# NURSES and FAMILY HEALTH PROMOTION

## Concepts, Assessment, and Interventions

# FAMILY SOCIAL SUPPORT

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PATRICIA ROTH

A kind heart is a fountain of gladness, making everything in its vicinity freshen into smiles.

WASHINGTON IRVING

## OBJECTIVES

*On completion of this chapter, the reader will be able to:*

1. Differentiate between the concepts of social network and social support
2. Analyze the relationship among the variables of social support, stress reduction, and well-being
3. Describe the influence of contemporary social trends on conventional and progressive family forms
4. Analyze the effectiveness of various types of networks in providing social support to families and individuals
5. Assess family needs for social support with awareness of cultural determinants
6. Evaluate the contribution of social support to the integration of health-promoting behaviors into family lifestyles
7. Develop effective strategies for implementing the concept of social support in nursing education, research, and practice

The advance of technology has nurtured a revolutionary age marked by rapid and dramatic change. Although the specter of an uncertain future challenges individuals and interpersonal relationships, accelerated change also presents a wealth of opportunity. These same opportunities require decisions unknown to previous generations. People seek healthier, more satisfying lifestyles and are faced with hard choices concerning the use of technology to assist fertility, improve pregnancy outcomes, deter chronic illness, and delay death, decisions that profoundly influence family life.

Changes in family life-cycle patterns have increased correspondingly during the last two decades, due to the lower birthrate, the longer life expectancy, the changing role of women, and the increasing incidence of divorce and remarriage. Previously, childrearing occupied adults for an entire life span, but it now occupies less than half of adult life prior to old age, giving new meaning to the concept of family. Since women have always been central to the functioning of the family, the changing role of women is pivotal to shifting family life-cycle patterns. Women are seeking to establish personal life goals, making career choices, establishing two-career marriages, having children later, and having fewer children or no children at all. Not surprisingly, women have difficulty establishing concurrent functions outside of the family and experience special life-cycle stresses as they are expected to bear emotional responsibility for all family relationships. Although the role of women in altering the family life cycle is significant, recognition must be given to the strain that vastly accelerated change puts on families, whether the changes themselves are enhancements or detriments (Carter & McGoldrick, 1988).

Life change, as a multidimensional concept, has been implicated in the social etiology of life stress,

with the number and magnitude of life change events serving as a measure of stress. It is generally assumed that the greater life change an individual experiences, the more the individual must adapt. Although it has been hypothesized that stress is a major determinant of well-being, empirical research findings indicate that stressful events may have a limited impact on well-being, even when viewed from a longitudinal perspective (Murrell, Norris, & Grote, 1988). Thus, researchers argue that those models that explore the direct effects of stress on well-being are inadequate and that the role of social psychological resources in the stress process must be considered (Barerra, 1988). One of the most frequently examined coping resources is social support. Although the evidence is not conclusive, there is general consensus that the negative effects of life stress are reduced for persons with strong social support systems (Krause, 1990). The concept of social support has emerged as a major variable in health-related research, but there is lack of conceptual agreement on the definition of social support from study to study and how it functions to buffer the effects of stress or to protect health (Ryan & Austin, 1989). The purpose of this chapter is to explore the concept of social support as a health status variable, to consider the implications of social support for the traditional nuclear family and newer family forms, and to propose nursing interventions to improve the quality of social support for families.

## THE CONCEPT OF SOCIAL SUPPORT

One of the most important distinctions to be made concerning social support is the difference between the number of relationships a person has and the person's perception of the supportive value of social interactions. The former is the social network, and the latter is perceived social support. Because the terms are frequently used interchangeably, further clarification is indicated.

A *social network* may be defined as the set of relationships of a particular individual or a set of linkages among a set of persons. Structurally, networks include size, density, accessibility, kinship-reliance, stability, and frequency of contact. (Hall & Wellman, 1985). Although the size or extent of the social network may be an indication of the degree of social support available, it is questionable to assume that benefits are directly proportional to the size of the network or that having a relationship is equivalent to getting support. These factors merit consideration when multiple social connections are used or when a single social connection, such as being married or having a confidant, is used. It is likely that a positive association exists between social network size and amount of social support. However, the problems generated from important social relationships contribute significantly to the degree of stress people experience in their lives. Therefore, consideration of the quality of the social relationship is important in addition to consideration of the availability or extent of the social network (Ryan & Austin, 1989).

*Social support* focuses on the nature of the interactions taking place within social relationships as these are evaluated by the individual. Perceived social support involves an evaluation of whether a pattern of interactions is helpful and to what extent. Distinguishing between social networks and social support is important because these concepts may have differing effects on the health status of the individual and considerable implications for research and clinical practice. Social support, as perceived by the individual, may be more strongly associated with health outcomes because it is a more direct indication of the support actually afforded a person, whereas the demands and constraints of network membership may dilute the beneficial effects (Schaefer et al., 1981).

Social support can have a variety of components, each serving a variety of supportive functions. Schaefer et al. (1981) identified the emotional, tangible, and informational functions separately. *Emotional* support includes intimacy, ability to confide in one another, and a sense of attachment contributing to a feeling that one is cared about or that one is a member of the group. *Tangible* support involves direct aid or services, including providing money or goods, providing a caretaking function, or performing a service. *Informational* support includes providing advice or information to assist in problem solving and giving feedback concerning an individual's progress. Thoits (1982) identified social support as the degree to which a person's basic social needs (affection, esteem, approval, belonging, identity, and security) are gratified through interaction with others. The functional aspects of social support include both socioemotional and instrumental aid. Another conceptualization of social support, based on Weiss's theory of the provisions of relationships (1974), identified five dimensions of support: intimacy, social integration, worth, nurturance, aid, and assistance (Weinert, 1987). These varying definitions are indicative of the conceptual and methodological issues that have emerged in researching the concept of social support. These issues have included inadequate conceptualization, lack of recognition of the multidimensionality of the concept, and the proliferation of measurement strategies. Ryan & Austin (1989) suggest that it is difficult to integrate the results of research on social support due to these issues. However, increased awareness of the complexity of the phenomena is apparent as researchers attempt to develop hypotheses derived from theory, and to explore both quantitative and

qualitative approaches to capturing the nuances of social support.

## SOCIAL SUPPORT, STRESS, AND WELL-BEING

The concept of social support has emerged as a major variable in health-related research. Much of the research has explored the concept of social support in relation to caregiving, social isolation, and stressful life events such as illness and death (Baillie, Norbeck, & Barnes, 1988; Chappell & Badger, 1989; McHaffie, 1992; Sankar, 1991). In view of the hypothesis that social support fosters better adaptation to stressful life events, some studies have explored the dimension of physical health while others have focused on psychological well-being, using both objective measures and subjective indicators.

The exact nature of the role of social support in mediating stressful life events is the subject of continuing research. Krause (1986) summarizes the buffering hypothesis in discussing social support, stress, and well-being among older adults. Proponents of this hypothesis maintain that social support reduces the impact of stress by giving greater clarity to the situation and by facilitating the development and implementation of a sensible plan of action for dealing with the problem. In addition, social support may also reinforce the individual's positive self-concept and provide assurance that although the situation is difficult, it can be tolerated, and successful outcomes may follow the plan of action.

Barrera (1988) describes stress buffering as any condition that decreases the overall positive relationship between stressful life events and psychological distress. He suggests that two distinct models might be described as illustrating stress buffering effects. In the first model, there is a positive relationship between life stress and social support that could reflect the mobilization of social support in response to life's stressors. This model further proposes that social support serves to mitigate adverse reactions to precipitating stressors. The second model portrays social support as interacting with stress, but support is not independently related to either stress or outcome variables such as physical health or psychological disorder. In the second model, there is no relationship between the occurrence of life stress and the mobilization of support hypothesized.

In attempting to determine the current status of the stress buffer model, Barrera (1988) states that there has been some evidence for the stress moderating influence of social support, but study results are contradictory. Cohen and Wills (1985) conducted an extensive literature review of stress buffering and found inconsistent support for the model. Based on their findings, Barrera (1988) suggests that there is a need to reconsider the assumptions of the Stress Buffer Model and to specify more exactly the conditions under which it can be observed. In reappraising the model, he identifies the following issues that merit consideration: (1) buffering effects are apparent for only certain types of social support, (2) buffering effects occur when social support matches the needs presented by life event stressors, and (3) buffering effects conform to a curvilinear rather than a linear model. He proposes that there is a need to explore alternative models to explain the relationship between social support, stressful life events, and psychological distress. Further, there is a need to move beyond cross-sectional studies to more longitudinal studies to explore changes inherent in the recovery from life stress and the changing needs that emerge. Finally, Barrera (1988) notes that there is a paucity of studies that address the ways in which social support contributes to the occurrence of positive events, influences their appraisal, or is mobilized due to positive life experiences.

With these caveats in mind, clinicians must view the implications of social support realistically in planning care for clients and recognize both the value and limitations of current research efforts.

## SOCIAL TRENDS AND EMERGING FAMILY FORMS

Within the past generation, family life-cycle patterns have changed dramatically, causing some to emphasize the breakdown in traditional values and behaviors and to view with alarm the decline and decay of the traditional family. Traditional families, consisting of a husband who is considered head of the household and responsible for family support and the wife who is responsible for child care and home care and their children, have had social, legal, and religious sanction. Bahr (1988) challenges the notion of family deterioration and indicates that the available evidence from this century and even from earlier times does not support a decline in family vitality, strength, solidarity, or positive influence in people's lives. He suggests that the traditional family of nostalgic memory never existed, except perhaps in a tiny segment of the population—the moneyed leisure class—and even then, historical evidence does not reveal the values, behaviors, and personal qualities associated with the traditional family. The view of the traditional family as a safe solidarity of kinship, caring, responsibility, and love is not readily supported. In reality, Bahr (1988) suggests that traditional structures were intolerant, intractable structures that produced a tragic loss of human potential—structures that stifled human creativity, opportunity, and growth. With recognition of the pain that still mars family relationships, Bahr maintains that today's families are not

only viable, but stronger, more resilient, and more rewarding units in which to live than families of the past.

Nevertheless, the American family is changing and may be best characterized by horizontal movement rather than decline. There is a major shift in the proportion of families of various types, a shift of a magnitude sufficient to indicate the necessity of a thoughtful examination of the implications for the societal structure. Traditional families are a smaller proportion of American families, with families consisting of the male breadwinner and female homemaker composing a minority but still sizable component of family structures. Variant forms of family life now make a relatively large contribution to the mix of families and the increased importance of this diversity must be recognized and incorporated into the perception of American family life. These forms consist of two-earner families, single-parent families, childless families, and blended families. They may also consist of persons who live together without conventional marriage in heterosexual, gay, or lesbian relationships (Chilman, Nunnally, & Cox, 1988). Emerging family forms may include the presence of emancipated children and their offspring or elderly relatives who are unable to live independently. Thus the paradigm for middle-class American families is currently more or less mythological, relating in part to existing and emerging patterns and in part to the ideal standards of the past to which most families compare themselves.

## Gender, Roles, and Family Structure

Many of the changes occurring in family forms can be viewed as adaptations to the changing images of women, their desires, and their resources. (Dornbusch & Strober, 1988). Women have always been central to the functioning of the family and their identities have been associated with the role of mother and wife, and their life-cycle phases linked to childrearing activities. A longer life expectancy means that women now have a time frame equal to that of the childrearing years to engage in other life options. Women have come to need and want a personal identity and have sought that identity through education, career, and other avenues of self-development. Technological advances have enabled women to plan their involvement in childrearing, but conflicting goals and multiple role demands continue to create considerable stress (Carter & McGoldrick, 1988).

A review of the research in gender roles and the family indicates that while more women are working outside of the home, they continue to do most of the domestic labor. Women also tend to modify their employment because of family constraints, although men usually do not. Women also engage in more kinkeeping and care of elderly relatives than do men. Not surprisingly, women face conflict between the traditional feminine roles of being nurturant, supportive, passive, and domestic as opposed to the expectation of achieving and being egalitarian (Caycedo, Wang, & Bahr, 1991). In addition to the demands of multiple roles, women continue to face occupational segregation and disparate earnings from their male counterparts, a situation that becomes increasingly complex for women who are single parents or heads of household (Strober, 1988).

Changes in family structure have also posed challenges and new life stressors for men. In discussing the role of men in families, especially fatherhood, Morgan (1990) notes that little attention has been given to the male role in family-centered research but that the situation is changing. He attributes a renewed interest in male roles to changes in patterns of employment and economic life, increasing divorce rates, and issues concerning custody of children. Changing patterns in employment have included shifts from heavy industrial work to lighter industrial, nonmanual and service occupations and the growing participation of women in the workforce. These changes affected the gender character of the workplace and further deteriorated the myth of the male breadwinner. The declining workforce participation of men due to male unemployment and, possibly, a growing disenchantment with the breadwinner role have provided another impetus. With increasing divorce rates (many petitions initiated by women), the position of men in the family has been undermined. In addition, custody of children frequently went to women, underlining the centrality of the mother's role and the marginality of the father's role. There is also some evidence to suggest that fathers suffer more from divorce, and the issue of lone fathers has begun to receive attention, although they are a minority of single-parent households. Thus attention has again shifted to the role of men in families, issues of masculinization, and sources of resistance to change.

Although men's attitudes have become more egalitarian, evidence of change in actual practice in crucial areas of child-care responsibility and domestic labor is difficult to come by. Morgan (1988) cautions that men have few motives to support change in their domestic roles and have the physical and economic power to resist such changes. Even in those situations where attitudes support change, the practical realities may limit options. While new styles of masculinity are developing in exploring the themes of tenderness, softness, and nurturing, they may lack substance and are occurring in a domestic context which has changed little. There are also factors which support change, however, including the altered work environment, the view of work as a less salient factor in identity, and the experiences and attitudes of women who are able to exert considerable

influence in the family structure as well as in the social policy arena. Clearly, domestic and family life have been more resistant to change in gender relations than have some areas of employment and the public sphere.

### Implications for Social Support

The continued existence of traditional family structures and the emergence of variant family forms have implications for social networks and social support for family members. In traditional families, specific roles and functions are prescribed. Therefore, the structure may be in place for developing social networks and orchestrating social support. In addition, the present social, legal, and religious structures tend to respond with a greater degree of significance to traditional families in need. Therefore, the potential may exist for eliciting social support if these social structures favor the family form and lifestyle. However, such assumptions may not always be warranted. In contrast, nontraditional families may find that some forms of social networking and sources of social support are not available to them. For example, the single parent frequently lacks the option of participating fully in school, church, or social functions due to time constraints. An elderly person lacking a spouse, children, or other significant relationships may be isolated from any significant support systems and may lack the ability to mobilize effective substitutes using existing sources. A single male, caring for aging parents, may find little support in the workplace or through existing social and health policy. A view of the continuum of family lifestyles is essential to understanding their needs, their methods for enhancing the quality of their lives and relationships, and their potential for accessing social support when confronted with life stress.

## SOCIAL NETWORKS AND SOCIAL SUPPORT IN FAMILIES

The influence of the social network and of social support in mediating the effects of family stress has emerged as a major domain in family-centered research in the last decade, reflecting similar lines of inquiry and limitations as previously described concerning health-related research and social support. In addition to defining the concept and categorizing the types of social support, family-centered research has focused on what types of social networks offer support to the family in times of stress, in what ways, and for what types of stressor events.

### Support Networks

The major social support networks that provide support to individuals and families include neighborhoods, family, kinship, and self-help groups. Studies of these networks indicate that they usually provide a great deal of support, which has a positive effect on stress reduction. However, the issue of accessibility is not usually addressed. In any case, there is a great deal of variability among special networks in both availability and ability to provide support. For example, Norbeck et al. (1991) found differences among the social support needs of family caregivers of psychiatric patients from the age groups. Caregivers of adult patients reported having the least support. Many support needs were expressed, but the needed support did not exist. In exploring the residential differences in the composition of helping networks of impaired elders, Coward et al. (1990) found that severely impaired elderly in nonmetropolitan communities were less apt than their urban counterparts to be receiving aid from a formal provider and are significantly more likely to be receiving assistance from informal helpers exclusively. Although these studies indicate the lack of availability of certain types of supports, Walls and Zarit (1991) substantiated the important role black churches play in enhancing the lives of elderly black individuals. Although family networks were considered more supportive than church networks, this study found that perceptions of support from the churches were associated with well-being. These and other studies indicate that there are differences in availability of networks, the kind of support they offer, and the degree to which families make use of them.

### Family and Kinship Systems

In describing the characteristics of family and kinship systems when they are functioning as supportive mediators of stress, Caplan (1976) suggests that these systems act as (1) collectors and disseminators of information; (2) a feedback system; (3) sources of ideology; (4) guides and mediators in problem solving; (5) sources of practical aid and services; (6) a haven for rest and recuperation; (7) a control and reference group; (8) a source of identity; and (9) a contributor to emotional mastery. Research on the mediating effects of social support in reducing the family's vulnerability to stress has explored various facets of family life.

Stressful life events have been the subject of some studies that have explored expectations, sources, and availability of social support among family members. McHaffie (1992) found that parents with an infant in the neonatal intensive care unit expected emotional support from grandparents but there was a general feeling that they should stay in the background and become actively involved only if the parents requested. Types of support varied from visiting the baby to transport, caring for siblings, shopping, instilling a sense of hope, or simply showing that the infant and parents were a high priority.

Spousal relations have been the subject of some studies that explored social support and the spousal relationship. Living with a chronically ill spouse has a significant impact on family members, particularly those living with and caring for a homebound adult. DesRosier et al. (1992) found that women caring for husbands disabled with multiple sclerosis depended on their husband for support due to the social isolation of their caregiving responsibilities. They made personal space and time for themselves by setting apart a place in the home that was theirs or by declaring time out. These strategies help them to avoid or reduce the negative outcomes of the social support they received. In exploring the costs and benefits of social support in families, Robertson et al. (1991) found that external support can reduce the stress of individuals but it may also produce costs for the persons involved. This study substantiated that in families headed by a man with unstable work history, the wife's support from relatives and friends is associated with the husband's negativity toward the spouse.

Intergenerational support was the focus of a study conducted by Spitze and Logan (1990), who concluded that the key for older adults in receiving help is having at least one daughter, but there is no advantage to having additional children of either gender. Having daughters is most salient for phone contact, while frequency of visiting is affected by both gender and number of children. Matthews and Rosner (1988) noted that the presence of some siblings who did not help at all or helped only sporadically was associated with both the larger family size and the presence of male siblings. The effects of gender composition seem to reflect what is known about the differences in male-female helping behavior.

Attention has also focused on working women who provide support to elderly family members. Brody and Schoonover (1986) noted that working women continued to provide various types of support to a dependent elderly relative and sought assistance only with those areas in which they were not available to provide support. Exploration of family and kinship systems in providing social support continues to be the subject of research efforts across all phases of the life span, with varying results regarding stress reduction. Results depend on the position of family members and the developed patterns or support and resources exchanged.

## Mutual Self-Help Groups

Although self-help groups have existed for several decades, there has been a large expansion of both types and numbers of groups in recent years. Bumagin & Hirn (1990) identify these groups as consisting of diverse individuals who come together for a particular purpose, sometimes self-selected and other times imposed by external factors. The recent growth in self-help groups is attributed to a breakdown in traditional authority and institutions and to a need for services that may have been performed in the past by family, church, or neighborhood. Many hospitals and social service agencies often have groups that offer education and/or emotional support, while some groups have come into existence on their own, initiated by the needs of people in a given situation. Self-help groups have been formed to address multiple concerns of people, including addiction, crisis, life events, and medical conditions. Examples of such groups include Make Today Count, Parents Without Partners, Weight Watchers, Alcoholics Anonymous, Mended Hearts, Widow-to-Widow, and the Empty Candle.

Self-help groups may serve the purpose of information-sharing, emotional support, effecting behavioral change, or promoting personal growth. In addition to providing support for their members, these groups may also be action oriented and focus on changing attitudes or public opinion concerning their situation or on influencing public policy that affects their problem.

Most self-help groups function by providing information, a setting for mutual support, a reference group, and role models. The common rationale uniting professionally led groups and self-help groups is that people in similar situations can learn from and support each other (Bumagin & Hirn, 1990). Experiential knowledge is an important facet of this function, for it demonstrates that one is not alone in experiencing a problem but that others have been there and learned to cope. This approach may be used in conjunction with professional expertise, or it may be used as an alternative to standard professional care related to physical and/or mental health. George & Gwyther (1988) found that support group participation by caregivers of memory-impaired elderly had positive influences on caregivers' level of knowledge and perceptions of mutual support. They were unable to support a decrease in psychological distress.

Although self-help groups have proved beneficial for many people with various types of problems, they are not useful for everyone. For some American subcultures, discussing personal issues with a group of strangers is very difficult, creating an uncomfortable climate that is not helpful. Others find the group composition at such variance from their own background that they discontinue attendance. Additional barriers to involvement in these types of support groups may include transportation, timing of meetings, membership fees, and lack of care for dependent family members. Self-help groups are not a panacea for every type of personal or social problem, but they may be effective for those individuals who can benefit from the type of support offered and who can integrate the self-care philosophy into their personal regime for health and self-development.

## APPROACHES TO ASSESSMENT OF SOCIAL SUPPORT

Prior to exploring the use of the concept of social support in clinical practice, it is essential to examine methods that would be most appropriate for assessing individual and family needs for support. The process of assessment can be facilitated through an understanding of the various components of social support, the implementation of informal techniques for gathering information, and the use of formal questionnaires.

Previous research has indicated that numerous approaches have been used to evaluate the concept of social support, indicating the diverse and multifaceted nature of the concept. One important facet of assessment of support appears to focus on its social context, the people who are actual or potential providers of support. This can be accomplished through the use of a variety of tools and techniques. For example, family members are often responsive to the use of a genogram, which is a diagram of the family's constellation that shows the structure of intergenerational relationships. A second tool that may be helpful in exploring social networks is the ecomap, which diagrams the family's contact with others outside of the immediate family and may include people, agencies, and institutions (Ross and Cobb, 1990).

### Genogram

A genogram (Fig. 9–1) usually follows conventional geneologic charts and includes three generations or more if pertinent to the situation. Generational lines are indicated by horizontal rows, marital relationships by horizontal lines, and children by vertical lines. Children are rank-ordered from left to right, beginning with the eldest child. The names and the age of each individual, or the date of death if the person has died, are included in the symbol. Additional information pertinent to the health of each family member may be added as well as data concerning year of marriage, divorce, or adoption. This approach may be helpful in obtaining information about the family and its needs in a way that fosters involvement of all family members, but it may also evoke differing emotional responses from individuals as painful relationships or events are recalled. Therefore, the interviewer must be prepared to deal effectively with emotional responses that may be triggered by this process (Wright & Leahey, 1994).

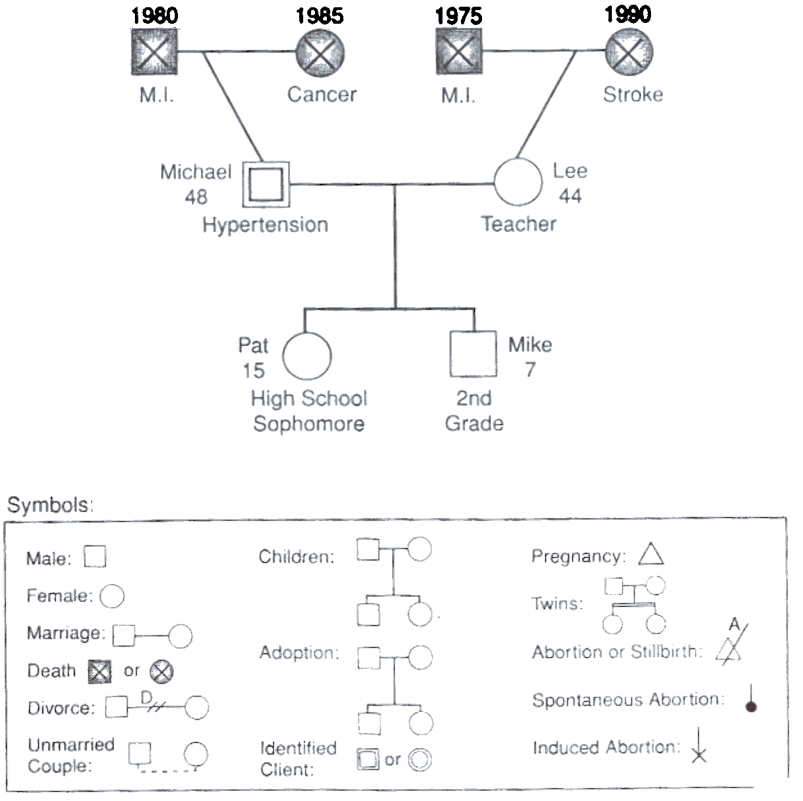


FIGURE 9–1. Family genogram.

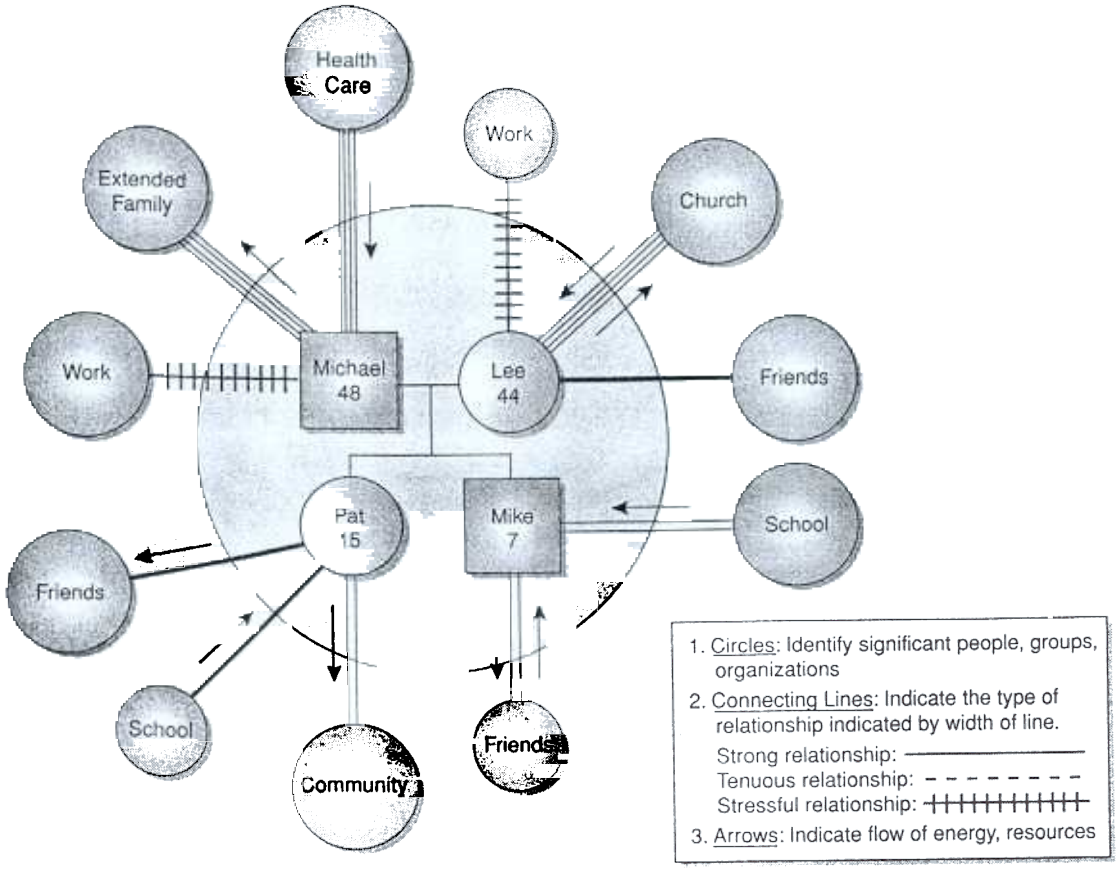


**FIGURE 9–2.** Family ecomap.

## Ecomap

The ecomap (Fig. 9–2) provides an overview of family relationships to various persons, institutions, or agencies and pictures nurturant of stress-laden relationships. The family or household is placed in the center circle, and the outer circles represent significant relationships in the family members' lives. Lines between the inner and outer circles indicate the nature of the connection. Straight lines indicate strong connections, and dotted lines indicate tenuous connections. Slashed lines indicate stressful relationships. The strength of the relationship is indicated by the width of the line. Arrows may be added to indicate the flow of resources and energy.

Both the genogram and the ecomap are assessment tools that can be used in a variety of settings to determine how individuals are linked to significant people and how they might have opportunities to interact in ways that provide social support. As indicated earlier, the presence of potential sources of support is not necessarily an indication of support being either provided or received, nor is it an indication of accessibility (Hartman, 1978).

## Indexes of Social Support

Formal methods for assessing support systems in terms of network analysis may include indexes such as the *Social Network Index* (Berkman & Syme, 1979). This tool includes information on marital status, number of close friends and relatives, frequency of contact, and membership in clubs and community organizations. The *Arizona Social Support Interview Schedule* includes measures of network size, support satisfaction, and support need (Barrera, 1981). These instruments may be useful in conducting research related to social networks or may be incorporated into family interviews or assessment guides.

In addition to network analysis, a second dimension of assessment of social support relates to the individual's subjective appraisal or relevant support dimensions. This may include happiness with key relationships, satisfaction with support, and adequency of social attachments. The *Norbeck Social Support Questionnaire* (Norbeck et al. 1983) asks respondents to identify significant persons in their lives, perceived support available, and important relationships lost. Schaefer et al.'s (1981) *Social Support Questionnaire* measures the

emotional, tangible, and informational functions of social support by using a similar identification of persons involved in one's social network and a rating of each person on the identified functions. Weinert (1987) has developed a social support measure, the PRQ 85, which measures the adequacy of social support and also involves identification of the persons in the network.

A third facet of assessment of support involves specific behavioral activities that are involved in helping. This aspect involves what systems actually do, how they do it, and with what type of results. Although the tools identified above incorporate functions of social support, others such as the *Inventory of Socially Supportive Behaviors* (Barrera, 1981) address this aspect with increased attention to the type and frequency of assistance.

The assessment of social support involves an analysis of the social network to ascertain the actual and potential sources of social support available, an indication from the client regarding his or her perception of the support available from these sources, and the specific helping behaviors that would be of assistance to this family in this situation. Ryan & Austin (1989) maintain that a combination of both quantitative and qualitative approaches may best capture the nuances of social support. Several studies (Sankar, 1991; Norbeck et al., 1991, DesRosier et al., 1992) have used qualitative methods to explore the role of social support in the caregiving process with selected populations, which may further strengthen assessment strategies.

## SOCIAL SUPPORT IN FAMILY HEALTH NURSING

Implementing the concept of social support in nursing care to families can be a complex and multifaceted undertaking because of the nature of the situations in which mobilization of support is indicated, the necessity of meshing formal and informal support networks, and the need for greater specificity in research concerning effective interventions and outcomes. Norbeck (1982) has identified several key assumptions to guide nurse clinicians in both assessing families and planning interventions:

1. People need supportive relationships with others throughout the life span to manage the role demands of day-to-day living, as well as to cope with life transitions and stressors that emerge.
2. Social support is given and received in the context of a network of relationships.
3. The relationships in the network have relative stability over time, especially those that compose the inner circle or primary ties for the individual.
4. Supportive relationships are basically healthy, not pathologic.
5. The type and amount of support needed is individually determined, based on individual differences and characteristics of the situation.
6. The type and amount of support that is available also is determined by characteristics of the individual and the situation.

Incorporating these assumptions into the nursing assessment is essential in order to gather relevant data regarding the actual and potential support available to the family and to develop realistic nursing interventions should the need be determined. Many interventions will relate to deficiencies in social support, and others may relate to personal or network deficiencies.

### Nursing Interventions in Support Deficits

Deficits in social frequency arise from situational problems in which there is a loss of support due to death, divorce, separation, relocation, or other reasons. Although many situational problems are not health problems, they are frequently accompanied by stress-related illnesses that bring families into contact with nurses and other health care professionals in an initial attempt to organize formal sources of support. Providing direct emotional support may be an initial nursing intervention, but a more effective long-term approach may be to assist the family to assess its own needs for support and to use its own natural helping systems. Related nursing interventions include facilitating acknowledgment of the loss, recognizing the grieving process, and using appropriate timing for introduction of various types of support. Occasionally, both lay and professional persons fail to provide adequate support because they urge use of appropriate types of support at inappropriate times. For example, a newly divorced woman with a child may benefit from family emotional, financial, or child-care support initially, but she may also need to mobilize formal support services such as counseling, legal advice, and health care. She may eventually benefit from involvement in a self-help group for single parents. However, Bond & Wagner (1988) note that it is important to recognize that the needs of individuals and families may differ in regard to type of support needed depending on how far along they are in understanding and responding to the situation.

A second type of problem or deficiency occurs when the problem or event exceeds the capacity of the network to provide support. These events are usually situational in nature rather than developmental, and they are usually beyond the range of the collective experience of the network. For example, in dealing with catastrophic illness, such as a disabling stroke, it may be possible to

identify a person in the network who, with professional assistance, may be able to provide support to the caregiving spouse. This may be an adult child, a sibling, or a close friend who can be assisted to provide emotional or tangible support if he or she knows what to expect during the process of rehabilitation and is aware of the adjustments that need to be made in living with chronic illness. Other options may include volunteer linking, or providing the opportunity for support from someone who has undergone a similar experience and thus can provide realistic guidance. A support group such as a stroke club may be useful to the couple at some point as well, particularly if participants share a common age, ethnic or religious affiliation, geographic location, or viewpoint about the nature and resolution of the problem (Bumagin & Hirn, 1990). If none of these avenues of support can be mobilized, it may be appropriate to continue to provide direct support or to arrange for other sources of formal or professional support.

A third type of social support deficit relates to difficulties that an individual may experience in establishing or maintaining a support network. An individual may lack the social skills necessary to maintain a social network or to increase a friendship network. Or, the individual may possess the social skills but lack the opportunity or finances due to family responsibilities or other reasons. Although social skill development or information on how to initiate contacts may be helpful in those situations where it is applicable, careful assessment of the situation is necessary to ascertain the real basis for the problem. In some cases, a support network may be available for a specific purpose that is not immediately apparent. For example, although it may appear that an older person has no immediate family and no access to transportation, closer evaluation may identify a network of neighbors who provide transportation, do daily checks, and shop for groceries. On the other hand, it may be readily apparent that an older woman who is providing care for a dependent spouse is homebound and lacks access to any type of socialization or assistance. After evaluation of the need, creative solutions can be developed through direct contact with potential sources of support. Environmental considerations may also be addressed, if and when this is possible. Some families may not have access to support because of locale, choice of neighborhood, or selection of housing. At times the decision of an older person to live with an adult child may totally isolate the older person from his or her peer group as well as other social contacts. A newly divorced individual may choose to move to a different city, eliminating all current support systems at a time when they may be badly needed, or a young couple may begin a family in a city in which they have no extended family to provide support. Sometimes these issues can be considered during the decision-making process so that benefits and negative factors can be explored. If the environmental situation cannot be changed, then alternative supports must be explored and mobilized as indicated.

Another type of deficit may relate to the network itself; relationships in the family may not always be healthy, or they may be more stressful than supportive. Examples include the existence of family violence or substance abuse in which a spouse or parent can be the source of a great deal of stress but also a source of support. Other problematic areas may include the existence of dependent relationships, overly solicitous concern, or continuous pressure to change behavior. Although some areas may require intervention by mental health professionals, other less destructive patterns may be amenable to nursing intervention. In some situations, family members can be encouraged to seek reciprocal relationships with peers outside the kin network. These friendship networks may provide the individual with needed support in order to cope with family stressors such as an aging parent, a child with behavioral problems, or an unemployed husband. In some cases, it may be necessary to decrease face-to-face contact with a family member who exerts highly negative attitudes of influence, particularly in times of high situational stress. Successful intervention is based on careful evaluation of the problem and mobilization of sources appropriate to the family and situation, using the combined efforts of family members and nurse clinicians.

## Meshing Formal and Informal Supports

A major component of the professional nursing role in relation to social support concerns the mobilization of informal support systems. Because this is a frequently identified nursing intervention in many settings, it may be helpful to identify several approaches to working with informal helpers. As a professional, the nurse's philosophical orientation to practice may provide an overarching influence in relation to client care and the use of family members, friends, or volunteers to provide support. Bond & Wagner (1988) identify several factors that are useful in successful planning to prevent psychological and physical distress and to promote health. They include the importance of maintaining a multisystem, multilevel perspective; an emphasis on the promotion of competence; empowerment of individuals and groups; and sensitivity to the development process of individuals, families, and other systems. These factors can be operationalized by considering carefully the community and family context, by building on an individual's strengths, by seeing how people can help themselves or may be helped by others, by ensuring that people take responsibility for selecting the

help they need, and by identifying ways for people who share problems to share solutions. Family health nurses must also recognize that informal supports can be mobilized into a partnership if recognition is given to the differences in the mode of operation between professionals and laypersons. The degree to which nurses as professionals believe that knowledge confers a superior status or authority may influence relationships with informal helpers. In some cases, such a stance may have a positive influence in the situation, and in others, it may be a serious deterrent to providing support. Taking too strong a position on any subject or alienating family members may close off access to sources of help or assistance.

Another essential component of the nursing role is to ascertain the helper's ability or readiness to take the responsibility for aiding another. For some, the role expectations may be very different from those previously encountered, and many adjustments will be necessary. In addition, family health nurses must be aware of changes in the informal helping network and be prepared to make adjustments accordingly. Changes occur in the ability of the informal helper to provide support because of life transitions, fatigue, illness, accumulated stress, and other factors. Mobilization of other sources of support may be necessary from formal and informal sources in a short period of time. Such a situation may occur when a family has been able to provide care to an elderly relative in their own home but may not be able to continue if the person begins to hallucinate, wander, or become incontinent. The ability to be knowledgeable of and combine the use of informal and formal support systems is difficult and challenging. However, due to unique relationships with families and involvement in a variety of settings, family health nurses may be in the best position to initiate successful partnerships between formal and informal support networks.

## Social Support and Family Health Promotion

The family as a basic unit of health management is a critical determinant of the health status and practices of individual members. In proposing a Health Promotion Model, Pender (1987) identifies the importance of interpersonal variables on health-promoting behaviors, including the contributions of significant others, and on family patterns of health care. Significant others could be family members, confidants, or close friends who are capable of influencing another because of the close nature of their relationships. Many times these persons may share a common household, workplace, or recreational activity, which serves to strengthen the bond and provide more opportunities for interaction as well as for integration of health-promoting behaviors. Although family patterns of health care influence family members' beliefs, values, and attitudes about health behaviors, other systems or persons influence family members to modify specific health practices or make lifestyle changes. See the Family Health Promotion Model in Chapter 2. Unit III covers content related to family nutrition, exercise, recreation, stress management, sleep, and adjustment to family transitions, which all are improved by social support.

Peer groups, teachers, counselors, and the media may also have a profound effect on the health practices of individuals, altering the influence of the family situation in a positive or a negative manner. Interaction with health professionals is another variable that may encourage diet modification, adoption of a specific exercise program, or alteration of lifestyle. Family members and significant others are important interpersonal variables in the development of health behaviors, and they are significant components of the social network. As such, they have the potential to be influential sources of social support in developing and maintaining healthful lifestyles.

Although family members and significant others may influence health behaviors and act as sources of social support, the question remains concerning what type of support under what circumstances will enhance the health and well-being of individuals and families. Research on the health protective benefits of social support has resulted in inconsistent findings and is not readily transferable to clinical practice. This is due in part to the differing conceptualizations of social support from study to study and the reliance on subjective measures of health. Anderson & Tomlinson (1992) note that the concept of health reflects differing paradigmatic influences as well as differing degrees of specificity, centrality, and reductionism. Both within and outside the discipline of nursing, the construct of family health suffers from even greater definitional confusion. Thus objective measurement is complex and elusive. Minimal research exists about understanding family process in relation to health promotion, preventing illness, or recovering from illness. However, two general strategies concerning social support and family health promotion may be helpful to consider.

The first strategy focuses on improving the supportive quality of network contacts. This strategy is based on the landmark work of Cassel (1974), who hypothesized a connection between deficiency of people's primary group ties and increased vulnerability to disease. He suggested that families and groups at risk be identified by their lack of fit with the social milieu and that the nature and form of social supports be determined and strengthened to protect these groups from disease outcomes. Family health nurses can implement this strategy in many different ways in a variety of settings. For example, developing educational programs in parenting that enhance

parent-child communication and include childrearing practices that foster self-esteem can lead to enhancement of family ties, decreased stress, and a supportive atmosphere for health-promoting lifestyles. Middle-aged persons caring for aging parents can be taught methods of providing support that permit elders to maintain independence and control over their own lives as long as possible, thus decreasing the situational stress involved on both sides. Either of these approaches could be particularly helpful to persons who are distant from immediate family members or whose role demands lessen social support opportunities.

A second general preventive strategy concerns providing people with access to meaningful social ties. In order for this strategy to be successful, opportunities must be available that maximize the expression of social support. Family health nurses can implement this strategy and foster health promotion by encouraging clients to seek information and support from qualified professionals, peers, self-help groups, and educational programs appropriate to their health needs. A support group may be helpful to assist persons to stop smoking, adjust dietary habits, or participate in an exercise program. Nurses can also facilitate the formation of support groups within the context of their practice to meet the needs of particular families who may be experiencing life transitions or other stressors. Family health nurses can provide information and explore alternatives prospectively with families in life circumstances that herald the approach of certain types of life events, such as caring for a disabled member, raising a grandchild following parental separation, or coping with chronic illness. For example, based on the results of a qualitative study, Kendall (1992) notes that support groups can be very helpful for persons with HIV. She recommends such groups be focused on human connections and believes that the groups can be used to help members reformulate meaning in their lives despite the possibility of death in the future. Since many HIV-infected individuals may be isolated from family and other sources of support, such a group may be of assistance to promote wellness or quality of life.

Because the social environment is capable of radiating both support and stress and because individuals differ in their receptivity toward the skillfulness in using social support, the implementation of these strategies presupposes a comprehensive network analysis and consideration of cultural determinants. The major strategies of improving access to social support and increasing the quality of available social support may be conducive to encouraging positive health behaviors in families and promoting lifestyles that enhance their well-being both in the present and across future generations.

## Implications for Nursing Research

Because family health nurses are involved in both direct and indirect clinical roles, multiple opportunities exist to define more clearly the concept of social support in relation to nursing practice. The family health system is emerging as a paradigmatic view for nursing, and Anderson & Tomlinson (1992) have proposed a classification that can be used to organize knowledge generation. The ultimate goal is the development of theory-driven interventions derived from conceptualizations about the future of family health. Kane (1988) indicates that empirical investigations of social support available to families is hampered by the lack of a theoretical basis. She proposes a conceptual model that presents family social support as a process of relationships between the family and its social environment. Both of these efforts are useful in addressing problems

## CHAPTER HIGHLIGHTS

A family may have different types and qualities of social support within the family or in other social relationships; however, the family's or individuals' perceptions of the value of the beneficial effects of the social support determine the outcome.

The types of social support include emotional, tangible, and informational support.

The evidence to support relationship of social support as a buffer for stressful life events and psychological distress is inconsistently reported in the literature.

In some families the quality of interactions and network influences health status and involvement in health promotion activities.

Assessment of social support can be facilitated by a diagram of the family constellation that shows intergenerational relationships and by a diagram of the family's contact with people, agencies, and institutions outside the family.

Social support deficits occur as a result of (1) loss of support, (2) when the problem exceeds the capacity of the network to provide support, (3) difficulty in establishing or maintaining a social support network, and (4) dysfunctional relationships.

The major family health nursing role is to assess a family's social support and to assist the family to identify and mobilize informal and formal support systems within the family and the community.

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related to the inadequate conceptualization of family health and social support. Barrera (1988) states that there is a necessity to explore other models beyond the Stress Buffer Model of social support to examine the effects of alternate coping resources and those variables which provide linkages between social support, stress, and distress. He also recommends further longitudinal studies to explore changes in the process of recovery from life stress and the changing needs of persons involved, as well as the relationship between positive life events and social support. Ryan & Austin (1989) note that nurse researchers are making considerable progress in developing instrumentation, hypothesis testing, and expanding theories. However, future research directions could include the exploration of problematic social ties, the timing of social support, the effectiveness of certain types of support under specifc circumstances (health, illness), and the availability and effectiveness of social support interventions. Consideration should also be given to exploring the concept with differing cultural groups and variant family forms. Although some attention has been given to family-centered research, issues of recruitment, measurement, and retention of multiple subjects provide considerable challenges (Moriarity, 1990). As family health nurses research these areas in relation to their own areas of practice, greater specificity regarding appropriate interventions and expected outcomes will be possible.

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