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The Multidimensionality of Social Support

by

Kathryn M. Huebert

A thesis
presented to the University of Manitoba
in partial fulfillment of the
requirements for the degree of
Master of Arts
in
Department of Sociology

Winnipeg, Manitoba
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KATHRYN M. HUEBERT

A thesis submitted to the Faculty of Graduate Studies of
the University of Manitoba in partial fulfillment of the requirements
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MASTER OF ARTS

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ABSTRACT

Inconsistent findings across studies regarding the contributions of social support to well-being of the elderly may reflect, in part, problems in the conceptualization and operationalization of the construct social support. To help reduce the ambiguity surrounding social support, this thesis identifies and empirically verifies the most common dimensions of social support and then examines which dimensions are most important to the well-being of the elderly.

Three dimensions of social support are identified from the literature: social embeddedness, enacted support, and perceived support. In terms of these dimensions, two different perspectives on social support are examined to determine which perspective helps to explain the relationship between social support and well-being of the elderly. First, it is suggested that the Direct Effects View of Social Support primarily focusses on enacted support and social embeddedness. Consistent with this view it is hypothesized that there is a direct positive association between these dimensions of social support and well-being of the elderly. Second, it is proposed that the Exchange View of Social Support conceptualizes social support mainly as enacted support and perceived support. In contrast to the Direct Effects View, the balance of enacted support exchanged as well as a person's perception of being supported are hypothesized as being important to the well-being of the elderly.

Secondary data analysis was conducted on data selected from a cross-sectional survey of 800 persons age 65 and over who lived in the community in metropolitan Winnipeg, Manitoba, Canada. Factor analysis and regression analysis were employed with these data.

Findings of the factor analysis revealed four social support factors. Three factors referred to enacted support: periodic provision of support; regular provision of support; and received support. The fourth factor referred to perceived support. Somewhat unexpectedly, the social embeddedness variables did not form a distinct factor.

Regression analyses did not provide substantive evidence for either the Direct Effects or Exchange View of Social Support. Relative to social support and demographic variables, health was the most significant correlate of well-being.

Three conclusions emerge from the thesis findings. First, health is a major factor affecting well-being of the elderly. Second, there is evidence that social support is a multidimensional construct. Third, the Direct Effects and Exchange View of Social Support lack explanatory power to elucidate the mechanisms of social support in relation to well-being. In addition to methodological problems, several factors that might account for the lack of explanatory power are discussed.

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CHAPTER 1

INTRODUCTION

Central to much social gerontological research has been the examination of life satisfaction, well-being, and quality of life of people over 60. This research shows self-reported well-being to be strongly related to three factors: health, socioeconomic status, and degree of social interaction (Larson, 1978). Focussing on social interaction, much of the more recent research explores the relationship between informal and formal support and overall well-being. The findings of these investigations are inconsistent and controversial. It is suggested that this reflects inadequate conceptualization and operationalization of the construct social support[1] (Thoits, 1982; Tilden, 1985). This thesis intends to help reduce the ambiguity surrounding the construct of social support by empirically examining its multidimensionality.

1.1 PRACTICAL IMPLICATIONS

The study of social support has important practical and theoretical implications. From a practical viewpoint, there is concern about the aging of the population and how this will affect the demand for health and social services for the elderly (Devereaux, 1987). It is projected that by the year 2051 the proportion of the Canadian population 65 and over will double (Dentin and Spencer, 1980). Associated with aging is an increased incidence of chronic diseases and subsequent disability (Wan et al., 1982). This suggests the need and the demand for health care services are likely to rise. Acknowledging this, there is

a trend away from costly institutional care towards alternative solutions such as home care support in the community (Chappell, 1985).

Focussing more on the individual level, there are certain social factors, such as retirement and widowhood, which affect the ageds' social support networks. When a person retires, the daily social interaction with coworkers is lost, resulting in alterations of the support network. Similarly with widowhood, there are support network changes; in many cases the loss of a spouse means the loss of an intimate social tie. Experiencing these losses in conjunction with possibly greater health problems, the older person turns first and most frequently to kin for support (Cantor, 1980).

Traditionally, women have been responsible for caring for aged family members. With greater numbers of women assuming full-time work roles outside the home, there may be fewer women available for this form of continuous home care in the future. There has been some evidence to suggest that middle-aged women are taking on the dual roles of working outside the home plus caring for the elderly; hence, this group has been referred to as women in the middle (Brody, 1981). The extra demands placed on this group of women will mean that they too are at risk for stress related health problems. In addition to needing alternative supportive care services for those elderly requiring constant care, supportive services will be needed to relieve those individuals providing the constant care.

In view of these factors, attention has turned to techniques for assessing and improving social support as a

way of facilitating health sustaining functions and in general enhancing overall well-being of the elderly. Gelein (1980) recommends that health care practitioners be educated to incorporate concepts of social support into practice. When doing the initial patient history, an assessment of the person's social network can also be included. Extending this further, Garrison and Howe (1976: 330) describe a clinical technique based on the assumption that the solution to a variety of client problems lies within the expectations and collective resources of an individual's social network. A "network session" is conducted in a client's home which includes all the significant members of the client's support network. The clinician coordinates and chairs the meeting and as a collective they attempt to resolve the client's problems. In a similar vein, Gallo (1982) goes so far as to suggest a new type of worker called a "networker." This person would be familiar with the principles of networks and would be in contact with clients as well as support network members.

In contrast to this emphasis on the helping professional, other investigators suggest that, based on network assessments, programs can be developed that are aimed at strengthening already existing networks and developing new networks where needed (Israel, 1982a; Mitchell and Trickett, 1980). It is argued that such programs are preventive in that they reduce vulnerability and risk of psychological dysfunction, and enhance competence and a sense of community. Pilisuk and Minkler (1980) examined a variety of programs that either explicitly or implicitly built supportive networks for the elderly. They found the programs very diverse in the ways they enhanced social support among older persons. The

findings illustrated the diversity of needs of the elderly and the importance of an equally diverse set of responses to meet the support needs (Pilisuk and Minkler, 1980).

Several investigators caution against naive intrusions into social support networks (Snow and Gordon, 1980; Stein et al., 1982). If a person's view and experiences of the network are not examined carefully, well meaning interventions can unintentionally cause more harm than good. For instance, a client's need for privacy may be violated, and the providers of support may experience their role as a burden.

Furthermore, there is some program evaluation research that suggests that network strategies are not successful. Cohen and Adler (1984) describe an experimental network service program that was conducted in a large single-room occupancy hotel in midtown Manhatten. One social worker and a student worked on-site in the hotel. When a client presented with a problem, the social worker first tried to deal with it utilizing network methods. For example, if a client was ill and needed help with groceries, the person's informal networks were explored to find the necessary assistance. An intervention was considered successful if a specified task was accomplished using a network contact. An evaluation of the program presented a somewhat disappointing picture. No network interventions were used for approximately one-half of the problems presented, and only 16% of the problems were successfully handled through a network procedure.

Brownell and Shumaker (1985) are also critical of some interventions, particularly those based on such values as

"rugged individualism." Simply put, they argue that social support is a complicated phenomenon that is influenced not only by individual behavior and ties with friends and family, but also depends on the social environmental context. A similar criticism is stated by Gottlieb (1981b). He examined two types of preventive interventions that involved the mobilization of informal resources: (1) intervention that focussed on improving the supportive quality of network contacts (e.g., training individuals in helping skills); and (2) intervention that focussed on efforts to bring people into contact with similar peers (e.g., self-help support group). In his analysis of two programs of the first type, he pointed out a common weakness: failure "to recognize that the reactions and perceptions of the intended beneficiaries were strongly conditioned by the sociocultural context in which they participated..." (Gottlieb, 1981b: 214). In other words, he suggested that without considering the context in which social support operates such social support interventions will be ineffective.

In part, the unsuccessful application of support interventions suggests the practical application of an inadequately understood complex phenomenon based on limited and often global data. Intervening in support networks simply because social support enhances well-being is not enough. Health, well-being, and social support are multidimensional concepts, and particular kinds of support may be related to specific categories of outcome (Mitchell and Hurley, 1981). Furthermore, the formal service providers have an impact on the informal supports of their clients regardless of whether support interventions are attempted (Chapman and Pancoast, 1985). Both the lack of

awareness of how formal services affect informal supports and the intervention weaknessess outlined, serve to underscore the critical need to gain a more precise empirical understanding of social support.

1.2 THEORETICAL IMPLICATIONS

Theoretical development in the area of social support is limited (Brownell and Shumaker, 1984). The reasons for the lack of theoretical advancement are debated in the literature. Heller and Mansbach (1984) argue that research is directed more toward demonstrating the connection between social support and health outcomes, rather than toward understanding the complexities of the support concept. It is suggested by Rook and Dooley (1985) that in the area of social support there are two different research traditions: (1) the analytic or theoretical tradition; and (2) the applied tradition. The analytic tradition emerged from earlier work on stressful life events in epidemiology, medical sociology, and social psychology. In contrast, the applied tradition developed out of the helping professions such as public health, clinical psychology, and social work. Rook and Dooley contend that it would be mutually beneficial to improve collaboration between these two traditions. This would allow empirical testing of the conceptual distinctions debated in the analytic literature, and also provide an opportunity for interventions to examine their underlying assumptions. Other researchers express the same concern when arguing that the first step toward evaluating the risks and gains of network interventions is conceptual clarification (Snow and Gordon, 1980).

In addition to a lack of theory, there is a lack of agreement regarding the meaning and measurement of the social support construct (Brownell and Shumaker, 1984; Cohen et al., 1985a, 1985b; Depner et al., 1984; Gottlieb, 1981a; Hirsch, 1979; Levy, 1983; McKinlay, 1980; Tilden, 1985; Ward, 1985). This is evidenced in two ways. First, in the literature there is often a vague or undefined usage of terms. For example, some authors confuse the constructs social network and social support (Shinn et al., 1984). Not all interaction in a social network constitutes social support. Second, there are several methodological problems. In particular, diverse measures of social support have been used (Brownell and Shumaker, 1984; Rock et al., 1984). The diversity of measures ranges from simply looking at marital status to the more elaborate social network questionnaire (Dean and Lin, 1977). This is noted in a psychometric review of social support and social network scales (Rock et al., 1984). In examining 29 studies in this area, the researchers found that social support and social network were defined as having anywhere from one to nine dimensions. Diverse definitions and measures result in inconsistent and contradictory research findings which make it difficult to compare, summarize, and draw conclusions from the literature (Vaux, 1985; Gottlieb, 1981a).

Illustrative of this problem are the inconclusive research findings surrounding social support and self-reported well-being of the elderly. One group of studies generally report an association between increased social participation and greater well-being. Graney (1975) in a longitudinal study of elderly women, found a positive relationship between happiness and social participation

activities. Particularly important were such variables as visiting friends and relatives and association attendance. Somewhat related, Mancini (1978) found a significant positive relationship between leisure satisfaction and psychological well-being. However, in a later study Mancini et al. (1980) reported that personal contact with friends, neighbors, and relatives did not relate to life satisfaction. Palmore (1972), also looking at life satisfaction, found self-rated health the predominant variable of influence, and organizational activity secondary. More recently, Rook (1984) examined the dual nature of social ties and found that both positive and negative social interactions were independently related to well-being. Negative social ties were defined as problematic relationships that involved such problems as invasion of privacy, being taken advantage of, broken promises, and conflicts. Regression analysis indicated that problematic ties were more consistently related to well-being than positive ties. Moreover, Rook found that positive ties were "significantly related to well-being only when they involved positive affect (particularly comfort) and sociability rather than provision of support per se" (Rook, 1984: 1106). In other words, the affective quality of the social ties appeared to be the important factor associated with well-being.

Looking at another group of studies that define support in terms of source of support, conflicting findings are also evident. Some researchers contend that peer friendships, not filial relationships, determine morale in old age (Blau, 1973; Lee, 1985). This is corroborated by Baldassare et al. (1984) who reported that perceived lack of companionship related to unhappiness. Contrary to this,

Castleman (1985) found no differential effect of friends and kin on well-being. Moreover, Felton et al. (1981) reported that friendship was differentially important depending on the environmental context. For an urban group of elderly persons, friendships played a critical role in well-being; whereas for a suburban group of elderly, health status was more important. This raises the possibility that different aspects of social support are more essential in different social contexts. In part, some of the conflicting research findings may be the result of social support being studied within different social contexts.

The findings to date suggest that social support is a complex phenomenon. This complexity is further illustrated when studies focussing on affective support are examined. Some researchers have found that subjective dimensions of social ties exhibit a stronger association with well-being than objective dimensions of social ties (Israel et al., 1984; Ward et al., 1984). This is in line with Porritt (1979) who reported that quality of support received during a crisis was more important than size of the network as a determinant of outcome. Similarly, Badura and Waltz (1984) found that socio-emotional support related positively to psychological well-being. These findings are in keeping with the argument that the presence of an intimate relationship serves as a buffer against gradual and traumatic changes that accompany old age (Lowenthal and Haven, 1968; Blau, 1973).

Nevertheless, there are some studies that do not support the argument that subjective dimensions of social support are more important than the objective dimensions of social support. Moriwaki (1973) examined whether the

quantity of contact (number of significant others) or quality of contact (perceived acceptance of self-disclosure) is directly correlated to psychological well-being of the elderly. She found that the number of significant others is more directly related to well-being, regardless of the level of self-disclosure. In another study of 1,200 men, Keith et al. (1984) found that confiding in another person has no effect on well-being. This study does not support the view of the importance of affective support; however, it raises the possibility of a male and female difference in affective support needs. Confiding in another person may be less important for men than it is for women. In another study of both elderly men and women, Simons (1983/84) also found low correlations between confiding and emotional status. More specifically, he found that the three psychological desires studied -- the desire for security, intimacy, and self-esteem -- were fulfilled by relationships with a variety of categories of people (e.g., spouse, adult children, friends). No single type of relationship was able to satisfy all three psychological desires. He contended that the inconsistent research findings in this area may be due, in part, to not considering the diversity of relationships in social networks.

Although this is not an exhaustive summary of research findings, this brief discussion serves to highlight two points. First, there are diverse interests and applications of social support; and second, there is great disparity in research findings. In sum, this reflects three problems in social support research: lack of theory; lack of consensus on a definition of social support; and diverse operationalizations of social support. Moreover,

the research suggests other factors that need to be considered in studying social support: positive and negative aspects of social ties; the environmental context including such factors as urban and suburban differences; and the diversity of social relationships. The goal of social support research is to determine the kinds of support that are most crucial in different contexts and the conditions that maximize the beneficial effects of support (Depner et al., 1984). The first step towards this end is a clear definition and delineation of the various dimensions of the construct social support. Although several authors conceptualize social support as multidimensional, this has yet to be empirically established.

This thesis, then, will examine the multidimensionality of social support. To begin, the literature will be examined to identify the salient dimensions of social support.[2] This will be followed by an empirical analysis to determine whether the dimensions of social support identified in the literature can be differentiated from a variety of social support and social network variables. Next, the dimensions of social support will be examined in relation to well-being to determine which dimensions are most important to the well-being of the elderly.

NOTES

[1] Social support is viewed as a construct. According to Kaplan (1964), constructs are ideas that cannot be directly or indirectly observed. For example, social support per se cannot be seen or touched in a concrete sense; rather it exists in peoples' minds as an idea or conception. The construct is created from a consensus of conceptions. Through a series of inferences, it is measured in the empirical world.

[2] Dimension refers to the subsets or categories of support abstracted from the overall construct social support (Babbie, 1983; Rock et al., 1984).

CHAPTER 2

DIMENSIONS OF SOCIAL SUPPORT

2.1 INTRODUCTION

Social support has received research attention for many years under the guise of different terms such as social participation, social interaction, social networks, informal networks, social bonds, and confidants (Tilden, 1985; Chappell, 1985). Despite the lack of consistent definition and measurement, there is a shared understanding that social support conveys the notion of "people helping people" (Levy, 1983: 1329). This notion of helping is seen in the dictionary definition of support:

> 1. carry (part of) weight of, hold up, keep from falling or sinking,...2. enable to last out, keep from failing, give strength to, encourage,...5. lend assistance or countenance to...(Sykes, 1982: 1072).

The dictionary definition provides a general understanding of what is meant by support, but fails to indicate the boundaries and properties of the construct which are important when operationalizing concepts for study.

This chapter moves beyond the general notion of social support as helping to examine the usages of the construct commonly found in the research literature. Very little has been written specifically on conceptualization of the construct. Most of the literature examines social support in relation to other variables such as well-being. Thus, to arrive at a definition of social support, the literature must be reviewed and a definition abstracted from it. As well, to gain a better understanding of the dimensions of

social support that are important to the well-being of the elderly, research findings concerning the relationship between social support and well-being are discussed.

To promote a fuller understanding of social support, the various studies are organized within their respective frameworks. It is important to note that much of the research does not explicitly specify underlying assumptions and theories. Nevertheless, no research is atheoretical; if not explicit, a theoretical perspective is implicit (Smith, 1981). Concepts do not exist in isolation but are used within a system or framework that selectively restricts their meaning. What follows, then, is a review of social support literature within the various frameworks in which the construct is embedded.

In reviewing past research, much of the work may be divided into three major frameworks or perspectives: (1) Buffer View of Social Support; (2) Direct Effects View of Social Support; and (3) Exchange View of Social Support. After a discussion of early contributions to the study of social support, an overview of the three frameworks is provided. Table 2.1 provides a summary of the frameworks by listing the major constructs and propositions. The frameworks are broad categorizations based on researchers' understandings of how social support operates. These categories are not mutually exclusive; some research may overlap another framework. As well, there is some diversity within frameworks. Following this, there is a discussion of the characteristics of social support. The outcome of this review will be a delineation of the most commonly used dimensions of social support and their relationship to well-being.

TABLE 2.1

FRAMEWORKS OF SOCIAL SUPPORT

Frameworks	Constructs	Propositions
1. Buffer View of Social Support	- Stressful Life Events - Social Support - Well-being	- Stressful life events are negatively related to well-being. - Social support is a buffer between stressful life events and well-being.
2. Direct Effects View of Social Support		
- Social Support as Helping Approach	- Social Support - Well-being	- Social support is positively related to well-being.
- Social Network Approach	- Social Network - Social Support - Well-being	- Larger and denser social networks are positively related to well-being. - Social networks influence the availability and access to social support.
3. Exchange View of Social Support	- Social Support Exchange - Well-being	- Unbalanced social support exchange is negatively related to well-being.

2.2 EARLY WORK ON SOCIAL SUPPORT

Early contributions to the study of social support arose in the 1970's from two disciplines, epidemiology and social psychiatry. Three authors in particular were responsible for formulating the initial conceptions of social support: Cassel, Cobb, and Caplan. Cassel (1976) subscribed to the epidemiological triad of host, agent, and environment. He was interested in the environmental factors (psychosocial processes) capable of changing human resistance and increasing susceptibility to disease agents. Past research was criticized for treating psychosocial processes as unidimensional. Instead, he argued that such processess are two dimensional, one category being stressors, and another category being protective or beneficial (Cassel, 1976). He envisioned the latter category as "protective factors buffering or cushioning the individual from the physiologic or psychologic consequences of exposure to the stressor situation" (Cassel, 1976: 113). In other words, he conceptualized support from the environment -- social support -- as cushioning the harmful effects of environmental stressors.

Cassel reviewed animal and human research linking such factors as crowding, rapid social change, and social disorganization with increased susceptibility to disease. Ill health was attributed to a lack of appropriate feedback from significant others in the social milieu. Individuals receiving disordered signs and signals experienced confusion which in turn disrupted their normal physiologic equilibrium, resulting in greater chance of illness. He suggested that it was more feasible to attempt to improve

and strengthen social supports than to reduce the exposure to stressors (Cassel, 1976).

Cassel never explicitly defined social support. He suggested that social support moderated stressors by providing feedback to the individual. His statements were too global to identify dimensions of social support or to operationalize the construct for research. However, Cassel's conception of social support set into motion many subsequent inquiries and strategies for enhancing social support.

Like Cassel, Cobb reviewed the research literature to examine the extent to which social support protects individuals as they pass through various life transitions and crises. In contrast to Cassel, he provided a more explicit definition of social support. He extended Cassel's feedback notion by clearly outlining specific areas of feedback information. Social support was seen as information leading the person to believe that s/he is cared for and loved, esteemed and valued, and a member of a network of communication and mutual obligation (Cobb, 1976). This definition emphasized the socio-emotional aspect of support. It highlighted the individual's subjective perception of being supported. Cobb viewed support in terms of the person-environment fit model. This model contended that illness resulted when the social environment failed to meet individuals' needs (Cobb, 1976; Kaplan et al., 1977). Thus, the person's perception of his/her needs being fulfilled was important.

Contrary to research on social support in the 1980's, Cobb intentionally omitted support that was task or action

oriented -- instrumental support. He argued that it was information rather than goods and services that was central to social support. He further stressed that there were not "dramatic main effects from social support" (Cobb, 1976: 302). By this he meant that the protective effects of social support were not as strong in everyday life; rather, social support had beneficial effects mainly during times of crises or change.

In constrast to Cassel and Cobb, Caplan focussed more attention on social support interventions (Caplan, 1974). First, he outlined his understanding of social support and then shifted attention to intervention strategies. Like Cassel, he was interested in social aggregates that provided individuals with opportunities for feedback about themselves and validations of their expectations of others. Extending Cobb's emphasis on subjective perception, Caplan accentuated individuality. The highly personalized regard that support groups had for members buffered against disease. Support groups were sensitive to the unique needs of individuals. More specifically, social aggregates offered three kinds of support to the individual: they helped "mobilize his psychological resources and master his emotional burdens; they share(d) his tasks; and they provide(d) him with extra supplies of money, materials, tools, skills, and cognitive guidance to improve his handling of his situation" (Caplan, 1974: 6). In brief, he identified three dimensions of social support: emotional, instrumental, and informational.

To emphasize the continuing nature of social support Caplan used the term "system". He defined a social support system as "an enduring pattern of continuous or

intermittent ties that play a significant part in maintaining psychological and physical integrity of the individual over time" (Caplan, 1974: 7). He did not mention any structural properties commonly associated with a systems approach. Instead, he focussed on the durability of the system of social ties. The family was identified as the best known support system.

Others have criticized Caplan's emphasis on support systems. Gottlieb (1983) charged that Caplan went too far by suggesting that social support was ubiquitous in the community. He reified social support systems by leaving the impression that they are recognizable entities, containing resources waiting to be tapped. Wellman (1981) also criticized the notion of social support system for de-emphasizing the multifaceted and often contradictory nature of social ties. He preferred the idea of social network. The distinction between the two terms will be addressed more fully later in this chapter.

In summary, the seminal works of Cassel, Cobb, and Caplan have two notions in common. First, social support only exerted its protective effects in stressful circumstances; and second, social support consisted of feedback or information from significant others. They differed in the dimensions of support they emphasized. Cobb completely omitted instrumental support, and stressed the saliency of the subjective perception of feeling supported. In contrast, Caplan included instrumental support; however, he put more emphasis on the importance of the social support system meeting individuals' needs. These three works set the stage for numerous investigations

within the perspective that views social support as a buffer.

2.3 BUFFER VIEW OF SOCIAL SUPPORT

In keeping with the early works on social support, a substantial body of research emphasizes the importance of social support as a buffer or mediator of stressful life events (Dean and Lin, 1977; Mueller, 1980). Within this perspective, social support is conceptualized as cushioning the harmful effects of various life stressors. A lack of social support during stressful times results in somatic and psychiatric illnesses (Rook and Dooley, 1985).

Essentially, this perspective has three constructs: stressful life events, social support, and well-being. There are two propositions linking these constructs. First, the occurrence of stressful life events is negatively related to well-being. Put differently, as stressors increase the onset and/or prevalence of illness increases. Second, social support is an intervening variable between stressful life events and illness. By moderating the impact of stressful life events, social support is positively related to well-being (Dean and Lin, 1977).

It was established in the first chapter that the social support literature abounds with controversial findings. Research within this framework is no exception. It is not uncommon to find studies that substantiate the buffer view of social support, as well as studies that dispute it.

Several studies support the buffer hypothesis by demonstrating a positive relationship between social support and well-being when a person is in crisis. For example, Badura and Waltz (1984) explored the relationship between serious illness, quality of interpersonal relationships and experienced socio-emotional support, and psychological well-being. They concluded that a supportive social environment was a key determinant of the positive dimension of well-being for individuals experiencing a life crisis (Badura and Waltz 1984). Similarly, Porritt (1979) looking at quality versus quantity of social support, found that quality of reactions to the person in crisis was more important to outcome than quantity of social support. As well, Thomas et al. (1985) in a study of elderly men and women found a positive association between good health and longevity, and social support. Stressor in this instance was used in a broader sense than stressful life events. Instead, the researchers argued that in general older people lead stressful lives because of the many losses they experience: general loss of vigor due to declining physiological functions; loss of income and prestige; and loss of significant relationships in their lives.

There are also studies that counter the buffer view of social support. Andrews et al. (1978) in an Australian study, found that neither coping style nor any of their three social support variates showed a mediating effect on the relationship between life event stress and psychological impairment. Instead, crisis support exerted an independent effect on psychological impairment. Similarly, Lin et al. (1979) tested the buffering hypothesis as well as the direct effects hypothesis of social support. They argued that social support may help

to prevent stressful life events from occurring by encouraging preventive health behavior; or social support may serve as a buffer reducing the drastic emotional and physical consequences of life stressors (Lin et al., 1979). The findings did not substantiate the direct effects view of social support and there was "very weak" evidence supporting the mediating effect of social support between stressors and illness (Lin et al., 1979: 116).

The lack of consistency in research findings in part reflects differing methodology and construct definitions. The precise boundaries of this framework are not explicit, evidenced by the vague limitations on the constructs. Stressors or stressful life events generally are conceptualized as features of the environment which pose a threat to physical and psychological well-being (Depner et al., 1984). In keeping with Selye's work on the general adaptation syndrome, stressors are defined as any object/event/process that elicits a stress response (Marsella and Snyder, 1981). In other words, stressors refer to any event that causes neuro-endocrine changes in the body upsetting the normal equilibrium, which in turn increases susceptibility to disease in general (Cassel, 1976; Gelein, 1980). Such a broad conceptualization results in empirical indicators that are as general as old age or as specific as illnesses such as myocardial infarction (see Thomas et al., 1985; Badura and Waltz, 1984).

This research also employs a broad conception of well-being. Empirical measures include such instruments as psychological well-being scales (e.g., Affect Balance Scale, Bradburn, 1969), psychological and physical

illnesses (e.g., schizophrenia, heart disease), and even longevity. On a conceptual level well-being is viewed as a multidimensional concept. It encompasses subjective evaluations of general satisfaction and happiness and also objective conditions such as general health and functional status (George and Bearon, 1980).

The broad conceptualizations of both stressful life events and well-being mean that the same research indicators can be used to measure different constructs. For example, Badura and Waltz (1984) use illness as an indicator of a stressful life event and Thomas et al. (1985) use illness as a measure of well-being. This results in a lack of comparability between studies precluding any type of conclusions being drawn.

The third construct in this framework, social support, is conceptualized as an intervening factor that enhances an individual's ability to cope with stressful situations. Generally, the definitions of social support conform to the conceptions of Cassel, Cobb, and Caplan. Similar to Caplan's understanding of support system, Thomas et al. (1985) and Lin et al. (1979) refer to support being accessed through social ties or relationships with other individuals. Moreover, several of the social support definitions refer to necessary provisions or basic needs being met through interaction (Badura and Waltz, 1984; Thomas et al., 1985; Thoits, 1982, 1986). Thomas et al. (1985) describe such provisions as a sense of security, a sense of being needed, and sharing of ideas and experiences. Badura and Waltz use Cobb's definition and refer to such needs as feeling cared for, loved, and

valued. As a result, the provision of material or instrumental support is de-emphasized.

In summary, the buffer perspective examines two relationships between three constructs: stressors in relation to well-being or illness; and social support as a mediator between stressors and well-being or illness. The boundaries of this framework are not explicit as evidenced by the broad definitions of all three constructs and the diversity of empirical indicators.

2.4 DIRECT EFFECTS VIEW OF SOCIAL SUPPORT

Another framework views social support as an ongoing part of everyday life, rather than as a buffer mobilized primarily by individuals experiencing life stressors (Rook and Dooley, 1985). As with the buffer approach, social support is conceptualized as gratifying needs. However, fulfillment of needs is required on a daily basis regardless of stressful life events. This approach is evident in empirical studies that do not measure life stressors, but instead examine the main effects of support on various dependent variables.

Within this perspective two major approaches are found. First, there is a vast array of studies that focus on individuals and the assistance or help they receive -- here referred to as Social Support as Helping. The second approach incorporates social network concepts and focusses on linkages between people -- here referred to as the Social Network Approach. Although both approaches view social support as an independent variable with direct effects on dependent variables such as well-being, they

differ in origin and consequently attend to different aspects of social support. It is helpful to review briefly each approach.

2.4.1 Social Support as Helping

This approach reflects the influence of disciplines such as sociology, medicine, and social work (Chapman and Pancoast, 1985). The sociological influence is seen in functionalist theories -- disengagement and activity theories -- found in social gerontology. As well, the focus on social integration in several studies reflects the influence of classical sociological works such as Durkheim (Badura and Waltz, 1984; Liang et al., 1980). Durkheim demonstrated the importance of social forces in creating moral integration. This, in turn, under certain circumstances placed constraints on the individual and prevented such acts as suicide (Durkheim, 1951). The implication is that social support as an aspect of social integration has an important influence on the behavior of individuals.

The influence of more applied disciplines, medicine and social work, is illustrated in the gerontological literature by the heavy emphasis on physical dependency and support (Chappell and Havens, 1985). In the formal health care system, medicine attends to physical deterioration and diseases of old age. This has resulted in a predominant view of social support as instrumental support; for example, studying instrumental activities of daily living such as meal preparation, shopping, and transportation.

The Social Support as Helping Approach contains two constructs: social support and well-being. The major hypothesis proposes that social support is positively associated with well-being. In contrast to the buffer framework, however, the ongoing main effects of support are explored.

Studies in this area may be categorized into three groups that reflect the emphasis on social integration and instrumental support. The first group of studies view all social interaction as supportive whether it is interaction with a spouse or interaction in a club. The second group of studies considers social support or assistance as distinct from social interaction. This conception focusses on patterns of social support by examining the source, type, and amount of social support. And finally, the third group of studies views social support as having two aspects, both subjective and objective dimensions. The most important dimension is the subjective aspect or quality of social support.

Research Examining Social Interaction. All studies in the first category concentrate on levels of social interaction or participation in different activities. The focus on social interaction of the elderly stems from early theories of aging. In the past an underlying assumption regarding the aged was that the rate of social interaction declines with age (Dowd, 1975). This gradual process of withdrawal, referred to as disengagement, was considered normal and functional for the aged person and society (Cummings and Henry, 1961: cited in Bultena and Oyler, 1971). Counter to this view, activity theory developed and presented empirical evidence

that the level of social interaction and life satisfaction were positively related (Dowd, 1975). Thus, proponents of activity theory argued that social interaction must be supportive if it is related to positive morale.

Studies of this type usually measure social interaction by self-reports of frequency of face-to-face contact, telephone contact, and participation in organizational activities (Bultena and Oyler, 1971). Results of such investigations are mixed. Some find a significant direct relationship between happiness and social activity (Graney, 1975). Others report little or no significant relationship between social interaction and life satisfaction (Bultena and Oyler, 1971; Palmore and Luikart, 1972; Mancini et al., 1980).

Research Distinguishing Social Interaction and Social Support. The second group of studies in this approach distinguish between social interaction and social support. In particular, they investigate the source of social interaction and support in terms of family, friends, or neighbours. The gerontological literature consists of several studies dealing with family interaction and intergenerational parent-child interaction (Chappell, 1983; Johnson, 1983; Lee, 1985). A consistent finding is that family members are major providers of assistance for older people (Stephens and Bernstein, 1984; Bild and Havighurst, 1976).

This is in line with Cantor's (1980) hierarchical-compensatory model. Cantor proposes that close kin, especially the spouse or adult-child, are turned to first for aid regardless of task. When close kin are not

available friends and neighbours are in turn asked for help. Similarly, Shanas (1979) suggests that a principle of family substitution operates whereby family members become available in serial order to provide support. Research has been carried out to test this model and principle. The various investigators generally view social support as the provision of assistance, but their measures reflect a central concern with who is providing the assistance.

Again, the studies in this area report inconsistent findings. Johnson (1983) analysed the patterns of support of 167 posthospitalized elderly. Her findings corroborated the principle of substitution. However, in another study of elderly residents of planned housing, the pattern of support and its relationship to well-being was less clear cut. Stephens and Bernstein (1984) examined support given by elderly residents, family, and nonresident friends. Analyses revealed that family and nonresident friends were the primary providers of support to respondents. Yet, relationships with nonresident friends did not appear to play an important role in well-being. It appeared that poor health was associated with both support and lower levels of satisfaction.

Some studies focus more on one source of support such as neighbours. Stein et al. (1982) examined the relationship between neighbour support and physical and psychosocial functioning. They found that elderly who receive and give less neighbour support function significantly less well, both physically and psychosocially. In another study, O'Bryant (1985) compared neighbour support given to three groups of older widows:

those who were childless, those with children in the same city, and those with children elsewhere. Childless widows did not receive more neighbour support despite their apparent greater needs. These findings counter Cantor's hierarchical-compensatory model.

Still other researchers are concerned with source of support in terms of informal and formal support (Chappell, 1985; Chappell and Havens, 1985). A study by O'Brien and Wagner (1980) examined the balance of formal and informal support of a sample of frail elderly. They reported that respondents with higher rates of informal social interaction received lower rates of formal aid and higher rates of informal aid. However, due to the low strength of empirical relationships, they suggested the possibility of informal support members blocking access to formal services. In contrast, Morris and Sherwood (1983-84) portray the relationship between informal and formal support as more complementary. They view the formal support services as ancillary to informal support. Formal services fill in the gaps in assistance in line with the capacity of the informal supporters to provide aid.

Research Examining Subjective Aspects of Social Support. The third group of studies in this approach examines the quality of social support. Generally, this group of researchers claim that the inconclusive evidence regarding the relationship between social integration or support and well-being reflects the overemphasis on objective aspects of social support (Lowenthal and Haven, 1968; Moriwaki, 1973; Liang et al., 1980; Ward et al., 1984). In opposition, these studies argue that the relationship between the objective aspect of support or

integration and well-being is mediated by the subjective dimension of support or integration. Although some studies do not support this hypothesis (e.g., Moriwaki, 1973), the major finding is that subjective assessments of social ties and support exhibit stronger associations with well-being than objective assessments (Lowenthal and Haven, 1968; Liang et al., 1980; Grams and Fengler, 1981; Blazer, 1982; Ward et al., 1984).

The foregoing illustrates the uncertainty surrounding the proposition that social support is positively related to well-being. As in the buffer perspective, the inconclusive research findings reflect the ambiguity surrounding the constructs in this framework. The construct well-being is multidimensional and researchers usually focus attention on just one dimension: morale, life satisfaction, psychosocial well-being, or physical health.

Similarly, what is included in the construct social support varies considerably; the studies discussed above suggest three different notions of social support: i.e., as social interaction; as the provision of instrumental assistance; and, as a subjective evaluation or perception. As well, it is proposed that each view of social support is positively related to well-being.

2.4.2 Social Network Approach

The second approach within the direct effects view of social support introduces another construct, social network. The Social Network Approach provides a means for studying the interplay between the individual and his or

her social world (Snow and Gordon, 1980). In other words, it provides a way to describe, quantify, and analyze the complexities of the social milieu (Marsella and Snyder, 1981).

This approach generally includes two constructs: social network, and well-being. The most common proposition is that larger and denser social networks are positively related to greater well-being. Density refers to the proportion of possible links or ties that actually exist in a social network (Shulman, 1976). Several works describe the social networks of persons known to have poorer mental health with social networks of a normal control population (e.g., Cohen and Sokolovsky, 1979; and Froland et al., 1979). Generally, they find that persons with poorer mental health have networks characterized by fewer linkages overall, fewer intimate relationships, and greater asymmetrical and dependent relationships (Mitchell and Trickett, 1980). This also applies to general health status. Gallo (1982) in his study of the elderly reported a moderate positive relationship between network size and health status. Similarly, Coe et al., (1984) found that elderly persons abandoned by both family and neighbour networks reported the poorest health status.

In all of these studies, social support is not explicitly defined. Implicit is the assumption that people with larger and denser social networks receive more social support than those with smaller and less dense social networks. Furthermore, as with the Social Support as Helping Approach, well-being is assumed to increase proportionally with the amount of support. There is not a

clear distinction between social network and social support.

Social network and social support are not synonymous, although many authors confuse the constructs and use them in the same way (Shinn et al., 1984). Generally, there is greater agreement as to what constitutes a social network, than what constitutes social support (Rock et al., 1984). A social network consists of nodes or points and relations. In the support literature, nodes commonly refer to individuals, but they can just as easily refer to groups, households, or other collectives. Relations are the lines joining the nodes. They represent relationships between people or collectives. More formally stated, then, the construct social network refers to a set of nodes and a set of ties connecting the nodes (Wellman, 1981).

To clarify further the distinction between social support and social network, it is useful to examine briefly how the social network construct has been applied. The social network construct has been employed in studying a variety of phenomena. In the 1950's Barnes, an anthropologist, found it more theoretically useful to study a fishing village in terms of interacting networks than by examining conventional categories of social class and kin (Barnes, 1954). Similarly, in a study of urban families in England, Bott (1957/1971) could explain more about segregation of conjugal roles by examining network density, than by looking at social class. Other authors have used social networks to examine urban social organization (Epstein, 1969), relationships in a work setting (Kapferer, 1969), mobilization of support (Boswell, 1969), help-seeking behavior (McKinlay, 1973, 1980), friendship

ties in contemporary society (Fischer, 1977), and well-being of the elderly (Ward, 1985). Regardless of the social behavior of interest, all these studies examined the structure, or pattern of social relationships that constitute a social network.

Social network is used in two different approaches: in what has been termed here the Social Network Approach; and, in the more formal and structural approach of Network Analysis. Although both approaches focus on patterns of social relationships, Network Analysis concentrates on mathematically describing network patterns. There is a fundamental assumption that social relationships delineate roles and define positions in the group, as opposed to the more conventional view that differences in attributes and positions affect social relations (Blau, 1982). More simply stated, in Network Analysis studies are designed in terms of social ties or relations, not in terms of characteristics of individuals.[1] In contrast, the Social Network Approach examines social relations or ties within a defined social network as a means or tool for condensing a large amount of information into concise quantifiable terms in order to analyze an individual's support relations (Froland et al., 1979). It is a starting point for a more complex investigation of how individual and environmental characteristics influence the transmission and availability of social support (Mitchell and Trickett, 1980).

In the social support literature the Social Network Approach is more common than Network Analysis. Many studies have employed the social network construct to examine social support (Garrison et al., 1976; Pilisuk and Minkler, 1980; Froland et al., 1981; Gallo, 1982). Unlike

Network Analysis which would usually look at both supportive and non-supportive ties of a network, research of the Social Network Approach tends to analytically limit the focus to supportive social ties of individuals' social networks. The research aim is to understand the functions (e.g. emotional or instrumental support) which social networks or support systems can perform for network members (Pilisuk and Froland, 1978). As a result, attention focuses on the flow of supportive resources through the ties of the network (Wellman, 1982).

Some authors consider the distinction between structure and content as useful in illustrating how social support fits in the Social Network Approach (Rook and Dooley, 1985). Structure refers to the pattern of relationships of a person's social network. It includes such network characteristics as size and density. Content refers to the nature of the helping transactions between the focal persons and members of his or her network. Content is influenced by structure insofar as structural characteristics affect the availability and quality of assistance or support. In other words, social support refers to a helping transaction whether it provides feedback, information, money, or transportation.

In this approach, then, social support is viewed as a function of the social relationships in which an individual is embedded. Social networks are important to understanding social support in that network characteristics influence how critical needs of network members are fulfilled (Pilisuik and Minkler, 1980). Social networks function as a powerful determinant of a person's

access to information, assistance, or support, which in turn affects well-being (McIntyre, 1986).

As for the construct well-being, it is generally viewed in the same way as observed in the buffer perspective. It is multidimensional including subjective perceptions of general happiness and satisfaction as well as objective evaluations of such things as overall health.

In review, the framework of Direct Effects of Social Support consists of two approaches: Social Support as Helping and the Social Network Approach. Both approaches are in agreement with the view of social support as exerting a direct effect on well-being. They differ in the aspects of social support to which they attend. The former approach focusses on the following aspects: social interaction or participation; source, type, and amount of assistance, especially instrumental support; and quality of support. In contrast, the central concern of the Social Network Approach is how social network characteristics affect access and availability of support which in turn influences well-being.

2.5 EXCHANGE VIEW OF SOCIAL SUPPORT

A more recent development in the social support literature is a third framework viewing social support as an exchange of resources. In this approach the focus is on the balance of personal or social costs and benefits involved in the interaction between those providing and those receiving support (Froland et al., 1981). There are basically two constructs: supportive exchange and

well-being. The major hypothesis states that unbalanced supportive exchange is negatively related to well-being.

This approach is grounded in exchange theory which drew its inspiration from utility theory in economics and reinforcement theories in psychology (Mutran et al., 1984). Actually, exchange theory is a frame of reference within which there are many theories (Emerson, 1976). Despite the many theories, there are some basic concepts and assumptions central to the exchange perspective.

The basic assumption underlying this framework is that interaction between individuals or collectivities can be characterized by attempts to maximize rewards and minimize costs (Dowd, 1975). Costs are incurred in two ways: through a negative exchange experience; or through the loss of benefits associated with an alternative course of action (Dowd, 1975). Rewards may have intrinsic and/or extrinsic significance for an individual, but above all a positive or rewarding exchange increases the likelihood of further exchange. Conversely, a negative or costly exchange reduces the likelihood of further exchange (Cook, 1982; Emerson, 1976). This means an exchange relation is not a single transaction between two people. Rather, it involves transactions sustained over time because people find the transactions rewarding.

This suggests that persons engaged in an exchange of supportive resources will continue their exchange only so long as the exchange is perceived as being more rewarding than it is costly (Froland et al., 1981). If reciprocal exchange of resources is not forthcoming or costs outweigh rewards, the exchange relation eventually dissolves.

However, for the dependent elderly, termination of the relationship may be unrealistic. For example, an elderly person with chronic health problems may rely on informal helpers for support with tasks of daily living. As the health of the person deteriorates it becomes increasingly difficult to maintain a balanced exchange relation. As a result, both parties in the relation may experience detrimental effects. The dependency may undermine the elderly person's morale and the providers of support may feel overburdened (Johnson, 1983; Lee, 1985).

Within this framework, then, conceptions of social support focus on exchange and the relationship of supportive exchange to well-being. For example, Minkler et al. (1983) hypothesized that a sense of supportive exchange or the perceived involvement in giving and seeking of advice and other forms of assistance may be significantly associated with perceived health status. However, they only found a significant positive relationship between advice seeking and perceived health status. There was no significant relationship between advice giving and perceived health status. Mutran and Reitzes (1984) found that among elderly widows and widowers, receiving help reduced negative self-feelings and giving help increased negative self-feelings. They suggested that receiving help from children operates as a reward and lessens negative self-feelings, while giving help to children operates as a cost and increases negative self-feelings. Counter to these findings, Stoller (1984, 1985) found that higher levels of informal assistance were associated with decreased psychological morale for both the caregiver and the elderly care receiver. This is consistent with exchange theory which suggests that high

levels of assistance create a power imbalance and place the older person in the role of dependent recipient (Stoller, 1984). As with the previous frameworks, the research findings are contradictory.

In part, the contradictory findings reflect the vague boundaries surrounding the constructs. In keeping with the other approaches, the construct well-being is defined broadly to include objective conditions such as health status and subjective evaluations such as life satisfaction and self-feelings (Minkler et al., 1983; Stoller, 1984, 1985; Mutran and Reitzes, 1984). However, unlike the other perspectives, this approach takes a different view of social support.

To illustrate, Shumaker and Brownell (1984: 13) define social support as "an exchange of resources between at least two individuals perceived by the provider or the recipient to be intended to enhance the well-being of the recipient." This definition makes the view explicit that support necessarily involves at least two persons. The term exchange suggests that there are potential costs and benefits associated with the exchange for both individuals. In other words, support occurs in the context of interpersonal relations. The nature of the relationship and the interactions it encompasses affects the social support exchange. Thus, for both parties in the exchange, social support may be accompanied by positive or negative aspects. Also, the definition specifies that resources are exchanged. Again, what are considered supportive resources depend on the researcher, including anything from advice to financial support.

In this framework, then, three new ideas surrounding social support are introduced. First, social support is a two-way exchange of resources. Second, the perceptions of both the care receiver and care giver are considered relevant and important. Lastly, it must not be assumed that social support is always encompassed in positive social interaction.

2.6 CHARACTERISTICS OF SOCIAL SUPPORT

In reviewing the three perspectives on social support, it is noted that each perspective highlights somewhat different characteristics of social support. In general the Buffer View of Social Support conceptualizes the construct as a sense of belonging, feeling cared for and loved by significant others of a person's support system. Moreover, social support is only important during stressful life events. In contrast, the Direct Effects View of Social Support envisions social support as ongoing daily social interaction, helping, assistance, a feeling of being supported and embedded in a social network. Contrary to both of these perspectives the Exchange View pictures social support as a two-way exchange between people. It involves perceptions of two parties and is encompassed by social interaction.

Each framework is operating from a different point of view and under a different set of assumptions. As such, each perspective offers a different way to view social support and provides different insights into how social support operates. However, despite the differences there are areas of overlap among the frameworks that serve to

highlight what is central to social support and helps to identify the dimenions of social support.

The themes common to the three perspectives may be grouped into three broad categories of social support. Barrera (1986) identifies these broad categories as social embeddedness, enacted support, and perceived support. It is argued here that Barrera's categories capture the three major themes found in the perspectives on social support. Furthermore, these categories represent three different dimensions of social support.

2.6.1 Social Embeddedness

Social embeddedness "refers to the connections that individuals have to significant others in their social environment" (Barrera, 1986: 415). This dimension incorporates ideas from the Buffer View -- ties to significant others in a support system -- as well as the idea of social network from the Direct Effects View.

Two prevalent approaches to measuring social embeddedness are seen in the Direct Effects View of Social Support. One approach consists of measuring the presence or absence of ties such as spouse and children (e.g., Johnson, 1983; Badura and Waltz, 1984), contact with family and friends (e.g., Jonas, 1979; Chappell, 1983; Lee, 1985), and participation in activites in the community (e.g., Graney, 1975; Bild and Havighurst, 1976; Mancini et al., 1980; Chappell, 1983).

The second approach is the Social Network Approach which measures a variety of characteristics of a social

network. Mitchell (1969) was the first to attempt to describe explicitly characteristics of networks. He delineated two sets of characteristics: morphological criteria and interactional criteria. The former referred to the patterning of the relations in the overall network and included such properties as size and density. Put simply, they referred to the shape of the network. The latter criteria referred to the nature of the relations between members of the network. These included properties such as frequency of contact, intensity of relations, and relationship durability. Subsequent attempts to specify precisely the properties of social networks have been similar to Mitchell's work (1969). There is some diversity in measures depending on such factors as the investigator's research interest and the boundaries of the network studied (e.g., informal versus formal network). However, the distinction between the overall network and ties of the network remains.

2.6.2 Enacted Support

A second dimension common to mainly the Direct Effects View and Exchange View of Social Support is enacted support. Barrera (1986: 417) defines it "as actions that others perform when they render assistance to a focal person." In other words, this dimension of social support is comprised of social support that actually occurs. In contrast to social embeddedness, enacted support examines what individuals actually do when they provide support. Generally, enacted support is measured by self-report accounts of support received or given by respondents (Stephens and Bernstein, 1984; Chappell, 1985).

Regardless of the specific measures used, there are similarities in the literature in the types of enacted support studied. Mitchell and Trickett (1980) summarize the social support functions provided by social networks as four types: (1) emotional support; (2) task-oriented assistance; (3) communication of expectations, evaluation, and a shared world view (appraisal support); and (4) access to new and diverse information and social contacts. It is argued here that the common functions of social networks are synonymous with types of enacted support. Table 2.2 is adapted from a table of the functions of social support (Mitchell and Trickett, 1980). It outlines several authors' views of the functions of social networks or what is called here types of enacted support. These functions are consistent with Barrera's (1986) notion of helping behaviors that constitute enacted support. For example, Israel et al. (1984) identify two major supportive functions: affective support and instrumental support. Affective support refers to such helping behavior as providing emotional and moral support (e.g., listening to an elderly person's health problems). Instrumental support refers to the provision of tangible aid and services (e.g., assisting an elderly person with grocery shopping).

In all, Table 2.2 summarizes five types of enacted support identified in this literature review. The five types of enacted support are as follows: emotional support, instrumental support, appraisal support, informational support, and companionable support. In addition to Mitchell's and Trickett's four types of support, this author added an 'other' category to capture any types of social support that did not fit in their four types. Common to the 'other' type of enacted support is

TABLE 2.2
TYPES OF ENACTED SUPPORT*

	EMOTIONAL SUPPORT	TASK-ORIENTED ASSISTANCE	APPRAISAL SUPPORT (communication of expectations)	INFORMATIONAL SUPPORT (access to new information)	OTHER
Antonucci and Israel, 1986	confiding, reassurance, talk with when upset, talk with about health	sick care	respect		
Baldassare et al., 1984	emotional support	instrumental help			companionship, social activities
Cohen et al., 1985b	emotional aspect of exchange	material aspect of exchange (e.g., money, food, medical aid)			
Froland et al., 1979	advice and assistance with emotional problems	place to live, find a job, money assistance			
Gallo, 1982	emotional support		feedback		
Garrison and Howe, 1976	affective resources	instrumental resources			

* adapted from Mitchell and Trickett, 1980

TABLE 2.2 continued
TYPES OF ENACTED SUPPORT

	EMOTIONAL SUPPORT	TASK-ORIENTED ASSISTANCE	APPRAISAL SUPPORT (communication of expectations)	INFORMATIONAL SUPPORT (access to new information)	OTHER
Heller and Mansbach, 1984	emotional support- listen, encourage, understand			problem solving support- explore alternatives, referrals	companionship support- enjoy company, have fun
Hirsch, 1979	emotional support- sharing feelings or personal concerns				social support- overall satisfaction with social interaction
Israel et al., 1984	affective support- provision of emotional and moral support	instrumental support- provision of tangible aid and services			
Levitt et al., 1985	affective aid	instrumental assistance	affirmation of personal worth		
Lieberman, 1986	exchange of emotional services	exchange of instrumental services		exchange of informational services	
Marsella and Snyder, 1981	expressive functions	instrumental functions			

TABLE 2.2 continued
TYPES OF ENACTED SUPPORT

	EMOTIONAL SUPPORT	TASK-ORIENTED ASSISTANCE	APPRAISAL SUPPORT (communication of expectations)	INFORMATIONAL SUPPORT (access to new information)	OTHER
McKinlay, 1980	emotional support	material aid and services	social identity	information new social contacts	
Mueller, 1980	emotional support	monetary or carry-ing out other tasks		informational support	
Oyabu and Garland, 1987	emotional support	instrumental support			
Pilisuk and Minkler, 1980	emotional support	material aid and services	social identity	information new social contacts	
Shulman, 1976	emotional support	services and material assistance			companionship
Snow and Gordon 1980	confidant	necessary services (e.g., health, transportation)			

TABLE 2.2 continued
TYPES OF ENACTED SUPPORT

	EMOTIONAL SUPPORT	TASK-ORIENTED ASSISTANCE	APPRAISAL SUPPORT (communication of expectations)	INFORMATIONAL SUPPORT (access to new information)	OTHER
Thoits, 1982	socioemotional aid (e.g., affection, sympathy, and understanding, acceptance, and esteem)	instrumental aid (e.g., advice, information, help with family or work responsibilities)			
Thoits, 1986	socioemotional aid	instrumental aid		informational aid	
Ward, 1985	expressive aid, confidant	instrumental help			
Wellman, 1981	emotional support	material and instrumental help and services	shared values and interests	information help and help contacting agencies	shared group activities

the notion of companionship. Five of the 22 studies in Table 2.2 considered companionship and social activities as a form of social support. Thus, a fifth type of enacted support is added and called companionable support. It refers to social activities involving companionship and sociability.

All types of enacted support are identified and studied in varying degrees in the three perspectives discussed above. The Buffer View focusses more on emotional and appraisal support. The Direct Effects View attends more to instrumental support and also to companionable support. The Exchange View puts some emphasis on perceived support, but includes all types of enacted support in the exchange of support. By explicitly outlining the types of enacted support, clarity and precision of the definition of social support is improved.

Despite the improved precision, it is important to acknowledge that the boundaries separating the five types of support are hazy. There is some overlap between emotional and appraisal support and also between task-oriented assistance and informational support. For example, Thoits (1982) includes affection, sympathy and understanding, acceptance, and esteem under one type, socio-emotional aid. She combines emotional and appraisal support. Similarly, she refers to advice, information, help with family or work responsibilities, and financial aid, as instrumental aid (Thoits, 1982). Thus, task-oriented and informational assistance are categorized together as instrumental support. Moreover, of the 22 studies outlined in Table 2.2, all but three identify both emotional and task-oriented support, almost half (10 of 22

studies) only identify these two types. Hence, both emotional and instrumental support appear to be the most frequently recognized types of enacted support.

2.6.3 Perceived Support

The third dimension is perceived support. Barrera (1986: 416) defines it "as the cognitive appraisal of being reliably connected to others." This is exemplified in the earlier works on social support, such as Cassels's (1976) emphasis on the feedback function of support. The importance of perceived support is also salient in the three perspectives of social support. The Buffer View suggests that the quality of support is more important than quantity of support. Quality of support necessarily involves the individual's subjective view of feeling supported. In the Direct Effects View some research suggests that the subjective dimension of support mediates between objective aspects of support and well-being. As well, a basic tenent of the Exchange View is that exchange of supportive resources will generally continue only so long as the exchange is perceived as rewarding. An individual's perception of the support exchange is critical in determining whether the exchange relation is maintained or dissolved.

Measures of perceived support usually consider at least one or two aspects of perceived support: perceived availability of support; and perceived satisfaction with support (e.g., Blazer, 1982; Coyne and Delongis, 1986). Some studies have been criticized for assuming that family relationships necessarily involve affection and assistance (Rook, 1984; Rook and Dooley, 1985; Ward, 1985). This

assumption ignores supportive exchanges that involve more negative social interaction. Similarly, strength of ties does not necessarily indicate support. Granovetter (1973, 1979, and 1982) argues that weak and strong ties play unique roles in different circumstances. The only way to ascertain whether a relationship is supportive to an individual is to use some measure of perceived support.

It is suggested, then, that social support can be conceptualized as three dimensional. One dimension, social embeddedness, captures the structure of social relationships in which a person is involved and affects the availability of social support. It is the more quantitative aspect of social support. A second dimension, enacted support, encompasses the types of social support that are actually provided. Lastly, the third dimension, perceived support, furthers the definition of social support by including a more qualitative aspect of the construct -- the person's perception of being supported.

The result is a definition of social support that allows precise communication.[2] The improved precision facilitates the selection of appropriate indicators to measure social support. As well, this comprehensive conceptualization of social support maintains the theoretical utility of the construct.

NOTES

[1] See the works of McCallister and Fischer (1978), Boissevain (1979), Burt (1980), Niemoller and Schijf (1980), Alba (1982), Berkowitz (1982), and Hall and Wellman (1985) for more indepth discussions of network analysis.

[2] Cohen (1980) outlines three objectives for scientific concept formation: (1) precise communication which refers to forming concepts and defining terms in a way that maximizes shared understandings, by controlling surplus meaning; (2) empirical import which refers to being able to link the social support construct to the world of sense experience; and (3) fertility or the theoretical utility of the construct. Utility refers to the usefulness of the concept in helping us understand the world -- knowledge gain.

CHAPTER 3

RESEARCH OBJECTIVES AND METHODOLOGY

This chapter outlines the research objectives and describes the methodology utilized in this thesis. From the review of the social support literature, three dimensions of social support have been identified. Below these dimensions of social support are summarized in the context of each perspective and the hypotheses to be tested are presented. Following this, four aspects of the methodology are discussed: source of the data; secondary data analysis; operationalization; and data analyses.

3.1 THE PERSPECTIVES AND THE DIMENSIONS OF SOCIAL SUPPORT

Each perspective of social support provides a different understanding of how social support operates. In view of the three dimensions identified in the previous chapter, social support within each framework may be summarized as follows. First, in the Buffer View, social support is seen mainly as the dimension of perceived support. The emphasis is on the person's perception of feeling cared for, loved and valued. Social support is considered an intervening factor that enhances an individual's ability to cope during stressful life events thereby preventing a decrease in well-being. It is not viewed as having significant effects during everyday life. In terms of the elderly, then, the most important aspect of social support would be perceived support during stressful times such as the loss of a spouse.

In contrast, a second understanding of social support is demonstrated in the Direct Effects View. Unlike the Buffer View, social support is considered to be multi-dimensional. Within the Social Support as Helping Approach of this perspective, social support is considered mainly to be the dimension of enacted support. In this instance the concern is with support received in everday life not just in crisis. As a result, attention is given mainly to task-oriented and emotional support that actually occurs and its relationship to overall well-being. As well, the Social Network Approach of this perspective attends to a second dimension of social support -- social embeddedness. This approach focuses mainly on the quantitative aspects of a person's social network which influence the availability and accessibility of enacted support and perceived support which in turn influences well-being. For the elderly, enacted support is of greater consequence when the older person's level of functioning starts to decline, for example, when mobility is limited due to chronic conditions such as arthritis. As well, social embeddedness may become important for some individuals as they experience various changes associated with aging. For example, with retirement some individuals' social networks may decrease in size as they have less contact with former co-workers.

A third understanding of social support is provided by the last perspective, the Exchange View of Social Support. In this view social support is conceptualized mainly as two-dimensional. The balance of enacted support as well as the person's perception of being supported are seen as important to overall well-being. For the elderly person it is proposed that receiving more than giving or giving more than receiving enacted support may have a negative

influence on well-being. Some research suggests that older people prefer to be independent and "not be a burden" to their children (Brody, 1981). Consequently, receiving more support than given may negatively influence well-being. Also for the elderly person the opposite situation may have a negative association with well-being. In this instance, the older person may not be receiving the enacted support that is needed or may be overburdened by giving more enacted support than is received.

Also worthy of note was the research evidence in all three perspectives suggesting that it may be quality not quantity of social support that is most important to well-being (Badura and Waltz, 1984; Rook, 1984; Porritt, 1979; Lowenthal and Haven, 1969; Liang et al., 1980; Blazer, 1982; Israel, 1982b). For example, in the Buffer View Porritt (1979) found that the quality of support reactions to a person in crisis were more important than quantity of support. In the Direct Effects perspective some investigators found that qualitative assessments of social support ties exhibited a stronger association with well-being than objective assessments (Liang et al., 1980; Israel, 1982b). Lastly in the Exchange View, Rook's (1984) findings suggested that positive and negative affective aspects of social ties are independent domains of experience and both influence well-being. In terms of the three social support dimensions this means that perceived support may have a greater effect on well-being than either enacted support or social embeddedness.

In summary, the importance of each of the dimensions of social support to well-being varies depending on the perspective utilized.

3.2 RESEARCH HYPOTHESES

The purpose of this thesis is to identify and empirically verify the most common dimensions of social support and then to determine which dimensions are most important to the well-being of the elderly. This study is concerned with social support during everyday life not simply during crisis. The incidence of physical and mental impairment resulting in dependency increases with advancing age (Brody, 1981). For the elderly person experiencing varying degrees of functional impairment this may mean some assistance of an ongoing nature, not just aid in times of crisis. Consequently, the Buffer View of Social Support is not the focus of this thesis. Instead, attention focuses on the Direct Effects and Exchange Views of social support. More specifically, this thesis will assess which of these two perspectives, helps to explain the relationship between social support and well-being of the elderly.

Two hypotheses are formulated to test the two perspectives. The hypotheses are stated below.

Direct Effects View of Social Support

Despite some diversity of approaches within the Direct Effects View of Social Support, the basic proposition is that social support exerts a positive effect on well-being; hence, the first hypothesis states:

1. The dimensions of social support (enacted support received, social embeddedness, and perceived support) are positively related to the well-being of the elderly.

As explained above, the importance of each dimension of social support within this perspective varies depending on the approach used by the researchers. If enacted support received has a stronger positive relationship to well-being of the elderly than social embeddedness or perceived support, then it supports the Social Support as Helping Approach. Alternatively, if social embeddedness is found to have a stronger positive relationship to well-being than the other two dimensions, it provides evidence in favor of the Social Network Approach. A third possibility is that perceived support may have a stronger positive relationship to well-being of the elderly than either social embeddedness or enacted support received. If this is the case, it would lend some support to the notion that it is quality not quantity of support that is important. Evidence consistent with any of these three alternatives supports the Direct Effects View. However, findings consistent with the latter alternative, could also be interpreted as support for the Exchange View of Social Support. If the latter alternative is found, the results of testing the second hypothesis must be considered to determine the most appropriate interpretation.

Exchange View of Social Support

Central to the Exchange View of Social Support is the relationship of supportive exchange to well-being. This view suggests that imbalances of enacted support exchange are more important to well-being than any of the dimensions of social support. Either receiving more enacted support than giving or giving more enacted support than receiving may have a negative influence on well-being. This is tested by the second hypothesis.

2. **Unbalanced exchange of support is negatively related to well-being of the elderly when controlling for social embeddedness, enacted support received, and perceived support.**

Put differently, this hypothesis suggests that the relationship between exchange of support and well-being is curvilinear. Extremes of either receiving more enacted support or giving more enacted support tend to decrease well-being. Whereas when the exchange of enacted support is more balanced, in the middle of either extreme, well-being tends to increase.

The results of testing the two hypotheses are considered together in order determine the most appropriate interpretation of the findings. First, if the dimensions of enacted support received, social embeddedness, and perceived support are significantly and positively related to well-being while there is no evidence that supportive exchange is related to well-being, then the results support the first hypothesis and the view that social support directly affects the well-being of the elderly. As well, if only enacted support received or social embeddedness is significantly related to well-being, it suggests that within the Direct Effects Perspective either the Social Support as Helping Approach or Social Network Approach is more helpful in explaining the relationship of social support to well-being for the elderly. Furthermore, it would indicate that either the dimension of enacted support received or social embeddedness is important for this group.

Second, if there is only evidence of a relationship between perceived support and well-being, and no evidence

supporting the other dimensions, then it suggests that the dimension of perceived support is more helpful in explaining well-being of the elderly. This finding would be consistent with both the Direct Effects View and Exchange View of Social Support.

Third, if the second hypothesis is supported and there is only weak or no evidence supporting the first hypothesis, then it indicates that the Exchange View of Social Support helps to explain the relationship of social support and well-being for the aged. This would suggest that enacted support is again important, but the balance of enacted support between the giver and receiver must be considered for the elderly.

Fourth, it is also possible that there may be some evidence supporting both hypotheses. In other words, regression analysis may show that all three dimensions of social support plus supportive exchange contribute to some degree in predicting well-being of the elderly. If so, the proportion of variance accounted for by each dimension would be examined to assess which dimension was contributing the most to well-being.

Lastly, the results may not support either hypothesis. This would not entirely rule out the possibility of social support being important to the well-being of the elderly; rather, it may indirectly suggest that the Buffer View of Social Support is more useful in explaining the relationship between social support and well-being of the elderly. As well, the possibility exists that such a finding may be due, in part, to methodological problems

such as inadequate operationalization of the dimensions of social support.

The methodology utilized for this thesis is outlined below. More specifically, the next four sections of this chapter discuss the source of the data, secondary data analysis, operationalization, and data analyses.

3.3 SOURCE OF DATA

The data analysed are part of a larger cross-sectional survey designed to examine peer and intergenerational support networks among the elderly and their relevance for the home care service program in Manitoba, Canada [1] (Chappell, 1979). Thus, the methodology employed here is secondary data analysis. It is important to know enough about the original study to make sound decisions in data manipulation and analyses. In view of this, the purpose, target population, sample, and data collection procedures of the original study are outlined below.

Purpose of the Original Study. The purpose of the larger study was twofold. It examined the "comparative roles played by peer (both family and non-family) and intergenerational (with an emphasis on family) relations among the elderly" (Chappell, 1979: 13). As well, the study examined the relation between the elderly's support networks and utilization of the home care delivery system (Chappell, 1979). The second purpose examined the social support construct -- elderly's support networks -- as an independent variable affecting the dependent variable -- utilization of the home care delivery system.

Target Population of the Original Study. The target population for the larger study was elderly persons (age 65 years and over) who lived in the community in metropolitan Winnipeg of Manitoba (Chappell, 1983). As such, persons living in long-term institutions and persons under age 65 were excluded. This permitted a more indepth study of the community living elderly population.

Sample of the Orginal Study. The study included a stratified random sample of 400 home care recipients and 400 non-recipients of home care living in Winnipeg (Strain and Chappell, 1982). For the non-recipients of home care a random list of elderly persons in Manitoba by name, address, sex, and birth date was obtained from the Manitoba Health Services Commission. The sample of home care users was obtained from a random listing of all users in the central home care office. To ensure sufficient numbers of old elderly men, the total sample of 800 was stratified by age and sex.[2] All respondents were age 65 and over and lived in the community.

Data Collection Procedures of the Original Study. The data for the survey were collected by personal interviews in 1980. Interviews took from one and one-half to two hours to complete and interviewers completed two to three interviews per day. Interpreters were used to interview respondents who did not speak English. The refusal rate for the total sample was 25% and for the 400 non-recipients of home care it was 34%. Given this refusal rate, the principal investigators assessed the effect of refusals and ineligibles upon the final sample. Ineligibles included respondents who were deceased, hospitalized, or had moved. In terms of age and sex,

refusals and ineligibles were strikingly similar to the final sample. The investigators concluded that refusals and ineligibles had no effect on age and sex, and were themselves randomly distributed (Strain and Chappell, 1982).

The data collected in the interviews included information on the following: demographics; support provided by peer family, peer non-family, and intergenerational family relationships; confidant relationships; perceived health; and life satisfaction (Chappell, 1979). Particularly relevant here, the data on informal support looked at availability of social support, frequency of contact and satisfaction with social support, and types of support activities engaged in and with whom (Chappell, 1983). In comparison to other surveys examining social support, this survey incorporated very comprehensive measures of social support. The details of the measures are discussed in section 3.5, Operationalization.

3.4 SECONDARY DATA ANALYSIS

In utilizing secondary data analysis, the data for this thesis are extracted from the larger study and examined with a different focus than that of the original study (Hyman, 1972). The design for the thesis is achieved by rearranging parts of the original survey and by eliminating those portions that are not relevant to the thesis. This thesis then, has both the strengths and limitations of a cross-sectional survey as well as secondary data analysis.

3.4.1 Strengths and Limitations

One major strength of secondary data analysis is that it economizes on money, time, and personnel. Bowen and Weisberg (1980) argue that it makes economic sense to share the data that are collected so that others need not duplicate the effort. As well, given the time and expense involved in survey research, it is useful to study data to the fullest by additional analyses. In effect the data base is multiplied when used repeatedly for diverse purposes (Hyman, 1972).

A limitation of secondary data analysis is the danger of misusing or misapplying the measures of the original study. In using indicators that happen to be available, investigators sometimes measure concepts by inappropriate means (Hyman, 1972). Put differently, there is a danger of slippage between the concepts and indicators. In this thesis, this limitation is minimized in that the goal is to examine the construct social support which was a major concept of focus in the original study. In other words, there is some overlap between the purpose of the thesis and purposes of the original study. Therefore, the correspondence between original study indicators and thesis constructs are more likely to be appropriate.[3]

Other limitations stem from the design of the original study. In the original study the data are based on self-report indicators and collected in personal interviews. This presents two categories of problems: problems associated with self-report data, and problems associated with interviews.

Problems Associated with Self-report Data. Although self-report measures are not perfect indicators in that they are subject to recall error, they are worthy of use where better measures are not feasible. In studying social support there are no practical alternatives to asking people about their relationships. In most situations it is not possible to gather reliable, long term, behavioral data (Bernard et al., 1979/80). However, it is important to be aware of the degree of measurement error that may be present in the data due to self-report. In turn, any measurement error may be considered when interpreting the thesis findings.

The indicators for the three dimensions of social support are affected by varying degrees of measurement error. The measures of the dimension social embeddedness are expected to have the greatest amount of error. Generally, the longer the required period of recall and the more precise the measure, the greater the measurement error (Dunham, 1983; Deseran and Black, 1981; Killworth and Bernard, 1976; Williams, 1981). The measures of social embeddedness require respondents to remember the numbers of people in their social network as well as frequency of interaction with various network members. This involves fairly detailed recall over time. To minimize this error, respondents were given a specific time period of one year when responding to these questions.

Some error is also expected for the social support dimension of enacted support. Self-report research suggests that data have varying rates of accuracy depending on what is measured (Midanik, 1982). Some studies have found greater accuracy for indicators that measure items of

a factual nature such as education and occupation (Maisto et al., 1982; Aiken, 1986). This suggests that measurement error for this dimension will vary somewhat. There is likely to be less error in indicators measuring types of support that occur on a regular basis, for example, instrumental support such as regular weekly shopping. However, for support that occurs less frequently or regularly, for instance giving advice about a job, the error will increase.

Some measurement error may also affect the indicators measuring perceived support. The accuracy of these measures in terms of other relationships reciprocating the contact is not important; there are no correct responses. However, there is always the possibility that respondents will give socially desirable reponses that do not reflect their true perception of whether or not they feel supported.

Problems Associated with Interviews. As with other data collection techniques, there are certain strengths and limitations associated with interviewing. In contrast to a mail-out survey, interviews increase the likelihood that respondents are answering the questions the research has set out to ask. The advantage of personal interviews is that interviewers can use various non-verbal cues such as facial expressions and tone of voice to assist in communication, therefore avoiding misinterpretations. Furthermore, when misinterpretations occur, interviewers can rephrase questions and explore any new issues that arise that are pertinent to the study (Chappell, 1979).

A major drawback to interviewing is interviewer bias and distortion due to differing interviewer characteristics and techniques (Smith, 1981). Certain procedures were utilized in the original study to help decrease the problems associated with interviewing. First, interviewers received a two to three hour training session to familiarize them with standard interviewing techniques and the study questionnaire. As well, they had ongoing contact with the project co-ordinator who addressed any interviewer concerns, plus reviewed completed questionnaires and provided feedback to interviewers.

In summary, three potential limitations are noted. First, slippage between indicators and study constructs which has been minimized because social support is operationalized in a very comprehensive fashion in the original study. Second, the problems associated with self-report may result in varying degrees of measurement error. Third, the problems of interviewing may affect both reliability and validity of the data. Where possible various steps were taken to minimize these limitations. As well, these limitations were taken into account when interpreting the thesis findings.

3.5 OPERATIONALIZATION

Much diversity exists in the measurement of social support. Measures range from simply asking marital status (Dean and Lin, 1977) to more elaborate scales such as the Support Network Inventory (e.g., Stephens and Bernstein, 1984). More commonly frequency measures are used (Rook, 1984). For example, many investigators measure frequency of respondents' contact with family, friends, and

neighbours; and contact usually includes visiting, phoning, or letter writing (e.g., Bultena and Oyler, 1971; Graney, 1975; Jones, 1979; O'Brien and Wagner, 1980; Mancini et al., 1980). In addition to frequency of social contact, some investigators ask respondents whether they receive specific types of support such as emotional and instrumental support (e.g., housekeeping), and if so, who provides the support (e.g., Stein et al., 1982; Johnson, 1983; Morris and Sherwood 1983/84; O'Bryant, 1985).

In this thesis, frequency and types of support measures are used. However, the social support measures are more comprehensive in that they address both giving as well as receiving social support and also include respondents' perceived satisfaction with support. The variables selected from the original study as indicators of the construct social support, as well as the dependent and control variables are outlined below. Table 3.1 lists the three social support dimensions and how they were operationalized. Appendix A contains the selected questions from the original study interview schedule used to collect the data used in this study (Chappell and Strain, 1980).

Social Embeddedness. Social embeddedness refers to the ties or relationships to significant others within an individual's social environment. To measure this dimension, six composite variables are created from a series of variables in the original study. These variables are considered to be network properties characteristic of this dimension.

TABLE 3.1

OPERATIONALIZATION OF MAJOR CONSTRUCTS

Constructs	Operationaliztion
Social Embeddedness	- Number and frequency of contacts (visits, telephone, mail) with relatives. - Number and frequency of contacts (visits, telephone, mail) with close friends. - Number and frequency of contacts (visits, telephone, mail) with neighbours.
Enacted Support	Provision to others or receipt of assistance for the following types of activities: - help with grandchildren - help when someone else is ill/being helped when ill - personal advice - financial assistance - providing a home for others/ staying in someone else's home - household tasks - transportation - emergency assistance - shopping
Perceived Support	Self-reported level of satisfaction for the various types of enacted support provided or received: - very satisfied - somewhat satisfied - neither satisfied nor dissatisfied - somewhat dissatisfied - very dissatisfied

Respondents were asked how many relatives, close friends, and neighbours they had seen or heard from in the last year. They were specifically asked about relatives in the following categories: father, mother, brothers, sisters, spouse, sons, daughters, uncles, aunts, cousins, nieces, nephews, grandsons, granddaughters, great grandsons, great granddaughters, and any other relatives. They were then asked the frequency with which they saw those persons as well as the frequency with which they phoned or wrote.

Enacted Support. Enacted support refers to the actual types of support received or provided by respondents. Respondents were asked if they received assistance from or provided assistance to person(s) in their social network. As well, they were asked about the frequency with which they received or provided assistance. In total, they were asked about assistance in the following nine categories: help with grandchildren, help with illness, advice about personal problems (e.g., job), financial assistance, providing a home for others, household tasks, transportation, emergency aid, and shopping. The majority of these types of assistance can be considered instrumental support with the exception of advice about personal problems which is more in line with emotional support.

Perceived Support. The dimension of perceived support refers to whether a person actually feels supported. It involves the cognitive appraisal of being connected to others (Barrera, 1986). This dimension was measured directly by asking respondents how satisfied they were with the various types of support that they provided

and received. More specifically, respondents were asked whether they were very satisfied, somewhat satisfied, neither satisfied nor dissatisfied, somewhat dissatisfied, or very dissatisfied with the help they received and provided in each of the categories outlined under enacted support.

Exchange of Support. Support exchanged refers to the balance between support received and support provided by respondents. It was measured by creating a composite variable that involved several calculations. First, frequency of enacted support received in each category of assistance (illness, advice, finances, home, household tasks, transportation, emergency help, and shopping) was subtracted from the frequency of enacted support provided within the respective categories of assistance. For example, the frequency of assistance received from others with finances was subtracted from the frequency of assistance given to others with their finances. After this series of calculations, the resulting eight scores were summed to provide an overall indication of whether the respondent provided more or received more enacted support. This resulted in a variable consisting of positive and negative values. Positive values indicated that respondents provided support more frequently than they received support. Conversely, negative values indicated that respondents received support more frequently than they provided support. A value of zero indicated a balance in the frequency of support provided and received.

Well-being. A variety of terms have been formulated to reflect a general sense of well-being: quality of life, morale, happiness, adjustment, and life

satisfaction (George and Bearon, 1980; Neugarten et al., 1961). Although these terms are used interchangeably, there are conceptual distinctions and different indicators employed to measure each concept (George and Bearon, 1980). The Life Satisfaction Index A (LSI-A) developed by Neugarten et al. (1961) was selected as a measure of well-being in the original study and was used as a measure of the dependent variable in this thesis. It consists of 20 items and is a global measure of psychological well-being that is based on the extent to which an individual: (1) takes pleasure from daily activities; (2) regards life as meaningful; (3) feels successful in achieving major life goals; (4) holds a positive self-image; and (5) maintains optimistic attitudes and moods (Neugarten et al., 1961). The LSI-A was developed specifically for an older population and was standardized on a sample of 92 noninstitutionalized people between the age of 50 and 90. It has been widely used for assessing subjective perceptions of well-being of the elderly and has received a substantial amount of empirical support (George and Bearon, 1980).[4]

Control Variables. Health and socioeconomic status have consistently been found to be related to subjective well-being (Larson, 1978). Several studies have shown a significant direct association between health and well-being (Larson, 1978). In particular, perceived or self-rated health appears to be a better predictor of well-being than physicians' ratings (Kozma and Stones, 1978).

Numerous studies have also shown that persons of lower socioeconomic status tend to have lower subjective

well-being (Larson, 1978; Kozma and Stones, 1978). Even when socioeconomic status is broken into its components -- income, education, and occupational status -- each component is positively correlated with well-being (Larson, 1978). Of the three factors, income is the factor most consistently related to well-being. Moreover, there is some evidence that income has a stronger relationship to well-being at lower levels of income (Larson, 1978; Kozma and Stones, 1978).

As well, there is some evidence that age, gender, and marital status are related to subjective well-being; however, the evidence is less consistent. Some studies have shown a small decrease in well-being with age, but when controls such as health and income are introduced the relationship between age and well-being disappears (Larson, 1978; Kozma and Stones, 1978). The relationship between gender and well-being is also uncertain. For example, in one study Bild and Havighurst (1976) found that women had lower life satisfaction than men. However, they suggested that the difference may have been due, in part, to the interaction with other factors such as widowhood. Studies generally show that married people have higher well-being than widowed, separated, or divorced persons (Larson, 1978). Although again, this relationship decreases when control variables such socioeconomic status are introduced.

In view of the foregoing findings, the following variables have been selected from the original study to be treated as control variables in data analyses: age, gender, marital status, income, education, occupation, health and functional disability. Health entailed four separate measures (see Appendix A). First, chronic illness

was measured by asking respondents to identify their health problems from a list of 14 health problems. Second, perceived health was ascertained by asking respondents how their health was in general. That is, they were asked whether their health was excellent, good, fair, poor, or bad for their age. Third and fourth, respondents were asked to indicate the total number of sick days as well as total number of hospital days they had in the past year. Functional disability refers to difficulties with such activities as eating and grooming and it can be related to health. Respondents were asked to indicate whether they required assistance with 14 different activities.

In review, there are five sets of measures selected from the original study. First, to measure social embeddedness six variables are included. Second, 17 variables are included to measure enacted support. Third, perceived support is measured by 17 variables. Fourth, the dependent variable is measured by the Life Satisfaction Index A. Lastly, 11 control variables including such factors as health and income are selected.

3.6 DATA ANALYSES

Data analyses involved both descriptive and multivariate statistics and entailed two sets of analyses. First, factor analysis was employed to determine the factor structure of the social support measures. Second, regression analysis was utilized to test the hypotheses concerning the relationship between social support and the well-being of the elderly. The Statistical Package for the Social Sciences (SPSSX) was used for all computer analyses (Nie, 1983).

Before beginning the data analyses, descriptive computer procedures were run including frequencies and percentage distributions, along with measures of central tendency and dispersion. This analyses provided descriptive information about the study sample.

Next, factor analyses was employed to verify the factor structure of the social support measures. This was necessary given the inconclusive findings regarding the factor structure of social support. Some studies have found that more subjective measures of social support, such as perceived adequacy of support, load on a separate factor from frequency measures of social support--the more objective measures of social support (Ward et al., 1984; Thomas et al., 1985; Blazer, 1982). Still other investigators report the possibility of three social support factors. In a study of college aged respondents three separate social support factors were found: network structure, network functions, and intimacy of social ties (Fondacaro and Heller, 1983; Swindle, 1983; cited in Heller and Mansbach, 1984). The first two factors are similar to the dimensions proposed here: social embeddedness, and enacted support. Heller and Mansbach (1984) also found that three factors of social support emerged; however, the factors were not as distinct. The first factor included network functions such as emotional and problem solving support, but both of the second and third factors contained network variables such as frequency of contact with relatives. These findings support the multidimensionality of social support, but also underscored the need to examine the factor structure of the social support measures.

3.6.1 Factor Analysis

In this study, factor analysis is used for confirmatory purposes to ascertain whether social support is composed of three factors: social embeddedness, enacted support, and perceived support. The goal is to summarize patterns of intercorrelations among variables. In so doing, it reduces a large number of variables to fewer underlying dimensions. The major steps in factor analysis includes preparing the correlation matrix, determining the number of factors to be considered, extracting a set of factors from a correlation matrix, rotating the factors to increase interpretability, and finally, interpreting the results (Tabachnick and Fidell, 1983).

Initially, preliminary analysis involved principal components extraction to estimate the number of factors, and to examine the correlation matrices for correlations greater than or equal to .30. The next analysis was orthogonal varimax rotation of the factors. This method of factoring eliminates the effects of unique and error variability and is commonly reported by researchers (Tabachnick and Fidell, 1983).

Adequacy of extraction and number of factors was evaluated in two ways. First, the number of factors with eigenvalues greater than one provided an estimate of the maximum number of factors. Second, the scree test (Cattell, 1966) was performed. The test involves plotting factors on a two dimensional graph and provides information on the percent of variance accounted for by each of the factors in the solution (Tabachnick and Fidell, 1983).

Adequacy of rotation was assessed by inspecting the factors. The matrices were visually examined for meaningfulness and patterns of correlations among variables. The criterion of simple structure was considered (Thurstone, 1947). If simple structure is present only a few variables correlate highly with each factor. Complexity increases as the number of variables correlating highly with each factor increases.

The final step in this first set of analyses was interpreting the factors. Loadings in excess of .30 were considered eligible for interpretation (Tabachnick and Fidell, 1983). In general, loadings in excess of .71 (50% overlap in variance between the variable and factor) are considered excellent, .63 (40% of variance) are considered very good, .55 (30% of variance) are considered good, .45 (20% of variance) are considered fair, and .32 (10% of variance) are considered poor (Tabachnick and Fidell, 1983). The factor loadings were inspected for meaningfulness and complexity. Comparison was made with the three hypothesized social support dimensions identified in the literature. Each factor was then given a label reflecting the meaning associated with the variable loadings on the factor.

3.6.2 Regression Analysis

The second set of analyses using multiple regression, assessed the relationship between well-being and several independent variables: the dimensions of social support (8 variables); social support exchange (1 variable); and 11 control variables. With 800 respondents and 20 independent variables, the cases to variables ratio was 40:1, which is

above the minimum requirements of 20:1 (Tabachnick and Fidell, 1983).

Generally, three major steps were followed in doing the regression analyses. First, all the independent variables (social support and control variables) were examined for linearity, normality, and multicollinearity. As a result of the evaluation of these assumptions, three continuous variables were truncated, five continous variables were recoded into categories, and three categorical variables were recoded into fewer categories. The details of these transformations are outlined in the findings chapter. Second, a series of regression analyses were run using stepwise multiple regression. The goal was to obtain the best solution or model explaining the variance in the dependent variable well-being. Finally, based on the findings of the regression analyses, the study hypotheses were rejected or accepted accordingly.

In review, the methodology utilized for this thesis is secondary data analysis. Data were selected from a survey that examined peer and intergenerational support networks among the elderly. A number of variables were selected that corresponded to the three dimensions of social support. These variables were factor analyzed to ascertain their underlying factor structure. Following this, regression analyses were employed to test the hypotheses.

NOTES

[1] The Peer and Intergenerational Support Networks Among the Elderly: Their Relevance for the Home Care Service Bureaucracy study was supported, in part, by a National Health Scholar award (No. 6607-1137-48, Health and Welfare Canada) to Neena L. Chappell, PhD., Director, Centre on Aging, University of Manitoba.

[2] In studying the aged a distinction is often made between those persons under 75 years old "young-old" and those persons over 75 years old "old-old" (Shulman, 1980). The two age groups have different lifestyles, life expectancies, and needs; therefore, it is sometimes useful to distinguish the two groups.

[3] In addition, the student is working closely with the principal investigator of the original study. Consequently, the student will have access to information on the original study that may not be found in study documents.

[4] In the original study by Chappell (see above NOTE 1) only total scores of the Life Satisfaction Index A were coded. Without the scores on the 20 individual items of the index, it is not possible to calculate the alpha coefficient to test reliability.

CHAPTER 4

RESEARCH FINDINGS

The research findings are presented in four sections. First, a description of the sample is provided. Second, the results of the factor analysis of the social support measures are described. Third, the findings of the regression analyses, testing the two hypotheses, are presented. Lastly, there is some discussion of the thesis findings.

4.1 DESCRIPTION OF THE SAMPLE

As stated in Chapter 3, data for this thesis came from a stratified random sample of 400 home care recipients and 400 non-recipients of home care living in Winnipeg. According to Chappell and Blandford (1987), about 15% of elderly individuals living in Winnipeg use home care services. In this sample, then, home care recipients are oversampled. To compensate, homecare recipients were weighted by a factor of .29 and non-recipients were weighted by a factor of 1.71. As shown in Table 4.1, this resulted in 116 (14.5%) cases of home care recipients and 684 (85.5%) cases of non-recipients.

Selected characteristics of the sample are presented in Table 4.1. Consistent with the distribution of males and females in the elderly population, a slightly greater percentage (54%) of respondents were female. Approximately one quarter (24.3%) were in their sixties, slightly less than half (44.9%) were in their seventies, and about one third (30.8%) were over eighty. Just over half (51.8%)

Table 4.1

SELECTED SAMPLE CHARACTERISTICS

Home Care Services		Gender	
Recipients	14.5%	Male	46.0%
Non-recipients	85.5%	Female	54.0%
	-------		-------
(n=800)	100.0%	(n=800)	100.0%

Age		Years of Education	
65-69	24.3%	0 - 8	43.5%
70-74	22.2%	9 - 12	38.9%
75-79	22.7%	13 +	17.7%
80-84	15.4%		-------
85-89	11.4%	(n=792)	100.1%
90 +	4.0%		

(n=800)	100.0%		

Marital Status		Major Occupation in Life	
Single	7.3%	Professional/high level management	20.5%
Separated/divorced	4.2%	Low level management	27.1%
Married	51.8%	Semi-skilled	22.4%
Widowed	36.8%	Farm laborer	4.6%
	-------	Homemaker	25.4%
(n=800)	100.0%		-------
		(n=800)	100.0%

Total Monthly Income	
$0 - $499	60.7%
$500 - $999	26.6%
$1,000 - $1,499	6.4%
$1,500 +	6.3%

(n=719)	100.0%

Note: Total percentages may not equal 100% due to rounding. Where 'n' does not equal 800, the remainder represent missing values.

were married, and just over a third (36.8%) were widowed. Typical of most elderly individuals today, the majority (82.4%) of respondents received no more than high school education. Consistent with this level of education, less than one quarter (20.5%) worked in professional or high level management positions. Plus, over half (60.7%) of the respondents reported a monthly income of less than five hundred dollars.

Table 4.2 summarizes descriptive statistics of the demographic and health variables included in the analyses. Similar to other findings reported for older people, the statistics on the health variables suggest that most respondents were in good health (Graney, 1985). As reflected in the mean score (M=3.86) of perceived health, the majority (70.4%) of respondents rated their health as good or excellent. In addition, most reported no sick days (77.1%) or hospitals days (79.1%) in the past twelve months. Almost three-quarters (71.5%) of respondents did not have any functional disabilities and the mean number of chronic health problems was low (M=3.14).

In summary, these sample characteristics are consistent with the characteristics of the elderly population of Winnipeg.

4.2 FACTOR STRUCTURE OF SOCIAL SUPPORT

The social support measures outlined in Chapter 3 were subjected to factor analysis to determine whether the three dimensions of social support (social embeddedness, enacted support, and perceived support) could be verified. Forty variables were factor analyzed using principal components

Table 4.2

RANGES, MEANS, AND STANDARD DEVIATIONS OF THE DEMOGRAPHIC AND HEALTH VARIABLES

Variable	Range	Mean (M)	Standard Deviation (SD)
DEMOGRAPHIC VARIABLES			
Gender - male/female	0-1	.54	.50
Age in years	65-90	75.84	7.05
**Marital status			
not married/married	0-1	.52	.50
not widowed/widowed	0-1	.37	.48
Education	0-17	9.22	3.60
**Occupation			
not professional/prof.	0-1	.48	.50
not semi-skilled/semi-sk.	0-1	.22	.42
not homemaker/homemaker	0-1	.25	.44
*Income	1-4	2.50	1.13
HEALTH VARIABLES			
Perceived health	1-5	3.86	.93
*Number of sick days			
no days/some days	0-1	.23	.42
*Number of hospital days			
no days/some days	0-1	.21	.41
*Functional disabilities			
no disabilities/some disab.	0-1	.29	.45
Number of chronic conditions	0-14	3.14	2.12

* indicates that the variable was recoded to improve linearity with the dependent variable. Section 4.3.2 provides details of how the variables were recoded.

** nominal level of measurement variables were recoded into a series of dichotomous variables.

extraction and varimax rotation. Multiple factor solutions were derived to determine the solution that was most appropriate with respect to eigenvalues, the scree test, and factor parsimony.

As shown in Table 4.3, the enacted support items loaded on three factors. One factor referred to the frequency of enacted support received by respondents from others in their support network. Conversely, the other two factors referred to the frequency of various types of enacted support that respondents provided to others in their support networks. The factors concerning the provision of enacted support differed in the types of enacted support they included. One factor (Factor 2) consisted of types of enacted support that generally occur less frequently, such as providing assistance in an emergency or providing a home for someone; thus, it is referred to as periodic provision of support. The other factor (Factor 3), labelled regular provision of support, contained types of enacted support that usually occur more frequently, such as help with household tasks and shopping. One item, providing transportation, loaded on both factors; however, it loaded highest (.43) on the third factor, regular provision of support.

As discussed in the literature review, the Direct Effects View of Social Support more commonly focusses on the source, type, and amount of support individuals receive as opposed to the type and amount of support people provide to others. In short, this view proposes that the more support individuals receive, the higher their level of well-being. The factor analysis of enacted support items suggests that received support and provided support

Table 4.3

ROTATED FACTOR LOADINGS OF SOCIAL EMBEDDEDNESS AND ENACTED SUPPORT ITEMS

Social Support Item	Factor 1	Factor 2	Factor 3	Factor 4	Factor 5	Factor 6	Factor 7
ENACTED SUPPORT ITEMS							
- Illness frequency receive	.55						
- Finances frequency receive	.52						
- Household tasks freq. receive	.73						
- Transportation freq. receive	.56						
- Shopping frequency receive	.73						
- Advice frequency provide		.65					
- Finances frequency provide		.74					
- Home frequency provide		.36					
- Transportation freq. provide		.31	.43				
- Emergency frequency provide		.57					
- Illness frequency provide			.61				
- Household tasks freq. provide			.69				
- Shopping freq. provide			.69				
SOCIAL EMBEDDEDNESS ITEMS							
- Number relatives				.65			
- Number friends					.83		
- Interaction friends					.84		
- Number neighbours						.77	
- Interaction neighbours						.79	
- Interaction relatives							.71

Note: For clarity, factor loadings of less than .30 have been omitted from the table.

are distinct factors of enacted support. Consequently, for later analyses testing the Direct Effects View, enacted support was based on the factor score of enacted support received. That is, a factor score was generated by summing the factor score coefficients of the first factor shown in Table 4.3 and refers to enacted support received.

The six social embeddedness items loaded on four separate factors (see Table 4.3): (1) total number of relatives (Factor 4); (2) total number and frequency of interaction with close friends (Factor 5); (3) total number and frequency of interaction with neighbours (Factor 6); and (4) frequency of interaction with relatives (Factor 7). Since only one or two variables loaded highly on each of these factors, they were insufficiently defined to be considered factors in the final solution. As a result, all six social embeddedness variables were retained and included in subsequent analyses.

When the perceived support items were factor analyzed, the first factor had an eigenvalue (6.01) three to four times the size of the other eigenvalues, indicating the presence of a general factor. This factor contained nine of the original 17 perceived support items and included satisfaction with both enacted support provided and received; therefore, the original label of perceived support was maintained (see Table 4.4). For later analyses, a factor score was calculated by summing the factor score coefficients of this factor.

In review, factor analyses indicated that the social support measures contained four factors. Three factors referred to enacted support with the first factor concerned

Table 4.4

ROTATED FACTOR LOADINGS OF PERCEIVED SUPPORT ITEMS

Social Support Item	Factor 1
- Satisfaction providing help with grandchildren	.43
- Satisfaction providing help with illness	.86
- Satisfaction providing help with finances	.42
- Satisfaction providing home	.62
- Satisfaction providing help with household tasks	.34
- Satisfaction providing help in emergencies	.81
- Satisfaction providing help with shopping	.85
- Satisfaction receiving help with illness	.39
- Satisfaction receiving help with shopping	.85

Note: For clarity, factor loadings of less than .30 have been omitted from the table.

with receiving support and the latter two concerned with providing support: (1) received support; (2) periodic provision of support; and (3) regular provision of support. A fourth factor referred to perceived support and consisted of items measuring satisfaction with various types of enacted support. The social embeddedness items did not load in a reliable pattern; thus, they were treated as six separate variables.

The factor analysis findings support a multidimensional view of social support and are consistent with other research findings. In keeping with Ward et al. (1984), Thomas et al. (1985), and Blazer (1982), the more subjective measures of social support, in this case perceived support items, loaded together on one factor. Also, similar to other research findings (Heller and Mansbach, 1984; Revicki and Mitchell, 1986), embeddedness variables such as frequency of interaction with relatives

did not form a distinct factor. As explained by Barrera et al. (1981), network variables are not coterminous with other support measures. For example, network size may be viewed as a measure of the number of people who potentially can or actually have provided support to the individual. As well, network size encompasses different relationships. Given that the relative, friend, and neighbour variables loaded on separate factors, social embeddedness items may differ according to type of relationship. In view of this, it is not surprising that social embeddedness items did not form neatly into one factor of social support.

4.3 PREDICTORS OF WELL-BEING

Multiple regression analyses were performed to assess the two perspectives and determine the relative importance of each dimension of social support to the well-being of the elderly. Before discussing the results of the regression analyses, the following are presented: (1) descriptive analyses findings; (2) results of testing the assumptions underlying regression analysis; and (3) bivariate correlation findings. Then the regression results are presented testing the two hypotheses.

4.3.1 Descriptive Analyses Findings

On the basis of the factor analyses, the following nine social support variables served as independent variables to test the hypotheses: six social embeddedness variables; one enacted support factor; the perceived support factor; and one exchange variable. The remaining independent variables included in the analyses were demographic and health variables: gender, age, education,

marital status, occupation, income, perceived health, number of chronic conditions, number of hospital days and sick days, and functional disability.

Table 4.5 presents descriptive information about the measures of social support and well-being. The mean score for number of relatives was three (M=3.00) which represented 14 to 20 relatives. The mean score for number of close friends was 3.69 indicating that on average respondents had three to four close friends. As for number of neighbours, the mean score was 2.54 which represented an average of three to four neighbours. At a general level, respondents received as well as exchanged support. However, the positive mean score (M=1.67) of support exchanged indicates that generally respondents provided more support than they received. Lastly, the mean score (M=2.99) of perceived support suggests that in general respondents were satisfied with support they received and provided.

As for the dependent variable, well-being, the mean and standard deviation are consistent with the descriptive findings of the original sample used to standardize the instrument. As shown in Table 4.5, the mean was 13.44 and the standard deviation was 3.69. This mean is slightly higher than the mean score (M=12.4) of the original sample and the standard deviation of 3.69 is only slightly smaller than the standard deviation (SD=4.4) of the original sample (George and Bearon, 1980). Overall, the majority of respondents report a moderate to high level of well-being.

Table 4.5

RANGES, MEANS, AND STANDARD DEVIATIONS OF THE SOCIAL SUPPORT VARIABLES AND WELL-BEING

Variable	Range	Mean (M)	Standard Deviation (SD)
SOCIAL SUPPORT VARIABLES			
*Total # relatives	1-4	3.00	1.40
*Frequency interaction relatives	1-4	2.48	1.11
Total # close friends	0-50	3.69	4.37
*Frequency interaction friends	0-4	1.92	1.36
*Total # neighbours	1-4	2.54	1.14
*Frequency interaction neighbours	0-4	2.03	1.41
*Received support	1-5	2.98	1.42
*Perceived support	1-4	2.99	1.41
Support exchanged	-22-25	1.67	10.64
WELL-BEING			
LSI-A	0-20	13.44	3.69

* indicates that the variable was recoded to improve linearity with the dependent variable. Section 4.3.2 provides details of how the variables were recoded.

4.3.2 Evaluation of Assumptions

Part of the analyses involved identifying variables with outliers and evaluating the assumptions of linearity, normality, and multicollinearity. Univariate outliers were detected by inspecting frequency distributions. On three continuous variables the presence of outliers effected linearity with the dependent variable well-being. To improve linearity, the extreme values on these three continuous variables were dealt with by truncating the variables no more than two (+ or -) standard deviation points from the mean.

The three continuous variables that were truncated included age, education, and support exchanged. Age was truncated so that respondents over age 90 were grouped together. Education was truncated so that all those with 17 or more years of education were grouped together. Lastly, support exchanged was truncated at both the upper and lower ends. Scores ranged from -37 to +44. All scores less than -21 were grouped together and given a value of -22 and all scores greater than +24 were grouped together and given a value of +25. Negative scores indicated that respondents received more enacted support than they provided and positive scores indicated that respondents provided more enacted support than they received. Tables 4.2 and 4.5 provide descriptive information about the truncated variables.

Linearity between the independent variables and dependent variable was examined using the analysis-of-variance test for nonlinearity (statistic 2 of the breakdown procedure in SPSSX). As discussed by Blalock

(1979: 428-431) r-squared substracted from the eta-squared statistic indicates the proportion of variation explained by a nonlinear relationship. That is a difference of more than 5% between r-squared and eta-squared indicates a nonlinear relationship. Lack of linearity was detected in several independent variables. To improve linearity, five continuous variables were coded into categories, and three categorical variables were recoded into fewer categories. These tranformations are described below and as noted above Tables 4.2 and 4.5 provide descriptive information about the measures.

The five continuous variables that were coded into categories included income, enacted support received, total number of neighbours and relatives, and perceived support. Categories were created according to the frequency distribution of each variable. Income was categorized into four categories (1-4) where one indicated a low income and four indicated a high income. Enacted support received was recoded into five categories (1-5) where a low score indicated low frequency of receiving support and a high score indicated high frequency of receiving support. Also, two continuous embeddedness variables were categorized. Total number of neighbours was grouped into four categories (1-4) and total number of relatives was grouped into five categories (1-5). For both variables, a low score indicated a small number of neighbours or relatives and a high score indicated a large number of neighbours or relatives. Lastly, perceived support was coded into five categories (1-5) where a low score indicated less satisfaction with support and a high score indicated greater satisfaction with support.

The last few variables to be modified to improve linearity were three of the social embeddedness variables. Frequency of interaction with relatives, close friends, and neighbours were recoded from seven categories to four or five categories depending on their frequency distributions. For all three variables a low score indicated less frequent interaction and a high score indicated more frequent interaction.

Finally, some variables were recoded into dichotomous variables. Both the number of sick days and number of hospital days were recoded into two categories: no days and some days. As well, two discrete variables, marital status and occupation, were recoded into a series of dichotomous variables (see Table 4.2).

Normality was examined in the initial regression analyses by requesting and examining residual scatterplots. In SPSSX the expected normal residual values are estimated and plotted against the actual residual values. According to Tabachnick and Fidell (1983), if the distribution of residuals is normal, the points fall along a straight line running from the bottom left to the upper right corners of the graph. Distributions that are not normal deviate from the straight line by curving above or below the line depending on how the residuals are skewed. No failures of normality were detected.

After checking normality and determining that linear relationships existed between the recoded independent variables and well-being, further analyses assessed whether the independent variables were multicollinear. Multicollinearity was assessed by identifying moderate

bivariate correlations among the independent variables, and then monitoring the stability of parameter estimates of these variables in the regression analyses.

In addition to some of the dichotomous variables (e.g. married and widowed) being multicollinear, the health variables and some support variables emerged as multicollinear. Specifically, respondents indicating more chronic health conditions were more likely to report both poorer perceived health and more functional disabilities. Also for support exchanged, respondents indicating that they more frequently provided enacted support than they received, were more likely to report better perceived health and fewer functional disabilities. In contrast, those indicating that they received more enacted support were more likely to have a larger number of chronic health conditions and functional disabilities. All the multicollinear variables were entered in separate regression analyses.

4.3.3 Bivariate Correlation Findings

To assess the degree of association between the dimensions of social support and well-being, bivariate correlations were computed before proceeding to the regression analysis. The correlations between the support variables and well-being are presented in Table 4.6. All but two variables (interaction with neighbours and total number of relatives) are significantly related to well-being; however, overall the correlations are quite low ranging from .07 to .21. According to Blalock (1979), a large sample increases the possibility of obtaining statistical significance. Considering the large sample size (n=800) in conjunction with the low magnitude of the

Table 4.6

BIVARIATE CORRELATIONS BETWEEN SOCIAL SUPPORT VARIABLES AND WELL-BEING (LSI-A)

Variables	Well-being (Life Satisfaction Index-A)	
SOCIAL EMBEDDEDNESS		
Total # relatives (n=746)	r= .06	p=.08 NS
Interaction relatives (n=741)	r= .10	p=.01
Total # close friends (n=722)	r= .14	p=.00
Interaction friends (n=746)	r= .07	p=.05
Total # neighbours (n=720)	r= .21	p=.00
Interaction neighbours (n=746)	r= .05	p=.21 NS
ENACTED SUPPORT		
Received support (n=688)	r=-.20	p=.00
PERCEIVED SUPPORT		
Perceived support (n=711)	r= .15	p=.00
SUPPORT EXCHANGED		
Enacted support exchanged (n=743)	r= .20	p=.00

Note: - Where 'n' does not equal 800, the remainder represent missing values.
- NS refers to 'not statistically significant' (p >.05)

correlations, the relationships between the social support measures and well-being are weak and for some support measures non-existent. For example, of the six social embeddedness variables, total number of neighbours has the highest correlation to well-being. Nonetheless, this correlation is quit moderate (r=.21).

The most interesting pattern is found for enacted support received and enacted support exchanged. Enacted support received is inversely related to well-being (r=-.20) and enacted support exchanged is positively related to well-being (r=.20). This suggests that the dimension of enacted support may be differentially related to well-being depending on the direction of the exchange. That is, the more enacted support older people receive, the lower their level of well-being. In other words, those elderly indicating that they receive greater levels of enacted support, for example assistance with finances or household tasks, report decreased well-being. Conversely, elderly people who provide more enacted support than they receive report higher levels of well-being. It seems that elderly people who provide more assistance to others in the way of helping with such things as finances and household tasks, have greater well-being.

Bivariate correlations were also calculated among all the independent variables. Two sets of correlations were noteworthy. First, correlations among items measuring the dimensions of social support (social embeddedness, enacted support received, and perceived support) ranged from very low correlations (r=.07; p<.05) to moderate correlations (r=34; p<.000). The correlation between total number of neighbours and interaction with neighbours was .33

($p<.000$). Similarly, periodic and regular provision of support had a correlation of .34 ($p<.000$). Lastly, there was a correlation of .32 ($p<.000$) between regular provision of support and perceived support. In sum, these correlations suggested that some aspects of social support are related but otherwise distinct dimensions.

A second set of correlations interesting to note were the correlations between social support and health. Various dimensions of social support had higher correlations with health than with well-being. For example, respondents receiving more enacted support, reported more chronic health conditions ($r=.32$; $p<.001$), some functional disabilities ($r=.41$; $p<.001$), and lower perceived health ($r=-.29$; $p<.000$). The pattern was somewhat different for the exchange of support. Respondents who provided more enacted support than they received, had better perceived health ($r=.31$; $p<.000$) and fewer functional disabilities ($r=-.38$; $p<000$). However, the relationship between number of chronic conditions and enacted support exchanged was weaker ($r=-.19$; $p<.000$) suggesting that despite chronic conditions respondents still provided some support to others. These correlations suggest that the most influential factor affecting the provision of enacted support to others is functional disability. It is plausible that as functional ability declines the person's capacity to provide support to others declines.

The dimensions of perceived support and social embeddedness demonstrated different relationships to health than enacted support. Overall, the significant correlations between the measures of both dimensions and

measures of health were low ranging from (+ or -) .09 to .16 ($p<.02$). Perceived support had a weak negative relationship with number of chronic conditions ($r=-.09$; $p<.01$) and functional disabilities ($r=-.10$; $p<.01$). Conversely, it had a weak positive relationship to perceived health ($r=.15$; $p<.000$). Only two of the six embeddedness variables were significantly related to health measures. Number of close friends and neighbours had low negative correlations with number of chronic conditions, -.11 ($p<.003$) and -.12 ($p<.000$) respectively. Total number of neighbours was the only embeddedness item that was associated with functional disabilities ($r=-.16$; $p<.000$). Lastly, both number of close friends ($r=.10$; $p<.005$) and neighbours ($r=.11$; $p<.002$) had weak positive relationships to perceived health. These findings suggest that health is not related to the dimensions of social embeddedness and perceived support. However, it does highlight that different dimensions of social support have different relationships to health.

4.3.4 Regression Analyses Findings

Regression analysis was conducted to test the two hypotheses. This section briefly reviews the hypotheses, describes how they were tested, and presents the results of the regression analysis.

The first hypothesis tests the Direct Effects View of Social Support and states:

1. The dimensions of social support (enacted support received, social embeddedness, and perceived support) are positively related to the well-being of the elderly.

As outlined in Chapter 3, two approaches are found within the Direct Effects View. If enacted support received has a stronger positive relationship to the well-being of the elderly than social embeddedness or perceived support, the Social Support as Helping Approach is supported. If social embeddedness has a stronger, positive relationship to well-being of the elderly than enacted support received or perceived support, it provides evidence consistent with the Social Network Approach. This approach states that the more quantitative aspects of a person's social network influence the availability and accessibility of social support which in turn influences well-being. Another possibility is that perceived support may have a stronger positive relationship to well-being than social embeddedness or enacted support received. Such evidence would suggest that it is the quality and not quantity of social support that is the most important to well-being. Findings consistent with this latter suggestion could, however, also be interpreted as support for the Exchange View of Social Support. If this situation occurs, testing the second hypothesis assists in determining which view is most appropriate.

The Exchange View of Social Support suggests that imbalances of social support transactions affect well-being. Either receiving more than giving enacted support or giving more than receiving enacted support has a negative influence on well-being. In other words, a curvilinear relationship is hypothesized between the exchange of social support and well-being. This is tested by the second hypothesis.

2. Unbalanced exchange of support is negatively related to well-being of the elderly when controlling for social embeddedness, enacted support received, and perceived support.

Testing the hypotheses entailed two steps in the regression analyses. The first step partially tested the second hypothesis by evaluating the assumption of a linear relationship between the exchange of support and well-being. This step did not provide any information on whether exchange of support is a significant predictor of well-being.

The second step of testing the hypotheses was regression analysis. Both the first and second hypotheses were tested simultaneously using multiple regression. The goal was to assess the relationship between the various dimensions of social support and well-being. Multiple regression provides information on which combination of independent variables acting together accounts for the largest amount of variation in the dependent variable well-being. The social support variables found to account for the largest proportion of variance in well-being provided evidence to support or reject each hypothesis.

Step 1. Hypothesis #2 states that there is a curvilinear relationship between exchange of support and well-being. As explained in section 4.3.2, nonlinearity between exchange of support and well-being was examined using the analysis-of-variance test for non-linearity (statistic 2 of the breakdown procedure in SPSSX). After truncating exchange of support no more than two (+ or -) standard deviation points from the mean, a comparison of

eta-squared (eta-squared=.07) and r-squared (r =.04) revealed only an additional 3% of variation explained by nonlinearity. This means the relationship between exchange of support and well-being is linear and refutes the second hypothesis which proposes a curvilinear relationship between the variables.

Step 2. To test hypotheses #1 and #2, well-being as measured by the Life Statisfaction Index A (LSI-A), was regressed in a stepwise manner on the independent variables. The probability level of .05 was used as the criterion for retaining variables.

Significant correlates for LSI-A are shown in Table 4.7. Respondents with greater well-being were more likely to have better health, more education, a larger number of neighbours, more interaction with relatives, and to provide more enacted support than they receive. In total, 16% of the variance of well-being was explained. Most of the variation was accounted for by variables related to health. Number of chronic health conditions was the primary predictor explaining 9% of the variation. Perceived health and functional disability were multicollinear with number of chronic conditions. Both of these measures were run in separate analyses and were found to account for 13% and 6% of the variance respectively.

The remaining explained variance of well-being was accounted for by education (3%) and three social support variables (4%). Total number of neighbours accounted for 2% of the variance in well-being. Exchange of enacted support and frequency of interaction with relatives each explained 1% of the variance.

Table 4.7

CORRELATES OF WELL-BEING (LSI-A)

Predictors	b	Beta	f	p	r^2
# of chronic health conditions	-.52	-.30	76.23	<.000	.09
(Perceived health)	(1.44)	(.36)	(117.30)	(<.000)	(.13)
(Functional disability)	(-2.00)	(-.25)	(50.08)	(<.000)	(.06)
Education	.17	.18	27.30	<.000	.03
Total number of neighbours	.49	.15	19.68	<.001	.02
Exchange of enacted support	.03	.09	6.42	<.01	.01
Interaction with relatives	.25	.08	5.30	<.02	.01

$R^2 = .16$; $f = 38.19$;
df = 5 and 714; $p < .000$

Note: - Only significant variables are shown here. The variables in brackets are multicollinear with those appearing immediately above and were run in separate regression analyses.
- R^2 is calculated by summing r^2 of the variables not in brackets.

Overall, then, relative to the social support variables, health variables accounted for two to three times more of the explained variance in well-being. This suggests that health is a more important determinant of the well-being of the elderly than social support. However, given that the total amount of explained variance is 16%, most (84%) of the variance in well-being remains unexplained.

These findings do not provide strong support for either hypothesis. In terms of hypothesis #1 outlined above, two social embeddedness variables (total number of neighbours, frequency of interaction with relatives) accounted for some of the explained variance in well-being. That is, elderly indicating a larger number of neighbours, report a higher level of well-being; and, elderly reporting a higher level of well-being, also indicate that they have more frequent contact with their relatives. From the Social Network Approach within the Direct Effects perspective, a large number of neighbours and high frequency of interaction with relatives indicates greater availability and access to social support which in turn enhances well-being. However, considering that together total number of neighbours and interaction with relatives only explained 3% of the variance and also that none of the other four social embeddedness variables were significant predictors of well-being, this finding offers only minimal support for this perspective and does not strongly support the first hypothesis.

As well, little support is provided for hypothesis #2 which tests the Exchange View of Social Support. This view maintains that imbalance in the exchange of social support

in either direction (receiving more or receiving less) is detrimental to well-being. As noted above, exchange of enacted support had a positive linear relationship to well-being and accounted for 1% of the variance in well-being. That is, it was found that elderly people who received more enacted support than they provided, experienced a decrease in well-being. Conversely, elderly people who provided more enacted support than they received, reported an increase in well-being. Contrary to the Exchange View, only one type of imbalance in the exchange of support (receiving more support than is given) had a negative relationship with well-being. Consequently, this thesis does not support the Exchange View.

4.4 DISCUSSION

In this section each of the significant correlates with well-being are discussed in relation to other results found in the literature. In some cases, the findings are congruent with the literature; nevertheless, there are some inconsistencies that are examined.

First, the most important predictors of well-being were the health variables. This thesis found that health variables accounted for 6% to 13% of the explained variance in well-being. This compares favorably to Larson's (1978) estimates that health and physical disability account for 4% to 16% of the variance in well-being. Similarly, it is close to Okun et al.'s (1984) estimates that health explains between 8.5% and 14.4% of the variance in well-being. As well, the direction of the relationship between health and well-being was congruent with a common finding of many studies. That is, older persons reporting

poor health are less satisfied with their lives than those reporting good health (Palmore and Luikart, 1972; Markides and Martin, 1979; Elwell and Maltbie-Crannell, 1981; Lee and Ellithorpe, 1982; Lohr et al., 1988).

The next most important correlate of well-being of the elderly was education. It accounted for 3% of the explained variance in well-being. At first, this finding appears to differ somewhat from the literature. That is, when the three components of socioeconomic status (income, occupation, and education) are considered, the literature indicates that income is most consistently related to well-being (Larson, 1978; Kozma and Stones, 1978). In contrast, this thesis found that of the three SES variables only education explained some of the variance in well-being. Palmore and Luikart (1972) suggest that education may be more important to well-being for those with below average income levels. It is possible that the association of education to well-being found here is related to low income levels. Over half (60.7%) of this sample had monthly incomes of less than five hundred dollars.

The remaining significant correlates of well-being were social support variables: total number of neighbours, exchange of enacted support, and interaction with relatives. Both of the social embeddedness measures were positively related to well-being which is consistent with other research findings.

The third most important predictor of well-being was total number of neighbours. Respondents indicating a larger number of neighbours, reported higher levels of

well-being. Studies examining neighbour support emphasize the unique role played by neighbours in supporting the elderly. According to Cantor (1980), as a person ages there is a tendancy to become neighbourhood bound. When this occurs, the distinction between friends and neighbours blurrs as often friends live in the neighbourhood. The most frequent form of support provided by neighbours is short-term emergency assistance (Cantor, 1980; Froland et al., 1981). Neighbours' proximity makes it easier for them to assist in crisis by doing such things as summoning an ambulance. As well, there is some evidence to suggest that neighbours are important in socialization (Cantor, 1980). Again it is the proximity of neighbours that allows for day-to-day social contact. Both support in emergencies and social contact are considered to be particularly important for those with limited mobility and those with no children or with children residing in other cities (Cantor, 1980; O'Bryant, 1985).

It is interesting to note that total number of neighbours was found to be important to well-being, instead of frequency of interaction with neighbours. This suggests that it is the perceived availability of neighbours, as opposed to social contact, that contributes to the well-being of the elderly. Knowing someone nearby can be relied on to provide help should the need arise, may provide some peace of mind for an elderly person. Other types of support such as emotional and instrumental support may be provided more by family and friends. This is in agreement with Keller's (1968: cited in Froland et al., 1981) view that in general relationships with neighbours combine a fairly high level of knowledge about many aspects of one another's lives with a fairly low level of involvement.

In contrast to the finding regarding neighbours, interaction with relatives was more important than total number of relatives. Initially, this finding appears to counter some of the results found in the literature. Several studies investigating family versus non-family interaction and well-being have found a positive relationship between interaction with friends and well-being, and mixed findings surrounding the association between interaction with family and well-being (Wood and Robertson, 1978). In contrast, this thesis found a positive relationship between interaction with relatives and well-being. The apparent discrepancy between the literature and this finding decreases when the use of the term family is examined. More specifically, when family interaction is reviewed in the literature the focus tends to be on intergenerational parent-child interaction (Chappell, 1983). Much of the literature refers to interaction between older persons and their children (e.g., Lee and Ellithorpe, 1982). In this thesis, interaction with relatives refers to all family including siblings, aunts, uncles, and cousins, as well as children and grandchildren. It may be that parent-child interaction has a less positive effect on well-being; instead, interaction with friends and other relatives closer in age may have a greater influence on well-being. In other words, interaction with peers who have more interests and experiences in common, regardless of kinship, may be what is important to the well-being of the elderly (Blau, 1973 cited in Wood and Robertson, 1978).

The third social support measure that accounted for some of the variance of well-being was the exchange of enacted support. Somewhat unexpectedly, it was found that

imbalance of supportive exchange in either direction (receiving more than giving or vice versa) was differentially related to the well-being of the elderly. Although this finding only accounted for a very small percentage (1%) of the explained variance of well-being, it is important for it highlights the complexity surrounding social support processes. Actually, when additional factors are taken into account, this finding becomes more plausible. For example, when factors such as norms surrounding the exchange of support, diverse measurement of support exchanged (e.g. types of relationships included), and types of social support are considered this finding seems reasonable.

The first factor, norms surrounding social support exchange, refers to the beliefs and attitudes surrounding social support transactions. It is possible that the elderly have certain expectations and attitudes that influence their perceptions and views of giving and receiving support. For example, some research highlights the importance of independence for the elderly. In an anthropological study of fifty older people, Wentowski (1981) found that older people like to give and do not like to be indebted. Even when they can no longer reciprocate equally, they send token returns, such as a jar of jelly, as a way of contributing something in repayment. The people in her study were very wary of accepting "charity". As well, some other research points out the importance of autonomy and independence for the elderly, especially in relation to children (Hawley and Chamley, 1986). Brody et al. (1983) found that many elderly women would prefer to pay a professional than ask family or friends to help. Other researchers further suggest that giving support to

others provides the older person with a sense of usefulness, efficacy, and productivity (Ingersoll-Dayton and Antonucci, 1988). In other words, providing support may enhance a person's feeling of being needed. In view of these findings, it seems quite plausible that providing more than receiving support may be positively associated with well-being.

Another possible factor that helps to explain this finding concerns the diversity of types of relationships that researchers have studied. Generally, the exchange of social support is seen as involving at least two people giving and receiving various types of social support. It is reciprocal when support received is equivalent to support given. In this thesis social support exchange was operationalized as the overall difference between the frequency of enacted support given and the frequency of enacted support received for each type of enacted support (e.g., transportation, shopping). This operationalization did not consider two other characteristics of exchange. One, no distinction was made for the type of relationship; rather, social support exchanged included exchanges with relatives, friends, and neighbours all together in one overall rating. Two, support exchanged measured frequency of support exchanged; it did not examine the amount or quantity of the support exchanged.

This differs from some of the research reported in the literature. Some researchers measure reciprocity of social support within specific relationship categories (i.e., children, friends, and spouse) and others measure it between specific dyads. For example, Roberto and Scott (1986) examined patterns of exchange between dyads of older

adults and their best friends. Their findings supported the Exchange View in that older persons with reciprocal friendships reported less distress with their relationships than those reporting inequitable friendships. However, they also found that the elderly receiving more support than they give reported more anger than those giving more support than they receive or in reciprocal friendships. In contrast, Lee and Ellithorpe (1982) looked at morale or life satisfaction and the exchange of aid between older adults and their children. Similar to this thesis, they found that mutual aid or exchange of social support was a significant predictor of morale, and also it only accounted for 1.5% of the variance of morale. These divergent findings may be due in part to the focus on different levels of reciprocity (i.e., overall exchange, dyadic exchange, or exchange within categories of relationships) as well as different types of relationships (e.g., children, friends). As suggested by Kart and Longino (1987), it is possible that the Exchange View deals with exchange in specific reciprocal relationships, not in an aggregation of relationships. Also, supportive exchange may take on different meanings for people depending on the types of relationships involved.

The characteristic concerning quantity of support exchanged, also may add to the divergent findings. Some studies investigate the presence and absence of equal exchange and others examine the extent of the support exchanged either in terms of frequency or amount of support. For example, in keeping with this thesis, Lee and Ellithorpe (1982) measured only the frequency with which aid was exchanged, and as noted above, they also reported similar findings. Another study used open-ended response

questions to ascertain the amount and type of support received and given, and then applied numerical codes to obtain ratios of the degree of support exchanged (Kart and Longino, 1987). Contrary to this thesis, their study found that respondents who gave the most support, tended to have the lowest level of life satisfaction. In part, the different measurement of exchange may account for the varied findings.

Finally, another factor that may account for the varied findings surrounding the exchange of support concerns the types of social support investigated. In this thesis enacted support consisted of items that are generally considered to be instrumental support; emotional support was excluded. Thus, restating the earlier finding, it was found that instrumental support exchanged had a linear relationship with well-being such that those providing more instrumental support than they receive have greater well-being.

This differs from some of the other studies examining support exchange. More specifically, other researchers have found a differential effect of support exchanged depending on the type of social support (e.g., Ingersoll-Dayton and Antonucci, 1988; Kart and Longino, 1987). Rook (1987) found a curvilnear relationship between overall support reciprocity and loneliness. However, evidence of linear relationships were found between specific types of support exchange and relationship satisfaction. In contrast to this thesis finding regarding instrumental support exchange, she found that women who provided more instrumental support than they received were less satisfied with their children than women who received more

instrumental support than they provided. Yet for emotional and social support exchanged, no significant association was found with relationship satisfaction. Aside from the fact that such studies as Rook's examine different dependent variables, the differential findings for emotional and instrumental reciprocity suggest that the effects of support exchanged may vary with the type of support. Consequently, the lack of consistency between this thesis finding and other studies may reflect the different types of social support investigated. This suggests that there are possibly differential effects for emotional and instrumental supportive exchange.

In summary, it is suggested that several factors surrounding social support need to be considered to better understand the various study findings on the exchange of support. In particular, it is important to consider norms surrounding the exchange of support; operationalization of support exchanged (e.g. types of relationships included); and type of social support examined.

Briefly reviewing, five predictors of well-being were found that accounted for 16% of the explained variance. Those with greater well-being were more likely to have better health, more education, a larger number of neighbours, more interaction with relatives, and to provide more enacted support than they receive. In terms of the perspectives, these findings do not support either the Direct Effects or Exchange View of Social Support. However, the findings highlight the complexity of social support processes and suggest other factors that may be important to consider in studying social support. The implications of these findings are discussed in the concluding chapter that follows.

CHAPTER 5

CONCLUSIONS

After briefly reviewing the thesis findings outlined in the preceding chapter, this chapter discusses the major conclusions, research limitations, and implications for future research.

5.1 SUMMARY AND CONCLUSIONS

Summary. This thesis identified and empirically examined the most common dimensions of social support and then assessed two perspectives on social support to determine the relative importance of each social support dimension to the well-being of the elderly. Three dimensions of social support were identified from the literature: social embeddedness, enacted support, and perceived support. Contrary to the dimensions identified, this thesis found that social support items formed four social support factors. Three factors referred to enacted support: periodic provision of support; regular provision of support; and received support. The fourth factor referred to perceived support. Somewhat unexpectedly, the social embeddedness items did not load as one factor.

This thesis also revealed some interesting findings concerning factors that are important to the well-being of the elderly. The majority of explained variance in well-being was accounted for by health variables. That is, over half (9%) of the explained variance (16%) was attributed to number of chronic health conditions, and again in a separate analysis, perceived health accounted

for (13%) of the explained variance, and functional disability accounted for 6%.

The remaining explained variance in well-being was accounted for by education and three social support variables. Those reporting more education, a large number of neighbours, and more frequent interaction with relatives, indicated higher levels of well-being. Also, those elderly indicating that they gave more support than they received, reported greater well-being.

Conclusions. Three conclusions emerge from these findings. First, relative to social support and demographic factors, health is a major factor affecting well-being. In keeping with numerous other studies, self-reported health was the strongest predictor of well-being (Palmore and Luikart, 1972; Larson, 1978; Kozma and Stones, 1978; Markides and Martin, 1979; Lohr et al., 1988). Intuitively this makes sense, for an individual's level of health has the potential to impact on almost all major life areas such as work and leisure activities as well as relationships with family and friends. For example, these data indicated that respondents reporting more chronic health conditions and functional disabilities, received more enacted support. Health, in particular functional disability, seems to affect giving and receiving of support. In this study, the elderly with functional disabilities were most likely to receive more support than they provided to others. Given that poor health is associated with lower well-being and that those in poorer health receive more support, it is plausible then that elderly receiving support report lower levels of well-being.

Stephens and Bernstein (1984) comment on the complexity of the relationship between social support and health. In their study of elderly residents of planned housing, they found that residents with chronic health problems were more socially isolated from other residents and from family than healthier residents. The residents with more supportive relationships were those experiencing serious illnesses requiring hospitalization. The investigators speculated that the greater degree of isolation among residents with poor chronic health resulted from interference of their health with interpersonal relationships. Possibly, those in poor health do "not possess the stamina or mobility needed to sustain social ties, or it may be that other people, especially older people, may avoid associating with chronically unhealthy individuals" (Stephens and Bernstein, 1984: 148). Although the reason is unclear, health seems to be related to both social support and well-being.

A second conclusion concerns the multidimensional view of social support. Generally, these findings are consistent with a multidimensional view of social support. More than one social support factor was found and the social support dimensions were relatively independent of each other. However, these data raise further questions about what constitutes the dimensions of social support.

Similar to other reported findings, perceived support formed one dimension and social embeddedness or network variables did not form a distinct dimension (Blazer, 1982; Heller and Mansbach, 1984; Ward et al., 1984; Thomas et al., 1985; and Revicki and Mitchell, 1986). Generally, it seems that measures of perceived support are independent of

social network measures; however, there is a lack of cohesiveness among network measures. Possibly, the low consistency among the embeddedness variables reflects the inclusion of distinct variables. For example, these data suggested that there may be differences among network measures by type of relationship. Embeddedness measures of relatives, close friends, and neighbours loaded on separate factors and were differentially related to the well-being of the elderly. This may suggest that relatives, friends, and neighbours are conceptually distinct aspects of social embeddedness that need to be considered separately.

Unlike other studies, these thesis findings suggested another distinction that may be important to include in the conceptualization of social support. It may be useful to distinguish between enacted support received and enacted support provided. This distinction was evidenced in two ways. First, factor analysis indicated three factors of enacted support based on distinctions between receiving and providing support: (1) received support; (2) periodic provision of support; and (3) regular provision of support. Second, a measure of the exchange of enacted support, based on the balance of enacted support received and provided, accounted for 1% of the explained variance of well-being of the elderly. Those elderly reporting that they provided more support than they received, had higher levels of well-being. Despite the small amount of explained variance accounted for by support exchanged, overall these measures seem relatively independent suggesting that social support is a multidimensional construct. In agreement with Barrera (1986), then, the value of a global construct of social support is questionned and it is suggested that social

support scales should not be used interchangeably. It is important to carefully identify the dimensions of social support that are of research interest and then examine the measures for consistency.

The third conclusion supported by this thesis concerns the two perspectives on social support. The findings do not provide strong support for either the Direct Effects View or the Exchange View of Social Support. As noted above, most of the explained variance of well-being was accounted for by health variables. In total, only 16% of the variance of well-being was explained. In other words, the majority of the variance of well-being was unexplained and, relative to health, the dimensions of social support contributed little to the variation in well-being.

The limited amount of explained variance of well-being as well as the modest correlations among social support measures and well-being are consistent with other findings reported in the literature. To illustrate, Kart and Longino (1987) found correlations ranging from .06 to .16 ($p<.01$) between measures of social support (received and given) and life satisfaction. As well in other studies, only modest amounts of explained variance are accounted for by social support variables. In two different studies examining various correlates of psychological well-being, the total amount of explained variance was under 30% and most of it was accounted for by variables other than social support (Rook, 1984; Mutran and Reitzes, 1984). In one set of analyses, Rook (1984) found health accounted for half of the total explained variance of psychological well-being. The remaining explained variance was accounted for by age and number of problematic social ties. The number of

supportive social ties had little effect on well-being. Mutran and Reitzes (1984) also examined psychological well-being of the elderly. For married persons, involvement in community activites accounted for most of the total amount of explained variance for both dimensions (affect and negative affect) of psychological well-being. Poor health accounted for a significant proportion of explained variance of negative affect, but not positive affect. Finally, receiving and giving help did not account for any of the explained variance of either dimension of psychological well-being.

The lack of adequate empirical confirmation of the relationship between social support dimensions and well-being, suggests the Direct Effects View and Exchange View lack the explanatory power to elucidate how social support is related to well-being. As well, it raises questions about the predictive utility of the construct social support. Stated differently, neither view has substantially increased our understanding of the relationship between social support and well-being. As well, regardless of the lack of understanding, it is not possible to predict various outcomes of well-being based on measurements of social support.

Several factors might account for the lack of explanatory power and predictive utility. First, it may be that both views have excluded other variables that are important to well-being of the elderly. Every model or perspective directs attention to a limited realm of knowledge which necessarily excludes other variables (Dubin, 1978). Possibly, both the Direct Effects and Exchange View have overlooked other significant variables

related to well-being. Second, these two views might oversimplify the relationship between social support and well-being. As suggested in Chapter 4, when additional factors are taken into account, the findings relevant to the Exchange View of Social Support make more sense. Perhaps these perspectives need to be modified to incorporate additional factors that consider some of the complexities surrounding social support. Finally, it may be that the two perspectives assessed here are inadequate in explaining the relationship of social support to well-being for the elderly. Possibly, another perspective such as the Buffer View of Social Support may shed more light on understanding social support processes and well-being. Each of these three factors is discussed below.

The first factor that may account for the lack of explanatory power and predictive utility of the social support perspectives is that each view may have excluded other important variables affecting well-being. In the social support literature, other variables not emphasized in either the Direct Effects of Exchange Views have been found to be associated with the well-being of the elderly. It is suggested that some of these variables may be useful to consider as they might help to increase knowledge of how social support operates.

One variable that some studies report as important to well-being is activity involvement. Mutran and Reitze (1984) found that activity involvement accounted for a substantial proportion of the explained variance in psychological well-being for both married and widowed elderly. As well, Markides and Martin (1979) reported that

activity involvement and health emerged as the strongest predictors of life satisfaction. Activity involvement reflects participation in community and social activities. Such involvement may simultaneously provide companionship as well as enhance feelings of self-worth and independence which in turn may contribute to well-being.

A second set of variables that are reported in some studies as significant to well-being are intrapersonal characteristics. For instance, Heady et al. (1984) found that among other variables such as socioeconomic status and health, personality trait variables such as extraversion, optimism, and personal competence had a considerable effect on well-being. In another study not specifically addressing well-being, Krause (1987) found a nonlinear relationship between emotional support and locus of control beliefs. Briefly stated, the results indicated that there is a threshold for the effects of support. Beyond a certain point, increased emotional support from others serves to erode feelings of control. Possibly, this may account for the thesis finding that those receiving more support than they provide, had lower well-being. Receiving a lot of support from others may reduce the elderly's feelings of control which results in lower well-being.

A third set of variables that may be important to social support processes and well-being are norms and attitudes. As discussed in Chapter 4, various norms and attitudes surrounding social support may affect support transactions and influence well-being. It is possible that norms and expectations operating in different contexts influence what is exchanged and how it is interpreted by the donor and recipient. Reiterating earlier comments,

several researchers have noted the importance of independence, autonomy, and a sense of usefulness for the elderly (Wentowski, 1981; Brody et al., 1983; Hawley and Chamley, 1986). Moreover, these attitudes are thought to influence who is asked for support and how the elderly person feels about receiving and giving support. To illustrate, Stephens and Bernstein (1984) observed that elderly residents of planned housing placed different values on different relationships. Relationships with other residents were least valued whereas relationships with family were most valued. They found that the relationships that were most valued, accounted for most of the support. This suggests that values placed on relationships may influence who is turned to for support. Speculating further, it follows that whether or not such attitudes or expectations are fulfilled may in turn affect well-being.

Besides excluding other variables, it is possible that the Direct Effects and Exchange Views oversimplify the relationship between social support and well-being. Some models or theories deliberately oversimplify in order to clarify understanding (Dubin, 1978). Oversimplification may facilitate understanding of phenomena that are difficult to comprehend because of complexity; however, in simplifying models there is a corresponding decrease in precision. A second factor, then, for the lack of explanatory power and predictive utility of these perspectives is oversimplification of the relationship between social support and well-being.

Several factors add to the complexity of social support. First, some research suggests that the various

types of social support may have differential effects on well-being. For example, there is modest evidence that emotional support, in comparison to instrumental support, has a stronger effect on well-being. Israel (1982b) examined the relationship between social networks and psychological well-being of elderly women. She found that affective support (emotional support) explained a significant amount of the variance in well-being and instrumental support did not. In another study Kart and Longino (1987) found that only emotional support received, not instrumental or social support, had a statistically significant association with life satisfaction. These findings are consistent with Rook's (1984) investigation of the effect of supportive and problematic ties on psychological well-being. She found that both types of social ties affected well-being, but problematic ties had a greater effect than supportive ties. An explanation put forward was that problematic ties were more affect-laden than the supportive ties. Her data suggested that network members who function as supporters are not necessarily the individuals toward whom the greatest positive or negative affect is felt. In other words, the important social ties that affect well-being appear to be relationships associated with stronger emotions. It is more likely that stronger emotions are consistently associated with emotional support than with instrumental support; thus, Rook's findings are congruent with Israel's (1982b) and Kart and Longino's (1987). This is also consistent with the early work done on social support by Cobb (1976). It will be recalled from chapter 2 that Cobb (1976) emphasized the socio-emotional aspects of support such as a person feeling cared for and loved.

The differential effects of the various types of support are compounded further when exchange of support is considered. Well-being may vary not only by the type of support, but also, as found in this thesis, by the balance of exchange of the various types of support. This suggests that in studying social support it may be important to consider these two factors simultaneously. Doing so can be complicated. Supportive exchanges may entail more than one type of support in one transaction. For instance, the donor may provide instrumental support to an elderly person and receive emotional support in return, not instrumental support. If only one type of support is examined or the balance of support is based solely on exchange within the specific types (e.g. emotional support given is compared only to emotional support received), then the degree of reciprocity may be misinterpreted.

Another factor that contributes to the complexity in understanding social support processes is the influence of relationships. Pearlin (1985) emphasizes the importance of relationships to social support:

> Whether support will be forthcoming, what it will be, how long it will last, the nature of its qualities-all of these aspects of support are determined not solely by the actions of the recipient nor solely by the status of the donor, but by the nature of their relationship and the interactions it encompasses (Pearlin, 1985: 50).

Social support is closely entwinned with relationships, but little is known about the exact nature of the association between social support and relationships. This thesis found that family, close friends, and neighbours were differentially related to well-being. Family and neighbours, not close friends,

accounted for a small percentage of the explained variance in well-being. For family, frequency of interaction was important, whereas for neighbours the number of neighbours, not interaction, was significant. This suggests that family and neighbours are important to the elderly, but for different reasons. Relationships with family may be more affect-laden than relationships with neighbours. Family may provide more emotional and instrumental support over the long term and neighbours may provide more emergency support in times of crisis. This is congruent with Stephens and Bernstein's (1984) study of elderly residents in planned housing. As stated above, residents placed more value on supportive relationships with family than with other residents. The investigators found that the value placed on relationships was closely linked to the amount of time that individuals had known each other. They concluded that proximity alone does not outweigh the importance of such factors as family bonds and longevity as determinants of supportive relations.

Rook (1984) argues that it is the interplay of supportive and problematic social relationships that is most important to the well-being of the elderly. As discussed earlier, both problematic and supportive social ties affected well-being and the degree of affect associated with the relationships seemed to be the factor influencing well-being. Problematic ties were relationships that consistently provoked conflicts or feelings of anger. Supportive ties represented people who were turned to for companionship, emotional support, and instrumental support. Her data showed that supportive ties "were significantly related to well-being only when they involved positive affect...and sociability rather than the

provision of support per se" (Rook, 1984: 1106). This means the relationship context in which the support is exchanged may be important to consider when examining how social support and well-being are related. Rook's study serves to emphasize that social support operates within the context of interpersonal relations and that the positive or negative affect evoked within the relationships may reduce or enhance well-being.

The discussion to this point has identified other variables not included in the Direct Effects or Exchange Views and other complicating factors not explicitly addressed in either view. A third possibility for the lack of explanatory power and predictive utility of these perspectives might be that they are inappropriate models to explain the relationship between social support and well-being. Instead, the Buffer View of Social Support may be more useful in increasing understanding of social support processes and well-being.

Both the Direct Effects and Exchange View propose that the dimensions of social support have a direct effect on the dependent variable well-being. Alternatively, it is possible that the various dimensions of social support make an indirect contribution to well-being as argued by proponents of the Buffer View of Social Support. Generally, this view holds that social support is an intervening factor that acts as a buffer to cushion the effects of stressful life events on well-being. In a review of the various models within the Buffer perspective, Barrera (1986) found most evidence in favour of a negative association between social support and psychological distress or physical illness (distress/illness) and a

positive association between stressful life events and distress/illness. It was interesting to note that the association between social support and distress/illness varied depending on the dimension of social support examined. Generally, he found that studies using measures of enacted support reported a positive relationship between social support and distress/illness. Conversely, studies examining perceived support and a few studies examining social embeddedness found a negative relationship with distress/illness.

Barrera (1986) offered more than one interpretation of these observations. First, the positive relationship between enacted support and distress/illness is consistent with the Support Seeking Model. This model states that those individuals exhibiting the "greatest symptomatology should receive and/or seek the most enacted support" (Barrera, 1986: 429). Second, the negative relationship between the remaining two dimensions of social support and distress/illness is in agreement with Attachment Theory (Barrera, 1986). According to Barrera (1986), this theory argues that support is a primary requisite for psychological well-being and without attachments people may develop some degree of psychological distress. In other words, if the number of network members is small and perception of being supported is low, this may result in psychological distress.

These thesis findings partially support Barrera's observations. A modest positive relationship ($r=.32$; $p<.000$) was found between enacted support received and number of chronic conditions consistent with the Support Seeking Model. As well, two of the social embeddedness

measures (number of close friends and neighbours) and perceived support had negative associations with the number of chronic conditions. However, the correlations were very low ranging from -.09 to -.12 ($p<.02$) and associations were only found for two of the six embeddedness measures.

Kart and Longino (1987) offer an alternative view incorporating the Buffer View. They suggest the possibility that exchange of social support may provide an indirect contribution to well-being. In other words, they suggest linking the Exchange View and Buffer View together. In such an approach, a high level of support would be defined as relationships that are reciprocal or symmetrical and lower levels of support would be defined in increments of asymmetry in relationships. Thus, it would be hypothesized that individuals with reciprocal support relationships would be better able to cope with stressful life events than individuals with more asymmetrical support relationships.

Unfortunately, these data did not allow for testing the Buffer View of Social Support or examining the possibilities suggested by Barrera (1986) and Kart and Longino (1987). However, these data in conjunction with Barrera's observations reinforce the view that social support is a multidimensional construct. As well, the thesis findings suggest that direction of support exchanged might be important to the well-being of the elderly. Given this it may be useful to explore the possibility of linking the Exchange View and Buffer View together as suggested by Kart and Longino (1987).

In review, three conclusions emerge from the thesis findings. One, health is a major factor affecting well-being of the elderly. Two, there is evidence that social support is a multidimensional construct. Three, neither the Direct Effects nor Exchange View received strong support in this study. This suggests that both views lack explanatory power to elucidate the mechanisms of social support in relation to well-being. As well, the lack of empirical evidence suggests that the predictive utility of social support is limited. Several factors that might account for the lack of explanatory power and predictive utility were discussed. However, one additional possibility may be that this thesis has failed to adequately test the Direct Effects and Exchange Views. Various methodological problems encountered in this study may have limited some aspects of testing these perspectives. The limitations of this research are addressed in the section that follows.

5.2 RESEARCH LIMITATIONS

It is important to consider the above noted concluding comments in light of the research limitations of this thesis. Several caveats are discussed in this section.

One research limitation concerns a problem that plagues most studies based on data collected through self-report, i.e., social desirability. The original study from which the thesis data were obtained did not include any indicators of social desirability. Although it could not be assessed, it is possible that respondents' answers to some questions concerning social support were biased in a socially desirable direction. In particular, this may

have affected measures of supportive exchange and perceived support. For example, if independence was important to some respondents, they may have found it more acceptable to report that they have provided support to someone rather than to admit that they have received support from someone. This may have resulted in under reporting of support received which in turn may have biased supportive exchange in the direction of providing more than receiving support. Consequently, the data here may present a slightly inflated picture of supportive exchange provided. It is also conceivable that respondents' answers to perceived support items may have been biased. The most socially desirable response would have been to report being satisfied, not dissatisfied, with either support they provided or received.

Compounding the problem of social desirability are the limitations to the operationalizations of some concepts, especially, supportive exhange and perceived support. As described in earlier chapters, supportive exchange measured the overall difference between frequency of enacted support given and the frequency of enacted support received. This type of operationalization emphasized the symmetry (or assymmetry) in the frequency of enacted support received and given. It was not sensitive to two aspects of supportive exchange. First, this type of global operationalization did not permit investigation of dyadic exchange or exchange within categories of relationships such as relatives, friends, or neighbours. Consequently, different levels of reciprocity could not be examined as done in some other studies.

Second, the measurement of support exchange predominantly focussed on the exchange of different categories of instrumental support (e.g. finances, household tasks etc.). It did not measure emotional support exchanged or consider exchange of support involving more than one type of social support (e.g. instrumental and emotional support in one transaction). This may have resulted in misinterpretation of the degree of reciprocity for some respondents because of the lack of precision of this measure. More specifically, these data may have missed support exchanges involving other than instrumental support; thus, some supportive exchanges may have appeared more asymmetrical than they actually were in practice. Given that support exchange was the most important measure in testing the Exchange View of Social Support, it is possible that this thesis did not adequately test the Exchange View.

There were also some limitations to the operationalization of perceived support. As outlined in Chapter 2, perceived support refers to the cognitive appraisal of being connected to others (Barrera, 1986). The measure used in this thesis asked respondents how satisfied they were with the enacted support they received and provided. The focus was exclusively on respondents' perceived satisfaction with various types of instrumental support. This instrument did not tap respondents' perceptions of the availability of their supportive ties. Put differently, it did not directly capture the respondents' "confidence that adequate support would be available if it was needed ..." (Barrera, 1986: 417). As a result, the thesis findings concerning perceived support

may be more aptly interpreted as referring to satisfaction with instrumental support.

Another limitation concerns respondents' perception and interpretation of social support activities. As Heller et al. (1986) have pointed out social support involves an appraisal process. Whether or not social actions are defined as supportive depends on how the activity is perceived and interpreted. This can be illustrated by an example of an elderly woman and her daughter shopping. The event, shopping, may be perceived and defined differently by each person involved in the activity. The daughter may interpret the event primarily as assisting her mother with shopping by providing transportation and carrying groceries. Alternatively, the elderly mother may define the event mainly as a social activity. For her this may be perceived as an opportunity to spend some time with her daughter and visit. In terms of this thesis, the mother's interpretation and reporting of the event would have been defined as 'interaction with a relative' instead of assistance with shopping 'instrumental support'. This means respondents' perception of assistance may have resulted in varied reporting of social support such that some support activities may have been missed.

One more caveat concerns the overall findings in general. Only 16 percent of the variance of well-being was accounted for by the variables examined in this thesis. Although this is in keeping with other reported findings of studies in this area (e.g., Larson, 1978; Rook, 1987), it raises questions about the explanatory power and predictive utility of the Direct Effects and Exchange Views in dealing with the relationship between social support and

well-being. Several reasons for the inadequacy of these perspectives were discussed above. These reasons can be summarized as follows. First, the lack of empirical support may suggest that there are other factors not included in these perspectives which are important to the well-being of the elderly. Second, it may reflect the global emphasis of these views. In other words, the Direct Effects and Exchange View may fail to address the complexity inherent in social support processes, especially when such factors as types of enacted support and relationships are considered. Third, there may be alternative views such as the Buffer View of Social Support that better explain the relationship between social support and well-being. Lastly, it may be that this thesis has failed to adequately examine these two perspectives.

There are several reasons why these data may not have adequately tested the two views. For the Direct Effects View problems in operationalization may have restricted investigating the relationship between social support and well-being. First, as noted above, only one type of enacted support was studied - instrumental support. As discussed earlier, some evidence in the literature suggests that emotional support may be the most important type of support affecting well-being. Thus, this thesis failed to examine a rather important aspect of social support. Second, the measure of perceived support was limited in that it only tapped satisfaction with support, specifically satisfaction with instrumental support. It did not capture whether respondents generally felt supported. That is, it did not measure respondents' level of assurance that support would be available if needed. The result of both these limitations is that the more

affect-laden aspects of social support were not examined. This means the Direct Effects View was only partially tested.

Testing the Exchange View was also limited by problems in operationalization. Most importantly there were problems in the measurement of support exchanged. In part, this may be reflective of the limitations of using secondary analysis. It will be recalled that the original study examined the roles of peer and intergenerational relationships among the elderly as well as elderly's support networks and utilization of home care services. The approach used to study social support was more in keeping with the Direct Effects View. Although there were measures of receiving and giving support, the focus was not on examining the Exchange View. In other words, there was some slippage between the idea of support exchange and actual measurement of the construct. As stated above, the indicators for support exchange did not capture different types of support exchanged nor did it allow the examination of different levels of reciprocity.

A final limitation concerns the basic design of this thesis. The original study consisted of a cross-sectional survey which means the data were collected at one point in time. As a result, this thesis could not test for cause-and-effect relationships. Instead, this thesis could only explore possible associations between variables. To adequately assess the causal relationships within the two perspectives on social support, longitudinal data are required.

Despite these limitations, the thesis findings in conjunction with other reported findings in the literature serve to highlight the complexity of social support. Moreover, this thesis has identified other factors that may be important to consider in future research.

5.3 IMPLICATIONS FOR FUTURE RESEARCH

In view of the aforementioned limitations, there are at least three important issues to consider in future research. First, to be better able to assess the various perspectives on social support, operationalization of some concepts could be improved. Specifically, it is important to give careful thought to the diverse ways of operationalizing exchange and how each way may relate to well-being. Similarly with perceived support, it would be advantageous to employ more than one measure that would capture the individual's perceptions of both availability and adequacy of support.

A procedure has been developed by Fischer and his colleagues for surveying personal networks (Fischer, 1977; McCallister and Fischer, 1978). This method focusses on a segment of respondents' networks which involves a variety of people who are important sources of valued exchanges. In brief, the procedure consists of asking respondents to name people with whom they engage in specific exchanges -- companionship, emotional support, and instrumental support -- and then elicits various information about these network members and the nature of the exchanges. Rook (1987) has modified this method to include investigation of both support received and provided. She argues that even though the questions in this procedure are not exhaustive, they

provide a reasonable representation of the kinds of interpersonal exchanges that are essential to well-being (Rook, 1987: 147).

Utilizing a procedure such as this has three advantages over the measures of support used in this thesis. One, it taps more than one type of social support and most importantly emotional support. Two, it measures support at the dyadic level which allows the analysis of reciprocity at more than one level such as within different categories of relationships or at the dyadic level. Three, this procedure measures satisfaction with specific types of support so if it is used in conjunction with at least one more global measure of perceived support, both respondents' perceptions of availability and adequacy of support are captured. One disadvantage of this procedure is that by focussing on valued exchanges, it excludes support exchanges with less valued network members. However, depending on the research interests the advantages may outweigh the disadvantages.

A second issue to consider in future research is the complexity surrounding social support. It would be useful to include some additional factors in the investigation of social support. For example, it may be useful to include some measures of attitudes and norms surrounding social support and individuals' satisfaction level with relationships involving support exchange. Attitudes and norms may be measured using attitude scales such as the one used by Brody et al. (1983). In one study, Brody and her colleagues used a Likert type scale to measure attitudes relating to gender-appropriate roles and responsibility for care of the aged. A similar type of question format might

be used to examine elderly's attitudes towards giving as well as receiving support.

Given that relationships are often multifaceted, it can be difficult to capture respondents' satisfaction with relationships. One approach is to use multiple indicators. For example, Rook (1987) employed multiple measures to examine social satisfaction of older women. A scale on loneliness provided a global measure as to whether a person perceived a discrepancy between desired and actual social relationships. As well, more specific aspects of relationship satisfaction were tapped by asking questions about certain relationships (e.g. with family and friends) and respondents' feelings about closeness to different people.

A third issue to consider in future research is research design. As stated above, this study was based on data from a cross-sectional survey; thus, it could not address issues of causality. In light of the lack of explanatory power of the various perspectives on social support, there is a need for longitudinal research for it offers two advantages. First, longitudinal research provides a better understanding of causality. Second, longitudinal studies would permit examination of changes in social support as life circumstances change. This would help to identify determinants of social support change and their effects. Longitudinal research does have some disadvantages that are important to consider. In addition to being costly, this type of research often suffers from validity problems such as sample attrition and testing effects (Smith, 1981). These problems tend to be more serious for panel studies that extend over a long period of

time such as five years. Therefore, it may be better to follow a sample of elderly for a shorter period of time.

Another strategy that may be useful in studying social support is utilizing a multi-method approach that includes both qualitative and quantitative data. A qualitative component may provide valuable insights into how the elderly perceive and participate in social support processes. Plus, a quantitative component would complement the qualitative data by empirically testing some of the insights gained from more qualitative research.

5.4 PRACTICAL IMPLICATIONS

The results of this thesis in the context of other reported findings in the literature, have practical implications for professionals involved in various types of programming for the elderly. Israel et al. (1984) suggest that generally there are four types of programs with implications for enhancing social support: (1) programs aimed at developing new social support, e.g., self-help groups; (2) programs aimed at providing social or health services in a way that enhances naturally occurring support networks; (3) programs aimed at tapping "natural helpers" in the community, e.g., peer support; and (4) programs involving community members in cooperative problem-solving which may enhance support networks as a by-product. Four findings of this thesis suggest specific issues to consider when developing and implementing these types of programs.

First, in keeping with numerous other studies, this thesis found that health was the strongest predictor of well-being. The practical implication of this finding is that programmers need to be aware of the health needs of

program participants. For example, social service programs might be designed to accomodate routine health maintenance activities (e.g., taking medications) and have strategies in place to handle health care emergencies that may arise.

The other thesis findings with practical implications for programming are specifically related to social support. That is, a second finding of practical relevance was that neighbours and relatives were differentially related to well-being. In other words, these data suggested that different types of support are provided by different members in a person's support network. The implication for helping professionals is that they need to be aware of the different types of relationships (e.g., neighbours and relatives) and the support they provide to their clients. For example, a health care professional involved in home care might explore the possibility of neighbours as well as relatives providing various types of support to an elderly client.

A third finding with practical implications concerns the exchange of social support. The thesis data indicated that providing support was associated with greater levels of well-being. In other words, giving support to others may provide the older person with a sense of usefulness and independence which in turn contributes to well-being. This suggests that programs might aim to facilitate interactions that are characterized by mutual exchange and interdependence. Some ways to accomplish this are by using peer support activities and self-help groups, both of which emphasize peers helping peers. For example, in a program involving peer support activities, the aim might be to provide social support to elderly in need, but also efforts

might focus on finding ways that the elderly in need may provide support to their peers. This could be facilitated by keeping in mind a fourth finding of this thesis -- that there are different types of social support that can be exchanged. To illustrate, in a situation where an elderly person is receiving instrumental support (e.g., help with meals), it is important to explore ways the elderly person might reciprocate or provide support to others. This elderly person might not be able to provide instrumental support, but may be able to provide emotional support to others. As well, professionals working with clients individually need to recognize the existence of the client's expertise from which they can learn and share. It is important that the elderly client not be placed in a dependent role; instead, the professional might strive toward establishing an interdependent relationship with the client.

In addition to applying some of the knowledge gained from study findings such as these thesis findings, it is important that programmers monitor their program activities in order to gain an understanding of their effects. By integrating the results from program evaluations with other reported findings in the literature, it will help to increase our understanding of how social support operates and with what effects.

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APPENDIX A

QUESTIONS USED FROM THE INTERVIEW SCHEDULE

QUESTIONS USED FROM THE INTERVIEW SCHEDULE

1. Sample Status — 1 - Home care user; 2 - Nonuser

2. Gender — 1 - Male; 2 - Female

3. In what year were you born? What month? What day?

4. How many years schooling do you have?

5. What is your Marital Status?

6. What was you major occupation in life?

7. Individual Elderly Income
   Now I would like to ask you a few questions about your income and expenses. What you tell me is confidential information?

   Monthly Income:
   a) From own Resources (private pensions, pension from private companies, wages, salary, income from business, farm, professional practice, rents, interests from dividend, insurance annuities) $__________

   b) From Pensions or Allowances (such as Old Age Security, Guaranteed Income Supplement, War Veterans Allowance/Pensions, Social Allowance, Public Welfare Agency, Unemployment Insurance, Canada Pension Plan Old Age Assistance) $__________

   c) From other Sources (regular cash help from children, relatives, or friends, church service groups, or private agency etc.) $__________

   TOTAL $__________

8. Now I'd like to ask you a few things about your family and friends. For each person I name, I'll ask you a series of questions.

   (ASK THE FOLLOWING QUESTIONS FOR EACH PERSON LISTED: Father, Mother, Brothers (up to 5 brothers), Sisters (up to 5 sisters), Spouse, Son (up to 5 sons), Daughters (up to 5 daughters), Uncles, Aunts, Cousins, Nieces, Nephews, Grandsons, Granddaughters, Great Grandsons, Great Granddaughters, any other relative you have seen

or heard from in the last year (eg. in-laws, second cousin etc.))

a) Is ________________ living? 1 - no 2 - yes
9 - missing

b) How many living? (where applicable)

c) How many have you seen or heard from within the last year? (where applicable: ASK REMAINING QUESTIONS ONLY FOR THOSE THEY HAVE HAD CONTACT WITH IN LAST YEAR)

d) If living, how old is he/she (age)?

e) How often do you see him/her?
1 - Never
2 - Once every 2-3 years
3 - Once a year
4 - Several times a year
5 - About once a month
6 - Several times a month
7 - Once a week, or more
9 - Missing

f) How often do you talk on the phone or receive a letter from him/her?
1 - Never
2 - Once every 2-3 years
3 - Once a year
4 - Several times a year
5 - About once a month
6 - Several times a month
7 - Once a week, or more
9 - Missing

g) How satisfied are you with this relationship?
1 - Very satisfied
2 - Somewhat satisfied
3 - Neither satisfied nor dissatisfied
4 - Somewhat dissatisfied
5 - Very dissatisfied
9 - Missing

9. Other than relatives, how many people do you consider as close friends? That is, how many of your friends do you feel close to, confide in, etc.?

a) Of these close friends, can you tell me a little bit about the ones you feel closest to? How often do you see him/her?

9. a) continued...

1 - Never
2 - Once every 2-3 years
3 - Once a year
4 - Several times a year
5 - About once a month
6 - Several times a month
7 - Once a week, or more
9 - Missing

b) How often do you talk on the phone or receive mail from him/her?

1 - Never
2 - Once every 2-3 years
3 - Once a year
4 - Several times a year
5 - About once a month
6 - Several times a month
7 - Once a week, or more
9 - Missing

c) How satisfied are you with this relationship?

1 - Very satisfied
2 - Somewhat satisfied
3 - Neither satisfied nor dissatisfied
4 - Somewhat dissatisfied
5 - Very dissatisfied
9 - Missing

10. Other than relatives, how many people do you have as neighbours?
I'd like to ask you a bit about your neighbours. (ASK: HOW MANY? IN EACH CATEGORY)

a) How many neighbours seen in each category of frequency seen?

1 - Never
2 - Once every 2-3 years
3 - Once a year
4 - Several times a year
5 - About once a month
6 - Several times a month
7 - Once a week, or more
9 - Missing

b) How many neighbours do you talk on the phone with or receive mail from in each of the following categories?

1 - Never
2 - Once every 2-3 years
3 - Once a year

10. b) continued...

4 - Several times a year
5 - About once a month
6 - Several times a month
7 - Once a week, or more
9 - Missing

c) How many neighbours fall in each of the following categories of relationship satisfaction?

1 - Very satisfied
2 - Somewhat satisfied
3 - Neither satisfied nor dissatisfied
4 - Somewhat dissatisfied
5 - Very dissatisfied
9 - Missing

11. People often help others at special times or during some kind of special circumstances. We would like to know a bit about the help YOU might have PROVIDED or are PROVIDING for family, friends, or neighbours.

(ASK THE FOLLOWING QUESTIONS FOR THESE 9 ACTIVITIES:
(1) Helping with grand children
(2) Helping out when someone is ill
(3) Giving advice about job, personal problems, etc.
(4) Financial assistance such as paying dental expenses or others, vacation expenses of others
(5) Providing a home for others
(6) Household tasks
(7) Transportation
(8) Emergency assistance
(9) Other (eg. shopping)

a) First have you ever helped with this?

1 - Never
2 - Yes, in past
3 - Yes, currently
9 - Missing

b) How often do/did you help?

01 - Everyday
02 - Several times a week
03 - Once a week
04 - Several times a month
05 - Once a month
06 - Several times a year
07 - Once a year
08 - When occasion arises
09 - Other (SPECIFY)
10 - Never
99 - Missing

11\. c) How satisfied are you with this?

1 - Very satisfied
2 - Somewhat satisfied
3 - Neither satisfied nor dissatisfied
4 - Somewhat dissatisfied
5 - Very dissatisfied
9 - Missing

12\. Now for the same activities we were just talking about, I'd like to know if you have RECEIVED or are RECEIVING any help from others.

(ASK THE FOLLOWING QUESTIONS FOR THESE 8 ACTIVITIES:
(1) Helping out when you are ill
(2) Giving you advice about job, personal problems, etc.
(3) Financial assistance/handling money such as depositing cheques, paying bills, etc.
(4) Providing a home for you
(5) Household tasks
(6) Transportation
(7) Emergency assistance
(8) Other (eg. shopping)

a) First have you ever received help with this?

1 - Never
2 - Yes, in past
3 - Yes, currently
9 - Missing

b) How often do/did they help?

01 - Everyday
02 - Several times a week
03 - Once a week
04 - Several times a month
05 - Once a month
06 - Several times a year
07 - Once a year
08 - When occasion arises
09 - Other (SPECIFY)
10 - Never
99 - Missing

c) How satisfied are you with this?

1 - Very satisfied
2 - Somewhat satisfied
3 - Neither satisfied nor dissatisfied
4 - Somewhat dissatisfied
5 - Very dissatisfied
9 - Missing

13. Some people have difficulty doing some things without help. Would you please tell me if you can do the following things or if you require assistance?

    1 - No 2 - Yes 3 - Missing

    (1) Using a telephone
    (2) Feeding/eating
    (3) Dressing and undressing yourself, including shoes
    (4) Washing, bathing, grooming
    (5) Cutting your toenails
    (6) Taking medication or treatment
    (7) Nursing care
    (8) Getting about the house
    (9) Getting in and out bed
    (10) Going out of doors in good weather
    (11) Going out of doors in any weather
    (12) Going up and down stairs
    (13) Watching TV or listening to the radio, reading, or writing
    (14) Preparing meals

14. Now I have a list of health problems that people often have. I'll read them and you tell me if you have had any of them within the last year or otherwise still have after effects from having had them earlier.

    0 - No 1 - Yes 9 - Missing

    (1) Heart and circulation problems (HARDENING OF THE ARTERIES, HIGH BLOOD PRESSURE, HEART TROUBLES, ANAEMIA, OR OTHER BLOOD DISEASES)
    (2) Have had stroke
    (3) Arthritis or rheumatism
    (4) Palsy (PARKINSON'S DISEASE)
    (5) Eye trouble not relieved by glasses (CATARACTS, GLAUCOMA)
    (6) Dental problems (TEETH NEED CARE, DENTURES DON'T FIT)
    (7) Chest problems (ASTHMA, EMPHYSEMA, T.B., BREATHING PROBLEMS)
    (8) Stomach trouble (INCLUDING LOWER GASTRO-INTESTINAL PROBLEMS)
    (9) Kidney trouble (INCLUDING BLADDER TROUBLES)
    (10) Diabetes
    (11) Foot trouble
    (12) Nerve trouble (INCLUDING ALL MENTAL ILLNESS OR EMOTIONAL PROBLEMS)
    (13) Skin problems
    (14) Other (SPECIFY)(INCLUDING AMPUTATIONS)

15. About how many days have you spent in a hospital during the last twelve months?

16. About how many days during the past twelve months have you been sick in bed at home all or most of the day?

17. For your age, how would you say, in general, your health is?
    1 - Excellent (NEVER PREVENTS ACTIVITIES)
    2 - Good for your age (RARELY PREVENTS ACTIVITIES)
    3 - Fair for your age (OCCASIONALLY PREVENTS ACTIVITIES)
    4 - Poor for your age (VERY OFTEN PREVENTS ACTIVITIES)
    5 - Bad for your age (HEALTH TROUBLES OR INFIRMITY ALL THE TIME PREVENTS MOST ACTIVITIES, OR REQUIRES CONFINEMENT TO BED)
    9 - Missing

18. Life Satisfaction Index "A"

Here are some statements about life in general that people feel differently about. Would you read along with me each statement on the list and tell me if you agree with it, disagree with it or if you are not sure one way or the other. PLEASE BE SURE TO ANSWER EVERY QUESTION ON THE LIST.

(1) As I grow older, things seem better than I thought they would be....
(2) I have gotten more of the breaks in life than most of the people I know....
(3) This is the dreariest time of my life....
(4) I am just as happy as when I was younger....
(5) My life could be happier than it is now....
(6) These are the best years of my life....
(7) Most of the things I do are boring or monotonous....
(8) I expect some interesting and pleasant things to happen to me in the future....
(9) The things I do are as interesting to me as they ever were....
(10) I feel old and somewhat tired....
(11) I feel may age, but it does not bother me....
(12) As I look back on my life, I am fairly well satisfied....
(13) I would not change my past life even if I could....
(14) Compared to other people my are, I've made a lot of foolish decisions in my life....
(15) Compared to other people my age, I make a good appearance....
(16) I have made plans for things I'll be doing a month or year from now....

18. continued...

(17) When I think back over my life, I didn't get most of the important things I wanted....
(18) Compared to other people, I get down in the dumps too often....
(19) I've gotten pretty much what I expected out of life....
(20) In spite of what people say, the lot of the average man is getting worse, not better....

TOTAL SCORE _______