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ABSTRACT

A detailed review of research was conducted on the relationship of social support of older adults to their general health and well being, and the findings were applied to educational outcomes and performance. The following dimensions of social support were examined: (1) an ecological framework or perspective of social support, (2) definitions and theoretical perspectives, (3) methodological concerns, (4) social support and overall adult adaptation (focus on health), and (5) social support and educational outcomes for older adults. The findings on the nature of social support were equivocal, pointing out a great many false assumptions and methodological problems in considering the health and well being of older adults. For example, some studies suggest that social supports decline with age, while others suggest that the patterns of social support reside with the individual and are relatively constant throughout life. The picture of the lonely, friendless older person may be largely a myth. Therefore, applying the results of such research to educational outcomes is, at best, merely suggestive. On the one hand, educational outcomes for older adults may be somewhat independent of social support variables and influenced primarily by self-characteristics. On the other hand, the role of social supports in the educational outcomes of older adults may be relatively important but not fully appreciated. The study suggests a model of social support in older adult education. The notion of "convoys" or the dynamic networks of social support that accompany the individual throughout life may be useful in such a model. Such a notion is the first step toward integrating social support theory and research in older adult education. A 66-item reference list concludes the document. (KC)

The Ecology of Social Support and Older Adult Adaptation: A Review of Research and Educational Implications

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All of the great religions of the world, in one way or another, advocate a prescript called the "Golden Rule." "Love thy neighbor as thyself" (Leviticus, XIX, 18) has become the ethical watchword for centuries. Only in more recent decades have we become sensitized to the realization that this golden rule may really be what we today call "social support."

OVERVIEW

Over the past two decades, many empirical studies have examined the importance of the concept of social support in relation to human behavior. Social support refers generally to a "buffering effect" attained by intervening between a given externally-generated stress and its consequences for individual well-being (Kahn and Antonucci, 1981). Such social support can, of course, take a variety of forms, including the provision of information or empathic understanding by peers, through informal channels. Social scientists have become increasingly interested in the influence which social support exerts on psychological and physical health. Recent research has demonstrated that social support, derived from informal social networks, exerts a beneficial influence on the maintenance of physical health (Dohrenwend & Dohrenwend, 1980), can protect people from the negative effects of life stress (French, 1974; Hinkle, 1974), and can positively contribute to psychological well-being (Moos, 1974). Major empirical studies of social support and physical

illness indicate that social support networks may be associated with recovery and coping with serious physical illness and injury (Gottlieb, 1981). Social support networks have been associated with improvement of symptoms in patients with essential hypertension, migraine, and asthma (Berle et al., 1952), chronic intrinsic asthma (De Araujo et al., 1973), stroke (Robertson & Suinn, 1968), cancer (Weisman & Worden, 1975) and congestive heart failure (Lewis, 1966). Other studies have demonstrated the critical contribution of social support for many different lifespan outcomes, including adolescents facing the stress of puberty and adults adapting to marriage and parenthood (Holmes and Rahe, 1967;

More recently, the study of social support has focused on issues which face older adults, including health, retirement, and widowhood (Kahn and Antonucci, 1981). The effect of social support is most commonly seen when any of an individual's primary life roles is changed, particularly in an unpredicted and undesirable direction. Since such role changes are more frequent in later adulthood, the concept of social support provides an important approach to understanding how older adults cope successfully with change. Kahn and Antonucci (1981) suggest that a meaningful framework for understanding the link between social support and older adult well-being should include the following propositions: 1) An individual's need for social support, at a given time, is a joint function of characteristics of both the person and the situation; 2) The quality or adequacy of social

support is determined by characteristics of the person, the situation, and the convoy or personal network which the individual brings to a given situation. Many studies have variety of older adult settings, including work and family, have not only shown dramatic effects of social support (particularly in health, morale, and life satisfaction), but have confirmed the significant moderating role of the individual's convoys or personal networks (House and Wells, 1977; Kahn and Antonucci, 1981; Pinneau, 1975).

PURPOSE OF PAPER

The primary purpose of this paper is to provide a detailed review of the research on the relationship of social support of older adults and their general health/well-being and to apply these findings to educational outcomes and performance. This paper will examine the following dimensions of social support:

1) An ecological framework or perspective to social support;
2) Definitions and theoretical perspectives;
3) Methodological concerns;
4) Social support and overall older adult adaptation (focus on health);
5) Social support and educational outcomes for older adults.

AN ECOLOGICAL FRAMEWORK

The guiding perspective or theoretical framework for this review of research is an ecological or systems model for viewing later adult development. The major principles of this approach are the following (Schiamberg, 1985):

1. The aging person, like all other individuals, is a self-controlled system. The main fact of aging, however, is that its processes gradually reduce the level and scope of this self-control of behavior and physiological functioning.
2. The manifestations of aging are ecological and cultural, as well as behavioral and physiological. Not only the people around the older adult, but the structure of society may impose restrictions, such as retirement, limited access to employment and education, and so on. These restrictions may induce many of the apparent symptoms of social and physical helplessness, lack of motivation, and inability to cope, which are sometimes attributed to older adults.
3. The idea that old age is simply a deteriorating state of human existence is both a misconceived and denigrating concept. For the healthy person, old age is a phase of

life span development. Older persons not only can learn and develop, but such learning and development are an inevitable result of positive adjustment.

4. The processes of aging are multifaceted. These processes depend on the interaction of behavior and physiological functioning in the individual. An exclusively biological view of aging (e.g., that aging is primarily the result of cellular exhaustion of DNA deterioration) is probably incomplete. The most probable primary origins of the symptoms of aging are in the behavioral domain--in the way that the individual has ordered his or her life throughout the lifespan (e.g., exercise, work, and social interactions).
5. Later adulthood, like other periods of life, involves opportunities for self-determination. For example, individual adaptation often requires the ability to learn and develop new ways and organized patterns of living, the application of social skills in reestablishing relations with others, and astuteness in adjusting to limited economic resources.

DEFINITIONS AND THEORETICAL PERSPECTIVES

Social support is a term frequently employed but rarely defined. Wallston, Alagna, DeVellis and DeVellis (1983) observed that it has been defined in numerous ways. However, many

definitions tend to be tautological in nature. For example, social support is "support accessible to an individual through social ties" (House 1984). Kaplan, Cassel and Gore (1977) have described it in terms of basic social need gratification. Carveth and Gottlieb (1979) speak in terms of material aid or information exchange. Lowenthal and Haven (1968) emphasize interaction with a confidant. Social support appears to encompass many diverse phenomena and includes a complex variety of constructs, not all of whose components are shared (Wallston et al., 1983). A general definition would describe social support as the aid, solace and/or information provided by individuals or groups, through informal or formal contact.

Components of Social Support. Variety in conceptualizations of social support is hardly lacking. Indeed, Hermalin (1980) has identified 13 subcategories of social support. Nevertheless, most can be placed within two major dimensions: 1) a quantitative/qualitative dimension and 2) an instrumental/expressive dimension. "Qualitative" may refer to "goodness" measures, e.g., perception of interaction adequacy. Researchers vary in their emphasis on the relative importance of one, or the other, or both. Instrumental support refers to information and material assistance, while expressive support includes the provision of understanding and acceptance. Here too, emphasis on one or the other varies. Wallston et al. (1983) consider Caplan's (1979) "tangible" versus "psychological" support to be analogous to their "instrumental" and "expressive"

conceptualizations. However, they question Pinneau's (1975) inclusion of "information" in his tripartite division, composed of "assistance," "emotional support" and "information," since this last can be demonstrated to serve both assistance (instrumental) and emotionally supportive (expressive) functions.

Cobb (1979) provided one of the first definitions in the mid-1970s. He defined social support as information leading people to think that they belong to a network of mutual obligation and communication and, furthermore, that they are esteemed and valued. Cobb (1979) identified four types of support: 1) social support or "communicated caring," 2) instrumental support or "counseling," 3) active support or "mothering," and 4) material support or "goods and services" (see figure 1). Although instrumental, active and material support may involve or suggest social support, none equal its importance, individually or in combination. Social support is wholly informational and includes three component parts--emotional support, esteem support and network support. Emotional support carries the message that one is loved or cared for. This information is generally transmitted within a context of intimacy and mutual trust. Alternatively, esteem support is generally communicated within a public context. The recipient's sense of personal worth, value, esteem and identity are acknowledged and reaffirmed. Network support involves three kinds of information which serve to ensure an individual's position within a structure of shared obligation and communication. This shared information

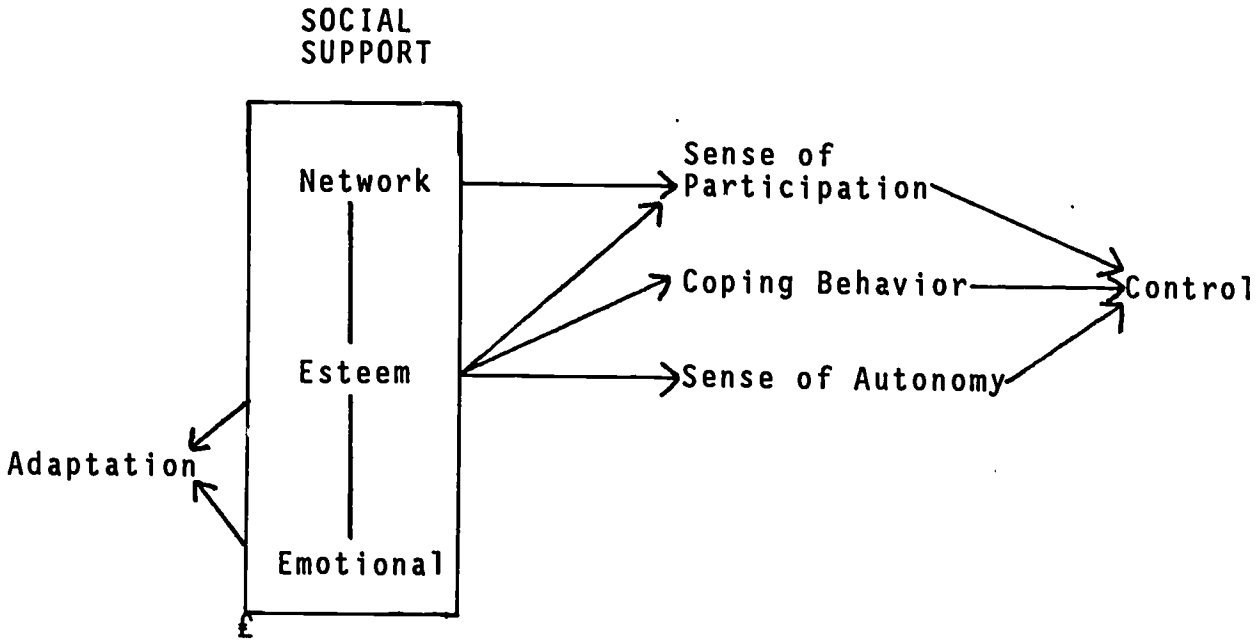

Figure 1. An hypothesis about the mechanism through which social support might operate to improve an individual relationship with the environment, thereby reducing psychosocial stress and thus relieving strain. (From S. Cobb, "Social Support and Health Through the Life Course." In M. Riley (Ed.), Aging From Birth to Death: Interdisciplinary Perspectives. Boulder, CO: Westview Press, 1979)

includes the history of the social network (analogous to Kahn's "convoy"), the availability of goods and services on demand, and the formulation of effective methods of coping with various life dangers.

Kahn (1979) observed that agreement among those who formulate definitions of social support tends to be elusive, at best. Partial measures of social support generally include trust and mutual confidence in another, the ability to influence another, and the sense of responsibility to respond to another's efforts to influence. In order to reduce ambiguity, Kahn (1979) defined social support as interpersonal transactions which include at least one of the following: (1) the communication of positive affect, (2) affirmation of another's perceptions, behaviors or opinions, or (3) the provision of symbolic or material aid. However, it is the "convoy" of social support which he considers crucial to an understanding of the aging process. The convoy is defined as a set of significant others with whom one moves through the life course, sharing a mutual reliance for the giving and receiving of social support. Kahn (1979) has formulated four general propositions related to the convoy and its effects: (1) Well-being and relative success in performing social roles and coping with life changes and transitions is determined by the adequacy of one's social support. (2) The adequacy of the social support given and received is determined by the formal properties of one's convoy. (3) The formal properties of one's convoy are determined by

demographic and situational variables (e.g., sex, age, residence and race). A direct, causal sequence may be apprehended in combining the three hypotheses--demographic characteristics to convoy structure to adequacy of social support (both qualitative and quantitative) to well-being or lack of same. (4) The buffering effect of social support in moderating the impact of stressors (e.g., job loss, bereavement, or imposed residential change) on well-being represents a fourth hypothesis (see Figure 2 for summary of these 4 propositions).

Use of the concept of the convoy in research, necessarily requires specification and measurement of its formal properties. These properties include those of the convoy in its entirety, as well as the dyadic links between a particular subject and individual members of his/her convoy. Although a complete set of formal network properties has not yet been formulated, Kahn credits Barnes' (1972) research on network analysis with clarifying his own thinking, in the development of partial descriptions of convoy properties. Properties of the entire convoy include: size (number of members), internal connectedness (percentage of members acquainted or related through giving or receiving of support), external connectedness (number of members related to clearly-defined categories of others, e.g., community leaders), stability (average length of membership), homogeneity (members' shared characteristics), symmetry (percentage of mutual

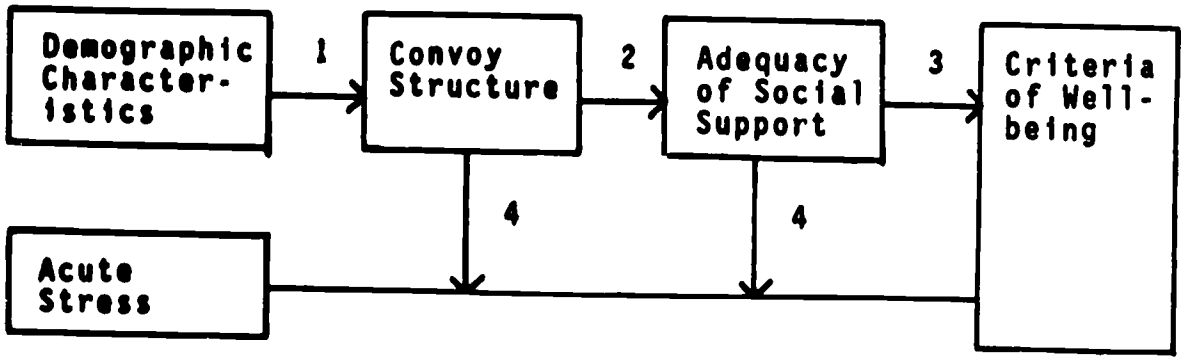

Figure 2. A summary of Kahn's four propositions regarding convoys of social support. (From R.L. Kahn, "Aging and Social Support." In M.W. Riley (Ed.), Aging From Birth to Death: Interdisciplinary Perspectives. Boulder, CO: Westview Press, 1979.)

giving and receiving supportive relationships). Properties of dyadic links include: frequency (number of transactions during specified time units), magnitude (perceived importance of transactions), initiative (number and percentage of transactions initiated by subject and convoy members), range (number of life areas tapped in transactions, e.g., employment, family), type (affect, affirmation or aid as primary content of transaction), symmetry (predominantly supportive through giving, receiving, or both), duration (length of relationship), and capacity (support potential).

Kahn and Antonucci (1981) assert that social support buffers the deleterious effects of stress throughout the life course, as evidenced by the complementary relationship between "roles" and "convoys." The former is defined as a set of prescriptive and proscriptive behaviors associated with commitment to a particular position in social space. Contending with role-related expectations and demands is a primary source of chronic stress throughout the life cycle, while acute stress often accompanies role change, reduction and loss, during the aging years. Convoys are dynamic networks of social support which are seen to accompany the individual, as he moves through the life cycle. Membership is limited to persons considered valuable sources of social support and typically develops through the numerous roles an individual assumes, during his lifetime (e.g., spouse, parent, friend, employee, neighbor, or supervisor). Although one's inner circle of close family and friends may be expected to remain

stable over time, those whose convoy membership is primarily role-dependent may be expected to undergo significant change, as roles are relinquished or replaced. For these individuals, the recurring losses associated with aging may prove devastating.

Changes in the characteristics of convoys from birth to death offer many opportunities for further research. In convoys during old age, we may reasonably predict greater instability (loss of members) and asymmetry (fewer opportunities to give than receive), reduced initiative (tendency to await rather than initiate interaction) and changes in interaction type (increase in direct aid and decrease in receipt of affirmation and affect). Therefore, the "youthful" qualities displayed by some older adults may reflect the presence of symmetrical relationships within relatively large convoys. Conversely, significant changes in convoy patterns may explain, in part, phenomena typically ascribed to the aging process.

Victimization and Social Support. A useful perspective for examining the relationship between aging and social support is the concept of victimization. Dunkel-Schetter and Wortman (1981) trace the parallels between victims of uncontrollable, aversive life events and older adults, in their need for social support and the problems associated with its availability and adequacy. Their conclusions prepare fertile ground for further research:

1) The elderly are "victimized" in numerous ways by the aging process, e.g., multiple losses, including death of spouse, friends and relatives, decline in physical

health, financial status, prestige and social participation.

2) The elderly appear to benefit from social support in ways not unlike those of victims.

3) The elderly appear to need increased opportunities to ventilate feelings and receive validation from others that their responses are appropriate to their circumstances. Confronting undesirable life events is often accompanied by feelings of fear, uncertainty, anxiety and confusion, as one's long-held assumptions are seriously challenged. The belief that these feelings may be abnormal and indicate poor coping ability or loss of sanity tend to intensify a person's suffering. Not unlike Cobb (1979) and House's (1984) conception of social support, Dunkel-Schetter and Wortman maintain that acquiring information from others, particularly similar others, serves to significantly reduce this secondary suffering. Information includes opportunities to express feelings and fears, clarify options, develop practical coping skills and compare experiences with a non-judgemental other.

The work of Rosow (1967, 1970), Lowenthal & Haven (1968), Butler & Lewis (1977), Raphael (1977) and Henkin (1979) suggest that older adults appear to share this increased need to ventilate feelings and receive

validation from similar others that their responses are appropriate to their circumstances. For example, talking openly with a spouse or peer may provide relief for an older adult male overwhelmed by feelings of worthlessness, due to retirement. Similarly, sharing feelings of anger and resentment with a sympathetic friend regarding a child's apparent neglect, may enable an older adult female to realize she is not alone in experiencing these feelings. Sharing concerns with a confidant seems to provide protection and promote adjustment to various age-related losses--widowhood, retirement, reduced social roles and interaction.

4) The quality of support received by a significant percentage of the older adult population appears to be deficient.

5) Deficiencies in support may be linked to feelings of discomfort, vulnerability and helplessness when confronted with physical and/or emotional suffering. Resultant withdrawal or avoidance deprives victims and older adults alike from the support and assistance they clearly need.

METHODOLOGICAL CONCERN

House (1984) has further explored the definitions of social support as well as related ambiguities and methodological

problems. He defined social support as "the flow between people of emotional concern, instrumental aid, information or appraisal" (House, 1984). The sources of social support can be both personal (e.g., family, friends, and co-workers) or impersonal (or more formal) sources. The latter would include "sources from which people can obtain specific services, assistance, or advice . . . [such as] self-help support groups and professional psychotherapists, to mention just two of the most obvious." For House, the behavioral components of social support may range from mere proximity to another to the active provision of feedback, advice, information, directives, expressions of encouragement, esteem, concern, affirmation or assistance, in the form of money, environmental change, time or labor.

There is mounting experimental evidence that the simple presence of familiar others in a potentially stressful situation can reduce both physiological arousal and feelings of anxiety. However, it is not altogether clear exactly how this process works and the specific mechanisms that are presumably at work to protect individuals against stress. However, the development of tools which facilitate the precise measurement of social support within people's lives remains elusive. For example, the nature of the connection between social support and outcomes such as health raises substantial methodological issues. How does a social scientist measure the presence or absence of social support in human experience? Likewise, how can the presumed effects of improved health, longevity or well-being be precisely

measured? One frequently used indicator of the presence of social support has been the level or degree of an individual's social integration (i.e. the degree to which a person has access to - or is isolated from - potential sources of support). According to House:

> "Current interest in the effects of social support is in part an outgrowth of a long tradition of research on social integration versus isolation by sociologists and social epidemiologists. These studies, which have been for the most psrt cross-sectional or retrospective in nature have pretty consistently found better mental and physical health and greater longevity among persons who are higher on various measures of social integration than among those who are lower, especially when comparing the married to the unmarried. (House, 1984)

The problem with these studies however, is that it is difficult to determine if the mental or physical illness is the result of social isolation (i.e., lack of social support) or the cause of it.

House (1984) sees the longitudinal or prospective study as one route toward resolution of this dilemma, since the few studies of these types completed to date appear to confirm the hypothesis that social integration levels are precursors of health. A prospective study conducted in Alameda County, California is illustrative in this regard. In 1965, self-report data on social relationships and health were secured from a sample of 5,000 men and women. A follow-up on mortality rates was conducted in 1974. The results indicated that individuals ranking low on social relationship measures in 1965 experienced a

30 to 300 percent greater likelihood of death by 1974, despite controls for age and 1965 health status (Berkman and Syme, 1979). However, the lower levels of social integration and higher probability of death may reflect a significant problem with self-report data on health status, such as the possible presence of pre-existing illness at the start of the study. Using data from the Tecumseh Community Health Study, House, Robbins and Metzner (1982) conducted a replication study of the Alameda County effort. In addition to self-report data, the Tecumseh study included comprehensive medical examinations and tests on 1,432 women and 1,322 men, completed between 1967 and 1969. A follow-up on mortality rates in 1979 confirmed the findings of the California study, with one notable exception. Mortality rates among women ranking low in social integration were significantly lower than their male counterparts. House suspects an unmeasured form of social integration prevalent in traditional small-town communities may account for this difference. Limiting measurement of contact to those contexts generally considered "social" fails to capture the benefits derived from participation in a "network of friendly neighborhood contacts," within other contexts (e.g., gardening, child care and hanging laundry). Nevertheless, national trends appear less than encouraging. During the past twenty-five years, a decline in social supports, networks and significant informal social relationships has been matched by an increase in efforts to seek assistance from these same resources. Indeed, contemporary Americans are more likely

to be living alone and less likely to marry, visit informally or hold membership in voluntary organizations.

Approaching an understanding of the ways in which these changing patterns are affecting our well-being, health, and the quality and length of our lives is clearly a formidable task. House recommends the development of research studies which seek to identify and assess the structures through which social support functions, the factors which facilitate or impede the development of supportive relationships, and the conditions under which these relationships both succeed and fail to significantly affect stress levels and health status.

Although previous research indicates social support can serve to improve health, reduce stress and buffer the latter's impact on health status (House, 1981; Berkman and Syme, 1979), future aging research will need to explore the manner in which social support is distributed throughout the life course and whether its effects change at various life stages (House and Robbins, 1983). Generally, aging research has examined social support as a means of protection against the physical effects of numerous losses associated with advancing years. Nevertheless, many questions remain unanswered. Age-related social losses are not necessarily experienced as a loss of social support, as evidenced by widowers who remarry and widows who successfully establish and maintain supportive relationships with others (Cleveland and Gianturco, 1976). Some studies suggest social isolation among the aged is a myth and that the maintenance of

one intimate relationship is the key element in maintaining morale (Ingersoll and Depner, 1980; Shanas, 1979). Therefore, the predicament of lonely, older adult individuals in poor health may be less a consequence of age than a reflection of a life-course attitude and behavioral style. Research on the timing and patterning of exposure to both stress and social support throughout the life course may yield valuable information regarding the quality of current relationships, health status and levels of adaptation. A life-course perspective may also shed additional light on the relationship between class, sex, race and status inconsistency and an individual's exposure and response to stress, as well as the interaction of these factors with age, in relation to other variables.

The importance of perceived social support was clearly demonstrated in Blazer's (1982) study with an older adult community population. Although mortality status was predicted by three distinct parameters of social support--frequency of social interaction, perceived support and roles and available attachments, perceived social support proved to have the highest predictive value. Blazer offers three possible explanations for the impact of perceived social support on health status: (1) Its effects may be due to the altering of an individual's perception, such that the impact of perceived social stressors may be significantly reduced. (2) Reduced use of health services and subsequent reduction in health-promoting behaviors may be due to impaired perceived social support, i.e., the quality of support

available to the individual--a perception which may vary according to present health and/or emotional status. (3) A decline in health status may be due to an impairment in perceived support growing out of an impaired support network. Clearly, our knowledge of what social support is, how it functions and the complex inter-relationships among its parameters and health status remain speculative. Perhaps not surprisingly, Blazer's recommendations for future research involve the development of improved, simplified measures of social support which will allow for simultaneous examination of its various parameters. However, since no standard for evaluating parameters of social support, particularly perceived support, has yet been developed, correcting this deficiency should assume equal importance.

Methodological Problems. There appear to be three primary methodological problems in the measurement of social support, which significantly affect conclusions drawn from available research in this area (Wallston, et al., 1983). (1) Inferring a causal role of support is difficult, due to the prevalence of retrospective and cross-sectional data. For example, the finding that mental or physical illness may be the result of social isolation (i.e., lack of social support) is problematical because it is difficult to determine if mental or physical illness is the result of social isolation or the cause of it. The work of Mitchell and Trickett (1980) and Heller (1979) indicate that prospective or longitudinal studies are not without problems. For example, assistance is frequently confounded with an

individual's ability to elicit support or use secured support to advantage. (2) Inadequate conceptualizations and operationalizations of social support are not uncommon. The fact that social support is not a unitary construct frequently goes unrecognized. And, most studies fail to operationally distinguish support types measured, despite adherence to a multidimensional view of support. (3) Comparison and resolution of contradictory findings is, of course, hampered by inconsistency in measures employed.

Correlates of well-being. The importance of social support for health and well-being has long been recognized. The classic studies by the sociologist Durkheim established that individuals are much less likely to commit suicide if they are integrated into groups or enduring relationships such as family, religious organizations, or work groups. Following on the increased focus on research on life stress over the past decade, there has been a dramatic increase in research and writing on the topic of social support. Many studies appear to suggest that individuals who can utilize such resources of social support have reduced rates of psychological or biological impairment, compared to those who are without these resources. However, the measures of social support that have been used have often been diverse, and the findings have sometimes been inconsistent or contradictory.

Numerous reviews of research have found a link between social support and aspects of health and illness (Wallston, Alagna, DeVellis and DeVellis, 1983; Caplan, 1979; Cobb, 1979;

Haggerty, 1980; Mitchell and Trickett, 1980). However, Cohen, Teresi and Holmes (1985) have noted a lack of longitudinal data and rather unsophisticated network measures have significantly hampered research examining the relationship between social networks, physical symptoms and stress. In their study, 133 elderly residents of various mid-Manhattan hotels were followed for one year, using 19 network variables. The results suggested that social networks play a significant role in the reduction of physical symptoms and provide protection against the deleterious effects of increased stress levels. Therefore, patients' future health status can be reliably predicted by integrating information about their present health status and social networks. Bolstering a patient's social network may then prove equally important to a medical intervention.

Cohen and Syme (1985) examined the relationship between health and social support. They defined social support as "the resources provided by other persons", including information, material - instrumental contributions, a sense of affiliation or belonging, or emotional support and intimacy. Such support can come either from individuals or from larger social organizations. According to Cohen and Syme (1985) this social support may either enhance health, regardless of given stressors, or may serve as a buffer to those stressors. Unfortunately, as they point out, we need to move beyond these simple and well-established general relationships to more specific considerations of hypotheses about the relationship of social support to mediators of health -

biological, behavioral, and emotional. Syme and Cohen identify several critical issues to be addressed:

1) The type of causal models necessary to guide research;
2) The possibility that changes in social relationships may themselves be stressors;
3) And the further possibility that at least some of the relationship between health and social support may be spurious. That is, the relationships may derive from preexisting personality characteristics of persons that, in turn, determine both health outcomes or the attributes of social support.

Another methodological problem having to do with the relationship of social support and health/well-being is the variation of social support over the life span (Pearlin, 1985; Schultz and Rau, 1985). Such life-span factors have particular relevance to the question of social support and older adults. The complexity of the problem is noted in the common finding that different types of stressful problems may require different solutions and that social supports are contained in ongoing relationships that vary over time (see discussion of social convoys). With reference to life-span variations, there is good reason to recognize the differential patterns of social support over the lifespan. For example, the most crucial aspect of support for children appears to be <u>performance,</u> through close ties with significant others (Boyce, 1975). During the years of early and middle adulthood, work and family roles are a source of

both stress and social support (Kasl and Wells, 1985). In later adulthood, social support continues to play an important role in general health and well-being, although this role is not different or more important than in earlier life phases (Minkler, 1985).

Summary and Recommendations. Although identification of the relative importance of various aspects of support and their relationship to stress, physical health and general well-being will require additional work, evidence of the benefits of naturally-occurring social support is both abundant and consistent, across a wide variety of methods and physical impairments. This assertion is well supported by a review of literature on intervention, adaptation to illness, rehabilitation and recovery.

Wallston et al. (1983) offer several recommendations for future research. The inclusion of health indicators and social support in large-scale national longitudinal studies holds the greatest promise for determining the relationship between disease onset and social support. Models designed to explain one aspect of social support and its effects may be fruitfully applied to others. For example, Wallston and Wallston (in press) and Ajzen and Fishbein's (1980) research on social norms may blend well with Geertsen et al.'s (1975) work on the impact of the values and attitudes of various sources of support. Jenkins' (1979) and Caplan's (1979) models may be incorporated into studies addressing issues other than social support and stress, and

social support and regimen adherence, respectively. Wallston et al. (1983) clearly consider social support to warrant further study, particularly in the areas of conceptualization, measurement and methodology.

Wallston et al. (1983) see social support operating within four important dimensions: (1) amount (quantity), (2) nature (quality), (3) type (instrumental/expressive) and (4) source. Further research is required in order to determine whether quality or quantity of support is of greater importance, and how various outcomes and individuals may differ in emphasis. These issues are also relevant to the study of various sources of support. Further research is also needed in order to determine whether similar processes are evident in rendering instrumental versus expressive support. Use of the term "support" in reference to both may achieve little in the way of precision and clarity. Perhaps "support" would be more appropriately reserved for expressive functions and another term, e.g., "assistance" employed to identify instrumental behaviors. Other semantic problems present themselves. Although "support" suggests positive involvement, one's involvement with others may be less than growth-enhancing. Garrity (1973) and Lewis (1966) have demonstrated that during rehabilitation, social support may promote dependency. DiMatteo and Hays' (1981) work indicates social support provided by families may actually serve to increase, rather than alleviate stress. Therefore, a deeper understanding of social support may necessitate an analysis of

both providers and recipients of social support--the prices paid and benefits reaped by each, in any transaction identified as supportive.

Social support as a property of the environment which an individual may access has been the primary focus of most research in this area, to date. However, directing attention toward personal variables which serve to facilitate or inhibit the attraction and constructive use of social support, may lead to a fuller understanding of its effects. Pattison, De Francisco, Wood, Fraiser and Crowder's (1975) finding that psychological functioning was associated with social support in one's network size is illustrative in this regard. Therefore, rather than a direct causal link between social support, health and general well-being, an explanation of the positive association between these two may be found in a correlation with a third "person" variable.

Learned Helplessness as a Social Support Framework. Wallston et al. (1983) note that poor health and high mortality rates have been linked to exposure to life events which are negative, unexpected and beyond one's ability to control. Several studies have included social support in examining issues related to locus of control and health. Conger, Sawrey and Turrel (1958) demonstrated that companionship among animals reduced the incidence of peptic ulcers, due to exposure to uncontrollable shocks. Perhaps more telling is Schulz's (1976) finding that, rather than limited to the mere presence or absence of social

support, the ability to predict and control interpersonal transactions may significantly influence health outcomes. Schulz's suggestion is bolstered by Caplan et al.'s (1976) description of several variables intervening between adherence and social support, which are not unlike Seligman's (1975) components of learned helplessness. These variables include motivation level, mood states (e.g., depression and anxiety), perception of one's competence, and level of contingency between a behavior (nonadherence) and its consequences. Therefore, health outcomes may be influenced by social support through disruption or avoidance of learned helplessness behaviors. Indeed, the work of Johnson & Leventhal (1974), Rodin (1980) and Seligman (1975) indicate that the deleterious effects of uncontrollable and unpredictable life events can be reduced by engaging in behaviors which clarify contingencies, and increase predictability and a sense of control.

Wallston et al. (1983) offer several recommendations for further research in social support: (1) Differentiating among various social support components. (2) Identifying the physical health outcome stage during which social support is introduced. (3) Relating social support causally to other variables, through use of extant theory. (4) Examining individual factors which may affect psychological processes related to social support. (5) Careful consideration of measurement protocols which are consistent with particular theoretical conceptualizations of social support.

SOCIAL SUPPORT AND EDUCATIONAL OUTCOMES

Given the equivocal nature of the findings on social support, the health/well-being of older adults and the related methodological problems, the application of such findings to educational outcomes is, at best, merely suggestive. On the one hand, educational outcomes for older adults (e.g., attendance in a formal or informal educational program or success in such a program) may be somewhat independent of social support mechanisms, influenced primarily by such variables as self characteristics (e.g., self concept, previous experience or success in educational endeavors). There already exists a substantial body of research which may be taken to support the significant role of such self characteristics. On the other hand, there may be good reason to expect that the role of social support mechanisms in the educational outcomes of older adults may, in reality, be relatively important, but not fully appreciated, either from theoretical or practical perspectives. We will briefly review a few exemplary studies which point to an emerging social support perspective to older adult education, and then propose a social support model of older adult education.

Heisel, Darkenwald and Anderson (1981) noted that within the older adult population (sixty years of age and older), white females tended to be the most active consumers of various types of educational programs. They also tended to have achieved

higher educational and income levels than non-participants. Course selection and motivation appear to be related to sex, age and educational level. Women and the undereducated "old old" (seventy five years of age and older) cite personal interest as the primary motive for involvement. Men, college graduates and those in their early sixties may enroll in programs to facilitate job advancement. Women, high school dropouts and those over sixty-five tend to select hobby or social/personal improvement courses, while men, those in their early sixties, and college graduates with higher incomes, tend to select career-related classes. In general, within the older adult population, black men and black women, the "old old", and individuals low in income and educational levels were least likely to participate in adult education programs. Programming and marketing changes in the form of personal "social-linkage strategies" are discussed as ways of rendering educational opportunities more accessible to these groups. For example, an older adult living in an outlying area or urban ghetto and fearful of street crime will tend to be less than enthusiastic about enrollment in a night course. Community organizations the older adult is affiliated with, such as churches and senior citizen centers, may serve as a foundation upon which to begin to build effective social linkages. Such studies provide evidence for at least two conclusions: (1) With the exception of those who, for one reason or another, are typically excluded from - or exclude themselves from - educational opportunities, <u>most older adults</u> are, or can be,

successfully involved in older adult educational programs, within their current variety and structure. Such positive outcomes appear to result either from self characteristics (e.g., income, prior educational level, motivation, and so on), or from existing convoys or social linkages, or from a combination of both. (2) Excluded groups (e.g., Blacks and low income individuals), however, require specific and targeted "social-linkage" or "social-support" efforts.

Sadowski and Schill (1979) outlined intriguing parallels between senior citizen centers and community college programs in terms of accessibility, voluntary participation, instrumental and expressive functions and opportunities, and low percentage of older adult enrollment. The psychosocial theoretical construct "affiliation" was presented as an explanation for older adults' interest or reticence in participating in such voluntary organizations. Affiliation is composed of four factors: (1) information, (2) assistance, (3) self-evaluation and (4) stimulation. Consistent with the definitions of social support in this paper (Cobb 1979; House 1984), Sadowski and Schill's findings indicate that gathering new information is the major reason older adults affiliate with or join social or educational groups. A most practical recommendation growing out of their work is the placement of a senior center within a community college complex and/or the presentation of college courses, within local senior centers. While it is not clear that Sadowski and Schill (1979) address the needs of the "hard-core"

educationally-excluded older adults (old-old, frail elderly, low-income, low educational background, and so on), nonetheless, the relationship between their notion of "affiliation" and social support appears to have broad practical import.

In conclusion - albeit a tentative one - one might propose a model of social support and educational outcomes in the form of testable hypotheses which might more meaningfully include social support, in older adult education. The notion of "convoys" or the dynamic networks of social support which are seen to accompany the individual as he/she moves through the life cycle, may be particularly useful in framing such hypotheses: (1) The adequacy of social support, and specifically educational outcomes, is related to the properties of the entire older adult convoy (e.g., size or number of members; internal connectedness or the extent to which convoy members are acquainted or related to each other, through giving or receiving support, and so on); (2) The adequacy of social support and/or educational outcomes is related to the properties of the dyadic links or relationships that comprise the convoy (e.g., frequency or number of transactions; the perceived importance of the transactions; the range of the transactions or the number of significant life areas tapped; the symmetry of the transactions or the extent to which one provides or receives support, and so on); (3) The impact of the formal properties of convoys on the quality of social support, or the success of educational outcomes, is influenced or mediated by demographic variables (e.g., age - "young-old" or

"old-old", income, educational level, and so on). These hypotheses are, of course, an initial step toward integrating the provocative challenges of emerging social support theory and research in older adult education.

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