This is to certify that the

thesis entitled

Perceived Social Support and Physical and its Effects on Mental Well-being of the Able Elderly

presented by

Anat Barlev

has been accepted towards fulfillment
of the requirements for

Master degree in Arts

L Abeles

Major professor

Date 12-15-99

PERCEIVED SOCIAL SUPPORT AND ITS EFFECTS ON MENTAL AND PHYSICAL WELL-BEING OF THE ABLE ELDERLY

By

Anat Barlev

A THESIS

Submitted to
Michigan State University
in partial fulfillment of the requirements
for the degree of

MASTER OF ARTS

Department of Psychology

1999

ABSTRACT

PERCEIVED SOCIAL SUPPORT AND ITS EFFECTS ON MENTAL AND PHYSICAL WELL-BEING OF THE ABLE ELDERLY

By

Anat Barlev

The following study addressed the relations between Perceived Helpfulness of Confidants and Depression, Actual Health, Perceived Health, and Memory Complaints among 206 community-dwelling older adults (Mean age = 71), and also investigated the relationship between gender and Perceived Helpfulness of Confidants. Participants who reported having a confidant had significantly less depression than participants with no confidant (t (204) = -2.458, $p < .05$). In addition, higher Perceived Helpfulness of Confidants was related to better Beck Depression Inventory (BDI) scores, better Actual Health, and better Perception of Health (r = -. 298, r = -. 185, r = -. 214; df = 205, $p < .01$). Greater depression was related to higher Memory Complaints (r = .233, df = 205, $p < .01$). In addition, the majority of married men named their spouse as a confidant while married women named a non-spouse as a confidant (Chi-square = 41.069, df = 1, $p < .001$).

To all the people that help me believe in my dreams.

ACKNOWLEDGMENTS

I have been very fortunate to be surrounded by a supportive network of people that I treasure, who sincerely care for my well-being. First, I would like to thank my advisor and committee chairperson, Dr. Norman Abeles. Dr. Norman Abeles truly cares about his students. He has helped me grow and develop as both a clinician and a researcher. I am most thankful for his generosity with his precious time. No matter how busy he is, he has always made himself available when I needed his help. Thank you Dr. Abeles. I would also like to express thanks to the members of my thesis committee, Dr. Joel Nigg and Dr. Rey Frankmann. Dr. Joel Nigg offered many helpful comments and crticisms throughout the completion of this thesis, but more importantly he always made me believe that I can take the extra step to improve my work. Many thanks also go to Dr. Ray Frankmann, for passing some of his abundant statistical knowledge to me, and for always expecting the best of me.

I would like to thank my Mother and Father for their support and encouragement. I would not be the person I am today without their love and modeling of what it means to be a good person on this earth. I would especially like to thank my brother, Arie, who kept his belief in me, even when I stopped. Arie- I am very fortunate to be your sister. I would also like to thank Paulina Barlev. Paulina- I am very glad that you became a part of our family.

Finally, I'd like to thank Alex Grimm for always being there for me, even when I could not be there for him. Alex- I am very fortunate to have you in my life.

TABLE OF CONTENTS

LIST OF TABLES

INTRODUCTION

Many different types of social support have been discussed in the literature. These include (1) Esteem support: information that one is esteemed and accepted; (2) Informational support: help in coping with problematic events; (3) Social companionship: spending time with others in leisure and recreation; (4) Emotional support: emotional support when needed; (5) Instrumental support: provision of financial aid, material resources and needed services. Different types of social support are distinct in theory; nevertheless, many are often mixed in practice. This particular study focused on perceived emotional support.

Barrera (1986) divides all types of social support into three dimensions. These are (1) *Social embeddedness*: focusing on the size of the network, the number of connections or linkages individuals have to other persons; (2) *Perceived support*: which consists of subjective appraisal of support, satisfaction with relationships, and perceived closeness to network members; and (3) *Enacted or received support*: how much help an individual receives from his or her network.

According to Robinson and Garber (1995), there are clear differences between social embeddedness, perceived support, and enacted support. They suggest that a division of social support exists because measures of enacted support and the size of support networks were not strongly related to measures of perceived support. Perceived support was more highly correlated with well-being than received support or size of social network, reinforcing the notion that these two dimensions may have different roles to play in the support process (B. R. Sarason et al., 1987).

Social support plays a major role in life satisfaction and well-being of younger and older populations. Positive relations between social networks, support, and interpersonal adaptation have been consistently shown for adults (Cohen & Wills, 1985). Social support networks and availability of support also have been identified as protective factors in studies of risk for poor behavioral and mental health outcomes in children (Bost, Vaughn, Washington, Cielinski & Bradbard, 1998).

Social support changes throughout one's lifetime. During infancy, caretakers and family usually dominate social networks. During childhood, the social network expands to include other adults and peers. There is also a shift toward developing greater intimacy relationships with peers. Peers begin to play an important role in the child and young adolescent's life. Older adults however, report smaller social networks and spend less time with others in comparison to young adults and children. The following study investigated perceived helpfulness of confidants and its effects on depression, physical health, perception of health, and memory complaints in the able elderly. In other words, perceived helpfulness of confidants' impact on the elderly was investigated. We begin by discussing models of social support.

Models of Social Support

There are two main models of social support: direct effect and stress-buffering models. Robinson and Garber (1995) review these models.

First, the direct effect model suggests that perception of high social support contributes to well-being. Despite the level of stress encountered, social support has a negative relation with distress and a positive relation with adjustment. Also, deterioration in the social network (Social Embeddedness), or the amount of support received from the

social network (Enacted Support), can result in increased distress and possible psychopathology. It can lead to low perception of support. For example, regardless of how individuals become depressed, adequate social support or its absence, improves, maintains or exacerbates the depressive condition.

Second, the stress-buffering model according to Cohen and Wills (1985), suggests that social support protects individuals from the potential harmful influences of stressful events. According to the model, high perception of social support is hypothesized to prevent the occurrence of stressful life events. Social support could potentially affect how a particular event will be perceived; it may be perceived as a threat and result in stress or it may be perceived as less of a threat and result in less stress, or even increased well-being.

According to Cohen and Wills (1985), social support can be a buffer against stress. The other possibility, the direct-effect model of social support benefits individuals whether or not stress is present. Cohen and Wills suggest that a general beneficial effect of social support could occur because it "provides persons with regular positive experiences and a set of stable, socially rewarded roles in the community" (p.311). This kind of support is related to overall well-being and it provides a sense of predictability, stability and respect in a person's life. Lang, Featherman, and Nesselroade (1997) found that when individuals perceive others to be available across time, social self-efficacy beliefs are strong. In other words, whenever individuals perceive adequate social support, they feel better about themselves as a person in this society.

Williams, Ware, and Donald (1981) found that life events and social support do not have to interact directly. Instead, adequate social support has a positive effect for an

individual regardless of the severity of one's life circumstances. This supports the direct effect-model of social support. Fernandez, Mutran, and Reitzes (1998) suggest that the direct effect rather than the buffering model is more significant in explaining the effects of social support, self-esteem, and stressors on depression. According to Depner and Ingersoll-Dayton (1988), being involved in social relationships is already beneficial to well-being since it contributes to one's feeling of integration in the society. That can contribute to adequate perception of social support.

Demographics

For the elderly population in the United States, life expectancy is 73 years for men, and is 80 years for women. After age 80, women outnumber men by almost 3 to 1. Those who make it to an older age such as 65 can expect to live longer, 19 years for women and 15 years for men (La Rue, 1992). According to the American Psychological Association (APA) working group on older adults (1998), the population of Americans 65 years and older has more than tripled since 1900. About 13 percent of the U.S. population include persons over 65 years. By the year 2030, it will increase to approximately 20 percent. The older population is getting older.

The older population may be divided into 3 sub-populations: "younger old" (ages 65-75), "older old" (ages 75-85), and "oldest old" (ages 85+). From 1900 to 1994, the "younger old" (ages 65-74) sub-population became 8 times larger; the "older old" (ages 65-75) sub-population became 14 times larger; and the "oldest old" (ages 85+) population became 28 times larger. Apparently the "oldest old" sub-population is growing faster than the other two sub-populations. Also, the ethnic and racial minority sub-population over 65 years old is growing faster than the older population in general. Minority persons

are expected to represent up to 25 percent of older adults by the year 2030.

Psychological Well-being of Older Adults

According to the APA working group on older adults (1998), family and friends are important social supports for many elderly. About four of five older adults report having at least one confidant, that is someone they can talk to and share intimate details of their lives with. General life satisfaction at older age is relatively good, and is associated with good health, satisfying with financial situation, reliable social relationships, and a sense of control over one's life. Older adults usually maintain a positive outlook on life and may seek new challenges and activities that stimulate their mind and contribute to their well-being. For example, they take classes, exercise, study new things, travel, etc. However, there are also problems that older adults experience. Depression is one of the growing problems among older adults.

Older Population and Depression

According to Cohen and Wills (1985), high social support has a well-documented association with lower depressive symptoms and higher life satisfaction for older adults. The study of the social environment of the depressed older adult is pivotal to the understanding and management of depression in later life. Blazer (1983) found that depressed subjects tend to have physical health impairment, and impairment in activities of daily living. In addition, impairment in social support was frequent in the depressed. This investigation showed that depressed elderly were likely to have non-supportive social networks. Also, high perception of social support was a significant predictor of reduction in major depression at follow-up.

Surveys collected in the U.S. and several European countries showed that about

1%- 2% of older adults have been found to have major depressive disorders. Rates of clinically significant depressive symptoms are higher in older than in younger adults. Depressive symptom counts reflect symptoms that are attributable to minor depression, bereavement, substance abuse, or a medical condition (Kasl-Godley, Gatz, & Fiske, 1998). Older adults experience more medical conditions and more bereavement than do younger adults. Psychological symptoms and syndromes often co-exist with physical illness (APA working group on the older adult, 1998).

According to the APA working group on the older adult (1998), major depressive disorder affects about 1 percent of older adults, while dysthymia, a less severe form of depression affects about 2 percent of older adults. Major depressive disorder is the most common late onset psychological problem in older adults. Mood disorders can present themselves differently in older than in younger adults. About 20 percent of older adults in the community report clinically significant depressive symptoms. Older adults who are in the hospital, either outpatient or inpatient, and those in long-term care settings, are considered to be at high risk for depressive symptoms and syndromes. The highest suicide rate of any age sub-population is found in older adults. Suicide risk increases dramatically for Caucasian men ages 65 to 85 who live alone.

Older adults who are suffering from depression are likely to experience anxiety, agitation, memory problems, and bodily complaints. Thus one might expect that older adults report greater amounts of clinically significant depressive symptoms. However, older adults are less likely to complain of depression or feeling sad than other sub-populations. Depression can be associated with memory complaints and cognitive impairment (APA working group on the older adult, 1998). Somatic symptoms and

memory complaints often mask depression. The well-being of older adults is influenced by various concerns including perceptions of poor memory performance. Specifically, many older adults complain about poor memory performance, when in fact, their memory performance is intact.

Memory Complaints and Depression

There is a marked incongruity between complaining about memory and actual memory performance. Williams, Little, Scates, and Blockman (1987) stated that complaints about memory can occur with or without an actual deficit in memory. Older adults who complained about memory, sometimes performed better on memory tasks than those who did not complain. What can account for memory complaints? The Larrabee and Levin (1986) study supports the indication that patients' memory self-ratings were mostly related to the affective state rather than to objective memory performance. For those individuals whose depression lifted, either through the administration of anti-depressants and/or therapy, memory complaints declined. Also, subjective memory complaints are predicted to have a stronger link with somatic aspects of depression rather than mood-only related characteristics of depression (Collins & Abeles, 1996). That investigation showed that both affective and somatic aspects of depression were significantly related to subjective memory complaints.

Levy-Cushman and Abeles (1998) found similar results. Elderly people who reported greater memory complaints, scored higher on the Beck Depression Inventory (BDI; Beck et al. 1961) and the Geriatric Depression Scale (GDS; Yesavage, Brink, Rose et al., 1983), than those who reported fewer memory complaints. In addition, greater number of physical health complaints were reported with higher reported memory

complaints.

Social Embeddedness

The social network of the older adult (Social Embeddedness) is often more fragmented at older age than at other time periods of life. Older adults may be more vulnerable to the harmful effects of an impaired social network than other populations (Blazer, 1983; Prince et al., 1997). Depner and Ingersoll-Dayton (1988) suggest that aging affects the social network by reducing its size, but also by increasing the need for support. Older adults experience the loss of loved ones including spouses, other family members, and friends more frequently than younger adults (APA working group on the older adult, 1998). As a result, the social network becomes smaller. If the social network is small and not as much support is available during difficult periods of time, less support may be perceived.

Perception of low support is associated with depression. There is evidence that perceptions of adequate support are associated with decreased depressive symptomatology (Fernandez, Mutran, & Reitzes, 1998; Kessler et al., 1994; Krause, 1997; Oxman et al., 1992). Oxman and Hull (1997) came up with three explanations as to how perceptions of adequate support are associated with decrease in depressive symptomatology. First, people who perceive adequate support are more likely to receive the type and amount of support they need. Second, perception of adequate support buffers the effects of stressful situations. And third, perceptions of adequate support provide a general belief that one is cared for and valued.

Revicki and Mitchell (1986) studied a sample of 210 adults age 65 years and older. They examined four social support factors that affected physical and mental health

of their sample. These were (1) Support intensity: the socioemotional value of social contacts; (2) Social contacts: the frequency of social contacts; (3) Social resource availability: instrumental assistance provided by the social network, and (4) telephone contacts: the frequency of telephone conversations. Older adults with many social contacts reported fewer mental and physical health problems. The number of social contacts and available resources from others contributed to an adequate perception of social support. Older adults with active and frequent social contacts and perceived availability of support, were more likely to perform physical and instrumental activities of daily living. It is likely that the greater the support one receives, the greater the perception of adequate support.

Physical Well-being

Physical well-being in older age is subject to many different factors. Functional limitations caused by physical disability can have devastating effects on psychological well-being. A significant relationship seems to exist between an elder's level of perceived social support and health risk (Lubben, Weiler, & Chi, 1989; Veiel & Baumann, 1992). In other words, adequate perception of social support can benefit one's health. There are four theories that can account for the relationship of social support and health (Lubben & Gironda, 1996). The first states that if an individual has strong social ties, vulnerability to stress-related illness may be reduced (Thoits, 1982). It is speculated that believing that one has good communication with a support network can stimulate the immune system, and protect one against illness. A second theory suggests that social isolation can have a direct physiological effect, increasing rates of morbidity and mortality among older adults (Berkman, 1985; Blazer, 1982). A third theory posits that a

strong social support network can encourage an elder to engage in health enhancing behaviors, and a fourth theory states that during an illness, social networks can provide the appropriate support that will lead to better recovery (Cohen & Syme, 1985). An additional explanation could be that there is also a tendency on the part of older adults to provide less assistance and be less helpful to others when they are not well themselves. That can make older adults feel less productive and positive, and in turn lead to depression and physical illness (Buunk & Hoorens, 1992).

Oxman and Hull (1997) reported that older adults who had a close supportive social network a month before undergoing open heart surgery, had positive perceptions of their social support a month after surgery. Perceived adequacy of social support one month following surgery predicted less depression and less impairment in activities of daily living for the elderly.

Inadequate social support has been associated with an increase in mortality rates among people of all ages (Blazer, 1982). According to Levitt et al., (1985) stress increases the salience of support, particularly if health is considered as a factor. There is a relationship between physical disability, health problems, reduced life satisfaction and suicidal ideation (Blazer, Hughes & George, 1992; Rudd, 1993). In other words, health problems and reduced life satisfaction contribute to suicidal ideation. Physical disability can impair an individual's social support network. An older person with a physical disability might use the phone less and go out less often. This in turn will lead to less contact with a support network and will lead to low perception of available social support. In addition, perceiving inadequate social support can lead to feelings of loneliness, abandonment, depression and physical illness. This would be deleterious to

life satisfaction, health and well-being of the older adult.

Cutrona, Russell, and Rose (1986) examined the effects of stress and social support on the physical and mental health of the elderly. Subjects were interviewed initially and then interviewed for the second time after 6 months. The average age of the sample was 70, and 62% of the sample were women. Older adults who perceived higher levels of social support at the initial interview, reported better physical health at the second interview than those who initially perceived lower social support. This is an example of how perception of social support can lead to better or worse health outcomes.

The degree of physical disability can also have an impact on social support. According to Newsom and Schulz (1996), older adults with greater physical disability reported fewer sources of instrumental support and face-to-face contact with network members. In addition, Newsom and Schulz (1996) found that satisfaction with the social network was perceived to be very low with increased physical disability. Lower levels of perceived support, were associated with greater physical impairment. Perceived support measures were the strongest predictors of life satisfaction. The higher older adults' perception of availability of social support, the higher was the rating of life satisfaction, health, and perceived health.

Perceived Support and Depression

What comes first?

One can ask whether or not there is a cause and effect relationship between social support and well-being in older adults. The question of causality can be difficult to ascertain when it comes to the association between perceived social support and symptomatology of depression. When a person is depressed, the person may perceive

their social support more negatively than it is. Higher levels of depression can lead to fewer interactions with network members, and actual decline in social support. However, if older adults have low perception of their social support, it can lead to stress, depression and can eventually turn to a physical illness. Phillips and Stanely (1994) reported that older adults who experience stressful life events have lower perceptions of available social support. Before having sought help, older adults demonstrated poorer psychological well-being, reported more physical health problems, indicated a higher level of unpleasant stressful events, and perceived greater deficits in the amount of social support available to them. According to these data, perception of low social support can lead to low perception of physical and mental health well-being.

Newsom and Schulz (1996) through structural equation modeling separated depression and social support. Their results suggest that depressive symptomatology is a cause rather than a consequence of lower social support. The authors demonstrated that lower perceived social support increased levels of depression. They support that perceived support is of greater value than instrumental support in the prediction of depressive symptomatology.

Quality of Support

Potts (1997) studied a retirement community and examined the role that friends play in older adults' life. Concerning size of the network (Enacted Support), older adults who live in the retirement community reported having a larger number of friends living within the retirement community, than friends living outside the retirement community. However, both perceived quality and confidant relationship scale scores were higher for friends living outside of the retirement community than for friends within it. Perceived

adequacy of social support from friends living outside the retirement community predicted low levels of depression, whereas perceived social support from friends within the retirement community failed to do so. This demonstrates that adequate perception of social support, which according to Barrera (1986) is satisfaction with relationships and the closeness one feels towards his or her network members, is related to lower symptomatology of depression. The length of time respondents lived in the retirement community had no effect on respondents' levels of depression and their reported levels of social support from friends living inside or outside of the retirement community.

Antonucci, Fuhrer, and Dargigues (1997) found similar results. They examined the association between social relations and mental health, specifically the effects of social networks (Social Embeddedness) and social support (Perceived Support) on depressive symptomatology. The sample consisted of 3,777 non-institutionalized older persons over the age of 65, living in southwestern France. The first independent variable used social network measures and the second independent variable used social support measures. The interaction between social network and social support measures was also investigated.

A social network describes the structure of the network, who is in the network and how many members are in the network. Social support was defined as the qualitative aspect of the support, how satisfied members were with the support they received. This measures perception of support (Barrera, 1986). The results demonstrated that older adults who were satisfied with the quality of their support relationships reported significantly lower levels of depressive symptomatology, than those who were less satisfied (Antonucci et al., 1997).

This study demonstrated that a social network that included a combination of family and friends was associated with reduced depression, as long as there was satisfaction with the quality of the relationships. The quality of the relationships contributed more to well-being than the number of members in the social network. Perceived support contributed more to well-being than Enacted support. If an elderly person has a large network that contains family and friends, but satisfaction with the quality of the relationships is low, well-being would be rated low. If the person has fewer members in the network but is satisfied with the quality of the relationships, well-being would be rated high. This supports the notion that perceived satisfaction with social support is more predictive of well-being than received social support. Quality relationships in one's life may be sufficient to contribute to perceived adequacy of psychological and physical well-being of the older adult.

Quality relationships such as reporting having a confidant, a person that one can share all their troubles and concerns and feel close to, is believed to be beneficial for the older adult's well-being. According to Silliman (1986), life stress precipitates the onset of depression and having a confidant can be protective in certain situations for older adults. The confidant model predicts that the most important feature of a person's social network that contributes to their well-being is whether or not they have a confidant. Vasudha and Korte (1994) argue that a confidant is significant to the need for intimacy and emotional security. According to Zunzuneguie, Beland, Liacer and Leon (1998), elderly persons who were involved in social activities and had someone to confide in, reported less depressive symptomatology than older adults who were involved in social activities but had no one to confide in. They also found that men were more likely than

women to lack a confidant. The confidant model implies that having a quality relationship with at least one person contributes to the well-being of older adults greater than a large social network that lacks a confidant.

Family and Friendship Relationships

Newsom and Schulz (1996) reported that family contacts more strongly predicted perceived support, suggesting that the participants in the study based their assessment of support more on contact with family than with friends. Although receipt of support from friends is important for older adults, there could be a difference between perceiving availability of support from family and actual receipt of support from family. Cicirelli (1989) suggests that the existence of siblings in older people's lives, rather than the frequency of interaction with them can be sufficient to account for well-being. In other words, perception of support from family contributes to well-being of older adults. It seems that feeling help from the family is available as opposed to receiving help from the family are two different processes.

Silverstein, Chen, and Heller (1996) found that initially, excessive instrumental support from children, specifically for the widowed subjects and also for married subjects, led to some elevation in mood, but later it led to decline in mood. The authors suggest that older adults can view excessive instrumental support from children as "...loss of autonomy and control associated with relying on others for the satisfaction of basic needs" (p971). This suggests that instrumental support is of lesser value than perceived support and can even harm well-being of older adults.

Arling (1976) found that widows who had children living close-by had no higher morale than widows who did not have living children, or whose children lived at least an

hour away. In this study, widows' involvement and contact with friends was more strongly associated with well-being than involvement with their children. Widows had close relationships with friends and that led to higher perception of support from friends. It is suggested that perceived support from friends is a stronger contributor to older adults' well-being than perceived support from children. Depner and Ingersoll-Dayton (1988) strongly recommend distinguishing between relationships that older adults have with their families-spouses, children, and siblings-and those they have with friends. The authors argue that each kind of a relationship is associated with different kinds of support. They also suggest that there are gender differences for older men and women in their social interactions.

Gender Differences

Levitt, Antonucci, Clark, Rotton and Finley (1985) and Akiyama, Elliott, Antonucci (1996) suggested that aging can cause alterations in some, but not all aspects of support. They found that men and women tend to draw on different sources of social support. Men rely more heavily on the spouses' relationship. Women on the other hand, tend to draw on a more extended network for support. Among the married elderly, men claimed that they receive most support from their spouse; women report receiving most support from persons other than their spouse. This finding can be explained by men's reports that they are more satisfied with their marriage than women, and that women are more satisfied with friends (Antonucci & Akiyama, 1987).

Akiyama et al. (1996) found that elderly men and women, married or unmarried reported that they have more women in their network than men. It is important to note that ecologically, in the population, the number of older women is larger than the number

of older men. Cicirelli (1989) found that men who have siblings are closer to their sisters than to their brothers. Also, women's closeness to their brothers was significantly greater than men's closeness to their brothers. For both genders, conflict with a sister led to higher rates of depression. According to this investigation, the perception of close relationships with sisters is important for both genders. An additional explanation for having more women in a social network than men for both genders is that it may be socially easier to get closer to women than to men. Antonucci and Akiyama (1987), and Depner and Ingersoll-Dayton (1988) found that women were more likely than men to have more friends in their social network, and therefore were more likely to receive emotional support from their friends. This leads to the speculation that women in general receive and give more emotional support than men.

Conclusion

This review of the literature strongly suggests that social support plays a major role in older adults' lives. Perception of social support is the subjective appraisal of support. According to Barrera (1986), it has two main components: satisfaction with the relationships, and perceived closeness to network members. High perceived social support seems to be of greater benefit to the well-being of older adults than actual receipt of support (Enacted support) or the number of people that are in the social network (Social Embeddedness) (Blazer, 1982; Cohen & Syme, 1985). Low perceived support is associated with depression and physical health impairment. The importance of the quality of social relationships versus the number of persons that is in the network has been compared. It is suggested that having quality relationships (e.g. confidants), and perceiving these relationships as helpful contributes to the well-being of older adults.

Specifically, quality relationships are more significant than the number of people in someone's social network. Quality of relationships contributes to perception of high social support. The literature suggested gender differences between elderly men and women. It demonstrated that men and women tend to have different social networks. Men rely more heavily on the spouse and women rely on a more extended social network.

It was noted that depression is related to memory complaints. Is it possible that social support is also related to memory complaints? Specifically, can high perception of social support lead to fewer memory complaints? Memory complaints and depression, as well as memory complaints and perceived social support were examined in this study.

HYPOTHESES

In light of the above literature review on social support, depression, physical health, and memory complaints in the able elderly, the following hypotheses are offered:

1. Participants who report having at least one confidant in their lives, someone they can talk with about all their troubles and concerns, will have lower depression scores, higher perceptions of health scores, higher actual health scores, and lower memory complaints scores than subjects who do not report having a confidant.
2. Participants who indicate strong support from their confidants will have better scores for depression, actual health, perception of health, and memory complaints, than will participants who indicate weak support from their confidants. Helpfulness scores (Perceived Social Support) will correlate negatively with BDI, actual health, and memory complaints scores, and positively with perception of health scores.
3. Participants with greater depression will report significantly greater memory complaints. Depression scores will correlate positively with memory complaints. In addition, participants with no depression will have significantly lower memory complaints than participants with higher level of depression.
4. There will be gender differences in regard to social support, as well as the type of confidant specified. First, women will report a greater number of confidants than men. Second, women will perceive higher helpfulness ratings for confidants than men. In addition, married men will name their spouse as a confidant while married women will name someone other than their spouse as a confidant.

METHODS

Participants

Two hundred and six participants aged 55 and older were recruited from senior citizen groups, senior nutrition sites, and retired faculty from Michigan State University (MSU). Phone calls and subsequent site visits were made to the senior citizen groups and nutrition sites. A 20-minute explanation of the project was presented and individuals were invited to sign up for a structured interview and mental health assessment inventories. Follow-up phone calls were made to schedule actual appointments. Individuals were given the option of contacting the coordinator of the project by phone and scheduling an appointment at that time. Retired staff and faculty from MSU were sent flyers describing the project along with a cover letter, which instructed them to call the MSU Psychological Clinic to arrange appointments if they were interested in participating in the research.

Procedure

Individuals who agreed to participate either came to the MSU Psychological clinic or a home visit was arranged if travel to the university was not possible or not wanted. Trained graduate students from the department of Psychology at MSU administered interviews and tests. All participants signed a permission form, which gave them the option to terminate participation at any time. The entire structured interview, and mental health assessment inventories took about 1-1.5 hours to administer.

Also, feedback either in person or by telephone was given to every participant in the research. The feedback was designed to give information to participants regarding their mental health. If significant depression or other mental health concerns were

found, this was conveyed to the individual along with proper counseling referrals.

Measures

1) Multilevel Assessment Instrument (MAI)

(Lawton, M. P., Moss, M., Fulcomer, M., & Kleban, M. H., 1982).

The MAI is an interview capable of measuring the well-being of the aged in the areas of behavioral competence (health, cognition, time use, social interaction, etc.), psychological well-being, and perceived environmental quality. In the development of the MAI, the performance of 590 older people in groups composed of community residents, in home service clients, and people awaiting admission to an institution was determined. Interviewers received three days of intensive training. All 590 respondents were interviewed in their homes.

Reliability: Summary rating scales in seven domains were completed by using an interviewer and a "reader-rater" for 484 of the 590 respondents and by an interviewer and interview observer for the remaining 106. According to Lawton et al, "In the sample of 484, interviewers and reader-raters agreed with either a 0 or 1 point discrepancy in 95% of all instances: intraclass correlations ranged from .88 (Activities of Daily Living) to .58 (Social Interaction"). Reliabilities (Alpha) of the 7 main MAI scale domains were as follows: Physical health (.74), Cognition (.87), Activities of daily living (.93), Time use (.71), Social interaction (.77), Personal adjustment (.86) and Perceived environment (.81). Retest reliability, done at a 3 week interval on 22 cases was acceptable, with the exception of the physical self-maintenance sub-index, where the variability was very low, the majority receiving a perfect score. The Social interaction form includes two subindices defined by a principal components analysis that yielded two firm and

rationally meaningful factors: interaction with friends, five items and interaction with family, six items. An additional eight items were retained for the full domain index because of their face validity. They included Lowenthal's 1964 "confidant" item and number and proximity of friends and relatives who live outside of someone's home.

Validity was determined by doing summary ratings, multiple correlations, and by constructing a "dummy variable" representing independent versus dependent groups. Lawton et al, conclude that the reliabilities and validities of the MAI indices and subindices were affirmed by several different approaches.

The Use of the MAI: Because analysis has been done separately for each domain, portions of the MAI need not be used if desired. For the present study, the researcher added two additional questions pertaining to the presence and helpfulness of confidants. Reliability data would be reported about the current sample.

2) Beck Depression Inventory (BDI)

(Beck, A. T., Ward, C. H., Mendelson, M., Mock, J., & Erbaugh, J., 1961).

The BDI is a 21 item, 4-point discrimination scale that rates the intensity of depression symptoms. Psychometric properties of the scale are reviewed in Beck et al., (1961). High correlation on the Spearman-Brown split-half item analysis ($r = 0.93$), and the significant relationship between the individual category scores and the total scores indicates high reliability for the instrument. Highly significant relationship between the scores on the inventory and the clinical ratings of Depth of Depression (in the two validation studies, study I, $r = 0.65$, and study II, $r = 0.67$) and the power to reflect clinical changes in the Depth of Depression, attest to the validity of the instrument. This

inventory has been studied for reliability and validity in the elderly (Gallagher, Niles, & Thompson, 1982; Gallagher, Breckenridge, Steinmetz, & Thompson, 1983). Results of studies with the elderly show that the BDI has respectable internal consistency and stability for use in research with this population. For example, congruence between conventional cut-off scores on the BDI and selected diagnostic classifications of the Research Diagnostic Criteria (RDC) (Spitzer, Endicott, & Robins, 1978) for detection of Major and Minor Depressive Disorders in 102 elderly outpatients was high. Only 16.7% were misclassified by customary BDI cutoff scores (Gallagher et al, 1983). These results indicate that the BDI can also be used as a screening instrument for identification of clinically depressed elders.

CONSTRUCTION OF SCALES

For the purpose of this study, the following scales have been constructed:

Perceived Helpfulness of Confidants: Each participant identified zero or more confidants and rated each of these on a Likert Scale that ran from (1) "not helpful" to (5) "extremely helpful." These ratings were summed for each participant to create a "helpfulness" score. The internal consistency of the scale was satisfactory (reliability for the current sample, Cronbach's alpha = .89, item-total correlations ranged from .45 to .76).

Depression: Each participant completed the Beck Depression Inventory (BDI). The scores on all the inventory items for each participant were summed. These sums ranged from [0-33]. For the BDI, higher sums indicate greater depression levels. The internal consistency of the scale was satisfactory (reliability in the current sample, Cronbach's alpha = .77, item-total correlations ranged from .11 to .57). The BDI was also divided into levels of depression according to Beck (1987). A score of 0-9 indicates a normal range; 10-15 indicates minimal depression; 16-19 indicates mild to moderate depression; 20-29 indicates moderate to severe depression, and a score of 30-63 indicates severe depression. Since only one subject received a score above 29, we did not make a severe depression category and excluded this score from the scale.

Perceived Physical Health: This scale was established by summing items 13, 15, and 16 on the MAI. Subjects could score a total of 3-10. Higher scores indicate a greater perception of health. The internal consistency of the scale was satisfactory (reliability in the current sample, Cronbach's alpha = .70, item-total correlations ranged from .48 to .62).

Actual Health: This scale was established by summing the standardized scores of items 17, 18, 19, and the total number of illnesses listed from items 22a through 22x of the MAI. The internal consistency of the scale was satisfactory (reliability in the current sample, Cronbach's alpha = .67, item-total correlations ranged from .44 to .64).

Memory Complaints: This scale was established by summing the raw scores of items 24, 24a, 25, and 25a from the MAI. The internal consistency of the scale was satisfactory (reliability in the current sample, Cronbach's alpha = .65, item-total correlations ranged from .35 to .54). Higher scores indicated greater memory complaints.

Analyses

To test hypothesis 1, independent sample t-tests compared mean depression, perception of health, actual health and memory complaint scores between those that report having a confidant and those with no confidant.

To test hypothesis 2, Pearson r correlations were computed between helpfulness score and depression, perception of health, actual health, and memory complaints.

To test hypothesis 3, Pearson r correlation was computed between depression scores (Beck Depression Inventory) and memory complaints. In addition, an independent sample t-test was conducted between no depression and a higher level of depression.

To test hypothesis 4, independent sample t-tests compared between gender and number of confidants as well as gender and helpfulness of confidants. Also, a Chi-square test between gender and type of confidant specified was conducted.

RESULTS

Demographic data were collected for the following categories: Age, gender, martial status, and education. In addition, information regarding health, memory complaints, housing, and psychological well-being was obtained.

Age and Gender. Two hundred and six participants ranging in age from 55 to 91 (Mean, Median, Mode = 71; SD = 7.1) agreed to take part in the research. The sample included 129 (63%) female and 77 (37%) male participants.

Housing. One indication of the independence of these participants is that 78% lived in a single family home or in a duplex and 17% resided in apartments. Only 5% were in housing specifically for the elderly. In addition, the majority lived with at least one other person, with only 34% living alone.

Marital and Work Status. While the majority of the sample was married, the percentage was not overwhelming (60%), with 31% widowed and the remaining 9% either divorced or never married. As expected, most individuals were not in the work force, but almost 25% were employed at least part-time.

Education. About 35% of the sample obtained a high school degree. The majority of the sample attended some college, with 2% earning an Associate's degree, and over 60% obtaining at least a Bachelor's degree or higher degrees.

Health. In general, this sample of older adults viewed their overall health as good or excellent (80%) with only 3% rating themselves in poor health. An overwhelming majority (95%) left their neighborhood at least once per week and was able to drive a car. In addition, 76% felt their health was the same or better than 3 years ago with over 92% stating their health either had none or virtually no impact on their ability to engage in

activities.

In addition, when participants asked to rate their overall health compared to others of the same age, about 60% rated their health as better than most other people. Within the past 12 months, 83% had not been in the hospital; 65% had been sick in bed one day or less; and the average number of reported visits to the doctor in the past year was 5.5 (SD = 6.5) with the median = 4 and the mode = 3.

The total number of illnesses in the past year ranged from 0 to 10 with the mean, median and mode = 3 (SD = 2). Of the illnesses, arthritis was most frequently listed (54%), followed by hypertension (33%) and cataracts (22%).

Memory. Forty-two percent indicated they experienced memory problems in the past and 84% of these indicated memory problems were still present. Twenty-three percent admitted to difficulty in the past with knowing the time of day, day of the week, or month of the year. About 60% of these continued to have this problem.

Depression. In regards to depression, this sample is relatively well-adjusted with few reporting significant depression. For example, scores on the Beck Depression Inventory (BDI) ranged from 0 to 33 with the mean score 7.1 (SD = 6). Scores less than or equal to 9 are considered normal for this population.

Tests of Hypotheses

Hypothesis 1: The first hypothesis predicted that participants who reported having at least one confidant in their lives, someone they can talk with about all their troubles and concerns, would have lower mean depression scores, higher perceptions of health mean scores, higher actual health mean scores, and lower memory complaints mean scores than subjects who do not report having a confidant. Relevant results are shown in Table 1.

To test Hypothesis 1, independent sample t-tests were conducted to compare mean depression, perception of health, actual health and memory complaint scores between those that reported having a confidant versus those with no confidant. There was partial support for this hypothesis. Participants who reported having a confidant scored significantly lower on the BDI (Beck Depression Inventory) than participants with no confidant ($t(204) = -2.458$, $p = .015$).

Table 1. Means and Standard Deviations for Participants with and without Confidants

	BDI		Perception of Health		Actual Health		Memory Complaints	
	Mean	SD	Mean	SD	Mean	SD	Mean	SD
Confidant	6.67	5.07	8.20	1.59	.004	3.24	.89	1.21
No Confidant	9.13	7.10	7.70	1.90	.276	3.00	1.16	1.34

A t test revealed that there was no significant difference on perception of health scores for those that report having a confidant and those with no confidant ($t(204) = 1.58$, $p = .116$). On perception of health scale, the mean score for those that have a confidant was not significantly different than for those who do not have a confidant.

A t test revealed that there was no significant difference on actual health scale

scores for those that report having a confidant and those with no confidant (t (204) = -.400, p = .689). The mean score for actual health for those with a confidant was not significantly different than for those without a confidant.

A t test revealed that there was no significant difference on memory complaints scale scores for those that report having a confidant and those with no confidant (t (204) = -1.199, p = .232). The mean score for memory complaints was not significantly different for those with a confidant than for those without a confidant.

Hypothesis 2: This hypothesis predicted that participants who indicated strong support from their confidants will have better scores for depression, actual health, perception of health, and memory complaints, than will participants who indicated weak support from their confidants. We expected that helpfulness scores of confidants would correlate negatively with BDI, actual health, and memory complaints scores, and positively with perception of health scores.

This hypothesis was partially supported. Pearson correlations were computed between helpfulness score and depression, perception of health, actual health, and memory complaints. As expected, participants with greater perceived support from their confidants had lower depression scores, better perceptions of health and better actual health. Participants with greater support from their confidants did not report lower memory complaints (r = -.121, df = 205, p = .083). There was a significant correlation found in the predicted direction between helpfulness of confidants and depression (r = -.298, df = 205, p < .01), between helpfulness of confidants and actual health (r = -.185, df =205, p < .01), as well as between helpfulness of confidants and perception

of health (r = -.214, df = 205, p < .01).

Hypothesis 3: The third hypothesis predicted that subjects with greater depression would report significantly greater memory complaints. We expected that depression scores would correlate positively with memory complaints. There was a significant correlation found in the predicted direction (r = .233, df = 205, p < .01). In addition, a t test revealed that the mean score of memory complaints for subjects with no depression were significantly lower than the mean score of subjects who reported moderate to severe depression levels (t (163) = -3.74, p = .000). See results in Table 2.

Table 2. Memory Complaints Means and Standard Deviations for Participants with no Depression and Moderate to Severe Depression.

	Memory Complaints	
	Mean	SD
No Depression	.84	1.15
Moderate to Severe Depression	2.33	1.32

Hypothesis 4: This hypothesis predicted that (1) Women would report a greater number of confidants than men. (2) Women would perceive greater social support (higher helpfulness ratings for confidants) than would men. In addition, (3) Married men will name their spouse as a confidant while married women will name someone other than their spouse as a confidant. The relevant results are shown in Table 3.

The first and second parts of the hypothesis were not supported by the data. A t test revealed that the mean of total confidants for women was not significantly greater than the mean of total confidants for men (t (204) = -1.351, p = .178).

Both, men and women perceived social support from their confidants similarly. A

t test revealed that the mean helpfulness of confidants score for men was not significantly different than for women.

Table 3. Number of Confidants and Helpfulness of Confidants Means and Standard Deviations for Women and Men.

	Number of Confidants		Helpfulness of Confidants	
	Mean	SD	Mean	SD
Women	5.3	3.0	20	12.78
Men	4.7	3.2	17	11.35

The third part of the hypothesis was supported. A Chi-square analysis revealed that as predicted, the majority of men named their spouse as a confidant while most women named a non-spouse as a confidant (Chi-square (1, 166) = 41.069, p=.000). See results in Table 4.

Table 4. Numbers and Percents of Married Men and Women who Named their Spouse or Some Other Person as a Confidant.

	Confidant				
	Other		**Spouse**		Total
Men	15	23.8%	48	76.2%	63
Women	77	74.8%	26	25.2%	103
Total	92	55.4%	74	44.6%	166

Post-Hoc Analyses: Post hoc analyses included a Pearson correlation matrix among the following variables: perceived helpfulness of confidants; depression; perception of health; actual health, and memory complaints. See results in Table 5.

Table 5. Correlation Matrix Among all the Main Variables

	Perceived Helpfulness of Confidants	BDI (depression scores)	Perception of Health	Actual Health	Memory complaints
Perceived Helpfulness of Confidants	1.000	-. 298**	. 214**	-. 185**	-. 121
BDI	-. 298**	1.000	-. 405**	. 307**	. 233**
Perception of Health	. 214**	-. 405**	1.000	-. 344**	-. 256**
Actual Health	-. 185**	. 307**	-. 344**	1.000	.118
Memory Complaints	-. 121	. 233**	-. 256**	.118	1.000

****. Correlation is significant at the 0.01 level (2-tailed).**

The results confirm our findings. Table 5 demonstrates that there is a correlation between memory complaints, depression and perception of health. Depression and perception of health were entered into a regression model as predictors of memory complaints. We were interested to examine further the relationship between these variables. The combination of the two variables accounted for 8.5% of the memory complaints total score (R square = .085, p = .000). Each of the variables turned out to be a significant predictor. According to this study, higher depression and a lower perception of health contribute to greater memory complaints.

In addition, all variables (Perception of helpfulness of confidants, perception of health, actual health and memory complaints) were entered into a regression model as predictors of depression. The combination of these four variables accounted for 25% of the BDI's total scores (R square = . 25, p = .000). Most variables turned out to be significant predictors of depression, except for memory complaints.

DISCUSSION

Importance of a Confidant

The first hypothesis predicted that participants who reported having at least one confidant in their lives, someone they can talk with about all their troubles and concerns, would have lower mean depression scores, higher perceptions of health scores, higher actual health scores, and lower memory complaints scores than subject who do not report having a confidant. This hypothesis was partially supported. Subjects who reported having a confidant scored significantly lower on the Beck Depression Inventory (BDI) than subjects with no confidant. However, there was no significant difference on perception of health, actual health and memory complaints between those that reported having a confidant and those who lacked a confidant. Quality relationships such as reporting having a confidant are believed to be beneficial for the older adult's well-being. According to Silliman (1986), having a confidant can be protective against depression. Elderly persons who were involved in social activities and had someone to confide in, reported less depressive symptoms than older adults who were involved in social activities but had no one to confide in (Zunzuneguie et al., 1998). Our results show that having a confidant can be protective against depression. It is important to note that even though our sample reported very low levels of depression, the availability of a confidant in their lives protected them against higher depression.

Here are some possible explanations as to why the rest of the hypothesis was not supported. Our sample was very independent with 78% of the elderly living in a single family home. The health of the sample was quite good with 80% viewing their health as

good or excellent. In addition, 65% of the sample reported being sick in bed one day or less during the past year. As would be expected, the healthier people are, the more positively they view their health. Whether or not one has a confidant, good health will contribute to better perceptions of health. In addition, lacking a confidant did not mean lacking a social network. All participants reported having a social network. One can possibly benefit from a supportive social network even if one lacks a confidant. That can lead to better actual health and perception of health. Also, 60% of the sample attained at least a Bachelor's degree. This is a very highly educated group, and higher education is correlated with better actual health. Higher education is often correlated with higher socioeconomic status, and that contributes to better health. We did not have a specific scale for socioeconomic status in our study.

The availability of a confidant contributed to fewer memory complaints. However, it did not reach significance. In addition, whether one reports having a confidant or not, memory complaints can be indicative of memory impairment. Unfortunately, this study did not measure participants' objective memory performance.

Importance of Perception of Social Support (Helpfulness of Confidants)

The second hypothesis predicted that higher perceptions of social support, helpfulness scores of confidants would correlate negatively with BDI, actual health, and memory complaints scores and positively with perception of health scores. This hypothesis was partially supported. Pearson correlations were computed between helpfulness scores and depression, perception of health, actual health, and memory complaints. As expected, participants with greater support from their confidants had

lower depression scores. Perceptions of adequate support are associated with decreased depressive symptomatology (Antonucci et al., 1997; Fernandez, Mutran, Reitzes, 1998; Kessler eat al., 1994; Krause, 1997; Oxman et al., 1992). There are three explanations of why perceptions of adequate social support are associated with less depression according to Oxman and Hull (1997). First, people who perceive adequate support are more likely to receive the type and amount of support they need. Second, perceptions of adequate support buffer the effects of stressful situations. And, third, perceptions of adequate support provide a general belief that one is cared for and valued.

In addition, participants with greater perception of support from their confidants reported better perception of health as well as actual health. According to Veiel and Baumann (1992), subjectively believing that one has good relationships in their lives can benefit one's health. According to Lubben and Gironda (1996), there are a number of theories that can account for the relationship of social support and health. First, if an individual has strong social ties, vulnerability to stress-related illness may be reduced. Basically, feeling that one has good communication with a support network can stimulate the immune system and protect one against illness. A second theory suggests that strong social support can encourage an elder to engage in health enhancing behaviors. A third theory states that during illness, social networks can provide the appropriate support that will lead to better recovery. Newsom and Schulz (1996) found that the higher older adults' perception of social support, the higher was the rating of life satisfaction, health, and perceived health. Better actual health will lead to higher perceptions of health.

Participants with greater perception of support from their confidants did not report lower memory complaints. It is important to remember that the connection between

social support and memory complaints has not been established in the literature. This study attempted to find such a relationship, although with not much success. Again, we are dealing with very healthy, well-adjusted, highly educated and independent people. Perhaps we would get different results with a sample of participants with a wider range of educational attainments and a broader range of social class standings.

Memory Complaints and Depression

The third hypothesis predicted that participants with greater depression scores would report more Memory Complaints, as well as those subjects with higher level of depression would report more memory complaints than those with no depression. This hypothesis was supported. Depression scores were positively correlated with memory complaints. In addition, participants with Moderate to Severe depression reported more memory complaints, than participants with no depression. A possible explanation for this finding is that depression is related to cognitive impairment, which can lead to lower memory performance. Lower memory performance can lead to memory complaints. Depression also makes one feel worthless and it is possible to complain about memory performance as a result of feeling negatively about oneself.

In addition, the literature shows that according to Larrabee and Levin (1986), patients' memory self-ratings were mostly related to the affective state rather than to objective memory performance. When patients' depression lifted through the administration of anti-depressants or therapy, memory complaints declined. According to Collins and Abeles (1996), both affective and somatic aspects of depression were significantly related to subjective memory complaints. Additionally, Levy-Cushman and Abeles (1998) found that elderly people who reported more memory complaints scored

higher on the Beck Depression Inventory than those who reported fewer memory complaints.

Gender Differences and Social Support

Hypothesis 4 consists of three parts: The first part predicted that women would report more confidants than men. This was not supported by the data. A possible explanation for this finding is that even though women are taught to pay closer attention to building relationships in their lives, while men are taught to strive for independence and to not display the need for support, all participants volunteered for the study. It is likely that these participants were not afraid to reach for help and to have their mental health assessed. In addition, it seemed that most participants' social skills, including the men, were quite developed. It is possible that men's social skills improve as they become older. Nevertheless, Antonucci and Akiyama (1987) and Depner and Ingersoll-Dayton (1988) found that women had a larger social network than men. Furthermore, according to Zunzuneguie et al., (1998) men were more likely than women to lack a confidant. Even though this part of the hypothesis did not reach significance, women's mean of total confidants was greater than men's mean of total confidants.

The second part of the hypothesis predicted that women would perceive greater social support (higher helpfulness ratings for confidants) than would men. This was not supported by the data. Both men and women perceived social support from their confidants similarly. Since women have more confidants in their network, it is possible to speculate that they receive a greater amount of social support and therefore perceive a greater amount of social support. A possible explanation for the result is that the number

of confidants is not significant to perception of social support. Having at least one confidant who is perceived as helpful may be just as beneficial as a few confidants that are perceived as helpful. Thus in the final analysis it may be the quality of confidants that is most beneficial. It may be that having more than one confidant increases quality of social support but that is an empirical question still to be determined.

The third part of the hypothesis predicted that among the married participants, married men would name their spouse as a confidant while married women will name someone other than their spouse as a confidant. This was supported by the data. The majority of men named their spouse as a confidant while most women named a non-spouse as a confidant. Again, gender socialization is a possible explanation for this finding. Since women are more socialized to develop relationships, their confidant can be someone other than their spouse. However, since men may be less socialized to develop relationships, once they develop a relationship with their spouse, the spouse becomes their confidant. Also, it is possible that men give less social support to their wives in marriages. According to Antonucci and Akiyama (1987) men are more satisfied with their marriage than women, and women are more satisfied with friends. In addition, according to Levitt et al., (1985) and Akiyama Elliott, and Antonucci (1996), among the married elderly, men claimed that they receive most social support from their wives, while women report receiving most support from persons other than their spouses.

Limitations of Study

The results of the study are limited to the extent that they may not generalize to more impaired populations. Our sample was very high functioning. The majority of

participants were well-educated, physically healthy, and experienced very little depression. Since most of the questions raised in this study were about perceived helpfulness of confidants and that relationship to health, depression, and memory complaints, having such a high functioning sample may have produced fewer significant results, than if the sample was more impaired in those domains. The study found that higher depression was related to higher memory complaints. The study did not find a relationship between perceived social support and memory complaints. It may be possible to find a relationship between social support and memory complaints with a more depressed sample. In addition, participants were self-selected, so it is more likely that these individuals were motivated to participate in a research project. This may be additional support for their high functioning status.

Another limitation of the study is that objective memory performance was not measured. It is important whenever measuring memory complaints to also measure memory performance and separate genuine memory complaints from memory complaints that stem from other reasons.

Also, helpfulness of confidants was not clearly defined in the questionnaire. Participants may have interpreted it in more than one way. There can be emotional, financial, physical, and other types of support. It would be beneficial to tease out the kind of help that protects against depression and physical illness.

Implications

Results of this study suggest that social support is beneficial for older adults. Especially for perceiving close relationships and finding them helpful. Even though this

sample reported very little depression, those that reported having at least one confidant had significantly lower depression scores than those reporting not having a confidant. The existence of a confidant in an older adult's life may protect one against depression. In addition, the quality of the relationships, having helpful confidants, may also contribute to better physical health and protect one against illness. This indicates that mental health professionals who are working with older clients should inquire about their client's social support. Particularly, they should ask whether their client has a confidant. Then they should ask if their client is satisfied with the relationship and finds the confidant helpful.

Directions for Future Research

The current sample was fairly homogenous in terms of the participants' level of functioning. It would be beneficial to conduct this study with a more impaired population and see if results will be duplicated.

In addition, whenever measuring memory complaints, it would be helpful to measure objective memory performance to separate complaints due to poorer performance and complaints due to other reasons, such as depressive symptomatology.

LIST OF REFERENCES

Akiyama, H., Elliott, K., & Antonucci, T. C. (1996). Same-sex and cross-sex relationships. Journal of Gerontology: Psychological Sciences, 51b, 374-382.

Antonucci, T. C., & Akiyama, H. (1987). Social networks in adult life: A preliminary examination of the convoy model. Journal of Gerontology: Social Sciences,42, 512-527.

Antonucci, T. C., Fuhrer, R., & Dartigues, J. F. (1997). Social relations and depressive symptomatology in a sample of community-dwelling French older adults. Psychology and Aging, 12, 189-195.

APA working group on the older adult (1998). What practitioners should know about working with older adults. Professional Psychology: Research and Practice, 29, 413-427.

Arling, G. (1976). The elderly widow and her family, neighbors and friends. Journal of Marriage and the Family, 38, 757-768.

Barrera, M. (1986). Distinctions between social support concepts, measures, and models. American Journal of Community Psychology,14, 413-445.

Beck, A. T. (1987). Beck Depression Inventory: Manual. San Antonio, Tex.: Psychological Corporation.

Beck, A. T., Ward, C. H., Mendelson, M., Mock., & Erbaugh, J. (1961). An inventory of measuring depression. Archives of General Psychiatry, 4, 561-571.

Berkman, L. F. (1985). The relationship of social networks and social support to morbidity and mortality. In: S. Cohen and S. L. Syme, eds. Social support and health (pp. 241-262). Orlando, FL: Academic Press.

Blazer, D. G. (1983). Impact of late-life depression on the social network. American Journal of Psychiatry, 140, 162-166.

Blazer, D. G., Hughes, D., & George, L. K. (1992). Age and impaired subjective support: Predictors of depressive symptoms at one-year follow up. Journal of Nervous & Mental Disease, 180, 172-178.

Blazer, D. G. (1982). Social support and mortality in an elderly community population. American Journal of Epidemiology, 116, 684-694.

Bost, K. K., Vaughn, E. B., Washington, N. W., Cielinski, L. K., & Bradbard, R. M., (1998). Social competence, social support, and attachment: Demarcation of construct domains, measurement, and paths of influence for preschool children attending head start. Child Development, 69, 192-218.

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.

Cicirelli, V. G. (1989). Feelings of attachment to siblings and well-being in later life. Psychology and Aging, 4, 211-216.

Cohen, S., & Syme, S. L. (1985). Issues in the study and application of social support. In: S. Cohen & S. L. Syme, (eds.), Social support and health. (pp. 3-22). New York, New York: Academic Press.

Cohen, S., & Wills, T. A. (1985). Stress, social support, and the buffering hypothesis. Psychological Bulletin, 98, 310-357.

Collins, M. W., & Abeles, N. (1996). Subjective memory complaints and depression in the able elderly. Clinical Gerontologist, 16, 29-54.

Cutrona, C. C., Russell, D., & Rose, J. (1986). Social support and adaptation to stress by the elderly. Journal of Psychology and Aging, 1, 47-54.

Depner, C. E., & Ingersoll-Dayton, B. (1988). Supportive relationships in later life. Psychology and Aging, 3, 348-357.

Fernandez, M. E., Mutran, E. J., & Reitzes, D. C. (1998). Moderating the effects of stress on depressive symptoms. Research on Aging, 20, 163-182.

Gallagher, D., Neis, G., & Thompson, L. W. (1982). Reliability of the beck depression inventory with older adults. Journal of Consulting and Clinical Psychology, 50, 152-153.

Gallagher, D., Breckenbridg, J., Steinmetz, J., & Thompson, L. (1983). The beck depression inventory and research diagnostic criteria: Congruence in an older population. Journal of Consulting and Clinical Psychology, 51, 945-946.

Kasl-Godley, J. E., Gatz, M., & Fiske, A. (1998). Depression and depressive symptoms in old age. In I. H. Nordhus, G. R. VandenBos, S. Berg, & P. Fromholt (Eds.), Clinical Geropsychology (pp.211-217). Washington, DC: American Psychological Association.

Kessler, R. C., Kendler, . S., Heath, A., Neale, M. C., & Eaves, L. J. (1994). Perceived support and adjustment to stress in a general population sample of female twins. Psychological Medicine, 24, b317-334.

Krause, N. (1997). Anticipated support, received support, and economic stress among older adults. Journal of Gerontology: Psychological Sciences, 52B, p284-p293.

Lang, F. R., Featherman, D. L., & Nesselroade, J. R. (1997). Social self-efficacy and short-term variability in social relationships: The MacArthur successful aging studies. Psychology and Aging, 12, 657-666.

Larrabee, G. J. and Levin, H. S. (1986). Memory self-ratings and objective test performance in a normal elderly sample. Journal of Clinical and Experimental Neuropsychology, 13, 275-284.

La Rue, A. (1992). Aging and neuropsychological assessment. New York, New York: Plenum Press.

Lawton, M. P., Moss, M., Fulcomer, M., & Kleban, M. H. (1982). A research and service oriented multilevel assessment instrument. Journal of Gerontology,37, 91-99.

Levitt, J. M, Antonucci, C. T., Clark, C. M., Rotton, J., Finley. (1985). Social support and well being: Preliminary indicators based on two samples of the elderly. International Journal of Aging and Human Development, 21, 61-77.

Levy-Cushman, J., & Abeles, N. (1998). Memory complaints in the able elderly. Clinical Gerontologist, 19, 3-24.

Lowenthal, M. Lives in distress. New York, New York: Basic Books.

Lubben, J., & Gironda, M. (1996). In H. Litwin (Ed.), The social networks of older people: A cross-national analysis, (pp.143-161). Westport, Connecticut: Praeger.

Lubben, J. E., Weiler, P. G., & Chi, I. (1989). Health practices of the elderly poor. American Journal of Public Health, 79, 731-734.

Newsom, T. J., & Schulz, R. (1996). Social support as a mediator in the relation between functional status and quality of life in older adults. Psychology and Aging, 11, 34-44.

Oxman, T. E., Berkman, L. F., Kasl, S., Freeman, D. H., & Barrett, J. (1992). Social support and depressive symptoms in the elderly. American Journal of Epidemiology, 135, 356-368.

Oxman T. E., & Hull, J. G. (1997). Social support, depression, and activities of daily living in older heart surgery patients. Journal of Gerontology: Psychological Sciences, 52B, 1-14.

Phillips, M. A., & Stanley, A. M. (1994). Impact of Psychological and physical health, stressful events, and social support on subsequent mental health help Seeking among older adults. Journal of Consulting and Clinical Psychology, 62, 270-275.

Potts, M. K. (1997). Social support and depression among older adults living alone: The importance of friends within and outside of a retirement community. Social

Work, 42, 348-362.

Prince, M. J., Harwood, R. H., Blizard, R. A., Thomas, A., & Mann, A. H. (1997). Social support deficits, loneliness and life events as risk factors for depression in old age. Psychological Medicine , 27, 323-332.

Silliman, R. A. (1986). Social stress and social support. Generations, 10, 18-20.

Revicki, D. A., & Mitchell, J. (1986). Social support factor structure in the elderly. Research on Aging, 8, 232-248.

Robinson, S. N., & Garber, J. (1995). Social support and psychopathology across the life span. In D. Cicchetti, & D. J. Cohen (Eds.), Developmental Psychopathology, V(2) (pp.162-209). New York, New York: John Wiley & Sons, Inc.

Rudd, M. D. (1993). Social support and suicide. Psychological Reports, 72, 201-202.

Sarason, B. R., Shearin E. N., Pierce G. R., & Sarason, I. G. (1987). Interrelations of social support measures: Theoretical and practical implications. Journal of Personality and Social Psychology, 52, 813-832.

Silverstein, M., Chen, X., & Heller, K. (1996). Too much of a good thing? Intergenerational social support and the psychological well-being of older parents. Journal of Marriage and the Family, 58, 970-982.

Spitzer, R., Endicott, J., & Robins, E. Research diagnostic criteria: Rationale and reliability. Archives of General Psychiatry,35, 773-782.

Thoits, P. A. (1982). Conceptual, methodological, and theoretical problems in studying social support as a buffer against life stress. Journal of Health and Social Behavior, 23, 145-159.

Williams, M., Little, M. M., Scates, S. & Blockman, N. (1987). Memory complaints and abilities among depressed older adults. Journal of Counseling and Clinical Psychology, 55, 595-598.

Williams, A. W., Ware, J. E., & Donald, C. A. (1981). A model of mental health, life events and social supports applicable to general populations. Journal of Health and Social Behavior, 22, 324.

Vasudha, G., & Korte, C. (1994). The effects of a confidant and a peer group on the well being of single elders. International Journal of Aging & Human Development, 39, 293-302.

Veiel, H. O.F. & Baumann, V. (Eds.) (1992). The meaning and measurement of social support. New York, New York: Hemisphere.

Yesavage, J. A., Brink, R., & Rose, T. L. (1983). Development and validation of a geriatric depression scale. Journal of Psychiatric Research, 17, 31-49.

Zunzuneguie, M. V., Beland, F., Liacer, A., & Leon, V. (1998). Gender differences in depressive symptoms among Spanish elderly. Social Psychiatry and Psychiatric Epidemiology, 33, 195-205.