

Editorial

Gerontology has had a long standing interest in the area of social interaction and social support. One of the reasons is the search for a better understanding of the everyday observation that social interaction is important in the lives of individuals, no less true in old age than when we are younger. Research in the 1970s and continuing into the 1980s focused on the types, the extent and the sources of support for elderly members of society. This research was important because, at the time, it was generally believed that the nuclear family abandoned their elders to long-term institutional care, and that seniors were largely isolated, especially from their families. Gerontological research exposed this common belief as myth and documented the extensiveness of social ties in old age.

However, most of this research did not directly examine the relationship between interaction and quality of life; nor did it tend to examine the supportiveness of social interaction; rather it frequently assumed social interaction was supportive (Chappell, 1992). During the 1980s, research on social support in later life began examining the empirical relationship between social support and well-being. These studies asked whether interaction is positively related to the quality of life of elders, as is so often assumed. It has generally confirmed a relationship between the two concepts, social support and well-being, both directly and indirectly, although research is by no means unanimous in this area. That is, social support is associated with quality of life in our day to day living even in the absence of stress, and it is also related to quality of life during times of stress with more support related to enhanced well-being (see, for example, Cohen & Syme, 1985; Kessler & McLeod, 1985; House & Kahn, 1985; Antonucci, 1990).

The wealth of empirical studies during this period lead to a recognition of the tremendous complexity in human relationships. By the late 1980s, researchers were turning from correlational studies of support and well-being to investigations of the processes involved. It is, however, an area where the questions are more plentiful than the answers (Montgomery, 1996). It is now accepted that the concept of social support is multi-dimensional and people are asking which aspects are important for the maintenance and enhancement of what types of quality of life. For example, Pearlin (1985) hypothesizes the specialization of support. In other words, different sources of support may be more effective for different problems. Support for a technical problem at work might of necessity come from a colleague rather than from family. Support with child rearing may best come from other parents rather than from friends or work colleagues. Evolution of a problem may also call for different types of support at different times. For example, a person may require informational support and later on emotional support. Importantly, problems are seldom isolated from one another, but we know little

about the role of social support in the multiplicity of problems.

There has also been increasing recognition that social support can have negative as well as beneficial effects. Wortman and Conway (1985) cite studies in which most healthy persons report that they will go out of their way to cheer up a person with cancer, but the majority of cancer patients report the unrelenting optimism of others as unauthentic and disturbing. It is unhelpful when others minimize their problems. Antonucci (1990) notes that negative relations may have a more powerful effect on than positive relation to well-being; that negative interactions can affect psychological and emotional health more strongly than supportive relationships.

Added to the complexity of the concept of social support is the complexity of the concept of quality of life, which has been measured as mortality, specific morbidity, other indicators of illness, such as disability, various indicators of psychological well-being, overall indicators of life satisfaction and morale, and mental impairment. The spectrum is broad and there is not as yet a good understanding of whether certain types of social support are more important for a particular aspect of well-being than for others. Certain types of social support may be beneficial; others may be harmful. Indeed, we still do not have conclusive answers concerning questions of causality. The assumption is that social support leads to enhanced well-being, but the causal direction may be the reverse with illness and/or decreased mental functioning and/or decreases in other aspects of well-being leading to less involvement with others and to less social support. Diminished well-being may decrease social competence. Is the well-documented relationship between social support and well-being spurious, with other factors operative; is the relationship linear or curvilinear?

If social support does enhance quality of life, the process or mechanism through which this occurs is not yet understood. Underlying processes could include the provision of advice and information whereby those receiving support are enhanced through being able to seek out better services; the underlying process could be the actual provision of services and tangible assistance from members of the social network; social support could work through social control and peer pressure whereby individuals are pressured into healthy lifestyles; there may be a direct physiological link with social support affecting individuals psychologically which in turn influences physiological susceptibility to various illnesses through the neuro-endocrine or immune functioning systems. Research in all of these areas is continuing. The area is complex and fascinating.

In addition, much of the research on social support in old age has been focused on caring and assistance. This is an area of concern to families and friends because they are the most frequent providers of care. It is of importance to policy-makers and practitioners because of the demands on the health care system with deteriorating health in old age. Gerontologists have been recording the vast amount of care that comes from the informal network, from family and friends, for over three decades. It is estimated that, regardless of whether a country provides universal comprehensive health

care insurance or not, the informal network provides between 75 and 85 per cent of total personal care received by seniors (Kane, 1990). Much is known about the sources of that support, especially from women (mainly wives and daughters). Much is also known about the content of that support, especially the tasks undertaken, relating to activities of daily living. More recently, increased attention has turned to the stress and burden experienced by caregivers. Less research has dealt with areas such as rewards of caregiving or reciprocity in caregiving.

We have no evidence to suggest that families are becoming less likely or less willing to provide care to elders than was the case in the past (Doty, 1986). Even when formal care is provided, informal care persists (Chappell, 1994a). There has been much concern around the issue of the cost of formal provision of care in areas traditionally provided by family and friends. The evidence suggests that it is not particularly costly, and that those in need use formal services very judiciously. Furthermore, there is a consistent suggestion that providing formal care in these areas may affect cost savings in other areas of the system and that the formal provision of home care need not be a cost add-on. The system must be treated as a whole for cost effectiveness to become a reality (Chappell, 1994b).

Interest in the area of informal caregiving has been fuelled in the 1990s by the rhetoric of health reform. Instead of the lack of recognition of caregivers so evident in the 1970s, there is a political recognition of caregiving and community care as a cornerstone of the rhetoric of health reform. With cost cutting in the health care system, tightening of eligibility criteria for services, and removal of many of the social services from community care, the issue of putting greater burden on informal caregivers, especially women (who predominate both as informal caregivers and as formal health care workers) has become very timely for researchers.

The papers appearing in this issue of the *Canadian Journal on Aging* contribute knowledge to this important area, both in terms of social interaction and in terms of caring. A particular gem within this volume is the paper by Hazel McRae on friendship ties among elderly women living in three different settings in a small rural Nova Scotian town. These working-class women have the capacity to acquire friends in old age, as do middle class women reported in other research. These working-class women were very organizationally involved; this is reported both for middle-class and higher class women in other research. For these women, a close friend is first and foremost a confidant who is someone who can be trusted; many are long time friends who have built up trust in a relationship that makes them feel competent, liked and needed.

The paper by Julie McMullin and Victor Marshall examines childlessness, stress and well-being and reports that friend support reduces stress in similar ways for both parents and childless persons. Having a close friend reduces stress while having close family ties does not, but a close family member mediates the effect of stress on well-being while a close friend does not. Furthermore, being a parent does not contribute to well-being – older

childless individuals and parents will each enjoy enhanced well-being provided they are able to secure extensive social networks. Childlessness may be important to the extent that childless individuals may have a smaller extended family to call on and family support was found to be related to stress.

Alun Joseph and Bonnie Hallman turn their attention to the location triangle, that is the spacial arrangement of the employed caregiver's home, work place, and care recipient's home. Not surprisingly, they find that job effects are more likely to be reported for respondents with dual responsibilities (child care and elder care) than by respondents with only elder care responsibilities. Interaction between travel time effects and the nature of family responsibilities is most evident among those with the longest travel time to elders. It is respondents with dual responsibilities *and* a longer journey to work who are most likely to have urged their elderly relatives to move closer. There is much more adjustment to the home elder axis on the location triangle than to the home work axis because individuals have greater control in this area. This study draws attention to travel time and distance as an important factor in elder care, especially when it is recognized that only a small minority of independent elders cohabit with the caregiver, most live apart.

Sandra Crowell and associates pursue reports that seniors receiving home care services may not be those who are most dependent, by asking who receives care in the community, what types of services do they receive and how do they compare with those living in institutions? The results show that more than twice as many elderly Nova Scotians as Newfoundlanders use home care services despite similar point prevalence in institutional care and similar proportions being hospitalized. Newfoundland appears to target more disabled seniors since they have a lower rate of use overall, but a higher rate for disabled elderly. The article by Mario Paquet presents a conceptual framework for understanding caregivers' resistance to use of formal support services, while the paper by Mårten Lagergren from Sweden examines factors related to transference to an institution. They find that functional disability and dementia predict institutionalization, but not living arrangements, marital status and other social variables, including social support.

The papers in this issue demonstrate the breadth and complexity of research being conducted in the area of social support. Through research such as this, our knowledge will continue to advance.

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