled? \_\_\_\_\_

When did you become totally disabled so that you could not work? Date: \_\_\_\_\_

What date did you first see a doctor? \_\_\_\_\_ Name of doctor \_\_\_\_\_

Describe your illness \_\_\_\_\_

Have you returned to work yet? Yes  No  If yes, what date? \_\_\_\_\_

Have you ever received disability payments for the same illness? Yes  No  If yes, what year? \_\_\_\_\_

IF CONFINED IN HOSPITAL

Name of Hospital \_\_\_\_\_

Address of Hospital \_\_\_\_\_

Date Admitted \_\_\_\_\_  AM  PM Date Discharged \_\_\_\_\_

IF DISABILITY IS DUE TO ACCIDENT

A. Date of accident \_\_\_\_\_  AM  PM B. How did it happen? \_\_\_\_\_

C. Did it happen at work? Yes  No  D. Did you file for Workers Compensation? Yes  No

E. Is there a lawsuit? Yes  No

F. If yes, give attorney's name: \_\_\_\_\_

Address \_\_\_\_\_ Phone No. \_\_\_\_\_



12) 815-1234

ATTENDING-PHYSICIAN'S STATEMENT

REV. 1/85)

Patient \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_

A. MEDICAL CONDITIONS/DIAGNOSIS

- Indicate the specific presenting diagnoses on the line provided next to the diagnostic categories listed below.
- Indicate by a checkmark (✓) those conditions which are the immediate cause of disability.

IMPORTANT: THIS CLAIM CANNOT BE PROCESSED WITHOUT AN INDICATION OF THE CAUSE(S) OF DISABILITY.

DIAGNOSTIC CATEGORY	SPECIFIC DIAGNOSIS	PRIMARY CAUSE OF DISABILITY ✓
1. Trauma	A: Fracture _____	_____
2. Neoplasm	A: Benign _____	_____
	B: Malignant _____	_____
3. Circulatory	A: ASCVD _____	_____
	B: M.I. _____	_____
	C: Hypertension _____	_____
4. Respiratory	A: Asthma _____	_____
	B: Chronic Obst. _____	_____
5. Digestive	_____	_____
6. Genito-Urinary	_____	_____
7. Neurological	_____	_____
8. Musculo-Skeletal	_____	_____
9. Cataracts	_____	_____
10. Mental Disorder	_____	_____
11. Other	_____	_____
12. OBS-GYN	_____	_____
13. Diabetes	_____	_____

Is patient's illness directly related to Alcoholism? Yes  No

B. Give SPECIFIC DATES OF TREATMENT: Office: \_\_\_\_\_  
 Home: \_\_\_\_\_  
 Hospital OPD: \_\_\_\_\_

If HOSPITALIZED for this disability: Date Admitted \_\_\_\_\_ Date Discharged \_\_\_\_\_

Name of Hospital: \_\_\_\_\_ Address \_\_\_\_\_

If SURGERY was performed, give the date(s): \_\_\_\_\_

Type of Surgery: \_\_\_\_\_

Is patient receiving Chemotherapy, Cobalt treatment or on Dialysis? \_\_\_\_\_

If yes, give dates of treatment \_\_\_\_\_

What is the ANTICIPATED DURATION of this disability? From \_\_\_\_\_

Is the Disability related to the patient's EMPLOYMENT? Yes  No

Is patient having personal or family problems as a result of being disabled? Yes  No

C. MATERNITY DISABILITY

Date of most recent treatment for this disability: \_\_\_\_\_

Date claimant was unable to work because of this disability: \_\_\_\_\_

Date of delivery (approximate): \_\_\_\_\_

What is the ANTICIPATED DURATION of this disability? From \_\_\_\_\_

Are there other disabling conditions accompanying this pregnancy? Yes  No

If YES, please list: \_\_\_\_\_

Signature _____	Name (Print) _____	Address _____	Phone _____	Date _____
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## **APPENDIX 2**

### **SURVEY INSTRUMENT**

**Columbia University School of Social Work**

Case Number \_\_\_\_\_

**TELEPHONE INTERVIEW**

My name is \_\_\_\_\_ I am a social worker working at District Council 37 at your union.

I would like to inform you that you were selected randomly with other members to be included in a study that your union's Health and Security Plan is doing.

The study looks at the factors affecting early return to work among female members who go out on short term disability. It also looks at the role of friends, neighbors, co-workers, supervisors at work and other significant people in assisting you during short term disability and return to work. In the first part of this interview I am going to ask you about your job, medical conditions and in the second part I am going to ask about your social support system (relatives, friends, neighbors).

Your cooperation will help your union to plan better services for you and other members who go out on short term disability.

The interview takes forty minutes.

May I begin?

1. YES
2. NO

(IF NO, INTERVIEWER SHOULD ASK WHEN SHE WILL BE ABLE TO DO THE INTERVIEW. IF THE MEMBER REFUSES TO PARTICIPATE, WRITE THE DATE: \_\_\_\_\_  
 YEAR / MONTH / DAY





Columbia University School of Social Work

Code No. Col. No.

15. When did you stop working because of your last illness?

YEAR / MONTH / DAY

16. Before your last illness our records show that you were working for NAME OF EMPLOYER Is this correct?

- 1. yes 2. no

(IF NO, ASK WHERE EMPLOYED)

17. When did you begin working there?

YEAR / MONTH / DAY

18. To which union local do you belong? NUMBER

19. Before you went out on short term disability, how many hours did you work in the week? NUMBER OF HOURS

20. Was this part time employment? 1. yes 2. no

21. Which shift did you work? 1. DAY SHIFT 2. EVENING SHIFT 3. NIGHT SHIFT 4. ROTATING SHIFT

22. During the last three years how many jobs did you hold (including your current job)? NUMBER

23. How much was your biweekly salary before you went out on short term disability? (AFTER TAXES)

24. How much did your W2 FORM show you made last year (1986)?

25. Has anyone in your family started working or worked more hours as a result of your last illness? 1. yes SPECIFY 2. no

26. What is your current marital status? 1. SINGLE 2. MARRIED 3. SEPARATED 4. DIVORCED 5. WIDOWED 6. LIVING WITH A SIGNIFICANT OTHER

Table with 2 columns (Code No., Col. No.) and 12 rows for data entry.

Code No. Col. No.

27. If the member is married or living with a significant other, ask:

Is your spouse (or significant other) working?

1. yes 2. no

_____	_____
-------	-------

28. What is the highest level of education that you have completed?

(Please put a check next to the choice which describes the respondent's education level).

- 1. GRADE SCHOOL
- 2. SOME HIGH SCHOOL
- 3. FINISHED HIGH SCHOOL (INCLUDING GED)
- 4. SOME COLLEGE
- 5. FINISHED COLLEGE
- 6. SOME GRADUATE SCHOOL
- 7. GRADUATE DEGREE

_____	_____
-------	-------

29. What is your ethnicity?

- 1. WHITE
- 2. BLACK
- 3. HISPANIC
- 4. OTHER (SPECIFY \_\_\_\_\_)

_____	_____
-------	-------

30. How long have you lived at your current address? \_\_\_\_\_

_____	_____
-------	-------

31. In the past two years, how many places have you lived?

NUMBER \_\_\_\_\_

_____	_____
-------	-------

32. How many people live in your household?

NUMBER \_\_\_\_\_

_____	_____
-------	-------

33. How are they related to you? Start with the oldest.

RELATIONSHIP	AGE
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

34. Is anybody else contributing to the family income?

1. yes 2. no

_____	_____
-------	-------

35. Who are they?

RELATIONSHIP
1. _____
2. _____
3. _____
4. _____
5. _____
TOTAL _____

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Code No. Col. No.

36. How many people depend on you for their major source of income? Include your spouse, children, elderly relatives, and others.

NUMBER \_\_\_\_\_

37. Have you returned to work?

- 1. no (IF NO GO TO QUESTION 38)
- 2. yes (IF YES GO TO QUESTION 39)

38. When do you expect to go back to work?

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
YEAR / MONTH / DAY

Code No.	Col. No.

GO TO QUESTION 51

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FOR THOSE WHO RETURNED TO WORK

Code No. Col. No.

39. When did you return to work?

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
 YEAR / MONTH / DAY

\_\_\_\_\_|\_\_\_\_\_|

40. How much did you want to return to work?

- 4. VERY MUCH WANTED TO RETURN TO WORK
- 3. WANTED SOMEWHAT TO RETURN TO WORK
- 2. WANTED TO RETURN TO WORK A LITTLE BIT
- 1. DID NOT WANT TO RETURN TO WORK

\_\_\_\_\_|\_\_\_\_\_|

41. How much did you miss being at work when you were on short term disability?

- 4. VERY MUCH
- 3. SOMEWHAT
- 2. A LITTLE BIT
- 1. NOT AT ALL

\_\_\_\_\_|\_\_\_\_\_|

42. How many of your co-workers do you consider friends?

NUMBER \_\_\_\_\_

\_\_\_\_\_|\_\_\_\_\_|

43. How much did you miss your friends at work when you were on short term disability?

- 4. VERY MUCH
- 3. SOMEWHAT
- 2. A LITTLE BIT
- 1. NOT AT ALL

\_\_\_\_\_|\_\_\_\_\_|

44. How many of your co-workers or other people at work (supervisor, shop-steward, employer, etc.) did you see or talk to when you were on short term disability?

NUMBER \_\_\_\_\_

\_\_\_\_\_|\_\_\_\_\_|

**INTERVIEWER:**

**USE THE FOLLOWING GRID TO ANSWER QUESTIONS 45 THROUGH 48.**

45. Give the first name of five of the co-workers or other people at work that you consider closest to you. (IF APPLICABLE)

	NAME	WHO	HOW OFTEN SEEN	HOW OFTEN TALKED TO ON THE PHONE		
1.	_____	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____	_____
4.	_____	_____	_____	_____	_____	_____
5.	_____	_____	_____	_____	_____	_____

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46. Who is this person?

(INTERVIEWER: IDENTIFY EACH PERSON LISTED IN QUESTION 45 IN THE "WHO" COLUMN.

PLEASE READ THE FOLLOWING LIST TO YOUR INTERVIEWEE.)

1. CO-WORKER
2. SHOP-STEWARD
3. SUPERVISOR AT WORK
4. UNION REPRESENTATIVE
5. OTHER (SPECIFY)

(INTERVIEWER: FOR QUESTIONS 47 AND 48, PLEASE ASK ABOUT EACH PERSON LISTED IN QUESTION 46.)

47. When you were on short term disability, how often did you see this person?

7. DAILY
6. SEVERAL TIMES A WEEK
5. ONCE A WEEK
4. SEVERAL TIMES A MONTH
3. ONCE A MONTH
2. LESS THAN ONCE A MONTH
1. NOT AT ALL

48. When you were on short term disability, how often did you talk to this person on the phone?

7. DAILY
6. SEVERAL TIMES A WEEK
5. ONCE A WEEK
4. SEVERAL TIMES A MONTH
3. ONCE A MONTH
2. LESS THAN ONCE A MONTH
1. NOT AT ALL

49. When you were on short term disability did you feel isolated from your job?

0. DONT KNOW
1. VERY ISOLATED
2. ISOLATED
3. NOT TOO ISOLATED
4. NOT AT ALL ISOLATED

Now I'd like to know how pressed financially were you when you were on short term disability.

50. Some people find it hard to pay for things while they are out on short term disability.

How pressed were you on a scale of 1 to 7 in which 1 is not pressed at all and 7 is very much pressed?

(INTERVIEWER: USE 0 FOR NOT APPLICABLE)

	N/A	Not pressed at all						Very pressed	
	0	1	2	3	4	5	6	7	
1. Mortgage payments	—	—	—	—	—	—	—	—	
2. Rent	—	—	—	—	—	—	—	—	
3. Food expenses	—	—	—	—	—	—	—	—	
4. Medical care	—	—	—	—	—	—	—	—	
5. Car payments	—	—	—	—	—	—	—	—	
6. Other (SPECIFY)	—	—	—	—	—	—	—	—	


GO TO QUESTION 62

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FOR THOSE WHO ARE STILL OUT OF WORK

Code No. Col. No.

51. How much do you want to return to work?

- 4. VERY MUCH WANT TO RETURN TO WORK
- 3. WANT SOMEWHAT TO RETURN TO WORK
- 2. WANT TO RETURN TO WORK A LITTLE BIT
- 1. DO NOT WANT TO RETURN TO WORK

--	--

52. How much do you miss being at work?

- 4. VERY MUCH
- 3. SOMEWHAT
- 2. A LITTLE BIT
- 1. NOT AT ALL
- 0. DONT KNOW

--	--

53. How many of your co-workers do you consider friends?

NUMBER \_\_\_\_\_

--	--

54. How much do you miss your friends at work?

- 4. VERY MUCH
- 3. SOMEWHAT
- 2. A LITTLE BIT
- 1. NOT AT ALL
- 0. DONT KNOW

--	--

55. How many of your co-workers or other people at work (supervisor, shop-steward, employer, etc.) did you see or talk to on the phone during the last month?

NUMBER \_\_\_\_\_

--	--

INTERVIEWER:

USE THE FOLLOWING GRID TO ANSWER QUESTIONS 56 THROUGH 59.

56. Give the first name of five of the co-workers or other people at work that you consider closest to you. (IF APPLICABLE)

	NAME	WHO	HOW OFTEN SEEN	HOW OFTEN TALKED TO ON THE PHONE	
1.	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____
4.	_____	_____	_____	_____	_____
5.	_____	_____	_____	_____	_____

57. Who is this person?

(INTERVIEWER: IDENTIFY EACH PERSON LISTED IN QUESTION 56 IN THE "WHO" COLUMN.

PLEASE READ THE FOLLOWING LIST TO YOUR INTERVIEWEE.)

- 1. CO-WORKER
- 2. SHOP-STEWARD
- 3. SUPERVISOR AT WORK
- 4. UNION REPRESENTATIVE
- 5. OTHER (SPECIFY)

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(INTERVIEWER: FOR QUESTIONS 58 AND 59, PLEASE ASK ABOUT EACH PERSON LISTED IN QUESTION 57.)

58. During the past month when you were on short term disability, how often did you see this person?

- 7. DAILY
- 6. SEVERAL TIMES A WEEK
- 5. ONCE A WEEK
- 4. SEVERAL TIMES A MONTH
- 3. ONCE A MONTH
- 2. LESS THAN ONCE A MONTH
- 1. NOT AT ALL

59. During the past month when you were on short term disability, how often did you talk to this person on the phone?

- 7. DAILY
- 6. SEVERAL TIMES A WEEK
- 5. ONCE A WEEK
- 4. SEVERAL TIMES A MONTH
- 3. ONCE A MONTH
- 2. LESS THAN ONCE A MONTH
- 1. NOT AT ALL

60. During the past month when you were on short term disability did you feel isolated from your job?

- 0. DON'T KNOW
- 1. VERY ISOLATED
- 2. ISOLATED
- 3. NOT TOO ISOLATED
- 4. NOT AT ALL ISOLATED

Now I'd like to know how pressed financially were you when you were on short term disability.

61. Some people find it hard to pay for things while they are out on short term disability. How pressed are you now on a scale of 1 to 7 in which 1 is not pressed at all and 7 is very much pressed?

(INTERVIEWER: USE 0 FOR NOT APPLICABLE)

	N/A	Not pressed at all						Very pressed	
	0	1	2	3	4	5	6	7	
1. Mortgage payments	—	—	—	—	—	—	—	—	
2. Rent	—	—	—	—	—	—	—	—	
3. Food expenses	—	—	—	—	—	—	—	—	
4. Medical care	—	—	—	—	—	—	—	—	
5. Car payments	—	—	—	—	—	—	—	—	
6. Other (SPECIFY)	—	—	—	—	—	—	—	—	


62



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FOR ALL RESPONDENTS

Code No. Col. No.

Now I'd like to ask you questions about your job satisfaction.

62. Before you went out on short term disability, how satisfied were you with the amount of money you made each week? Which statement best describes your feelings:

_____	_____
-------	-------

- 5. VERY SATISFIED
- 4. SATISFIED
- 3. SOMEWHAT SATISFIED
- 2. NOT TOO SATISFIED
- 1. NOT AT ALL SATISFIED

63. Before you went on short term disability, how satisfied were you with the type of work you were doing?

_____	_____
-------	-------

- 5. VERY SATISFIED
- 4. SATISFIED
- 3. SOMEWHAT SATISFIED
- 2. NOT TOO SATISFIED
- 1. NOT AT ALL SATISFIED

64. Before you went out on short term disability, how satisfied were you with your relationship with the following people?

	0	5	4	3	2	1		
	N/A	Very Satisfied	Satisfied	Somewhat Satisfied	Not too Satisfied	Not at all Satisfied		
Supervisor at work								
Co-workers								
Shop steward								
Employer								
Union representative								
Other (SPECIFY)								

65. Before you went out on short term disability did you have conflicts with the following people?

	0	4	3	2	1		
	N/A	Very Frequently	Often	Rarely	Not at all		
Supervisor at work							
Co-workers							
Shop steward							
Employer							
Union representative							
Other (SPECIFY)							

66. All in all, how satisfied have you been with your job?

_____	_____
-------	-------

- 5. VERY SATISFIED
- 4. SATISFIED
- 3. SOMEWHAT SATISFIED
- 2. NOT TOO SATISFIED
- 1. NOT AT ALL SATISFIED

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67. Which of the following statements best describes you? (CHOOSE ONE) \_\_\_\_\_

1. I LIKE MY WORK AND IT IS IMPORTANT TO ME, SO THE MONEY SEEMS UNIMPORTANT.
2. WHILE I ENJOY MY WORK, THE MONEY IS IMPORTANT TOO.
3. I DONT REALLY LIKE MY WORK, BUT I NEED THE MONEY.

68. Which of the following statements best describes you? (CHOOSE ONE) \_\_\_\_\_

1. I WORK HARD FOR MY AGENCY BECAUSE I WANT IT TO DO WELL.
2. I'M GLAD IF MY AGENCY DOES WELL, BUT I DONT FEEL PERSONALLY INVOLVED IN ITS SUCCESS.
3. I DONT CARE HOW MY AGENCY IS DOING, AS LONG AS MY JOB IS NOT AFFECTED.

69. Most people agree that a job offers a variety of things to a worker. Please tell me from the following list that I will be reading, which things have been an important part of work for you.

Use a scale from 1 to 5 in which 5 is the most important and 1 is not at all important.

	1	2	3	4	5		
1. FINANCIAL REWARDS	—	—	—	—	—	_____	_____
2. A WAY OF ORGANIZING THE DAY	—	—	—	—	—	_____	_____
3. STATUS	—	—	—	—	—	_____	_____
4. A CHANCE TO SOCIALIZE WITH OTHERS	—	—	—	—	—	_____	_____
5. A REASON TO FEEL GOOD ABOUT MYSELF	—	—	—	—	—	_____	_____
6. SOMETHING TO THINK ABOUT	—	—	—	—	—	_____	_____
7. A PLACE TO LEARN	—	—	—	—	—	_____	_____

I'd like to get an idea of exactly how you spend your time at work.

70. Some jobs are independent of work that other people in the workplace are doing, and some are very connected with the work that others do. How connected is your job with other people's jobs? \_\_\_\_\_

(INTERVIEWER: PLACE RESPONSE INTO BEST-FITTING CATEGORY)

4. VERY CONNECTED WITH A LOT OF OTHER PEOPLE
3. VERY CONNECTED WITH ONE OTHER PERSON
2. ONLY A LITTLE CONNECTED
1. NOT AT ALL CONNECTED (WORK ALONE)

71. Which of the following statements describes you? \_\_\_\_\_

1. ON THE JOB I DO MANY NEW THINGS.
2. SOME OF MY JOB IS VARIED AND SOME IS ROUTINE
3. MY JOB INVOLVES DOING THE SAME THING OVER AGAIN

72. How many other people are there in your workgroup team or crew? \_\_\_\_\_  
 NUMBER \_\_\_\_\_

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73. How do you rate the following statements on a scale of 1 to 7 in which 1 is "strongly disagree" and 7 is "strongly agree."

	Strongly disagree			Strongly agree					
	1	2	3	4	5	6	7		
1. My job requires lots of physical effort	—	—	—	—	—	—	—		
2. Most of the time my job requires travelling from one location to another	—	—	—	—	—	—	—		
3. Most of the time my job requires mobility around the office	—	—	—	—	—	—	—		
4. Most of the time my job requires standing around	—	—	—	—	—	—	—		

Now I'd like to ask you about your medical condition.

74. What has the doctor told you is wrong with you?  
\_\_\_\_\_

75. Are you taking medicine?

1. yes 2. no

(IF YES GO TO THE NEXT QUESTION)

76. How much longer do you have to take it?  
\_\_\_\_\_

77. Other than medication, are you undergoing any medical treatment?

1. yes 2. no

78. Have you been hospitalized because of your last illness?

1. yes 2. no

(IF YES GO TO THE NEXT QUESTION)

79. How many days did you stay in the hospital because of your current illness?  
\_\_\_\_\_

GENERAL WELL BEING QUESTIONNAIRE (Questions 80 - 105)

The following are questions about how you feel and how things have been going with you during the past month.

80. How have you been feeling in general? (DURING THE PAST MONTH)

- 1. IN EXCELLENT SPIRITS
- 2. IN VERY GOOD SPIRITS
- 3. IN GOOD SPIRITS MOSTLY
- 4. I HAVE BEEN UP AND DOWN IN SPIRITS A LOT
- 5. IN LOW SPIRITS MOSTLY
- 6. IN VERY LOW SPIRITS


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81. Have you been bothered by nervousness or your "nerves"?  
(DURING THE PAST MONTH)

- 1. EXTREMELY SO -- TO THE POINT WHERE I COULD NOT WORK OR TAKE CARE OF THINGS
- 2. VERY MUCH SO
- 3. QUITE A BIT
- 4. SOME -- ENOUGH TO BOTHER ME
- 5. A LITTLE
- 6. NOT AT ALL

82. Have you been in firm control of your behavior, thoughts, emotions, OR feelings?  
(DURING THE PAST MONTH)

- 1. YES, DEFINITELY SO
- 2. YES, FOR THE MOST PART
- 3. GENERALLY SO
- 4. NOT TOO WELL
- 5. NO, AND I AM SOMEWHAT DISTURBED
- 6. NO, AND I AM VERY DISTURBED

83. Have you been under or felt you were under any stress or pressure?  
(DURING THE PAST MONTH)

- 1. YES -- ALMOST MORE THAN I COULD BEAR OR STAND
- 2. YES -- QUITE A BIT OF PRESSURE
- 3. YES -- SOME - MORE THAN USUAL
- 4. YES -- SOME - BUT ABOUT USUAL
- 5. YES -- A LITTLE
- 6. NOT AT ALL

84. How happy, satisfied, or pleased have you been with your personal life?  
(DURING THE PAST MONTH)

- 1. EXTREMELY HAPPY -- COULD NOT HAVE BEEN MORE SATISFIED OR PLEASED
- 2. VERY HAPPY
- 3. FAIRLY HAPPY
- 4. SATISFIED -- PLEASED
- 5. SOMEWHAT DISSATISFIED
- 6. VERY DISSATISFIED

85. Have you been bothered by any illness, bodily disorder, pains, or fears about your health?  
(DURING THE PAST MONTH)

- 1. ALL THE TIME
- 2. MOST OF THE TIME
- 3. A GOOD BIT OF THE TIME
- 4. SOME OF THE TIME
- 5. A LITTLE OF THE TIME
- 6. NONE OF THE TIME

86. Has your daily life been full of things that were interesting to you?  
(DURING THE PAST MONTH)

- 1. ALL THE TIME
- 2. MOST OF THE TIME
- 3. A GOOD BIT OF THE TIME
- 4. SOME OF THE TIME
- 5. A LITTLE OF THE TIME
- 6. NONE OF THE TIME


87. Have you been feeling emotionally stable and sure of yourself?  
(DURING THE PAST MONTH)

\_\_\_\_\_

- 1. ALL THE TIME
- 2. MOST OF THE TIME
- 3. A GOOD BIT OF THE TIME
- 4. SOME OF THE TIME
- 5. A LITTLE OF THE TIME
- 6. NONE OF THE TIME

88. How concerned or worried about your HEALTH have you been?  
(DURING THE PAST MONTH)

(Use a scale from 0 to 10 in which 0 is not at all concerned and 10 is very concerned.)

Not at all concerned

0 1 2 3 4 5 6 7 8 9 10

Very concerned

— — — — — — — — — — — — — — — —

\_\_\_\_\_

89. How DEPRESSED or CHEERFUL have you been? (DURING THE PAST MONTH)  
(Use a scale from 0 to 10 in which 0 is very depressed and 10 is very cheerful.)

Very depressed

0 1 2 3 4 5 6 7 8 9 10

Very cheerful

— — — — — — — — — — — — — — — —

\_\_\_\_\_

90. Have you had severe enough personal, emotional, behavior, or mental problems  
that you felt you needed help DURING THE PAST YEAR?

\_\_\_\_\_

- 1. YES, AND I DID SEEK PROFESSIONAL HELP
- 2. YES, BUT I DID NOT SEEK PROFESSIONAL HELP
- 3. I HAVE HAD (OR NOW HAVE) SEVERE PERSONAL PROBLEMS, BUT HAVE NOT FELT I NEEDED PROFESSIONAL HELP
- 4. I HAVE HAD VERY FEW PERSONAL PROBLEMS OF ANY SERIOUS CONCERN
- 5. I HAVE NOT BEEN BOTHERED AT ALL BY PERSONAL PROBLEMS DURING THE PAST YEAR

91. Have you ever seen a psychiatrist, psychologist, or social worker about any personal, emotional, behavior, or mental problems concerning yourself?

\_\_\_\_\_

- 1. YES -- DURING THE PAST YEAR
- 2. YES -- MORE THAN A YEAR AGO
- 3. NO

92. Do you discuss your problems with any members of your family or friends?

\_\_\_\_\_

- 1. YES -- AND IT HELPS A LOT
- 2. YES -- AND IT HELPS SOME
- 3. YES -- BUT IT DOES NOT HELP AT ALL
- 4. NO -- I DO NOT HAVE ANYONE I CAN TALK WITH ABOUT MY PROBLEMS
- 5. NO -- NO ONE CARES TO HEAR ABOUT MY PROBLEMS
- 6. NO - I DO NOT CARE TO TALK ABOUT MY PROBLEMS WITH ANYONE
- 7. NO -- I DO NOT HAVE ANY PROBLEMS

## Columbia University School of Social Work

I am going to read several statements and you tell me which best describes how often you felt or behaved this way  
DURING THE PAST WEEK.

	Rarely ( $< 1$ day)	Some of the time (1-2 days)	Occasionally (3-4 days)	Most of the time (5-7 days)		
93. I felt that I was just as good as other people	0	1	2	3		
94. I had trouble keeping my mind on what I was doing	0	1	2	3		
95. I felt depressed	0	1	2	3		
96. I felt that everything I did was an effort	0	1	2	3		
97. I thought my life had been a failure	0	1	2	3		
98. My sleep was restless	0	1	2	3		
99. I felt lonely	0	1	2	3		
100. People were unfriendly	0	1	2	3		
101. I enjoyed life	0	1	2	3		
102. I had crying spells	0	1	2	3		
103. I felt sad	0	1	2	3		
104. I felt that people disliked me	0	1	2	3		
105. I could not get "going"	0	1	2	3		

**Columbia University School of Social Work****SOCIAL SUPPORT QUESTIONNAIRE**

**Many times we have to call upon others to give us help in different areas such as listening to our personal problems, giving advice about problems, and providing company or other help. In the following questions we would like to know about the available support you have from different people such as your spouse, family members, relatives, co-workers, friends, supervisors at work, shop steward, union representative, the church, and others.**

## Columbia University School of Social Work

Patison Psychosocial Kinship Inventory (modified)

Code No. Col. No.

**Relatives**

Do you have any relatives that live in New York City or near by?

1. no
2. yes

| |

IF YES ASK THE FOLLOWING QUESTIONS:  
(INTERVIEWER: USE THE GRID FOR ITEMS 2 - 11)

1. How many are they?

NUMBER \_\_\_\_\_

| |

2. How many of them can you turn to for help?

NUMBER \_\_\_\_\_

| |

3. Could you give the first name or initial of five of the relatives that you consider the most important? (IF APPLICABLE)

| |

4. Is this person male or female?

1. female
2. male

5. How is this person related to you? (IF APPLICABLE)

1. PARENT
2. CHILD
3. AUNT/UNCLE/NEPHEW/NIECE
4. SPOUSE
5. GRANDMOTHER/FATHER
6. SIBLING
7. OTHER (SPECIFY)

6. How often do you see or talk with this person?

6. DAILY
5. AT LEAST ONCE A WEEK
4. AT LEAST ONCE A MONTH
3. SEVERAL TIMES A YEAR
2. ONCE A YEAR
1. LESS THAN ONCE A YEAR

7. How close does this person live to you?

5. LIVES IN THE SAME APARTMENT OR IN THE BUILDING
4. WITHIN SAME BLOCK OR BUILDING DISTANCE
3. WITHIN ABOUT 30 MINUTES BY PUBLIC TRANSPORTATION
2. ABOUT TWO HOURS BY PUBLIC TRANSPORTATION
1. BEYOND TWO HOURS BY PUBLIC TRANSPORTATION



Columbia University School of Social Work

8. To what degree can you turn to this person?

- 5. VERY FREQUENTLY
- 4. OFTEN
- 3. ON SOME OCCASIONS
- 2. RARELY
- 1. NOT AT ALL

Code No. Col. No.

9. To what degree do you help this person in times of need?

- 5. VERY FREQUENTLY
- 4. OFTEN
- 3. ON SOME OCCASIONS
- 2. RARELY
- 1. NOT AT ALL

10. To what degree would you say you have conflicts with this person?

- 5. VERY FREQUENTLY
- 4. OFTEN
- 3. ON SOME OCCASIONS
- 2. RARELY
- 1. NOT AT ALL

11. How satisfied are you with the help you receive from this person?

- 5. VERY SATISFIED
- 4. SATISFIED
- 3. SOMEWHAT SATISFIED
- 2. NOT TOO SATISFIED
- 1. NOT AT ALL SATISFIED

	Name	M/F	Relation	See/talk	Close	Turn to Help	Conflicts	Satisfied
1								
2								
3								
4								
5								


Patison Psychosocial Kinship Inventory (modified)**Friends**

Do you have any friends that live in New York City or near by?  
(Not including co-workers that they consider friends)

_____	_____
-------	-------

1. no
2. yes

**IF YES ASK THE FOLLOWING QUESTIONS:  
(INTERVIEWER: USE THE GRID FOR ITEMS 2 - 11)**

1. How many are they?

NUMBER \_\_\_\_\_

_____	_____
-------	-------

2. How many of them can you turn to for help?

NUMBER \_\_\_\_\_

_____	_____
-------	-------

3. Could you give the first name or initial of five of the friends that you consider the most important? (IF APPLICABLE)

4. Is this person male or female?

1. female
2. male

_____	_____
-------	-------

5. How often do you see or talk with this person?

6. DAILY
5. AT LEAST ONCE A WEEK
4. AT LEAST ONCE A MONTH
3. SEVERAL TIMES A YEAR
2. ONCE A YEAR
1. LESS THAN ONCE A YEAR

6. How close does this person live to you?

5. LIVES IN THE SAME APARTMENT OR IN THE BUILDING
4. WITHIN SAME BLOCK OR BUILDING DISTANCE
3. WITHIN ABOUT 30 MINUTES BY PUBLIC TRANSPORTATION
2. ABOUT TWO HOURS BY PUBLIC TRANSPORTATION
1. BEYOND TWO HOURS BY PUBLIC TRANSPORTATION

7. To what degree can you turn to this person?

5. VERY FREQUENTLY
4. OFTEN
3. ON SOME OCCASIONS
2. RARELY
1. NOT AT ALL

Columbia University School of Social Work

Code No. Col. No.

8. To what degree do you help this person in times of need?

- 5. VERY FREQUENTLY
- 4. OFTEN
- 3. ON SOME OCCASIONS
- 2. RARELY
- 1. NOT AT ALL

9. To what degree would you say you have conflicts with this person?

- 5. VERY FREQUENTLY
- 4. OFTEN
- 3. ON SOME OCCASIONS
- 2. RARELY
- 1. NOT AT ALL

10. How satisfied are you with the help you receive from this person?

- 5. VERY SATISFIED
- 4. SATISFIED
- 3. SOMEWHAT SATISFIED
- 2. NOT TOO SATISFIED
- 1. NOT AT ALL SATISFIED

	Name	M/F	Relation	See/talk	Close	Turn to Help	Conflicts	Satisfied
1								
2								
3								
4								
5								


Patison Psychosocial Kinship Inventory (modified)**Neighbors**Do you know any of your neighbors? |\_|\_|\_|\_|\_|

1. no
2. yes

**IF YES ASK THE FOLLOWING QUESTIONS:  
(INTERVIEWER: USE THE GRID FOR ITEMS 2 - 11)**

1. How many are they? |\_|\_|\_|\_|\_|

NUMBER \_\_\_\_\_

2. How many of them can you turn to for help? |\_|\_|\_|\_|\_|

NUMBER \_\_\_\_\_

3. Could you give the first name or initial of five of the neighbors that you consider the most important? (IF APPLICABLE)

4. Is this person male or female? |\_|\_|\_|\_|\_|

1. female
2. male

5. How often do you see or talk with this person?

6. DAILY
5. AT LEAST ONCE A WEEK
4. AT LEAST ONCE A MONTH
3. SEVERAL TIMES A YEAR
2. ONCE A YEAR
1. LESS THAN ONCE A YEAR

6. How close does this person live to you?

5. LIVES IN THE SAME APARTMENT OR IN THE BUILDING
4. WITHIN SAME BLOCK OR BUILDING DISTANCE
3. WITHIN ABOUT 30 MINUTES BY PUBLIC TRANSPORTATION
2. ABOUT TWO HOURS BY PUBLIC TRANSPORTATION
1. BEYOND TWO HOURS BY PUBLIC TRANSPORTATION

7. To what degree can you turn to this person?

5. VERY FREQUENTLY
4. OFTEN
3. ON SOME OCCASIONS
2. RARELY
1. NOT AT ALL

Columbia University School of Social Work

Code No. Col. No.

8. To what degree do you help this person in times of need?

- 5. VERY FREQUENTLY
- 4. OFTEN
- 3. ON SOME OCCASIONS
- 2. RARELY
- 1. NOT AT ALL

9. To what degree would you say you have conflicts with this person?

- 5. VERY FREQUENTLY
- 4. OFTEN
- 3. ON SOME OCCASIONS
- 2. RARELY
- 1. NOT AT ALL

10. How satisfied are you with the help you receive from this person?

- 5. VERY SATISFIED
- 4. SATISFIED
- 3. SOMEWHAT SATISFIED
- 2. NOT TOO SATISFIED
- 1. NOT AT ALL SATISFIED

	Name	M/F	Relation	See/talk	Close	Turn to Help	Conflicts	Satisfied
1								
2								
3								
4								
5								


Patison Psychosocial Kinship Inventory (modified)**Significant others**

Are there any other persons in New York City who either are important to you or that you care about? |\_|\_|\_|\_|

1. no
2. yes

**IF YES ASK THE FOLLOWING QUESTIONS:  
(INTERVIEWER: USE THE GRID FOR THIS ITEM)**

1. How many are they? |\_|\_|\_|\_|

NUMBER \_\_\_\_\_

2. How many of them can you turn to for help? |\_|\_|\_|\_|

NUMBER \_\_\_\_\_

3. Could you give the first name or initial of five significant others that you consider the most important? (IF APPLICABLE)

4. Is this person male or female? |\_|\_|\_|\_|

1. female
2. male

5. How is this person related to you?

1. PARENT
2. CHILD
3. AUNT/UNCLE/NEPHEW/NIECE
4. SPOUSE
5. GRANDMOTHER/FATHER
6. SIBLING
7. PROFESSIONAL
8. OTHER (SPECIFY)

6. How often do you see or talk with this person?

6. DAILY
5. AT LEAST ONCE A WEEK
4. AT LEAST ONCE A MONTH
3. SEVERAL TIMES A YEAR
2. ONCE A YEAR
1. LESS THAN ONCE A YEAR

7. How close does this person live to you?

5. LIVES IN THE SAME APARTMENT OR IN THE BUILDING
4. WITHIN SAME BLOCK OR BUILDING DISTANCE
3. WITHIN ABOUT 30 MINUTES BY PUBLIC TRANSPORTATION
2. ABOUT TWO HOURS BY PUBLIC TRANSPORTATION
1. BEYOND TWO HOURS BY PUBLIC TRANSPORTATION

8. To what degree can you turn to this person?

5. VERY FREQUENTLY
4. OFTEN
3. ON SOME OCCASIONS
2. RARELY
1. NOT AT ALL

Columbia University School of Social Work

Code No. Col. No.

9. To what degree do you help this person in times of need?

- 5. VERY FREQUENTLY
- 4. OFTEN
- 3. ON SOME OCCASIONS
- 2. RARELY
- 1. NOT AT ALL

10. To what degree would you say you have conflicts with this person?

- 5. VERY FREQUENTLY
- 4. OFTEN
- 3. ON SOME OCCASIONS
- 2. RARELY
- 1. NOT AT ALL

11. How satisfied are you with the help you receive from this person?

- 5. VERY SATISFIED
- 4. SATISFIED
- 3. SOMEWHAT SATISFIED
- 2. NOT TOO SATISFIED
- 1. NOT AT ALL SATISFIED

	Name	M/F	Relation	See/talk	Close	Turn to Help	Conflicts	Satisfied
1								
2								
3								
4								
5								


Case No.  
Card No.

## Columbia University School of Social Work

Barrera (1981) Scale.

Inventory of Social Supportive Behaviors (ISSB) (Modified)

1. In the past month, did you feel you needed people to talk to about your personal problems, thoughts, or private feelings?
  4. QUITE A BIT
  3. SOMETIMES
  2. A LITTLE
  1. NOT AT ALL
  
2. In the past month, have you needed help with things like shopping, a ride somewhere, etc?
  4. QUITE A BIT
  3. SOMETIMES
  2. A LITTLE
  1. NOT AT ALL
  
3. In the past month, did you want to meet, go out with, or have fun with people?
  4. QUITE A BIT
  3. SOMETIMES
  2. A LITTLE
  1. NOT AT ALL
  
4. In the past month, did you feel you needed to borrow money or other things?
  4. QUITE A BIT
  3. SOMETIMES
  2. A LITTLE
  1. NOT AT ALL
  
5. In the past month, did you feel you need to seek advice related to your personal matters - family, children, illness?
  4. QUITE A BIT
  3. SOMETIMES
  2. A LITTLE
  1. NOT AT ALL




## Columbia University School of Social Work

If you need someone to listen to your personal problems or to your private feelings to whom of the following people would you go to talk? During the last month how often did you talk about your personal problems or private feelings with the following people?

Code No. Col. No.

	1=yes 2=no 0=N/A*	6 Daily	5 Several times a week	4 Once a week	3 Several times a month	2 Once a month	1 Not at all	0 N/A**	Code No.	Col. No.
1. spouse									_____	_____
2. family member (sibling, parents, children)									_____	_____
3. relatives (niece, nephew)									_____	_____
4. neighbors									_____	_____
5. friends (not at work)									_____	_____
6. co-workers									_____	_____
7. other (informal group) (SPECIFY)									_____	_____
8. no one									_____	_____
9. formal organiza- tion (SPECIFY)									_____	_____

## INTERVIEWER:

\* Use when the person does not exist

\*\* Use when the subject says she didn't ask for help because she didn't need it

## Columbia University School of Social Work

If you could not do your shopping because of illness or other reasons, which of the following people would you go to? During the last month how often did you ask the following people for this help?

Code No. Col. No.

	1=yes 2=no 0=N/A*	6 Daily	5 Several times a week	4 Once a week	3 Several times a month	2 Once a month	1 Not at all	0 N/A**		
1. spouse										
2. family member (sibling, parents, children)										
3. relatives (niece, nephew)										
4. neighbors										
5. friends (not at work)										
6. co-workers										
7. other (informal group) (SPECIFY)										
8. no one										
9. formal organiza- tion (SPECIFY)										

## INTERVIEWER:

\* Use when the person does not exist

\*\* Use when the subject says she didn't ask for help because she didn't need it

## Columbia University School of Social Work

Some people feel depressed or frustrated because of their illness. If you were in this situation which of the following people would you talk with? During the last month how often did you talk with the following people about your frustration because of your illness?

Code No. Col. No.

	1=yes 2=no 0=N/A*	6 Daily	5 Several times a week	4 Once a week	3 Several times a month	2 Once a month	1 Not at all	0 N/A**		
1. spouse										
2. family member (sibling, parents, children)										
3. relatives (niece, nephew)										
4. neighbors										
5. friends (not at work)										
6. co-workers										
7. other (informal group) (SPECIFY)										
8. no one										
9. formal organiza- tion (SPECIFY)										

## INTERVIEWER:

\* Use when the person does not exist

\*\* Use when the subject says she didn't ask for help because she didn't need it

## Columbia University School of Social Work

Some people need a ride to the doctor, to the job, or other places. If you need a ride to the doctor or other places, which of the following would you go to? During the last month how often did you ask this type of help from the following people?

Code No. Col. No.

	1=yes 2=no 0=N/A*	6 Daily	5 Several times a week	4 Once a week	3 Several times a month	2 Once a month	1 Not at all	0 N/A**		
1. spouse										
2. family member (sibling, parents, children)										
3. relatives (niece, nephew)										
4. neighbors										
5. friends (not at work)										
6. co-workers										
7. other (informal group) (SPECIFY)										
8. no one										
9. formal organiza- tion (SPECIFY)										

## INTERVIEWER:

\* Use when the person does not exist

\*\* Use when the subject says she didn't ask for help because she didn't need it

## Columbia University School of Social Work

If you would like to go out for fun or visit someone or have company, which of the following people would you go to? During the last month how often did you go out or visit the following people?

	Case No. Card No.		Code No.		Col. No.					
	1=yes 2=no 0=N/A*	6 Daily	5 Several times a week	4 Once a week	3 Several times a month	2 Once a month	1 Not at all	0 N/A**		
1. spouse										
2. family member (sibling, parents, children)										
3. relatives (niece, nephew)										
4. neighbors										
5. friends (not at work)										
6. co-workers										
7. other (informal group) (SPECIFY)										
8. no one										
9. formal organiza- tion (SPECIFY)										

## INTERVIEWER:

\* Use when the person does not exist

\*\* Use when the subject says she didn't ask for help because she didn't need it

## Columbia University School of Social Work

If you need advice related to your personal matters, such as marital difficulties or problems with children, which of the following people would you go to? During the last month how often did you talk about your personal matters with the following people?

Code No. Col. No.

	1=yes 2=no 0=N/A*	6 Daily	5 Several times a week	4 Once a week	3 Several times a month	2 Once a month	1 Not at all	0 N/A**		
1. spouse										
2. family member (sibling, parents, children)										
3. relatives (niece, nephew)										
4. neighbors										
5. friends (not at work)										
6. co-workers										
7. other (informal group) (SPECIFY)										
8. no one										
9. formal organiza- tion (SPECIFY)										

## INTERVIEWER:

\* Use when the person does not exist

\*\* Use when the subject says she didn't ask for help because she didn't need it

Columbia University School of Social Work

If you need advice related to your job, which of the following people would you go to ask for this help? During the last month how often did you ask the following people for this type of help?

Code No. Col. No.

	1=yes 2=no 0=N/A*	6 Daily	5 Several times a week	4 Once a week	3 Several times a month	2 Once a month	1 Not at all	0 N/A**		
1. spouse										
2. family member (sibling, parents, children)										
3. relatives (niece, nephew)										
4. neighbors										
5. friends (not at work)										
6. co-workers										
7. other (informal group) (SPECIFY)										
8. no one										
9. formal organiza- tion (SPECIFY)										

INTERVIEWER:

\* Use when the person does not exist

\*\* Use when the subject says she didn't ask for help because she didn't need it

## Columbia University School of Social Work

Some people encourage each other to do things, such as go to school, go on a trip, or go back to work. During the last month, how often did the following people encourage you to go back to work.

Code No. Col. No.

	1=yes 2=no 0=N/A*	6 Daily	5 Several times a week	4 Once a week	3 Several times a month	2 Once a month	1 Not at all	0 N/A**		
1. spouse										
2. family member (sibling, parents, children)										
3. relatives (niece, nephew)										
4. neighbors										
5. friends (not at work)										
6. co-workers										
7. other (informal group) (SPECIFY)										
8. no one										
9. formal organiza- tion (SPECIFY)										

## INTERVIEWER:

\* Use when the person does not exist

\*\* Use when the subject says she didn't ask for help because she didn't need it



Columbia University School of Social Work

If you need to borrow \$100, which of the following people would you ask for this type of help? During the last month how often did you ask the following people for this type of help?

Code No. Col. No.

	1=yes 2=no 0=N/A*	4 Once a week	3 Several times a month	2 Once a month	1 Not at all	0 N/A**		
1. spouse								
2. family member (sibling, parents, children)								
3. relatives (niece, nephew)								
4. neighbors								
5. friends (not at work)								
6. co-workers								
7. other (informal group) (SPECIFY)								
8. no one								
9. formal organiza- tion (SPECIFY)								

INTERVIEWER:

\* Use when the person does not exist

\*\* Use when the subject says she didn't ask for help because she didn't need it

How much would you say you are satisfied with the help you receive from the following people?  
 Rank your satisfaction on a scale from 1 to 5.  
 (INTERVIEWER: USE THE FOLLOWING SCALE)

Code No. Col. No.

Case No.   
 Card No.

- 0. DONT KNOW
- 1. NOT AT ALL SATISFIED
- 2. NOT SATISFIED
- 3. SOMEWHAT SATISFIED
- 4. SATISFIED
- 5. VERY SATISFIED
- 6. NOT APPLICABLE

1. spouse			<input type="text"/>	<input type="text"/>
2. family member (sibling, parents, children)			<input type="text"/>	<input type="text"/>
3. relatives (niece, nephew)			<input type="text"/>	<input type="text"/>
4. neighbors			<input type="text"/>	<input type="text"/>
5. friends (not at work)			<input type="text"/>	<input type="text"/>
6. co-workers			<input type="text"/>	<input type="text"/>
7. supervisor (at work)			<input type="text"/>	<input type="text"/>
8. shop-steward (at work)			<input type="text"/>	<input type="text"/>
9. church (SPECIFY)			<input type="text"/>	<input type="text"/>
10. professionals (doctors, social workers, etc.)			<input type="text"/>	<input type="text"/>
11. union (SPECIFY)			<input type="text"/>	<input type="text"/>
12. other (SPECIFY)			<input type="text"/>	<input type="text"/>

How useful is the help/support you receive from the following people?

Rank the importance on a scale from 1 to 5.

(INTERVIEWER: USE THE FOLLOWING SCALE)

- 0. DONT KNOW
- 1. NOT AT ALL USEFUL
- 2. NOT USEFUL
- 3. SOMEWHAT USEFUL
- 4. USEFUL
- 5. VERY USEFUL
- 6. NOT APPLICABLE

Code No. Col. No.

Case No.  
Card No.


1. spouse						
2. family member (sibling, parents, children)						
3. relatives (niece, nephew)						
4. neighbors						
5. friends (not at work)						
6. co-workers						
7. supervisor (at work)						
8. shop-steward (at work)						
9. church (SPECIFY)						
10. professionals (doctors, social workers, etc.)						
11. union (SPECIFY)						
12. other (SPECIFY)						