

Aging and social support

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Abstract

This entry describes the concept of social support and provides an overview of the mechanisms through which it contributes to a healthy and long life. It draws on the task-specificity and the hierarchical compensation models to explain differences in the availability of social support in late life. Though it is often suggested that the emergence of public services erodes the provision of informal support empirical support shows otherwise. The state and the family provide different forms of help to older adults, referred to as specialization or mixed-responsibility. Empirical evidence favors the complementary (crowding in) hypothesis rather than the substitution (crowding out) hypothesis. Future analyses should consider macrosocial determinants of social support in late life.

Main text

Social support is a powerful predictor of living a healthy and long life. Large, well-controlled prospective studies show that social support has an impact on older adults' health independently of potentially confounded factors such as socioeconomic status, health-risk behaviors, use of health services, and personality. This entry discusses social support and then how it is related to aging.

Social support refers to positive exchanges with network members that help people stay healthy or cope with adverse events (Thoits 2011). Researchers typically distinguish the following types of supportive behavior: instrumental aid, the expression of emotional caring or concern, and the provision of advice and guidance.

Epidemiologists introduced the concept of social support in the 1970s to explain why people who are embedded in social networks enjoy better mental and physical health.

Characteristic of social support is that it involves behavioral exchanges (giving and receiving) that are intended as helpful and are perceived as such. Social support needs to be distinguished conceptually from the other ways through which people benefit from having close relationships. The first is that networks provide opportunities for companionship and social engagement. Shared leisure activities serve as a source of pleasure and stimulation, whereas the participation in meaningful community activities brings social recognition. Social control is a second mechanism responsible for the healthful effects of social relationships. Social control operates directly when network members consciously attempt to modify a person's health behavior, or indirectly when people internalize norms for healthful behavior. Third, relationships provide access to resources that transcend an individual's means. To have relationships is to have access to other people's connections, information, money and time. The different functions of relationships (social support, companionship, social control and access to resources) are related to each other, and not easily separated in everyday life.

Social support is basically positive. Of course not all our interactions with others are pleasant and enjoyable. Personal relationships can function as a source of stress, conflict and disappointment. For that reason it is important to distinguish positive social exchanges (support) from negative social exchanges (Rook 1997). Examples of the latter are encounters characterized by rejection and criticism, violation of privacy, or actions that undermine a person's pursuit of personal goals. Ineffective assistance or excessive helping are other forms of negative interactions.

From the start, a major focus of social support research has been the question of how and why social support has salubrious effects. In this line of research social support is the independent variable. Two theoretical models have been dominant in the literature. The direct effects model maintains that social support operates at all times. The support people receive helps them maintain an overall sense of stability and self-worth and helps them in their efforts to improve their situation. According to the buffering effects model, social support operates when people are under stress. Social support helps people cope with setbacks and serves as a protective barrier against threats to well-being. Underlying mechanisms are physiological, in the sense of moderating levels of cardiovascular reactivity, and psychological, in the sense of restoring self-esteem, mastery and feelings of competence. The direct effects model and the buffering effects model are not competing theoretical frameworks. Each is couched in its own empirical tradition,

and empirical support has been found for both (Cohen & Wills 1985). Tests of direct effects are generally based on data from the general population, whereas tests of buffering effects consider individuals undergoing stressful life events, such as a serious illness, marital problems or the loss of a loved one.

Studies published in the 1980s showing that supportive behaviors at times have negative rather than positive consequences formed the impetus for new theoretical developments. One set of theoretical specifications pertains to the nature of support exchanges. For example, to better understand direct effects, researchers have suggested looking at the reciprocity of exchanges. Drawing upon equity theory, the idea is that receiving more support than one gives leads to distress and guilt. Over-benefitting is not only a violation of the norm of reciprocity but may also lead to a state of dependency. Whereas reciprocity focuses on the balance between support giving and support receiving, the optimal matching hypothesis, which is a specification of the buffering effects model, focuses on the kind of support received. This hypothesis suggests that support is most effective when it matches specific needs. If people do not receive the right kind of support, then strains will not be reduced. A second set of theoretical specifications pertains to the meanings assigned to support exchanges. It has been suggested, for example, that the effects of receiving support are moderated by self-esteem. For some, receiving support has self-threatening qualities because it implies failure and an inability to cope on one's own. For others, receiving support has self-enhancing qualities such as evidence of love and caring. According to this perspective, people will react negatively to help if it causes damage to their self-esteem. A complementary perspective is that the perceived motivation for support exchanges determines their impact on well-being. Exchanges perceived to be motivated by affection rather than obligation or reciprocity are presumably most beneficial to the recipient.

A line of research that has been more prominent in the social gerontological literature has focused on explaining differences in the availability of social support. Here social support is the dependent variable. Questions about the access to support are particularly relevant to the elderly given that the loss or disruption of relationships is common in later life. Coinciding declines in older adults' health and mobility, leading to an increase in the support required from others, further underscore the relevance of the issue of how older adults negotiate transitions in their relationships. The convoy model of social support (Kahn & Antonucci 1980) emphasizes that

pools of available contacts and needs for resources from others are patterned by older adults' life histories.

Network composition is a dependable indicator of the sources, the quantity, the quality and the types of support to which older adults have access (Dykstra 1993). Relationships tend to be specialized in their support provisions. Knowledge about the different types of relationships composing networks provides insight into available support. According to the task-specificity model, different types of relationships best provide support that is consonant with their structures. Neighbors can best handle immediate emergencies because of their geographic proximity, kin can best perform tasks requiring long-term commitment, and friends can best be relied on for issues particular to a generation or life course phase that assume similarity in interests and values. The marital dyad can function in all the previously described task areas, since that unit shares proximity with neighbors, long-term commitment with kin and, frequently, similarity in interests and values with friends. In agreement with the task-specific model, available evidence indicates that partners are the primary providers of support in old age. Kin and non-kin generally differ in the support they provide. Family members are more likely than are friends to provide instrumental support such as help with transportation, shopping and household chores. Family members are less likely than are friends to provide emotional support such as exchanging confidences, advice or comfort.

There is also considerable overlap between kin and non-kin in the support they provide: family members can be major sources of emotional support and there are friends who provide long-term instrumental support. This happens when the usual primary providers are not available (spouseless and/or childless older adults). A compensatory hierarchy of support providers exists. Ties lower in the support hierarchy are invoked when higher-placed ties are not available. The position in the hierarchy follows socially-shared views on who should provide help. The partner is generally the first to provide assistance when older adults are in need of help with the activities of daily living. In the absence of a partner or when the partner is impaired, adult children are likely to step in. In the absence of children or when they live too far away, support is likely to come from friends, siblings or other family members, or neighbors. The hierarchical-compensatory model has been criticized for not keeping up with demographic reality. It is based on a conventional view of the family and fails to address the complexities in commitments that arise with divorce and new partnerships.

Though friends, members of the extended family and neighbors often step in when needed, instrumental support provided by these relationships has a fragile basis. Given the absence of culturally-prescribed obligations to provide such help to older network members, commitment and support expectations tend to be individualized within the relationships, and are subject to continuous negotiation. Relationships with peers are more susceptible to dissolution if exchanges are unbalanced than are parent-child relationships. The availability of friends, relatives and neighbors for intense support-giving depends on the buildup of reciprocity over the course of their interactions with older network members (Komter 2005).

The hierarchical-compensatory and task-specificity models focus on types of relationships and the normative expectations to provide support associated with them. A drawback of the focus on relationship types is that the gendered nature of social life remains hidden. Women are both expected to and do provide more support to aging family members. This is not to say that men do not undertake instrumental tasks. Though men and women do equal amounts of care-giving as spouses, men's participation in non-spousal care-giving is conditioned by their relationships with women (Calasanti 2003). Men often function as back-ups for their care-giving wives and sisters. Sons who act as primary caregivers are likely to be only children, to have no sister, or to have a sister living far away from the parent. Research shows a gender-typed specialization of the kind of support-giving tasks that are performed. Men are more likely to engage in activities such as odd jobs in and around the house, and paper work, bills and finances, whereas women are more likely to perform household tasks and personal care.

Family members provide the majority of the care that frail older adults receive. A long-standing debate is whether the emergence of public services erodes the provision of informal support. Empirical evidence favors the complementary (crowding in) hypothesis rather than the substitution (crowding out) hypothesis. Public services increase the total level of support; they extend rather than replace informal support. With the introduction of public care, informal support-providers appear to redirect their efforts to previously neglected or partially unfulfilled areas of support, rather than reduce their overall effort. Research shows furthermore that formal help is called in as a last resort. Though informal networks respond to increasing incapacity by expanding the scope of their assistance, there is a point beyond which the needs of the older adult exceed the resources of the network. At that point supplementary support is sought in public services. The state and the family provide different forms of help, referred to as specialization or

mixed-responsibility (Brandt, Haberkern & Szydlik 2009). Professionals take on the complex, time intensive and repetitive tasks, allowing family members to take on the non-technical and spontaneous forms of help.

The imbalanced focus in the gerontological literature on help provided by children creates the impression that all older people need help and downplays their role as helpers in old age. Within families, more support goes down generational lines than goes up (Albertini, Kohli, & Vogel 2007). Parents provide money, gifts, affection and advice to their offspring until very late in life. A role reversal occurs only when the older generation is encountered with difficulties functioning independently. That is when the direction of exchange of assistance and services starts flowing predominantly from the bottom to the top

Over the years there has been a methodological shift from relying on marital status, numbers of close friends and relatives, church membership and other proxy variables to represent exposure to social support to more carefully examining the actual transactions in relationships. Nevertheless, a generally agreed upon measure of social support does not exist. This lack of consensus is not surprising given the wide range of disciplines in which social support is studied. Large epidemiological studies require brief measures. The crude nature of these measures leaves open what characteristics, structures or processes of social interactions are most consequential for health. Psychologists tend to rely on measures of anticipated support: the belief that others will provide assistance in the future should a need arise. A criticism of these measures is that they might say more about the person than about the quality of his or her relationships. They are a way of measuring social support that makes it indistinguishable from a personality trait. In defense, one can argue that anticipated support is based on assistance that has actually been provided in the past. Sociologists (House et al. 1988) emphasize the necessity of distinguishing structural measures of support (existence or interconnections among social ties) and functional measures of support (actual exchanges of assistance and help). An issue that has yet to be resolved is whether to use global or relationship-specific measures. Global measures, whereby respondents are requested to rate supportive exchanges with their friends, neighbors and relatives taken together, have the advantage that they are relatively easy to administer. The disadvantage is that they provide little insight into the relative importance of various social network ties. Relationship-specific measures, whereby an inventory is made of the supportive quality of selected

relationships in the network, have the drawback that they are cumbersome to collect. Furthermore, their aggregation is not always straightforward.

Social support researchers are faced with a constant trade-off between breadth and depth of analysis. It is important to acknowledge that social support is amazingly complex. To advance our understanding of how social support works we need first to pay careful attention to our relationship measures, distinguishing tangible support exchanges from embeddedness. Secondly, we need to simultaneously assess the mechanisms that produce the positive outcomes hypothesized for social support. In doing so, we should more often make use of reports from multiple actors in the social network. Enriching information collected from one person with information from others helps uncover biases. A discrepancy between persons regarding the content and significance of their relationship might highlight conflicts or differences in dependencies.

Apart from a microsocial focus on the pathways by which social support influences well-being, there is a need for macrosocial analysis of the determinants of levels and types of social support. People's support networks are shaped in part by the locations they occupy in a larger social structure stratified by age, sex, and socioeconomic status and organized in terms of residential communities, work organizations, and religious and voluntary associations. Demographic developments such as the extension of life, the drop in birth rates, the increases in divorce and remarriage, and migration set limits for the potential availability of family support. Welfare arrangements influence the resources potentially available for redistribution through families and formal services. There is ample room for sociologists to make their mark in the social support literature which so far has been dominated by psychologists and epidemiologists.

SEE ALSO: Aging, Mental Health, and Well-Being; Caregiving; Elder Care; Family Structure; Health behavior; Life Course and Family; Social Integration and Inclusion; Social Network Analysis; Social Support

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