

## Therapy and social support 1

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Psychotherapy and social support:  
Integrating research on psychological helping  
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Abstract

Psychotherapy interactions and social support conversations have many similarities, as well as some important differences. Researchers studying these two manifestations of psychological helping -- often known as formal and informal helping -- usually apply a separate set of concepts and methods to each and tend to locate their work in separate bodies of literature. This paper argues that such a division of the field is unnecessary and unproductive. It outlines several ways in which the two bodies of literature might inform each other and argues for conceptual integration of the two fields.

Psychotherapy and social support: Integrating research on psychological helping

Psychological helping is both ubiquitous and multifarious. Here are two examples. The first is an excerpt from an interaction between a therapist and a young woman with anorexia:

Client: But I don't eat, their thing is that I don't eat because I like the way I am, and that I'm not trying to help myself, but I eat! There's nothing I can do, look I went away, I proved to them, I went away for a week. I didn't do anything. I laid around and ate. And I didn't gain any weight. And-

Therapist: You also proved it to yourself.

Client: Yes.

Therapist: Because you know, you have a lot of ... they shake your self confidence.

Client: Yes, I wonder sometimes too ... But there was seven-six days proof that it can't be m- I mean, I ate really. I ate. I know I did.

(from Labov & Fanshel, 1977, pp.369-370, edited for readability.)

The second excerpt is from a conversation between a woman who was being treated for breast cancer and a fellow patient who was trying to be helpful:

Woman: ... Within sort of about well I think it was about two weeks of having discovered the lump I was in and out of hospital, but it was after that that it seemed to drag on. It was then about two months before I actually started chemotherapy.

Fellow patient: Yes and there have been all of these stages you have got to go through. Yes, it is, it is like living through a black hole in some way, isn't it? Can you see any light at the end of it?

Woman: Well I feel a bit hopeful now that my treatment is coming to an end.

Fellow patient: What about the reaction that you had?

Woman: Well, I am very sore...

(unpublished raw data from present authors, edited for readability.)

Psychologists studying these two manifestations of psychological helping would be likely to apply a different set of concepts and methods to each one. To analyze the first, they would usually draw from a range of concepts and methods in psychotherapy research, and publish their results in a clinical, counseling or psychotherapy journal. To analyze the second, they would usually draw from a separate body of concepts and methods from the areas of informal helping or social support, and publish their results in a social psychology journal. The central contention of this paper is that this division of the field is unnecessary and unproductive. Each of the two ways of looking at helping represent largely distinct bodies of literature, even though they are analyzing many of the same phenomena. We are here arguing for some integration of the two fields.

The two types of helping are sometimes labelled as formal and informal (Cowen, 1982; Wills & de Paulo, 1991). Formal helping refers to psychological therapy, counseling, and so on. We will sometimes just use the term therapy as a less technical way of saying formal helping; we are not making a distinction between counseling and therapy for the purposes of this exposition. Informal helping refers to helping between ordinary people in everyday settings<sup>1</sup>.

In practice, there is a continuum of helpers according to how much formal training they have had in psychological helping processes (Guerney, 1969; Orford, 1992), which also tends to correlate with differences in occupational status and in the setting in which they operate. At the pure informal helping end of the continuum are the untrained helpers, such as neighbors, partners or fellow hospital patients (Cowen, 1982; Milne, Cowie, Gormly, White & Hartley, 1992); at the formal helping end are the trained helpers such as psychological therapists, counselors and psychiatrists. In the middle of the

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<sup>1</sup>There is considerable overlap between the fields of social support and informal helping. Social support typically has a somewhat broader scope, including, for example, giving tangible support, such as lending money. Informal helping is somewhat more narrowly focused towards psychological helping. However, the distinction is not at all clear cut.

continuum is a group of helpers with some specialized training or experience in psychological helping, such as mental health paraprofessionals, clergy, family doctors, etc. They are not a clearly defined grouping (although some of them may be referred to as non-professionals or mental health para-professionals), as they show some features of the formal helpers (e.g., a higher status) and some features of informal helping (less theory based and less structured helping).

There is now an overwhelming body of evidence attesting to the benefits of formal helping (Lambert & Bergin, 1994). However, the evidence on the outcome of informal helping and social support is more restricted. A limited body of evidence shows that informal and non-professional helping can be effective. The outcome of mental health paraprofessional helping appears to be roughly the same as that of professional helping (Christensen & Jacobson, 1994; Durlak, 1979; Faust & Zlotnick, 1995), at least for problems of mild to moderate severity, thus suggesting an equivalence in outcome between the middle of the continuum and its formal helping end. As Faust and Zlotnick (1995) point out, this parallels the well known “Dodo bird verdict” in psychotherapy research (Luborsky, Singer & Luborsky 1975; Stiles, Shapiro & Elliott, 1986), in which different therapies appear to have the same outcomes, even though they use seemingly very different approaches. This finding makes it important to determine what is going on in each of these different types of helping to produce equivalent results.

There are no studies that directly compare helpers at the informal helping end of the continuum with paraprofessional or professional help, as a research design that prohibits people from getting informal help would not be ethical or feasible. There is a wealth of correlational data showing that better social support is associated with positive indices of mental and physical health (e.g., Cohen & Wills, 1985), but the direction of causality is open to question (Dooley, 1985). Some controlled experimental studies have looked at the effectiveness of giving people additional social support (e.g., Kennel, Klaus, McGrath, Robertson, & Hinkley, 1991). In general, studies have shown that social support results in benefits to both physical and psychological well-being (e.g., Helgeson & Cohen,

1996; B.R. Sarason, Sarason & Pierce, 1990).

Several scholars have written about the process of psychological helping across a range of helping relationships (e.g., Frank, 1973; Goodman & Dooley, 1976; Rogers, 1957; Schofield, 1964; Strong, 1968; Wills, 1982; Winefield, 1987). Rogers (1957), whose principal concern was in theorizing about the important ingredients of counseling and psychotherapy, nevertheless explicitly included informal helping in his domain. He boldly conjectured that it was the helper’s attitudes (of empathy, positive regard and genuineness), rather than training or techniques, that were the important components of successful therapy. This formulation led to a considerable degree of empirical work, which has shown the importance of the client-therapist relationship in helping (Bohart & Greenberg, 1997; Horvath & Luborsky, 1993). Other possible common helping processes include persuasion (Frank, 1973) and client self-disclosure (Pennebaker, 1995).

The picture so far can be summarized under the frequently used categories of structure, process and outcome, drawn from the program evaluation literature (Donabedian, 1980). Structure refers to fixed aspects of a service, such as where it takes place and by whom it is delivered, process refers to how it is delivered, and outcome refers to what happens as a result. The important comparisons between formal and informal helping within each category are:

Category	Formal/informal helping comparison
Structure	Major differences in setting, status
Process	Possibly common processes operating?
Outcome	Limited research suggests both effective

Because mental health professionals sometimes perceive any equation between formal and informal helping as threatening, it is important to be clear that we are not intending to disparage formal psychological therapy or psychological therapists. Our view is that both formal and informal helping

have their proper roles. Two potential misconceptions of our position need to be addressed at the outset.

First, we are not suggesting that formal and informal helping are identical or that anyone can do therapy. The majority of therapists clearly possess, by virtue of their training, experience, or aptitude, the skills for helping clients deal with complex or long-standing psychological problems (Strupp, 1986).

Second, we are not claiming that all informal helpers possess natural talent, nor are we, we hope, romanticizing informal helping. In practice, informal helpers may often not be very skilled, and sometimes informal helping does not work at all well (Pistrang, Clare & Barker, 1999). But, at their best, informal helpers may do very similar things to trained therapists and counselors, and their very informality and similarity to the helpee may be an important asset in giving them credibility with the helpee and in allowing them to empathize with the helpee's experiences (Cowen, 1982). This principle of similarity and informality is at the heart of the self-help and mutual support movement, in which people with common concerns attempt to give and get help from each other (e.g., Humphreys & Rappaport, 1994; Jacobs & Goodman, 1989).

Thus we are not attempting to set up a competition between the two types of helping. We are simply attempting to consider both within a common framework, and to show what each field of research has to offer the other. Our central concern is to examine ways of understanding the mechanisms of psychological helping relationships, in particular to address generic processes that might be relevant across the full range of the helping spectrum. This argument, that there may be commonalities across a range of helping relationships, has been made before (Wills, 1982; Winefield, 1987); the present paper is attempting to develop this idea further and to identify specific ways in which it could be implemented by researchers in both social support and psychotherapy.

Given that the literatures on formal and informal helping appear to have developed in largely separate universes, is it fruitful to attempt to bring them together, and can anything be done to accomplish this? How might researchers from each of the two areas learn from each other, and would

the field benefit from some degree of integration? The following sections address some possible answers to these questions.

**What can social support researchers learn from the psychotherapy literature?**

One of the first empirical studies to examine informal helping was Gurin, Veroff, and Feld's (1960) survey of how people coped with their worries and unhappiness. They distinguished between informal and formal sources of help, and found, as have subsequent studies, that people tended to say they would use informal helping rather than therapy or counseling. At the same time, Blood and Wolfe's (1960) book on marital relationships examined what they labelled "the mental hygiene function of marriage", i.e., how partners provide help for each other's emotional problems. Somewhat earlier, Rogers (1957) had theorized that the qualities of good psychotherapeutic relationships were the same as the qualities of other good relationships.

The majority of subsequent work was produced by researchers working within the social support tradition. This was initiated by the landmark papers of Cassell (1976) and Cobb (1976), who independently reviewed clinical, epidemiological and experimental evidence of the impact of supportive relationships on physical and emotional health. That good social relationships have a positive effect was an appealing notion, in that it resonated with the values held by many social scientists of the importance of community (e.g., S.B. Sarason, 1974), and research in social support gathered in momentum from the early 1980s (Cohen & Wills, 1985).

Although the early studies had been conducted by researchers from several disciplines using a number of different research approaches, a characteristic social support paradigm began to emerge in the mid-1980s, at least within psychology. Studies conducted within this paradigm generally employed: (1) retrospective self-report methods to assess participants' evaluations of the help that was available to them during some stressful event, hypothetical or actual; (2) correlational rather than experimental research designs, and (3) a category system that analyzes social support in terms of its functional components, for example, emotional, informational, and instrumental support.



Research within this paradigm has been valuable in consistently demonstrating that people who say they have good social support tend to report better psychological well-being. So there is clearly a phenomenon which is in need of further investigation, since we do not yet know what it is about social support that produces its benefits, always assuming that there is a causal mechanism operating (Dooley, 1985). It is less clear, however, whether research within this paradigm can produce findings that will allow us to progress beyond global conclusions about the outcome of social support.

The paradigm has a number of drawbacks which limit how much can be learned about what actually goes on in supportive interactions. First, the unit of analysis (Elliott, 1991) tends to be broad, in that participants usually rate the type of support available to them generally from particular relationships, rather than looking at smaller units, such as a specific interaction or some individual responses within an interaction. Second, the standard social support categories -- emotional, instrumental, and informational support -- are themselves broad (e.g., emotional support can cover a large number of different approaches to helping). Third, there is little conception of helping as a process of change. Good informal helping communication may result in the helpee making significant changes, and one goal of research is to find what aspects of supportive communication might bring this about.

A useful parallel can be drawn between the state of the social support literature now, at the start of the century, and that of the psychotherapy research literature of thirty or forty years ago, in the 1960s and 1970s. At that time it had become clear that psychotherapy was on average a beneficial intervention, and the first well-designed outcome studies (e.g., Sloane, Staples, Cristol, Yorkston, & Whipple, 1975) and also the first meta-analyses (Smith & Glass, 1977) were being published. Around the same time, as discussed above, theorists were speculating about which mediating variables were responsible for these positive outcomes. Notable examples were Rogers' (1957) hypotheses about core conditions, Frank's (1973) notions about persuasion and social influence, and operant behavioral concepts of explicit and subtle social reinforcement (Murray & Jacobson, 1984). A further development at that period was the

growth of systematic process research, which aimed to test these hypotheses by measuring the variables that were hypothesized to be agents of change during the therapeutic interaction (Kiesler, 1973).

Thus psychotherapy researchers have been grappling for the last thirty or forty years with similar problems to researchers in the field of social support and informal helping, namely understanding the underlying processes in helping. What might the field of informal helping and social support have to learn from this enterprise? We make five suggestions for how research and theory might be developed.

1. Study process as well as outcome

The major subdivision in psychotherapy research is between outcome research and process research. Outcome research examines what happens as a result of the therapy -- roughly speaking, whether or not the client gets better -- whereas process research looks at what happens between the client and the therapist during the course of the therapy. Most researchers would acknowledge that both kinds of research have their place: outcome research to demonstrate the efficacy (or otherwise) of therapeutic interventions; process research to elucidate what factors are responsible for their beneficial (or harmful) outcomes.

Psychotherapy process researchers have looked at many different variables: e.g., therapist empathy, client disclosure, therapeutic alliance, depth of interpretation (Elliott, 1991; Greenberg & Pinsof, 1986). Although process research has to date yielded a useful body of results on the correlations between process and outcome (Orlinsky, Grawe, & Parks, 1994), many commentators believe that it has not yet fulfilled its early promise of identifying the key change mechanisms of psychotherapy. This may partly be due to the use of inappropriate conceptual models, for example, Stiles and Shapiro (1989) explicate and criticize the implicit "drug metaphor" which much process research appears to be based on (i.e., that processes, like empathy, are analogous to the active ingredients of a pharmacological treatment). So social support researchers can learn from the past errors as well as from the successes of existing process research.

There is little analogous work in informal helping and social support. Most research has concentrated on looking at the outcome of different types of support, but relatively little is known about the process of its delivery. As we will discuss below, existing instruments and methods from therapy process research could easily and fruitfully be applied to social support interactions.

If the aim is to learn what are the important ingredients in supportive conversations, then it is important to analyze actual supportive conversations. It has been a weakness of the social support field that relatively few studies have examined specific behaviors in actual interactions (Burlinson, Albrecht, & Sarason, 1994). Some researchers have looked at helpees' retrospective accounts of interactions (e.g., Dakof & Taylor, 1990; Lehman, Ellard, & Wortman, 1986) and a handful have looked at actual or simulated interactions in a controlled setting, (e.g., Cutrona & Suhr, 1994; Pasch & Bradbury, 1998; Pistrang & Barker, 1998; Tracey & Toro, 1989). However, these remain exceptions to the dominant paradigm, in which self-report measures are predominantly used. This is in contrast to standard psychotherapy process research, where it is common for studies to use observational methods, in which raters code clearly defined process variables from video or audio records of the conversation (e.g., Barkham & Shapiro, 1986; Greenberg & Pinsof, 1986; Labov & Fanshel, 1977; Rice & Greenberg, 1984). These variables may then be related to outcome or to other aspects of process.

## 2. Study intention as well as impact

Psychotherapy researchers (e.g., Goodman & Dooley, 1976) distinguish between the helper's intention (the cognitions preceding the behavior), the behavior (or verbal response) itself, and the impact of the behavior. Thus, for example, suppose that a hospital patient is worried about a forthcoming operation. A nurse, intending to reassure the patient, may say "Don't worry, it will all turn out right in the end", and the impact of this response may be for the patient to feel dismissed. All three components are important to study, and it is important to be clear about which components one's concepts refer to.

The commonly used social support categories tend to blur this intention/response/impact

distinction. For example, is “esteem support” a kind of support which aims to raise the person’s self-esteem (intention), a kind of support which contains reference to self-esteem (response), or a kind of support which results in increased esteem (impact)? Clear specification would be useful, as one finding from both the social support and the psychotherapy literatures is that intention does not always correspond to impact: well-intentioned attempts to help can often go awry. For example, Lehman et al. (1986) interviewed a sample of parents whose child had been killed in a car accident. Some of the responses they report, such as “You can have another child. It can’t be that bad”, although presumably well-intentioned, were experienced as unhelpful and probably upsetting by the recipients. In the psychotherapy context, Elliott (1985) conducted a cluster analysis of clients’ experiences of helpful and unhelpful therapeutic events (i.e., things that the therapist said or did during the therapy). Some examples of client reactions to unhelpful events were “He seemed to be attacking me. He made it seem like I was looking at my problem from a narrow, one-sided point of view” and “It was something that I knew about; something that everyone knows about; it was the same old story.” Thus a helpful intention by no means guarantees a helpful impact.

### 3. Measure constructs that capture generic processes

The existing social support literature tends to focus on a restricted range of variables to describe support. Often just the three categories of instrumental, informational, and emotional support are used to capture the positive aspects of interactions (Helgeson & Cohen, 1996), and global ratings of the problematic communication are used to capture the negative aspects (Rook, 1984). Although these variables are useful as an overall categorisation of the type of support activity, variables assessing other aspects of social interactions can potentially facilitate links with psychological theory, and possibly also have more face validity for the participants in the interactions.

An example of a variable that satisfies both of these criteria is empathy. There is a rich body of theory concerning its role in helping interactions (Bohart & Greenberg, 1997) and in developmental psychology (Feshbach, 1997), and being understood or not seems to be a central factor in how people

evaluate their social interactions. Empathy can be assessed using a self-report instrument, the Relationship Inventory (Barrett-Lennard, 1986), which has been extensively used in psychotherapy research but can also easily be adapted to other kinds of helping relationships (Gurman, 1978).

However, empathy in informal relationships may be communicated in different ways than in professional helping. In psychotherapy, empathy tends to be communicated by therapist reflections or interpretations (Barkham & Shapiro, 1986; Elliott, Filipovich, Harrigan, Gaynor, Reimschuessel & Zapadka, 1982). In informal helping, the limited research so far (Bachelor, 1988; Pistrang, Picciotto & Barker, in press) suggests that empathy may be carried in a wider variety of helping responses. For example, Pistrang et al.'s (in press) qualitative study of the informal helping conversations of couples who were expecting their first baby found that empathy was communicated not only by such responses as checking out or articulating meaning, but also by responses that offered solutions or carried a sense of mutuality (although offering solutions could also be experienced as low empathy, depending on the context and timing).

#### 4. Adapt some of the innovative methods from therapy research

Therapy process researchers have developed some interesting approaches that could easily be adapted for studying social support. For example, what has come to be called the “events paradigm” uses procedures from task analysis to examine in detail “significant events” in psychotherapeutic interactions (Rice & Greenberg, 1984). Such events may be, for example, moments in the therapy which the client felt were particularly helpful or unhelpful, or they may be determined a priori on theoretical grounds, e.g., moments when the client is expressing a conflict between the self as they are and the self that they would ideally like to be. Events paradigm studies then look for commonalities in how the helper is responding across these predefined classes of events, to see what makes for a positive therapeutic resolution.

Another method, sometimes used in conjunction with task analysis, is tape-assisted recall (also known as Interpersonal Process Recall or IPR). This involves tape-recording an interaction and then

playing it back to the participants, in order to assess the thoughts and experiences that they had during the interaction (Elliott, 1986). Participants' experiences can be then linked up to the actual helper behavior in order to investigate associations between intention, behavior, and impact. For example, Elliott, James, Reimschuessel, Cislo, and Sack (1985) used tape-assisted recall to examine the associations between the type of response mode used by the therapist and the kind of helpful or hindering impacts, finding, for example, that therapist interpretations were associated on the one hand with client insight, but on the other hand with client perceptions of the therapist reacting negatively to them.

##### 5. Design research to address general theories of helping

As we discussed above, several theorists have examined the role of possible common factors or processes that might underlie psychological helping in general. This was partly in response to the “equivalence paradox” in psychotherapy outcome research (Stiles et al., 1986): that seemingly different psychotherapeutic approaches appear to produce roughly equivalent outcomes. One resolution of the paradox is to conclude that any differences in ways of helping between different approaches are essentially superficial, and that at a deeper level some fundamental processes underlie all successful psychotherapeutic relationships (Hubble, Duncan & Miller, 1999).

There are many possible ways to categorize such possible fundamental processes. For instance, Goldfried (1980) suggests the examples of offering the clients direct feedback, and providing them with a corrective emotional experience; Karasu (1986) lists factors of affective experiencing, cognitive mastery and behavioral regulation; Stiles et al. (1986) list warm involvement and communication of a new perspective; Lambert and Bergin (1994) list support factors, learning factors and action factors. Clearly there is considerable overlap across each of these. Our own preferred terms -- establishing a helping relationship, making meaning, and promoting change -- combine those of Stiles et al. (1986) and Lambert and Bergin (1994), and are intended to be applied to informal helping and social support as well as to psychotherapy.

Establishing a helping relationship primarily occurs in the initial phase of therapy, but continues throughout. It involves the therapist empathizing with the client's feelings, and the ability of the client and therapist to construct a mutually satisfactory working alliance (Horvath & Luborsky, 1993), which involves forming a bond and agreeing on the tasks and goals of therapy. Much social support takes place within existing relationships (with important exceptions, such as between fellow patients in medical settings), but we would argue that processes similar to the therapeutic alliance must be present if the relationship is to provide effective help. Informal helping is more likely to build on components of the therapeutic bond, such as empathy and mutual respect, rather than on aspects relating to tasks and goals, which are more likely to remain implicit.

Making meaning involves the therapist being able to throw new light on the client's problems and experiences, so that the client is able to see them from a new perspective (Brewin & Power, 1999). This may be achieved by such activities as traditional psychodynamic interpretations, helping the client to explore their own inner world in a client-centered relationship, and giving a formulation or challenging dysfunctional beliefs in cognitive-behavioral approaches. They all share the feature of giving new meaning to the client's problems, and this new meaning may be sufficient in itself to bring about clinical change (Stiles et al., 1990). Lay helpers do not usually draw upon formal psychological theory for their interventions, but may be able to offer a different perspective on the problem by drawing on their own experience; this is often referred to as "experiential knowledge" in the mutual support literature (Borkman, 1990).

Promoting change refers to active attempts by the therapist to bring about change, such as engaging in problem-solving with the client or suggesting new ways to think or behave. These are largely the province of the cognitive-behavioral approach, since psychodynamic and client-centered methods tend to favor the client being able to initiate their own changes. Informal helpers, particularly those in existing close relationships, tend to rely heavily on problem solving, in the form of advice, although it may not always be very effective (Barker & Lemle, 1987; Knowles, 1979; Pistrang &

Barker, 1998).

The above categories are all process variables, in the sense that they are a way of describing what the helper is doing or trying to do in the conversation, or, in philosophical terminology, the type of speech act that is being performed (see Searles, 1973; Stiles, 1992). The latter two categories also can be used to assess the outcome of an interaction, since the creation of new meaning and behavioural or cognitive change are often part of how effective helping is defined.

In addition to being a useful way to describe helping conversations, these categories could also be used as a framework for interventions aimed at teaching people to become better psychological helpers. For example, Cape, Barker, Buszewicz, and Pistrang (2000) use a similar framework to conceptualize the kinds of strategies family doctors may employ to help patients who come to them with psychological disorders. A number of counselor skills training programmes (e.g., Egan, 1982), often directed at non-professional helpers, also use this kind of conceptual system to organize their approach.

### Summary

We have argued that social support researchers have mostly conducted their studies within a rather restricted paradigm, with respect both to the methodological approaches adopted and the concepts used. We have outlined some ways in which they could potentially broaden their lines of inquiry in order to make contact with the wider clinical and counseling literatures on psychological helping. We will now examine the issues that arise in building bridges in the opposite direction, i.e., what psychotherapy researchers and theorists can learn from research in informal helping and social support.

### **What can psychotherapy researchers learn from the social support literature?**

If social support researchers have mostly conducted their studies with little reference to the work done on professional psychological helping, then psychotherapy researchers on the other hand have tended to pursue their work in isolation from the broader context in which psychological help



occurs in the community at large.

This isolation is odd because, as a social-psychological activity, informal helping is in many ways more important than formal helping. It has been repeatedly demonstrated that people in trouble tend more often to seek informal rather than formal help. Part of the evidence comes from general population surveys (e.g., Barker, Pistrang, Shapiro, & Shaw, 1990; Veroff, Kulka & Douvan, 1981), which show that people express a preference for informal helpers, at least for everyday emotional problems. Further evidence comes from epidemiological work. Goldberg and Huxley (1992), in a comprehensive survey of the psychiatric epidemiology literature, concluded that “episodes of disorder are fairly common in the population, but ... only a small minority will be seen by mental health professionals” (Goldberg & Huxley, 1992, p.5). The National Comorbidity Study (Kessler et al., 1994) found that only 26% of people with a psychological disorder had ever used mental health specialty services, and the UK National Survey of Psychiatric Morbidity (Bebbington et al., 2000) found that fewer than 14% of people with a neurotic disorder were currently receiving any form of professional treatment. Some researchers have conceptualized help-seeking as a chain or pathway. In other words, people with a problem will first try to get help from their everyday environment, and if that is insufficient or unsatisfactory, they may then try formal helpers (Rogler & Cortes, 1993; Wade, Howell & Wells, 1994). Thus people with psychological problems appear to manage their own form of “stepped care” (Haaga, 2000), starting out with the most accessible, community based forms of intervention, and only progressing to professional sources of help if the problem is not resolved.

A related argument is that the growth of formal helping, i.e., psychological therapies, is a reflection of the lack of integration in contemporary Western society. This view can be traced back to influential thinkers at the beginning of the twentieth century. Durkheim (1897) viewed an elevated suicide rate as partly a reflection of a less integrated community, and Kropotkin (1902) viewed mutual aid in society as a natural process determined by human evolution. Thus the extent of therapy and counseling in society may reflect our society’s failure to promote meaningful relationships in everyday

life. Schofield (1964) captured this notion in the title of his book “Psychotherapy: the purchase of friendship”.

Therapists’ professional need to see their clinical work as special and unique can often make them reluctant to regard it as one manifestation of a generic activity of psychological helping. As we have argued above, we are not intending to diminish the value of what therapists are doing. However, we do think that, in seeking to emphasize its unique value, the field has shut itself off from some potentially valuable bridges to other areas of psychological research and theory: in particular that formal helping research and practice do have things to learn from research on informal helping and social support. These areas can be discussed under four headings:

1. Study the full range of the phenomenon to understand basic processes

Studying the simpler activity of informal helping can potentially enable psychotherapy researchers and practitioners to see the more complex activity of psychotherapy and counseling within its broader context. Analyzing simple attempts to help in everyday interactions may yield understanding about generic helping processes. However, it is not wholly accurate to see informal helping as a rudimentary activity. In some respects it is more complex than therapy, since much informal helping takes place within long-standing relationships that may have their own complicated dynamics (Coyne, Ellard & Smith, 1990; Pistrang et al., in press). But the history and the nature of informal helping relationships can be studied as variables in their own right, in order to examine their influence on the helping process.

We will offer two examples of how research on helping outside of therapy may elucidate key components and processes that operate within therapy. The first comes from studies of the facilitative role of empathy. It is part of clinical lore that if a client receives insufficient empathy from the therapist, the client will not progress with exploring their feelings (Bohart & Tallman, 1997). Instead, clients will attempt to repeat or restate their feelings, until they either experience empathy from the therapist, in which case they will continue with their self-exploration, or until it becomes clear that empathy will not

be forthcoming, in which case the client will probably switch to another content area. Such interpersonal processes have been captured vividly in the context of medical interviews. Using qualitative methods, Suchman, Markakis, Beckman, and Frankel (1997) analyzed what happened when patients offered their doctors “empathic opportunities”, in particular the consequences of doctors missing these empathic opportunities. Their data show that missed empathic opportunities resulted in the patient losing the chance to articulate valuable clinical information. The medical interview is somewhat different from a social support conversation, but it is likely that similar phenomena occur in both settings. The processes are probably clearer outside of therapy because fluctuations in empathy are probably greater: there is no lack of examples of low empathy, in everyday relationships or in doctor-patient communication.

A second example is Pennebaker’s work on emotional disclosure (e.g., Pennebaker, 1995; Pennebaker, Kiecolt-Glaser & Glaser, 1988), in particular what happens when people disclose their troubles to another person, or into a journal or a tape recorder. Pennebaker and his colleagues have demonstrated that emotional disclosure has positive effects on physical health, as reflected in improved immune function and fewer health center visits. Such disclosure of personal troubles thus constitutes a rudimentary analog of psychotherapy. One interpretation of these findings is that they show the importance of helping clients construct a personal narrative. Because simply telling the story of your troubles to someone else (or indeed into a tape recorder) produces benefits, perhaps what is happening is that the process of telling is a way of helping the person to organize and make sense of the material. This may be analogous to the process of disclosure in the presence of an empathic therapist. As Bohart and Greenberg (1997) put it “empathy is a process of coconstructing symbols for experience ... the therapist’s contribution to the basic self-articulation and narrative-formation process that has been shown to be therapeutic in studies of journaling and of account making after trauma” (Bohart & Greenberg, 1997, p.6).

## 2. Study the full range of the phenomenon to understand unique processes

Some readers may have disagreed with the argument in the previous section, and come to the opposite conclusion: that it is inappropriate to generalize from studies of elementary helping processes. Perhaps psychotherapy is indeed a unique activity, *sui generis*?

There is value in both positions. As we have suggested above, there are common processes that operate across the helping spectrum, so in that sense formal and informal helping are similar. Yet it is also clear that most informal helping interactions are qualitatively different from those with trained helpers. For example, Pistrang et al.'s (1999) single case study of informal helping shows a husband who was unable to listen to his wife's concerns about his heart disease because he was too wrapped up in concerns of his own. His closeness to the problem meant that he was unable to distance himself enough to help effectively -- one of Coyne et al.'s (1990) dilemmas of helping.

Such studies can highlight the potentially unique contribution of trained therapists, in terms of distance from a problem, empathic abilities, and the availability of a range of interventions. Thus, as well as helping to understand the commonalities, studies of informal helping also throw into sharper focus the unique factors working in formal helping.

### 3. Examine the interpersonal context of therapy

Therapy usually takes place in the context of other helping. People in trouble will look for help wherever they can get it: both before they find a formal therapeutic relationship (if they do at all) and also during the time they are in that relationship. In the words of Cowen (1982), "help is where you find it".

Cross, Sheehan and Kahn (1980) found that participants in both treatment and control groups in a comparative therapy outcome study sought "alternative advice and counsel." Surprisingly, the rate of informal help-seeking was greater in the two treatment groups than in the control group. This differential rate of help-seeking may have provided an alternative explanation for some of the gains in outcome experienced by the therapy groups compared with the control group.

It seems likely that this finding is not unique. Seeing a therapist for an hour a week does not

necessarily mean that for the rest of the time people do not discuss their troubles with friends and family, or other people in their social environment, such as colleagues or bartenders. In fact, seeing the therapist may help open up their inner world, and so cause them to discuss their thoughts and feelings more readily and more widely.

For therapy researchers, this finding implies that measures of informal support could usefully be incorporated into therapy outcome studies, to enable further examination of the relationship between informal help-seeking and outcome. For therapists, the implication is that their (the therapist's) input may be only one of several sources of help that the client is obtaining, and to see their own input in that context. However, the finding also points towards the possibility of using informal helping processes explicitly in therapy, an issue we now turn to.

#### 4. Enhancing social support processes as part of therapy

Because clients' problems often center around their relationships with other people (Horowitz, 1979), a goal of psychological therapy is often to improve how the client relates to other people. However, it is rare for social support processes to be explicitly considered in this context.

For example, although interpersonal theories of depression (e.g., Coyne, 1976; Gotlib & Hammen, 1992) include poor social support as a causative factor in depression (Brown & Harris, 1978), the interpersonal approach to therapy pays little attention to how clients give and receive support.

Couples therapy and family systems therapy tend to focus on resolving conflict, rather than on promoting helping. To some extent this is understandable, as negative interactions are generally associated with decreased well-being (Rook, 1984) and with lower relationship satisfaction in couples (Gottman & Krokoff, 1989). However, the neglect of the positive aspect of helping behavior does seem counter-productive, given that it also appears to be an important component of relationship satisfaction (Barker & Lemle, 1984; Nye, 1976; Pasch & Bradbury, 1998).

Group therapy is an important exception, in that it explicitly harnesses the interpersonal helping process for therapeutic ends. The central rationale of group therapy is to set up a miniature

social system where people are able to help one another. In his classic text, Yalom (1975) lists altruism as one of the “curative factors” in this approach. Also, mutual support (or self-help) groups rely entirely on the benefits of informal helping from similar others. They are located more towards the informal helping end of the helping continuum, but many authors have proposed alliances between the mutual support movement and mental health professionals (Jacobs & Goodman, 1989).

There is also a long tradition within community psychology and public health of using social support processes and natural social networks to foster individual well being (e.g., Collins & Pancoast, 1976; Gottlieb, 1981; Parry, 1988). Milne’s (1999) book “Social therapy” gives a comprehensive account of how mental health professionals might incorporate the findings of research on informal helping and social support into their work. His possible interventions range from the “proximal”, such as addressing social support processes in couples therapy, to “distal”, such as working with planners to help create physical environments that foster positive social interaction.

### Summary

In summary, we have shown how research on social support can potentially highlight both what psychotherapy has in common with social support, and also how it is uniquely different from it. We have considered how people with psychological problems often seek informal help as well as, or as an alternative to, psychological therapy. Thus it is important that therapists and therapy researchers understand the context in which psychological help is given: for most people with psychological problems therapists are not the preferred source of help, and even those people who do seek out a therapist may often be obtaining other help in addition to their therapy. It is arguably only when the client’s informal helping network breaks down that they need the services of mental health professionals. Finally, we have argued that attending to clients’ informal helping networks may also provide a way of enhancing the benefits of therapy.

### **Conclusions**

We have argued that the two fields of psychotherapy and social support are presently

unnecessarily disparate. Our central contention is that they can each learn from the other and that both would benefit from more integration and examination of common processes.

For informal helping and social support researchers, using psychotherapy research approaches and theories would help to take the field away from its currently rather restricted methodological approach. The psychotherapy and counseling setting has been a fertile test bed for theories about the important processes and core elements in psychological helping. Many of these ideas and research methods could fruitfully be applied to the social support context. Furthermore, empirically supported ways of psychological helping can be taught in a brief form to non-mental health professionals, for example, family doctors (Gask, Usherwood, Thompson & Williams, 1998; Roter, Hall, Kern, Barker, Cole & Roca, 1995).

For therapists, counselors and psychotherapy researchers, studying informal helping processes reveals the context in which formal help occurs and also can help connect psychotherapy back to its foundation in general psychological research and theory. The informal helping relationship allows ideas about fundamental and generic processes in helping to be tested, and throws into sharper focus those factors that are unique to professional helping.

One way in which the field might progress is for researchers to identify generic processes of psychological helping, such as establishing a helping relationship, making meaning and promoting change, in a variety of helping contexts. This research will probably entail using both discovery-oriented, qualitative methods as well as more traditional quantitative approaches. Theories developed in one setting can then be tested out and refined in other ones. The ultimate goal is to develop a theory of how human relationships can lead to positive psychological change.

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