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The Contribution of Social Support and Communal Coping to Psychological Well-being

Jacqueline Stanford
B. App. Sci. (Psych) (Hons)

Submitted in partial fulfilment of the requirements for the degree of Doctor of Psychology (Health)

School of Psychology
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July 2003
I certify that the thesis entitled:

The contribution of social support and communal coping to psychological well-being

submitted for the degree of Doctor of Psychology (Health)

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ACKNOWLEDGEMENTS

Firstly I want to acknowledge my deep thanks and appreciation of Kate. Thankyou for all the work you have put into this portfolio. Your patient discussion, reading and guidance has been much appreciated.

Thank you also to the agencies in which I completed my placements and for the clients who I worked with and enabled me to use their stories to demonstrate the importance of social relationships.

Finally, thank you so much to my family and friends for helping me complete this piece. Thank you Matt for your patience and support. Your dedication is much appreciated. Thank you to all my friends for your encouragement and support, you have made the journey much easier.
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CHAPTER ONE: INTRODUCTION

Coping is the term used to describe the process of facing and dealing with stressors (Lazarus & Folkman, 1984). Coping consists of both the appraisal of the stressor (what it means to me) and the action to respond to the stressor (what I do about it) (Lazarus & Folkman, 1984). The ability to cope well has been associated with both physical and psychological well-being (House et al., 1988).

Traditional conceptualisations of coping have been criticised for focusing on the individual (e.g., Hobfoll, 1989), without recognising the social dimension of people's lives (e.g., Lyons, Milkelson, Sullivan, & Coyne, 1998). As we all live in a social world, in both families and communities, this social dimension needs to be accounted for when addressing coping strategies and outcomes. Without such a framework it is not possible to gain a comprehensive understanding of the coping factors that influence well-being.

Social support is one way in which the research into coping has accounted for the social dimension and it consists of the provision of support in the context of social relationships (Lyons et al., 1998). Social support has consistently been shown in the literature to be related to positive health outcomes, including physical and psychological well-being (e.g., House, Landis, & Umberson, 1988). Within the broad framework of social support there are different functions that social support may serve, such as the provision of emotional support and or tangible support. Furthermore, the different types of support have been found to be important from different people at different times, such as the importance of emotional support from
family and friends when facing a diagnosis of cancer, or informational support from professionals when requiring medical advice (e.g., Rose, 1990).

The relationship between social support and well-being suggests that exploring social support may be used to increase understanding of people's well-being, and in turn, used to intervene and improve people's well-being. As such, addressing social support in the therapeutic setting may allow a greater understanding of clients and their presenting issues, by allowing insight into the precipitating, perpetuating, and protective factors related to the social context of the individual's problems. Low levels of social support may increase an individual's vulnerability to the negative effects of stress (Cohen & Wills, 1985) and as such, precipitate adjustment difficulties. Low levels of social support may also perpetuate psychological problems, as low levels of support have been associated with prolonged distress (Salovey et al., 2000). On the other hand, effective utilisation of support may serve as a protective factor, both in relation to assistance with coping with a stressor (Cohen & Wills, 1985) and the benefits associated with an awareness of being supported (Oxman et al., 1992). Understanding of the limitations of social support may indicate potential therapeutic interventions to improve client’s well-being. Strategies may be implemented that utilise existing levels of social support or which develop the client's social support networks, in order to counter the negative effects of poor psychosocial well-being.

Consideration of social support helps us to explore coping in a less individualistic manner through inclusion of a social element of coping (Lyons et al., 1998), although social support alone does not account for the complexities of the
social interactions in which people may engage (Lyons et al., 1998). The limited social complexities accounted for by social support results in an incomplete understanding of coping, which in turn results in limitations to the development of coping skills in the therapeutic setting. The concept of communal coping has been developed to address this limitation in the coping literature.

Communal coping is a coping approach that incorporates a social or shared element to both the appraisal of stressors and the action element of coping (Lyons et al., 1998) rather than simply with the action element as with social support. Communal coping involves considering both the problem and the responsibility for the problem to be that of two or more people, to be faced together (Lyons et al., 1998).

Communal coping allows for a greater distinction between people's coping strategies than simply focusing on the more passive concept of social support, as there are two dimensions on which to evaluate people's coping (appraisal and action). The theory of communal coping may be used in therapeutic settings to increase our understanding of the social dimension of a client's difficulties beyond our understanding obtained in relation to social support factors. Communal coping allows greater understanding of the precipitating, perpetuating, and protective factors related to a client's presenting difficulties. A lack of communal coping may be conceptualised as contributing to a client's difficulties. In turn, strategies that encourage use of communal coping or more effective use of communal coping may contribute to improved psychological well-being (Hobfoll et al., 1994).
Both the social support and communal coping literature will be explored in the following sections in order to provide a greater understanding of these concepts and how they may relate to clients' difficulties in a social or therapeutic setting. Following this, social support and communal coping will be explored in relation to four cases in order to demonstrate their relative utility in both understanding the client and in directing the therapeutic approach. While factors other than social support and communal coping are important in understanding the case studies and in relation to the therapeutic approach, the specific focus in this paper will be on the value of social support and communal coping. Following the discussion and evaluation of the four cases, an overall discussion will be presented that explores the role of social support and communal coping in the therapeutic setting and whether communal coping adds to our understanding and therapeutic approach, beyond the role of social support.

Social Support and Psychological Health

Social support is the provision and receipt of support in facing and dealing with stressors that occur in the context of social relationships (Shumaker & Hill, 1991). Social support as a broad concept has been related to well-being (Turner, Sorenson, & Turner, 2000) and there are numerous concepts within social support that may determine the influence of social support on well-being. Social support may be considered in terms of its structure and function (Shumaker & Hill, 1991), actual and perceived support (Cohen & Wills, 1985), the mechanisms through which social support influences health (buffering or direct effect) (Shumaker & Hill, 1991), as well as the costs and benefits of the support in terms of positive and negative
interactions (Rook, 1990). While social support is related to both psychological and physical health, the relationship with psychological health will be the focus in this paper. Each of the different aspects of social support will be considered in terms of their relationship to psychological well-being, as it may be that certain aspects of social support are more critical for psychological well-being.

Structure and function of social support.

The structure and function of social support are often considered to be the two principal components of social support (Shumaker & Hill, 1991). The structure of social support refers to the connections within a person’s social network and the type of support connections (Oxman, Berkman, Kasl, Freeman & Barrett, 1992). The function of social support refers to the resources that are provided by people within the social support network, such as providing emotional support, tangible or instrumental support and informational support (Shumaker & Hill, 1991).

In terms of psychological well-being, both the structure and function of social support have been negatively related to depression (Shumaker & Hill, 1991). Increases in both the number of people in a social network and in the types of support received have been associated with lower levels of depression (Shumaker & Hill, 1991). While both the structure and function have been related to well-being, the function of social support (e.g., emotional support) has been found to be a more important predictor of well-being than the structure of the support (e.g., size and frequency of contact) (Antonucci, Fuhrer & Dartigues, 1997; George, Blazer, Hughes, & Fowler, 1989; Oxman et al., 1992). In terms of the different functions of
support, the adequacy of emotional support, such as talking through problems, appears to be more important than the adequacy of tangible support, such as assistance with cleaning, cooking and transport (Antonucci et al., 1997; Oxman et al., 1992). These findings suggest that development and utilisation of support, according to the function, may be therapeutically more beneficial, rather than simply increasing the size of the social support network. It seems clear that it is the quality of the support provided that is more important than the quantity of support.

Gender differences are evident in both the amount and the type of social support that is received (Flaherty & Richman, 1989). In terms of structure, Flaherty and Richman (1989) have found men have more extensive networks than women, suggesting men may be advantaged in well-being due to greater opportunity to receive support from more sources. Despite their larger networks, research has consistently found women have more intensive support networks, they are likely to have more confidants, and women both receive and provide more social support than men, suggesting their well-being may be advantaged (e.g., Flaherty & Richman, 1989; Fuhrer, Stansfeld, Chemali, & Shipley, 1999; Shumaker & Hill, 1991). With regard the function of support, the presence of more confidants for women suggest women have the potential to receive greater emotional support than men, which in turn is related to greater well-being (Fuhrer et al., 1999). With the function of support being more strongly related to well-being than the structure of support, and with a closer link evident between social support and psychological well-being evident in women (Bansal, Monnier, Hobfoll, & Stone, 2000), it appears women are advantaged in terms of social support. Yet, although the findings with regard structure and function of social support are suggestive of greater psychological well-
being for women, women in general have higher rates of psychological distress than men (Fuhrer et al., 1999). An exploration of the different facets of social support may allow a greater understanding of why some women have poorer psychological health and why some people who appear to have adequate support still have poor psychological well-being. While factors other than social support are influential in determining well-being, the focus will remain on the impact of different social support elements on psychological well-being, such as the perception of support.

_Peceived support vs actual support._

Actual support is the support that has been provided to a person or is readily available, whether or not the individual is aware of the support (Shumaker & Hill, 1991). Perceived support is the individual’s perception of what social support they have received and what is available to them, and how they perceive the adequacy of the support (Oxman et al., 1992). An understanding of both perceived and actual support is important in developing an understanding of a person’s support system, in terms of both the structure and function, as it allows understanding of two factors which may differentiate the benefits of social support. Greater actual levels of social support are related to decreased psychological distress (Bolger, Zuckerman, & Kessler, 2000). Perceived availability of support has also been found to be important in influencing well-being (Lakey, Tardiff, & Drew, 1994; Oxman et al., 1992), as social relationships may allow individuals to feel secure with the knowledge that help will be provided when and if necessary. Perceived support may also provide a generalised belief that a person is cared for and valued (Oxman et al., 1992; Salovey et al., 2000).
While both actual and perceived support have been positively related to well-being, the perception of the available support has been found to be more important than the actual support received (Newland & Furnham, 1999; Oxman et al., 1992). This greater importance may be because perceived support is more closely related to effective utilisation of support. In terms of psychological adjustment, clients with depression may not perceive support to be available due to their negative thinking, and as such not utilise the support effectively. In this way, therapeutic approaches to increase both awareness and utilisation of support may be important in terms of improving psychological well-being. In particular, improving awareness and utilisation of emotional support is important due to its close positive relationship with well-being.

**Buffering effects vs direct effects of social support.**

The mechanisms through which social support influences health and well-being may vary. Social support may influence health by directly or indirectly affecting healthy or unhealthy behaviours (Shumaker & Hill, 1991). Direct effects are when the influence of social support on well-being is attributable to an overall beneficial effect of the support on psychological adjustment (Cohen & Wills, 1985), with increased social support associated with well-being regardless of the individual's stress level (Salovey et al., 2000). Buffering effects are when social support serves to protect people from potentially adverse effects of stressful events (Cohen & Wills, 1985), such as the benefits experienced from social support when facing a stressful life experience.
Both the direct and buffering roles of social support have been associated with improved psychological well-being (Stansfeld et al., 1998). Specifically, the direct effects of emotional support have been found to be predictive of good mental health in men and women (Ritter, Hobfoll, Lavin, Cameron, & Hulsizer, 2000; Stansfeld et al., 1998). In terms of buffering effects, social support was found to moderate the relationship between work stressors and psychological dysfunctioning, as measured by psychosomatic complaints, depression, irritation/strain, and social anxiety (Frese, 1999). Oxman et al. (1992) proposed that the level of intimacy in relationships contribute to the buffering effects of the support offered. They found higher levels of intimacy were related to the buffering effects of stressful situations, resulting in stressful situations having a lesser impact on the individual’s psychological well-being.

The combined findings with respect to the direct effects and buffering effects of social support, suggest people with higher levels of social support are likely to have better psychological adjustment generally due to the buffering effect. In addition, they are likely to cope better in the face of stress due to the direct effects of social support. While support may positively influence well-being directly or through a buffering effect, it is important that adequate support is provided. The support needs to meet the needs of the recipient and the recipient needs to be aware of the support and be able to effectively utilise the support. It is important to consider each of these components in conjunction with each other when evaluating someone’s social support.
In addition to the evidence supporting the role of both direct and buffering effects of social support, there is evidence of a reciprocal relationship between emotional experience and social support (Salovey et al., 2000). Not only does the provision of social support influence one’s emotional state, but a person’s emotional state also influences the likelihood that social support is provided. Therefore those people who experience positive emotional states are more likely to receive support to assist them through future stressors while those with negative emotional states are less likely to receive support to improve mood or face additional stressors. The greater support people who are psychologically well adjusted receive may be due to the greater attraction people have to psychologically well adjusted people, rather than those experiencing psychological difficulties. This finding has significant implications for clients who are experiencing long term psychological difficulties, as the longer the difficulties persist, the less likely they will be to receive the social support they require, leading to further exacerbation of their psychological difficulties. As such, therapeutic interventions may need to be multifaceted, targeting the psychological difficulties as well as implementing strategies to increase effective utilisation of support.

*Positive effects vs negative effects of social support.*

Social exchange theory (Homans, 1961) posits that social interactions, in which social support is provided and received, entails both rewards and costs. Social relationships can be a source of stress as well as support, and Rook (1990) suggested that negative social exchanges, including ineffective social support and unwanted or aversive social contact, have potent effects on psychological well-being. As such, it
is insufficient simply to consider the positive effects of social support when exploring the social context of individuals’ difficulties.

Research (e.g., Fuhrer et al., 1992; Lakey et al., 1994; Rook, 1984; Schuster, Kessler, & Aseltine, 1990; Stansfeld et al., 1997) has indicated that negative social exchanges were more influential in determining psychological well-being than were positive social outcomes for both men and women. As such, it is important that there is a greater amount of positive social exchange and interaction than negative interactions in order to promote well-being. The greater impact of negative interactions may be because not only is a need for support not met but also additional stress exists with which the individual is required to cope. The added stress from negative interactions increases the need for effective support, resulting in an impact of negative social interactions and poor support that is greater than the benefits associated with positive social interactions and the provision of adequate support. As such, it is important that strategies are implemented to encourage a decrease in negative interactions as well as an increase in positive interactions.

Relationships are not uniformly positive or negative and the same relationships might provide both positive and negative interactions at different times or in different situations (Rook, 1984), as well as involving costs and constraints (Coyne & DiClemente, 1986). Therefore the balance and impact on well-being of both the positives and negatives of social interactions needs to be considered for a full understanding of the impact of support. Stansfeld et al. (1997) found that positive interactions and support within social relationships helped alleviate the negative impact of problematic relationships. The role of positive and negative interactions
may explain why some women have poorer psychological health while having more intimate relationships, as the negative interactions involved in their sources of social support may outweigh the positive interactions (Stansfeld et al., 1997). There may also be an imbalance between the provision and receipt of support for women (Fuhrer et al., 1999), resulting in them providing support to others while their own needs are not met. While the presence of more intimate relationships might suggest that there are more opportunities to receive social support, women also have been found to provide greater amounts of social support, which may burden the women and lead to poorer health outcomes (Fuhrer et al., 1999).

The importance of exploring the balance of positive and negative interactions as well as the provision and receipt of support is evident in the therapeutic setting. It may be important to implement strategies to decrease the negative interactions and costs of support, while also increasing the positives. Balance is required within each of the facets of support, such as the function that the support fulfils. In order to achieve balance in the provision and receipt of support it may be important to decrease individuals’ sense of responsibility for other people’s well-being, so that the provision of support does not exceed their resources.

*Social support summary.*

The relationship between social support and psychological well-being is complex. Social support consists of both the structure and the function of support, and it is the function, particularly emotional support, that has been related to positive well-being (Antonucci et al., 1997). Gender differences are evident in the type and
amount of social support received, with women having more close relationships and being involved in both the provision and receipt of more support than men, particularly emotional support (Flaherty & Richman, 1989).

Other factors, such as the perception of support, the mechanism through which support operates and the positive and negative effects of support, also impact upon the relationship between social support and well-being (e.g., Cohen & Wills, 1985; Shumaker & Hill, 1991). Perceived support is commonly thought to be more important than actual support (Oxman et al., 1992). Social support may operate directly in helping an individual cope with a stressor, or it may act as a buffer against potential stressors. Both of these mechanisms are important to consider when looking at the role of social support on psychological well-being as both have been positively related to well-being (Cohen & Wills, 1985).

In terms of the positive and negative effects of relationships and support, negative social interactions appear to have a greater impact on psychological well-being than do positive interactions, but positive interactions are able to counter the effect of negative interactions (Stansfeld et al., 1997). The relative degree of support provided and received may also be an important factor in the consideration of the effect of social support, with providing more support than is received having a negative impact on well-being (Fuhrer et al., 1999). With some people giving an abundance of support while maintaining well-being, and the importance of the perception and adequacy of support (Hobfoll, Nadler, & Leiberman, 1986; Oxman et al., 1992) that enables them to effectively provide the degree of support. It may be also that those people who provide greater support than they receive are actually
engaging in communal coping and consider both the stressor and the solution to be something in which they are involved (Lyons et al., 1998), rather than consider themselves to be simply providing support.

Consideration of the different facets provided by social support may allow understanding of the benefits of social support. Although social support is still limited in terms of understanding the way in which people cope as while it is support given to a person in need, it is still an individual who is in need and who has the responsibility of facing the stressor. Consideration of a stressor as a problem shared by more than one person, a component of communal coping, may reduce the burden of the stressor.

Communal Coping

Communal coping is when both the appraisal of a stressor and the action of coping occur in the context of close relationships (Lyons et al., 1998). The stressor is considered to be ‘our’ problem to deal with together, rather than ‘your’ or ‘my’ problem that is dealt with by the individual. Lyons et al. suggested that there are three components that constitute the process of communal coping. Firstly, there is a communal coping orientation, which requires at least one person to hold the belief that joining together to deal with a particular problem is beneficial, necessary and/or expected. The second component is communication among the parties about the stressor, particularly communication about the details and the meaning of the situation to those involved. The last component involves cooperative action in which individuals collaborate to construct strategies that are aimed at reducing the negative
impact of the stressor. This definition indicates that communal coping goes beyond social support. Communal coping is not what one person can do for another, it is a collaborative approach to a stressor that involves joining together in attitude and action. While social support may be provided within a relationship that involves communal coping, communal coping is not necessarily included in relationships that involve social support, as communal coping requires a greater social involvement than social support.

Hobfoll et al. (1994) proposed a dual-axis model of coping that embraces the concept of communal coping. The dual axes represent the two dimensions of general coping strategies, and both of these dimensions need to be considered in the evaluation of coping strategies in order to determine the presence of communal coping. Firstly, there is the prosocial-antisocial dimension that allows recognition of the social world, in which people live and face stressors. Prosocial coping increases the likelihood of support being available, which has been associated with greater psychological well-being, whereas antisocial coping was associated with lower levels of available support (Monnier, Stone, Hobfoll, & Johnson, 1998). The second component is the active-passive dimension, which recognises the breadth of coping actions that may be implemented. This model of coping will be used to evaluate communal coping in the case studies with the addition of asocial coping, a third factor which Blechman, Lowell and Garrett (1998) added to the prosocial-antisocial dimension.

The benefit of using Hobfoll et al.’s dual-axis model to explore coping is that it focuses less on the emotional aspects of coping on which other models place great...
emphasis (e.g., Carver, Schcier, & Weintraub, 1989; Folkman, Lazarus, Dunkel-Schettcr, DeLongis, & Gruen, 1986), rather it focuses more on behavioural strategies. Within the dual-axis model of coping (Hobfoll et al., 1994) prosocial-active coping can be considered to capture the essence behind communal coping, as it recognises both the social appraisal and the social action component of coping. Gender differences exist in terms of the coping strategies utilised. Women engage in more prosocial coping and men with more antisocial coping (Hobfoll et al., 1994; Wells et al., 1997), although they engage in similar levels of active coping (Hobfoll et al., 1994; Wells et al., 1997). Considered together these findings suggest women engage in greater communal coping than men do.

Communal coping is not necessarily successful coping, rather it is a type of coping that takes into account the social dimension of the coping process. While benefits have been associated with communal coping, such as increased emotional well-being (e.g., Hobfoll et al., 1994; Wells et al., 1997), costs have also been associated, such as the forced focus on a painful issue in group therapy (e.g., Lyons et al., 1998). Findings supporting the benefits of communal coping will be presented below, followed by the possible costs of communal coping.

In terms of the benefits associated with communal coping, Wells, Hobfoll and Lavin (1997) and Blechman, Lowell and Garrett (1998) found utilising prosocial-active coping was associated with better emotional outcomes. The prosocial act of joining with others to face a stressor and the positive action of assertive action and information exchange, were associated with less depression and anger and greater
positive affect than other styles of coping, such as antisocial coping. Antisocial coping was associated with greater depression and anger (Wells et al., 1997).

In terms of gender differences in the use of coping strategies and the related benefits to psychological adjustment, Hobfoll et al. (1994) found more factors were associated with psychological distress in men than were evident in women. These factors included low social joining, low support seeking, aggressive action, cautious action and antisocial action. This finding suggests that men may have a narrower band of beneficial coping strategies than women. It may also mean that men who are psychologically distressed may be choosing strategies other than assertive action, which has been found to be beneficial, while men who are not psychologically distressed choose assertive action. Recognition of these gender differences needs to be included in therapeutic relationships in order to promote the most helpful strategies. Helping male clients to identify helpful coping strategies and then to increase their use of these strategies may assist with psychological well-being.

Communal coping is more than either engaging with others or taking an active role in facing a stressor. Communal coping involves both the appraisal of a stressor and the action in response to the stressor to be that of more than that of one person, in other words it consists of active and prosocial coping. Hobfoll and Schroder (2001) found when active and prosocial coping are linked, they lead to a broad array of positive psychological and behavioural outcomes, such as lower stress and depression, leading to more positive outcomes that associated with active or prosocial coping alone. As such, exploration of client’s coping strategies needs to determine the degree of both prosocial behaviour and active coping. When
communal coping is considered to be the most beneficial approach to a stressor exploration of both prosocial and active behaviour may facilitate intervention strategies to increase either or both of these factors in order to facilitate communal coping.

While communal coping has been found to have many benefits, such as reducing emotional distress (e.g., Hobfoll & Schroder, 2001), there are also possible costs associated with communal coping that need to be recognised (Lyons et al., 1998). Understanding of costs and benefits is important in order to have a full understanding of how people's coping strategies may impact on well-being. Firstly, Lyons et al. raised the issue of equality in the distribution of effort and benefits. Some people may extend more effort than the benefits they experience, whereas others may experience the benefits associated with communal coping without extending much effort into the process. The potential negative effects of the inequality in provision and receipt of support parallels the negative effects identified in relation to inequality with social support (Rook, 1984) and again it may be the perception of support that is important. For psychological well-being, it is important that there is a balance between provision and receipt of support and communal coping. An imbalance in either direction of support and communal coping may be associated with poor psychological adjustment.

Secondly, the costs of communal coping may limit adaptation to individual responsibility with new circumstances, despite the benefits of communal coping for social cohesion. Communal coping may be beneficial for as long as an individual is within that social context and their needs are being met, but when leaving the group
in which they engage in communal coping there may be difficulties in operating at the necessary individual level (Lyons et al., 1998). In order to limit the negatives of communal coping a balance needs to exist between social engagement and autonomy. Individuals ideally need to be able to cope with stressors with their own resources, but utilise communal coping in order to lessen the strain of coping, by facing the stressors with joint action.

A third possible cost of communal coping is that the distress of others in a situation can force all individuals into sustained confrontation with distressing aspects of the stressor, leading to sustained arousal (Selye, 1976). There may not be opportunity for the individuals engaging in communal coping to take respite from the situation (Lyons et al., 1998). The sustained arousal may then lead to greater emotional distress than if the individual had been left alone to cope with the stressor, due to the lack of opportunity for respite. This potential cost of communal coping may be particularly apparent in a group therapy setting in which the members share the same issue and are required to continually face the difficulties through both their own experiences and the experiences of the group. In a group setting, individuals may not be able to take respite from the issue when needed.

Finally, obligations may arise from being involved in communal coping (Lyons et al., 1998). If all the people involved with an issue are not engaging in communal coping there is the potential that those who are engaging in communal coping are providing the support and considering other people’s problems to be their own, yet are not receiving the same support with their own problems. There may be a sense of expectation about reciprocal support involving being supportive of others, even when
their own stressors may not have been resolved or their needs not yet met. Again, this potential cost may be apparent in a group therapy setting. People may feel the need to be more supportive of a particular member of the group and focus their energy on this role, rather than working through their own issues. As such, it is important that therapists observe the dynamics and validate the experiences of all members and encourage equality in terms of time spent sharing about difficulties and looking at strategies to cope with the difficulties.

In summary, communal coping involves prosocial-active coping, problems are considered to be that of more than one person, and the responsibility of the group. People join together in both the appraisal of stressors and in actions to respond to the stressor. While there are some potential costs associated with communal coping, engagement in communal coping has been associated with greater psychological well-being as opposed to antisocial or asocial passive coping.

Conclusion

The social dimension of coping has been accounted for with both social support and communal coping. While there are potential negative effects of engaging in social support and communal coping, they have both been associated with better psychological well-being. As such, in a therapeutic setting it may be beneficial to incorporate strategies to increase effective use of social support and communal coping in addition to strategies targeting the specific psychological difficulties clients’ experience. Therapeutic strategies may aim to increase the size and composition of social networks, increase use of aspects of social support that would
be most useful, decrease negative effects of social support, and reframe difficulties where necessary to allow for communal coping.

Four case studies will now be presented that refer to both social support and communal coping as an aid to better understand these clients, their difficulties and their treatment plans.
CHAPTER TWO: BEN: A YOUNG MAN EXPERIENCING DEPRESSION,
CHRONIC BACK PAIN, UNEMPLOYMENT AND RECENT SEPARATION
FROM HIS WIFE

This chapter includes an exploration of the role of social support and communal
coping in understanding and treating a young man with depression. The roles of
social support and communal coping are used to increase our understanding of the
factors influencing his psychological well-being, as well as being incorporated into
his treatment plan. Ben has recently separated from his wife and moved out of the
family home in which his wife, Rebecca, and his two sons live. Ben was seen for
nine sessions as an in-patient in a hospital psychiatric unit and then twice as an
outpatient.

Reason for Referral

Ben is a 27 year old man who was admitted to the hospital psychiatric unit for
treatment of depression. Ben was admitted following a confrontation with his wife,
Rebecca, from whom he had recently separated. Ben became upset and angry when
he saw another man in her house. He broke into Rebecca’s house, resulting in her
calling the police and having a restraining order placed on him.

Presenting Problem

Ben reported experiencing depressed mood, insomnia, social withdrawal, low
levels of motivation, feelings of guilt, worthlessness and irritability, and suicidal
thoughts. He exhibited substantial negative thinking in relation to his situation and
the issues he faced. Ben reported that these symptoms began about twelve months ago, a number of months after he injured his back at work, and which had resulted in chronic back pain and his inability to work. His depressive symptoms were exacerbated following his separation from his wife. Ben reported a change from experiencing reduced interest in activities and a somewhat lowered mood, to experiencing no interest or pleasure in activities and a chronically depressed mood accompanied by regular periods of crying, which impacted significantly on his social functioning. Following the exacerbation of symptoms Ben was diagnosed with Major Depressive Disorder by his psychiatrist and he was prescribed Effexor and Cosec daily, as well as Clonazapan and Stilnox PRN. Ben reported his loss of his relationship with his wife to be his greatest concern and he stated that the breakdown of his relationship was the biggest factor contributing to his inability to cope with the stressors he was facing.

*Presentation*

On presentation Ben was dressed casually and appeared somewhat dishevelled, with an unshaven face and unruly hair. His speech was normal in terms of rate and volume. His affect was flat and consistent with the depressive content themes that emerged. In terms of content, Ben reported feelings of depression, low motivation and worthlessness, and some suicidal thoughts, although he was able to guarantee his safety. When talking about the problems with his wife, Rebecca, Ben became tearful. Ben also appeared quite anxious; his fidgeting when asked to discuss what he would do upon discharge indicated this. Ben’s thought processes appeared normal in terms
of stream and form. No perceptual abnormalities were noted. In terms of cognition, Ben appeared to have normal attention, concentration and memory.

**Background to Presenting Problem**

Ben had been depressed for approximately one year, and his depression appears to be related to a number of life stressors that he has experienced, including the separation from his wife, as well as a work injury which resulted in chronic back pain and subsequent unemployment. Following his back injury and subsequent unemployment Ben began to experience some depressive symptoms, including low mood, but he was unaware these symptoms were related to depression. He became very irritable and unmotivated to do even the limited number of activities he has managed previously in spite of his chronic pain.

Ben has undergone a number of operations to try and fix the injury that had lead to the back pain. Throughout the twelve months following his injury, his depression worsened and impacted negatively on his relationship with his wife. Ben was aware of his negative mood and its impact on his wife and two sons, and in response Ben decided to leave the family without consulting his wife and go camping alone for a couple of weeks in order to provide them with some respite. This departure indicates Ben was not engaging in communal coping with his wife as he saw the difficulties as his to face alone and he was unable to discuss his concerns with Rebecca. Upon his return from the camping trip, neither Ben's mood nor his relationship with Rebecca was improved. The lack of improvement in his mood and their relationship lead to Ben leaving again. On the second occasion that he left, Rebecca decided she did not
want him to return as her feelings toward him had changed. Rebecca reported that Ben was a burden and that she no longer believed she was in love with him. She asked him not to return and they decided to separate. Following their separation, Ben’s depression worsened, his feelings of hopelessness increased and suicidal thoughts emerged. He was diagnosed with depression by his psychiatrist and prescribed anti-depressants (Effexor and Cosec). Four weeks following their separation Ben drove past Rebecca’s house in order to see if she was home and saw a man in the house. At that point Ben became very angry. The man escaped from the house before Ben broke into the house where he began to sob and plead with Rebecca to resume their relationship. Rebecca called the police and had a restraining order placed on Ben. Following his angry outburst Ben was admitted to hospital.

*Personal History*

*Family history.*

Ben’s parents separated when he was about three years old, and he lived with his mother and his older sister, as well as his aunt and grandma. His relationship with his mother was very close throughout his childhood and adolescence, and from the way he described the relationship, it was quite dependent. Ben was not required to take on any responsibilities within the home. His family, including his mother, sister, aunt and grandma, tried to protect Ben from any stress or difficulties as they perceived him to be unable to cope. In terms of social support and communal coping it appears Ben’s family provided any support they perceived Ben needed, including tangible and emotional support, and as such Ben was not required to seek support. Furthermore, the consequence of his family taking responsibility for the issues Ben
faced, is that Ben was prevented from engaging in communal coping as he was not required to take a prosocial or active role.

Ben remained in close contact with his father through his childhood and adolescence. When he was 17 years old his father died unexpectedly. Ben struggled to cope with the death of his father and experienced feelings of guilt as he had forgotten to visit his father on the day before he died.

Ben started dating Rebecca when they were 16 years old. When they were 20 years old they began to live together, they had a son, James, then four years later they married, and then had a second son, Liam. They were together for 12 years in total. In a similar way to Ben’s upbringing, Ben was not required to take on many responsibilities around the house and was quite dependent on Rebecca for both emotional and tangible needs. Both Ben and Rebecca reported that Rebecca took responsibility for running the house and looking after the children. Rebecca reported she avoided telling Ben when something was wrong with her, including a potential cancerous lump in her breast, due to her concern that he would be unable to cope.

Rebecca worked full time, and continued to be responsible for running the house and caring for the children even when Ben stopped working due to his back injury. In a similar way to his upbringing, it appears Ben had limited need to actively seek social support or engage in communal coping with Rebecca, as support was provided and problems were often not seen as his with which to deal.

Ben began to experience symptoms of depression following his back injury and unemployment, which resulted in friction between him and Rebecca. Following
Ben's second voluntary departure from the family home, Rebecca reported she realised her feelings had changed and that Ben added stress to her life. At this point Rebecca asked Ben not to return to their home, and so Ben returned to his parental home with his mother, sister, aunt and grandmother. Ben's separation from Rebecca added to the difficulties which Ben was already experiencing, such as his unemployment.

Employment.

Ben worked for 5 years as a landscape gardener. He stopped work two years ago, following a work related injury to his lower back. Since the injury, Ben has undergone a number of operations to try and fix his back and decrease his chronic pain. Ben was unable to return to work due to the requirements of his Workcover insurance.

Social.

Ben reports having a large social network, particularly from the football club with which he is involved. Prior to his work injury Ben used to play football and spent much time at the club. As he is no longer able to play football he has taken up coaching. Coaching has enabled Ben to stay very active with the club, in which most of his friends are also involved. From Ben's reports, social activities at the club are generally superficial, based around small talk and drinking alcohol. Ben commented that he only drinks socially, but that sometimes he and his football mates drink excessively, and that Ben tends to drink excessively when stressed. Ben reported he had developed some good friends through the football club, but through further exploration it became apparent that these relationships are based mostly around social functions and these relationships are relatively superficial.
In addition to his football friends, Ben has a small number of family friends who are a few years older than he, and who Ben reports are like brothers. Ben knows they are available whenever he needs them, and while he does not regularly seek support from them, he perceives them as being available to provide any support he may require.

**Formulation and Treatment Plan**

Ben is a 27 year old man who was admitted to the psychiatric unit with depressed mood, insomnia, social withdrawal, low levels of motivation, feelings of worthlessness and irritability, and suicidal thoughts. These symptoms are suggestive of a diagnosis of Major Depressive Disorder of moderate severity.

Factors that may have rendered Ben vulnerable to depression are his family history of instability beginning with his parents’ divorce when he was a young boy. Personality factors that may have predisposed Ben to depression are his dependent personality style, which is apparent through his passive role in his family life and in his relationship with his wife.

Ben’s depression appears to have been precipitated by his back injury, his chronic pain, and his unemployment status. The literature in the area of back pain indicates that individuals experiencing back pain tend to withdraw socially, due to the limited mobility and the depression that may be associated with the back pain (Ferroni & Coates, 1989; Maloney & McIntosh, 2001; Pfingsten, Hildebrandt,
Leibing, Franz, & Saur, 1997). In addition, the level of pain and disability experienced is related to the coping styles used (Mercado, Carroll, Cassidy, & Cote, 2000) and the way in which the pain is appraised (Grant, Long, & Willms, 2002), with less healthy coping styles and negative appraisals associated with greater pain. Furthermore, Ben’s changed circumstances challenged his beliefs about his identity and role within the family. Specifically, Ben experienced a loss of the role of family provider and the ability to labour around the home. Ferroni and Coates (1989) found men who experience a back injury frequently have an altered self-concept due to their inability to fulfil the roles they once did, such as being a provider through paid work, and the need they have to rely on others. Also, unemployment has been associated with decreased social support and higher levels of depression (Jackson, 1999). Considering these findings about back pain and unemployment, it is suggested that men who experience a back injury with resulting chronic back pain and unemployment are less likely to use social support available to them effectively following injury. At one level they have withdrawn socially, and at another level any use of social support reinforces their negatively altered self-concept that they are dependent on others. In terms of Ben’s response to his back injury and unemployment, an altered self-concept was evident. Following his injury he withdrew from social situations and stopped engaging in those activities in which he was still able to participate, including playing with his sons. An exploration of how Ben copes with his chronic back pain may be useful from a social support framework. The use of communal coping may add to the understanding of coping with chronic back pain by seeing how Ben might re-conceptualise the problems and difficulties he faces. Specifically, by engaging with others and considering his back pain and limited mobility as a joint problem to face together with friends and family,
the burden may be lessened. Further, through engaging with others, Ben has the opportunity to provide support to others increasing his sense of community and purpose.

Ben's separation from his wife exacerbated his depressive symptoms. Beyond the role loss associated with his back injury and unemployment, Ben lost further roles as a consequence of his separation from Rebecca, including his role of husband, and active father.

In terms of support, Ben's need for support increased at the same time as the people available to provide support decreased. Marital dissolution often involves the loss of the individual's closest support, particularly for men who often cite their spouse as their only confidant (Shumaker & Hill, 1991), and they may not utilise other supports to compensate for the lost support. Although Ben did not engage in communal coping while married, his separation was associated with a loss of future communal coping opportunities, due to the loss of 'us' that he experienced with Rebecca. Ben reported experiencing feelings of isolation in dealing with his problems and confusion about accepting support from others.

Those who experience marital difficulties and marriage dissolution are also likely to experience poorer physical and psychological health (Windle & Dumenci, 1997; Wu & Hart, 2002). The loss of a marriage relationship implies the loss of a source of support, and it is the loss of support that contributes to poor health. Social support operates as a protective factor, and for people like Ben who lose their primary source of support the negative impact of relationship loss is evident. Ben had
difficulty adjusting to being alone and making personal decisions. As he said he believed in the permanence of marriage, research suggests he is more likely to experience greater levels of the negative effects of marital dissolution than someone who does not believe in the permanence of marriage (Simon & Marcussen, 1999).

In addition to precipitating factors, Ben reported using many cognitive distortions including catastrophising, black and white thinking, and personalisation. His negative cognitive style may have maintained his depressive symptoms as well as influencing the negative experience of chronic pain (Fisher & Johnston, 1996). Other perpetuating factors include his financial and housing issues. These operated as practical barriers to achieving independence from his family of origin, particularly his mother. A third factor that appeared to perpetuate his depression is Rebecca’s unwillingness to resume their relationship, evidenced by her relationship with a new man. The unlikelihood of reconciliation had resulted in Ben losing his most intimate relationship, where he was previously supported, which had resulted in increased emotional distress for him and created a need for further support.

The main protective factor Ben has is the tangible and emotional support he receives from family, particularly from his mother, Rebecca’s mother and some family friends. Ben also reports receiving limited tangible and emotional support from his football friends and extended family. In terms of the support provided, it appears that Ben does not need to ask for help, but rather support is given. While the Ben still receives benefits from the support provided, he has not learnt to identify his need of support, how to seek and initiate support, or how to engage in communal coping.
The therapeutic goals consisted of treating his depression with Cognitive Behaviour Therapy (CBT), processing the breakdown of his relationship with Rebecca, and increasing his use of the social support available to him, encouraging him to engage in active and prosocial coping.

**Treatment**

*Session 1 & 2: Assessment.*

The first two sessions with Ben consisted of an assessment of his history of depression, and an exploration of related issues and the symptoms, which included decreased motivation to engage in activities he previously enjoyed. Ben reported high levels of depression and was not interested in actively engaging with people, including those in the unit and his family. Ben presented the issues with Rebecca as being of greatest concern, as although he had withdrawn socially he strongly desired to remain married to Rebecca. Ben appeared to be putting all his energy into trying to understand her unwillingness to work on the issues. He constantly came back to the question of ‘why are we separated?’ and appeared to ruminate on this issue.

Following the assessment we decided to attempt to work through the issues with Rebecca, in order to increase Ben’s understanding of the issues, and to facilitate closure of their relationship. We also decided to challenge his negative thinking with CBT strategies and to develop strategies to increase his use of social support.

*Sessions 3-5: Addressing his relationship with Rebecca.*

Ben appeared to alternate between having given up hope and still having some hope of reconciliation with Rebecca. Following agreement from Rebecca to come in
to discuss the issues between her and Ben, he was quite anxious and uncertain, and said that he did not believe discussing the issues with Rebecca would help.

In terms of coping strategies Ben used in response to stressors, he appeared to engage in asocial coping by withdrawing from other people, and utilised passive coping strategies, such as rumination on the issues. These coping styles are considered unhealthy and ineffective and may have led to his prolonged distress, as he was not engaging effectively with other people or allowing closure on the issues.

In the session with Rebecca, she presented issues similar to Ben regarding the difficulties between them, such as no longer loving Ben and frustration at Ben’s dependence and lack of involvement around the house. She reported feeling indifferent to Ben and concerned about giving him false hope. Rebecca also reported frustration at his continual phone calls, as she was not given opportunity to work through her feelings towards Ben. At the end of the session Rebecca agreed to do some couple’s work, with the clear goal of working through the issues: not a focus on reconciliation.

We had one couple’s session in which we discussed the past and the values they hold and share. We then looked at some of the issues in their relationship, such as Ben’s dependence, Ben’s anger and depression, and Rebecca’s changed feelings. Both Ben and Rebecca were able to discuss their feelings and their responses to the other’s feelings.
Session 6: Evaluation.

I met with Ben and discussed how he felt about the session with Rebecca. He reported feeling that there was no hope of reconciliation and that the session with Rebecca had gone badly. After we discussed the session in more detail Ben said he felt more positive. He acknowledged he had been dependent on Rebecca in the same way as he had been dependent on his family of origin. He realised that his dependence was one of the central issues in the breakdown of his relationship and he became adamant to do better and not be reliant on or a burden to others. We discussed how a balance was needed in relationships such as marriage. Following the session Ben agreed not to make contact with Rebecca until the next session, in light of her complaint of him contacting her too frequently.

Following the sixth session Ben’s depression appeared to have lessened and he was engaging more with people in the hospital unit, including actively participating in the group sessions. He was allowed day leave and decided to visit his family and some friends.

Case discussion.

Ben’s depression worsened following observing the man’s car outside Rebecca’s house again when he was on day leave visiting family and friends. He reported experiencing suicidal thoughts at this time. Despite the clear guidelines, Ben had experienced some hope of reconciliation with Rebecca when she was willing to discuss the issues, and he took her continued relationship with the man as presenting a mixed message. Ben, his psychiatrist and I then decided to focus on helping him move on, rather than on working through issues with Rebecca. Ben and I decided to
help him focus more on the other aspects of his life by engaging in his role as father and friend, and helping him to utilise his social support networks.

Session 7: Focus on roles in life.

During this session Ben reported having given up hope on restoring his relationship with Rebecca. He said he was determined to move on from their relationship, yet he still appeared to be holding on to some hope. He presented with flat affect, and the session was interspersed with periods of him crying. Ben reported having lost interest in mixing with other people at the hospital and had stopped attending group sessions. We talked about the importance of attending the group sessions as they provided an opportunity to learn strategies and increase social interactions. We discussed strategies he could use to help him move on from his relationship with Rebecca, such as planning things to do with his sons and with his mates. By the end of the session he had agreed to spend time with his sons and friends, had recognised the benefits of utilising the supports available to him and the importance of engaging in positive activities. The objective behind these proposed activities was to have Ben be proactive in his use of social supports and start facing his stressors together with those around him.

In order to gain a greater understanding of his coping strategies Ben was asked to complete the dual-axis model of coping questionnaire. The results indicated that Ben does not have a customary way of coping with difficult situations, possibly suggesting indecisiveness with the use of coping strategies. He reported moderate use of both healthy and unhealthy approaches when faced with stressors, including assertive action, aggressive action, social joining, social support, antisocial action
and instinctive action. Ben reported low use of cautious action and avoidance of stressors. These findings suggest Ben generally uses an active approach to problems, while this is promising, the combination of healthy and unhealthy approaches may be contributing to his poor psychological well-being. As such, therapeutic intervention involved a further promotion of the coping strategies that have been associated with improved well-being, including seeking social support, assertive action and social joining, as well as exploring the limitations of other coping styles. We discussed the benefits and costs associated with different coping responses and considered a number of scenarios from Ben’s life and discussed effective coping strategies for these situations and how they could be achieved.

Sessions 8-9: Discharge planning.

I met with Ben and discussed the past weeks and the issues that had arisen for him. Ben’s depressive symptoms appeared to have reduced, as evidenced by his improved mood, increased motivation and reduced negative thinking. His first comment was that it had been a good week and he had only called Rebecca once, although he reported he continually thought of her and wanted to call her many times. We explored the meaning that their separation had for Ben and reviewed strategies he could use to distract himself when he was having difficulty coping. We discussed the reasons and thoughts behind his suicidal thoughts and the plans he had made the previous week. We discussed the importance of engaging in positive activities in to try and focus on existing roles in life. While Ben reported he was no longer experiencing any suicidal plans or thoughts, we discussed ways of monitoring his thoughts once he had been discharged and determined strategies, such as calling the hospital, that he could use if he experienced future suicidal thoughts.
As Ben had returned from day leave drunk we talked about the risks and issues associated with his drinking behaviour and how he needs to be responsible for himself. As Ben had been informed that he was soon to be discharged, we discussed things he needed to do when discharged, such as finding independent living accommodation and sorting out his finances. We brainstormed possible approaches to finding accommodation and financial stability before determining the approach that appeared likely to be most effective. We also discussed strategies to cope with the emotional issues, such as keeping busy, but still allowing time to process his feelings. These strategies were to provide Ben with a framework and some direction, in order to increase his positive focus.

We discussed strategies than can keep him out of hospital, such as utilising the support he has around him and engaging in healthy coping strategies. We also addressed factors that may make it more likely that he will be readmitted, such as using the CBT strategies he had learnt, including challenging his negative thinking. Ben appeared to be very motivated to be discharged home at this time and he reported he believed he had accepted the dissolution of his marriage and wanted to focus on the future. Ben also seemed to have an understanding of the difficulties he would face at home. This level of insight and motivation was a marked improvement on previous sessions. We talked about his fears related to discharge including a fear of not being able to cope on his own. We also discussed strategies, such as engaging with other people, that he could use to cope with these fears. He agreed not to consume any alcohol during the first week of being discharged, in order to focus on utilising healthy coping strategies, as he reported he tended to drink excessively
when stressed. Ben also agreed to find constructive activities, such as engaging with his friends, to do with his days. As in previous sessions, Ben was encouraged to engage with others in order to utilise the support available to him from his family and friends. Again his change in mood was associated with a change in group and social interaction. As Ben’s mood improved he began to engage more with other clients and participated more in activities in the groups, supporting the reciprocal relationship between depression and opportunities for social support through social engagement.

Sessions 10 & 11: Outpatient.

Following Ben being discharged from hospital I had two sessions with Ben as an outpatient. After leaving hospital Ben had moved in with some family friends whom he considers to be like brothers. He considered this to be the best living arrangement for him at the time. He reported not wanting to be a burden to anyone, which indicates he has some difficulty in accepting support from other people and still considers his difficulties are his problems to be dealt with by himself alone. While Ben was utilising some tangible support from his friends, such as accepting food and shelter, it was due to necessity as he did not have an income and had no other house in which he could stay indefinitely. Ben reported difficulty accepting emotional support from people, the type of support associated with improved psychological adjustment (Antonucci et al., 1997). We began challenging Ben’s attitudes associated with receiving help, in order to promote more effective utilisation of support and increase opportunities for communal coping. Increased social support and communal coping may in turn have been able to lessen the burden he felt from facing his difficulties due to the relationship between social support, communal coping and
well-being. Following the discussion of the benefits of support, Ben agreed to continue to try and utilise social support and assertive action.

We discussed the difficulties Ben had experienced during the past week at home, and looked at the positive strategies he used to cope with his difficulties and depressed mood, such as catching up with a friend, and how he could implement the positive strategies when faced with difficult situations. We specifically looked ahead to the coming week and discussed potential stressors and what he could do to cope with them. Ben admitted having had some suicidal thoughts during the past week, but had not formulated a specific plan. Ben reported no current suicidal thoughts, and reported he would contact the hospital or the Crisis Assessment Treatment Team (CATT) if he experienced any suicidal thoughts.

We also focused on Ben’s strengths in coping with his loss of his marriage and other stressors, such as his back pain, and his strengths as a father. The focus on his strengths was in order to provide a positive focus and to encourage Ben to continue to engage in healthy coping strategies.

In these sessions it became apparent that Ben would punish himself for any happiness he experienced and for the mistakes he felt he had made in the past that had led to his marriage dissolution. Ben would increase the pain he was experiencing by avoiding people and through discussion we decided it was important to celebrate his birthday, particularly with his children in order to begin countering his maladaptive responses. Ben’s children were considered to be important in helping with his depression, as while he sometimes felt very unmotivated to engage in
activities, Ben reported always enjoying their time together. We also looked at his negative interpretation of his life, and how he focuses on the negatives rather than the positives. He agreed to try and engage more with his children and to focus on positives, such as his children, by drawing on cognitive behavioural strategies he learnt in the hospital group sessions.

Conclusion of therapy.

Ben missed three sessions, and then was readmitted following a suicide attempt. Ben was referred to the hospital psychologist as my university placement in the psychiatric unit was soon to terminate.

Evaluation of Therapy and Reflections about the Role of Social Support and Communal Coping

The therapeutic goals for Ben related to treating his depression with Cognitive Behaviour Therapy (CBT), processing the breakdown of his relationship with Rebecca, and increasing his use of the social support available to him, and encouraging him to engage in active and prosocial coping.

While Ben understood the principles of CBT and was able to challenge his negative thinking when he made a concerted effort, he had difficulty incorporating these strategies into his daily habits. In terms of processing the issues surrounding the breakdown of his relationship with his wife, a joint session was conducted. It was decided not to continue with joint sessions due to Ben’s misinterpretation of the purpose of the sessions and difficulties Ben had coping with a renewed realisation he was separated and that Rebecca had no intention of resuming their relationship. Ben continued to have difficulty accepting the loss of the relationship, although he was
able to use CBT strategies to manage some of his negative thinking associated with
the loss of the relationship.

In terms of social support, Ben had a strong support network available from
family, family friends, and friends through social connections. Ben was offered both
tangible and emotional support, although he often did not utilise these effectively,
and he frequently rejected offers of support due to a fear of being a burden. Ben was
able to recognise the availability of this support and he was encouraged in therapy to
engage more with other people and utilise the support they offered, in order receive
the maximum benefit of the support.

Ben did not appear to engage in communal coping, as he considered his back
pain and unemployment to be his issues, which he had to face alone. While Ben
considered the issues to be his, he did require and utilise support, particularly from
his wife Rebecca, in terms of financial support and practical support related to his
decreased mobility. Ben’s inability to utilise communal coping to face the issues
associated with his back pain and subsequent unemployment when married to
Rebecca, has left him in a position where he no longer has the opportunity to engage
in communal coping. Following his injury and then again following his separation
Ben began to experience depressive symptoms, such as feelings of hopelessness. Ben
reported not liking to have to rely on others nor did he like the self-pity he
experienced. Through the experience of having to rely heavily on others and through
Rebecca’s expression of her frustration about his dependence, Ben appeared to have
gained insight into his dependent role with his family and wife. This insight had
challenged Ben’s beliefs about his role as the head of the house and resulted in an
avoidance of seeking support. As such, he neither used the social support available to him effectively, nor engaged in communal coping, which required Ben to consider the problem to be his and Rebecca’s, which the two of them would deal with together. His ineffective use of support contributed to Ben’s position, in which he needs to effectively utilise the social support available to him, in order to face the difficulties he is experiencing. Particularly when his depression is heightened, Ben becomes very insular and engages in unhealthy coping strategies, such as excessive alcohol consumption.

In summary, while Ben neither utilises the social support available to him effectively nor engages in communal coping, he does have a support network, including family, friends and professions that, if utilised effectively, may contribute to positive change. The social support available to Ben and the manner in which he utilises the support explains in part both why he experiences depression and why he continues to struggle with depression. His lack of engagement in communal coping adds to this understanding by providing an explanation as to why he does not utilise or benefit to the greatest extent possible from the support available. Ben’s individualistic approach to problems limits the benefits he can experience.

Ideally, further therapy would focus on challenging his individualistic beliefs in order to encourage him to utilise the social support available. In addition, encouragement to engage in activities, such as socialising, to create a sense of belonging and connectedness to other people may be beneficial. While Ben is unable to work due to his injury and the associated Workcover issues finding a role in which he can find satisfaction may be therapeutically beneficial. Beyond utilisation of
social support, therapy may aim to reframe some of his difficulties in which others are involved, from being his own, to being problems faced by the people involved, and as such would benefit from being worked on as a group.
CHAPTER THREE: LINDA: A WOMAN WITH CHRONIC DEPRESSION

This chapter includes an exploration of the role of social support and communal coping in understanding and treating a woman with a long history of depression. When Linda is living at home she has appointments with her psychiatrist, a psychiatric nurse and a community volunteer weekly. While admitted to the hospital psychiatric unit Linda continued to see her psychiatrist, was involved in group therapy sessions and had a psychiatric nurse available at all times. In addition Linda was seen for 6 psychology sessions during her admission to the psychiatric unit in the hospital.

Reason for Referral

Linda, a 50 year old woman with a long history of depression, was admitted by her psychiatrist to the hospital due to suicidal thoughts and being at risk of self-harm. She was referred to me to help her engage more with other people, including people within the unit.

Presenting Problem

Linda reported experiencing depressed mood, sleep difficulties, social withdrawal, low levels of motivation, feelings of worthlessness, irritability, and suicidal thoughts. Linda reported having been depressed for over some 22 years and that periodically the symptoms worsen and her suicidal thoughts increase. Linda reported having no insight into the factors that contribute to her depression, or to the fluctuations in her depression.
Presentation

Linda was seen in her room in the psychiatric unit and would sit or lie on the bed during the sessions. On presentation Linda wore a casual tracksuit, had very short hair and wore no makeup, she did not appear to take any pride in her appearance. Linda appeared withdrawn and inattentive, lying on the bed with her eyes mostly closed throughout the session. Linda’s speech was somewhat slowed and quiet. Her affect was flat, regardless of the content of her speech. Linda’s thought processes appeared normal in terms of stream and form. Linda reported some passive suicidal thoughts, but reported they had diminished since her time of admission. Linda’s attention, concentration and memory appeared limited, with difficulty evident in recalling details of the past and requiring questions to be repeated.

Background to Presenting Problem

Linda was diagnosed with depression 22 years ago, she has been prescribed anti-depressants throughout this period, and has been admitted into psychiatric units two or three times each year. Linda has chronic suicidal thoughts and has attempted suicide on numerous occasions, usually taking an overdose of medication or cutting her wrists. Linda commented that her suicide attempts had reduced since her son was born, 12 years ago. She stated this was because she did not want her son to live with his father, as she did not believe his father would reliably provide for his needs. After her death, she wanted her son to live with one of his two sisters, and therefore she wanted to defer her suicide until they were old enough to support him.
Linda appeared to have very little insight into her depression and suicidal behaviour. Linda has difficulty identifying factors contributing to her depression and she said she has no influence over her depression. The one factor Linda could identify which was related to changes in her depression was time. She reported believing that she has to wait until the chemicals in her brain change in response to medication or the passing of time and that there was not anything she could do to speed up the process, indicating a very passive role in her depression. Similarly, Linda has poor insight into her suicide behaviour. On one hand she did not appear to recognise that a suicide attempt may result in death and therefore leaving her son in a likely position of living with his father. At the same time, Linda considered herself to be 100% committed to committing suicide, believing she has not been successful only due to people preventing her from being successful. Linda reports no longer associating with a number of the friends she had in the past, as they would contact Linda’s psychiatrist and tell him of her suicidal thoughts when Linda spoke of them to her friends. Linda perceives herself to have been betrayed by her friends and believes this lead to the dissolution of the relationships with her friends.

In terms of treatment, Linda receives pharmacological and psychological treatment. The medication Linda is currently prescribed includes Zoloft for her depression, and Diazepam for her anxiety, both as a daily treatment and PRN. Linda has also had one previous course of Electroconvulsive therapy (ECT) to help manage her depression.

The psychological treatment and professional support Linda receives involves weekly appointments with her psychiatrist, who she considers to provide emotional
support. A psychiatric nurse visits Linda at home once a week, and encourages Linda to engage in some activities outside of the house. A volunteer visits Linda weekly to provide some social contact. In addition to these weekly contacts, Linda is admitted approximately three times a year to the hospital and stays there for about a three week period. During this time Linda continues to see her psychiatrist, and this may occur three or four times a week. While in hospital she does not receive visits from the psychiatric nurse or the volunteer, but is encouraged to attend group sessions which provide a supportive environment in which to discuss issues and learn coping strategies. A psychiatric nurse is available at all times while she is an impatient and throughout this admission I met with Linda twice each week.

Linda has regular contact with numerous professionals and support agencies to assist management of her depression, each of which enable her to maintain a passive role in coping with her depression. The passive role promoted by the amount of support received is suggestive of Linda being over supported with managing her depression, and that there may be insufficient focus on encouraging Linda to independently manage her depression and engage in life.

**Personal History**

**Family history.**

Linda is the middle of three children and she grew up with her parents and two sisters. Her upbringing was very controlled and Linda's father was physically and emotionally abusive towards her and her sisters. Her mother was a passive woman and Linda resents her mother for not protecting her against her father. Linda also had
a poor relationship with her two sisters, disagreeing on many attitudes and values. Linda’s father died eight years ago, but Linda rarely saw him in the years proceeding his death and therefore reported not finding that his death had any impact on her life. Linda continues to have a poor relationship with her mother and sisters and only sees them when obliged such as at family functions.

Linda left home at sixteen in order to escape the family and she said to see the world. Linda describes this period of her life as being her most happy time. She said this was because she was carcfccc. During that time she spent about three years travelling overseas before returning to Australia where she began working in a library to support herself.

Linda was married at twenty five, and had two daughters, who are now 20 and 22 years old. When her second daughter was two years old Linda and her husband separated. As neither Linda nor her husband sought a divorce, they remain married. Linda has had a couple of relationships of brief duration since their separation, one of which led to the birth of her son. That relationship did not continue, leaving Linda to take sole responsibility for her son, who is now 12 years old. Linda is quite ambivalent towards each of her children, commenting that “I suppose I love them, but in a funny kind of way. I wouldn’t want anything bad to happen to them I guess”. Linda considers her children to be a source of stress rather than providing anything positive to her life. Linda’s oldest daughter has recently moved out of home, resulting in a somewhat improved and less conflictual relationship. Both her younger daughter and her son remain living at home, and her younger daughter cares for her son when Linda is admitted to hospital.
Employment.

Linda has not worked for 22 years due to her depression. She is supported by government benefits, including the disability pension. Prior to her depression Linda worked part-time in a library. Aside from the financial restraints associated with unemployment, Linda’s unemployment and related lack of workplace relationships decreases Linda’s opportunities to develop relationships in which support can be received or provided.

Social.

From Linda’s family history it is apparent that neither her family of origin nor her children provide any social support to Linda that she recognises or utilises. In terms of friends, Linda has cut herself off from many of her friends due to disagreements. Linda does not work, and therefore does not have work colleagues who may be able to provide some level of support. The one person Linda considers to be a friend is a woman who lives three hours away from her home whom Linda met in a psychiatric in-patient unit. Linda has little contact with this lady and she waits for her to initiate contact. Linda appears to be passive within her existing relationships, and does not seek or utilise support that is available.

Formulation and Treatment Plan

Linda is a 50 year old woman admitted to hospital due to depression and suicidal thoughts. She was referred to me to encourage her to engage more with people in the unit. Linda’s history of abuse and control by her father may have been a predisposing factor to her depression, as may have been her distant relationship with her mother. Linda’s relationship with both of her parents may have led to an avoidant attachment.
style, which is suggested by her lack of relationships and the short duration of existing relationships. A poor attachment style may have in turn predisposed Linda to depression. Linda also reported low self-esteem, leading to psychological vulnerability, so that the presence of stressors may have resulted in an inability to cope. In terms of personality factors, Linda appears to be passive and dependent, evident by her passive role in the treatment of her depression, and the dependency she has on numerous professionals.

A precipitating factor to Linda’s depression may have been the control and boundaries she saw as imposed upon her ‘carefree years’ when she married and commenced the routine she associated with family life. Linda’s comment that the years in which she travelled were her happiest due to being carefree, in conjunction with her perception of her children as a responsibility that brings no joy, may suggest that Linda’s depression is in response to the controlled lifestyle she feels she needs to live. Linda’s response to control and responsibility may be a reaction to the control in which she lived as a child under the discipline and control of her father. The current episode of depression may have been precipitated by the stress of school holidays and the need for Linda to look after her son all day. Linda does not appear to cope with responsibility, taking a passive and dependent role in the face of responsibility.

It might be that the high levels of support provided to Linda might actually be reinforcing her dependency and passivity. These professionals appear to provide to her needs while Linda appears to return little commitment or assume any responsibility. This lack of reciprocity may be perpetuating her depression. Linda is enabled to play a passive and sick role with her depression as all supports focus on
attending to her needs, rather than encouraging her to participate and engage actively in coping with her depression.

Low levels of support are associated with higher levels of depression (House et al., 1988). Linda reports receiving little support, particularly from family and friends, yet she receives substantial amounts of professional support. The perception of support has been found to be more important in determining the benefits to well-being than the actual support available and provided (Oxman et al., 1992). As such, it appears Linda’s perception of available support may limit her effective use of the support available from professionals, and may also be apparent with family and friends. Also, the emotional support from professionals may be limited due to professional boundaries, and as it is emotional support that is more strongly associated with lower levels of depression (Antonucci et al., 1997) the limitations to professional support may also be limiting the benefits Linda experiences.

Furthermore, Salovey et al. (2000) found a reciprocal relationship between social support and depression. Depressed people seek lower levels of support than non-depressed people do, and those with lower levels of support have higher levels of depression. This relationship may be contributing to Linda’s depression, as she has low levels of support outside of the support she receives from professionals, and does not seek to increase social support. Another perpetuating factor may include her beliefs about her depression being outside her control, which enables Linda to play a passive role in her depression.
While the professional support may partially be reinforcing the factors contributing to Linda’s depression, such as her passivity, the same supports have the potential to act as protective factors. While Linda has few social connections and supports, she has an abundance of professional support that may be utilised as a protective factor. In terms of her suicidal thoughts, her son’s age and her concerns about his father’s ability to parent appear to be protective.

As I only had a limited number of sessions with Linda, our therapeutic goals were to develop insight into the role that Linda may have in perpetuating her depression and encourage her active participation in overcoming with her depression. The goal was also to encourage Linda to engage more with the people around her, including those within the unit. The combined approach of targeting Linda’s depression and her use of social support aimed at positively impacting the reciprocal relationship between social support and depression.

*Treatment*

*Session 1 & 2: Assessment.*

In the first two sessions I obtained a life history, including Linda’s relationship with family and friends, and what she believes precipitates her depression. We also discussed social interactions and depressed behaviour in order to identify areas for intervention.

Linda was encouraged to participate in the group sessions in order to engage with other people, and we spent some time challenging the reasons why Linda
prefers not to go to the groups. Linda reported perceiving the groups to be a waste of time, with nothing helpful being offered and that they are just a whinge session. As she has not been for a long time, Linda agreed to attend a group session in order to determine if her reasons for not attending the group were accurate.

Following discussion about her frustration with her poor sleep, which she reported was always unsettled, I asked Linda to keep a diary of sleep and mood patterns to determine accuracy of recall of sleep and mood, and we agreed to discuss it next week. The goal was to develop some insight into the variations of mood and sleep and use this to challenge her beliefs that she is always really depressed, that nothing influences her mood and that she never sleeps well.

Session 3: Understanding of mood and behaviour.

In this session we reviewed Linda’s diary and used the information as a basis for intervention strategies. Linda had only completed the diary of her sleep problems and we used this to look at the variations in her sleep and how different events may have influenced her sleep. Linda was able to acknowledge there were variations in her sleep and that on two occasions she could attribute these to higher levels of anxiety. From Linda’s reports it appears that her anxiety has a more significant influence than her depression on her sleep. We spent some time discussing strategies to improve sleep and reduce anxiety, including deep breathing, allocating worry time and setting up a sleep routine. Linda agreed to try and make some changes in her anxiety management by utilising some of the suggested strategies.
In terms of positive behavioural activities we discussed some ways Linda may be able to use the resources around her to increase her pleasurable activities and social interactions. Linda was quite negative throughout the discussion about changing her behaviour, indicating feelings of hopelessness with regard to trying to change her behaviour in any way. Linda reported her days mostly consist of sleeping, cleaning and sitting, with little interaction with her children. Linda reported low motivation to do anything that she once enjoyed, including gardening and reading, and was quite adamant that doing any activities would not help her mood as she was not interested in doing them and could not be bothered investing the energy. When Linda has increased activities, such as attending coffee with her psychiatric nurse who visits weekly, Linda considers the effort to be a waste of time and has found activities do not influence her mood. Linda reported she goes for coffee just to keep the nurse happy. We discussed how the thoughts associated with an event are important in determining the benefits experienced as a result of the event, and how Linda's negative thinking was preventing her from obtaining any enjoyment from going out for coffee. We then considered alternative ways of thinking, but Linda was quite adamant that engaging in activities would not improve her mood.

While Linda was unable to see a way in which engaging with other people and activities may be a positive experience when discharged, Linda was participating to a greater extent with the other clients and with the group sessions. Following our previous session, Linda had attended the group and found some of the content to be helpful. While she remained quite negative about some of the group sessions, she continued to participate and interacted to a greater extent with other clients. Outside of the group sessions Linda was also interacting with other clients to a greater extent,
particularly with people in the outdoor area allocated to those who smoke cigarettes. These behaviour changes may partially be attributed to challenging her thoughts and expectations about engaging with others and in the group sessions.

Session 4: Roles in life.

In this session we discussed Linda’s roles in life and what could be changed or focused on to try and improve her mood. We also reviewed the strategies Linda was implementing to try and improve her sleep.

We discussed how the group sessions were going and Linda reported that they were “not too bad”, and that she had managed to find a couple of things that were helpful. Linda had decided to keep going to the group sessions, but this decision appeared to be made partly because it was an easy decision and that it would keep the hospital staff happy. Linda’s mood appeared to be slightly brighter and she sat up on her bed as we spoke, rather than lying down.

Linda reported trying to monitor her sleep behaviour more closely and found that sometimes deep breathing helped, but often she forgot to use deep breathing when experiencing sleep difficulties. Linda said she had difficulty using worry time and believed she was unable to control her thoughts about events and situations that produced anxiety. Linda said she had not been able to develop a sleep routine, and she attributed this partly to being in hospital and needing to fit with the hospital routine.
Linda and I discussed her role of being a mother and the issues and difficulties she had with her children. In light of her parental responsibilities, Linda did not believe there was anything she could do in her current situation to make life better. She appeared quite passive, reporting believing that only time would help improve her mood as then her children would move out of home. Linda reported life might be better when not responsible for them any longer, even though she engages minimally with them. I drew attention to how she is now considering her situation may be able to improve if particular responsibilities changed. While she was able to consider life may be better, she was unable to identify what she may do with her time. This adds further support to the view that Linda prefers to be passive, as it is the loss of a role and responsibility that may improve mood, rather than engaging in some activity, or new role, that may add a sense of purpose. Following this session I asked Linda to complete the dual-axis model of coping scale, to gain insight into how Linda approaches situations and what strategies she implements to cope with stressors.

In terms of treatment, Linda reported that she is considering ECT at the recommendation of her psychiatrist. She had a course of ECT six years ago and found it helpful.

*Case discussion.*

I spoke with a psychiatric nurse who has known Linda for about 5 years between our sessions. We discussed Linda’s past admissions and the nurse said Linda was normally more isolated than she had been on this admission, and that Linda usually refused to attend group sessions or any joint activity. We discussed how she was engaging more with other clients and engaging in the group sessions during this
admission, which may be related to time we spent challenging her negative thoughts about attending the group sessions and engaging with others.

Session 5: Revision and discharge planning.

I spoke briefly with Linda about the ECT, which she had begun in the week between our sessions. Linda’s mood appeared brighter, with greater range in affect, including some appropriate laughter. While her mood had improved, Linda still reported being unmotivated to engage in activities that she had previously found pleasurable. As Linda was being discharged this week we spent some time reviewing the importance of recognising her variations in mood and sleep and the factors associated with these changes, such as lack of anxiety management. We reviewed the possible activities that Linda may consider engaging with that may lead to improved mood, including contacting her friend.

We also reviewed the coping questionnaire Linda had completed to consider how the information might be incorporated into her treatment plan. The questionnaire results indicated Linda engages in few coping strategies. She reported not using aggressive action, social support, cautious action, avoidance, antisocial action or instinctive action. She reported sometimes using assertive action and social joining, although these behaviours were not apparent in her reports of any coping with stressors. It may be possible to develop Linda’s use of assertive action and social joining through therapy as Linda appears able to identify with them and see the potential role the strategies may have in her life. The restricted range of coping strategies appears more likely to be due to Linda taking a very passive role with any stressors she faces rather than due to having little insight and awareness of her
coping responses. Linda appears to be very passive in her coping with stressors, neither engaging in active coping, nor avoiding the situation. Linda appears to be passive in both seeking social support, as she waits for her friend to call, and she only utilises professional support that is provided to her with no cost. Linda is also passive in decision making, even if the decision relates directly to her, such as the decision to undergo a course of ECT.

We discussed the potential benefits of using positive coping strategies and decided to discuss how Linda may implement them into her life. Linda had been discharged by the following week, and as such we were unable to therapeutically focus on her coping strategies.

*Readmission/ Session 6.*

Three months after Linda was discharged from the hospital, she was readmitted with suicidal thoughts. I met with Linda for one session, and we discussed her concerns with the memory problems she was experiencing with the current course of ECT. The ECT was having some effect on improving her mood, but Linda was finding the memory problems distressing. Linda appeared resistant to making a decision to discontinue the ECT and wanted others to make the decision. She agreed it would be important to talk to her doctor about ECT. Linda was discharged by the end of the week and I did not meet with her again.
Evaluation of Therapy and Reflections about the Role of Social Support and Communal Coping

The therapeutic goals for Linda were to increase her insight into the role that she has in perpetuating her depression, thereby promoting a more active role, and also to increase social interactions to facilitate the exchange of social support. By focusing on both her depression and social support the aim was to intervene in the interaction between depression and social support and promote greater change.

In terms of Linda’s depression, Linda was asked to monitor her mood and sleep patterns and to identify any variation in them. She was also asked to consider what factors might have contributed to these variations. Challenging Linda’s beliefs about her role in her sleep and mood through monitoring patterns was only partially successful as Linda only made note of her sleep patterns. This information was used to demonstrate the role of anxiety in her sleep behaviour, and then implement anxiety management strategies. Relaxation strategies were partially successful, although Linda had difficulty remembering to implement the strategies. Linda’s passive approach was apparent with her reports of inability of monitoring and challenging thoughts, and her view that they were outside of her control.

In terms of social interactions, we challenged Linda’s perception of the group sessions being unhelpful by encouraging her to test her beliefs. Attending the group resulted in Linda changing her beliefs to some extent, with Linda reporting the groups to be somewhat helpful. Linda then began to engage in both the group sessions and with the other clients outside of these sessions. Linda remained resistant to change in other behaviours, such as engaging in previously enjoyable activities,
believing no benefit would come from engaging in activities. Linda appeared to have a strong investment in her passive behaviour, possibly due to the role her passive behaviour played in facilitating the provision of support from others.

While Linda received substantial support from numerous sources, the presence of professional support as opposed to social support is limited, both with regard to furthering the amount of support and the perception of the reason behind support. In professional relationships there is limited opportunity to further the support provided, as the professional determines the boundaries of the contact and support. Another difference in support from professionals as opposed to friends is the recipient’s perception of support from professionals being a requirement of their job, rather than a choice. Perceiving support to be an obligation may limit the perception of being cared for and the benefits associated with the support received. Furthermore, professional support does not empower Linda to make choices and take control, which reinforces Linda’s passive approach to relationships and support.

In addition, the use of professionals to fulfil support requirements decreases the opportunities to engage in communal coping. In professional relationships the difficulties are considered to be the client’s, such as in Linda’s case, and the professionals aim to assist clients in coping with the problems faced. Also, while the responsibility may be that of the professionals and the client in terms of finding strategies to help decrease the depression, Linda’s passive role in her depression indicates she perceives the responsibility to be that of the professionals. Her passive approach was particularly evident when Linda began her third course of ECT that
resulted in memory problems, with Linda taking a passive role in the decision of discontinuing, wanting others to make the decision for her.

Another issue that partially relates to communal coping is Linda's lack of provision of support to others. Research into social support indicates the negative effect of greater provision than receipt (Fuhrer et al., 1999), but it may also be that being a passive recipient of support and not providing support may also have negative psychological consequences. As such, it may be beneficial to assist Linda identify areas in which she can provide support to others.

In relation to the social support dimension of the treatment of depression, there is still a great need for Linda to both seek social support and engage in communal coping. It may be important for increased social support and communal coping to occur in the context of greater engagement of other activities and roles in life; although Linda's resistance to increased activity would need to be overcome. In terms of Linda's limited social network, it would be first important to increase the size of her network so that people were available to Linda. Increasing the support available may be difficult without also decreasing Linda's levels of depression, due to the reciprocal nature between social support and depression (Salovey et al., 2000). Once a support network was established, encouragement to utilise support would be necessary, as may social skills training to increase Linda's ability to effectively communicate her needs and desires.

From consideration of Linda's situation, it appears that an increase in social support would be necessary prior to any encouragement to engage in communal
coping. Communal coping appears to be more comprehensive than social support as it involves reciprocal support and as such, effective use of social support may be a prerequisite for communal coping.
CHAPTER FOUR: DONNA: A MOTHER EXPERIENCING ANGER MANAGEMENT ISSUES

This chapter includes an exploration of the role of social support and communal coping in understanding and treating a woman with anger management issues. Donna was seen for ten sessions as an outpatient at a psychology clinic.

Reason for Referral

Donna is a 42 year old single mother of a son diagnosed with Attention-Deficit Hyperactivity Disorder (ADHD) and Asperger’s disorder. Her son is prescribed Ritalin to manage his ADHD. Donna was referred to the clinic for anger management training, as she found her impulsive and aggressive behaviour was leading to confrontation with others.

Presenting Problem

Donna reported experiencing difficulties managing anger. She has little insight into the underlying reasons behind her anger and is often unaware that her anger is building. Donna reports that her anger just appears and she has no control of her mood and aggressive behaviour. When she first presented at the clinic Donna reported mostly experiencing anger toward her neighbours, whom she reported continually violated the rights of others. To begin with she denied experiencing any anger toward her son, although she came to identify experiencing anger toward her son throughout the therapy sessions.
Presentation

Donna presented as neatly dressed and well-groomed. Donna appeared somewhat frustrated and tense. Donna's speech was pressured, speaking fast and forcefully. Her affect was appropriate to the content, showing frustration when discussing difficulties with her son's behaviour and the lack of support available. Donna's thought processes appeared normal in terms of stream and form. Her attention, concentration and memory were normal.

Background to Presenting Problem

Donna reported always being able to control her anger as she grew up. She reports having experienced anger management issues since the birth of her son eight years ago. Donna's son was diagnosed two years ago with ADHD and then further diagnosed with Asperger's Disorder last year. In the years proceeding these, Donna experienced many difficulties with her son, resulting in much frustration. Since her son was diagnosed with ADHD and Asperger's Disorder, Donna has been able to understand better her son's behaviour, but the diagnoses have also led to the realisation that the behaviour issues will be a long term problem. Donna reports that she feels she uses all her patience with her son and therefore when someone else provokes her, she is unable to retain control.

Personal History

Family history.

Donna grew up on a farm with her parents, an older and younger brother and a younger adopted sister. Donna reported respecting her father and that she was always
concerned about disappointing him. She perceived her father loved her unconditionally, whereas her mother was physically abusive of Donna. Whenever her father went to the pub to drink, Donna’s mother would take her anger toward her father’s drinking out on the children. Donna can remember being hit by any objects that were nearby her mother, including a horse bridle. Donna reported believing she was clothed and fed by her mother but never loved. Donna did not relate to her older brother or have a good relationship with him. She reports he is very much like her mother. He would also tease Donna and was a very angry man, who could not be satisfied. Donna had a much better relationship with her younger brother, with whom she would often unite with against their mother or brother. Donna reports now believing her younger brother had ADHD as a child, as he could never pay attention to anything, did not learn at school and was regularly in trouble. As he grew up he began to lose control of his anger. He has been involved in drugs and theft, and is currently in jail for dealing drugs. Donna had a good relationship with her younger adopted sister when they were growing up, but when her sister reached 18 and became independent she cut herself off from the family and Donna no longer has any contact with her.

Donna left home at 18 years of age and spent twelve years living independently in Melbourne before moving to Queensland when she was 30. During her time in Melbourne Donna was involved in a few short term relationships. When she moved to Queensland she met a man with whom she had a ten month relationship. Donna became pregnant to this man but miscarried twins. A couple of months later the relationship ended, following which, Donna found she was pregnant again. Due to her previous miscarriage and doctors statement at that time that she would be unable
to have children due to medical complications, Donna said she did not believe she would go full-term and therefore did not tell her ex-partner about the pregnancy until she was 7 months pregnant. Donna moved back to Melbourne to have her son, as she wanted to be near family so she could receive support when needed. Donna’s ex-partner said he would be supportive and involved in their son’s life but his new partner has not allowed him any contact with Donna or their son. Donna has had the sole responsibility of raising her son. Donna’s ex-partner has not met his son, which Donna reports is frustrating and disappointing for her.

While Donna returned to Melbourne in order to be closer to her family support network, Donna stated that her mother was very manipulative with the support she provided and she only helped when it suited her. At one stage Donna was unable to get out of bed due to being ill and her mother refused to come and help look after her son. While Donna perceived caring for her son to be her responsibility, she still reached out for support in this role. The rejection by her mother appears to have influenced Donna’s future behaviour as she now rarely seeks support from anyone. While she was once active in seeking social support, she now operates very independently. Similarly, Donna sought her mother’s approval and support for many years, but she reports she stopped seeking her mother’s approval three years ago, at the time of her father’s death. Donna said she has lost respect for her mother and the way she behaved in situations to manipulate others for her own gain.

When Donna’s father died, there were significant implications for the family. In Donna’s view her mother and older brother became more selfish, she said they took all the family money and did not even provide a headstone for her father’s grave. The
lack of headstone was a source of division between family members and resulted in anger for Donna, leading to a complete breakdown of the relationships between Donna and her mother and brother. Donna no longer has any contact with her mother or older brother, but reported still experiencing strong feelings of anger toward them and believes she would be unable to control her aggressive behaviour if she was to see either her mother or brother. She does not have contact with her brother in jail, or her adopted sister who has disowned the family. As such, Donna is isolated from all family members.

*Employment.*

Donna has no qualifications beyond completing high school. She has held numerous jobs of various descriptions, including administration, sales and cleaning roles. Donna currently works four hours a week as a cleaner in people's houses and businesses. She is currently looking for work that is more challenging and that will offer her more hours.

*Social.*

Donna reports having a number of friends but finds relationships with them to be difficult due to her son's behaviour. Most of her friends are unable to tolerate her son for any length of time, leading to Donna feeling isolated and alone with the responsibility of caring for him. When Donna does feel she has the freedom to have a night out when someone she trusts is caring for her son she tends to drink excessively. Donna recognises her alcohol consumption as being a way of escaping from the pressures of her responsibilities.
Formulation and Treatment Plan

Donna reported experiencing anger that she was unable to control, and the anger was directed towards her family due to her perception of their selfishness, her neighbours due to her perception of their behaviour violating her rights and her son due to his difficult and non-compliant behaviour.

In terms of factors that may have predisposed Donna to have anger management issues, the family modelling of anger is important. Anger was either expressed without control, such as by her mother, or it was repressed and dealt with in a passive way, such as the way her father may have used alcohol to escape family pressures. The abuse Donna experienced by her mother and brother may have also predisposed Donna to anger management difficulties, as she was placed in the role of victim for many years.

Donna’s son’s behaviour appeared to be the precipitating factor of her anger issues, as she reported feeling her coping resources were depleted by his behaviour and therefore reported feeling she was unable to manage any other stressors. In addition, Donna sought help from the Outpatient clinic at this time as her son was becoming more stabilised at school, leaving Donna to feel able to invest some time and energy for herself.

Factors that perpetuate Donna’s anger management difficulties include the low support she receives with caring for her son. Donna not only has the responsibility of being a sole parent, she has the responsibility of a son with behaviour problems. The ongoing behaviour issues with her son also perpetuate her anger.
In terms of protective factors, Donna does have some friends with whom she can have a good time. While they only provide limited tangible support with occasional baby-sitting and limited emotional support in terms of helping Donna cope with the difficulties she faces, they are able to help her have a good time and enjoy life.

Our therapeutic goals were to gain an understanding of Donna’s anger, find strategies to help her cope with situations that provoke anger, and to maximise the benefits of the support Donna does have available.

_Treatment_

_Sessions 1 & 2: Assessment of issues and concerns._

Donna spent some time discussing her son and his behaviour but was unable to acknowledge that he was source of her anger at this point. She said that caring for him is difficult, as she constantly needs to find new strategies to manage his behaviour. Donna also reported feeling isolated as she is unable to go out and socialise much and she finds other parents and children do not want to spend time with them due to her son’s difficult behaviour. Donna perceives herself to be alone, and needing to face stress and difficulties with her own resources as there is no one else who can be relied upon.

Donna also reported her family life as being of concern, as she no longer has contact with any family members. When growing up Donna reported loving her father and respecting him a great deal. Her father died three years ago. Her
relationship with her mother was abusive, and her brother often victimised Donna. Since her father’s death, Donna no longer associates with her mother and older brother, as she considers they were selfish, placing their own desires ahead of respect for her father. Donna no longer sees her younger brother, as he is in jail. Her younger adopted sister has distanced herself from the family, so Donna no longer sees her.

We discussed Donna’s relationship with her son’s father, and how the lack of contact leads Donna to feel guilty and disappointed that there is no father involved and that her son does not have a male role model. Donna is particularly concerned about the impact of no male role model as her son goes through adolescence, and has requested a male teacher to help provide some degree of role modelling from a male. Donna considers it to be her responsibility to have all of her son’s needs met, and as she perceives there to be no available support in meeting his needs, Donna often feels frustrated and overwhelmed by the responsibility.

Sessions 3 & 4: Exploration of anger.

We spent two sessions exploring Donna’s anger. In the first session we explored the messages Donna’s family has provided about anger. Donna has only seen anger being expressed without control from her mother and brother, or has seen it repressed by her father, who was a very passive man and constantly avoided home by going to the pub and drinking. As her younger brother grew up and was able to confront his older brother, he also began to express anger without control. In other words, Donna grew up in a very angry household, in which anger was used to get one’s own way and to communicate needs. Donna reported always experiencing anger, but that she was good at controlling it until the birth of her son. Donna considers her difficulties
began at this time as she was investing all her energy and patience into caring for her son and felt like the pressures of life exceeded her coping resources.

We also spent time exploring Donna’s current feelings of anger, the situations that provoke anger and how she deals with the anger she experiences. Donna again reported anger at her neighbours and how she is unable to process these feelings without expressing them to the person who has made her angry. We discussed the process about how Donna reports not feeling much anger toward her son, but that she spends most of the sessions discussing her son and his behaviour. When questioned in detail about her responses to her son’s behaviour Donna was able to recognise she sometimes reacts to situations badly. Through a discussion of her reactions Donna was able to identify that she does experience anger toward her son. Donna appeared to have difficulty accepting the anger she felt toward her son, and appeared to be quite defensive of the feelings she experienced. We talked about how when faced with a chronic issue where coping resources are demanded, stress is constant, and therefore any additional pressures can lead to feelings of being out of control. We discussed how feeling solely responsible for her son was depleting her resources and exacerbating these feelings of difficulty in coping.

*Sessions 5 & 6: Psycho-education about anger.*

We spent two sessions exploring anger from a psychological perspective. We looked at the positive and negative role of anger, the factors that may lead to anger, what happens within the individual when experiencing anger, and what may be done to help anger be used in a positive, rather than negative way.
Within these two sessions we also discussed how Donna could utilise the limited support that is available to her, such as after school care and occasional baby-sitting from friends. Donna reported some anxiety about leaving her son with other people as most people did not understand Asperger’s Disorder and therefore were unable to respond appropriately to his needs. We talked about ways in which this difficulty may be overcome, such as by providing carers with some information about Asperger’s Disorder, and then at the same time learning to let go of full responsibility. It appears Donna has learnt to be solely responsible for her son for so long that she now has difficulty utilising and seeking support. Donna was encouraged to seek support from a friend who was living temporarily with her and her son due to housing difficulties, and ask her friend to look after her son for an evening to allow Donna to catch up with another friend.

Sessions 7 & 8: Understanding Donna’s anger.

Building upon previous discussions about anger, in these two sessions we explored what triggers and maintains Donna’s anger. We then looked at some of the strategies that may be used to cope with anger, helping Donna avoid feeling anger when it is not helpful and then expressing anger in a positive and helpful way when the situation would benefit from expression of anger. Donna was asked to keep an anger diary to allow insight into the triggers of her anger.

We continued to discuss Donna’s utilisation of support and she reported she had asked her friend living with her to care for her son, allowing Donna to catch up with another friend. Donna reported feeling liberated at being able to do this and agreed to
continue to look for opportunities in which she could meet her own needs, rather than focusing solely on the needs of her son.

Sessions 9 & 10: Development and utilisation of anger management strategies.

Donna recognised the need to acknowledge her anger and analyse it more closely. From her anger diary it appears Donna experiences anger mostly when she is tired or when she feels guilty about feelings of anger. When she is tired Donna finds it difficult to think through the implications of her response to others’ behaviour. We discussed the importance of taking time out and ensuring her own needs were met. We also looked at identifying warning signs and then strategies that Donna may be able to use to avoid expressing her anger in a way she would later regret. One of the strategies Donna thought would be helpful was walking away, and counting to ten. Donna tried this on a couple of occasions and found it to be helpful.

The other main situation in which Donna feels her anger becomes out of control is when she feels guilty about experiencing anger. Donna mostly feels guilty about anger when she responds in anger toward her son, as she feels his behaviour is not his fault but is a result of his Asperger’s Disorder. Donna reported perceiving most of her son’s behaviour to be due to his Asperger’s. Donna appeared at times to use the explanation to justify his behaviour, rather than to encourage her son to be involved in strategies that may help both of them to cope better with the situations they face. Through discussion Donna was able to identify that it is okay to experience anger when she feels her needs are being violated or when everything seems too hard. Donna decided to try and channel her anger into an appropriate and helpful response, such as trying to help her son understand how his behaviour can affect other people.
Challenging Donna’s belief that anger is always negative and destructive, and promoting a more adaptive belief about anger that included the potential benefits of anger if expressed appropriately led to Donna feeling a reduced sense of guilt about the anger she was experiencing. This in turn reduced the level of anger she experienced.

While Donna has limited support available to her and does feel the sole responsibility of caring for her son, Donna was able to recognise that she had not been utilising the support available to her. Donna recognised this was due to feelings of guilt of not being able to do it on her own. While Donna was still in a position where caring for her son was her responsibility she was better able to accept and seek support from others in coping with some of the difficulties she faced. Utilising support from others led to Donna investing more energy into meeting her own needs and therefore greater satisfaction. This greater satisfaction in turn increased her tolerance of her son’s behaviour, leading to less anger and frustration.

_Evaluation of Therapy and Reflections about the Role of Social Support and Communal Coping_

Donna presented to the outpatient client for anger management training. Since her son’s birth eight years ago, Donna has had difficulty controlling her anger. Her son was diagnosed with ADHD two years ago and with Asperger’s Disorder one year ago. The diagnoses of ADHD and Asperger’s Disorder helped Donna to understand her son’s difficult behaviour, but she still finds herself becoming angry. She reports feeling she uses all of her patience with her son, and therefore has none in reserve for
other confrontations. To begin with, Donna reported not becoming angry at her son, or at her situation, but throughout the sessions Donna was able to recognise anger she felt toward her son. Throughout the sessions we explored Donna’s anger as well as implementing some anger management strategies.

In terms of support, both emotional and tangible support may have an important role in improving Donna’s psychological well-being. Unfortunately, while Donna reported having friends, she also reported feeling isolated in her role as a single mother. Donna does not feel she has adequate support around her to assist her in her responsibilities. Having a child with a disability is associated with both greater need for support and lower provision of support (Fox, Vaughn, Wyatte, & Dunlap, 2002). As such, there is often a greater discrepancy between ideal support and actual support received in terms of both the function of the support and the amount of support.

Furthermore, it is also less likely for Donna to be able to engage in communal coping as people often distance themselves from Donna and her son due to her son’s behaviour. Also Donna’s resources and energy are often depleted from caring for her son that she does not have the resources to provide support to others. While there is the potential for someone else to step into the role of sharing both the problem and the responsibility with Donna, it is less likely due to her son’s disability. As such, the goals were to increase Donna’s use of social support, rather than encourage communal coping. It appeared that establishing and utilising a social network was more important for Donna in the short term.
While it is more difficult for Donna to utilise social support and communal coping due to her son's disability, the therapy focused partially on ways in which the support available could be maximised. Beyond anger management we looked at the resources Donna had available to her, including opportunities to develop a friendship network and the social support that this would provide. As Donna is a single mother she feels that she does need to do things alone. This sense of isolation with responsibility has been reinforced by her mother, who would not provide support even Donna sought support. In addition, Donna has found other parents and children to distance themselves from herself and her son, due to his behaviour, resulting in Donna feeling quite isolated. Donna reported having a small number of friends, but reported having difficulty spending time with them, as she had to find activities suitable for her son to do, or find someone to baby-sit, which she reported was difficult. It appeared Donna was somewhat apprehensive about seeking support as she was unsure people would be able to cope with her son's behaviour, and also because she had learned to be independent following rejection from her mother. As such, we discussed the importance of using support in terms of her own well-being as it would enable her to take more care of herself and therefore have more resources, including patience, available for her son. We also spoke about ways in which Donna may utilise the support available more effectively, such as after school care. Donna agreed to ask a friend to look after her son, which enabled Donna to socialise. Donna found this beneficial and was able to seek support more frequently. She also did some research into after school care and planned to gradually introduce it into her son's life.
In summary, while Donna was willing to seek support within the available options and try to use it in the most effective way, there were still barriers that limited her options. Having a child with a disability can be quite isolating, as people often distance themselves. Furthermore, being a single mother reduces the available support and in particular limits the opportunities to engage in communal coping. There is limited opportunity for Donna to share the problem of her son’s behaviour, and while at times she may be able to share the responsibility by seeking support, in general it is her responsibility.

In terms of future directions, Donna would be encouraged to continue to seek further support where available, using it in the most effective way. It may also be helpful for her to connect with other mothers of children with disabilities, so that there may be a shared understanding to increase the potential for communal coping.
CHAPTER FIVE: A GROUP FOR MOTHERS WITH POST NATAL DEPRESSION (PND)

This chapter includes an exploration of the role of social support and communal coping for a group of women with Post Natal Depression (PND). The group consisted of five women, who were all experiencing PND following the birth of their first child. The purpose of the group was to provide a supportive environment in which the women could learn strategies to help alleviate their depression, and to help them cope with parenting and offer support to one another within a communal orientation. Some of the activities were based on Cognitive Behaviour Theory (CBT) and these included identifying and challenging negative thinking; other activities involved relaxation, assertion training and learning to increase positive experiences.

Firstly, the members of the group will be introduced, then the potential role of social support and communal coping in group settings will be discussed. Following this the group sessions will be described, drawing attention to the role of social support and communal coping. Finally, a summary will be presented looking at the role of social support and communal coping in a group for women with PND.

Introduction to the Members of the Group

Each of the five members of the group were first time mothers and had babies between the ages of 8 weeks and 8 months. The women were referred to the clinic by their Maternal and Child Health Nurse for assessment and treatment of PND.
Belinda is a 32 year old mother. She and her husband spent five years trying unsuccessfully to conceive after which time they sought IVF treatment. Belinda and her husband became pregnant with twins through IVF. Belinda's pregnancy with fairly uneventful, but she had an emergency caesar at 36 weeks due to medical complications. Belinda said she found it very difficult to seek help and support even when she felt she was not coping with the twins. She eventually asked her mother and mother-in-law for help but experienced some feelings of guilt about not being able to do it on her own. Belinda perceived her mother as being a mother who was able to cope with everything, making it more difficult for Bclinda to seek support from her mother, due to feelings of inadequacy. Belinda reports her husband to be supportive but that sometimes he does not realise how much support and help she needs. Whenever Belinda expressed a need to him, he would respond to the best of his ability.

Danielle is a 32 year old mother, and she and her husband had a long distance relationship during the pregnancy due to her husband's work. The long distant relationship added a lot of stress to the relationship and decreased the available support to Danielle. Just before the birth Danielle moved to Melbourne to be with her husband. As a result of this move, their child was born away from all of their family and friends. Danielle reported always being an anxious person but found she was unable to cope with the anxiety and depression following the birth of her son.

Jessica is a 29 year old mother, and she and her husband had not planned to have children at this stage and had only just married. Throughout Jessica's pregnancy they moved house three times as they were in the process of renovating their own house.
They spent some time living with Jessica's parents but this became stressful so they moved in with a friend for a period of time. During the time with their friend Jessica fell down the stairs and due to concerns about the risk to the baby they moved back into Jessica's parents' house. They remained living there until their son was about 5 months old. In addition to the stress of an unplanned pregnancy and their living situation, Jessica found it difficult to adjust to being dependent on her husband. She reported finding it stressful losing her income and needing to be financially dependent.

Katie is a 34 year old mother. She and her partner had not planned to have children at this time and they found it difficult to adjust to the pregnancy. Katie experienced complications throughout both the pregnancy and the labour. She also had difficulty with her daughter, experiencing sleep and feeding difficulties. Katie was able to seek some support from her mother, but this was limited as her mother was caring for her step-father who had cancer. Katie reported inconsistent information about her partner, on one hand saying he was supportive and on the other sharing examples of when she felt unsupported, suggesting a discrepancy between actual and ideal support.

The fifth member of the group is Michelle, a 32 year old mother. Michelle and her husband planned to have a child, but did not expect the complications they experienced with the pregnancy, labour and parenting. Michelle had a somewhat similar experience to Katie in terms of pregnancy, labour and feeding. She also had many medical complications and struggled to cope. Furthermore, Michelle's mum was also only available to provide support in a limited capacity, as she was caring for
her husband who had cancer, which was only diagnosed during the pregnancy. Michelle experienced a lot of guilt about utilising support, particularly from her mother. She also felt guilty, as she perceived herself to be a failure as a mother as she was unable to breastfeed.

Using Social Support and Communal Coping as a Conceptual Framework

The group setting allows a unique opportunity for people to provide and receive social support, and it also allows the potential for communal coping to occur, in which the group members work together to help overcome the difficulties of members of the group. While the opportunities are present for the exchange of support, it is still important that the members be open to utilising the support. While social support may be available, it is the effective utilisation of the support that is important for psychological well-being.

Groups may be focused on many different areas, and as such provide different functions. Groups have the opportunity to provide each of the different functions of social support. There is opportunity for emotional support by listening and acknowledging the difficulties the other members are experiences. There is also opportunity for informational support, such as within this group which is based on looking at strategies to cope with PND. Tangible support may be able to be provided by members of the group, such as a mother offering to baby-sit another mother’s child. With research showing that emotional support being the most important influence on women’s depression (Antonucci et al., 1997), it is important that a
supportive environment is fostered in which the women are able to share their difficulties.

While social support would ideally be available and utilised within the group context, there is also an opportunity for members of a group to join together and engage in communal coping. In terms of a group for women with PND this may involve taking on a problem as a group, such as a mother’s difficulty with her baby’s sleep behaviour. Further to this, the women would then take on the responsibility of the situation and seek to find solutions or strategies to decrease the difficulties of the baby’s sleep problems. The group format also offers the opportunity to observe other women, who may be perceived as capable, express their difficulties in coping with parenthood. Hearing other women express similar difficulties enables a feeling of not being alone with the difficulties experienced.

While both social support and communal coping may occur within a group context, these processes are not automatic. It is important that groups are run with consideration of these factors and that the members are encouraged to work together. In addition, the group needs to be willing to engage with each other, both in terms of support provision and receipt.

*Group Therapy Sessions*

*Session 1: Introduction.*

The purpose of the first session was to introduce ourselves and for the members to get to know a little about each other. There were two therapists and the five
women. Each of the members of the group had an opportunity to talk about the difficulties they had experienced during the pregnancy, the labour, and events since the birth of their children. The benefits of the group process were apparent as the women were able to realise they are not the only ones who have struggled with being a mum. Michelle and Katie found it particularly helpful to identify the similarities in their experiences.

Session 2: Positive experiences

The second session involved looking at the amount of positive experiences included in each of their days, and then identifying strategies to increase the number of positive experiences. The group also shared how their week had been and what their mood had been throughout the week. There was quite a variety of responses with Katic reporting a bad week as her partner had lost his job, and she had found her job is no longer available, whereas Danielle reported a good week, with some low periods but generally quite positive.

Session 3: Relaxation strategies

The third session consisted of learning relaxation strategies, both for scheduled relaxation time, but also for situations evoking feelings of anxiety. Some members of the group reported being sceptical about the benefits of relaxation, particularly Jessica, but reported being willing to give it a try. Each of the women reported they had engaged with people more during the past week and they had tried to increase the number of positive experiences. Each woman reported the activities had a positive effect on their mood.
By the end of this session the group had become quite cohesive and supportive of each other, so much so that the women all exchanged phone numbers and talked about getting together to have lunch one week. The generalisation of support within the group sessions to support at home is encouraging.

(Session 4: Assertion training)

In the fourth session we looked at assertive communication and how it differs from passive and aggressive communication. Most women in the group reported generally being passive, particularly surrounding issues with their child. All the women, apart from Jessica, reported wishing they had been able to communicate assertively about breast feeding, as they had all tried to breast feed and had been unable. They reported believing that assertive communication would have decreased the stress and pressure they experienced about feeding. Jessica reported difficulties being assertive with her mother who kept providing advice that Jessica did not want to use. We practiced assertive communication with role-plays, and each of the mothers reported they thought the skills they learnt would be beneficial.

In terms of mood, Danielle, Belinda and Jessica reported having had a good week and had found the relaxation strategies helpful, even though Jessica had been dubious about their benefit. Both Michelle and Katie appeared depressed. Katie stated at the end of the group that she had managed to find a job, but she had mixed feelings as it would mean she would no longer be able to attend the group, which she was really valuing. The group agreed to keep in contact with Katie. This commitment to remain in contact shows the way in which the group had identified with each other and considered each other to be a part of their support network.
Session 5: Family messages

In session five we discussed how family upbringing and values shape parenting, and how the different experiences of a husband and wife may lead to differences of opinion about how to raise their child. Through discussing family experiences we identified unhelpful beliefs. Each of the women were able to recognise unhelpful beliefs they had developed through their upbringing, such as, “if my baby cries my baby is a bad baby, and that makes me a bad mother”. We spent some time challenging these beliefs and substituting them with more realistic and appropriate beliefs. Belinda reported she had begun to change some of her beliefs. Belinda reported she used to believe that seeking help means she had failed as a mother, but that she could now acknowledge that seeking help did not mean she had failed as a mother, and she was now slowly learning to seek support. The difficulties Belinda experienced in utilising support demonstrates the complexity of social support, not only does it need to be available and appropriate to the needs of the person, but the person also needs to feel able to accept and utilise the support.

The group found this session to be emotionally draining and by the end of the session they reported feeling exhausted. At the same time they were each motivated to practice their new thoughts during the week. The mood of each member of the group appeared to have improved, and each reported doing more activities at home and with friends and reported enjoying activities more.

Session 6: Negative thoughts

In session six we used two case studies to look at the negative thoughts of hypothetical mothers. These scenarios were used as a stimulus for discussion about
the negative thoughts members of the group experience. Each member of the group could identify with one or both of the case studies. They also reported feeling that they found it too hard to implement the strategies they had been equipped with, and at times questioning the usefulness of the techniques. We discussed some ways to practice and encourage the use of strategies, even when it was difficult, such as putting reminders on the fridge.

Each of the women in the group reported stress at home related to the husband’s work. They found the difficulties at home sometimes competed with their ability to care for themselves and receive the support they felt they needed. We discussed these stressors, and the members of the group appeared to benefit from knowing that the other women in the group were in a similar situation. The women began to provide suggestions and support to each other, and appeared to take an interest in each other’s problems. This exchange was an example of the women adopting a sense of communal support.

Following this session all the women went to Michelle’s place to have lunch. The support apparent within the group sessions was beginning to generalise to the home environment.

Session 7: Positive vs negative thoughts

We looked at all the thoughts the women could remember from the morning prior to attending the group, and then distinguished the positive from the negative. The mothers still reported more negative than positive thoughts, so we spent time challenging and reframing their thoughts. Belinda reported equal positive and
negative thoughts and reported an instance where she used effective assertive communication with her husband. The group encouraged and supported Belinda for her success and the group appeared to take some ownership of the success. The shared ownership supports the cohesion that had developed in the group and the way in which communal coping was beginning to operate.

On the whole, the group members appeared quite happy and while there were some difficulties that each woman had faced, they had managed to utilise strategies and had found the situations had not had a detrimental effect on their mood. Jessica, on the other hand, appeared quite flat and very tired, she reported frustration with her husband and felt he was not being sufficiently supportive. The group worked together to help Jessica challenge some of her thinking and help her determine strategies that may help their relationship. Jessica appeared appreciative of the supportive group environment in which she could discuss her feelings, as well as receive emotional and practical support.

Session 8: Revision of challenging negative thoughts

Negative thinking was challenged again in session eight. It was a session in which the group was able to present thoughts they were struggling with that were preventing their progress in managing their depression. Michelle did not attend as she was unwell. Katie returning to the group, presented as quite depressed. This low mood was due to losing the job she had just started. She had been told she did not meet the requirements of the position. The remainder of the group appeared generally positive with Danielle, Jessica, and Belinda reporting a good week. We used Katie’s situation to challenge negative thoughts, although Katie had difficulty identifying her
thoughts and then also had difficulty challenging and substituting negative thinking. The group tried to assist Katie to identify how she may be feeling following losing her job, but Katie appeared resistant. While she was quite negative in her language and her affect was flat and depressed, Katie reported her mood was okay and that she would rate it about 6/10, indicating being more happy than depressed. It appeared Katie felt she needed to put on a positive face, as the other women in the group all appeared to be coping much better. While the other women tried to provide a supportive environment in which Katie could ventilate her frustration, Katie appeared resistant to accepting support, which demonstrates the importance of being receptive to the support offered and utilising it effectively. At the end of the session it was recommended that Katie consider some other support, such as individual therapy, to allow her to learn the skills and strategies she had missed by being away from the group.

Session 9: Goal setting and conclusion

As this was the last session, we discussed the anxieties the women may be experiencing about the structured and therapeutic part of the group coming to an end. Each of the women reported some concern that they might go back to where they had come from in terms of depression and they were worried what they would do without the structured support of the group. Each of the women reported significant improvement in mood throughout the nine sessions and felt they had benefited significantly from the group. We spent some time looking at possible coping strategies, including continued contact with group members, and also challenging negative thinking about their ability to cope. While the structured part of the group had come to an end, the women found comfort in the fact they could still be in
contact with each other and continue to be supportive of each other. The women engaged in communal coping by together determining a solution for their fears about the group coming to an end.

We then spent some time looking at each woman's short term and long term goals, discussing ways in which she could achieve her goals. The group was again very supportive, trying to determine the best way of achieving each woman’s goals.

*Evaluation of Therapy and Reflections about the Role of Social Support and Communal Coping*

The group processes and dynamics allow a close look at how social support and communal coping may operate within a support group. In terms of the factors the women identified as contributing to their depression, lack of support and isolation was a clear theme. All of the women had difficulty adjusting to their new role as mother and found they did not have the support they ideally needed. As a result of the depression, as well as the complications of caring for a child, each of the women reported decreased social involvement. Social involvement can be both a source of stress and a source of support, consisting of both positive and negative interactions. Throughout the sessions each of the women reported increased social activities and reported the increased activities had a positive impact on their mood.

The group itself operated as a source of support for each of the women, as can be determined from their concerns about the group coming to an end, and Katic’s concerns about not being able to remain in the group due to work commitments. The group offered an environment in which emotional support was provided, as was
informational support. The literature supports the beneficial role of emotional support, particularly for women’s emotional well-being (Antonucci et al., 1997). Women who received emotional support experienced lower levels of depression and this was evident within the group setting.

The dynamics of the group changed throughout the nine sessions. At the beginning of the group, the women looked to the two therapists for guidance and support and then throughout the nine weeks they were able to look more and more to each other for support. This shift was especially apparent by the group’s decision to exchange phone numbers and have lunch together.

The group appeared to move beyond simply providing support to each other when requested or when the need was apparent. Over time the women appeared to take on each other’s problems and consider them to be the difficulty of the group that they could face together. The sharing of each other’s problems generally occurred with stressors and situations that each member of the group could identify with to some extent, such as the impact of husband’s work stress on their own coping, and what could be done to look after their own well-being.

Overall the group appeared to be effectively providing support to each other, in particular emotional support. There also appeared to be the beginnings of communal coping in which the problems of individuals within the group where considered to be the problems of the group which would be faced together. While there are potential costs associated with the provision of support (Rook, 1994) and with communal
coping (Lyons et al., 1998), the women in the group appeared to benefit greatly from the group dynamics.
CHAPTER SIX: CONCLUSION ABOUT THE ROLE OF SOCIAL SUPPORT
AND COMMUNAL COPING IN PSYCHOLOGICAL WELL-BEING

The cases presented in this portfolio have highlighted the importance of social support and communal coping in the treatment of psychological problems, and the transition to psychological well-being. In the case of Ben, it appeared that ineffective use of his support networks was contributing to his depression, whereas Linda appeared to not perceive that support was available from her friends and family. On the other hand, Linda was receiving high levels of support from professionals, which had the negative effect of increasing her passive role in coping with her difficulties. In the cases of both Ben and Linda broader issues than social support and communal coping were impacting their psychological distress, and as such the consideration and therapy in relation to social support may have not been considered to be pertinent at that time by Ben and Linda. In Ben’s situation the desire for reconciliation with his wife and for improved health and work situation were of paramount importance. As such, intervention within a social support framework may have been more beneficial following resolution of these issues. Similarly social support may not have been successful at this time for Linda due to the severity of her depression. While her depression was being treated with anti-depressants and ECT, it may have been more appropriate to ensure stability of mood prior to focusing on social support. Furthermore, greater focus on changing her passivity may have been beneficial in conjunction with therapy from a social support framework.

In the other two cases the focus on social support was more successful, and in each case the lack of social support was of primary concern. Donna appeared to lack
support in her role of single mother of a child with a disability, yet at the same time she did not appear to effectively utilise the support that was available to her. For the women in the PND group, each of the mothers reported feeling inadequately supported and perceived this lack of support to have contributed to their depression. In each of the case studies, the relationship between both low levels of support and ineffective utilisation of support, as well as poor psychological well-being has been a contributing factor.

While the negative impact of low support on well-being was apparent in each of the cases, the benefits of increased support throughout the therapeutic relationship were not so clearly evident. The lack of benefit from social support appeared to be related to continual ineffective use of support, such as that by Ben and Linda, which, as stated above, may be related to the dominance of other issues. Both Donna and the women in the PND group increased their utilisation of support and were able to see the positive impact social support can have on psychological well-being. While social support does not remove the stressors and difficulties that people face, it does provide support with coping with stressors, reducing their negative impact.

Social support allows an understanding of factors that relate to the development of psychological difficulties, and allows some insight as to how psychological well-being may be improved. In each of the cases there was a lack of support or a perceived lack of support that may have been contributing to the clients' psychological difficulties. At the same time, social support is a somewhat limited concept, as it does not take into account the complexities of the social relationships in which we engage. Communal coping, on the other hand, allows both the appraisal
and action component of coping to be considered from a social perspective. The benefits of communal coping were apparent within the PND group, as they were able to receive the benefits of social support as well as the benefits of feeling connected, the sharing of difficulties, and the collaborative approach to solving problems.

In terms of the cases discussed, the negative impact of not utilising communal coping in a marriage relationship is evident in Ben’s case. While married he was unable to conceptualise his back injury and unemployment as an issue that he and Rebecca could face together, and as such engaged in very individualistic and unhealthy coping strategies. His unhealthy coping strategies contributed to their separation, removing his opportunity to engage in communal coping with his wife. He was unable to receive the benefits of communal coping, such as improvements to his psychological well-being, as there was no longer an ‘us’ with which to engage in communal coping. Neither Linda nor Donna appeared to engage in communal coping, which appeared to be related to passive unhealthy coping strategies for Linda and due to the difficult circumstances of raising a child with a disability for Donna. The ability to engage in communal coping presumes sufficient psychological and physical strength to be involved in the interactions of support. The group was the one case where the effective use of communal coping emerged strongly. Throughout the group processes, communal coping emerged. The group began to see their difficulties as difficulties that could be shared by the group and with which the group could determine strategies to overcome. Examples of this consist of the decision to keep meeting as a group in response to the women’s fears of losing the support and the effect the loss of support may have on their well-being. It appeared that the
development of this coping style was associated with further improvement of psychological well-being for the group.

In summary, both social support and communal coping appear to be useful concepts in both the consideration of clients' difficulties and in their treatment plan. However, there are limitations in relation to the need for other issues to be resolved and for sufficient psychological and physical resources to be available. Communal coping appears to be a higher level of coping, as it may involve social support, but also involves taking on the problems as a group, and as such development of adequate social support appears to be a necessary first step. Additionally, communal coping appears to emerge more easily in a group in which the clients are presenting with the same issue, as the clients are on an equal level with the objective of working on the same basic issues.

Further exploration of these issues would ideally involve consideration of strategies to develop the structural component of social support, as a support network is a necessary first requirement of utilising support. Additionally, further exploration of the factors necessary to engage in communal coping would be helpful in determining how best to assist clients develop this coping style.

Social support and communal coping are just two factors that are involved in clients' well-being and psychological adjustment. They may precipitate or perpetuate client difficulties, or on the other hand may protect them and promote well-being. The case studies explored in this professional portfolio indicate that these factors do
play an important role and therefore should ideally be considered in relation to clients' therapy.
References


