Insights from a Nursing Research Program on Social Support

Miriam J. Stewart, Mary Lou Ellerton, Geraldine Hart, Alexandra Hirth, Karen Mann, Donna Meagher-Stewart, Judith Ritchie, and Gail Tomblin-Murphy

Cet article met en lumière les implications conceptuelles et pratiques d'un programme de recherche en sciences infirmières, dont l'accent est mis sur le soutien social. Le cadre de travail conceptuel à la base du programme comporte les éléments suivant : les diverses dimensions du concept de soutien social; le lien au stress et à l'habileté d'adaptation; et les effets sur la santé. Ces associations feront l'objet de précisions à travers des exemples provenant de huit études d'évaluation et quatre études d'intervention. Le programme de recherche a généré de nouvelles connaissances et appuie les résultats déclarés d'autres recherches menées sur le thème du soutien social.

This paper highlights the conceptual and practical implications of a nursing research program that focuses on social support. The diverse dimensions of the construct of social support; its relationship to stress and coping; and its impact on health, health behaviour, and use of health services are explicated in the conceptual framework underpinning the program. These associations will be elucidated by citing examples from eight assessment studies and four intervention studies. The research program yielded new insights and reinforced reported findings of other social-support research.

Social support is a significant factor for nurses: it influences health status (House, Umberson, & Landis, 1988; Kaplan & Toshima, 1990), health behaviour (Bloom, 1990), and use of health services (Birkel & Repucci, 1983). Nurses have made significant contributions to the scrutiny, conceptualization, and measurement of social support and to its use in interventions; nursing interventions, in turn, can help mobilize and augment the social support that clients receive.

Conceptual and practical insights have emerged from a five-year nursing research program, the aims of which were as follows: to assess the social support received by diverse populations; to examine the conceptual links among social support, coping, and stress; and to test the impact of support interventions on health outcomes. Examples from eight assessment studies and four intervention studies (see Table 1)

Miriam J. Stewart, Ph.D., Mary Lou Ellerton, M.N., Geraldine Hart, M.N., Alexandra Hirth, M.N. (deceased), Karen Mann, Ph.D., Donna Meagher-Stewart, M.N., Judith Ritchie, Ph.D., and Gail Tomblin-Murphy, M.N., are with the Dalhousie University School of Nursing in Halifax.

Table 1 *Social Support Research Program: An Overview*

Support Domain	Assessment Project	Intervention Project
Support for persons with chronic illness and their family caregivers	Mothers of children with a chronic illness (N=90)	Telephone-support intervention for children with a chronic illness and their families (N=120)
	Children with a chronic illness (N=60) Children experiencing stressful health-care encounters (N=80)	*Computer peer support for children with chronic illness*[1]
	Men with hemophilia and HIV/AIDS and their family caregivers (N=90)	Telephone-support groups for men with hemophilia and HIV/AIDS and their family caregivers (N=10)
	Persons with stroke (N=48) or heart failure (N=48) and their family caregivers	Peer home-visit support for caregivers of stroke survivors (N=30)
	Psychosocial factors associated with re-admission for IHD (N=100)	Fact-to-face support groups for couples coping with IHD (N=38)
Support for professional caregivers	Support, stress, job satisfaction, and coping among nurses in HIV/AIDS care, in community (N=63), hospital (N=114)	Support groups and mentors for community and hospital-based nurses HIV/AIDS care[2] (N=100)
	Support, stress, and satisfaction experienced by community health nurses (N=101)	
Peer and professional support	Partnership of health professionals and members of self-help groups (N=96)	Education resources for health professionals[2]

[1] Study proposal in development stage
[2] Available from Self-Help Canada

will be cited throughout, to illustrate sources, types, and appraisal of support; links between stress and social support and between coping and social support; and the effect of social support on health, health behaviour, and use of health services. Information about the methods and measures of these projects is available from the authors upon request.

Social support is defined here as *interactions with family members, friends, peers, and health professionals that communicate information, esteem, aid, or emotional help. When these communications are perceived as supportive, they may enhance coping, moderate the impact of stressors, and promote health* (Stewart, 1993). The multifaceted dimensions of the construct of social support — structure, function, and appraisal — were investigated as part of the research program.

Sources of Support

The *structure* of social support comprises lay sources such as partners/spouses, family members, friends, neighbours, co-workers, volunteers, and self-help groups, as well as professional sources. Professionals can provide intermittent specialized support and mobilize lay support (Norbeck, 1988).

The findings of the studies in our five-year program are consistent with those of other research on support providers (e.g., Dakof & Taylor, 1990) in that most support was provided by family members and/or within close relationships. Both mothers of children with a chronic illness (Stewart, Ritchie, McGrath, Thompson, & Bruce, 1994) and persons with ischemic heart disease (IHD) (Stewart, Hirth, Klassen, Makrides, & Wolf, in press) indicated that most of their support came from spouse/partner, family members, and friends. Children with chronic conditions indicated that their key supporters were their parents and other family members. Sources of support for professional caregivers were found to be similar to those for lay caregivers, with one exception — professionals named co-workers more frequently. Canadian nurses working as HIV/AIDS caregivers gave their sources of support as spouses/partners, family members, friends, and *associates*.

The support provided by or sought from health professionals and peers emerged as a theme in several of the studies in the program. Some mothers of children with a chronic illness indicated that they perceived health professionals as providers of support, but others reported that they received inadequate support from health professionals. Ellerton, Ritchie, and Caty (1994) observed that young children actively

sought and received the support of nurses during venipuncture. In contrast, studies of stroke survivors, persons with cardiac disease, and men with hemophilia and HIV/AIDS found that health professionals were infrequently identified, by both the client and the family caregiver, as sources of support.

The studies revealed that the peer supporter and the recipient should be very closely matched, and they uncovered a preference for disease-specific peers in dyadic or group relationships. Men with AIDS and hemophilia sought support from identical peers — that is, men with AIDS and *hemophilia*, and not persons with AIDS from other causes (Stewart, Hart, & Mann, 1995). Mothers of young children with cystic fibrosis sought support groups comprising mothers of *young* children with *cystic fibrosis*, and not mothers of variously aged children with another chronic illness. The study of children with chronic conditions revealed that they received less peer support than their healthy counterparts.

The findings of these studies have implications for support interventions, particularly those involving both professionals and peers. Nursing interventions can be guided by respondents' preferences for peers who might provide affirmational support (involving feedback and appraisal). The assessment studies in the research program indicate that we must look more closely at certain personal and illness dimensions — such as cause of the illness, time elapsed since diagnosis, gender, age, marital status, and impact of the illness. The findings of the intervention studies with stroke survivors and hemophiliacs with HIV/AIDS and their family caregivers, and with couples coping with myocardial infarction (MI) reinforce the importance of peer matching.

Functions of Support

The functions of support are fourfold: emotional, instrumental (practical), informational, and affirmational. The function should be specific to the stressors encountered (Cutrona, 1990), and type and source of support should be matched (Dakof & Taylor, 1990). Mothers of children with a chronic condition reported that they received informational support from health professionals, but typically they did not receive needed feedback (affirmation support), understanding (emotional support), or reassurance. Hemophiliacs with HIV/AIDS and their family caregivers (who found it stressful to cope with uncertainty about the course of the illness and the treatment options) received informa-

tional support from professionals, but practical aid from relatives and emotional support primarily from spouses and members of the immediate family.

The investigation into the relationship between self-help groups and health professionals revealed that professionals act as consultants, educators, and referral resources (providers of informational support), while peers are valued for their emotional support and for their affirmational support based on first-hand experience with a stressor (experiential knowledge) (Stewart, Banks, Crossman, & Poel, 1994). The findings of this study are similar to those of the study with men who had hemophilia and HIV/AIDS: participants favoured an approach whereby mutual aid/support groups are led jointly by peers and professionals — an approach that acknowledges the importance of both professional and experiential knowledge. Therefore, the telephone-support groups for hemophiliacs with AIDS and their family caregivers and for parents of children with chronic illness, as well as the face-to-face-support groups for couples coping with MI, were co-facilitated by a peer and a professional. In the intervention studies, professionals provided mainly informational support, while peers offered affirmational and emotional support.

In many of the studies, a pattern of support specialization emerged across the groups of respondents: family members were perceived to specialize in practical support, health professionals in informational support, intimates (spouses/partners) in emotional support, and peers in affirmational support. However, spouses also provided other types of support. This suggests that support figures do not always substitute for one another, and that nurses might assess clients' and caregivers' unmet expectations for particular kinds of support from particular sources.

Appraisal of Support

As social support may be either perceived as available from the social network, or actually received (delivered) (Sarason, Sarason, & Pierce, 1990), it is important that we distinguish between the two (Dunkel-Schetter & Bennett, 1990). If support is to be appraised with respect to its direction and its benefits or drawbacks, nurses should assess clients' receipt of support as well as their perceptions of the kinds of support that are available.

Direction

Support can be either unidirectional/non-reciprocal or bidirectional/ reciprocal; norms of equity and reciprocity (Tilden & Galyen, 1987) suggest that it should be bidirectional. Social exchange and equity theories indicate that social support can involve benefits and costs to both recipient and provider. Nevertheless the notion of reciprocity has largely been ignored in studies of social support (Winemiller, Mitchell, Sutcliffe, & Cline, 1993) — despite the fact that non-reciprocal relationships within their social networks diminish the self-esteem of people with illnesses and increase their sense of indebtedness (Simmons, 1994).

One study in our research program found that, as their illness progressed, stroke survivors and persons with severe heart disease were concerned about their inability to reciprocate spousal support, because of increasingly limited function and reduced ability to provide certain types of support. Gottlieb (1989) found that many caregivers of the chronically ill experienced lack of reciprocity. In contrast, the findings of two studies revealed that the family caregivers of men with hemophilia and AIDS and the mothers of children with a chronic illness did not express the negative feelings of burden typically associated with the unequal caregiver-recipient relationship. Perhaps the commitment to a long-term intimate relationship overshadowed the need for immediate reciprocity. This reflects the relatively recent notion of lifespan reciprocity (Antonucci & Jackson, 1990) and indicates that there might be several types of reciprocity, depending on the particular relationship. During the course of another study, reciprocity emerged as a key characteristic of partnership and of a relationship involving health professionals and members of self-help groups. The assumption that interventions involving peers typically promote reciprocity (Katz, 1993) informed the design of the telephone-support group interventions for hemophiliacs with AIDS and their family caregivers and for parents of children with a chronic illness. Reciprocity with peers and exchange of information and support were cited as key benefits of the face-to-face-support groups for couples coping with MI and of the telephone-support groups for persons with HIV/AIDS.

Drawbacks

Network support can also have negative effects (Brenner, Norwell, & Limacher, 1989); indeed most social relationships feature both supportive and stressful elements (Rook, 1990), and ties with friends and families can be a source of stress and conflict. Drawbacks affect both provider and recipient. The provider might experience overload or

overexposure to chronic and acute stresses, or might be overly protective, committed, or emotionally involved. The recipient might experience diminished trust, loss of support, bad advice, learned helplessness, or relational costs (La Gaipa, 1990). Support might be perceived as unhelpful, particularly if it undermines the recipient's sense of self-esteem. The negative aspects of social networks have not been sufficiently researched, and measures of social support typically disregard the negative aspects of relationships.

Perceptions of low support can reflect the absence of a supportive relationship or the presence of a negative, *conflicted* relationship (Coyne & Bulger, 1990). Conflict and negative interactions correlate with low perceived support more strongly than do positive ones (Schuster, Kessler, & Aseltine, 1990). Negative relationships in our study of health professionals and members of self-help groups entailed conflict, power struggle, competitiveness, dominance, territoriality, and judgemental behaviour. Men with hemophilia and AIDS experienced prejudice and insensitivity from health professionals and avoidance by friends. Mothers of children with a chronic illness received conflicted support involving criticism or condescension from family and friends, but mostly on the part of health professionals, some of whom reportedly communicated information in a heartless fashion (Stewart et al., 1995).

Even successful relationships involve lapses in support, miscarried support (Sarason et al., 1990), and failed support modes or functions (Eckenrode & Gore, 1990). The mothers of children with a chronic illness were concerned less about conflict than about miscarried and *absent* support — anticipated support that did not materialize. One mother explained that her husband failed to "participate as much as I would like. I know if I asked him, he would. But I don't feel like I should ask him. I feel like he should volunteer." The mothers' descriptions of their partners' failure to enforce the child's treatment regimen and positive health behaviours represented *miscarried* support. The intervention studies found that men with AIDS and their family caregivers received inadequate information and attention from health professionals, while the caregivers of stroke survivors found it stressful to contend with *absent* support from family, friends, and health professionals.

Such drawbacks can have a more powerful influence on health (House et al., 1988; Rook, 1990) and use of health services than the more general benefits of support. Therefore, both the supportive and non-supportive features of clients' interactions and relationships should be assessed.

Duration of Support

Support will either endure or dissipate over time. Network changes (Bernard et al., 1990) and patterns of support in chronically stressful situations, such as illness or caregiving, have yet to be examined. The investigation of the role of social support in early re-admission to hospitals for cardiac disease found that persons who were re-admitted received less support from neighbours than persons who were not re-admitted. Mothers of children with a chronic illness indicated that support did not endure, and that when they needed support — at the time of diagnosis when they were overwhelmed by new caregiving demands — they did not receive it. As a result, our current telephone-support trial focuses on parents of chronically ill children under seven years of age.

These studies have implications for the timing of support interventions. One such intervention was directed at new family caregivers of persons who had experienced a severe stroke for the first time and had recently been discharged. The studies also have implications for the duration of support, which is important for determining intervention "dose" and stability of outcome. Reports of telephone-support interventions suggest that their typical six-week duration was inadequate (Gottlieb, 1991). One intervention study in our program involved a peer visiting the home of the new caregiver of a stroke survivor twice weekly over 12 weeks, with impact re-assessment after three and six months. In the delayed post-test interviews, caregivers said they missed the visits when they had been terminated. The telephone-support interventions for hemophiliacs with HIV/AIDS and their family caregivers also lasted 12 weeks — longer than most telephone-support interventions reported in the literature. Post-intervention interviews showed that both the affected men and their caregivers would have liked them to continue.

These findings indicate that in order to determine the needs of their clients, nurses should assess: types of support required or available for various stressors; sources of support; reciprocity of support; costs and benefits associated with support; satisfaction with support; behaviours perceived as supportive or non-supportive; underuse and overuse of support resources; and timing and duration of support. However, support is one of many factors that nurses must assess. A screening interview focusing on satisfaction with support and number and type of supporters could therefore be followed by a detailed assessment of the support needs of clients at risk (e.g., those who are lonely or isolated). Nurses could test the long-term impact of support interventions
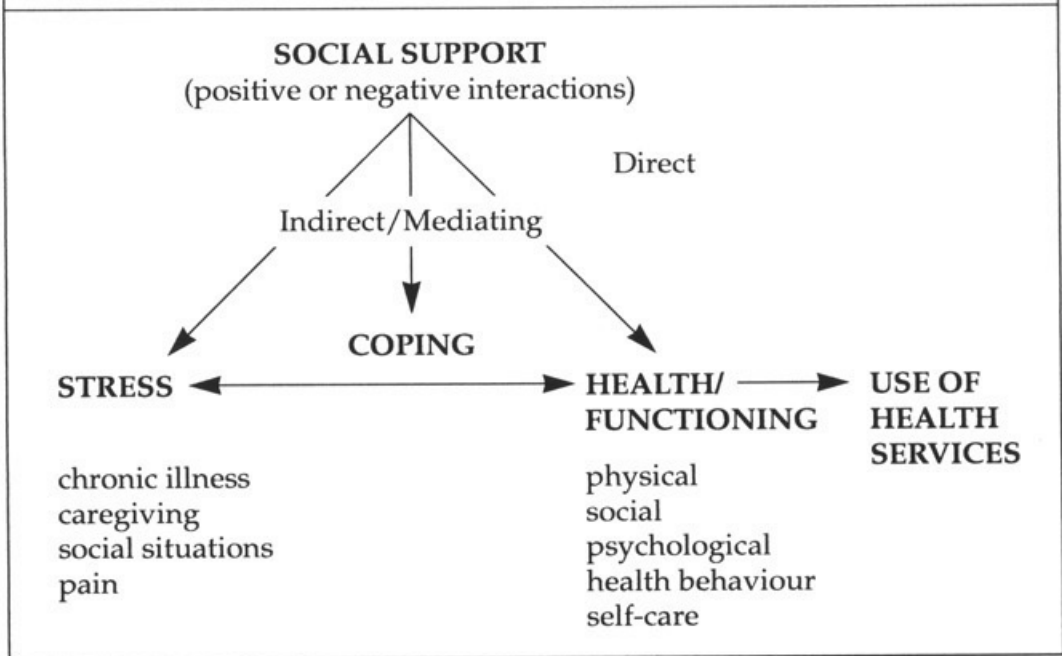
designed to lessen the impact of negative interactions and absent support.

Relationship between Stress and Social Support

Figure 1 represents the conceptual framework of the research program: the relationships between social support and stress, social support and coping, and social support and health. The two-way arrow indicates that the stress-social support relationship is reciprocal. The arrow from support to stress indicates that support can be stressful. Attribution, social exchange, and social comparison theories have been invoked to interpret miscarried or inadequate helping (Buunk & Hoorens, 1992). In our study with mothers of children with a chronic condition, conflict with their spouse over the child's care and absent anticipated support were perceived stressors. The investigation of the support needs of men with hemophilia and AIDS and their family caregivers revealed that insensitivity, prejudice, and avoidance on the part of friends and health professionals were particularly stressful. The children who had chronic illnesses identified peer relationships as a major everyday life stressor and restrictions that inhibited social activities and relationships as a major illness-related stressor.

Conversely, support can mediate or moderate the impact of stressful situations on health and functioning (Figure 1). This framework acknowledges that a stressful situation can be chronic or acute. Stress-moderating processes determine a person's reaction to or appraisal of stress (Eckenrode & Gore, 1990). Our study with persons with ischemic heart disease identified instructive differences involving stress appraisal and social support. Persons admitted for the first time appraised the stress associated with their condition as less central and threatening, and received less emotional and affirmational support from health professionals, than persons with multiple admissions for cardiac illness. The mothers of children with a chronic illness described specific types of support from specific sources with respect to specific stressors or caregiving burdens. In the investigation of resources influencing young children's coping with a stressful procedure, supportive nursing interventions were associated with reports of less pain. In a different context, support was related negatively to stress experienced by community health nurses. All intervention studies were based on the premise that support has a moderating effect on appraisals of stressfulness in chronic illness and caregiving. It is therefore predicted that the telephone-support groups for parents of children with a chronic condition will result in decreased parental perceived stress.

Figure 1 *Framework of Social Support Research Program*

SOCIAL SUPPORT
(positive or negative interactions)

Direct

Indirect/Mediating

COPING

STRESS ←——————→ **HEALTH/** ——→ **USE OF**
                          FUNCTIONING   **HEALTH**
                                               SERVICES

chronic illness   physical
caregiving   social
social situations   psychological
pain   health behaviour
                       self-care

Social Support and Coping

This research program recognizes the limitations of an individualistic perspective that ignores the social context of coping (Folkman et al., 1991). The way in which an individual copes is affected by others, irrespective of whether the person seeks support. The two-way arrow in Figure 1 suggests that the support-coping relationship is reciprocal.

Social support is conceptualized as a coping resource or a form of coping assistance (Thoits, 1986). The arrow from social support to coping indicates that supportive persons can affect appraisal, sustain coping efforts, and influence choice of coping strategies. Social support may also augment the coping resources that are available to deal with stressful encounters. Furthermore, receipt of support can change the trajectory of coping. Finally, perceived availability of social support has been linked to coping effectiveness (Bennett, 1993).

Conversely, the arrow from coping to support indicates that how a person copes can provide clues to potential supporters about whether support is needed and, if so, the types of support that are needed (Silver, Wortman, & Crofton, 1990). People who use avoidance and distancing strategies tend to have fewer support resources, while support-seeking has been linked to greater provision of support (Dunkel-Schetter & Skokan, 1990). Indeed, how one copes can influence the course of interpersonal interactions and the nature and quality of

support that will be received (Silver et al.). Thus social support influences coping abilities, while coping strategies influence the type of support that is sought and received.

Several studies in the program explored the links between coping and support. The study of children's support found that healthy children sought support from friends as a coping strategy more often — and had more supporters — than children with a chronic illness. The investigation of nurses in HIV/AIDS care revealed that the coping strategies "seeking support" and "positive reappraisal" related positively to receipt of social support. The key coping strategy for hemophiliacs with AIDS and their family caregivers, "seeking support," was directed at specific support functions or sources; they most frequently sought informational support. In contrast, men with hemophilia and AIDS who coped by avoiding others, rather than by seeking support, did so because of fear of negative reaction and concern about confidentiality. For persons admitted for IHD, "seeking support" was also the most common coping strategy.

In contrast, most coping behaviours used by young children undergoing a painful procedure were directed at self-protection, and less often included support-seeking. Persons skilled at seeking support are more effective than others in obtaining it; however, coping is a developmental skill that may not be learned until adolescence or adulthood. Nevertheless, the coping behaviours of these young children were influenced by supportive interactions with nurses, and their level of preparation for the procedure was positively related to their ability to seek informational support, again suggesting links between coping and social support.

The support interventions for hemophiliacs with AIDS and their family caregivers, for MI survivors and their spouses, and for family caregivers of stroke survivors helped them cope with the demands of a chronic condition. Those living with HIV/AIDS reported increased problem-focused coping and actions, particularly seeking information and advocacy. Peer visitors explained about coping strategies to caregivers of stroke survivors; caregivers noted improved information-seeking and distraction from stress. The couples coping with MI reported enhanced problem-focused and relationship-focused coping.

We found that coping strategies can also be relationship-focused. In close support relationships, the coping of one partner influences the coping behaviours of the other (Gottlieb & Wagner, 1991). Evidence of "relationship coping" was revealed in the mothers' appraisal of interactions with the child's father. Mothers described their efforts to keep

the marriage together and cope with their spouse's lack of involvement in caring for the child with a chronic condition. They used "active engagement" (shared problem-solving and open discussion) or "protective buffering" (protecting the spouse from the demands of caregiving) (Coyne & Downey, 1991) to cope with such relationship stressors. Couples dealing with MI reported using more active engagement following the education-support intervention. Hemophiliacs with AIDS and their family caregivers used primarily coping strategies to keep their "personal relationships normal"; absent support and conflicted support in their relationships were predominant stressors. In contrast, participants with heart failure and stroke, who were on average 69 years of age and married for 40 years, reported experiencing stressors and support as a couple and satisfaction with their spousal relationship — possibly reflecting mastery of relationship coping in long-term, stable relationships.

Impact of Social Support on Health, Health Behaviour, and Use of Health Services

In Figure 1, the two-way arrow between social support and health depicts a bidirectional relationship. The arrow from support to health indicates that integration in a social network, and the ability to draw support resources from the network, can maintain health and facilitate recovery (Bloom, 1990). There is evidence that social support enhances health outcomes and reduces mortality, whereas stressful social relationships can prolong physical dysfunction (Kaplan & Toshima, 1990). Furthermore, negative interactions are more predictive of depression and poor emotional health than supportive interactions (Coyne & Downey, 1991; Rook, 1990). Socially integrated persons are less likely to have high rates of schizophrenia, depression, tuberculosis, hypertension, accidents, and pregnancy complications (Ford & Procidano, 1990; House et al., 1988).

In this research program, proximal health outcomes were classified as physical, psychological, and social. Consistent with the buffering model (Quittner, Glueckouf, & Jackson, 1990), our intervention trials hypothesize that support will have a moderating impact on health outcomes in the context of chronic stressors. The face-to-face-support intervention for couples coping with MI decreased negative affect of spouses. The pilot for another intervention suggested that telephone support for persons living with AIDS can enhance psychological health by decreasing social and emotional loneliness. Finally, the ongoing telephone-support groups for parents of young chronically ill children

are predicted to enhance parents' psychological health and their perceived caregiving competence.

Two assessment studies revealed that support was associated positively with the health of nurses. Increased total support and work-related support were found to be related to diminished burnout among community health nurses, and emotional support was negatively associated with emotional exhaustion (a component of burnout) among nurses working in AIDS care.

The arrow from health to social support indicates that health and illness affect availability and quality of social support. Illness is a major stressor, involving loss of relationships, status, independence, ability to work, and social mobility, as well as threat of death and loss of a loved one. The continued need for social support in chronic stressful situations such as illness can deplete support, drain the social network of resources that contribute to support, and result in alienation and estrangement (Stewart, 1993). Thus support can diminish over time. In one of the studies in the program, men with hemophilia and AIDS and their family caregivers reported isolation and avoidance by formerly supportive friends. In another, mothers of children with a chronic illness, particularly those facing extensive caregiving demands, reported lack of anticipated support from members of their network. One investigation found that persons re-admitted for IHD reported less support from neighbours than those admitted for the first time, perhaps because of their diminished ability to reciprocate.

The arrow from social support to health outcomes indicates the projected impact of support. Members of a social network may influence health behaviour directly by providing information and indirectly by encouraging compliance with regimens and maintenance of healthful behaviours; they can provide advice, act as a role model, or discourage inappropriate health behaviours (Bloom, 1990). Zimmerman and Connor (1989) found the greatest influences on health behaviour to be supportiveness, encouragement, and exemplary behaviour, on the part of family members, friends, and co-workers. Intervention studies have shown that support from family members and others can result in smoking cessation, weight loss, blood pressure control, and improved diet.

The face-to-face support for couples coping with MI resulted in increased perceived efficacy to make requisite lifestyle and health changes. Spouses and survivors reported increased confidence. However, negative outcomes, such as reinforcement of poor health behaviours or diminished self-care, can also result from network inter-

actions. For example, mothers expressed concern about the impact of interactions with peers on self-care and adherence to regimens among adolescents with diabetes or cystic fibrosis.

Finally, the arrow from health/functioning to use of health services indicates that members of the social network can influence use of health services by providing support, acting as screening and referral agents, and sharing help-seeking values associated with mobilization of support (Dunkel-Schetter & Bennett, 1990).

Seeking "formal" support from health professionals may not always be appropriate. The investigators conducting the study with family caregivers of stroke survivors anticipated that those who received peer support would be less likely to seek "inappropriate" professional intervention. Use of health services was measured through pre-test, post-test, and delayed post-test interviews. Significant decreases were noted, from pre-intervention to six-month interviews, in phone calls to physicians and in visits to physicians' offices and hospitals. Another study found that mothers discussed their need for support with caregiving demands pertaining to clinic appointments and to the use of health services. Thus support for family caregivers may influence the client's use of health services. This indirect influence might be taken into account when support interventions are being planned.

Summary and Conclusion

This program has yielded new insights and reinforced earlier research (see Table 2). The complex conceptual linkages among coping, stress, social support, and health require further study. Clinically relevant and feasible assessment strategies for nursing are needed; furthermore, the impact of nursing interventions that mobilize and foster social support require testing.

Table 2 *Themes Emerging from Assessment and Intervention Studies*

Themes Emerging from Assessment Studies

- Different types of providers for different types of support
- Support from both professionals and peers
- In chronic stressful situations, support can dissipate over time
- Delayed or altered reciprocity is acceptable in close relationships
- Chronic stressful situations can lead to problems with support from partners, friends, and professionals
- The coping strategy "seeking support" is positively related to social support; relationship coping strategies can help maintain network relationships
- Members of the social network can affect health behaviours both positively and negatively
- Support to family caregivers can affect recipients' use of health services
- Certain types of social support are associated with indicators of nursing burnout

Themes Emerging from Intervention Studies

- Different modes for different people
- Satisfaction with interventions: peers, professionals, participants
- Support processes: social comparison, social exchange, social learning
- Peer-professional partnership
- Support intervention outcomes (quantitative)
    - Loneliness ↓
    - Negative affect ↓
    - Social support need ↓
    - Social support satisfaction ↑
    - Use of health services ↓
- Perceived benefits (qualitative)
    - Talking with someone with similar experience
    - Knowing others in same situation
    - Affirmation and encouragement
    - Increased confidence, competence, empowerment
    - Enhanced communication
    - Satisfaction of emotional support needs
    - Satisfaction of information needs — knowledge ↑
    - Impact on coping → moved to action
    - Impact on interactions within natural network
    - Comfort in relationships with peers
    - Friendship/companionship

References

Antonucci, T.C., & Jackson, J.S. (1990). The role of reciprocity in social support. In B.R. Sarason, I.G. Sarason, & G.R. Pierce (Eds.), *Social support: An interactional view* (pp. 173–198). New York: Wiley.

Bennett, S.J. (1993). Relationships among selected antecedent variables and coping effectiveness in postmyocardial infarction patients. *Research in Nursing and Health, 16,* 131–139.

Bernard, H., Johnson, E., Killworth, P., McCarthy, C., Shelley, G., & Robinson, S. (1990). Comparing four different methods for measuring personal social networks. *Social Networks, 12,* 179–215.

Birkel, R.C., & Repucci, N. (1983). Social networks, information seeking, and the utilization of services. *American Journal of Community Psychology, 11(2),* 185–205.

Bloom, J.R. (1990). The relationship of social support and health. *Social Science and Medicine, 39,* 635–637.

Brenner, G.F., Norwell, W.R., & Limacher, M. (1989). Supportive and problematic social interactions: A social network analysis. *American Journal of Community Psychology, 12,* 831–836.

Buunk, B.P., & Hoorens, V. (1992). Social support and stress: The role of social comparison and social exchange processes. *British Journal of Clinical Psychology, 31,* 445–457.

Coyne, J.C., & Bulger, N. (1990). Doing without support as an explanatory concept. *Journal of Social and Clinical Psychology, 9(1),* 148–158.

Coyne, J.C., & Downey, G. (1991). Social factors and psychopathology: Stress, social support and coping processes. *Annual Review of Psychology, 42,* 401–425.

Cutrona, C. (1990). Stress and social support: In search of optimal matching. *Journal of Social and Clinical Psychology, 9(1),* 3–14.

Dakof, G.A., & Taylor, S.E. (1990). Victims' perceptions of social support: What is helpful from whom? *Journal of Personality and Social Psychology, 58,* 80–89.

Dunkel-Schetter, C., & Bennett, T. (1990). Differentiating the cognitive and behavioral aspects of social support. In B.R. Sarason, I.B. Sarason, & G.R. Pierce (Eds.), *Social support: An interactional view* (pp. 208, 267–296). New York: Wiley.

Dunkel-Schetter, C., & Skokan, L. (1990). Determinants of social support provision in personal relationships. *Journal of Social and Personal Relationships, 7(4),* 437–450.

Eckenrode, J., & Gore, S. (1990). *Stress between work and family* (pp. 55–59). New York: Plenum Press.

Ellerton, M.L., Ritchie, J.A., & Caty, S. (1994). Factors influencing young children's coping behaviours during stressful health care encounters. *Maternal-Child Nursing Journal, 22,* 74–82.

Folkman, S., Chesney, M., McKusick, L., Ironson, G., Johnson, D.S., & Coates, T.J. (1991). Translating coping theory into an intervention. In J. Eckenrode (Ed.), *The social context of coping* (pp. 240–260). New York: Plenum Press.

Ford, G., & Procidano, M. (1990). The relationship of self-actualization to social support, life stress and adjustment. *Social Behaviour and Personality, 18(1),* 41–51.

Gottlieb, B.H. (1989). A contextual perspective on stress in family care of the elderly. *Canadian Psychology, 30(3),* 596–607.

Gottlieb, B.H. (1991). Peer telephone dyads: Putting conclusions on hold. *American Journal of Community Psychology, 19(1),* 123–132.

Gottlieb, B.H., & Wagner, F. (1991). Stress and support processes in close relationships. In J. Eckenrode (Ed.), *The social context of coping* (pp. 165–187). New York: Plenum Press.

House, J.S., Umberson, D., & Landis, K. (1988). Structures and processes of social support. *Annual Review of Sociology, 14,* 293–318.

Kaplan, R M., & Toshima, T. (1990). The functional effects of social relationships on chronic illnesses and disability. In B.R. Sarason, I.B. Sarason, & G.R. Pierce (Eds.), *Social support: An interactional view* (pp. 427–453). New York: Wiley.

Katz, A.H. (1993). *Self-help in America: A social movement perspective.* New York: Twayne.

La Gaipa, J.J. (1990). The negative effects of informal support systems. In S. Duck (Ed.), *Personal relationships and social support* (pp. 122–139). London: Sage.

Norbeck, J.S. (1988). Social support. *Annual Review of Nursing Research, 6,* 85–109.

Quittner, A.L., Glueckouf, R.L., & Jackson, D.N. (1990). Chronic parenting stress: Moderating versus mediating effects of social support. *Journal of Personality and Social Psychology, 56(6),* 1266–1278.

Rook, K. (1990). Parallels in the study of social support and social strain. *Journal of Social and Clinical Psychology, 9(1),* 118–132.

Sarason, R.B., Sarason, I.G., & Pierce, G.R. (1990). *Social support: An interactional view.* New York: Wiley.

Schuster, T., Kessler, R., & Aseltine, R. (1990). Supportive interactions, negative interactions and depressed mood. *American Journal of Community Psychology, 18,* 423–438.

Silver, R., Wortman, C., and Crofton, C. (1990). The role of coping in support provision: The self-presentational dilemma of victims of life crises. In B. Sarason, I. Sarason, & G. Pierce. *Social support: An interactional view* (pp. 397–426). New York: Wiley.

Simmons, S. (1994). Social networks: Their relevance to mental health nursing. *Journal of Advanced Nursing, 19,* 281–289.

Stewart, M. (1993). *Integrating social support in nursing.* Newbury Park, CA: Sage.

Stewart, M., Banks, S., Crossman, D., & Poel, D. (1994). Partnerships between health professionals and self-help groups: Meanings and mechanisms. *Prevention in Human Services, 11(2),* 199–240.

Stewart, M., Hart., G., & Mann, K. (1995). Living with haemophilia and HIV/AIDS: Support and coping. *Journal of Advanced Nursing, 22,* 1101–1111.

Stewart, M., Hirth, A., Klassen, G., Makrides, L., & Wolf, H. (1997). Stress, coping and social support as psychosocial factors in readmission for ischaemic heart disease. *International Journal of Nursing Studies, 34(2),* 151–163.

Stewart, M., Ritchie, J., McGrath, P., Thompson, D., & Bruce, B. (1994). Mothers of children with chronic conditions: Supportive and stressful interactions with partners and professionals regarding caregiving burdens. *Canadian Journal of Nursing Research, 26(4),* 61–82.

Thoits, P.A. (1986). Social support as coping assistance. *Journal of Consulting and Clinical Psychology, 54,* 416–423.

Tilden, V., & Galyen, R. (1987). Cost and conflict: The darker side of social support. *Western Journal of Nursing Research, 9(1),* 9–18.

Winemiller, D.R., Mitchell, M.E., Sutcliffe, J., & Cline, D.J. (1993). Measurement strategies in social support: A descriptive review of the literature. *Journal of Clinical Psychology, 49(5),* 638–648.

Zimmerman, R.S., & Connor, C. (1989). Health promotion in context: The effects of significant others on health behavior change. *Health Education Quarterly, 16(1),* 57–75.

Acknowledgements

Erratum

In the article "Centres for Health Promotion Research in Canada," by Miriam Stewart (Volume 29, No. 1, Spring 1997), the valuable contributions of Judith Kulig, Regional Centre for Health Promotion and Community Studies; Michel O'Neill, Groupe de recherche et d'intervention en promotion de la santé de l'Université Laval; and Cynthia Smith, Alberta Centre for Well-Being, were inadvertently omitted from the Acknowledgements.