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CHAPTER 1

Issues in the Study and Application of Social Support *

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Introduction

Since the 1970s, there has been a dramatic increase of interest in the concept of social support as it affects health and well-being. This interest is reflected in an explosion of research as well as an increase in the number of treatment and intervention programs that use social support for therapeutic assistance. The phenomenon is especially remarkable because of the breadth of disciplines concerned with the concept—including anthropology, architecture, environmental design, epidemiology, gerontology, health education and planning, psychology, social work, and sociology.

This book provides a systematic and critical assessment of this outpouring of work, a guide for doing further research on social support and health, and a source of information on the implications of existing work for clinical practice and public policy. Our goal is to facilitate evaluation of what has been done, to identify gaps in knowledge, and to see more clearly what work yet needs to be done.

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In an attempt to integrate a body of literature that includes multiple perspectives, definitions, and outcomes, we have adopted broad definitions of both social support and health. *Social support* is defined as the resources provided by other persons. By viewing social support in terms of resources—potentially useful information or things—we allow for the possibility that support may have negative as well as positive effects on health and well-being. In the same spirit of breadth, we have accepted the World Health Organization's definition of health as including physical, mental, and social well-being.

Since the meaning and significance of social support may vary throughout the life cycle, we have made an explicit effort to address the different types and functions of social support at different periods in life. Thus, we have paid special attention to the varying nature and importance of social supports during childhood and adulthood as well as to the changing roles of family, friends, spouses, and children at different points in the life cycle.

The purpose of this chapter is to place the book within a conceptual and historical context. We discuss the potential importance of support research, disciplinary differences in perspective, alternative mechanisms by which support may affect health, and focus on selected issues central to the study of social support and health.

Importance of Support Research

The increasing interest in the concept of social support among those concerned with health and well-being can be attributed to several factors. One is its possible role in the etiology of disease and illness. This is an especially important issue because of the difficulties we continue to have in understanding the causes both of noninfectious diseases (including coronary heart disease, stroke, cancer of various sites, mental illness, and arthritis) and infectious diseases where variations in host susceptibility are of critical etiological significance.

Another reason for the increasing attention being paid to social support is the role it may play in treatment and rehabilitation programs instituted following the onset of illness. The benefits of altering behavioral and emotional characteristics in such programs have been increasingly recognized. These changes often require that people stop doing things they previously have done and begin doing things they have not done before. Often, it is important that people accept new self-perceptions. While the value of supportive social relationships in promoting these changes has been assumed, it now needs to be assessed critically. This is of special importance as interest in self-help programs becomes more widespread.

A third reason for increased interest in the concept of social support is its potential for aiding in the conceptual integration of the diverse literature on psychosocial factors and disease. Since the 1950s, behavioral scientists have attempted to identify psychosocial factors that affect health and well-being. From this work has emerged a long list of factors that seem to be of importance. The length of this list is both encouraging and distressing. It is encouraging because it suggests that "something" about psychosocial functioning is of possible importance for disease etiology. It is distressing because of the seeming lack of a central theme in the diversity of findings. The concept of social support is attractive because it may provide an integrative explanation of these findings. Thus, many of these psychosocial factors may affect health and well-being primarily through their disruptive impact on social networks. For example, a considerable body of research has demonstrated a higher rate of disease among persons who have experienced job changes, job loss, residential moves, migration, and the death of a loved one. All of these events involve the disruption of existing social relations. The disruption of interpersonal relationships may also explain why those who are married have lower rates of disease than those who are single, widowed, or divorced and why those exhibiting type A behavior (and who tend not to invest the energy required to maintain close relationships with others) have higher rates of coronary heart disease. Conversely, the lower rates of disease often observed among members of religious groups (such as Mormons and Seventh-Day Adventists) and among women may also be seen as a reflection of enhanced social support in those groups.

Clearly, social support provides a parsimonious conceptual model for the diversity of psychosocial findings related to health. It is important, however, to recognize that with sufficient ingenuity and motivation, it is relatively easy to find consistent patterns of results using virtually any hypothesis. Such consistency, therefore, should be viewed with appropriate caution and skepticism. Nevertheless, a concept that can provide a meaningful and parsimonious integration of seemingly diverse findings is clearly worth careful study.

Models of Social Support as a Causal Factor in Illness and Health

Support has been implicated in the etiology of and recovery from both physical illness and psychological distress. Although there has been a tremendous amount of work attempting to establish the beneficial effects of support on health and well-being (see reviews by Broadhead *et al.*, 1983;

Leavy, 1983; Chapters 11 through 15 of this book), relatively little work has focused on *how* increased support improves health.

Etiology of Disease

During the last five years, there has been considerable interest in determining whether positive relationships between social support and health occur because support enhances health and well-being irrespective of stress level (direct or main effect hypothesis) *or* because support protects people from the pathogenic effects of stressful events (buffering hypothesis) (See Chapter 13 by Gore and Chapter 11 by Kessler & McLeod in this volume.) Although this issue is posed as if only one of these mechanisms is correct, recent research provides evidence for *both* direct and buffering effects of social support on health and well-being (see reviews by Cohen & Wills, 1984; Kessler & McLeod, chapter 11 in this volume). The direct and buffering processes may, however, be linked with different conceptions (and hence types of measures) of social support (Cohen & Wills, 1984; Reis, 1984; Thoits, in press). Direct effects generally occur when the support measure assesses the degree to which a person is integrated within a social network, while buffering effects occur when the support measure assesses the availability of resources that help one respond to stressful events.

It is our position that further emphasis on the comparison of the direct effect and buffering models will not significantly increase our understanding of how social support prevents illness and/or enhances health. Instead, future work should examine more specific hypotheses about how social support relates to various behavioral, emotional, and physiological mediators of health. Some specific hypotheses that provide possible explanations for the direct effect and buffering models follow.

The *direct effect hypothesis* argues that support enhances health and well-being irrespective of stress level. Such a direct benefit could occur as a result of the perception that others will provide aid in the event of stressful occurrences or merely as a result of integrated membership in a social network. The perception that others are willing to help could result in increased overall positive affect and in elevated senses of self-esteem, stability, and control over the environment. These psychological states may in turn influence susceptibility to physical illness through their effects on neuroendocrine or immune system functioning (Jemmott and Locke, 1984), or through changes in health-promoting behaviors (e.g., decreased cigarette smoking, decreased alcohol use, and improved diet or exercise patterns). Membership in social networks may also result in increased senses of predictability, stability, and control because they provide the opportunity for regularized social interaction and the concomitant feedback that allows

adoption of appropriate roles and behaviors (Cassel, 1976; Hammer, 1983; Hirsch, 1981; Thoits, 1983). Again, these psychological states may affect health through their influence on behavior and physiological response. Feedback and direction from others may also aid in the avoidance of life stressors that would otherwise increase the risk of both psychological and physical disorder.

In a sociological view of this process, Thoits (in press) suggests an alternative link between role involvement and health. According to this view, role relationships provide a set of identities, a source of positive self-evaluation, and the basis for a sense of control and mastery. Health is enhanced because role involvement gives meaning and purpose to one's life, and hence reduces the likelihood that profound anxiety and despair will be experienced.

In the extreme, the mechanisms just described suggest that support and health are linearly related; that is, an increase in support will be beneficial to health irrespective of the existing level of support. (See Broadhead *et al.*, 1983 for a review of evidence for such a gradient.) There is at least some evidence, however, that only very low levels of support are associated with decreases in well-being (cf. Berkman & Syme, 1979; House, 1981; House, Robbins & Metzner, 1982; Kahn & Antonucci, 1982). Hence, there may be some minimum threshold of social contact required for health maintenance, and increases above that level may be unimportant. These data also suggest an alternative causal model in which isolation (possibly acting as a stressor) causes ill health rather than support promoting better health (see Berkman, Chapter 12 in this volume).

In contrast to the direct effect model, the *buffering hypothesis* argues that support exerts its beneficial effects in the presence of stress by protecting people from the pathogenic effects of such stress. In this model, support may play a role at two different points in the stress-pathology causal chain (Cohen & McKay, 1984; Gore, 1981; House, 1981). First, support may intervene between the stressful event (or expectation of that event) and the stress experience by attenuating or preventing a stress response. In short, resources provided by others may redefine and reduce the potential for harm posed by a situation and/or bolster the ability to cope with imposed demands, hence preventing the appraisal of a situation as stressful. Second, support may intervene between the experience of stress and the onset of the pathological outcome by reducing or eliminating the stress experience or by directly influencing responsible illness behaviors or physiological processes. House (1981) suggested three ways in which support may alleviate the impact of the stress experience: Support may reduce the importance of the perception that a situation is stressful, it may in some way tranquilize the neuroendocrine system so that people are less reactive

to perceived stress (Bovard, 1959; Cassel, 1976), of it may facilitate healthful behaviors such as exercising or attending to personal hygiene, proper nutrition, and sufficient rest.

Support and Symptom Reporting

Much social support research on disease etiology has focused on self-reported symptomatology rather than on clinical pathology. Evaluation of such research must include a caution regarding the use of self-reports of symptoms as "objective" measures of disease symptomatology. Awareness of internal sensations and reporting of symptoms do not necessarily represent an exact correspondence to actual physiological change. Symptom reporting is influenced by a variety of physiological, personality, social, and cultural factors (Mechanic, 1972; Pennebaker, 1982). Social support may affect symptom reporting by altering physiological states (pathology) as described earlier, or by affecting psychosocial factors. For example, support may influence perceptions of whether reporting more symptoms will elicit reinforcement or punishment from others. It may also affect self-image, which in turn influences what symptoms are encoded and reported. Although work on the effect of support on symptoms is interesting in its own right, symptom measures cannot be viewed as proxies for direct measures of clinical pathology. Evaluation of the association between social support and disease must therefore include further research using more "objective" measures of pathology.

Recovery from Illness

A relationship between social support and recovery from physical illness may be mediated by the effects of support on health behavior and/or the mobilization of the immune system. In the case of health behaviors, information from others about proper health care and about coping with illness may influence perceived and actual ability to affect health status. Instrumental aid, such as nonprofessional patient care, may also have a direct impact on the patient's well-being, and information about the esteem in which a person is held by others may influence motivation to get well and consequently increase compliance with medical regimens and performance of health care behaviors. Feelings of belonging, elevated self-esteem, and security engendered by social support may also directly aid in recovery from physical illness by facilitating mobilization of the immune system (Jemmott & Locke, 1984). Support-induced elevations in self-esteem, ability to cope, and motivation to get well may similarly aid in recovery from mental health problems by directly influencing emotional and cognitive states.

associated with the disorder or by increasing compliance with medical regimens.

It is likely that the role of social support in both etiology and recovery are, to some degree, similarly mediated. In both cases, support may influence health through the promotion of self-care and immunologic competence. Future work should focus on these mediators and on the emotional and psychological states that trigger these mechanisms. This work should also recognize that support is a complex concept that can only be understood when research is designed to investigate specific conceptions of support that are theoretically linked to the processes under consideration.

Issues in the Study and Application of Social Support

This volume contains over a dozen chapters that include detailed discussions of both conceptual and methodological issues as they apply to multiple settings, multiple age groups, and multiple perspectives. It is beyond the scope of this chapter to provide a thorough or even a representative preview of these issues. Instead, our goal is to highlight some issues that we view as important across disciplines and across perspectives. In general, we raise conceptual and methodological questions and suggest alternative approaches but do not provide answers.

Issues Related to a Contextual Perspective

One of the attractive aspects of studying the role of social support in health and health maintenance is its seemingly simple, magic-bullet-like quality. Unfortunately, but predictably, this simplicity is more illusion than reality. An adequate (predictive) model of the relationship between social support and well-being must consider individual differences in need or desire for such support, as well as the social and environmental contexts in which support is perceived, mobilized, given, and taken. Following are some of the questions that a realistic conception of the support process must address (cf. House, 1981; Pearlin, Chapter 3 in this volume). Our intent here is not to define a list of variables to be included in every study of support, but rather to indicate the complexity of the process, to suggest a range of theoretical issues, and to provide a list of issues that may be critical in the design of successful interventions. The emphasis here is on the buffering model; that is, support as a resource to aid in response to stressful events.

However, a number of the issues we raise are also relevant to the direct effect model.

Who is providing the support? The same resource may be acceptable from one giver but unacceptable from another. Roles of the giver and receiver, norms for these roles, and issues of the perceived equity, reciprocity, and appropriateness of the transaction are all relevant in determining if a supportive behavior from a particular giver will have a positive impact. For example, a person overwhelmed by job demands may be more affected by support from a co-worker or supervisor who has relevant information about the situation than by support from a nonjob friend or a spouse.

What kind of support is being provided? The specific resource that is provided may or may not beneficially affect well-being, depending on its appropriateness for the situation and person. For example, a monetary gift or loan may be invaluable in the face of unemployment and worthless in the face of bereavement.

To whom is the support provided? Characteristics of the recipient that may be important in determining the effectiveness of a supportive behavior include personality, social and cultural roles, and resources available to the receiver from alternative sources. The recipient's ability to attract, mobilize, and sustain support is also critical to the support process.

For which problem is support provided? The appropriateness of a specific kind of social support may be dependent on a match between the type of support offered and the type of problem encountered. For example, marital conflict, unemployment, and bereavement may elicit very different support needs.

When is the support provided? Social support that may be optimally effective at one point may be useless or even harmful at another. Consider, for example, the course of the need for support for self-esteem elicited by job loss. Workers who lose their jobs when a plant closes may attribute their loss to the economy or poor plant management and not suffer any initial threat to self-esteem. However, after several months of unemployment they may start to question their self-worth. At this point, support for self-esteem may become crucial.

For how long is support provided? Although many networks function well in providing short-term aid, long-term provision of support may place demands on a network that are beyond its capacity. The ability of givers to sustain support and/or change the kinds of support offered over a prolonged period is central to questions about the role of support for the chronically ill or those suffering long-term stress.

What are the costs of giving and receiving support? The cost of giving and receiving support and perceptions of these costs can be critical in determining whether it is asked for, whether it is given, and the impact of

support-giving on the relationship between giver and receiver. It is likely that perceptions of support availability, often measured by support scales, are strongly influenced by the respondents' estimates of the cost of giving and whether they can "afford" to solicit such support.

How do these various issues interact in determining support level? An adequate model of support must recognize the complex interactions of the various factors just discussed. For example, the availability of long-term support is likely moderated by the roles of persons providing the support. Thus, the obligations of spouse and family to provide support over prolonged periods may make these sources more stable in long-term situations than are friends, acquaintances, and fellow workers. This relationship can be further complicated when one considers the kind of support being provided. Hence, an acquaintance at work might lend money for a short period but provide self-esteem support for a long period, whereas a family member may lend one money for a long period but provide support for self-esteem over only a short period. Clearly, a thorough understanding of the support process requires further conceptual and empirical consideration of the questions just raised and of the complex means by which these factors are related to one another.

Structural versus Functional Perspectives

The support process has been studied from two rather different perspectives. The issue is whether support is conceptualized in terms of the *structure* of an interpersonal relationship or social network or in terms of the *functions* that a relationship or network serve. The choice of perspective has a striking effect on the way a researcher studies support since each requires a different kind of support measure (see House & Kahn, Chapter 5 in this volume). Structural measures describe the existence of and interconnections between social ties (e.g., marital status, number of relationships, or number of relations who know one another). Functional measures assess whether interpersonal relationships serve particular functions (e.g., provide affection, feelings of belonging, or material aid). Although conceptually the issue of whether a measure is structural or functional is not necessarily tied to whether it is objective or subjective, practically the objectivity-subjectivity and structural-functional dimensions have been confounded. Structural measures (although mostly self-report) are generally considered to measure objective characteristics of social networks, while functional measures generally ask persons about their perceptions of the availability or adequacy of resources provided by other persons. (To our knowledge there is no existing research in which investigators objectively determined the availability of existing resources.)

What can be learned from investigating "objective" support structures? Because these measures are objective, they provide information about properties of networks around an individual, independent of personal characteristics (Hammer, 1983). Structural indices of social integration that include number of contacts with family, friends, and community, as well as number of active memberships in formal and informal groups, provide measures of embeddedness in a social system. As discussed earlier, being embedded in such a system implies that one receives the feedback from others that helps form self-identities and feelings of stability, predictability, and control over individuals' lives. Individual characteristics of network structure (e.g., marital status, number of network members, network density) can be used to determine whether various quantities and forms of social contact influence health. Structural measures also allow investigation of the effects of support defined in terms of the characteristics of networks in a group or society in addition to those at an individual level (see Hall & Wellman, Chapter 2 in this volume). Hence they can be used to specify the social characteristics of groups having higher (or lower) rates of disease than others.

Structural measures (individual or group) should not be viewed as proxies for measures of available resources. For example, a spouse may be a source of support but may instead, or also, be a source of conflict and stress. Having more social contacts not only provides more potential resources but also may create additional demands on time and increase the probability of interpersonal conflicts.

What can be learned from investigating "subjective" support functions? Subjective-functional measurement helps to tap individuals' psychological representations of their support systems. Since perceptions of support resources are affected by personal and environmental characteristics other than objective network structure, these representations may or may not be correlated with structural measures. Subjective-functional instruments are used in testing theories of the support process that emphasize the role of perceived (as opposed to objectively available) resources in determining whether support will affect health (see Cohen & McKay, 1984). To the degree that the relationship between support and health is mediated by psychological representations of available support, as opposed to objective structural relations, functional measures would be expected to provide better predictors of health and health behavior.

Measurement of multiple independent support functions can also help determine the particular resources that affect health and behavior and hence shed light on the mechanisms linking social support to health. For example, Schaefer, Coyne, and Lazarus (1981) found that instrumental support was more important than either informational or emotional support

in predicting depression in older persons. Seeman (1984) similarly found that greater instrumental support from family and friends, but not emotional support, was associated with less coronary artery disease. Such results suggest the possibility that the provision of services, financial aid, and so forth helps persons avoid stressful situations that may increase the risk of depression and/or CAD. On the other hand, studies of support functions that protect college students from the potentially pathogenic effects of stressful life events find that instrumental support is not an effective buffer, while informational and emotional support are effective (see Cohen, Mermelstein, Kamarck & Hoberman, in press). In short, measurement of multiple support functions can help isolate potentially operative mechanisms. Moreover, these mechanisms may differ across populations and situations.

Unfortunately, there is little systematic work characterizing network structures in terms of the functions that they normally provide. An increased understanding of structure-function relationships would help integrate existing literature and facilitate the development of effective interventions, since undoubtedly certain network structures are more effective sources of certain functions than others.

Kinds of Social Support

We believe that further advances in the ability to conceptualize and assess the *kinds of support being provided* are necessary before it will be possible to understand the support process and realize its clinical possibilities. In order to assess, manipulate, or intervene with the appropriate kind of social support, a typology that categorizes interpersonal resources into classes that are relevant to the support process is required. This is easily said, but the task is not easily accomplished. Various typologies of supportive behaviors or acts have been proposed by Antonucci and Depner (1982), Barrera and Ainlay (1983), Caplan (1979), Cohen and McKay (1984), Gottlieb (1978), Henderson (1977), House (1981), Moos and Mitchell (1982), Kaplan, Cassel, and Gore (1977), Shumaker and Brownell (in press), Silver and Wortman (1980), and Wills (Chapter 4) and Wortman and Conway (Chapter 14) in this volume.

As noted earlier, the multidimensional measurement of support functions is essential in determining the mechanisms by which support affects health and well-being. Type of support may be especially important in understanding when social support buffers the pathogenic effects of stress. Hence, buffering effects may occur only when the kinds of available support match the needs elicited by the stress a person is experiencing (Cohen & McKay, 1984). This issue is complicated somewhat in that, in many cases,

multiple needs are elicited by the same stressor and needs may shift over the course of the stress experience. Consider, for example, the role of the various sources of support following the death of a spouse. If the spouse provided a significant portion of the family income, then material support would be relatively more important. Information about the meaning of the loss may operate in terms of evaluating ability to cope. Emotional support may be operative in terms of convincing bereaved persons that there are still people who care. The need for each of these kinds of support may shift over the course of the bereavement period. For example, the need for informational support may come into play first, with needs for emotional support and material aid becoming important as the bereavement progresses.

As alluded to earlier, work investigating the impact of different kinds of support is in its infancy. Our purpose is not to offer any conclusions regarding the important categories of support, but rather to emphasize the importance of the development and use of representative typologies in solving the support puzzle. Understanding which supportive acts cause direct and/or buffering effects on health is especially important for planning interventions, since an efficient and powerful intervention would attempt to provide the kind of support most likely to be beneficial.

Measuring Social Support

Anyone attempting to review research on the relationship between social support and health faces the problem of trying to integrate a literature that has almost as many measures as studies. There are few or no data available on the psychometric qualities of most of these measures or on their relationships to one another. The development of sophisticated psychometric support instruments is imperative for further understanding of the support process. Scales that have demonstrated discriminative validity (e.g., are not highly correlated with social anxiety, personal competence, and social desirability) permit increased confidence that researchers are assessing social support and not some related personality factor. Moreover, internal and test-retest reliabilities allow increased accuracy in estimating the relationship of social support to various outcomes.

In addition to psychometric qualities, it is important to consider the method of choosing or designing an appropriate scale. It is no longer useful merely to use the available support measure or the one that worked for someone else. Support measures must be chosen (and designed) because they are tools to answer specific questions. Before selecting a scale, it is important to conceptualize clearly *what* about the support process one wants to learn from a study. Instruments differ on multiple dimensions,

including whether they assess (1) structure or function, (2) subjective or objective support, (3) availability or adequacy of support, (4) individual structures or functions or global indices, (5) several individual structures or functions versus simply one, (6) the role of persons providing support or simply whether support is available, and (7) the number of persons available to provide support or simply the availability of support (irrespective of the number of people). It is worth reemphasizing that the appropriate measurement technique depends on matching the measurement instrument to the question being posed. Only through use of appropriate instruments will we be able to provide clear answers to our questions.

Assessing Processes Linking Social Support to Health

The chapters in this book review a growing literature that links social support to health. In general, there is fairly strong evidence for an association between support and mental health (Kessler & McLeod, Chapter 11) and for a link between support and mortality (Berkman, Chapter 12). The evidence is less convincing, however, regarding a relationship between social support and physical illness (Berkman, Chapter 12; Wallston, Alagna, DeVillis & DeVillis, 1983).

It is not known why social support is associated with health. The correlational nature of existing data makes causal interpretations difficult. But even if social support is a causal factor in the etiology of illness or the maintenance of health, existing data provide little evidence as to what underlies these links. It is our position that significant advances in the understanding of support–health relationships will occur only if future studies focus on the *process* by which support is linked to well-being instead of on determining merely whether a link exists. It must be asked whether the effects of social support on health and well-being are mediated by behavioral change, physiological change, perceptual change, or some combination of these three.

Questions to be answered include the following: Does social support enhance or inhibit health promoting behaviors? Does support influence the operation of the immune system or other processes that trigger and maintain physiological responses associated with disease etiology (e.g., release of catecholamines or corticosteroids)? Does support influence the occurrence of (or perception of) potentially stressful events or the abilities or perceived abilities to cope with such events? Decisions on ways to operationalize social support and to specify hypothetical intervening processes should be based on *theoretical conceptions* or the process by which support is related to the outcome under consideration.

Longitudinal–prospective designs in which biological and behavioral

changes are continuously monitored provide a powerful tool to pursue these issues. The prospective emphasis on *changes* in health helps to exclude the possibility that results are attributable to an influence of health status on social support. Continuous monitoring of the variables under consideration allows a time-linked examination of the covariation of support, hypothetical mediators, and health. Moreover, longitudinal data permit investigation of the changes that occur in the processes linking social support to health as stressors and/or support needs persist over time (cf. Schulz & Rau, Chapter 7 in this volume).

An important issue in designing such studies is the time course of the development of a disease outcome. For example, although short-term changes in health-promoting behaviors may affect the etiology of a cold or the flu, such changes may be inconsequential in the course of a disease with a long developmental period, such as coronary heart disease. Hence, hypotheses regarding the link between support and illness must include consideration of the course of the diseases under study. In this light, it is worth noting that the lack of established relationships between social support and physical illness may be attributable to an insensitivity to the time course of disease etiology. In many cases, measures that assess social support at a particular point are compared with illness outcomes assessed at that same time or a short time later. These illness outcomes, however, may be determined by a process that spans a very long period.

Another critical issue in the design of prospective support research is the stability of support over the duration of the study. Measures of some conceptions of support, especially perceived availability, may fluctuate considerably over long periods. Moreover, for some populations, such as freshman college students and armed forces recruits, support will fluctuate as people are socialized into a new environment. In these cases, prediction from an initial assessment of support to an outcome occurring several years later would not provide a true prospective analysis. Hence, it is critical to consider the correspondence between longitudinal intervals and the stability of social support in the population under study when designing prospective support research.

Social Support and/or Personality?

There are two important questions regarding the role of personality in the relationship between social support and health. First, are there any effects of social support on health that occur above and beyond the effects of stable individual differences in sociability? This question addresses the possibility that social support is merely a proxy for personality factors, such as social competence and social anxiety, that are highly correlated with

support. Second, does personality play a role in the need for, development of, maintenance of, and mobilization of social support? In this section, we emphasize the first issue, since it is critical to interpreting existing literature, but we also comment on the second issue.

Existing research on the relationship between social support and health is almost entirely correlational. Some prospective studies have attempted to exclude the possibility that reported associations are attributable to illness determining support levels; however, the possibility still exists that some stable individual difference factor accounts for changes both in social support and in health. For example, Heller (1979) has pointed to the possibility that social competence affects both support levels and well-being, and others have implicated feelings of personal control, social anxiety, and introversion-extraversion. In addition to the scientific importance of the possibility that support measures are merely proxies for personality factors, as Kiesler (Chapter 17) has noted, this problem needs to be solved before social support research can affect public policy. In short, if the association between support and health is actually attributable to the influence of personality on both support and health, social support interventions would be fruitless.

The ultimate solution to this problem lies in experimental (intervention) studies in which persons are randomly assigned to support conditions (see Gottlieb, Chapter 15 in this volume). Intervention studies are imperative and those that are done with both theoretical and methodological sophistication will have an important impact on conceptions of the processes by which support affects health and well-being. However, these studies are expensive and difficult to carry out. The effectiveness of such manipulations depends on the appropriateness of the resources provided by the system, the interpersonal context in which those resources are made available, and whether persons perceive access to these resources in the way intended by the intervenor. In short, even if social support is causally related to health and well-being, proving it (and subsequently applying it) will require sophisticated methodological and clinical techniques. Despite the complexity of conducting intervention studies, the yield from such research is invaluable, and hence the extensive investment of time and effort is justified.

Although personality may provide a better explanation than support in some situations, it is likely that personality is not equally responsible for all sources and functions of social support. Research comparing multiple functions of support has found associations between support and well-being for some functions but not others, depending on the population and the situation (e.g., Cohen & Hoberman, 1983; Cohen *et al.*, in press; Henderson *et al.*, 1980; Schaefer *et al.*, 1981; Seeman, 1984). If it is assumed that these

various support functions are merely proxies for stable personality factors, different factors would need to be postulated for each kind of support. Although not impossible, this suggests that a single alternative personality factor explanation is probably invalid.

The second question raised earlier is whether personality plays a role in determining support levels. It would be naive to assume that the availability of support is determined totally by the social environment. Personality factors associated with sociability must play a significant role in the development of social networks, in the perceptions of support availability, and in the maintenance and mobilization of support (see Heller & Swindle, 1983).

It is also reasonable to expect that certain sources of support are less dependent on the supportee's personality than others. For example, personality is probably of relatively greater importance in making and maintaining friendships (kith) than in maintaining family (kin) ties, since support from kin often is viewed as an obligation implied by the relationship.

In sum, personality factors must be considered in the attempt to understand the relationship between social support and well-being. First, we need to examine the possibility that personality factors associated with sociability are primarily responsible for the relationships between social support and well-being that have been attributed to support-caused changes. There is suggestive evidence, however, that social support does play an important role—independent of personality—in this relationship. Second, we need to understand how personality factors influence the development and maintenance of support networks. In pursuing this issue, it is important to recognize that the roles of stable individual differences probably vary somewhat across situations and across sources of support.

The Individual versus the Group as the Unit of Analysis

The discussion so far has focused on research issues that derive from an approach viewing social support as a characteristic of individuals. In this view, individuals receive or give support to others under specific circumstances and with specific consequences. It is possible, however, to view social support as a characteristic of a group. One reason to adopt this perspective is the observation that rates of health and disease are patterned among social groups. Thus, while it is true that individuals get sick, it is also true that social groups exhibit consistent and patterned differences in rates of disease even though individuals come and go from them. For example, people in lower socioeconomic status groups have higher rates of virtually all diseases and disabilities than those in higher socioeconomic groups. Other such patterned and consistent differences in disease occurrence have been observed according to marital status, religious groups,

occupation, and so on. Similarly, people living in particular states in the United States consistently have higher morbidity and mortality rates for virtually every disease than people living in other states. Further, this difference persists over time even as people are born, die, and migrate. Since these differences in disease rates persist over time in spite of individual movement in and out of groups, there must be some persistent characteristic of groups themselves that should be considered in studies of health and disease.

An individual perspective on social support addresses the question of why one person gets sick while another person does not. A social perspective addresses the question of why one group or aggregation has a higher rate of disease than another. Clearly, interventions to strengthen supports can also be viewed from both of these perspectives. Individuals can be helped to strengthen supportive interpersonal relationships, just as environmental or occupational circumstances can be changed to encourage a greater frequency of supportive relationships on a group-wide basis. The latter perspective is of particular value in dealing with diseases and conditions of enormous magnitude and where an individual approach is logistically difficult. Thus, it is probably more efficient to improve supportive relationships in a group of elderly nursing home residents by environmental intervention than by individual counseling. The issue here, of course, is not whether one approach is better than another but the usefulness of different approaches depending on their purpose.

Social Support and Disease Prevention

Is it possible to prevent disease by modifying the supportive characteristics of social environments? Theoretically, such interventions would be more cost effective than either treating disease after it occurs or, in the case of the buffering hypothesis, trying to reduce people's exposure to stressors (see Cassel, 1976). As Gottlieb (Chapter 15) has pointed out, interventions can be directed at creating a new support system, strengthening an existing one, or training individuals in the social skills that would help them strengthen their own support systems.

Nonexperimental interventions—that is, interventions that are not being evaluated—are difficult to justify at this time. As noted earlier, there are plausible causal alternatives for correlational data linking support to health and well-being, and a lack of theoretically driven experimental interventions to clarify causality and direct intervention development. Kiesler (Chapter 17) has rightly argued that existing data are not sufficient to convince those forming health policy that social support interventions are an effective mode of health promotion. He has argued that not only is there

a lack of intervention research that is adequate from a scientific perspective, but also a lack of evidence on the impact of social support interventions on variables critical to public policy decisions—impacts such as reduced incidence of disease, lower medical costs, and reduced mortality.

Conclusion

In the early years of research on a concept, the published evidence tends to be uniformly positive and enthusiastic. It is only after a concept has generated some credibility that the complexities and inconsistencies in the literature become issues. Enough evidence has now accumulated regarding the concept of social support that these issues are worth raising. We have provided an overview of some current problems and questions facing those studying and implementing the social support concept. The remainder of this book builds on these questions, assesses the current status of social support research, and plots a course for future research and practice.

We hope this book will provide a timely appraisal of the substantial body of work on social support that has accumulated. As noted earlier, we have deliberately emphasized a broad approach to the field so that common denominators could be observed. For this reason, we have defined the concepts of social support and of health and disease very broadly, we have included as diverse a disciplinary perspective as possible, and we have attempted to address the roles of social support in varied settings and circumstances.

It is our hope that the approach we have chosen will permit a critical assessment of the work that has been done as well as provide a guide for work that yet needs to be done. While the challenge is substantial, the possible benefits are equally great. Progress in understanding the meaning and significance of social support holds important promise for improving our understanding of the causes of disease as well as for improving clinical practice and enhancing policy decisions regarding the prevention and treatment of disease and disability. Clearly, this task deserves our best efforts.

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