SOCIAL SUPPORT AND QUALITY OF LIFE AMONG ELDERLY

Varsha Singh
Assistant professor, Kamala Nehru College, University of Delhi, India
Email - varsha.singh1990@gmail.com

Abstract: *The aim of the present study was to assess the relationship between social network and quality of life (QOL) among elderly. For the purpose a sample of 50 individuals of 60 and above years of age were administered the Lubben's social network scale and WHO-QOL scale. The scores obtained on both the tools were correlated using Pearson correlation method. The results indicated a positive correlation of 0.68 between social support and quality of life and 0.58 between social relationships and social support; suggesting more the social relationships higher the social support and higher the social better is the quality of life.*

Key Words: ***Social Network, Old Aged and Quality of Life.***

1. INTRODUCTION:

The elderly population is now becoming of considerable concern around the world. The proportion of people age 60 and over is growing faster than any other group. From 1970 until 2025, the elderly population is expected to grow by approximately 694 million, or 223%. In 2025, there will be about 1.2 billion people over the age of 60; of which 80% will be living in developing countries (WHO, 2002). India like many other developing countries in the world is witnessing the rapid aging of its population. Urbanization, modernization and globalization have led to change in the economic structure, the erosion of societal values, weakening of social values, and social institutions such as the joint family. These changes jeopardize the custom of reciprocity for parental well-being. In effect, family support is often different from what it was in the past. Older persons are, therefore, in need of vital support that will keep important aspects of their lifestyles intact while improving their over-all quality of life (Dandekar 1993). Therefore, social support from family, friends, and community has become an important issue that should be recognized.

Social support is defined as feeling that one is cared for by and has assistance available from other people and that one is part of a supportive social network. Social networks refer to the structural characteristics of an individual's social relationships, including characteristics of the network, frequency of contact and subject's satisfaction with his/her social contacts. Types and sources of social support may vary. House (1981) described four main categories of social support: emotional, appraisal, informational and instrumental.

- Emotional support generally comes from family and close friends and is the most commonly recognized form of social support. It includes empathy, concern, caring, love, and trust.
- Appraisal support involves transmission of information in the form of affirmation, feedback and social comparison. This information is often evaluative and can come from family, friends, co-workers, or community sources.
- Informational support includes advice, suggestions, or directives that assist the person to respond to personal or situational demands.
- Instrumental support is the most concrete direct form of social support, encompassing help in the form of money, time, in-kind assistance, and other explicit interventions on the person's behalf.

Family, friends, and neighbors are important sources of support to elderly people (Beigel, 1985). The convoy model of social support (Kahn & Antonucci, 1980) postulates that each individual is surrounded by a convoy, a set of people to whom the individual maintains reciprocal emotional and instrumental support. This convoy includes specific people who make up the person's social network and who affect the person's well-being, the married in particular. These social support networks help to buffer stress and depression and

enhance morale and well-being (Bankhoff, 1983; Litwin, 1995b, 2000; Schaefer, Coyne, & Lazarus, 1981). The availability of social support and the existence of social networks may ensure emotional support (Thoits, 1995) and enhance a sense of control and self-esteem (Krause & Borawski- Clark, 1994). Scholars have traditionally argued that availability of kin and family ties protects against loneliness (Antonucci, 1990). Loneliness is an unpleasant feeling of dissatisfaction with existing social relationships, a perceived lack of intimacy, and a feeling of exclusion from social relationships that is influenced by some form of social relationship deficit (Andersson, 1986; Wiess, 1973). Loneliness is believed to be wide spread among elderly persons (Blake, 1979; De Jong-Gierveld, 1995; Victor et al., 2002). Various studies found the root cause of loneliness to be some form of social relationship deficit. Older people who maintained contacts with friends and were satisfied with these relationships expressed lower feelings of loneliness (Mullins, Smith, Colquitt,& Mushel,1 996).A positive relationship was found between having friends and life satisfaction and morale among elderly people (Mancini, 1980; Mullins & Mushel, 1992; Strain & Chappell, 1982). Arling (1976) found that having more friends in one's social network was related to less loneliness. Frequency of contact with neighbors and friends (but not with family) and the quality of relationships with friends were important in reducing feelings of loneliness (Mullins & Dugan, 1990). There is empirical evidence of its relationships with health, well-being and quality of life in old age. The density of an individual's social relationships, the degree to which he/she interacts with others and how much he/she receives and gives affect, instrumental support, and/or services are all associated with health indicators, subjective well-being, and quality of life measures.

The World Health Organization defines Quality of life as "an individual's perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns. It is a broad ranging concept affected in a complex way by the person's physical health, psychological state, personal beliefs, social relationships and their relationship to salient features of their environment"(Oort, 2005).

Quality of life has also been defined "as the satisfaction of an individual's values, goals and needs through the actualization of their abilities or lifestyle" (Emerson, 1985, p. 282).This definition is consistent with the conceptualization that satisfaction and wellbeing stem from the degree of fit between an individual's perception of their objective situation and their needs or aspirations (Felce & Perry, 1995).

One of the influential conceptualization of quality of life is that of Lawton who described it as 'the multidimensional evaluation, by both intrapersonal and social-normative criteria, of the person–environment system of an individual in time past, current and anticipated'. His dimensions were arranged in a continuum of objective (objective, environment, behavioural competence) and subjective (perceived quality of life, psychological well-being) dimensions. He argued that both objective and subjective dimensions were important for quality of life.

WHO has identified six broad domains which describe core aspects of quality of life cross-culturally: a physical domain (e.g. energy, fatigue), a psychological domain (e.g. positive feelings), level of independence (e.g. mobility), social relationships (e.g. practical social support), environment (e.g. accessibility of health care) and personal beliefs/spirituality (e.g. meaning in life). These domains of health and quality of life are complementary and overlapping.

Social support is one of the important factors that play a major role in maintaining well-being in the aged. McCauley *et al* (2000) indicated that the social relations integral to an exercise environment are significant determinants of subjective wellbeing, including perceived satisfaction in life, in older adults. McCulloch (1995) found social support was a significant predictor of quality of life. Similarly, Van Baarsen (2002) indicated that elderly who had lost a partner experienced lower self-esteem, resulting in higher emotional loneliness and social loneliness, that is, the perception of less support. Koukouli *et al* (2002) also suggested

that social support appears to play a significant role in explaining differences in subjective functioning; people living alone or only with a spouse, particularly the elderly, seem to be at greater risk for disability problems and should receive particular attention from preventive programs in the community. McNicholas (2002) asserted that social support, self-esteem, and optimism were all positively related to well being; and social support was positively related to self-esteem and optimism. Based on the above studies and reviews, the purpose of the present study was to assess the relationship between social support network and quality of life among elderly. The hypothesis for the study was the better the support network; the better would be the quality of life.

2. METHOD:

Participants: sample included 50 old aged individuals of 60 years and above, living in New Delhi and NCR region. The various characteristics of the participants are given below in the table. The mean age of the respondents was 70.3 (SD 6.53), with ages ranging from 60 to 85.

Characteristic	***No. of persons***	***Percentage***
Age		
60-65	11	22%
65-70	10	20%
70-75	17	34%
75-80	7	14%
75-85	8	10%
Gender		
Male	27	54%
Female	23	46%
Education		
NIL	1	2%
Primary	4	8%
Higher	3	6%
9th – 10th	6	12%
Secondary (11th – 12th)	4	8%
B.A.	20	40%
Post-graduate and above	12	24%
Family structure		
Nuclear	30	60%
Joint/extended	18	36%
Other	2	4%
Illness		
NIL	14	28%
Physical	35	70%
Psychological	0	0%
Both	1	2%
Physical mobility		
Difficulty in mobility	10	20%
No difficulty in mobility	40	80%
Marital status		
Unmarried	4	8%
Married	29	58%
Widow	17	34%

3. MATERIAL/TOOLS USED: Two tools Lubben's social network scale (LSNS) and WHO-Quality of life – BREF were used to test the social support/social networking and quality of life respectively.

- *Lubben social network scale (LSNS)*: developed by J. Lubben and M. Gironda is a brief instrument designed to gauge social isolation in older adults by measuring perceived social support received by family and friends which typically takes 5 to 10 minutes to complete. It consists of an equally weighted sum of 10 items used to measure size, closeness and frequency of contacts of a respondent's social network. It was originally developed in 1988 and was revised in 2002 (LSNS-R) along with an abbreviated version (LSNS-6) and an expanded version (LSNS-18). All the LSNS scales measure the level of perceived support received from family, friends and neighbors. The LSNS has been used in both practice and research settings and has been used primarily with older adults from a range of settings including the community, hospitals, adult day care centers, assisted living facilities and doctors' offices. The scale has also been used with specific elderly populations such as elderly diagnosed with breast cancer, myocardial infarctions and depressed elderly; other specific populations include homosexual and childless elderly. Caregivers have also been looked at as they often become an increasingly important part of the older person's daily life.

- *WHO-QOL- BREF*: is a tool that consists of 26 items and was derived from the (WHO) QOL-100 items tool. It includes seven items in the physical domain (physical state), six items in the psychological domain (cognitive and affective state), three items in the social domain (interpersonal relationship and social role in life), eight items in the environmental domain (relationship to salient feature of the environment), one item for general quality of life, and one item for health-related quality of life combining together as global domain. The individuals were required to rate their quality of life in the past 2 weeks. The item scores ranged from 1 to 5, with a higher score indicating a better quality of life. The (WHO) QOL-Hindi version was used for the present study; it consists of 26 items that show satisfactory psychometric properties and good internal reliability and was verified as a valid instrument for comprehensively assessing the quality of life in health care settings in India (Saxena, S., Chandiramani, K., & Bhargava, R. 1998).

4. DISCUSSION:

Analysis: The scores for WHO-QOL were obtained domain wise (physical, psychological, social relationship, environment and overall quality of life) and then scores of each domain was correlated with the scores of social network, using Pearson product moment correlation formula to see the relationship among each domain and social network. The correlations obtained were then analyzed and interpreted

5. RESULTS:

Table 1: Showing the correlation coefficients obtained and their significance on 0.05 and 0.01 level with N=50, df =48.

S.No	Variables	Correlation coefficient
1.	Social support and physical health	– 0.18
2.	Social support and psychological	0.02
3.	Social support and social relationship	0.58*
4.	Social support and environment	– 0.04
5.	Social support and overall QOL	0.68*

*value significant at both the levels 0.05 and 0.01

6. FINDINGS:

Social networks refer to the structural characteristics of an individual's social relationships, including characteristics of the network, frequency of contact and subject's satisfaction with his/her social contacts. Social support is defined as feeling that one is cared for by and has assistance available from other people and that one is part of a supportive social network. This convoy, a set of people to whom the individual maintains reciprocal emotional and instrumental support and includes specific people who make up the person's social network and who affect the person's well-being. These social support networks help to buffer stress and depression and enhance morale and well-being. However lack of social network and social support may lead to loneliness and feelings of depression and feeling of worthlessness. The World Health Organization defines Quality of life as an individual's perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns. It is a broad ranging concept affected in a complex way by the person's physical health, psychological state, personal beliefs, social relationships and their relationship to salient features of their environment. Various studies reviewed have indicated that social support enhances the quality of life, play an important role in maintaining the well-being and is positively related to self-esteem and optimism. For the present purpose 2 questionnaires Lubben's social network scale and WHO-QOL scale was used to assess the social network and quality of life among participants. The scores obtained on both the scales were then correlated to see the relationship.

As indicated in the result table no. 1 the correlation coefficient for social support and physical health is –0.18. Social support is the feeling that one is cared for by and has assistance available from other people and physical health includes facets such as activities of daily living, dependence on medicinal substances and medical aids, energy and fatigue, mobility, pain and discomfort, sleep & rest and work Capacity. The correlation value obtained is negative and weak which indicates an inverse relationship that is if one variable increases the other one decreases. Thus according to the value obtained if social support increases, the physical health decreases, this can be a possibility because more the social support more is, more is the dependence and less would be one's effort in daily activity leading to deterioration in physical health and quality of life. Having help from others for everyday needs may evoke feelings of insecurity and anxiety about the future and the availability of others who can help (Jacobsson et al. 2000, Ellefsen 2002), and it also implies dependency, at least in physical terms. Thus, not only health problems but also dependency on others per se may reduce older people's QoL. However because the correlation value obtained is not significant not much can be said about the established relationship between social support and physical health.

The correlation coefficient obtained for social support and psychological domain is 0.02 which is a very poor and low correlation. Social support is the feeling that one is cared for by and has assistance available from other people and psychological domain includes facets such as bodily-image and appearance, negative feelings, positive feelings, self-esteem, spirituality/religion/ personal beliefs, thinking, learning, memory and concentration. Since the correlation value obtained is very low and non-significant, nothing much can be said about the relationship between these two variables.

The correlation coefficient obtained for social support and social relationship is 0.58 which a strong and significant value. Social support refers to the feeling that one is cared for by and has assistance available from other people and social relationships include facets such as personal relationships, social support and sexual activity. The correlation value obtained indicates a positive relationship between the two variables, meaning that if one variable increases, the other variables would also increase. Thus the more the social relationships, higher is the social support. Family, friends, neighbors are important sources of support to elderly and help to overcome stress and feelings of despair. The reciprocity and exchange of affect among provide support and enhances one's overall quality of life also. The elderly tend to have a better quality of life if they receive regular care and support from family members as well as from friends and peers (Matt and Dean 1993).

The correlation coefficient obtained for social support and environment is – 0.04 which is a non-significant and very poor correlation. Social support refers to the feeling that one is cared for by and has assistance available from other people and environment includes facets such as financial resources, freedom, physical safety& security, health & social care, accessibility & quality, home environment etc. The correlation obtained is negative which suggests that if the environmental conditions improve the social support may decrease; however, since the correlation value obtained is very low and non-significant, nothing conclusively can be said about the relationship between these two variables.

The correlation coefficient obtained for social support and overall quality of life is 0.68. Social support is defined as feeling that one is cared for by and has assistance available from other people and quality of life is an individual's perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns. The correlation value obtained is positive and significant suggesting more is the social support, higher is the quality of life. Research on social support (and related concepts) carried out over the last 15 years in different contexts/cultures has demonstrated strong relationships with health and well-being across the lifespan, but especially in old age (Antonucci, Sherman, & Akiyama, 1996). Social support can be a buffer against stress, protect people against developing illnesses, provide emotional support, and increase the life span (Ross and Mirowsky 2002). The elderly tend to have a better quality of life if they receive regular care and support from family members as well as from friends and peers (Matt and Dean 1993). McCauley *et al* (2000) indicated that the social relations integral to an exercise environment are significant determinants of subjective wellbeing, including perceived satisfaction in life, in older adults. McCulloch (1995) found social support was a significant predictor of quality of life.

7. RECOMMENDATIONS:

This study established the relationship between social support and quality of life among elderly. Enhancing the social support and expanding ones social network would help in adjusting with better with the stressors experienced by the virtue of being at a life stage. Family, friends, relatives, colleagues not only help during difficult times but also make life enjoyable and the connectedness experienced develops into strength.

8 CONCLUSIONS:

Therefore from all the above discussions it can be said that social relationships provides one with the social network, which in turn leads to social support and this social support enhances ones quality of life. Hence it can be concluded higher the social network better is the quality of life. Social network and quality of life among elderly share a positive relationship.

REFERENCES:

1. Andersson, L. (1986). A model of estrangement including a theoretical understanding of loneliness. Psychological Reports, 58, 683-695.
2. Antonucci, T. C. (1990). Social supports and social relationships. In R. H. Binstock & L. K. George (Eds.), Handbook of aging and the social sciences. (pp.2 05-226).S anD iego, C A: Academic Press.
3. Arling, G. (1976). T he elderly widow and her family, neighbors and friends. Journal of Marriage and the Family, 38, 757-768.
4. Ballesteros. R.F; (2002). Social support and quality of life among older people in Spain. Journal of social issues, 58, 645-659.
5. Biegel, D. E. (1985). The application of network theory and research to the field of aging. In W. J. Sauer & R. T. Coward (Eds.), Social support networks and the care of the elderly: Theory, research and practice (pp. 251-274). New York: Springer
6. Bankhoff, E. A. (1983).Social support and adaptation to widowhood. Journal of Marriage and the Family, 45, 827-839.
7. Dandekar K 1993. *The Elderly in India*. New Delhi: Sage publishers.

8. Emerson, E. (1985). Evaluating the impact of deinstitutionalization on the lives of mentally retarded people. *American Journal of Mental Deficiency, 90*(3), 277.
9. Felce, D., & Perry, J. (1995). Quality of life: Its definition and measurement* 1. *Research in developmental disabilities, 16*(1), 51-74.
10. House, J. S. (1981). Work stress and social suvvort. Reading* MA: Addison-Wesley.
11. Kahn, R. L., & Antonucci, T. C. (1980). Convoys over the life course: Attachment, roles and social support. In P. B. Baltes & O. Brim (Eds.), Life-span development and behavior (pp. 253-286). New York: Academic Press.
12. Koukouli S, Vlachonikolis IG, Philalithis A. Sociodemographic factors and self reported functional status: the significant of social support. *BMC Health Serv Res* 2002; 2: 20. [Cited 2004 Sep 21]. Available from: URL: http:// www.biomedcentral.com/1472-6963/2/20
13. Kuyken, W., Orley, J., Power, M., Herrman, H., Schofield, H., Murphy, B., et al. (1995). The world health organization quality of life assessment (WHOQOL): Position paper from the world health organization. Social Science and Medicine, 41(10), 1403–1409.
14. Lubben, J., Gironda, M. (2004). Measuring social networks and assessing their benefits. In Social Networks and Social Exclusion: Sociological and Policy Perspectives. Eds. Phillipson, C., Allan, G., Morgan, D. Ashgate.
15. McCauley E, Blissmer B, Marquez D, Lerome G, Kramer A. Social relations, physical activity and well being in older adults. *Prevent Med* 2000; 33: 608-17
16. McCulloch BJ. Relationship of family proximity and social support to mental health of older rural adults: the Appalachian context. *J Aging Stud* 1995; 9: 65-81.
17. McNicholas SL. Social support and positive health practices. *West J Nurs Res* 2002; 5: 772-87.
18. Oort, F. (2005). Using structural equation modeling to detect response shifts and true change. *Quality of Life Research, 14*(3), 587-598.
19. Quality of Life Assessment. The WHOQOL Group, 1994. What Quality of Life? The WHOQOL Group. In: World Health Forum. WHO, Geneva, 1996.
20. Saxena, S., Chandiramani, K., & Bhargava, R. (1998). WHOQOL- Hindi: A questionnaire for assessing quality of life in health care settings in India [article]. National Medical Journal of India, 11(4), 160–165.
21. Van Baarsen B. Theories on coping with loss: the impact of social support and self esteem on adjustment to emotional and social loneliness following a partner's death in later life. *J Gerontol B Psychol Soc Sci* 2002; 157: S533- 42.
22. WHO. Active aging: a policy framework. Geneva: WHO. *WHO/NMH/NPH/02.8*. 2002.
23. Wiess, R. S. (1973). Loneliness: The experience of emotional and social isolation. Cambridge, MA: MIT Press.
24. Dalgard OS. Social support - Definition and scope. Retreived from In: EUPHIX, EUphact. Bilthoven: RIVM, <http://www.euphix.org> EUphact\ Determinants of health\ Environment\ Social support, on 16 March 2009.