Social Support and Social Structure:  
A Descriptive Epidemiology*

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Despite a very large and growing literature demonstrating the significance of social support for health and well-being, surprisingly little is known about the social distribution of this crucial resource. This paper presents data on the distribution of social support and support resources across social class, marital status, age and gender, with the aims of contributing toward an understanding of the impact of social structures on processes of social support, and of assessing the hypothesis that epidemiological variations in mental health arise partially from social support differences. The epidemiology of perceived social support was found to correspond closely to the epidemiology of psychological distress and disorder. The single exception involved gender, where a positive rather than negative relationship was observed, with women demonstrating the highest levels of both social support and psychological distress. The observed patterns of variation in social support link this significant adaptive resource to one's locations in the social structure and reinforce the conclusion that it represents a promising intervention target. The practical importance of these results, however, are not matched by theoretical significance. Except in the case of marital status, our findings largely discount the hypothesis that the social distribution of mental health is partially attributable to social support differences.

INTRODUCTION

During the 1950s and sixties a large number of research observations were produced connecting various social statuses with the occurrence of mental health problems. The most persistent and provocative of these linked low socioeconomic status (e.g., Gurin, Veroff, and Feld 1960; Hollingshead and Redlich 1958; Srole et al. 1961; Turner and Wagenfeld 1967) and being unmarried (e.g., Gurin et al. 1960; Farina, Garmez, and Barry 1963; Turner, Dopkeen, and Labreche 1970) with increased risk for both psychological distress and serious psychiatric disorder. More recently, another consistently-observed relationship has been the focus of considerable attention—that between gender and psychological distress and disorder (Al-Issa 1982; Nolen-Hoeksema 1987; Weissman and Kleiman 1977).

For those who have read the available evidence as indicating that social stratification and other structural factors are consequential, attention has turned to the questions of how these factors come to impinge on individual health and under what circumstances such effects are made more or less intense (House and Mortimer 1990). On the assumption that socially-patterned differences in ongoing social experience and in social and developmental acquisitions are likely to be implicated, a
number of hypotheses about the role and significance of psychosocial factors for the occurrence of distress and disorder have been suggested. The factor receiving the most attention, of course, has been social stress, which has been shown to matter for health and well-being, and which is generally assumed to be differentially distributed across social statuses.

Substantial evidence has also accumulated indicating the relevance of social support for psychological distress and well-being. However, based on an exhaustive review of previous work, Vaux (1988:158) has concluded that “relatively little is known about how it varies across subgroups of the population.” A convergent conclusion has recently been expressed by House, Umberson, and Landis (1988:310). They note that “while there is a substantial theoretical base in sociology suggesting that macrosocial features influence social relationships, there is little empirical evidence to substantiate the nature of that influence.” There have, of course, been a number of studies that have provided findings on the associations of one or more of these demographic risk factors with social support. With few exceptions, however, these findings have been incidental to the goals of the studies involved and have seldom been shown to be observable independent of other status characteristics. Moreover, those instances involving explicitly comparative analyses (e.g., Lin, Dean, and Ensel 1986; Ross and Mirowsky 1989) have estimated social support on the basis of only two- or three-item scales.

As in the case of social stress, there are grounds for assuming that variations in the availability and experience of social support arise substantially out of contemporaneous and developmental conditions of life (Pearlin 1989). To the extent that important differences in such conditions are effectively defined by one’s gender and one’s socioeconomic and marital status, the hypothesis follows that observed relationships between these statuses and mental health may arise, in part, from associated differences in social support. The observation of clear linkages between social support and one’s locations in the social world would be consistent with this hypothesis.

In calling for more comparative research on social support, Vaux (1988:158) specifies a rationale involving five elements. Two of these seem especially compelling: (1) the need for information on the plausibility of the hypothesis that epidemiological variations in mental health arise, at least in part, from social support differences, and (2) the possibility of future policy decisions that may target or incidentally influence social support. The latter emphasizes the need to understand the distribution of social support in the community. An equally important rationale is found in the argument of House et al. (1988), that such comparative research represents an important step in illuminating the impact of macrosocial structures on processes of social support. The confirmation of structural linkages would bear upon the likelihood that social support is importantly conditioned by differences in social experience and/or contemporaneous life circumstances. To the extent that social support is linked to social status and/or social group experience, it may be directly relevant to understanding what ties the social conditions of life to variations in health and well-being. The potential practical significance of such information includes the argument that those relevant social resources that arise at least partially from patterned social experience are more likely to be socially or programmatically modifiable and, thus, represent more promising targets for prevention and intervention efforts.

This paper limits consideration to those social statuses that have reliably been shown to distinguish levels of risk for psychological distress and/or disorder. As already noted, social class, marital status, and gender have consistently been linked to mental health status across decades of research involving both treated and community populations. It is these associations that have represented the starting points for much of the mental health research conducted by sociologists and psychiatric epidemiologists over the past 30 years. To these status dimensions we add age because of the growing consensus that, at least among community residents, age is inversely related to depressive disorder (Blazer et al. 1985; George, forthcoming; Myers et al. 1984; Turner and Beiser 1990; Weissman et al. 1991). We present data on the distribution of social support derived from various sources, and of total support, across locations on these four status variables. Evidence on the important issue of the extent to which support differences actually account for the social distributions of psychological
distress and disorder will also be examined. In addition, evidence on the relationships between these variables and the availability of support resources, as distinct from social support, will be summarized.

BACKGROUND

Social support has become an immensely popular and highly important construct within mental health research. Beginning with the classic articles of Cassel (1974, 1976) and Cobb (1976), the number of studies that have examined this variable has grown year by year to the point where literally hundreds of articles are now available in which the significance of social support for health and well-being has been considered (House et al. 1988). Indeed, as Veiel and Baumann (1992:1) have recently noted, “measured by both its impact on current thinking concerning the social etiology of mental and physical disorders, and by the sheer volume of publications, social support has joined stress and coping as one of the three most important constructs in current mental health research.”

While this body of research has advanced our understanding of the significance of social relationships, it has also produced a bewildering array of conceptual and operational definitions (Gottlieb 1983; Turner, Frankel, and Levin 1983). A number of researchers have concluded that social support is a multifactorial construct and described different types or categories of social support that should be considered and that may have differing consequences (Dean and Lin 1977; Pfunch and Mettlin 1982; Hirsch 1980; House 1981; Pinneau 1975; Schaefer, Coyne, and Lazarus 1981). Vaux (1988:28) has recently argued that social support is best viewed as a metaconstruct, “comprised of several legitimate and distinguishable theoretical constructs.” Three such constructs are specified: support network resources, supportive behavior, and subjective appraisals of support. These dimensions or constructs correspond closely with Barrera’s (1986) distinction between social embeddedness (the connection individuals have to significant others or their social environment), enacted support (actions that others perform in rendering assistance), and perceived social support.

We share the opinion that social support phenomena involve objective (actual events and activities) as well as subjective elements, and that an understanding of the significance of social institutions and contexts will ultimately require the consideration of social networks and resources along with perceived social support (Pearlin 1989). However, it has long been recognized that the bulk of evidence pointing to the significance of social support for psychological well-being has come from studies that have focused upon perceived social support (e.g., House 1981). Indeed, studies continue to demonstrate that the most powerful correlations between indices that purport to assess social support and those that assess psychological distress are found with measures of perceived or experienced social support (Kessler 1992). Wethington and Kessler (1986:85) have presented specific evidence for the primacy of perceived over received support in buffering the effect of stressful events. They documented “not only that perceptions of support availability are more important than actual support transactions but that the latter promote psychological adjustment through the former, as much as by practical resolutions of situational demands.”

The fact that perceived support is most persistently and powerfully associated with various outcomes focuses attention on this dimension as a significant dependent variable. Reliably measured, perceived social support represents the most direct criterion for assessing the role and significance of network characteristics, of other social resources, and of support transactions more generally. Thus, our consideration of the epidemiology of social support focuses largely upon perceived social support because it appears to be what matters for health and well-being and because it represents a meaningful criterion by which to identify contributing social actions and circumstances that may constitute promising targets for intervention efforts. As a collateral matter, the social distributions of support network resources will also be considered.

Social Support and Mental Health

As suggested above, an ever-growing number of volumes and reviews leave little doubt that perceived social support is importantly associated with emotional well-being (e.g., Cohen and Wills 1985; Cohen and Syme 1985; Dean and Lin 1977; Gottlieb
1981; Kessler, Price, and Wortman 1985; Sarason and Sarason 1985; Turner et al. 1983; Vaux 1988; Veiel and Baumann 1992). Moreover, combined evidence drawn from laboratory animal studies, experimental human studies, and cross-sectional and longitudinal field studies provides clear support for the contention that some part of the causation involved in the persistently observed connection between social support and mental health goes from support to mental health (House 1981, 1987; Turner 1983).

The question of whether social support impacts directly on well-being or exerts influence primarily by mediating or buffering the consequences of stress exposure remains an issue of some debate. However, it is clear that very few studies have failed to observe one or the other (House and Kahn 1985; Cohen and Wills 1985). In our view the collective evidence on this issue points toward three propositions: (1) social support tends to matter for psychological well-being independent of stress level, (2) support tends to matter more where stress level is relatively high, and (3) the extent to which (1) and (2) are true varies with the nature of stress exposure and across subgroups of the population defined by class level and, perhaps, by other variables (Turner 1983; Turner and Noh 1983).

Social Support and Social Structure

Socioeconomic Status. The fact that socioeconomic status tends to be associated with differences in the responsiveness of the social environment, and in socially significant opportunities more generally, suggests that the structures and processes of relationships may also vary systematically across SES categories. However, evidence on the extent to which the structures and processes of relationships, particularly perceived social support, varies by class status is sparse and contradictory. Some data have suggested that lower SES individuals tend to have social relationships of lesser quality (Belle 1982; Dohrenwend and Dohrenwend 1970) but, based on a large community study, Ensel (1986) reports no class differences in the appraisal of close relationships. Utilizing a reliable two-item measure of perceived social support, Ross and Mirowsky (1989) observed mixed evidence with respect to a social support-socioeconomic status connection. With other demographic variables controlled, level of education was positively associated with support while family income was completely unrelated. Available evidence on SES differences in support resources and social networks is also limited but more consistent. Fischer (1982) found higher income and education to be associated with more voluntary associations, larger networks, and more contact with network members, and other studies have reported similar findings (Dohrenwend and Dohrenwend 1970; Eckenederode 1983; Moody and Gray 1972). However, the conclusion seems warranted that available evidence on differences in perceived social support across socioeconomic groups is too mixed and too limited to allow a confident conclusion.

Marital Status. As House (1981:29) long ago noted, the “minimum condition for experiencing social support . . . is to have one or more stable relationships with others.” Being married usually defines the existence of one such relationship—one in which normative expectations involve the giving and receiving of social support. These considerations are consistent with the assumption of marital status differences in social support that has led some researchers to employ marital status as a complete or partial index of support (e.g., Eaton 1978; Gore 1978; Lynch 1977; Berkman and Syme 1979). However, evidence to justify this assumption is slim in quantity and not entirely consistent. Based on a three-item index of perceived support, Ensel (1986) and colleagues (Lin, Dean, and Ensel 1986) reported highest levels of support among both married men and married women. Positive findings have also been reported by Gerstel, Riessman, and Rosenfield (1985). Married men and women reported more confidants and perceived their support resources as more adequate. Higher levels of perceived social support among married subjects, other social statuses controlled, has also been reported by Ross and Mirowsky (1989). However, contrary findings of no marital status differences in relation to emotional support have emerged from studies of urban men (Stueve and Gerson 1977) and of nurses (Norbeck 1985). While the balance of evidence appears to support the widely-held assumption that married individuals enjoy higher levels of support than do the nonmarried, a clear
conclusion on the matter requires additional evidence.

Sex. Although a substantial number of studies have provided social support data by gender, the question of sex differences in level of support experienced also appears unsettled. Based on a rather complete review of available evidence, Vaux (1988:169) has concluded that "empirical findings regarding gender differences in social support are mixed and inconsistent." However, others have read the available evidence as indicating a tendency for women to experience more supportive relationships than men (Leavy 1983; Flaherty and Richman 1986) and, in a recent community study, Ross and Mirowsky (1989) found higher levels of perceived social support among women than among men. However, while women appear to be advantaged in terms of confidants and perhaps certain other support resources, many studies that have considered this issue have reported little or no difference by sex in level of perceived social support (e.g., Fusilier, Gan- ster, and Mayes 1986; Holahan and Moos 1982; Turner and Noh 1988). Thus, despite the fact that a number of studies and reviewers have concluded that women are advantaged with respect to social support, variously conceived and measured, such a conclusion appears premature.

Age. Most available research in this area has focused on age differences in support networks or support resources rather than social support (Vaux 1988). These studies generally indicate a decline with age in the quantity and quality of available networks and resources (e.g., Fischer 1982). In contrast, findings on perceptions or appraisals of social support have been quite inconsistent, with results indicating a decline in support across age (Zautra 1983), no differences by age (Turner and Wood 1985; Turner and Noh 1988), and increases in support with increasing age (Lin et al. 1986). Thus, the fact and nature of any connection between age and level of social support remains to be established.

In this paper the social distribution of perceived social support is examined with the goal of providing a useful increment in our understanding of the linkage between this significant health-relevant variable and statuses that describe one's location in the social system, on the one hand, and that define variations in risk for psychological distress or disorder, on the other. Because of the possible relevance of the availability of family and friends for perceived social support, findings on these resources are also reported.

METHOD

Sample

The data for this paper derive from interviews conducted in 1990 and 1991 with 1,394 adult residents of the six boroughs comprising Metropolitan Toronto. Eligible subjects included all individuals aged 18 to 55 living in their principal residence, who were fluent in English and physically and mentally capable of responding to the questionnaire. This age range was selected to allow use of the same assessment procedures for all subjects and to correspond to the ages of substantial risk for the occurrence of psychiatric and substance abuse problems, which are the central dependent variables in the larger study from which this paper is drawn. The sampling process was aided by a 1989 household enumeration conducted by Statistics Canada to develop a sampling frame for the Ontario Health Study. We were provided with a nonoverlapping representative sample of addresses selected from each borough in proportion to the 1986 population census. Since our sample was of household units, the Kish (1965) procedure was employed to assure the random selection of individuals from within sampled households. This procedure introduces a bias in that the probability of selecting any particular member of a household depends upon the number of eligible persons within that household (i.e., a person living alone has a probability of selection of 1.0 whereas a person living in a household of four eligible persons has a probability of only .25). These unequal probabilities of selection have been corrected for within the results to be reported by the application of appropriate weights. Our success rate in interviewing selected subjects was 77 percent which, we believe, allows the assumption of reasonable representativeness.

Measuring Social Support

As we have noted above, because evidence suggests its primary significance for health outcomes, perceived or experienced social support represents the central construct of
interest. In selecting measures of this domain, we recognized the possible relevance of support derived from four relatively distinct sources: spouse/partner, relatives, friends, and co-workers. The experience or perception of being supported was assessed in three of these domains by means of a modified and shortened version of the Provisions of Social Relations Scale, for which evidence of both reliability and construct validity is available (Turner et al. 1983). Using subsets of items from this scale, we separately assessed the level of support each respondent experienced from husband/wife/partner, from friends, and from relatives. It should be noted that spouse/partner support data were obtained from married respondents and from those who defined themselves as in a romantic relationship, whether or not they lived with their partner. A separate three-item scale was employed to assess co-worker support. Each of the four scales, which were scored such that high scores indicate greater support, shows highly satisfactory internal reliability (see Appendix A). The alpha coefficients (Cronbach 1951) based on the present data are: spouse/partner support .83; friend support .94; relative support .94; and co-worker support .75.

For each status dimension, we will present separate distributions of the four social support measures that include only those subjects receiving support from that source, and we will also consider two combined or summary indices. The first such index is simply the sum of the four scores standardized to achieve equal weighting. Individuals with missing data because they had no spouse/partner or were unemployed were assigned a zero on that dimension prior to standardization. The summary scores yielded by this procedure, of course, reflect the (perhaps questionable) assumption that experiencing little or no support from one’s spouse/partner or co-workers is still more support than not having a spouse/partner or co-workers. In an effort to obtain some information on the legitimacy of this assumption, we regressed the measure of depressive symptomatology described below on dummy variable categories contrasting those low and those high on spouse/partner support with those without a spouse or partner. The result ($b = -1.56, p < .05$ for low support and $-4.80, p < .001$ for high support) is consistent with, and provides support for, the assumption. However, the same analysis on co-worker support produced less comforting data ($b = 1.42$, n.s. for low support and $-2.02, p < .01$ for high support). Although the coefficient for low support does not reliably differ from zero, the fact that it is positive rather than negative leaves doubt about the assumption unresolved in the case of co-worker support.

The second summary score was developed by dividing the summed standard scores by the number of sources of support reported, yielding a per-source average score. These scores were then restandardized. Such scores, of course, are the precise equivalent of assigning each subject’s mean support score in instances of missing data. The first of these summary scores provides an estimate of the total quantity of support received from all sources and is, therefore, partly a function of the individual’s number of support sources. The second summary score acknowledges the possibility that one’s experience of being supported by others may be less a function of the number and diversity of perceived supporters than of the quality of the relationships one has, however limited in number.

Support resources were indexed by questions ascertaining the availability of and contact with relatives other than those with whom the respondent lived, and the availability of and contact with friends.

**Indexing Social Status**

As noted, we consider the statuses of gender, age, marital status, and socioeconomic status because they have been most reliably linked with variations in mental health, and because these linkages have been a major basis for decades of hypotheses and research aimed at understanding the social determinants of emotional disorder and well-being. For the purposes of descriptive analyses, subjects are grouped into four age categories: 18–25; 26–35; 36–45; and 46–55. The rationale for these particular groupings is limited to their intuitive appeal and the need for large enough numbers in each category to assure stable estimates of variations in both social support and mental health status. Within regression analyses age is employed as a continuous variable. Three marital status categories are distinguished: the never-married; the currently-married; and the previ-
ously-married, which combines the very small number of widowed with the separated and divorced in order to achieve an adequate sub-sample size.

For the purpose of these analyses, we chose to operationalize SES in terms of occupational prestige level for several reasons. First, many of the classic studies that generated or maintained the long-term scientific interest in the SES/mental health relationship employed occupational level, either singly (e.g., Goldberg and Morrison 1963; Turner and Wagenfeld 1967) or as the dominant element of a composite index (e.g., Hollingshead and Redlich 1958; Langner and Michael 1963). Second, we do not prefer education as an index, because average levels of education and the meaning of a given level of education with respect to conditions of life varies with the age of the respondents. It has been argued that this variability can obscure or distort estimates of social status and mobility (Goldberg and Morrison 1963; Dohrenwend and Dohrenwend 1969). Moreover, the present data reveal the not uncommon finding that the inverse relationship between education and psychological distress is not entirely linear. Specifically, those who begin but do not finish a post-secondary program, whether trade school, junior college or university, show higher levels of distress than those with only high school. However, those who complete any post-secondary program are less distressed than high school graduates. Our uneasiness with this circumstance is associated with the likelihood that the elevated distress observed among those who start but do not complete various programs is more a cause than a consequence of educational attainment. Finally, our preference for occupational level over personal or family income to estimate SES derives from the fact that the most missing data occurs on income. Respondents are simply less willing to provide income data than to describe their occupation. Because the question of the most appropriate index of SES is, at best, debatable, we repeated the analyses to be presented, employing a composite measure in which occupational level, education, and household income were equally weighted, with highly similar results.

The jobs of all employed respondents (including those temporarily laid off), and those of the spouses of married respondents, were coded in accordance with Hollingshead's (1957) seven occupational prestige categories. Unemployed subjects were assigned a score for the last job held. The prestige level assigned for the purpose of these analyses was either that of their own job or of their spouse's job, whichever was higher. While this procedure presumably results in a somewhat elevated class structure compared to other operationalizations, we believe it to estimate more adequately each respondent's position in the social hierarchy and the conditions of life to which they tend to be subjected.

**Mental Health Status**

We assess mental health status in relation to both depressive symptomatology and major depressive disorder. These dimensions were chosen because they represent the primary subjects of much of the available contemporary research. Depressive symptomatology is assessed using the Center for Epidemiologic Studies Depression Scale (CES-D), which is a widely-used and highly reliable index of depressive symptomatology (Radloff 1977; Devins and Orme 1985). Major depressive disorder was defined in terms of the Diagnostic and Statistical Manual of the American Psychiatric Association (1987), Version III, revised. The occurrence of this disorder was estimated utilizing the Michigan revision of the Composite International Diagnostic Interview (CIDI) (World Health Organization 1990), which was developed within a World Health Organization/National Institute of Mental Health collaborative project aimed at fostering cross-cultural comparative research (Robins et al. 1988). Evidence of excellent interrater reliability (Wittchen et al. 1991) and good test/retest reliability (Wacker et al. 1990) is available, as is evidence for validity based on concordance with clinical diagnoses (Spengler and Wittchen 1989; Janca et al. 1992).

**RESULTS**

Preliminary to assessing the status distributions of social support, we wished to assure ourselves that the typical patterns of psychological distress and disorder that we seek to understand are, in fact, observed within the present data. Table 1 presents mean CES-D scores and one-year rates of Major Depressive Disorder by sex, age, marital status and socioeconomic status. Both sets of comparisons quite uniformly replicate the distributions reported over several decades, based
TABLE 1. Depression Symptoms and One-Year Major Depressive Disorder by Demographic Characteristics

<table>
<thead>
<tr>
<th></th>
<th>Mean CES-D Score</th>
<th>N</th>
<th>DSM III-R MDD Rate</th>
<th>N</th>
</tr>
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<tbody>
<tr>
<td>Total</td>
<td>11.79</td>
<td>1391</td>
<td>10.6</td>
<td>1393*</td>
</tr>
<tr>
<td>Male</td>
<td>10.21</td>
<td>603</td>
<td>7.7</td>
<td>604</td>
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<tr>
<td>Female</td>
<td>13.10</td>
<td>788</td>
<td>12.9</td>
<td>789</td>
</tr>
<tr>
<td>p:</td>
<td>&lt; .001</td>
<td></td>
<td>&lt; .002</td>
<td></td>
</tr>
<tr>
<td>18–25</td>
<td>15.14</td>
<td>304</td>
<td>18.4</td>
<td>304</td>
</tr>
<tr>
<td>26–35</td>
<td>10.92</td>
<td>470</td>
<td>9.8</td>
<td>471</td>
</tr>
<tr>
<td>36–45</td>
<td>11.09</td>
<td>393</td>
<td>7.2</td>
<td>393</td>
</tr>
<tr>
<td>46–55</td>
<td>9.15</td>
<td>224</td>
<td>4.7</td>
<td>225</td>
</tr>
<tr>
<td>p:</td>
<td>&lt; .001</td>
<td></td>
<td>&lt; .001</td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>9.98</td>
<td>673</td>
<td>6.6</td>
<td>675</td>
</tr>
<tr>
<td>Previously Married</td>
<td>14.22</td>
<td>171</td>
<td>11.5</td>
<td>171</td>
</tr>
<tr>
<td>Never Married</td>
<td>13.70</td>
<td>547</td>
<td>15.8</td>
<td>547</td>
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<tr>
<td>p:</td>
<td>&lt; .001</td>
<td></td>
<td>&lt; .001</td>
<td></td>
</tr>
<tr>
<td>Major Professional</td>
<td>9.16</td>
<td>158</td>
<td>4.1</td>
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<tr>
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<td>10.53</td>
<td>317</td>
<td>7.5</td>
<td>317</td>
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<tr>
<td>Minor Professional</td>
<td>11.14</td>
<td>257</td>
<td>8.6</td>
<td>258</td>
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<tr>
<td>Clerical/Sales</td>
<td>13.36</td>
<td>378</td>
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<td>378</td>
</tr>
<tr>
<td>Skilled/Manual</td>
<td>10.41</td>
<td>97</td>
<td>4.9</td>
<td>98</td>
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<tr>
<td>Semi Skilled/Unskilled</td>
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<tr>
<td>p:</td>
<td>&lt; .001</td>
<td></td>
<td>&lt; .001</td>
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</tr>
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</table>

*19 cases missing on class

upon studies of both treated and untreated populations. Women report substantially higher levels of both depressive symptoms and disorder than do men, while the married, on average, experience substantially lower levels than do the never- or previously-married. With respect to socioeconomic status, the expected linear pattern is observed with increasing levels of occupational prestige associated with decreasing depressive symptomatology and increasing rates of major depressive disorder. However, this pattern is interrupted in both instances by substantially deviant scores in the skilled-manual category. Since examination of subjects in this category revealed that 75 percent were men, the possibility that these deviant scores may be an artifact of sex composition had to be considered. Separate analyses, however, revealed that the pattern is at least as pronounced among women as among men. It is assumed that the deviantly low levels of distress and disorder found in the skilled-manual category are real and deserving of additional research consideration. We return to this matter below. The increasingly accepted tendency for depression to decline with increasing age is clearly observed in these data, whether depressive symptoms or major depressive disorder is considered.

Sex and Social Support

The sex distributions of separate and combined indices presented in the extreme right hand column of Table 2 reveal a clear tendency for women to experience, or at least report experiencing, higher levels of social support. Somewhat surprisingly, this includes higher levels of co-worker support, despite the tendency for women to be found in lower-level and lower-paying jobs. A single exception is found in the case of spouse/partner support, where men reported slightly but nonsignificantly higher levels. The combined scores demonstrate a substantial advantage for women whether or not differences in the number of support sources is controlled.

The possibility that these differences may arise, in part, from variations in age, marital status or economic circumstance was assessed by adjusting the mean support scores for differences in these variables. Highly similar results emerged. Indeed, although the differences in perceived family support were slightly reduced and fell below the .05 criterion for statistical significance, all other results were identical to those presented. Thus, the observed gender differences are independent of variations in household income and of age and marital status. These
findings, along with the size and representativeness of our urban sample, provide rather compelling evidence for a substantial gender difference in the amount of social support typically experienced.

Since women experience substantially higher levels of social support than do men, these results provide little assistance in understanding the tendency for women to display higher levels of depressive symptoms and depressive disorder. Whatever the source of this elevated level of social support, it is clear that among women, as among men, higher levels of social support are associated with lower levels of distress. It thus follows that, without the advantage of higher support, distress levels among women could be even more elevated relative to men.

**Marital Status and Social Support**

Variations in social support by marital status are reported in the remainder of Table 2. Because preliminary analyses revealed a significant sex-by-marital-status interaction effect on total support scores, these distributions are presented separately for men and women. Except in relation to family support, where significant differences favoring the married are observed for both men and women, no reliable marital status differences in support are observed when the types or sources of social support are considered separately. The finding of roughly equivalent spouse/partner support across marital status categories requires comment. While it illustrates that nonmarital romantic relationships can be equally supportive, the likelihood should be recognized that selection processes contributed importantly to this result. This is so because unmarried subjects were asked to respond to the spouse/partner support items only if they were involved in a romantic relationship, whether or not they were cohabiting. Presumably, the perception of being involved in a romantic relationship must be based, at least in part, on the experience of one’s partner as emotionally supportive. Thus, only a minority of the never-married and previously-married are represented in these data, and it is clear that the failure to observe a marital status difference in spouse/partner support is an artifact of the exclusions involved. These exclusions do not occur in the combined scores, where clear contrasts by marital status are observed whether or not differences in the number of support sources are controlled.

Examination of gender contrasts within mar-
ital status categories reveals that the largest differences in summary scores are found among the never-married, and these contrasts are uniformly significant. Interestingly, significantly higher scores are observed for married women than for married men when the number of sources of support have been equated. These findings, along with the highly similar pattern of scores observed for men and women across marital statuses, appears to contradict the widely-favored hypothesis that marriage confers a greater social support advantage on men than on women.

Taken together, these findings confirm the expectation of marital status differences in perceived social support. The finding of higher levels of social support among both married men and married women lends some credibility to the use of marital status as a very rough index of differences in global social support.

The clearly-established connections between marital status and both age and household income raised the issue of the possible influence of these factors on our results. To evaluate this possibility, regression procedures were used to adjust these data for differences in age and household income. Highly similar means were observed along with precisely the same findings in terms of statistically significant differences.

**Socioeconomic Status and Social Support**

Distributions of social support scores across occupational prestige levels are presented in Table 3. To maintain adequate sub-sample sizes, subjects in the semi-skilled and unskilled categories have been combined. Because analysis of interaction effects provided no suggestion of differential SES/social support relationships by gender, only combined results are presented.

When each source of support is considered separately, no evidence is found of an association between socioeconomic status and the experience of social support. With these scores summed into more global measures, however, a relationship is observed whether or not variations in the number of support sources are controlled. This pattern is a generally linear one such that higher locations in the social system are associated with higher levels of perceived social support.

Within both summary measures, this linear pattern is interrupted by substantially deviant scores in the skilled-manual category. Interestingly, this is the same break in linearity observed in Table 1 for SES differences in both psychological distress and major depressive psychiatric disorder. Just as individuals classified in the skilled-manual category report substantially higher levels of social support than do individuals in adjacent categories, they also report substantially lower levels of both depressive symptomatology and major depressive disorder. We believe that this deviation from linearity is a meaningful rather than an aberrant finding that deserves additional consideration and investigation. In any event, these findings are precisely consistent with the hypothesis that class differences in psychological distress and disorder may arise, in part, from class differences in level of social support experienced.

**Age and Social Support**

As in the case of marital status, preliminary regression analyses revealed a significant age-by-sex interaction term in relation to the summary support measure. Accordingly, Ta-

<table>
<thead>
<tr>
<th>Source of Support</th>
<th>Major Professional</th>
<th>Lesser Professional</th>
<th>Minor Professional</th>
<th>Clerical Sales</th>
<th>Skilled/Manual</th>
<th>Unskilled/Semi-Skilled</th>
<th>Sig</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spouse/Partner</td>
<td>15.1 (139)</td>
<td>15.2 (231)</td>
<td>15.3 (179)</td>
<td>15.7 (243)</td>
<td>14.9 (76)</td>
<td>14.9 (92)</td>
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<tr>
<td>Relatives</td>
<td>17.8 (157)</td>
<td>17.7 (316)</td>
<td>17.5 (257)</td>
<td>17.1 (374)</td>
<td>18.5 (96)</td>
<td>18.1 (164)</td>
<td></td>
</tr>
<tr>
<td>Friends</td>
<td>18.5 (157)</td>
<td>18.8 (316)</td>
<td>18.6 (255)</td>
<td>18.7 (377)</td>
<td>18.3 (98)</td>
<td>18.3 (162)</td>
<td></td>
</tr>
<tr>
<td>Co-workers</td>
<td>5.7 (133)</td>
<td>5.7 (274)</td>
<td>5.5 (199)</td>
<td>5.4 (306)</td>
<td>5.9 (67)</td>
<td>5.4 (114)</td>
<td></td>
</tr>
<tr>
<td>Sum of Standardized</td>
<td>.56 (158)</td>
<td>.37 (317)</td>
<td>-.08 (258)</td>
<td>-.15 (378)</td>
<td>.31 (98)</td>
<td>-.50 (165)</td>
<td>***</td>
</tr>
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<td>Support Scores</td>
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<td></td>
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<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Number of Sources Controlled</td>
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<td>.17 (317)</td>
<td>-.00 (258)</td>
<td>-.09 (378)</td>
<td>.12 (98)</td>
<td>-.21 (165)</td>
<td>***</td>
</tr>
</tbody>
</table>

*p ≤ .05; **p < .01; ***p < .001.
ble 4 presents distributions separately for men and women. In considering these results, the fact that our sample is restricted to individuals aged 18 through 55 should be borne in mind.

Age differences in level of social support are observed in relation to both spouse/partner support and relative support, but only among women. Women over 35 report lower levels of spouse/partner support than their younger counterparts but higher levels of support from relatives. Statistically significant age variations in friend support are observed among men, but a meaningful interpretation of these differences cannot be offered. Inspection of the two summary indices reveals highly similar results for men and women despite a significant age-by-sex interaction in relation to total support scores. In each instance, the distribution is convex, with the lowest levels of support being found among those 18 to 25 years old and the highest levels being observed for subjects between 35 and 45 years of age.

This distribution approximates a mirror image of the age distribution of psychological distress recently reported by Mirowsky and Ross (1992), at least for the age range considered here. More detailed analyses of the present data revealed a curvilinear concave distribution of psychological distress, with the highest distress observed among the youngest subjects and the lowest occurring at about 44 years of age, generally corresponding to Mirowsky and Ross's findings, at least through age 55. This observation of complementary age distributions of social support and psychological distress is consistent with the hypothesis that variations in the experience of social support may partially explain observed age differences in psychological distress.

**Social Roles and Social Support**

Our analyses of the social distribution of social support has included consideration of the fact that our assessment procedure ties the experience of social support to occupancy of the roles of spouse/partner, friend, relative, and co-worker. Specifically, we have contrasted results derived from simply summing standardized scores across the four dimensions with those obtained when differences in the number of sources of support are controlled. In every case, the results were essentially unaffected by this control, which seems to raise a question about the significance of multiple roles. However, the contrary is suggested by Thoits's (1983, 1986) observation, confirmed in the present study, of an inverse relationship between symptoms of psychological distress and number of social identities.

While the construct of "social identities" tends to be viewed as a personal resource that is relevant to distress because it mediates the impact of life stress, there are clearly other

---

**TABLE 4. Social Support by Age and Gender**

<table>
<thead>
<tr>
<th>Source of Support</th>
<th>Gender</th>
<th>18–25</th>
<th>26–35</th>
<th>36–45</th>
<th>46–55</th>
<th>Sig.</th>
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</thead>
<tbody>
<tr>
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<td>(51)</td>
<td>15.5</td>
<td>(149)</td>
<td>15.1</td>
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<tr>
<td></td>
<td>F</td>
<td>15.3</td>
<td>(108)</td>
<td>15.7</td>
<td>(192)</td>
<td>14.9</td>
</tr>
<tr>
<td></td>
<td>Sig.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relatives</td>
<td>M</td>
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<td>(130)</td>
<td>17.2</td>
<td>(200)</td>
<td>18.0</td>
</tr>
<tr>
<td></td>
<td>F</td>
<td>16.9</td>
<td>(174)</td>
<td>17.8</td>
<td>(266)</td>
<td>18.5</td>
</tr>
<tr>
<td></td>
<td>Sig.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Friends</td>
<td>M</td>
<td>18.7</td>
<td>(130)</td>
<td>17.3</td>
<td>(202)</td>
<td>18.6</td>
</tr>
<tr>
<td></td>
<td>F</td>
<td>19.5</td>
<td>(174)</td>
<td>19.6</td>
<td>(266)</td>
<td>18.6</td>
</tr>
<tr>
<td></td>
<td>Sig.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Co-workers</td>
<td>M</td>
<td>4.9</td>
<td>(91)</td>
<td>5.4</td>
<td>(179)</td>
<td>5.6</td>
</tr>
<tr>
<td></td>
<td>F</td>
<td>5.5</td>
<td>(127)</td>
<td>5.9</td>
<td>(203)</td>
<td>5.9</td>
</tr>
<tr>
<td></td>
<td>Sig.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sum of Standardized Support Scores</td>
<td>M</td>
<td>-1.09 (130)</td>
<td>-0.08 (202)</td>
<td>.41 (176)</td>
<td>.04 (96)</td>
<td>***</td>
</tr>
<tr>
<td></td>
<td>F</td>
<td>-0.25 (174)</td>
<td>.29 (269)</td>
<td>.36 (217)</td>
<td>.29 (129)</td>
<td>*</td>
</tr>
<tr>
<td></td>
<td>Sig.</td>
<td>**</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* p ≤ .05; ** p < .01; *** p < .001.
tangible hypotheses. Principal among these is the possibility that increases in social roles or social identities tend to be accompanied by increases in the amount of social support that is experienced. Table 5 presents rather compelling evidence confirming this expectation. The highest social support scores are observed for individuals occupying all four roles, while the lowest are found among men and women with the minimum set of two roles, with roughly intermediate scores observed where three roles are held. The magnitude of these differences and the dramatically low scores observed for those individuals who hold neither the partner nor the co-worker role suggest a nontrivial connection between number of roles held and the level of social support one tends to experience. That more than sheer quantity of roles may be relevant is suggested by the divergence in mean support scores observed for both men and women in the two categories with three roles. Apparently, the addition of the co-worker role to the two essentially universal roles is of less consequence for social support than the addition of the partner role. While the differences for both men and women fall slightly below statistical significance ($p < .10$), they suggest a need to consider the nature as well as the quantity of roles held.

**Support Resources**

Our findings on the epidemiology of support resources can be summarized briefly because they offer little basis for attaching significance to such resources, at least as indexed by the availability of and contact with relatives and the availability of and contact with friends. Preliminary analyses revealed minimal correlation between the two indices of mental health and some of the four resource measures. However, regression procedures indicated that these measures of support resources are completely consequential when the perceptual measures are considered. Nevertheless, the fact that each resource measure correlates significantly with total social support leaves open the possibility that they are indirectly relevant for mental health.

With respect to sex differences in reported resources, our findings generally correspond to expectations. Although men reported the availability of more friends, women indicated significantly higher levels of contact with both friends and relatives. Thus, one basis for the higher levels of social support experienced by women may be the higher levels of contact they routinely have with both family and friends.

No relationship was observed between marital status and either the reported number of relatives or of friends living within geographic proximity to the respondent. However, significant and opposite relationships are observed on contact with relatives and contact with friends. Contact with relatives is highest among the married and lowest among the never-married, while contact with friends is highest among the never-married and lowest among the married. While these results may simply confirm the obvious, they also illustrate the less obvious point that one's marital status defines differences in one's social environment that go well beyond the presence or absence of a legally sanctified spousal relationship. It is also worth noting that these support resource differences, being opposite and apparently compensating in nature, presumably make little contribution to the higher levels of social support that married men and women tend to experience.

The results of analyses of the relationship between socioeconomic status and support

<table>
<thead>
<tr>
<th>TABLE 5. Total Support by Roles and Gender</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relative Friend</td>
</tr>
<tr>
<td>$\bar{X}$</td>
</tr>
<tr>
<td>----------------</td>
</tr>
<tr>
<td>Total Unweighted</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

* $p \leq .05$; ** $p < .01$; *** $p < .001$. 

---

Note: The table presents mean support scores for relative friendships and friendships by gender and marital status. The table shows that men and women differ significantly in their reported levels of support, with women reporting higher levels of support than men in both relational categories. The table also highlights the importance of co-worker roles in providing social support, with higher scores for men in this category compared to women. The significance levels indicate the statistical significance of these differences, with *** indicating $p < .001$, ** indicating $p < .01$, and * indicating $p < .05$. The sample sizes (in parentheses) provide context for interpreting the mean scores.
resources showed only contact with friends to be associated with the occupational prestige category. However, the direction of this relationship is the opposite of that observed for social support, with lower SES subjects tending to report more contact with friends than those with higher socioeconomic status. This finding, therefore, provides no assistance in understanding the social support distribution since it predicts differences that are the opposite of those observed.

Age appears to be associated with differences in certain support resources. Among both men and women, 18- to 25-year-olds report living close to a larger number of relatives than do older individuals. Presumably, those 25 and younger are less likely to have experienced the geographic mobility associated with occupational demands and changes. Degree of contact with relatives is also associated with age, but only among men. Here, the pattern of relationship corresponds to that observed in relation to social support, with lowest levels of contact being observed in the youngest and oldest age groups studied. Finally, substantial and statistically significant differences are observed for both men and women on level of contact with friends. We found the youngest group to have the highest level of contact with friends, which seems consistent with everyday experience. It should be noted, however, that it is inconsistent with our findings on social support. While contact with friends shows a weak positive, but statistically significant, relationship with summed support scores ($r = .10, p < .001$), the group reporting the highest level of contact with friends reports the lowest level of general support. Presumably, the very low level of social support experienced by younger subjects would be even lower in the absence of the observed elevation in contact with friends.

Based on the four simple indices of support resources that we employed, we found no evidence of the direct relevance of such resources for mental health. Moreover, except in the case of gender, the epidemiology of support resources provides little suggestion that such resources importantly condition the clearly significant dimension of perceived social support.

Social Support and the Epidemiology of Depression

One element in our rationale for examining the social distribution of social support was to assess the plausibility of the hypothesis that variations in social support play a role in explaining established epidemiologic patterns of mental health status. We suggested that observations indicating that the distributions of social support complement established distributions of depression would provide preliminary support for this hypothesis. With the exception of gender, such support is clearly provided by these results. However, the results provide no estimate of the magnitude of the contribution of social support differences toward understanding the epidemiology of mental health. We now turn to this issue.

Table 6 reports regression and logistic analyses. The contribution of social support in accounting for the associations between status characteristics and mental health is estimated by changes in the unstandardized regression coefficients for each status when measures of social support are controlled singly and in combination. Parenthetically, it should be noted that, whatever significance social support may have for understanding demographic variations in depression, its independent relevance is clearly displayed in these results, accounting uniquely for 9 percent and 4 percent of the variability in depressive symptomatology and depressive disorder, respectively.

As noted earlier, the fact that women report significantly higher levels of support than do men rules out social support differences as an explanation for the tendency of women to experience higher levels of depression. When total support is controlled, whether the four dimensions are equally weighted (Column 6) or optimally weighted (Column 7), the coefficient for sex increases 15 to 17 percent in relation to depressive symptoms and 11 to 14 percent in relation to depressive disorder. Our earlier suggestion that, without the advantage of higher support, distress levels among women would be even more elevated relative to men is thus confirmed by these results. Moreover, the results indicate that, despite the higher levels of support typically experienced by women, social support remains a relevant intervention target among women, as among men.

Despite the fact that the age distributions of depression and social support are closely complementary, the regression results make clear that age variations in social support contribute nothing toward understanding age
TABLE 6. Depression Symptoms Regressed on Demographic Risk Factors and Social Support

<table>
<thead>
<tr>
<th>RISK FACTORS</th>
<th>OLS Models</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>CES-D Depression:</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
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<td>b</td>
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<td>2.90***</td>
<td>3.29***</td>
<td>3.03***</td>
<td>2.88***</td>
<td>3.28***</td>
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</tr>
<tr>
<td>β</td>
<td>.15</td>
<td>.15</td>
<td>.17</td>
<td>.16</td>
<td>.15</td>
<td>.17</td>
<td>.18</td>
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</tr>
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<td>-.14***</td>
<td>-.14***</td>
<td>-.13***</td>
<td>-.12***</td>
<td>-.13***</td>
<td>-.14***</td>
</tr>
<tr>
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<td>-.14</td>
<td>-.13</td>
<td>-.14</td>
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<td>-3.71***</td>
<td>-1.95*</td>
<td>-1.63*</td>
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<tr>
<td>β</td>
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<td>-.10</td>
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<td>.52**</td>
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*p < .05; **p < .01; ***p < .001; †p < .10.

†† Scored such that higher numbers indicate lower SES.

Differences in mental health. In both analyses, age remains a significant predictor of depression and the coefficients observed are unchanged when social support is held constant. Whatever it is about aging that matters for well-being, variations in level of social support experience do not appear to be implicated.

In contrast, social support appears to have substantial explanatory significance in relation to marital status differences in distress and disorder. The coefficient representing the difference between married and previously-married subjects in depressive symptomatology is reduced by 50 percent when total support is controlled, and by 58 percent when the four indices are entered separately, primarily as a function of partner support.
The never-married coefficient is reduced by 30 and 18 percent, respectively, primarily due to co-worker support. Parallel findings are observed in relation to depressive disorder. For the married, the coefficient declines by 46 and 68 percent, while the never-married term is reduced by 85 and 100 percent. In this latter case, however, the fact that the original coefficient was not statistically significant does not permit us to be confident that the variance at issue is nonrandom.

The contribution of support differences to SES variations in mental health appears to be minimal in relation to depressive symptomatology and virtually nonexistent relative to major depressive disorder. This result at least partially arises from the offsetting effects of greater support from relatives among lower status subjects. In both analyses the addition of relative support increases the SES coefficient by 12 percent, indicating that the class gradient for depressive symptoms and disorder would be even greater if higher- and lower-status individuals experienced equal amounts of support from relatives. Despite this offsetting effect, however, total social support accounts for 15 percent of the association between SES and depressive symptomatology.

The analyses shown in Table 6 were further extended to assess the possibility that the role or significance of social support for mental health might vary across relevant social statuses. Five regression analyses were conducted in which the interactions of age, sex, marital status, and SES with each of the four support dimensions and with total support were separately assessed (not tabled). No statistically significant interactions were found. It appears that social support is about equally associated with depression across categories within each of the demographic risk factors considered. Accordingly, the previously-noted contributions of social support toward accounting for the epidemiology of depression can be assumed to derive from differences in level rather than impact of perceived social support.

CONCLUSIONS

Following Vaux (1988), two elements of a rationale for conducting comparative research on social support were specified: (1) the need for information on the plausibility of the hypothesis that epidemiological variations in mental health arise, at least in part, from social support differences, and (2) the possibility of future policy decisions that may target or influence social support. The latter emphasizes the need to understand the distribution of social support in the community. With respect to (2), we have presented social distributions of support in general and from specific sources, based on a large and representative urban sample. We found that women experience substantially higher levels of social support than do men, that married individuals report more support than their nonmarried counterparts, and that both of these distributions obtain independently of variations in other demographic risk factors. Estimating SES in terms of occupational prestige level, we found a generally linear pattern, with higher status levels being associated with higher levels of social support. Whether or not number of support sources was controlled, this linear pattern was interrupted by deviantly high scores in the skilled manual category. Finally, highly consistent age distributions of support scores were observed for men and women. These distributions were convex in nature, with the lowest levels of support found among 18- to 25-year-olds and the highest levels observed for subjects between 35 and 45 years of age.

The fact that the level of social support experienced varies systematically across each of the status characteristics considered represents crucial information for intervention efforts and supports two central assumptions that were important motivators of our analyses. These assumptions are: (1) that variations in the availability of social support arise, as do differences in exposure to social stress, substantially out of developmental and contemporaneous conditions of life (Aneshensel 1992; Pearlin 1989); and (2) that one’s gender and age and one’s socioeconomic and marital status effectively define significant differences in such conditions of life. Thus, one contribution of these findings is that they represent a step toward the illumination of the impact of social structures on processes of social support called for by House et al. (1988).

With respect to the first element of our rationale, we found the epidemiology of social support to demonstrate substantial similarity to the epidemiology of both depres-
sive symptoms and major depressive disorder. A positive rather than negative relationship was found, with women demonstrating the highest levels of both social support and depression. These findings thus provide no assistance in understanding the well-established tendency for women to display more depression. Our results make clear that higher levels of support contribute to lower levels of distress and disorder among women, as among men, and that, without the advantage of higher social support, depression levels among women would be even more elevated relative to men.

For each of the remaining demographic risk factors the correspondence with observed distributions of depression was very precise indeed. In the case of SES, this correspondence included the substantial deviation from linearity observed at the skilled-manual occupational level. Similarly, the observed distribution of social support by age represents a curvilinear mirror image of age variations in depression. These results are clearly consistent with the hypothesis that variations in social support across demographic risk factors, excluding gender, make some contribution to persistently observed mental health differences. However, our estimate of the magnitude of this contribution revealed it to be substantial only in the case of marital status, small but notable in relation to SES, and nonexistent in the case of age.

It has long been clear that social support matters for mental health. What these results have demonstrated is that the availability of this important resource is partly a function of conditions of life that vary in relation to one’s social status. This information is important for the planning of prevention and intervention programs aimed at reducing risk for mental health problems and is, therefore, of substantial practical significance. In contrast, the theoretical significance of these findings seems rather modest. Beyond deepening our understanding of why marital status matters for well-being, and accounting for a small portion of the SES variation in mental health, we have managed only to discount the specific explanatory hypothesis examined. The conclusion seems justified that we must look elsewhere for an understanding of the social contingencies that are relevant to variations in mental health risk by sex, age, and, to a substantial degree, by SES. In our view, the next logical step is to assess the extent to which the social distribution of other elements of the stress process, such as stress exposure and personal resources, are implicated in the epidemiology of psychological distress and disorder.
### APPENDIX A.
Measures of Perceived Social Support

#### A. Spouse/Partner Support
1. I feel very close to my husband/wife/partner.
2. I have a husband/wife/partner who would always take the time to talk over my problems, should I want to.
3. My husband/wife/partner often lets me know that he/she thinks I'm a worthwhile person.
4. When I am with my husband/wife/partner I feel completely able to relax and be myself.
5. No matter what happens I know that my husband/wife/partner will always be there for me should I need him/her.
6. I know that my husband/wife/partner has confidence in me.

#### B. Friends Support
1. I feel very close to my friends.
2. I have friends who would always take the time to talk over my problems, should I want to.
3. My friends often let me know that they think I'm a worthwhile person.
4. When I am with my friends I feel completely able to relax and be myself.
5. No matter what happens I know that my friends will always be there for me should I need them.
6. I know that my friends have confidence in me.
7. I feel that my friends really care about me.
8. I often feel really appreciated by my friends.

#### C. Relatives Support
1. I feel very close to my relatives.
2. I have relatives who would always take the time to talk over my problems, should I want to.
3. My relatives often let me know that they think I'm a worthwhile person.
4. When I am with my relatives I feel completely able to relax and be myself.
5. No matter what happens I know that my relatives will always be there for me should I need them.
6. I know that my relatives have confidence in me.
7. I feel that my relatives really care about me.
8. I often feel really appreciated by my relatives.

#### D. Co-workers Support
1. I feel close to the people at work.
2. I have people at work who would always take the time to talk over my problems, should I want to.
3. I often feel really appreciated by the people I work with.

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**Response Scale for All Four Measures:**

1. Very much like my experience
2. Much like my experience
3. Somewhat like my experience
4. Not at all like my experience

### REFERENCES


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