McNair Scholars Journal

Volume 15 | Issue 1 Article 2

2011

Conversation Elaboration and Emotional Well-Being In Perceived Social Support

Justin P. Andrews
Grand Valley State University

Follow this and additional works at: https://scholarworks.gvsu.edu/mcnair

Recommended Citation
Andrews, Justin P. (2011) "Conversation Elaboration and Emotional Well-Being In Perceived Social Support," *McNair Scholars Journal*: Vol. 15: Iss. 1, Article 2.
Available at: https://scholarworks.gvsu.edu/mcnair/vol15/iss1/2

Copyright © 2011 by the authors. McNair Scholars Journal is reproduced electronically by ScholarWorks@GVSU.
https://scholarworks.gvsu.edu/mcnair

Conversation Elaboration and Emotional Well-Being In Perceived Social Support

Justin P. Andrews
McNair Scholar

Brian Lakey, Ph.D.
Faculty Mentor

Introduction

Social support is an extremely diverse topic. It is the subject of approximately forty thousand scholarly articles when entered into the Grand Valley State University library database under the keyword, "social support." For example, social support has been linked to positive psychological health and low rates of disorders (Barrera, 1986; Finch, Okun, Pool & Ruehlman 1999; Sarason, Sarason & Gurung, 2001), major depression (Lakey & Cronin, 2008), and posttraumatic stress disorder (Brewin, Andrews, & Valentine, 2000). Also, people who do not have a strong social support system are subject to general psychological distress (Barrera, 1986; Cohen & Wills, 1985; Sarason et al., 2001).

There are three different constructs of social support (Barrera, 1986): social integration, perceived support, and enacted support. Perceived support is the only subconstruct that is consistently associated with psychological health regardless of the presence of stress (Finch et al., 1999). Perceived support does not just influence psychological health during periods of high stress (Burton, Stice, & Seely, 2004).

Perceived support consists of three influences: provider influences, recipient influences, and relational influences. Provider influences reflect agreement that some providers are more supportive than others; this is an indication of objective supportiveness. Recipient influences are the degree to which perceived social support reflects a recipient's personality. Relational influences are the extent to which a recipient perceives a provider as more supportive than the recipient perceives other providers and as more supportive than the provider is perceived by other recipients. Perceived support mainly consists of relational influences.

Social support is currently explained through the stress buffering theory (Lazarus, 1966; Cohen & Willis, 1985). Stress buffering is a theory of stress that occurs when individuals are better insulated or equipped by social support to deal with hazardous effects from stress. Support for stress buffering has been shown to help people that have poor mental health and a low social support network as opposed to people that have high social support networks (Lakey & Oreheck, 2010).

Social support research has often sought new intervention mechanisms; currently being tested is the relational regulation theory (RRT) (Lakey & Oreheck, 2010). RRT explains the association between perceived support and mental health. RRT accounts for the main effects that happen when people interact through conversations and shared activities rather than conversations about stress coping. Conversations that are unique to an individual and have an emphasis on conversation elaboration rather than on guidance and intervention would support relational influences.

Background and Significance

Individuals who do not have a strong social support system are subject to general psychological distress (Barrera, 1986; Cohen & Wills, 1985; Sarason et al., 2001) and disorders that include major depression (Lakey & Cronin, 2008), substance abuse (Wills & Cleary, 1996), and posttraumatic stress disorder (PTSD) (Brewin, Andrews, & Valentine, 2000). Also, it has been shown that positive psychological health and low rates of psychological disorder have been associated with high perceived support (Barrera, 1986; Finch et al., 1999).

There are three different constructs of social support (Barrera, 1986): social integration, perceived support, and enacted support. The first of these subconstructs, social integration, can be explained as the many types of different relationships or roles that an individual has. For example, a woman could be a wife, mother, sister, daughter, friend, and so on. The second, perceived support, is the most important of the subconstructs in relation to psychological health and disorder (Lakey, 2010). Perceived support is an individual's

personal belief that he/she is cared for and belongs to a social network of friends and family during periods of high stress (Cobb, 1976; Lakey 2010). The last subconstruct, enacted support, relates to the helping actions provided in a stressful situation (Lakey, 2010). Perceived support is the only subconstruct that is consistently associated with psychological health regardless of the presence of stress (Finch et al., 1999). Thus, perceived support does not just influence psychological health during periods of high stress (Burton et al., 2004).

Perceived support consists of three influences: provider influences, recipient influences, and relational influences. Provider influences are the mean difference among providers, averaged across recipients. Provider influences reflect agreement that some providers are more supportive than others and this is an indication of objective supportiveness. Recipient influences are the mean difference among recipients on how they perceive providers, averaged across providers. Recipient influences are the degree to which perceived social support reflects a recipient's personality. Relational influences are the extent to which a recipient perceives a provider as more supportive than the recipient perceives other providers and as more supportive than the provider is perceived by other recipients. Essentially, relational influences are a given person's unique profile for perceived supportiveness (Lakey, 2010). An example of this would be recipient A perceiving provider A as more supportive than provider B, while recipient B perceives provider B as more supportive than provider A.

The most dominant mechanism of social support is the stress and coping theory (Lazarus, 1966; Cohen & Willis, 1985). According to the stress and coping theory, stress occurs when people are better insulated or equipped by social support to deal with the hazardous effects from stress, which specifically supports stress buffering. Support for stress buffering has been found in individuals that have poor mental health and a low social support network as opposed to people that have high social support networks (Lakey & Oreheck, 2010). Essentially, when stress is absent, there is no link between social support and mental health (Cohen & Wills, 1985).

The stress buffering theory is highly developed and has been at the forefront of social support, but there are observable boundaries. Stress buffering utilizes enacted support. Lakey and Cronin (2008) have shown that there is much evidence for linking the main effects of social support with major depressive disorder, as opposed to little evidence for stress buffering (Brown & Harris, 1978). Another limitation is that there is a significant amount of research that has failed to find a link between enacted support and mental health (Barrera, 1986; Finch et al. 1999). Lastly, stress buffering cannot explain the association between mental health and perceived support (Lakey & Oreheck, 2010).

Perceived support mainly consists of relational influences. A mechanism that might be able to explain this is RRT (Lakey & Oreheck, 2010). RRT explains the association between perceived support and mental health. Lakey, Orehek, Hain, & VanVleet (2010) showed that relational influences were the strongest determinants of perceived support at 62% of the variance. Recipient traits influences showed 27% of the variance and influence of providers accounted for 7% variance. RRT accounts for the main effects that happen when people interact through conversations and shared activities rather than conversations about stress coping. Conversations that are unique to an individual and have an emphasis on conversation elaboration rather than on guidance and intervention would support relational influences.

The present study expands on previous research about perceived support and mental health by focusing on the importance of conversation elaboration for perceived support. This was accomplished by utilizing RRT, which describes a mechanism by which perceived social support is linked to better mental health regardless of presence of stress.

Method

Participants

The participants were one hundred male recruits from a company of Infantry Marine Corps Reservists at a Midwestern United States Marine Corps Home Training Center (HTC). The mean age of participants was approximately 23 years old; the majority were of European descent, but eight were of Hispanic descent, two of African descent, two of Asian descent, and one of Native American descent.

Measures

Participants were asked to complete questionnaires pertaining to perceived social support. Measures included demographics that asked about age, ethnicity, and gender. For Perceived Social Support, participants completed the 7 perceived support items from the Quality of Relationships Inventory (Pierce, Sarason, & Sarason, 1991), which is widely used in social support research.

Conversation Elaboration was measured by completing 10 items from the Conversation Elaboration Questionnaire, developed at Grand Valley State University (Sain & Lakey, 2011). The final measure was positive and negative affect, and participants completed 10 items from the Positive and Negative Affect Schedule (PANAS; Watson, Clark, & Tellegen, 1988).

Procedure

Initially, all of the Marines were briefed and asked to sign consent forms. Afterwards, all the Marines in each separate platoon were randomly subdivided into groups of four; this was done to reflect a fire team mindset. Confidentiality was maintained by assigning each Marine a participant number. Thus, when rating each other, Marines sat at a table and each Marine had a number displayed on a lanyard hanging around his neck. Each Marine was given a questionnaire that rated every other Marine within the group of four on four different measures. Participants indicated which target was being rated by writing the subject number on the appropriate questionnaire; thus, the Marines answered questions with regard to Marine 1, Marine 2, etc.

The first measure involved positive emotion experienced (e.g., proud, enthusiastic) when with, or talking to, the specific Marine in question. The second measure was negative emotion experienced (e.g., nervous, jittery) when with, or talking to the specific Marine in question. The third measure was the perceived supportiveness of the specific Marine (e.g., "Can you depend on this person to help you if you really need it?"). Lastly, the fourth measure

was the perceived quality of conversations with the specific Marine (e.g., "When we have a conversation, we can go back and forth for as long as we want"). When each Marine finished the set of questionnaires, they placed them in order according to their group number.

Results

Data was then collected, coded and analyzed using SPSS. Findings were consistent with RRT for relational influences (Table 1). Analysis shows that perceived social support was linked to high positive affect at (r = .517) and low negative affect at (r =.353), and that positive affect and negative affect were weakly correlated (r =.082). Perceived social supports' link to negative affect was lower than the perceived social support link to positive affect. Also, perceived social support and conversation elaboration were highly correlated at about (r =.769). Thus, we can infer that there is significant recipient trait variance for each of these constructs. Of interest is that perceived support is linked to higher negative affect for provider influences. This is consistent with Bolger's effects for visible support (Bolger & Amarel, 2007).

Discussion

The current study demonstrates a useful tool for studying social influences on relational influence and affect that could easily be adopted for use in studying information processing within clinical disorder. These results may help to build the basic science needed to support interventions by providers that match a recipient's unique personality. Some strengths of this study are the large sample size (n=100) and that many of the Marines knew each other for more than three years. The fact that many of the Marines knew each other previously also correlates with a possible weakness. For example, all recipients could have rated the same individual as the best provider. Another weakness is that a few of the senior Marines in this sample had just transferred units and this was their first drill; thus, they had not yet established a social network within the platoon. The last weakness is that this group was not a direct reflection of the diverse demographic within active duty but was reflective of the demographics of the Midwest. Future studies should track participants over a deployment having them fill out questionnaires pre-deployment, in theatre, and post deployment.

Table 1 : Correlation Matrix Predicting Perceived Social Support Among Marines Who Received Conversation Elaboration.

	Conversation Elaboration	Positive Affect	Negative Affect
Perceived Social Support	.769**	.424**	-.352**
Conversation Elaboration		.517**	-.259**
Positive Affect			.082

Note. **Correlation is significant at the 0.01 level (2-tailed).

Appendix

Measures

Demographic Form

How old are you? _____

What is your gender?

Male Female

What is your ethnicity? (i.e.: Polish, African-American, Greek, Hispanic, Irish)

_____

The following are statements about your conversations with participant #_____.

01. How often do you have contact with him?

A. Nearly every day
B. Several times per week
C. Several times per month
D. Less than once per month

02. How long have you known this person?

A. Less than 2 months
B. 2 – 6 months
C. 6 – 12 months
D. 1 – 2 years
E. 3 – 5 years
F. 6 + years

Please read each statement carefully and decide how much you agree or disagree with each.

A – Strongly disagree
B – Mildly disagree
C – Neutral
D – Mildly agree
E – Strongly agree

Conversation Elaboration (Sain & Lakey, 2011)

03. I enjoy talking with him because we have interesting conversations that last a long time.
04. It is difficult to find something he and I both want to talk about.
05. It is hard to have a conversation with him because he repeatedly says things that have no relevance to what I am talking about.
06. When we have a conversation, we can go back and forth for as long as we want.
07. My conversations with him usually end quickly.
08. I hardly ever change the subject when talking to him because he always has something interesting to talk about.
09. It is hard to talk with him because he never has anything new to say.
10. I think about how good our conversations are long after they end.
11. I normally forget our conversations soon after they are done.
12. When we have a conversation I often lose track of time and I don't realize how long we have been talking.

Perceived Social Support (Pierce et al., 1991)

13. To what extent can you count on him to listen to you when you are very angry at someone else?
14. To what extent can you turn to him for advice about problems?
15. To what extent can you really count on him to distract you from your worries when you feel under stress?
16. To what extent can you count on him for help with a problem?
17. If you wanted to go out and do something this evening, how confident are you that he would be willing to do something with you?
18. To what extent can you count on him to help you if a family member very close to you died?
19. To what extent can you count on him to give you honest feedback, even if you might not want to hear it?

Positive and Negative Affect (Watson, Clark, & Tellegen, 1988).
This scale consists of a number of words that describe different feelings and emotions. Read each item and then mark the appropriate answer in the space next to the word. Indicate to what extent you feel this emotion **when you are with or thinking about participant #_____**

A – Very slightly or not at all
B – A little
C – Moderately
D – Quite a Bit
E – Extremely

When I am with this participant I feel…

20. Excited.
21. Ashamed.
22. Upset.
23. Inspired.
24. Strong.
25. Nervous.
26. Guilty.
27. Determined.
28. Scared.
29. Hostile.
30. Enthusiastic.
31. Active.
32. Proud.
33. Afraid.

References

Barrera, M. (1986). Distinctions between social support concepts, measures, and models. *American Journal of Community Psychology,* 14, 413–445.

Brewin, C. R., Andrews, B. & Valentine, J. D. (2000). Meta-analysis of risk factors for posttraumatic stress disorder in trauma-exposed adults. *Journal of Consulting and Clinical Psychology*, 68, 748-766.

Bolger, N., Amarel, D. (2007). Effects of social support visibility on adjustment to stress: experimental evidence. *Journal of Personality and Social Psychology*, 92, 458-475.

Brown, G. W., & Harris, T. (1978). *Social origins of depression: A study of psychiatric disorder in women*. New York: Free Press.

Burton, E., Stice, E. & Seeley, J. R. (2004). A prospective test of the stress-buffering model of depression in adolescent girls: No support once again. *Journal of Consulting and Clinical Psychology, 72*, 689-697.

Cobb, S. (1976). Social support as a moderator of life stress. *Psychosomatic Medicine*, 38, 300-314.

Cohen, S. & Wills, T. A. (1985). Stress, social support, and the buffering hypothesis. *Psychological Bulletin*, 98, 310-357.

Finch, J. F., Okun, M. A., Pool, G. J. & Ruehlman, L. S. (1999). A comparison of the influence of conflictual and supportive social interactions on psychological distress. *Journal of Personality, 67*, 581-622.

Lakey, B. (2010). Social–clinical approaches to social support suggest new strategies for intervention. In J. E. Maddux & J. P. Tangney (Eds.) *Social Psychological Foundations of Clinical Psychology* (pp. 177 – 194). NY: Guildford.

Lakey, B. & Cronin A. (2008). Low social support and major depression: Research, theory and methodological issues. In K. S. Dobson & D. Dozois (Eds.), *Risk factors for depression* (pp. 385 – 408). Personality & Social Psychology Bulletin.

Lakey, B. & Orehek, E. (2010). Relational Regulation Theory: A new approach to explain the link between perceived support and mental health. *Psychological Review, 118*, 482-495.

Lakey, B., Orehek, E., Hain, K., & VanVleet, M. (2010). Enacted support's links to negative affect and perceived support are more consistent with theory when social influences are isolated from trait influences. *Personality and Social Psychology Bulletin, 36*, 132-142.

Lazarus, R.S. (1966). *Psychological stress and the coping process*. New York: McGraw-Hill.

Pierce, G. R., Sarason, I. G., & Sarason, B. R. (1991). General and relationship-based perceptions of social support: Are two constructs better than one? *Journal of Personality and Social Psychology, 61*, 1023-1039.

Sain, T., & Lakey, B. (2011). *A new measure of conversation elaboration.* Unpublished manuscript. Grand Valley State University.

Sarason, B. R., Sarason, I. G., & Gurung, R. A. R. (2001). Close personal relationships and health outcomes: A key to the role of social support. In B. R. Sarason & S. Duck (Eds.), Personal relationships: Implications for clinical and community psychology (pp. 15–41). New York: Wiley.

Watson, D., Clark, L., & Tellegen, A. (1988). Development and validation of brief measures of positive and negative affect: The PANAS scales. *Journal of Personality and Social Psychology, 54*, 1063-1070.

Wills, T. A., & Cleary, S. D. (1996). How are social support effects mediated: A test with parental support and adolescent substance use. *Journal of Personality and Social Psychology, 71*, 937–952.