

**SHE STANDS ALONE:
A Review of the Recent Literature
on Women and Social Support**

Martha L. Weber



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I am aware of the irony that while preparing this literature review on social support, as a mother I was also attending to my son's sudden health needs. During this time, I became aware of the need for, and benefits of, social support.

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Executive Summary

This study presents a broad overview of social support research. It presents both traditional and feminist perspectives, the pros and cons of research on gender differences, and an introduction to social support research on a number of specific issues pertaining to women. The following is a brief summary of each section of the literature review.

PART 1: SOCIAL SUPPORT DEFINITIONS AND LINKS TO RESEARCH

SOCIAL SUPPORT DEFINITIONS

The term “social support” covers a broad range of meanings. It is defined in functional, structural, and/or conceptual terms. Researchers agree that social support needs to be defined carefully when developing a research study.

Social support is studied objectively through quantitative methods such as network analysis, and through subjective evaluations, such as the perception of the helpfulness of support received.

PROBLEMS IN SOCIAL SUPPORT RESEARCH

Certain aspects of support are easy to study, such as how many people are in a support network. Other aspects are more difficult. True experimental designs are difficult, and therefore, causality cannot be determined. Self-reporting can be a problem area, therefore using multiple methods of assessment is recommended. Support now is being seen by some researchers as a process that can change over time, rather than as a stable entity. These researchers recommend assessing support on several occasions over the life of the stressful event.

LINKS TO HEALTH AND WELL BEING

Health can be defined using a biomedical model or by using a holistic one that includes the interaction of mind and body and the surrounding environment. Research has linked social support to health through physiological studies as well as theoretical models such as the “buffering hypothesis” and “main effect.”

WOMEN AND HEALTH

Why focus on women's health? There are many issues that affect only women, or affect women disproportionately. As well, most studies have included only white males, with results generalized to women. Women also are not a homogenous group—results may vary due to factors such as developmental stages or ethnicity. Gender roles also are thought to influence women's health.

STRESS, COPING AND SOCIAL SUPPORT

Stress is an element in the environment that poses a threat, and coping is an individual response to stress. There are many kinds of coping responses. Researchers are not sure if an individual brings a set of coping skills to a stressful event or whether coping changes depending on the situation. Studies have found, however, that some types of coping may be more effective for certain situations or at different stages of a stressor. One unique model of coping is presented in the context of "place," where environmental upheaval causes individuals to reassess and manage change. This is best done through interpersonal collaboration. Empowered collaboration refers to groups who share common values coming together to change their surrounding environment for the better.

Women and Coping. Traditional models that describe the way women cope have indicated that women rely more on emotion-focused coping and relationship-coping than methods linked to higher psychological distress. When assessment tools were evaluated, researchers found that positive aspects of emotion-focused coping had not been assessed. Once this adjustment was made, women were found to have lower levels of depression and hostility. When assessing relationship-focused research, this method of

coping was found to be a valued behaviour when placed in context of a woman's life. This indicates not only the need for assessments to consider the context of women's lives, but also the need to be cautious of assessment results.

Negative Coping. The current trend in health is toward individual responsibility. This includes education and prevention and the development of a healthy lifestyle. This trend does not take into account health determinants that are beyond an individual's control or the context of a behaviour. Social support research needs to look more deeply at the issues surrounding a woman's health choices to understand the reasons why these choices are made.

NEGATIVE ASPECTS OF SUPPORT

Not all support has positive aspects. The support itself may be ineffective or inappropriate, or the supportive person can create stress or conflict. Some researchers have found that negative interactions are more harmful than positive interactions are helpful. Also, the meaning of support to the individual receiving help is important, as support can imply dependence.

FACTORS THAT INFLUENCE SUPPORT

Environmental Distress and Support. The external environment can play a role in social support by providing opportunities for support interactions to take place, or by discouraging supportive behaviours. Household crowding is one example of a variable that can decrease supportive behaviour.

Major Life Events and Minor Stressors. Two important external determinants are daily hassles and major life events. Individuals dealing with major life events—such as death of a spouse—appear to receive more support than those deal-

ing with daily hassles, such as child care, although if an event lasts for a long period of time, support can wane. One researcher suggests looking at the relationship between major life events and daily hassles, claiming there is often a ripple effect between the two, and they can be additive in nature. Interpersonal conflicts have been identified as the most upsetting type of daily hassle.

Perceived and Received Support, and Reciprocity. Perceived support, or what a person expects to receive and what is actually received, may be different. Received support needs to be seen by the recipient as helpful. The persons giving support may think they are being helpful, when in fact, the recipient does not feel it is so. Reciprocity, or the exchange of support, varies among individuals and the relationships in which they are involved. Long-term relationships do not require immediate return on support as balance can be achieved over the length of the relationship.

Reciprocity and Social Obligation. It appears that the exchange of support needs to be balanced, otherwise feelings of obligation can result. The type of exchange and the relationship involved can influence the exchange (for example, a work supervisor is allowed to give more informational support than a co-worker). Relationships with family members, where support may be based on duty, may lead to greater feelings of obligation than relationships with friends, where the relationship is voluntary.

Individual Differences. Social support may be linked to an individual's health through their self-esteem, perhaps through feelings of worthiness of support. There also are many individual characteristics that have been linked to social support such as social skills, coping abilities, locus of control, meaning of life and personality traits.

SOCIAL CONNECTIONS

Social Ties and Subgroups. Social support systems that are normally stable can be undermined by chronic stressors. Some studies have shown that during some stressful events, certain subgroups in a community may receive less help. These are usually groups whose resources have been strained before the event. In addition, secondary stressors resulting from the initial event can also affect the support network.

Enhancement Through Support Groups. Mutual aid/self help (MASH) groups can provide valuable support to individuals who are undergoing stress from chronic illness or personal problems. There is a danger that the focus stays on the individual, rather than looking at outside influences.

Companionship and Intimacy. There are links between social support and intimacy. Friends are important, especially for women. One researcher suggests re-conceiving the marriage relationship as a context, rather than a descriptor of who people are.

PART 2: GENDER DIFFERENCES AND SOCIAL SUPPORT

There are many problem areas with traditional gender research, including criticism that the focus is not on underlying power structures but on biological differences. Some researchers, however, believe gender research can still be helpful to point out the differing needs and wants of women. If undertaking gender research, there are several guidelines to follow and researchers and policy-makers need to be aware that interpretation of data can result in potentially harmful outcomes for women.

There is limited research on gender differences and social support. Research problems in this area include a lack of adequate conceptualization and measurement. Women and men have different social networks. It also appears that both women and men choose women as their preferred helper. Women are not only informal supporters, but in professional capacities such as nurses and social workers, they are formal supporters as well. Women also are expected to be family caretakers not only for their own families but for in-laws.

WOMEN, WORK AND SOCIAL SUPPORT

It was assumed initially that working outside the home was detrimental to women's health. However, it now appears that work provides access to new support networks for women. There are many variables that can affect work satisfaction. Overall, work appears to have health benefits for women. For homemakers, there are assumptions that work roles of wife, mother and housewife are compatible, and that the home is seen as a sanctuary, or stress-free place. Some researchers now refute these assumptions.

PART 3: SOCIAL SUPPORT AND SPECIFIC GROUPS OF WOMEN

ABORIGINAL WOMEN

Aboriginal women have health care needs that are different from those of Aboriginal men and non-Aboriginal women. There is little comprehensive research data on Aboriginal women, especially Métis women. Social support can be a source of strength or a liability for Aboriginal women. Relocation to urban centres forces overcrowding in substandard housing. Aboriginal women represent the highest percentage of single-parent families in the country.

MINORITY WOMEN

Research seldom addresses issues of race and class differences, yet there are different concerns for women of varying ethnic backgrounds. Inequity is a major problem. Women from some cultures are reliant on family males for financial decisions, which can impact decisions about women's medical treatment and compliance. Social networks and links between members can be different for some ethnic groups. There is a need for health care providers to be culturally-sensitive.

PREGNANT WOMEN

Social support during pregnancy has been shown to be beneficial. Women who are socially disadvantaged, such as pregnant teenagers, can benefit especially from support.

LESBIANS

There is little research on health and lesbian women. Lesbians often face discrimination when attempting to receive health care. Health care professionals need to be educated about lesbians and health to create health care services that are welcoming to lesbians. One group on the Internet provides world-wide support for lesbians with informational support and chat groups that provide access to other lesbians. While this technology can offer support, one drawback is the availability of computer access.

OLDER WOMEN

Older women have different health needs than older men, yet there is little research on this group of women. Women generally live longer than men, but they do not enjoy good health. Older women received more drugs and suffer from more stress from poverty, loneliness and family caregiving. Employed older women, and women who volunteer, appear to have greater life satisfaction. This is possibly due to the in-

creased access to companionship and support. Reciprocity in support is important for older women, particularly with adult children than with friends.

RURAL WOMEN LIVING WITH VIOLENCE

There is little research on the support networks of women who live with violence despite the acknowledgment of the isolation that these women face. This is of particular importance to rural women, who not only are isolated socially, but geographically as well. For rural women the type of help that is available is different from that available to women who live in the city. Women who help this group by volunteering on crisis lines and educate the community are often isolated as well, and they face public harassment for their work. There have been a few initiatives by community groups to address the issue of violence. However there is still little funding from governments for shelters. The Saskatchewan Farm Stress Line is a unique way to support rural people. Problems are discussed with trained counsellors who have a farming background.

SEPARATED AND DIVORCED WOMEN

Divorce can be a stressful time for women, due in part to the disruption of their support networks. Social support can relieve distress, but the type of support is important. Friends and children have been reported to be the most helpful. Outside agencies are seldom used for support by divorced women.

ALCOHOLIC WOMEN

It appears that women alcoholics are more isolated socially than male alcoholics. Women alcoholics report less satisfaction with their support network, especially for emotional support. One study has shown that as children, women alcoholics report having had less supportive families than the control group.

WOMEN LIVING WITH AIDS

AIDS is increasing rapidly among minority, low-income women. Unlike gay men, women with AIDS often do not have strong support systems. Women also are faced with different issues than men, such as pregnancy. Women are often the caregivers of people with AIDS. It is often difficult for individuals with AIDS who are not well to maintain support systems. Disclosure of AIDS is a factor in developing or maintaining a support system. Sometimes disclosure means rejection. The development of professional, community support is required.

WOMEN LIVING WITH CANCER

Cancer causes long-term stress which can affect interpersonal relationships. Social support has been shown to be effective in the psychosocial adjustment and coping processes associated with the diagnosis and treatment of cancer. Support groups have shown to be an effective intervention. Young adults with cancer also benefit from support groups with peers as they have different needs than older cancer patients. Cancer research needs to address psychosocial issues for women, given that the quality of life for women is as important as disease treatment. There is little research on cervical cancer that integrates social and psychological issues with prevention and treatment of cancer. One researcher has found links between early family ties and women who are at high risk for cancer. The level of support in current relationships prior to cancer also can determine the level of support a person with cancer will receive. Caregivers often have a difficult time dealing with support needs of patients. One study has found family and caregivers have different definitions of support. Communication of support needs is important. Interventions also need to consider women's ethnic backgrounds.

WOMEN LIVING WITH CHRONIC ILLNESS

Chronic illness can mean significant life changes. Marital quality has been reported to influence support for the chronically ill. The expectations of family and health care professionals also can influence the well-being of the patient. Most of the caretakers of the chronically ill are women.

WOMEN LIVING WITH DISABILITIES

For people with disabilities, social integration has been found to improve social support. "Natural supporters" (not disability service providers) are individuals who provide support to disabled people. Such services have been criticized for being male-oriented. Several researchers suggest that the issues important to disabled women have been ignored by feminist researchers. Researchers need to redefine definitions such as "independent," to mean having control over one's life, rather than the ability to do certain tasks.

PART 4: FEMINIST RESEARCH METHODS

While there is no one type of feminist methodology, there is some common ground. This includes the idea that research is not value-free, and that values can impact all stages of the research process. Also, it includes a focus on the diversity of women's experiences and the effects of the social context within which a woman lives. For those who wish to use traditional methods, one group of researchers has several recommendations. Others recommend moving away from the biomedical model to include psychosocial and physical environments, developmental stages, and respecting and listening to women's different ways of "knowing."

Changing the research process to include more involvement by participants is also recommended. Research should not be limited to white, middle class women, and research tools need to be screened for bias, language barriers, reading levels and/or content congruence.

CONCLUSION

Research needs to have a broader scope not only of what areas are researched but how research is done. Context, socio-economic status and culture are some of the variables that need to be included if researchers are to develop a better picture of the lives women lead. As well, methods such as feminist participatory research, which reduces the power inherent in other research methods, are a vital way to gain an understanding of women and the process of support. Other research methods can be used if they incorporate feminist philosophy that acknowledges the bias that can influence research outcomes.

There are many groups of women who currently have not participated in research on social support. These include older women, Aboriginal women, immigrant women, women who live in poverty, disabled women, lesbians and adolescents. More research is needed with these groups, as often they are the women in our society who have less social support.

There is a great deal of research on individual characteristics of the persons receiving support, as well as their coping styles. There is little research on characteristics of caregivers or the benefits of caregiving. The emphasis on the individual can be a dangerous area, as it may lead to blaming individuals for their own lack of support. More research on external factors that contribute to support, and a focus on research as a process rather than a one-time event would be useful.

Research has shown that people prefer informal support (family, friends) over formal agency services. Studies also indicate that women are preferred as support givers. Women traditionally are involved in caregiving jobs at work. In attempting to increase women's support networks, what kind of implications are there for women as the primary support givers? what are the ways the community can encourage women to use formal agencies? how can these agencies become more welcoming to women, especially those women who are marginalized by society?

Technology has presented new possibilities for support, including emotional support through chat lines and e-mail, as well as up-to-date informational support. How can this technology be used to enhance support, and what are the detriments, such as who has access?

In order to provide support for those women who are not receiving it, or not receiving enough, we need to understand better how the support process works and what it is that women in specific situations really need. We need to understand the burden of being a caregiver, as well as the potential benefits. We need to explore how the various roles combine, such as caregiver and support receiver, and learn what it is that women are coping with on a daily basis. By including women in the research process, by listening to their voices, and by hearing their stories, perhaps one day no woman will ever have to stand alone.

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PART 1

SOCIAL SUPPORT DEFINITIONS AND LINKS TO RESEARCH

Social support currently is a large field of study in relation to health and well-being. Links between health and social support have been established, suggesting it is an important variable in the study of women's health issues. The major challenge of conducting research on the topic is the vast conceptual range of the term "social support" which is used to describe everything from qualitative, subjective views of help received, to quantified social network analysis. One of the purposes of this literature review is to describe the many ways social support is studied, with an explanation of terms and methods as defined by researchers. Research results from many years of study also are presented. Both traditional and feminist research is outlined, with a section on gender differences bridging the two methods.

SOCIAL SUPPORT DEFINITIONS

STRUCTURAL DEFINITIONS

Cohen (1988) describes three categories of support measures. He notes *social networks* are measured in terms of size, dispersion and frequency of contacts. Measures of *social relationships* assess the existence, type and quantity of

relationships. Functional aspects of *social support* are measured by type of support given, and the quantity or quality of that support.

CONCEPTUAL DEFINITIONS

Barrera (1986) defines three categories of social support. *Social embeddedness* is described as the connections that persons have to others in their social environments. These are measured through evidence of social ties, such as marriage, participation in community organizations, and contact with friends. These are not direct measures of social support; instead they indicate potential sources of support.

Another facet of social embeddedness is similar to what Cohen (1988) describes as social network measures and the structure of the network, such as density. Barrera describes *perceived social support* as a cognitive appraisal of being connected to others, and knowing that support is there if needed. Measurable elements of this category include the availability and adequacy of supportive ties. *Enacted support*, is described as actions performed by others when providing support, and is usually measured through self-reports from the individual receiving support.

FUNCTIONAL DEFINITIONS

A common description of support is by function or type.¹ Quick, Nelson, Matuszek, Whittington and Quick (1996) describe four categories of functional support. The authors define *emotional support* as the communication of support through feelings of caring, love, empathy, trust and concern, usually given by family and close friends. *Appraisal support* is giving evaluative information in the form of feedback, affirmation or social comparison. *Informational support* is advice and suggestions that assist a person in responding to personal or situational demands. *Instrumental support* is a concrete form of support, such as giving money, time or other interventions on behalf of another person.

PERCEPTUAL, DEVELOPMENTAL AND DYNAMIC DEFINITIONS

Quick, Nelson, Matuszek, Whittington and Quick (1996) define social support conceptually. A *perceptual* approach describes support in terms of believing one is cared for, loved, valued and belongs to a network of mutual obligation.² Other researchers define social support as the actions or information we receive from others that tells us we are cared for, valued, and that help will be available if we need it.³ In a *developmental* approach, social support looks at areas such as attachment theory, which states that secure attachments in childhood allow for the development of effective supportive relationships in adulthood.⁴ From a *dynamic* perspective, social support is described in terms of interpersonal transactions; an exchange between at least two people perceived to be intended to enhance the well-being of the recipient.⁵

¹Cohen, 1988.

²Quick *et al*, 1996.

³Major, Cooper, Zubek, Cozzarelli, and Richards, 1997.

⁴Quick *et al*, 1996.

⁵Quick *et al*, 1996.

Kfir and Slevin (1991) ask the question, “What is help?” They point out that how help *helps* is still unknown. They ask, “Why is it that certain information given by one person is just ‘information,’ whereas the same information given by another person is ‘help’?” (page 30). For those in need of help, there is a feeling that there are no possibilities. They describe *help* as something that creates new possibilities.

LINKS TO RESEARCH

Social support is defined as something received by an individual in order to enhance their well-being. Support can be something tangible—such as money—or intangible—such as reassurance. This simple idea becomes more complicated when researchers attempt to study this concept. When support is tangible, it can be measured easily. It is more difficult to study support that is intangible, such as an encouraging smile or a word of reassurance. There is a problem of measurement: what do we measure, and how do we measure it?

Support also depends on perception. In order for support to be helpful, it needs to be perceived by the receiver as being helpful.⁶ If a person is given money when she or he needs a hug or some encouragement, the act of giving money may not be seen as helpful. Research questions can ask: What kind of support is perceived as helpful and when? What happens when support is perceived as helpful? How does the person giving support know what kind of support to give and when to give it?

People seldom have only one person with whom they interact. Shumaker and Brownell (1984) state that “social support is an exchange of resources between at least two individuals perceived by the provider or the recipient to be intended to enhance the well-being of the recipient.”

⁶Buunk, Doosje, Jans and Hopstaken, 1993.

ent” (p. 13). It involves an interaction, which complicates further the study of support. Instead of considering only the person receiving support, the individual giving support needs to be included. Do they want something in exchange for giving support? Do the individuals receiving help feel indebted? What happens to the person There are who is always giving support but not receiving anything in return? Researchers need to be aware of the interactional and relational aspects of the support process.

The community in which we work and live is known as the *support network*.⁷ Social support within the network can be described as formal or informal.⁸ *Formal support* includes help from institutions and community agencies—such as a nurse, physician or priest—while *informal support* describes the help received from friends and relatives.⁹ This is an important distinction, as research has shown that most people in psychological difficulty turn to family and friends rather than professional help.¹⁰

In network analysis, researchers study the whole network, counting the number of people available to help and how frequently support is given.¹¹ In general, a person can rely on the support received from her or his network. However, at certain times—during the transition from high school to university, for example—there can be disruptions in the support system.¹² One of the criticisms of network analysis is that it quantifies support without addressing quality.¹³

Another area of research focuses on the characteristics or traits of the individual. It is suggested that certain personality traits such as ex-

troversion influence social support.¹⁴ Does someone who is friendly and outgoing have a larger network, and thus more potential support available than someone who is shy and has few friends? Are certain kinds of people more likely to ask for help and receive it?

These are a few of the areas that social support research encompasses based on the idea that support is not merely a single incident or an act between two people, but is a process involving many individuals and many different kinds of supportive acts, both real and perceived. General research questions include: What is supportive and when? How is it supportive? Who provides the support? What are the costs and benefits of receiving or giving support? In terms of women’s health, is social support different for women and men? If so, how and why is the support process different?

In summary, social support is a multi-dimensional concept that involves both tangible or intangible aid, including information, advice, and the communication of caring when an individual needs help. Knowing support will be available also is beneficial. Researchers study different facets of support, including the perspective of the person receiving help; the type of support that is given or received; or counting the number of people in a support network. It is important to define social support carefully to ensure that research methods are appropriate to studying the variables under investigation.

PROBLEMS IN SOCIAL SUPPORT RESEARCH

There are many areas of social support literature that currently are criticized by researchers, including problems with self-reporting, the design of studies, and the timing of measurement. Many social support studies rely on self-reporting, especially in documenting the types and

⁷Albarracin, Fishbein, and deMuchinik, 1997.

⁸Albarracin *et al.*, 1997.

⁹Albarracin *et al.*, 1997.

¹⁰Caspi, Bolger and Eckenrode, 1987.

¹¹Vaux, 1988.

¹²Vaux, 1988.

¹³Shinn, Lehmann and Wong, 1984.

¹⁴Von Dras and Siegler, 1997.

amount of support received.¹⁵ Problems with self-reporting include inaccurate or incomplete memory in retrieving past events, and distortions of relevant facts over time.¹⁶ Persons with high perceived support also appear to have a better memory for support, and therefore, record more support received than those with low perceived support.¹⁷ Those with higher perceived support also may be more generous in reporting support than others.¹⁸ Often it is unclear what is being reported: is it an element of the recipient's attributes or properties of the provider's behaviour?¹⁹ One way to address this issue is to use multiple assessment methods such as self-reporting and observational coding.²⁰ Another is to assess support received immediately.²¹ Attempts to keep the provider's behaviour constant (i.e., each provider in a study provides the same support the same way) also may be effective.²²

Cross-sectional research frequently is used in social support studies. Causality can be determined only by a true experimental design.²³ In social support literature, however, there are ethical problems in manipulating the variables of mental health and social support.²⁴ Panel studies that measure two variables together on at least two occasions when both variables are expected to change can be a useful design, (for example using LISREL analysis).²⁵

Researchers have examined social support mainly as a stable entity—an independent variable where outcomes are measured at the end of the

study.²⁶ Udry points to newer literature that suggests social support is a process that may be influenced by situations. For example, social support may decrease over time if a stressor becomes chronic.²⁷ Unless social support is measured over time, this aspect will remain unknown.²⁸ Collins, Dunkel-Schetter, Lobel and Scrimshaw (1993) agree that measurement of the timing of support is important, especially for long-term stressors. Most studies have failed to measure support on more than one occasion, and the authors recommend repeated measures of support to provide a more valid assessment of support received over the course of a stressor.

Methodological problems are a significant concern in social support research. Knowledge of such potential problems and corrective solutions is an asset when evaluating research studies. Careful consideration of methodology in developing and assessing social support research is needed. Clear descriptions and definitions of what will be studied, as well as how and why it will be studied, are useful in developing and evaluating a social support research study.

LINKS TO HEALTH AND WELL-BEING

Social support has been linked extensively, and both directly and indirectly, to health and well-being.²⁹ Much of the literature about health has come from a tradition where health has been described as the absence of disease.³⁰ This biomedical model is useful in curing and treating infectious disease and disease requiring surgical intervention.³¹ The drawback of this model is

¹⁵Pierce, Sarason and Sarason, 1992.

¹⁶Pierce *et al*, 1992.

¹⁷Lakey, McCabe, Segastiano, Fisticaro, and Drew, 1996.

¹⁸Lakey *et al*, 1996.

¹⁹Pierce *et al*, 1992.

²⁰Christensen, Benotsch, Wiebe and Lawton, 1992.

²¹Pierce *et al*, 1992.

²²Pierce *et al*, 1992.

²³Cramer, Henderson and Scott, 1996.

²⁴Cramer *et al*, 1996.

²⁵Cramer *et al*, 1996.

²⁶Udry, 1997.

²⁷Udry, 1997.

²⁸Udry, 1997.

²⁹Cohen, 1985.

³⁰Tamm, 1993.

³¹Tamm, 1993.

the exclusion of other factors such as the mind, body, spirit, the surrounding environment, and how those factors interact.³² Health, from a perspective of well-being, is described by the World Health Organization (WHO) in more holistic terms as not merely the absence of disease, but as a state of physical, psychic and social well-being.³³ Health is also seen by some as a harmonic balance with one's surroundings.³⁴ In linking health and well-being to social support, it may be useful to keep broad definitions of health in mind.

How is social support related to well-being? Cohen (1985) describes two mechanisms through which social support may work. The first, called *the main effect*, occurs when there is a general increased level of well-being simply as a result of being part of a support network. The *buffering hypothesis* suggests that stress in a crisis is reduced due to the specific help received. In addition, Schumaker and Hill (1991) note social support might influence health directly or indirectly by promoting safer health behaviours, by providing information, or tangible resources such as housing and transportation.

Kfir and Slevin (1991) discuss why informational support is so valuable. They describe two types of information: practical information that allows a person to make concrete decisions, and information that is about feelings and the meaning of life. They state that information means power and control to an individual by changing how a person relates to facts, and changing how an individual behaves. Information can help someone relax, by allowing things to fall into place, or it can motivate a person to act by helping with understanding and providing insight. Information, however, can be confusing

and contradictory. It therefore becomes important for health professionals to communicate information in a way that allows it to be understood to represent possibilities rather than despair.

Kfir and Slevin (1991) note that many individuals are not skilled in how they transmit information. Too much information, or information that is presented in a negative way, can result in an individual not hearing the information, or settling into denial. Instead, information should be used to stimulate a person. Information that is helpful presents the problem as an opportunity rather than a crisis, and presents options useful to making changes. The authors believe this helps the individual to move away from feelings of helplessness to feelings of control.

Support also has been linked to enhanced immune function and reduced mortality.³⁵ There are physiological studies that show neuroendocrine and hemodynamic responses are positively affected by receipt of support.³⁶ Whether looking at support from a physiological perspective or a holistic one, social support appears to have a strong relationship to health and well-being.

WOMEN AND HEALTH

Why focus on women's health? Rodkin and Ickovics (1990) explain that first, there are many health issues such as hysterectomy, breast cancer and dysmenorrhea that affect only women. Second, there are health concerns that affect women disproportionately, including osteoporosis, lupus and eating disorders. Third, health problems that affect both women and men traditionally have been studied using only male subjects with results generalized to women, leaving gaps in knowledge as to how these problems

³²Tamm, 1993.

³³Tamm, 1993.

³⁴Tamm, 1993.

³⁵Helgeson, 1993; Albarracin *et al.*, 1997.

³⁶Shumaker and Hill, 1991.

affect women specifically. Fourth, biologically and behaviourally, women have an advantage over men with regard to morbidity (general poor health, or the sum of a number of illnesses) and mortality. One explanation the authors give for this difference is that men do not get sick as frequently as women, but when they do, their illness is more serious.

Another reason to study women's health is the recognition that women are not a homogenous group. There is a need to study sub-groups of women, based on different criteria such as developmental stage, ethnicity, and geographic location, all of which can create different needs. By placing women in one group, specific needs of sub-groups are overlooked, and health services become organized around the needs of the dominant and most demanding group in the population.³⁷

In addition, psychosocial factors such as gender roles influence health outcomes.³⁸ Issues such as power, equality and control can affect women's well-being through interpersonal violence, sexual discrimination and harassment.³⁹ Baruch, Biener, and Barnett (1987) state women's gender roles have been shown to create vulnerability to stress. They argue that the tendency for women to have poorer mental health is related to their primary responsibility for the well-being of others, especially children. The role of single parent also is particularly stressful. The authors note that studies indicate the role of wife is related to psychological distress, especially depression. Yet for many women, marriage is associated with greater well-being. However, the authors state that negative interactions and marital conflict and dissatisfaction are strong indicators of distress for some women.

Social support is an important factor to consider when examining women's health issues. Women and support need to be studied from many perspectives, such as gender differences and developmental stages. When assessing support needs and research in relation to women's health, it is important to keep these many perspectives in mind.

STRESS, COPING AND SOCIAL SUPPORT

Stress is defined as a feature of the environment posing a threat to physical or psychological well-being. It is a result of negative life events that change usual activities and require an individual to make substantial behavioural readjustments.⁴⁰ *Strain* is a decrement in health or emotional well-being which is stress induced. *Stress process* is the interplay of these over time.⁴¹ *Chronic strains* are persistent conditions that require daily readjustment, interfering with performance of daily activities.⁴²

When faced with a stressful situation, there are two sources of perceived stress: the situation itself, which can threaten survival or loss of self-regard; and the reactions to the situation, where anxiety, or despair can threaten one's sense of self-control or cause interpersonal problems.⁴³ DeLongis, Lazarus and Folkman (1988) suggest that the relationship of stress to social support is the mediating effect of social support on appraisal and coping processes. For those with social support it is theorized they will face less stress as fewer situations will tax or exceed their resources. The authors conclude that when those with support do face stress, they will be better able to cope as a result of having support. Stress also serves as a cue for an individual to search

³⁷Repper, Perkins, Owen, Deighton and Robinson, 1996.

³⁸Rodin and Ickovics, 1990.

³⁹Rodin and Ickovics, 1990.

⁴⁰Thoits, 1986.

⁴¹Depner *et al*, 1984.

⁴²Thoits, 1986.

⁴³Thoits, 1986.

for resources to help them deal with threatening events.⁴⁴ The process of support in a stressful situation⁴⁵ includes: an individual encountering stress; appraising the threat; assessing their resources; engaging in coping; and experiencing a positive or negative outcome.

Coping is defined as attempts to meet environmental demands to reduce negative consequences.⁴⁶ Coping involves the ongoing process of appraisal and reappraisal of the person-environment dynamic.⁴⁷ Udry (1997) describes the process of coping as follows:

P Step one is the event itself, acknowledgment that it has happened;
 P Step two is the cognitive appraisal, how the person views the situation is important. Two people may appraise a situation quite differently, one viewing it as stressful, the other not; and
 P Step three is the emotional response, suggesting that the cognitive appraisal will influence the emotional response.

If the event is seen as threatening, the emotional response is thought to influence the coping response. The coping response will influence, in the case of medical problems, adherence to a rehabilitation program. Udry (1997) notes that this model has a *recursive nature*: it is an ongoing process where stressors are constantly being reappraised.

Udry (1997) defines *instrumental coping* as the attempt to cope through activities such as obtaining information on health conditions or listening to the advice of health care workers. In-

strumental coping appears to be the dominant strategy used for both acute and chronic medical problems. Udry notes, however, that this may be because other types of coping may have been used before seeking medical treatment. She suggests seeking medical help may be a marker that an individual is now ready to use instrumental coping. Coping may also be focused outward toward changing the environment (as in the case of *problem-focused coping*).⁴⁸ Inward focus includes *emotion-focused coping* that alters or controls emotional reactions.⁴⁹ *Perception-focused coping* is the cognitive attempt to change the meaning of a situation so it is perceived as less threatening.⁵⁰

Thoits (1986) describes a similarity between these types of coping and the categories of types of social support. She notes problem-focused coping and instrumental support both deal with changing or managing a situation. Emotion-focused coping and emotional support both involve negative emotions that accompany stress exposure. Last, she states perception-focused coping and informational support attempt to alter meanings of the stressful situation. She speculates that the way an individual attempts to handle stress is the same as the way people support others. She suggests it may be useful to conceptualize social support as coping assistance, or the active participation of others in an individual's stress management. She theorizes that social support might work like coping by:

P assisting the person to change the situation;
 P changing the meaning of the situation;
 P changing the emotional reaction to the situation, or
 P changing all three.

⁴⁴Pierce *et al*, 1992.

⁴⁵Gallant, Coons, Morokoff, 1994.

⁴⁶Thoits, 1986.

⁴⁷White, Richter and Fry, 1992.

⁴⁸White *et al*, 1992.

⁴⁹Thoits, 1986.

⁵⁰Thoits, 1986.

Udry (1997) adds two other types of coping, including *distraction coping* or *avoidance coping*—thinking about other things or actively doing something else. *Palliative coping* refers to a variety of self-help activities that reduce unpleasantness. An example Udry gives of palliative coping is getting more sleep.

Researchers disagree whether there is a set group of coping strategies that an individual brings to each situation, or if coping is different depending on the appraisal of the situation and the coping options and resources available.⁵¹ Certain situations may elicit different coping strategies. For example, one study found that coping in the workplace is more problem-focused, while health issues require more emotion-based coping.⁵² Thus, it appears that coping is more of an interaction between a person and a situation than either variable alone.⁵³ It also appears that problem-focused coping is more successful if the situation can be changed.⁵⁴ In fact, problem-solving coping may be maladaptive when used in uncontrollable encounters.⁵⁵

Toits (1986) concludes “the essence of social support: that others suggest alternative techniques or participate directly in an individual’s coping efforts, thus supplementing or reinforcing those efforts. Supportive efforts closely parallel coping efforts and can be derived from the same model” (p. 419). She argues that empathy or sympathy from others is a crucial condition in order to seek and accept support.

Mindy Fullilove (1996) situates coping and social responsibility in a unique context. She theorizes that as humans, we need to adapt to environmental changes. Any change in a per-

son’s physical or psychological environment requires developing new social and interpersonal links. A change can be minor and welcoming—such as household renovations—or large and needing major adaptation—such as loss of a home through an act of nature. She claims the most dramatic change for a woman is the birth of her first child. Women are now challenged to find environmental connections to help manage and respond to child care. She notes that many women live far away from extended families and have few people to guide them.

Fullilove (1996) describes *place* as a geographical space, as well as the people, things and lifestyles that are within these boundaries. Place is important for two reasons. First, there are features to each place that need to be mastered by those who interact in it. Second, once mastered, place can result in nurturing feelings of love and dependence. People can become emotionally attached to a place. Fullilove claims that by understanding the psychology of place, we can develop a better understanding of the grief, anger and other feelings associated with changes that come about in our place. With this understanding, we can also provide better interventions for people whose lives have been changed. She notes that often people have to manage this change on their own, and believes that interpersonal collaboration is the best way to manage and cope with environmental upheaval.

Fullilove (1996) also states that part of interpersonal collaboration is *empowered collaboration*, where people work together to improve their common lot. The stages of empowered collaboration are:

- P taking an inventory of the environment;
- P change the environment to make it more hospitable; and
- P strengthen the relationships with those people who participate in the environment.

⁵¹Udry, 1997.

⁵²Udry, 1997.

⁵³Udry, 1997.

⁵⁴Christensen, Benotsch, Wiebe and Lawton, 1995.

⁵⁵Christensen *et al*, 1995.

An important part of empowered collaboration is clarifying shared values, which can create a powerful bond between people, strengthening their ability to work together. Fullilove describes this as one way women can act together to empower their lives.

WOMEN AND COPING

Coons *et al* (1994) state traditional models of coping do not take into consideration the importance of women's roles, socialization, or status in society. They note coping often is studied as problem-focused or emotion-focused, with some research indicating that women are more likely to use emotion-focused coping than men, a method linked to higher psychological distress. They point to a recent study that found scales used to assess emotion-focused coping to be problematic—they do not assess the positive aspects of emotional coping. When “emotion-focused coping was unconfounded with psychopathology in the assessment scales, it enhanced adjustment in the face of stress for women but not for men” with women being less depressed and less hostile.⁵⁶

Another dimension that is not well assessed that is discussed by Coons *et al* (1994) is *relationship-focused coping*. Women often behave in a self-sacrificing way in relation to others, a behaviour that may appear dysfunctional. When placed in context (i.e., a woman protecting her spouse or children in order to restore, maintain or enhance family stability), it is seen as a valued behaviour appreciated by the family. This type of research indicates the need to assess social support through less traditional approaches.

NEGATIVE COPING

Kathryn Green (1994) notes that the current trend in health is a philosophy of individual responsibility. Part of this trend includes develop-

ing skills and supportive environments where people are encouraged to create healthy lifestyles that include regular exercise and nutritious diets. She points out that the problem with this trend is that it does not include health determinants that are beyond an individual's control and the context of their behaviour. She illustrates this point by discussing reasons why some women smoke. One of the factors in smoking is social class: an increasing number of women smokers come from low socio-economic backgrounds. Studies of women smokers have shown that smoking is used as a method of coping. Simms and Smith (1983) for example, found that women claimed that smoking helped them calm their nerves and relieved boredom.⁵⁷ Even though women were aware of the negative health consequences of smoking, they stated smoking helped them cope with stress.⁵⁸

These kinds of studies suggest that research into social support needs to reach beyond what appears to be the obvious issue (i.e., how can we support women in quitting smoking). Without understanding the importance of this kind of coping (why cigarettes instead of exercise are used to cope), certain support programs will be ineffective. Other studies noted by Green (1994) showed that coping strategies involving food intake and exercise also are related to external conditions. She reports findings on women who exercise regularly that showed they either did not have a spouse; had a spouse who was supportive of their exercise and helped with child care; and had children who were school-age or older. Green states instead of looking only at women's roles, it is important to compare different roles and circumstances of women, and examine how different roles affect men and women differently.

⁵⁷Cited in Green, 1994.

⁵⁸Graham, 1990; Wells and Batten, 1990, cited in Green, 1994.

⁵⁶Coons *et al*, 1994, p. 324.

As Green (1994) suggests, research needs to focus less on promoting healthy behaviours and more on studying the determinants of health. For social support research, this includes not only the question of what kind of support is offered and when, but also defining what exactly a woman is having to cope with, what resources are available to her, and what positive options she can be offered.

NEGATIVE ASPECTS OF SUPPORT

A support network does not always provide support.⁵⁹ Most supportive relationships contain both positive and negative aspects.⁶⁰ Relationships can be sources of conflict, with partners providing discouragement and disapproval that may be reciprocated, escalating the conflict.⁶¹ Henderson (1995) states that some research creates an artificial separation between stress and support. She suggests that people who provide support can also be a source of stress, citing the average marital relationship as an example. Vaux (1988) comments that individuals who are usually supportive, can, at times, be incompetent. The support itself can also be ineffective, inappropriate, or unwanted.⁶²

Rook (1984) found “negative interactions have more potent effects on well-being than positive social interactions” (p.1106). She states it is necessary to assess the specific qualities of a relationship rather than make assumptions based on role relationships. Lepore (1992) also found that the detrimental effects of social negativity (such as criticism, rejection, and conflicts) outweigh the benefits of positive support. He states

that while negative aspects are less prevalent in a relationship, they appear to be more powerful in their impact on emotional functioning. It also appears that persons with smaller networks are more affected by negativity, perhaps because they are less able to find support to help them cope. It is unknown whether social support is interchangeable from one domain to another: Lepore notes some support may be so specialized that no other relationship can substitute for it.

Some researchers have noted certain factors involved with negative interactions and ill effects on health.⁶³ These include:⁶⁴

P personality types (individual characteristics);
P absence of social support;
P frequency of negative interactions; and
P person(s) with whom the individual interacts (there is a greater negative impact when conflict is with a significant other).

Flett *et al* (1997) recommend that coping and problem-solving interventions focus on the negative responses that arise from conflict in interpersonal relationships. Helgeson (1993) states there also cannot be an assumption that needs are met simply because support has been given. Support receipt may be experienced negatively because it implies dependence. She concludes that for those in dependent roles, too much support can be troublesome. Some studies have also found that a high number of supporters also can be detrimental on the basis of being assessed as more intrusive.⁶⁵

⁵⁹Major *et al*, 1997.

⁶⁰Major *et al*, 1997.

⁶¹Abbey *et al*, 1995.

⁶²Major *et al*, 1988.

⁶³Flett, Hewitt, Garshowitz and Martin, 1997.

⁶⁴Flett *et al*, 1997.

⁶⁵Vaux and Harrison, 1985.

FACTORS THAT INFLUENCE SUPPORT

ENVIRONMENTAL DISTRESS AND SUPPORT

The external environment plays a role in the social support process by facilitating or constraining social interactions and friendship patterns.⁶⁶ There is some research evidence that implies household crowding disrupts relationships in general, and can interfere with social support specifically.⁶⁷ Studies suggest that chronic household crowding increases psychological distress due to negative effects of perceived social support.⁶⁸ In a study by Evans and Lepore (1993), high levels of crowding reduced levels of support-seeking behaviour, and reduced perceived support and support provision. The authors suggest that individuals living in crowded conditions may tune out social information, leaving them less aware of other people's need for support. Persons who show this lack of sensitivity to other's needs also may make themselves vulnerable to not receiving future support because people tend not to help those who did not support them. The authors offer an alternative explanation: residents in overcrowded environments may actively avoid social interactions because they may find them unpleasant. They also may not extend support because of the inherent expectation of reciprocity. A last important finding of this study was that the negative relation between social support and overcrowding appears to generalize beyond the crowded situation in the home into the larger community.

⁶⁶Shinn *et al.*, 1984.

⁶⁷Evans and Lepore, 1993.

⁶⁸Evans and Lepore, 1993.

An early study by Festinger, Schachter and Back (1950) with graduate students found that the physical layout of buildings affected the formation of friendships, as did physical arrangements of furniture and partitions.⁶⁹ More recent research has indicated that for hospital patients, there is more withdrawal as the number of beds per room increases. Studies have concluded that there is a need for well-defined private space where patients (or students) control access.⁷⁰ These studies show the wide range of external environmental influences on social support.

MAJOR LIFE EVENTS AND MINOR STRESSORS

Coping attempts to deal with major life events such as the death of a loved one, and/or minor stressors (daily hassles) such as traffic jams. Social support plays a different role in major events and minor stressors. The diagnosis of cancer, for example, is only the beginning of a long period of stress.⁷¹ Friends and family of those with acute illnesses also have to deal with their own emotions, leaving them less available to offer support.⁷² Studies have shown that support networks can function well at the beginning of a crisis, but can lag if the crisis appears to drag on.⁷³ Support can deteriorate if supporters begin to feel burdened or receivers feel smothered.⁷⁴

Minor stressors can include the demands of children, workplace overload and rush-hour traffic.⁷⁵ Research has indicated that hassles we face on a day-to-day basis are better predictors of

⁶⁹Cited in Shinn *et al.*, 1984.

⁷⁰Shinn *et al.*, 1984.

⁷¹Chesler and Barbarin, 1984.

⁷²Chesler and Barbarin, 1984.

⁷³Norris and Kaniasty, 1996.

⁷⁴Abbey, Andrews and Halman, 1995.

⁷⁵Caspi, Bolger and Eckenrode, 1987.

psychological distress than major life events.⁷⁶ It appears that individuals under major stress are more likely to seek and obtain support than individuals dealing with minor stressors.⁷⁷ Part of the reason may be due to the visibility of major life events—studies show that visible problems are more likely to elicit support than less visible ones.⁷⁸ The implication for social support research is to increase research on the stressors that women face on a day-to-day basis. What are the stressors? What is their impact? How do women cope (positively or negatively)? What are the consequences of not coping? What kinds of support do women want or need, and who will provide that support?

One study by Bolger, DeLongis, Kessler and Schilling (1989) showed that interpersonal conflicts were the most upsetting type of daily stressor. Their study also showed that certain types of distress occurred on particular days of the week (work overload was more common on work days). Women also were found to be more upset by daily stressors than men. Other studies, such as the one by Caspi *et al* (1987), have shown that daily stressors have different effects depending on the conditions under which they occur. The same event could be positive under certain conditions and negative under others. DeLongis *et al* (1988) discovered that an increase in daily stressors involved a decline in health and mood. However, there were large individual differences (some people actually had better moods as daily stress increased, leading the authors to surmise that some people may thrive on higher levels of stress). They offer other explanations for better moods when daily stress increased, such as high levels of self-esteem and social support. They point out that for certain individuals, signs of stress may indicate

a need to change how they are handling stress, or the need to change the situation. Last, they mention that some people may also use aches and pains as a way to get sympathy and support from others.

Most research shows that minor stressors are better predictors of psychological distress than major life events. However, Pillow *et al* (1996) suggest that studies may not have looked closely enough at the relationship between the two, and how one may affect the other. They state that minor stressors can also be a result of a major life crisis, such as financial stress or a child care burden following the death of a spouse. They point out that major and minor stressors might increase distress in an additive fashion. They offer two explanations. The *event vulnerability model* suggests that major events sensitize a person to minor stressors making them better remembered and more frequently reported. In contrast, the *inoculation model* states there is desensitization to subsequent events. Minor stressors that occur after a crisis may appear less negative than they really are. Also, an individual may develop coping mechanisms from the crisis that help them deal with future stressors. Last, the authors state a major event might induce a person to seek social support whereby the activated network is there to help with additional problems.

Pillow *et al* (1996) point out that in addition to minor and major events occurring in an additive fashion, major events may also be additive. Many major events naturally occur together, such as going to jail and losing employment. They recommend that future research look at how major events go together and affect psychological distress. Overall, they recommend investigating the ripple effect of minor and major stressors, suggesting that minor stressors often precede major events, and the understanding of these hassles may be more important than under-

⁷⁶Pillow, Zautra and Sandler, 1996.

⁷⁷Flett, Blankstein, Hicken and Watson, 1995.

⁷⁸Flett *et al*, 1995.

standing the event itself. Thus, in addition to more research on daily stressors and coping, the inter-relationship and additive nature of short-term stressors and major events becomes an important research area.

PERCEIVED AND RECEIVED SUPPORT, AND RECIPROCITY

Perceived support is defined as peoples' perception that they are valued, loved and esteemed by others.⁷⁹ *Received support* are the resources provided to the recipient.⁸⁰ Researchers agree that supportive acts cannot be judged by outsiders to be effective; they need to be perceived by the individual as being helpful.⁸¹ There are two types of perceived support:

- P *global support*: the general sense of the available support and how forthcoming it will be;⁸² and
- P *relationship specific support*: expectations of specific support that an individual may give.⁸³

Individuals not only have expectations about what support is potentially available, but also have expectations about the motivations of those offering support and the implications of the interactions on their relationships.⁸⁴ Dimensions of expectations include the question of whether the support provided will be a source of social support or conflict.⁸⁵ Pierce *et al* (1992) use an example of two college students receiving finan-

cial aid from a parent. For one student it is welcomed help, while for the other the aid evokes feelings of guilt and indebtedness.

Sarason, Sarason and Pierce (1990) describe three models of social support. *Reciprocity*, or the give and take of support, is an element of these support interactions:

- P the *network model* focusses on the individual's integration into the network and the interaction among network members;
- P the *received support model*: examines the support that is actually received or has been reported to have been received; and
- P the *perceived support model* relates to the support an individual believes to be available if she or he needs it.

There is much research that has shown perceived support to be linked to well-being.⁸⁶ Perceived support is associated in some studies with self-esteem and self-concept.⁸⁷ Received support, on the other hand, has not been shown to be as beneficial. In fact, some studies have shown a negative effect of received support on well-being.⁸⁸ It appears that one of the advantages of perceived support is that it may never have happened, where received support may be inappropriate or inept.⁸⁹

When support takes place, it can be viewed from different perspectives. When the focus is on the individual's account of the support received, it is called received support.⁹⁰ *Enacted support* focusses on the action from those giving the help.⁹¹ Researchers have noted that there often is

⁷⁹Pierce *et al*, 1992.

⁸⁰Pierce *et al*, 1992.

⁸¹Abbey, Andrews and Halman, 1995.

⁸²Pierce *et al*, 1992.

⁸³Pierce *et al*, 1992.

⁸⁴Pierce *et al*, 1992.

⁸⁵Pierce *et al*, 1992.

⁸⁶Norris and Kaniasty, 1996.

⁸⁷Sarason *et al*, 1993.

⁸⁸Norris and Kaniasty, 1996.

⁸⁹Norris and Kaniasty, 1996.

⁹⁰Sarason *et al*, 1990.

⁹¹Sarason *et al*, 1990.

a large discrepancy between what has been reportedly given and what is reportedly received, with higher levels of support reported to be given than received.⁹² Perceived support and enacted support do not seem to be strongly related.⁹³ One study on married individuals found that women have “wildly” incongruent perceptions about their spouses actual supportiveness.⁹⁴ It has been found that the perception of reciprocity is a better indicator of well-being than actual self-reports of support exchanged.⁹⁵

Individuals have different guidelines for reciprocity. Individuals who are not close require an immediate return on exactly what was given or an equivalent; an exchange in a long-term relationship is seen as a process over a period of time.⁹⁶ Within intimate relationships, there appear to be varying degrees to which reciprocity is considered between individuals, and that individual characteristics play a role in moderating the impact of perceptions of reciprocity on well-being.⁹⁷

RECIPROCITY AND SOCIAL OBLIGATION

The giving and receiving of support is a complex issue. According to social exchange theory, individuals do not try to maximize their “profits” when interacting with others, but they do attempt to receive some level of profit.⁹⁸ In general, it appears there needs to be equity in the support given or received. Negative feelings can arise in a relationship where one person is over- or under-benefited.⁹⁹ The problem is that not all

individuals enter a relationship with equal resources.¹⁰⁰ It appears that receiving help when one is unable or unwilling to reciprocate can result in negative feelings, such as obligation and indebtedness, fear of being unable to repay the debt, and uncertainty if and when the debt can be paid.¹⁰¹ When support is inequitable, a person can have feelings of resentment and unfairness when more support is given, and feelings of guilt and shame when more support is received.¹⁰² It has been suggested that the fear of being unable to reciprocate prevents some people from asking for support.¹⁰³

Kfir and Slevin (1991) believe that asking for help or support can be distressing because our culture sends a message that we should “do it ourselves.” They note that some individuals feel that asking for help may mean they are weak and dependant. Another problem with support is that it can change individuals’ roles (for example, suddenly becoming dependent when they have always been supportive). In today’s society, many people do not have family nearby to call on for help. Who, then, do these people turn to?

The type of exchange may influence reciprocity. Instrumental support exchanges are more likely to be asymmetrical and hierarchical than emotional exchanges (for example, parents giving financial support to children).¹⁰⁴ Inequities in instrumental support may be tolerated more than emotional support, as in the case of elderly parents who may tolerate support from their children as compensation for years of supporting the offspring.¹⁰⁵ Characteristics of support providers can influence the outcome of given support.

⁹²Sarason *et al*, 1990.

⁹³Lakey, McCabe, Seastiano, Fiscaro and Drew, 1996.

⁹⁴Kessler, Heath, Kendler, Neale and Eaves, 1992.

⁹⁵Sarason *et al*, 1990.

⁹⁶Antonucci and Jackson, 1990.

⁹⁷Buunk, Doosje, Jans and Hopstaken, 1993.

⁹⁸Henderson, 1995.

⁹⁹Buunk *et al*, 1993.

¹⁰⁰Henderson, 1995.

¹⁰¹Buunk *et al*, 1993.

¹⁰²Buunk *et al*, 1993.

¹⁰³Buunk *et al*, 1993.

¹⁰⁴Rook, 1987.

¹⁰⁵Rook, 1987.

Rook (1987) compared friendships with kin relationships and found that friendships are voluntary and based on mutual interests and social needs. Kin relationships are non-voluntary: they may involve greater formality and feelings of obligation. The implication is that in some kin relationships, support exchanges are based on duty. Kin relationships may be characterized by lower levels of support, especially if measured at a specific point in time, due to the anticipation of future interactions and the knowledge that kin relations will not dissolve if inequities of support exist. Norris and Kaniasty (1996) point out that a great deal of help people receive every day goes unnoticed because it is an expected part of daily routine.

Buunk *et al* (1996) found that reciprocal relationships at work are important. They assert that some asymmetry is expected in a relationship with a superior. The higher status position is expected to give more help and support. Relationships with peers involve more equal reciprocity. In fact, the authors found that individuals who believe they receive more help than they give to a co-worker can develop feelings of incompetence.

Reciprocity appears to be an important variable in the social support process. It appears that individuals do not like to feel indebted to others, and this may stop them from asking for needed support. Reciprocity also changes depending on the type of support given (for example, it is seen as acceptable for a supervisor to give informational support, but too much information from a co-worker is unacceptable). Exchanges are also different depending on the type of relationship. Long-term relationships do not have immediate reciprocity—it can be spread out over time. Measuring this type of support is more difficult than measuring an immediate exchange. Thus, when studying support, many variables including the type of relationship and type of support exchanged need to be addressed.

INDIVIDUAL DIFFERENCES

Most research studies classify support as an *independent variable*, meaning that it is an antecedent to health and well-being.¹⁰⁶ Currently, some research is exploring support as a *dependent variable*, suggesting that support has several determinants and antecedent influences.¹⁰⁷ This shift from independent to dependent variable suggests that individual differences may influence social support.¹⁰⁸

Research suggests that a major benefit of social support is its role in the maintenance of a positive self-concept, and this perhaps is the key to linking social support to health and well-being.¹⁰⁹ Self-esteem is described as a vital human need and has been shown to be a buffer against anxiety.¹¹⁰ Perceived support has been associated with self-esteem and self-concept.¹¹¹ Perceived support may be a function of the behaviours of significant others, such as parents and friends. However, it also includes past supportive behaviour, and individual perceptions of themselves as worthy of that support.¹¹² This research suggests that an individual's self-concept, and the degree to which a person believes she or he is supported may be based on prior interactions with others. Current support, then, may be dependent on these prior interactions.

It appears personality types may be linked to social support. Von Dras and Siegler (1997) suggest that individuals who are outgoing may develop friendships more easily, and have more extensive support networks. They describe the dimensions of extroversion that contribute to increase support networks as personal warmth,

¹⁰⁶Palfai and Hart, 1997.

¹⁰⁷Palfai and Hart, 1997.

¹⁰⁸Palfai and Hart, 1997.

¹⁰⁹Sarason *et al*, 1993.

¹¹⁰Greenberg, Pyszczynski, Burling, Simon *et al*, 1992.

¹¹¹Sarason *et al*, 1993.

¹¹²Sarason *et al*, 1993.

positive emotionality, assertiveness that attracts other individuals to the network and maintains friendships, and enough assertiveness to call on friends when they need help. Other individual characteristics that may influence social support include:

- P social skills;¹¹³
- P support appraisal expectations;¹¹⁴
- P appraisal of a stressful event and coping ability;¹¹⁵
- P neuroticism;¹¹⁶
- P high locus of control¹¹⁷ (this is important because threats to self-esteem have been shown to produce anxiety,¹¹⁸ assertiveness and lead to questions about meaning in life);¹¹⁹
- P sex, age, race and interpersonal skills;¹²⁰
- P coping (for example, those who distance themselves from a problem may be signalling to supporters they do not want information or advice);¹²¹ and
- P genetic factors.¹²²

The amount of stress in one's life is an interesting variable. The *social interactional model* suggests that stress can amplify negative personality characteristics that may lead to disruptions in social interactions and personal relationships.¹²³ The *support erosion model* states an individual's distress can lead to increased stress for supporters, resulting in a loss of support or decrease in quality.¹²⁴ Mental distress may ad-

versely affect the perception of social behaviour. Thus individuals with problems may receive less help (for example, depressed people have been found to be rejected on initial encounters by others).¹²⁵

Palfai and Hart note that anger coping styles may influence the availability of support (1997). There is also some evidence that anger coping styles can affect health by reducing the stress protection that can be provided by social support. The authors suggest that habitual anger or suppression styles can result in lower levels of available tangible and self-esteem support and reduce an individual's sense of belonging.

Support often requires that an individual in need of help must actively solicit support.¹²⁶ However, some individuals with poor social skills are less competent at garnering support than others.¹²⁷ A recent study by DeGarmo and Forgatch (1997) notes that individuals who are chronically stressed may be attracted to others who also are stressed, and exhibit the same qualities (i.e., irritability). The authors describe these individuals as less able to give support due to their own chronic stress. The individual in need of support has surrounded themselves with others who are incapable of helping. This is called the *principle of homophily*.¹²⁸

Characteristics of the supporter can influence the outcome of given support. One study found that support providers who were irritable or distressed themselves actually contributed to the distress of women with low socio-economic status.¹²⁹ Other characteristics of the support provider that influence support are perceptiveness, motivation and support skills.¹³⁰ Individuals who

¹¹³ Albarracin *et al*, 1997.

¹¹⁴ Von Dras and Siegler, 1997.

¹¹⁵ Francis, 1997.

¹¹⁶ Henderson, 1981, cited in Kessler, Heath, Kendler, Neale and Eaves, 1992.

¹¹⁷ Kessler *et al*, 1992.

¹¹⁸ Greenberg *et al*, 1992.

¹¹⁹ Zika and Chamberlain, 1987.

¹²⁰ Dunkel-Schetter, Folkman and Lazarus, 1987.

¹²¹ Dunkel-Schetter, 1987.

¹²² Kessler *et al*, 1992.

¹²³ DeGarmo and Forgatch, 1997.

¹²⁴ DeGarmo and Forgatch, 1997.

¹²⁵ Cramer *et al*, 1996.

¹²⁶ Vaux, 1988.

¹²⁷ DeGarmo and Forgatch, 1997.

¹²⁸ DeGarmo and Forgatch, 1997.

¹²⁹ DeGarmo and Forgatch, 1997.

¹³⁰ Dunkel-Schetter *et al*, 1987.

offer support may be motivated by self-interest, or reducing their own personal distress.¹³¹ It appears that personal characteristics, coping behaviour, and characteristics of the stressful situation all interact in the support process.¹³²

The introduction of individual characteristics into the social support process adds another complicated variable. This research suggests that certain individuals may be better able to solicit support, and/or give effective support. Individuals who have a difficult time coping, or who are less outgoing, may be less able to attract capable supporters. This vein of research has interesting implications, especially for women and health. Are we making a value judgement when we encourage women to be more extroverted in order to increase their social support? In order to increase support to vulnerable women, what is the downside of focusing on skill training (i.e., coping skills) and other individual interventions, especially when women are overloaded by exterior problems beyond their control?

SOCIAL CONNECTIONS

SOCIAL TIES AND SUBGROUPS

While social support generally is seen as a stable entity, studies have indicated that major life events can change support systems.¹³³ Norris and Kanisasty (1996) cite other research that indicates that even when help is adequate, it can be undermined by chronic stressors such as crime, household crowding, unemployment, illness, marital difficulties or parenting stress. One way support is undermined is that chronic stressors influence the perception of future available support. The authors suggest that the undermining of perceived support during a crisis

is a possible pathway for major stressful events that can lead to diminished psychological well-being. Riley and Eckenrode (1986) have noted that network events are perceived as more distressing when personal resources are low. They note that in addition to individual differences, research has uncovered certain sub-groups that receive less support than others.

Research by Norris and Kaniasty (1996) on flood victims has shown that not all victims receive the same level of support. Some victims, such as ethnic minorities and those with lower socio-economic status, received considerably less help despite having needs similar to those of other community members. The authors conclude that in the case of natural disasters, while community support is mobilized, it is not always equitably distributed. They note this is disturbing when combined with the fact that these sub-groups are already vulnerable because their assets have usually been strained before the event. Another effect on the support system is the persistent need of the disaster victims. The authors report picking up the pieces can last a long time, and the initial help offered by supporters will wane long before the recovery process is finished. The process of recovery can be lengthened as a result of secondary stressors, such as parenting, marital and financial stress. Another issue that affects support systems is the strain from being saturated with stories from the victims about the event. The authors point out that while victims may need to repeatedly tell their story, others may quickly lose interest and put up barriers to prevent victims from bringing it up once again.

The implication of this research is that not all groups are treated equally in a community when support is distributed. More research would be valuable on sub-groups within a community: what the needs of that specific sub-group are, why support is not forthcoming in certain cir-

¹³¹Dunkel-Schetter *et al*, 1987.

¹³²Dunkel-Schetter *et al*, 1987.

¹³³Norris and Kaniasty, 1996.

cumstances, and possible solutions about how to reach these groups. One such solution is the support or self-help group.

ENHANCEMENT THROUGH SUPPORT GROUPS

Support or MASH groups are mutual aid/self help groups that are formed to help individuals with specific personal problems, control issues (overeating, drug addiction), and chronic medical illness.¹³⁴ These groups may be peer-led or led by an outside facilitator. Humphreys states that studies on MASH groups for chronic illness have shown they can improve a member's knowledge of and ability to cope with their illness, as well as promote self-care behaviour (1997). He notes that adults with scoliosis in a support group, for example, had a more positive outlook on life, less shame about the disease, and less psychosomatic symptoms than those who were not in support groups. Diabetics in MASH groups showed a better knowledge of the disease, and had a higher quality of life and lower depression rates than diabetes patients who only had education about the illness.

Humphreys (1997) describes MASH groups as not only mechanisms for the treatment of health issues, but also as small communities where friends are made and members develop a sense of connectedness. He states the extension of relationships outside the support group, in the form of mentoring or sponsorship, is a valuable component, with those who form outside ties with other members showing the greatest improvement in mental health.

Henderson (1995) asserts that the process of an ongoing support group is different than the process of a group where individual members start

and end with the group at the same time. In groups that are continual, an individual starts in a position of needing help, reaches a level of equilibrium, then passes on help to newer members. While this appears to be a linear movement, the author points out that giving and receiving support often happens simultaneously. She states that some members of the group are in a fragile emotional state and are in a less favourable negotiating position.

In addition to the concept of givers and receivers, Henderson (1995) introduces the concept of *taker*. This is the individual who recognizes the benefits of giving, and initiates support out of that personal need instead of the need of the person in distress. The author warns this inherent danger in peer-related support has not been recognized previously, especially for individuals who have become takers and are themselves still vulnerable. She states that in peer support relationships, the needs of the receiver are usually clear. However, the needs of the giver can be ambiguous, and rejection of support by the receiver can be devastating. Rosen, Mickler and Collins (1987) explain that rejection of an offer of help also can be interpreted as rejection of friendship that is inherent in the offer of help. Henderson (1995) concludes that intervention using peer support needs to be monitored and used appropriately and safely, recognizing the needs of both parties in order to minimize risk and maximize benefits.

Elayne Rapping (1997) poses other limitations and criticisms of the self-help groups. Her concern is the focus away from political and social issues to individual pathology. She states "women in abusive relationships now are taught that they are suffering from a disease called 'co-dependency,' as are their equally 'sick' partners, rather than being encouraged to look at the unequal economic and political power relationships between men and women that facilitate

¹³⁴Humphreys, 1997.

and enforce the ‘normalization’ of such male abuse” (p. 61). Thus, while self-help groups can be a valuable source of support, there are inherent problems when the focus is only on how the individual can change, and no attention is paid to social structures beyond the individual’s control.

Humphreys (1997) points out additional limitations of support groups. They are not for everyone, with some people dropping out too quickly, and others staying but showing no improvement. He states research to date has supported individuals who claim support groups and combined MASH/professional treatment can improve mental and physical health.

Humphreys (1997) adds that support groups offer an alternative to our individualistic idea of “going it alone.” These groups also have promoted the idea of diversity with the establishment of groups for individuals such as gays and lesbians, minorities and women. He claims that MASH groups have received less attention in debates about health care than they deserve. Support groups, in addition to being effective, he points out, are cost-effective.

COMPANIONSHIP AND INTIMACY

Social support often is defined as the opposite of alienation.¹³⁵ Companionship and intimacy protects individuals from emptiness and despair.¹³⁶ Intimacy is important for establishing and maintaining close relationships.¹³⁷ Intimacy also is related to greater satisfaction and appraisal of support, and can also be a buffer to stress.¹³⁸ Intimacy has a similar definition to social support: feeling understood, cared for, appreciated, validated, and loved.¹³⁹

Research has shown that marriages that are unhappy have higher rates of negativity, and show more reciprocity of negative behaviours.¹⁴⁰ Studies indicate that women are less lonely in their friendships with other women than in their friendships with men.¹⁴¹ Women also report higher levels of happiness and satisfaction when they have a network of friends.¹⁴² For many single women, friends are considered family.¹⁴³

Preston (1995) suggests reconceiving the notion of marriage as a context, rather than an achieved status; and as an environment, rather than what the person is. Looking at marriage as a context introduces the idea of space that individuals occupy, rather than a descriptive term for people. Marriage then can be seen as a situation where individuals interact with each other, giving rise to social processes which, in turn, leads to the assumption of social roles. This link between intimacy, companionship and social support is an interesting one for women because research indicates that there are gender differences between women and men with regard to their intimacy needs and satisfaction levels.

¹³⁵Rook, 1987b.

¹³⁶Rook, 1987b.

¹³⁷Abbey *et al*, 1995.

¹³⁸DeGarmo and Forgatch, 1997.

¹³⁹Abbey *et al*, 1995.

¹⁴⁰Abbey *et al*, 1995.

¹⁴¹DeGarmo and Forgatch, 1997.

¹⁴²Paludi, 1992.

¹⁴³Paludi, 1992.

PART
2

GENDER DIFFERENCES AND SOCIAL SUPPORT

It is argued that much of the research on gender differences is problematic. Hare-Mustin (1991) describes two tendencies in the study of gender difference: the tendency to exaggerate gender differences, and the tendency to ignore them. She states that both views use the male as a standard of comparison, and neither want to deal with the underlying issue of inequality and women's relative lack of power. Power structures also are concealed when sex differences are seen as "natural"—suggesting it is beyond human capacity to change. Finally, the author suggests gender differences may also be construed as individual differences, putting the responsibility on the individual to change.

Paludi (1992) argues that sex is treated as an explanation rather than a starting point for research. As well, a focus on gender differences ignores within-group variability. Repper *et al* (1996) point out gender differences often are reported as biological differences even when the biological data are absent. They observe that research on gender differences is published, while studies on similarities between the sexes are not. Most important, interpretation of data

on gender differences often is used to form social policy that is harmful to women.¹ Paludi (1992) concludes that if actual gender differences such as wages earned by men and women are ignored it could lead to discrimination of women (i.e., inadequate child support).

Riger (1992) suggests that while biological differences between men and women are important, it also is important to distinguish between biological differences and the social meaning attached to those differences. Repper *et al* (1996) add that there are potential benefits to researching gender differences because there is an opportunity to "illustrate the potentially damaging effects of oppressive social structures and provide evidence of the special abilities, needs, wants and personal experiences of women" (p.40). Guidelines for non-sexist research include avoiding confusing description with explanation, confusing sex with gender, and reducing complex explanations to simplistic ones.²

¹Paludi, 1992.

²McHugh, Koeske, and Frieze, 1986.

Funding also is affected by perceived gender differences. Repper *et al* (1996) use examples of male alcoholics and substance abusers to explain. This group of men makes greater demands on health services, thus more money is spent researching them, leaving a vast gap in the knowledge of how alcohol and drug abuse affect women. The authors point out that this results in treatment devised for men which may be inappropriate for women who have different risk factors, different patterns of help-seeking behaviour, and different therapeutic needs and treatment responses. They state that attention in this area focuses on men because of public concern about male (mis)behaviour and efforts to keep the peace, neglecting women who are equally, but not as publicly, affected by this problem.

Shumaker and Hill (1991) claim researchers now argue there is significant evidence for the “identification of insufficient social support as an important risk factor for mortality and morbidity for a wide range of diseases” (p. 102). They point out, however, that most social support studies have been limited to white males. Studies that do include women do not investigate gender differences. Fortunately, this trend is changing as women’s health issues are currently gaining acceptance as a legitimate focus of study.³

Over the past three decades, sex differences have been reported in the causes, incidence, diagnosis, treatment and outcome of different psychiatric diagnoses. This imbalance is addressed and explained in terms of diagnostic practices, social structures, and physiology. Yet the focus of research and literature on women and mental health appears to be based upon understanding why sex differences exist, rather than upon addressing the social structures that permeate service cultures and organizations and contribute to the different experiences of men and women using mental health services.⁴

The few studies on gender differences and social support that exist suggest that the link between mental health and social support is stronger for women than men. However, there is a weaker yet more complex link between women’s physical well-being and support.⁵ Coons *et al* (1994) suggest this weaker link may be due to inadequate conceptualization and measurement of gender differences in social support research. For example, they note that few studies look at social network strains in addition to gains. Women, as the nurturing “network tenders,” may perceive their experience differently than men. An example is a study by Bolger and Eckenrode (1991) who found that visits to friends and neighbours buffered against stress only if they were “discretionary” rather than “obligatory.”⁶ Obligatory visits were found to increase distress. Coons *et al* (1994) state, “women’s traditional gender role demands that women provide emotional support and nurturing to family members as well as care of the sick” (p.325). They note women still are the primary caretakers of children, and are responsible for housework despite the fact that most women are employed outside the home. In addition, women bear these burdens of care and responsibility without the cultural expectation of emotional support for themselves. The authors conclude that women may receive so little emotional support and caretaking that positive benefits of high levels of support cannot be measured.

Coons *et al* (1994) make an important distinction with regard to how researchers define social support, and how this can affect women. Social support often is conceptualized as the opposite of social isolation.⁷ Isolation suggests social disconnection and alienation.⁸ By conceptualizing social support in this way, power, discrimination and inequity are not included.⁹ A study

³Gallant, Coons, and Morokoff, 1994.

⁴Repper, Perkins, Owen, Deighton and Robinson, 1996.

⁵Shumaker and Hill, 1991.

⁶Cited in Coons *et al*, 1994.

⁷Quick *et al*, 1996.

⁸Coons *et al*, 1994.

⁹Coons *et al*, 1994.

by Reifman, Biernat and Lang (1991) demonstrates this point. Employed mothers answered a survey on social support and stress and then were asked if their husbands “helped” with child care. This question implicitly assumes that child care is not part of the husband’s normal role.¹⁰ As the authors point out, having child care as part of the husband’s normal responsibilities may be as important to a woman’s health and well-being as his willingness to help out when asked. Coons *et al.*, conclude that measures of social support need to assess what is truly beneficial to women (1994).

Olson and Shultz (1994) note the socialization process does not encourage the formation of support networks for men because that process focuses more on self-reliance, autonomy and independence. The socialization process for women, on the other hand, focuses on verbal expression, and a search for intimacy. They state that women tend to seek out social support, while men utilize cognitive coping strategies such as assertive attitudes and leadership behaviours. Women also receive more emotional and appraisal support from friends and more instrumental support from their spouses. Last, the authors note that men report greater levels of informational and instrumental support from supervisors—all work related roles—while women’s perceptions of social support are from non-work roles.

In comparing social structures for women and men, Shumaker and Hill (1991) have found that:

P women have less extensive but more intensive networks than men;
P women and girls have confidants whereas many men have none; and
P when compared to those men who do have confidants, women have been found to have more.

Men often identify their wives as their only confidants, while women report they confide in both husbands and friends. Looking at the function of support networks, the authors observe that women receive more support from family and friends than men, their support is more varied, and they receive and use more emotional support than men. Women also state that being in a reciprocal or balanced giver-receiver relationship is the greatest influence of support satisfaction. Men claim the greatest support satisfaction influence is “being married.” Divorced men identify a spouse as the ideal support person. Last, Shumaker and Hill (1991) state that women are more likely than men to mobilize their support networks in times of need. However, when men do mobilize their support, they focus on their spouses for all types of support.

Lepore (1992) claims that women report having more positive and negative associations than men. Women are also more affected by negative and positive ties than men. While women receive more support than men during times of stress, negative social ties affect women more strongly. Nadler, Maler and Friedman (1984) note that gender also affects willingness to seek and accept help. Males are more likely to ask for help and be satisfied if the provider is female. Females are not affected by the sex of the helper. The authors conclude that asking for help is a threat to male self-esteem, and receiving help from a woman is non-threatening, which may help to explain why certain individuals seek help and others do not.

Both men and women rely more on women to give support or to serve as confidants.¹¹ In addition to being informal supporters, women also are more likely to be formal supporters (e.g., nurses, teachers, social workers). Thus, women

¹⁰Cited in Coons *et al.*, 1994.

¹¹Shumaker and Hill, 1991.

have dual “giver” roles, both at home and at work.¹² Women also are the primary caregivers of chronically ill and disabled people.¹³ As health funding deteriorates and the burden of care falls more to the family, we need to remember that this “family” is typically a mother, wife and daughter—not a father, husband or son.¹⁴

Shumaker and Hill (1991) observe that developmentally, there appears to be a shrinkage in network size as people get older, especially for men. Older women tend to have a larger network, are more willing to get involved with caregiving activities, and are more responsive to the life events of others. The authors note that across the lifespan, women are more likely to be both support receivers and givers than men. For older adults, when a spouse is not available, tasks usually fall to daughters and daughters-in-law instead of sons. The authors use the term “sandwich generation” to describe middle-aged women who are caretaking both children and elderly parents. “Society, the family, the professional community, and women themselves collude to delegate to women the primary responsibility for the well-being of the family.”¹⁵

What does research on gender differences mean to women and social support? It appears that men and women have different support needs, elicit support in different ways, and that context, expectations, and the meaning of support are different for men and women. When conducting social support research, we need to be aware of the impact of socialization and that implicit cultural expectations can be hidden in research questions, clouding the research response.

WOMEN, WORK AND SOCIAL SUPPORT

There has been a considerable amount of research on the effects of paid employment on women’s health. Women have special issues in this area, as most employed women are mothers, and mothers have unique family responsibilities, including child care.¹⁶ Initially, studies indicated that the extra burden of paid employment created stress for women. However, more recent studies show that women who work outside the home are “healthier” than those who do not.¹⁷ One of the explanations suggests that social support, provided in the work environment, acts as a mediator connecting paid work to better health.¹⁸

There are several theories that attempt to explain work and its effects on women’s health. For example, the job stress model suggests that long-term effects of stress and strain will ultimately harm women’s health.¹⁹ Another theory mentioned by Repetti et al, 1989, is the healthy worker effect that suggests comparisons made between working women and homemakers have not explored the possibility that women who are unhealthy are less likely to be employed.²⁰ The authors recommend using more longitudinal designs in researching the effects of employment and women’s health.

Baruch, Biener and Barnett (1987) discuss two other theories that present the conflicting view that multiple roles are helpful or harmful. The scarcity principle suggests that there is a fixed

¹²Shumaker and Hill, 1991.

¹³Thorne *et al*, 1997.

¹⁴Thorne *et al*, 1997.

¹⁵Margolin and McIntyre-Kingsolver, 1988, cited in Shumaker and Hill, 1991, p. 107.

¹⁶Matthews and Rodin, 1989.

¹⁷Repetti, Matthews and Waldon, 1989.

¹⁸Repett *et al*, 1989.

¹⁹Rodin and Ikovics, 1990.

²⁰Repetti *et al*, 1989.

and limited amount of energy, and multiple roles can create stress, work overload and negative health consequences. The enhancement hypothesis states that energy is not limited—in fact, multiple roles can increase energy. The authors explain that multiple roles offer stimulation, privileges, social status and social identity, and may be sources of self-esteem. One aspect of the enhancement hypothesis is that people can trade off or bargain around unpleasant tasks. However, this model does not reflect the reality of women's lives accurately. The authors point out that women—whether they are homemakers or surgeons—usually do not trade off visiting sick relatives or correcting homework. Thus, it appears that being a paid worker and a parent are different roles for women and men. The authors conclude that these models do not include the quality of relationships in addition to their neglect of gender issues.

Baruch *et al* (1987) note that little research has been conducted on the work strains of women who stay at home. There appears to be an assumption that the roles of homemaker, mother and wife fit together easily, when in fact they often are highly incompatible. The authors indicate research has shown homemakers report more demands on them than working women (both groups reported more demands on them than married men). Homemaking is one of the occupations in which women have less power and control. The authors argue that a major function of the role of wife and mother is to ensure that husbands and children are well and happy, but ask how much control does a woman really have over another person's welfare and happiness?

Another point made by Baruch *et al* (1987) is that the home has been seen as a sanctuary—a place to unwind from problems at work. They

state that this assumption reflects a male bias and assumes that women and homemaking roles are free from undue stress. Additionally, women's paid work is seen as an add-on role for married women, and a substitute role for unmarried women. When women enter the workforce, the risk factors are in many ways similar to those for men, such as coronary heart disease. Many studies, however, indicate that paid employment has health advantages for women.

While there are benefits to working outside the home, research has shown that there are variables that influence the costs and benefits of paid employment. Employment variables linked to a decrease in health are work-overload (including multiple-role strain and role conflict), even when both spouses work. Women, regardless of class, have a disproportionate amount of household work and child care duties.²¹ Heavy job demands that create fatigue may lead to increased risk of physical and mental health problems.²² Role quality appears to be critical in understanding the relationship between work and health. Some studies have shown that role quality is a better indicator of good health than role occupancy or the number of roles occupied.²³

Rodkins and Ikovics (1990) comment that it appears that women in high-powered careers have better health than women in low-status jobs such as clerical positions. Under-employment variables include the failure to be fully-utilized with regard to hours worked, wages paid and skills applied. Last, the authors note perceived control and attitude towards work also affect health. Matthews and Rodin (1989) point out “a surprising number of employed married women work

²¹Rodin and Ikovics, 1990.

²²Repetti *et al*, 1989.

²³Rodin and Ikovics, 1990.

non-day shift hours, that is, rotating shifts or full-time shifts in which more than half of the hours worked fall outside 8 a.m. to 4 p.m.” (p.1391).

Overall, it appears that paid employment is a benefit for most women.²⁴ Repetti *et al* (1989) suggest that factors that may influence the effects of employment on a woman’s health include marital status, a husband’s contribution to home labour, parental status, attitude toward employment, and job characteristics. Other variables are intrinsic factors, such as the challenge of the job, responsibility level, and possibilities for advancement.²⁵ Extrinsic job factors are income, hours, and relationships with co-workers.²⁶

Matthews and Roding (1989) note that “although women have entered the labour force in tremendous numbers since 1970, they are still by and large entering occupations that are dominated by women” (p. 1391). This may have an impact on the stress women face at work when analyzed in the context of control and stress. It has been documented that the amount of control one has over a task effects how stressful it is.²⁷ For women who are in positions of low power and high demand, there is a greater likelihood of depression, possibly because women are in the same situation in other roles.²⁸ A task that allows little control and yet is psychologically demanding, creates arousal and frustration leading to adverse health effects.²⁹ Baruch *et al* (1987) explain “a surgeon and a nurse, for example, may face similar levels of demands, but

they differ greatly in their power to control how they deal with these demands and thus in the stressfulness of their occupational role” (p. 131).

How does work improve women’s health? Employment offers women an opportunity to increase their social networks. Research has linked social isolation and lack of support as predictors of early mortality, depression and other physical and psychological dysfunctions.³⁰ Aston and Lavery (1993) add that paid employment gives women concrete and symbolic rewards not available to homemakers, which add meaning and structure to a woman’s life. In general, they note that paid employment expands women’s social networks beyond family ties, and provides them with the opportunity to focus on interests other than the family—interests that may be beneficial to psychological and physical health.

²⁴Aston and Lavery, 1993.

²⁵Aston and Lavery, 1993.

²⁶Aston and Lavery, 1993.

²⁷Baruch *et al*, 1987.

²⁸Aston and Lavery, 1993.

²⁹Baruch *et al*, 1987.

³⁰Repetti *et al*, 1989.

PART
3

SOCIAL SUPPORT AND SPECIFIC GROUPS OF WOMEN

The following section is a brief review of social support research on specific groups of women. While it is by no means an extensive review, nor a complete discussion, it introduces the idea that women are not a homogenous group, and that many groups have unique social support issues and needs.

ABORIGINAL WOMEN

Madeline Stout (1996) defines Aboriginal women as First Nations, Inuit and Métis women. While acknowledging that Aboriginal women have different health issues from men, Stout states they also have health values, beliefs and practices that vary from those held by Aboriginal men and non-Aboriginal women. Some of the areas that are different include higher rates of suicide among adolescents, and higher rates of diabetes, obesity, cervical cancer, sexually-transmitted diseases (STDs), and cardiovascular and respiratory problems. Despite these differences, she notes the lack of comprehensive health data on Aboriginal women, especially Métis women.

Stout explains these differences in terms of the *population health approach* that includes a wide range of factors that affect not just individuals, but entire populations. These elements are:

- | | |
|------------------|---------------------------------|
| P income | P health services |
| P social status | P child development |
| P social support | P biological and genetic makeup |
| P networks | P physical surroundings |
| P education | |

Cultural differences impact on ideals of “feminism.” Stout (1996) notes that most Aboriginal women do not accept the term because it does not match their sense of social reality (for example, beliefs about balanced female/male relationships). As well, many reject feminist solutions, such as jailing abusers in white prisons. Community healing approaches are, for many Aboriginal women, the preferred solution. Stout states, however, that Aboriginal women do have their own form of feminism, where the focus is on linking women’s domination to the oppression of all people, including men. She also notes that in addition to examining health problems, the spiritual way in which Aboriginal women address these issues also needs to be examined.

In addition to Aboriginal beliefs about feminism, beliefs about medicine are also different. Stout (1996) comments that for many Aboriginal women, there is confusion surrounding the term “medicine,” which can mean both spiritual-

ity in Aboriginal terms, and hospitals, doctors and medication. Another issue of Western medicine is its professionalized monopoly where health care professionals are a part of a profitable industry which is increasingly focused on serving scientific and economic interests over the health and well-being of the community. Part of this issue includes access to health care for Aboriginal women, who do not seek out Western health care that is insensitive to their cultural values. As a result, for example, they are often diagnosed later for cervical cancer and prenatal complications.

Stout (1996) states that social support networks for Aboriginal women can be a source of strength *or* a liability. Family violence is an overwhelming problem. One study in Ontario indicated that 80 per cent of First Nation women in the study sample had been subjected to family violence.¹ Another study on stress and family violence indicated that in Aboriginal families, extended families are sought out for support, with more men seeking support (66.7%) than women (46.7%).²

Stout (1996) also states that social support is affected as Aboriginal women move to the city for employment opportunities, or are forced to relocate due to violence in their homes. This increase in urbanization and community disintegration can affect the health of both women and children. She notes that women can be forced into unsafe, sub-standard and/or crowded housing where there is an increased risk of infection and disease. As well, there are more lone parent families headed by Aboriginal women living off-reserve (30%) than on-reserve (24%), and both family types exist in greater numbers among Aboriginal women than the Canadian national average (13%).³ She notes that the

health effects of single-parenting are stress-related, as well as related to illness linked to low incomes.

Stout also points out the strong support that Aboriginal women give each other, and acknowledges their spiritual strength in addressing these issues. Discrimination in the workplace, where women are often laid off for speaking out against sexual harassment or their rights, also affects Aboriginal women's lives.

MINORITY WOMEN

In this section, the term "minority" is applied to immigrant, racial minority and refugee women.⁴ Baruch *et al* (1987) state "it is unfortunate that the research we draw on, although addressing issues of gender, rarely includes analyses of race and class differences. To include women yet treat them as a homogeneous group is to limit severely the usefulness and accuracy of stress research" (p. 130). Simms (1996) points out there are many areas that specifically affect health for minority women. Some of these include:

- P differing cultural values that can result in isolation from mainstream society;
- P lack of access to culturally-sensitive health care services;
- P lack of knowledge and access to social support, such as pension benefits;
- P language barriers, where many women speak neither French nor English;
- P under-representation as health service providers and health training and policy-setting institutions (universities, hospitals); and
- P frustration and isolation resulting from racism and socio-economic status leading to stress.

¹Canadian Panel on Violence Against Women, 1993, cited in Stout, 1996.

²Manyfingers, 1994, cited in Stout, 1996.

³Canadian Institute for Child Health, 1994, cited in Stout, 1996.

⁴Simms, 1996.

The Canadian Advisory Council on the Status of Women (1995) add to this list a lack of education, poor nutrition, inadequate housing and sanitation, lack of social supports, low self-esteem and violence—in sum, “inequity.”⁵ Simms notes that to resolve these issues an interdisciplinary, multi-institutional, and coordinated approach to health care delivery is required.

Simms (1996) notes that many minority women are financially and socially dependant on others. This can influence access to health care and compliance with medical treatment. She explains that in some households, men make the financial decisions and may not believe that a particular treatment is relevant to the health care of their partners. She recommends an increase in understanding of cultural traditions so that physicians can include husbands early in the discussion of treatment to increase the likelihood of treatment compliance. She notes this is of particular importance for chronic illnesses such as diabetes and hypertension. Levy and Hawks (1996) agree with the need for cultural sensitivity, especially in the area of compliance and education. They point out that regular exercise, for example, is not part of the cultures of some ethnic groups. Attitudes on drinking, smoking, diet and body image also can vary among ethnic groups. Cultures that include a fatalistic belief toward chronic illness, or a belief that illness should be kept private, are other variables that can influence health care.

Some studies have shown there are differences between group support networks for different ethnic groups. One study that compared networks between ethnic groups showed that “middle-class Anglo-Celtic North Americans are more likely to have non-insular social networks with loose-knit social ties than other ethnic groups, especially Asians.”⁶ These loose-

knit ties of Anglo-Celtic families tend to limit the availability of support.⁷ Chinese community members appear to have stronger family links than Anglo-Celtic families.⁸ For many women who come from tight-knit cultures, separation from the extended family may lead to feelings of isolation, especially when compounded with language barriers and racism found in a new country.

PREGNANT WOMEN

Collins *et al* (1993) point out several ways social support can reduce stress during pregnancy. It may enhance feelings of well-being and personal control, and may reduce unhealthy behaviours such as smoking and alcohol use. Pregnancy also requires personal changes in health practices, and social support can provide guidance about proper nutrition and preparation for labour and delivery. Instrumental support, such as household chores and child care, can be useful, especially in the later stages of pregnancy. The authors state that some women may be at higher risk and need more support than others, such as single mothers, teenage mothers, and women with few economic resources.

Sandfort and Hill (1996) discuss support needs of pregnant adolescent mothers. Members of this population are high-risk because they are less likely to have graduated from high school, and are more likely to be poor and have low occupational status. The challenge is to provide help without fostering dependence. The authors note several ways to provide financial assistance to young, unmarried women, including direct financial support from the family, or sharing family living space with the pregnant teenager. This kind of aid can increase the chances the daughter will stay in school, and decrease the likelihood of additional children, thus directly

⁵Cited in Simms, 1996.

⁶Cook, 1994, p. 130.

⁷Levy and Hawks, 1996.

⁸Cook, 1994.

increasing long-term self-sufficiency. Young mothers who live at home and receive free child care from grandparents have the opportunity to build skills, whether through work or continued education, to secure better jobs in the future. The authors note that an important part of this area of research is to define carefully what we mean by “self-sufficiency.”

Collins *et al* (1993) point out that depression also is related to support during pregnancy. Women who report higher quality support also report lower levels of depression. Post-partum depression also is related to lower levels of support. The authors describe one study where women who receive more pre-natal support had better labour and healthier babies as rated by Apgar scales. It appears that material and informational support during pregnancy can affect Apgar ratings positively, while material and confiding support decreased difficult labour. Women with more network resources had babies with higher birth weights. The authors conclude that social support, especially for women who are socially disadvantaged, appears to have positive consequences both physically and psychologically for pregnant women and their children.

LESBIANS

Heterosexuality is an underlying assumption of Western society.⁹ Lynch and Ferri (1997) point out there is more research on gay men than lesbians. However, both groups are under-represented due to social stigma and the resulting invisibility, as well as issues surrounding lesbian or gay identity. Lesbians face the double-bind of sexism and sexual orientation. The authors also note that any group that is invisible to researchers also will have a higher risk for HIV transmission. Currently, there is little research on woman-to-woman transmission of HIV.

⁹Lynch and Ferri, 1997.

The Internet provides information on health care research for lesbians, including consideration of the lack of interest by researchers and the medical profession with regard to lesbian health care issues. Stacy Hart (1995) notes that lesbians may not seek health care as often as heterosexual women because they fear the personal treatment they may receive from medical staff. Surveys of health care providers have indicated that many hold negative beliefs and attitudes towards lesbians. In addition, Hart describes research that indicates lesbians often have been exposed to stereotypical comments, breaches of confidentiality, and have been referred to mental health specialists when they disclose their sexual orientation. As a result, many choose not to see health care professionals. Hart is concerned that lesbians do not have annual tests, such as breast examinations and Pap smears, and are therefore at higher risk for many medical conditions.

Hart (1995) notes that health research is conducted with mainly white, middle class women, leaving gaps in knowledge about lesbians from rural areas, older lesbians, lesbians of colour or bisexual women. She states that one of the problems with gathering data on lesbians is that many women do not openly identify themselves as lesbian. Another issue is the assumption that lesbians are at lower risk for certain health concerns (i.e., AIDS), because of the low suspected rates of transmission between women. She notes that some women who call themselves lesbians may have sex with men, or women who label themselves bisexuals only may have sex with women. Hart warns that researchers need to be aware of the effects of categorizing and labeling women.

Katherine O’Hanlan (1995), a gynecological oncologist from Stanford University, also notes that lesbians visit their doctors less frequently than heterosexual women. She asks, “How is a woman in a long-term relationship with another

woman supposed to identify herself when the only options on the questionnaire are single, married, divorced or widowed?" (p. 1). She recommends adding a welcoming option such as "domestic partnership" to acknowledge the existence of homosexual relationships. Lynch and Ferri (1997) state many individuals check the "single" category, which leaves important information beyond the reach of the health care provider, such as helping the individual access social support. The authors note lesbians also struggle with the medical community during times of crisis, especially when it comes to having long-term partners recognized as health decision-makers. Understanding the support network of lesbians and gay men is important, the authors point out, because many have been rejected by their families of origin, and have developed alternative support systems.

To help raise awareness of these issues, Robinson and Cohen (1996) recommend a re-evaluation of Canadian medical curricula to include gay, lesbian, and bisexual health care issues. They state that medical schools have an obligation to make sure that future doctors are competent to care for all members of society. The Arcadia Health Care Centre, in Seattle, Washington, also recommends creating health services that are welcoming to lesbians, including non-judgmental health care questionnaires, developing in-service training for staff to combat homophobia and to create lesbian-friendly and culturally sensitive staff.

A consistent theme in much of the literature is that lesbians need supportive environments, especially when it comes to health care. In attempting to address this issue, the Lesbian Mothers Support Society (LMSS) in Calgary provides on-line support for women around the world. They provide informational support through a small reference library, answering electronic mail from all over the world, and do research questionnaires on-line. Issues they deal

with include alternate insemination, concerns about children growing up in lesbian families, and step-parent adoptions by non-birth mothers. Lynch and Ferri (1997) note that social support for lesbians who are pregnant may be different than for heterosexual women because of possible rejection by members of their family of origin, and discrimination from their community, including their places of employment.

To help address the issue of social support for lesbians, the LMSS also provides peer support and on-line chat lines for women to connect with others like themselves. One problem with the on-line service is the fact that many women do not have access to this new technology. One woman of the LMSS opens her home on selected nights to allow her computer to be used by other women in the community.

OLDER WOMEN

An important area of study is health and older women. While medical advancements have increased the lifespan of men and women, Rodin and Ickovics (1990) argue that ironically, this is a major threat to women's health. They note that women generally live longer than men, and therefore, are at greater risk for disease development. These women will experience more stress from poverty, widowhood and family caregiving. They point out that older women receive little research attention despite the increase in health care needs. Older women receive more drugs (especially sedatives, analgesics, and diuretics) and are more likely to be over-medicated. Of particular concern are the health needs of older minority women. The authors warn that without intervention, the health of these women will lag further behind the rest of the population.

Social support is important in the lives of older women. Women living longer than men are more likely to be lonely and to become dependent on others. Stereotypical gender roles can

make it difficult for women to reach out actively for support when it involves leaving their own homes.¹⁰ Albarracin *et al* (1997) state that depression in older women is more strongly related to social support than to physical health. They report that greater life satisfaction in old age is related to the availability of social support, and that weak support networks are directly related to low immune function in older women. They note widows have less social support than women who have never married—this appears to be due to the way in which marriage may protect from loneliness. Last, widows with children have more support than widows with no children.

In one study, Rook (1987a) found that loneliness among elderly women is related to asymmetry in social support exchanges, whether through over-benefiting or under-benefiting. Reciprocity is not about a single incident, but is measured in overall feelings of reciprocity over time. In addition, reciprocity had different meanings depending on the relationship. For older women with children, reciprocity between them and their children was less important than reciprocity between the women and their friends. Women who received more instrumental aid from their children than they provided, had more satisfactory relationships with them. Rook notes one theory that mothers may store *psychological credit* in the child-rearing years that can be redeemed in old age, freeing them from feelings of having to reciprocate in later years. Another idea is that aid is more willingly accepted if it is perceived as needed because of factors beyond one's control, rather than due to a personal deficiency. Thus, the needs of older adults can be judged as legitimate. Older children who still relied on their parents for aid, were reported to have mothers with lower satisfaction. These support needs may not be seen as legitimate, or may be seen as an embarrassment. A third explanation

is that older women who can rely on children for support may be spared from having to ask friends for help. Rook suggests this frees a woman's time to spend with friends for leisure and other pleasurable activities. Kin and peer relationships may be most satisfying to older adults when they provide complimentary resources. Rook concludes children who provide instrumental support, may be indirectly contributing to their parent's good health.

Studies also have shown that older women who are employed have greater life satisfaction than women of the same age who are retired.¹¹ Aquino *et al* (1996) suggest that employment offers an access to companionship and social support. They state that the quality of relationships may be a better indicator of retirement satisfaction than the number of relationships. In addition, a positive relationship has been found between women involved in unpaid volunteer work and life satisfaction, possibly due to a bolstering effect on perceived social support. Social support may act as a mediator between volunteering and life satisfaction, or may be a cause of each (i.e., people with high levels of social support may be more likely to volunteer and are more content with their lives). The authors state that the implication of this kind of research is to focus on social support to assist the elderly to expand their view of multiple roles in retirement.

One study by Bromberger and Matthews (1996) compared traits related to the female gender role in middle-aged women. They found the gender-linked traits that may leave women vulnerable to psychological distress are not the nurturing, socially-sensitive and concerned characteristics, but rather the passive, restrained and ruminative qualities. In another study, Schulz and Rau (1985) discovered that individuals who do not

¹⁰Albarracin, Fishbein and Muchnik, 1997.

¹¹Aquino, Russel, Cutrona and Altmaier, 1996.

follow normative life cycles (i.e., older women going back to university) are likely to have unique social networks and support system needs, and may be at greater health risk. Part of the problem is that non-normative events occur infrequently, and these women have little knowledge and few skills of how to help when they occur. Thus, support network members may feel helpless and inadequate, leaving fewer opportunities for ventilation and validation for the person in distress. The authors recommend that support systems, in order to be helpful, need to be appropriately socialized.

RURAL WOMEN LIVING WITH VIOLENCE

Much of the research on women and violence has studied the individual characteristics of the violent man and battered woman. Little has appeared on social support networks despite the acknowledged isolation that abused women face.¹² One study by Eisikovits *et al* (1993) indicated that there was a relationship between men's violence and the social support available to them. The authors suggest that a larger social network may reduce men's inhibitions to be violent because they have other relationships available to them. They recommend that interventions include not only focusing on the individual, but also on the belief systems of the larger culture, including enlisting other professionals such as educators, religious figures, and media personnel. Although this study was conducted in Israel, it is interesting to compare this recommendation with the information in a Canadian newsletter on family violence that also promotes community involvement.¹³

Women who live in remote areas and are involved in violent relationships have unique social support needs. Physical isolation can

leave a woman believing she is the only person affected by abuse. Friends are harder to contact, and there is an increase in loneliness.¹⁴ Isolation leads to fear due to greater feelings of helplessness with no neighbours nearby, and the knowledge that the time it could take police or an ambulance to arrive might mean the difference between life and death.¹⁵ Rural women who have been assaulted are less likely to turn to police, neighbours, clergy or doctors for help. They are more likely to go to relatives or lawyers to protect their privacy.¹⁶ Geographic location affects both the willingness to solicit support, and the kind of help available.¹⁷ For women in rural areas, there is a lack of shelters.¹⁸

Community health care providers, religious leaders and police can all play a role in public education and social support for these individuals.¹⁹ There have been many collaborative initiatives undertaken to address family violence in rural areas. For example, in 1992, the Federal Government, in conjunction with the Canadian Farm Women's Network, funded a video on rural family violence entitled "Fear on the Farm."²⁰ The Church Council on Justice and Corrections set up a community education and development project in six communities to explore issues of family violence.²¹ While the government is willing to fund such projects, there is still a lack of government funding for shelters.²²

Other initiatives in rural communities to offer social support to abused women is the "safe home" (homes where families welcome abused women and children for short-term stays).²³

¹⁴Hymers, 1993.

¹⁵*Vis-à-vis*, 1993.

¹⁶Hymers, 1993.

¹⁷Hymers, 1993.

¹⁸Hymers, 1993.

¹⁹Hymers, 1993.

²⁰Merriam, 1993.

²¹Merriam, 1993.

²²Lovelace, 1993.

²³Albertson, 1993.

¹²Eisikovits, Guttman, Sela-Amit, Edleson, 1993.

¹³*Vis-à-vis*, 1993.

Shelters and transition houses are scarce in rural communities—often hours away—forcing a woman to leave her job, family and friends.²⁴ Safe homes have become an alternative for women who wish to stay closer to their communities.²⁵ There are problems, however, including the fact that women have to rely on safe home hosts for transportation, leaving them with feelings of powerlessness and dependence.²⁶

Women in rural communities who do volunteer work in the area of family violence have struggles. Donna Lovelace (1993) reports that women can suffer from public scrutiny and harassment for speaking out. Their husbands are chastised for not “keeping their women in line,” and their children are labelled at school as trouble-makers. Lovelace (1993) demands that we support these volunteers who educate the community, provide emotional support to abused women, drive women to shelters, and answer crisis lines. She states that we must stop denying the reality of family violence, and acknowledge the need for a response at all levels—from volunteers to governments.

The Farm Stress Line in Saskatchewan is an innovative way to support rural people. It is a toll-free line, where individuals can discuss financial, family and social problems and stress with trained counsellors who have a farming background.²⁷ Part of the service includes referral to other agencies, workshops on stress, and encouraging rural people in crisis to form self-help groups.²⁸ This is an example of how support can be mobilized, especially for individuals who are isolated geographically. Future research could study the effectiveness of this kind of support program.

²⁴Albertson, 1993.

²⁵Albertson, 1993.

²⁶Kirkpatrick, 1993.

²⁷*Vis-à-vis*, 1993.

²⁸*Vis-à-vis*, 1993.

SEPARATED AND DIVORCED WOMEN

Women who are separated or divorced often experience disruption in their social support networks through loss of contact with friends and spouse’s family.²⁹ In addition, there is the loss of their partner, who was possibly their primary source of support.³⁰ Depression and irritability also can disrupt existing support, especially if distress becomes chronic.³¹ People in distress tend to attract others with similar personality qualities, thus unhappy, divorced women may develop friendships with other unhappy women who are not effective supporters.³² For many women, separation and divorce can be a time of extreme distress,³³ lasting up to three to four years after the event.³⁴

Henderson and Argyle (1985) state that social support has been shown to relieve the negative effects of divorce or separation. However, it is the type of support network that is important. Larger, low-density networks that have a lower proportion of kin to non-kin members appear to be the most effective. Low-density networks appear to provide access to more diverse support and a better chance of finding others who are able to provide what is needed. In addition, they note, the type of support is important: a confidant and opportunities for positive feedback from others being the most useful. Friends are the most important source of support after divorce or separation. However, different types of support are needed from varying sources. While friends are important outside the home, within the home it is children who provide the greatest amount of affection and companionship. Formal

²⁹DeGarmo and Forgatch, 1997.

³⁰Henderson and Argyle, 1985.

³¹DeGarmo and Forgatch, 1997.

³²DeGarmo and Forgatch, 1997.

³³DeGarmo and Forgatch, 1997.

³⁴Henderson and Argyle, 1985.

agencies are rarely a primary source of help, and in one study, less than half the women who used professional organizations reported receiving help for a specified problem. Henderson and Argyle suggest that formal agencies may be better at helping a woman to mobilize her own support network, rather than encouraging her to use other forms of support.

ALCOHOLIC WOMEN

Several studies on women and alcohol dependence have found a relationship between a specific life crisis and the onset of excessive drinking.³⁵ Schilit and Gomberg (1987) note that most research has focused on isolation, showing that female alcoholics are more socially isolated than male alcoholics. This has led researchers to question the support network of women alcoholics, including what leads to this isolation, and how a woman's drinking affects others.

Schilit and Gomberg (1987) also report one study that found an imbalance of support given and received between alcoholic women and network members. Support network members reported giving more emotional support than they were receiving, and in some cases, receiving no reciprocal support. Results from another study by these authors showed that alcoholic women in treatment were more likely not to have a partner. In studying age differences, they report that younger women drank more in public than older alcoholics, but had fewer friends and relatives to rely on, and more stressful relationships. Overall, alcoholic women reported less satisfaction with their support networks, especially for emotional support. While there was little difference between groups for potential, material or practical support, in the area of emotional support, alcoholic women reported increased inadequacy and stress.

³⁵Schilit and Gomberg, 1987.

An interesting point in this study was the information about early support relationships. The authors found that alcoholic women were more isolated and had more unhappiness in their childhoods than the control group. This was similar to their perceptions of current support. As children, the alcoholic women had less supportive families. As adults, the alcoholic women had fewer support people, and reported being more lonely. While there appears to be a biological basis for alcoholism, the authors note that children in alcoholic families appear to receive less support. The authors recommend that interventions need to include all family members in treatment, not just the alcoholic or spouse.

WOMEN LIVING WITH AIDS

Currently, AIDS is expanding most rapidly among minority, low-income women.³⁶ Many in this group lack social support, and other resources such as the financial, legal and medical assistance.³⁷ One of the common problems mentioned by HIV-positive women is isolation.³⁸ Much of the research undertaken on social support and AIDS has been with male homosexuals, many of whom have strong social networks. Women represent a more diverse group, and this diversity can limit the formation of support groups for women.³⁹

Women also have unique needs compared to men (such as whether to terminate pregnancy or get pregnant if they are HIV-positive).⁴⁰ Another issue is the dual role of many women as a patient and caregiver.⁴¹ As caregivers, women often place their own health needs behind those

³⁶Murphy and Kelly, 1994.

³⁷Morokoff, Harlow and Quina, 1995.

³⁸Morokoff *et al.*, 1995.

³⁹Murphy and Kelly, 1994.

⁴⁰Murphy and Kelly, 1994.

⁴¹Hackl, Somlai, Kelly and Kalichman, 1997.

who are dependent on them.⁴² In addition, social ostracism is an issue because of public identification of AIDS with “evil,” deviance, drug use and sexual promiscuity.⁴³ Not only is the stigma of AIDS a problem, women are blamed specifically for passing it onto children, or in the case of prostitutes, passing AIDS onto men.⁴⁴ Stigmatization often leads to social isolation for women.⁴⁵

Walker, Pomeroy, McNeil and Franklin (1996) comment that social stigma also extends to those who care for people with AIDS. Social stigma can result in the caregiver responding to the patient as less valuable, less human, and less desirable. In addition, it can create secrecy. In the grieving process, this is known as “hidden grieving,” a term coined for those grieving an AIDS death. Hidden grieving can involve feelings of shame, guilt, embarrassment and anger, and can keep members from seeking support. The authors note that the energy used to keep the secret can drain the caregiver and cause tension between the caregiver and the dying individual. They recommend caregivers should have their support needs separated from the needs of the person with AIDS (PWA). As well, caregivers may need permission to spend time alone, seek support from others, attend to their own personal business, and obtain help in assuming new roles as old roles of the PWA begin to diminish.

Research on AIDS volunteers suggests barriers that may keep individuals from becoming involved, including limits of time and energy, fear of AIDS and death, and concerns about stigmatization.⁴⁶ Omoto and Schultz (1995) found an inverse relationship between social support and

volunteerism, with individuals who had less social support doing more volunteer work. They explain that those volunteering to work with PWAs may be interested in expanding their own support network. For those with strong support networks, the authors suggest that the grief involved in working in this area caused them to retreat to their network in order to obtain support to deal with their strong emotional reactions. The authors recommend that volunteer agencies may want to stress how the volunteers will benefit from their work, not just how they will be able to help others.

Kadushin (1996) also explains how women are involved in the care of an individual with AIDS. She notes that gay men rely on peers. However, as the disease progresses, peers may be over-taxed for a variety of reasons. AIDS has decimated the gay community, and peers are often over-burdened and greatly distressed because many friends may be infected. She recommends the family may be a source of untapped social support. Specifically, female siblings have been identified in the literature as the person a gay man is mostly likely to turn to for support because they are more likely to be open about homosexuality. Kadushin does not discuss how this approach may have detrimental effects for women as the burden of caregiving is placed on their shoulders. Other potential sources of support for gay men may need to be found.

While gay men receive more support from peers than family, hemophiliacs and heterosexuals with AIDS rely more on family than friends.⁴⁷ Peer counselling appears to be a favourable social support intervention for women with AIDS.⁴⁸ Social workers can also play a valuable role in support intervention. Scofield (1995) describes

⁴²Burdge and Money, 1996.

⁴³Kadushin, 1996.

⁴⁴Murphy and Kelly, 1994.

⁴⁵Burdge and Money, 1996.

⁴⁶Omoto and Schultz, 1995.

⁴⁷Green and Kocsis, 1996.

⁴⁸Anderson, 1996.

an early intervention model that includes preventive psychosocial care for people with HIV. Intervention can start as a part of the testing for HIV, or soon after a diagnosis is made. The process includes assessing immediate intervention needs, describing the social work role to the client, and laying the foundation for an ongoing relationship and access to social work services. Assessment of the social support system is a vital part of the process, with social workers playing a vital role in sustaining the family support system. By assessing the network's ability and willingness to provide support, the social worker can be helped to handle current needs and plan for possible future requirements. Scofield claims that early intervention and continued follow-up can help prevent psychosocial crisis inherent in the HIV and AIDS disease process. Addressing the practical side of this kind of intervention, she suggests delegating assessment and management of people with HIV/AIDS to community-based case managers. Lavoie and Kaplowitz (1996) agree with Scofield's team approach. They add the team needs to be knowledgeable about cultural, situational, and financial barriers to care, and that the team needs to include individuals who are capable of dealing with these issues. They describe the importance of communication between team members as essential to effective collaboration.

For people with AIDS, support intervention issues include stress management, counselling for depression and anxiety, and physical manifestations such as lesions, hair loss and "wasting" which take a toll on self-image.⁴⁹ It is recommended that interventions need to include basic needs such as housing, nutrition, personal safety and child care.⁵⁰ Other sources of stress which lead to psychological problems are isolation,

lack of financial resources, and the need to change patterns of physical intimacy.⁵¹ Psychological functioning such as anxiety, hostility, hopelessness, depression, and low self-esteem are related to satisfaction with or the perceived availability of social support.⁵² Green and Kocsis point out that individuals who are less well and have little energy may find it more difficult to maintain a support network, in part because they feel less like socializing (1996). Burdge and Money (1996) remind us that while it is important to counsel women on the value of good nutrition, we also need to be aware that this can be a challenge if there is no money to buy food, or if a woman does not have a refrigerator or stove. HIV-positive individuals with smaller support systems have been found to rely more heavily on hospital services. The worse someone's physical health is, the less likely she or he is to harness support. The authors suggest one of the issues in need of further study is the possible link between social support and willingness to seek, or compliance with, treatment.

Another important issue with regard to AIDS is disclosure. In order to obtain social support, a person must disclose her or his HIV-positive status. The person who hears the disclosure affects social support availability. Many HIV-positive women are reluctant to disclose their sero status, which can decrease possibilities for potential social support.⁵³ Women are most likely to disclose first to lovers and close friends, then to immediate family members, and last to extended family members.⁵⁴ In a study by Simoni *et al* (1995), it was discovered that women spoke mostly with their physicians or nurses. Next, women talked to family, social workers and

⁴⁹Murphy and Kelly, 1994.

⁵⁰Burdge and Money, 1996.

⁵¹Kadushin, 1996.

⁵²Kadushin, 1996.

⁵³Simoni, Hyacinth, Marks, Ruiz, Reed and Richardson, 1995.

⁵⁴Simoni *et al*, 1995.

friends. They talked least to counsellors and clergy. Reasons for disclosure varied. Women stated they believed their lovers had a right to know, and expressed concern for their lovers' health. The main reasons for disclosing to family and friends was to have someone with whom to talk.

Non-disclosure was cited as the desire to avoid personal rejection from lovers, or to maintain secrecy. Non-disclosure to parents was to protect them from worry, concern over stigma, shame or embarrassment, and ignorance ("They are old and wouldn't understand"). The study showed that responses from the support network varied as well. Parents usually provided emotional support and seldom withdrew. Some lovers provided emotional support. However, twenty per cent also left as a result of disclosure, confirming women's fear of rejection. Last, the study found a difference in the rate of disclosure among ethnic groups (with Spanish-speaking individuals disclosing the least), highlighting the need to provide culturally-sensitive intervention and clinical practice. Simoni *et al* (1995) reported that women who engaged in stigmatized behaviours, such as drug use or sex with other women, were less likely to disclose. The authors suggest these clients can best be supported by support groups and non-family members.

Collins and Coates (1997) recommend a multi-faceted approach to AIDS prevention, claiming that HIV is spread through ignorance and social inequities as much as through physical modes. They state there is a need to address the targeting of resources; social factors; discriminatory and fear-based public policy, and equitable use of new technology. They also discuss the need for distribution of information that reaches the most vulnerable groups, either through government agencies, or if these are unwilling, then by distributing public funds to private groups who will develop targeted, appropriate messages.

WOMEN LIVING WITH CANCER

Christine Dunkel-Schetter (1984) describes cancer as a stress process that can extend over months or years, where treatment can be painful, and where an ambiguity over recurrence exists. She lists several possible interpersonal changes as the prognosis worsens, including a decrease in social interaction, declining provision and satisfaction of support, and more prevalent problems with family and communication. A positive relationship has been found between social support and psycho-social adjustment and coping with diagnosis and treatment of cancer.⁵⁵

Dealing with cancer can alter a person's social relationships, their values, beliefs, meaning of life, and expectations for the future.⁵⁶ Cancer patients can be seen as victims who have no control over the event.⁵⁷ Social support appears to be beneficial for isolated patients and can mediate how an individual copes with stress related to the process.⁵⁸ After treatment, there can be subtle, long-term residual effects as the patient returns to everyday life.⁵⁹ Future research needs to deal with the ambiguity of the treatment outcome and how the individual will cope with this uncertainty.⁶⁰

Specifically for cervical cancer, Lambley (1993) notes key physiological vulnerability factors for women. These include how they are supported both socially and interpersonally, and how they cope with stress. He mentions early family ties can play a role (for example, adolescents with unsupportive parents may engage in high-risk behaviour to satisfy emotional and psychological needs). He found that women who have been

⁵⁵White *et al*, 1992.

⁵⁶Carpenter, Morrow and Schmale, 1989.

⁵⁷Blanchard, Albrecht, Ruckdeschel, Grant, and Hemmick, 1995.

⁵⁸Spiegle, Kraemer, Bloom and Gottheil, 1989.

⁵⁹Carpenter *et al*, 1989.

⁶⁰Carpenter *et al*, 1989.

found to be at high risk for cancer often have histories of early family problems. Not only do they engage in high-risk behaviour such as sex at an early age and sex with multiple partners, many have left home early and are not equipped with social skills to develop and maintain strong social ties in the future. In addition, they may have unsatisfying relationships and lack the emotional energy to develop new, supportive relationships, which increases their risk. This is similar to research results on alcoholic women who also reported less social support during adolescence than non-alcoholic peers.⁶¹ For cervical cancer, Lambley concludes that there are many factors that interplay simultaneously for dysplasia to progress to malignancy, and all of these factors need to be taken into account.

Lambley (1993) also states there is little in the research literature that integrates social and psychological considerations with medical treatment, or that deals with the prevention and treatment of cervical cancer. There is little support or psychological advice given to women who have been treated for cervical cancer, and what information is given pays scant attention to the interpersonal issues involved. He adds that in addition to treatment, there also is the stress of cancer diagnosis that can affect treatment outcome. He believes this is an area that needs consideration for the prevention of recurrence of the disease. One counsellor agrees, stating “not all patients need or want professional counselling, but all of them need to be listened to, as their search for meaning may be a very important part of the healing process.”⁶²

One study conducted in the United Kingdom points out barriers in communication between patients being screened for cervical cancer and health professionals.⁶³ It appears that health pro-

fessionals are concerned with control and surveillance, while women are generally seeking insurance and reassurance.⁶⁴ In another study, Blanchard *et al* (1995) compared the definition of support by parents of children with cancer and the definition held by health professionals. Parents defined support as compassion, skill in listening, and caring. Health workers described support in terms of being available, being consistent with the family, showing oneself as supportive, understanding and supporting the parental role, and assisting with needed resources. McKie (1993) suggests that community health workers can play a large role in reducing fear and anxiety by providing emotional support and informational support that increases knowledge of screening, causation and treatment.

Johnson and Meischke (1991) found that people with cancer are active information-seekers. They state there are two cancer information needs:

P cognitive needs about prevention, treatment, and detection; and
P affective needs, or, information on how to deal emotionally with cancer.

They note other studies have found other needs regarding cancer, including personal and social integrative needs, and tension release or escape. In their own study, the authors found that once diagnosed with cancer, people turn to authoritative channels, such as doctors, for their information. Dunkel-Schetter (1984) agrees. She found that informational support given from family and friends was often unhelpful and even bothersome.

Johnson and Meischke (1991) point out that in general, health care professionals have a difficult time handling the information and personal

⁶¹Schilit and Gomberg, 1987.

⁶²Brugge, 1994, p. 385.

⁶³McKie, 1993.

⁶⁴McKie, 1993.

needs of patients. Thus, individuals often turn to their interpersonal network for emotional support. Dunkel-Schetter (1984) recommends educating doctors on the importance of providing at least small amounts of emotional support, in addition to giving patients information. She describes team approaches where nurses and social workers are incorporated as emotional and information specialists. However, she notes they may not completely substitute for physician care. Last, Johnson and Meischke (1991) state the more barriers an individual encounters in trying to obtain information, the less likely she or he will seek out information actively.

Spiegel (1992) reports a study that measured the effects of a psycho-social intervention for women with cancer using a support group. The support group enhanced the quality of life for patients, and increased their feelings of control. It helped the women to gain control over strong emotions, and to make use of available social support. Patients frequently feel isolated as family, friends and health care workers often have a difficult time dealing with strong emotions. These feelings of isolation often leave a patient feeling removed from the mainstream of life, as if they are already dead. The author notes that social isolation is linked to greater mortality—participation in support groups may alter the risks associated with isolation.

Young adults with cancer have different needs than older people with cancer.⁶⁵ Roberts *et al* (1997) state that developing cancer at an early age disrupts normal developmental tasks such as establishing independence from parents, starting a career, finding a partner, and having children. They point out that young adults also are faced with the issue of their own mortality, something not usually dealt with until the sixth decade of life or later. The authors state this last issue can result in isolation from healthy peers who do not

want to deal with the issue themselves. These patients may not feel they have anything in common with older cancer patients. In a study by the authors on support groups for young adults with cancer, individuals stated they sometimes received too much support and not enough private time. Other members said that family members and friends withdrew or had trouble communicating after the diagnosis of cancer. All members stated they did not get enough information from their doctors, and the group process included giving informational support. Patients also discussed feeling disfigured or physically affected as a result of treatment.

Welisch (1993) points out group experience does not always appear to be beneficial. For example, a study comparing white and Asian women with cancer found cultural differences. Groups that focus on talking appear to be less relevant to Asian women who might be better served by groups that teach psychically-focused skills such as meditation, relaxation and massage. She notes that while many groups are short-term, there is a growing recognition for groups to continue for years throughout the disease process. In addition, patients' partners experience increased vulnerability to illness upon the death of the patient, indicating that support groups also would be helpful to the partner for the prevention of future disease. She reminds readers that staff who treat patients also need support. Studies indicating that happier staff served patients who adapted and coped better than patients who had less happy staff.

Dunkel-Schetter (1984) acknowledges the issue of support and cancer is complex. She states "stresses such as cancer have several simultaneous effects that take place over time and that are interwoven" (p.93). She notes, for example, that the stress placed on a person with cancer's family and friends can influence the quality and quantity of support. In a study of parents of children with cancer, Chesler and Barbarin (1984)

⁶⁵Roberts, Piper, Denny, and Cuddeback, 1997.

describe five core difficulties that parents and friends face with regard to giving/receiving social support:

- P concern about emotional impact;
- P maintenance of privacy and prior boundaries of a relationship;
- P concern about stigma;
- P effectiveness of help; and
- P attempts to deal with traditional role-stereotypes.

The authors report that friends' compassion and desire to help is complicated by their own emotional distress. In addition, good cues from parents about what kind of support is helpful not only made it easier to give support, it also made friends feel appreciated.

Another variable that can influence support is the prior communal relationship between the patient and supporter.⁶⁶ Williamson and Schulz (1995) found supporters who had been caring and responsive to the individual's needs prior to onset of cancer had less depression and feelings of being burdened than caregivers who reported few prior communal behaviours. The authors suggest that the new care-taking role may be taken on out of obligation rather than concern for another's welfare, or out of interest in maintaining the relationship. The authors conclude that with regard to caregiver support, the perception of the burden is important because early identification of supporters who are at high-risk of becoming distressed as a result of the caregiver role is important.

According to Payne *et al* (1996) there are several factors that interplay and determine an individual's response to cancer:

⁶⁶Williamson and Schulz, 1995.

- P inner resources of the patient and psychological make-up including coping abilities, and developmental life-cycle stage (young, mature, elderly) at the time of diagnosis; and
- P familial, social and cultural environment and financial support available

Exterior influences are medical parameters of the disease such as state at diagnosis, available treatments, and complications of treatment.⁶⁷

Future research can explore the nature of the communication of support and longitudinal studies to inspect the impact of disease stage on support interactions.⁶⁸ Analysis of the use of coping strategies, and more scrutiny on the impact of changes in the patient's social network would be useful.⁶⁹ One doctor asks, "Why do four women with an identical diagnosis have such different outcomes? We need to look more intensively at the woman, and less at the tumour."⁷⁰ Another doctor notes that early detection is not prevention and that more research is needed on the psycho-social issues arguing that women want better support systems and attention paid to their quality of life, not just a postponement of death.⁷¹

WOMEN LIVING WITH CHRONIC ILLNESS

Chronic illness for many people means major life changes. White, Richter and Fry (1992) note these can include loss or changes in employment and social roles, lifestyle changes, threats to self-image and self-esteem, disruption of normal

⁶⁷Payne *et al*, 1996.

⁶⁸Blanchard *et al*, 1995.

⁶⁹Blanchard *et al*, 1995.

⁷⁰Brugge, 1994, p. 388.

⁷¹Brugge, 1994.

life transitions, unpredictable futures, and decreasing resources. Coping requires cyclical adaptation, with disabilities creating psychological readjustment which affect social activities. In addition, this cycle may require continual adjustment and response patterns. Chronically ill patients use denial, acceptance-resignation and problem-solving techniques to help them cope. The authors note that some research has indicated coping that allows for some form of control over disease is related to positive adaptation. The family may be a better source of emotional support, and medical staff more important sources of informational and tangible support.⁷² Medical staff may be able to influence optimism and pessimism about the future—optimistic patients have been found to elicit more social support.⁷³

Marital quality plays a role in the amount of support received.⁷⁴ Women who reported better marital quality also reported higher levels of support from their partners and families, and less depression and illness demands.⁷⁵ It also is important to study family context because interpersonal understandings and misunderstandings of the magnitude of the illness affect well-being and substantial distress is experienced by the patient.⁷⁶ Patients who felt they were less able to meet family and medical staff expectations reported more depression.⁷⁷ Intervention should not only focus on mobilizing social support, but in helping to increase understanding and the adjustment of personal and interpersonal expectations about the illness.⁷⁸ Last, most of the care of chronically ill patients falls to women.⁷⁹

⁷²Hatchett, Friends, Symister and Wadhwa, 1997.

⁷³Hatchett *et al*, 1997.

⁷⁴Primomo, Yates and Woods, 1990.

⁷⁵Primomo *et al*, 1990.

⁷⁶Hatchett *et al*, 1997.

⁷⁷Hatchett *et al*, 1997.

⁷⁸Hatchett *et al*, 1997.

⁷⁹Thorne *et al*, 1997.

While biomedical intervention in health care remains intact, financial cutbacks have steadily decreased the preventive and supportive components of health care.⁸⁰ There is much public debate over hospital closures, but home care services remain hidden from public view.⁸¹

WOMEN LIVING WITH DISABILITIES

Because women live longer than men, a greater proportion of disabled people are women. Advancing age is linked to increased levels of chronic illness and disabilities.⁸² Storey and Certo (1996) claim that for the person with disabilities, social integration can lead to improved social support. Social integration and social support are important because they:

P are valued by society;
 P help people through stress and difficulties;
 P link people who are socially devalued to the community; and
 P meet the needs of those with disabilities that professionals cannot meet.

Despite the value of social integration, research has shown that individuals who are physically integrated are often socially segregated. The authors note the involvement of *natural supports* in the process of integration. Natural supports are “not disability service providers but people who provide assistance, feedback, contact, or companionship to enable people with disabilities to participate independently, or partially independently, in integrated employment settings or other community settings” (p. 63). The authors recognize that integration is more

⁸⁰Thorne *et al*, 1997.

⁸¹Thorne *et al*, 1997.

⁸²Thorne *et al*, 1995.

effective when natural support persons are involved, rather than specialized services or personnel. Natural supports also are those friends, family members or classmates who attend a community function with a person with disabilities (i.e., going to a concert together).

Storey and Certo (1996) state support on the job may include: continued skill training, social skills instruction, advocacy, community skill training, validation of instructional strategies, collection of subjective evaluations, collection of social comparison information, and job modifications and adaptations. The use of natural supports systems within a work context has been shown to be cost-effective with benefits that include a return on tax dollars.⁸³ There appears to be a link between employment and community supports. People with disabilities who have been integrated into a well-paying job are more likely to have more friends outside of the workplace, in part because they have the financial ability to participate in community activities.⁸⁴ Thorne *et al* (1997) criticize many of these programs stating they benefit men disproportionately (for example, by focusing on male-gender occupational skills).

Thorne *et al* (1997) also describe ideas that are oppressive for people with disabilities. The first is our society's obsession with perfect bodies that are strong, lean and graceful, which results in an unattainable body image for many women, especially those with disabilities. The second is the work ethic that promotes the idea of overcoming diversity, leaving those with disabilities feeling as if they are not contributing and/or personal failures.

Thorne *et al* (1997) note that for women specifically, research fails to look at more common female disabilities such as rheumatoid arthritis

and multiple sclerosis, and the inclusion of an analysis of the realities of daily living—such as being mother, housekeeper, worker and partner. For diseases such as fibro myalgia and chronic fatigue syndrome, not only is the impact on daily living ignored, the very existence of these diseases often is questioned.

Thorne *et al* (1997) also state there is currently little intersection between feminist literature and the issues of chronic disease and disability. Part of the reason is that disability rights activists have focused on the medical model of treatment, rehabilitation and policy, and have not included the socio-political issues of discrimination. The authors state that looking at disabilities forces a person to deal with their own issues of helplessness, dependency, pain and suffering. Thus, the authors argue, feminists view disabilities as creating forced dependency, threatening the hard-won advances women have made. There are, however, issues which overlap feminist and disability issues such as the loss of voice, debates on similarities and differences, independency and dependency, and integration and separation. The authors conclude that feminists could expand their understanding of the body further by incorporating the knowledge and experiences of people with disabilities.

Jenny Morris (1995) also comments on the feminist dialogue related to women with disabilities that has failed to include women with disabilities in the category of “women.” She describes a redefinition of the word “independent,” to mean control over one’s life, not the ability to perform every task. Morris has noted the lack of representation of the voices of women who are “cared for,” including their need to be caregivers to family and friends. Many disabled women also are caregivers providing physical and/or emotional support to family and friends, yet they often are seen solely as passive care recipients.

⁸³Storey and Certo, 1996.

⁸⁴Storey and Certo, 1996.

Morris (1995) notes that many disabled women have a difficult time asserting their independence within the family because they often are financially and physically dependent. They also often are not given the opportunity to be caregivers, and instead, they must fight for that right. There are costs, both financial and emotional, of negotiating for those things that other people take for granted every day, such as having a say in how personal needs are to be met. Morris notes that this is the area that feminist research needs to include in the area of caring and community care if they are to influence policy that will be helpful to disabled women.

PART

4

FEMINIST RESEARCH METHODS

McMillan and Schumaker (1997) define three types of research: basic, applied and evaluation. These methods differ in their purpose, the question to be studied, and the use of results. *Basic research* is research conducted to test a theory. There is little interest in the practical aspects of the research results. The concern of basic research is in “knowing, explaining and predicting natural and social phenomenon” (p. 19). *Applied research* is undertaken to provide a solution to a general problem. Findings are reported in general terms, not as specific recommendations. *Evaluation research* is concerned with a specific practice at a particular site, and the question, “Does this practice do what it is intended to do?” Evaluation research also can evaluate expenses of the research project, including specific costs related to conducting the study and/or the costs of implementing its recommendations.

McMillan (1996) breaks research into two categories. *Experimental research* attempts to discover causal relationships, where one factor is manipulated to observe its effect on another. In

non-experimental research, the researcher has no influence on the phenomenon under study, and does not or cannot manipulate it. The results of this kind of research are to describe a phenomenon or to discover relationships between factors.

McMillan and Schumaker (1997) differentiate between qualitative and quantitative approaches to research. They state there are two basic differences between these methods which are built on particular and different understandings of how the world works; the importance of context; what the ultimate purpose of research is, and the role of the researcher. Another difference they describe is the method used to gain knowledge. *Quantitative research* represents knowledge through statistic results using numbers. *Qualitative research* uses narration with words to represent facts.

In qualitative research, the gathering of data (words) is done in a variety of ways. Ambert, Adler, Adler and Detzner (1995) present the following list:

P oral words whether in conversation, sentences, or monologues;
P written words in journals, letters, autobiographies, scripts, texts, books, official reports, and historical documents;
P recorded field notes of observers or participants in meetings, ceremonies, rituals and family life;
P life histories and narrative stories in either the oral or written form; and
P visual observations (whether live, video-taped, or in pictures) or other modes of self-expression, such as facial expressions, body language, physical presentation of self, modes of dressing, and of forms of self-expression—e.g., how one decorates a home (p. 881).

Ambert *et al* (1995) conclude that qualitative research is about meaning, multiple realities, and the general socio-psychological context.

Feminist research methods are becoming more predominant in the research arena. Paludi (1992) states there is no one type of feminist methodology (i.e., qualitative or quantitative). Dalia Ducker (1994) notes, however, that research labelled “feminist empiricism” has several basic common beliefs about goals and methods:

First is acknowledging the role of values in research. This view contends that scientific inquiry is not value free and that social values have an impact on all aspects of the research process, including questions asked, variables studied, measures used, and conclusions drawn from findings. It also suggests that feminist researchers can use science to challenge the prevailing power structure, to foster social change, and to improve women’s lives. Second is an emphasis on studying social factors that influence feelings and behaviors. This view is based on the belief that it is necessary to go beyond explanations that attribute women’s feelings and behaviors to intra-psychic, possibly biologically determined characteristics and to examine situational and interpersonal factors as well. It also focuses on the diversity of women’s experiences and on the effects of the social context (p. 78).

Stanton and Gallant (1995) acknowledge the feminist use of the traditional, disease-based model in providing valuable information. They advise researchers who use these methods to be cognizant of drawbacks including:

P biological reductionism;
P fragmentation in research and health care;
P a focus on pathology rather than on health;
P a tendency towards atheoretical research and conceptual frameworks that fail to address adequately the multiple contextual determinants of health outcomes; and
P a lack of attention to diversity among subjects of the study.

To counter fragmentation where separate aspects of psychological, biological and behavioural factors are studied, Stanton and Gallant (1995) recommend looking at links among these factors (for example, links between behaviour, depression and smoking). They suggest studying a woman’s whole health system instead of single organs (for example, research could ask the question, “How do women decide to take hormones for menopause when it may reduce heart disease on one hand yet increase risks of developing cancer on the other?”). They conclude that too little research has been conducted on what factors are related to resiliency and other health-promoting attributes and behaviours.

Stanton and Gallant (1995) recommend the following factors be included in models for women’s health:

P potential interactions among biological, psychological and social factors;
P multi-faceted outcomes, both pathological and indicators of well-being in many realms (physical, psychological, social); and
P models grounded in theories that take into account the diverse contexts of women’s lives.

They also recommend looking at specific characteristics of activities that promote good health and match them to specific categories (such as older women with young children). Interventions need to address cost-effectiveness to create strong argument for changes in health care policy.

Rodin and Ikovics (1990) state that in addition to studying gender differences and specific health concerns for women, researchers need to recognize that women are not a homogenous group. They point out that race, ethnicity and socio-cultural factors that affect minority women (such as poverty, limited access to health care, lower educational and employment levels, and higher stress) are all variables. Women at different developmental stages also have different health needs. The authors add that lifestyle is another important difference between and among women.

DeGarmo and Forgatch (1997) stress it would be useful to include “characteristics” of the support person in examining the support process. One of the challenges of social support, for both the person receiving support and the person giving support, is the study of individual characteristics that does not include context. There is a danger in taking the individual view, where blame may be misplaced on individuals for negative outcomes, rather than including possible external factors.¹ By leaving out context, conceptual models and applications are limited.² Riger (1992) agrees that social context is an important part of research, and when ignored, she says, “the political is misinterpreted as personal” (p. 731). She states that underlying much research is the concept of “individualism,” which suggests that choices are made freely, with the implication that people get what they

deserve. Contextual factors in addition to individual characteristics that need to be included are: socio-economic conditions, exposure to violence, and ethnic and cultural norms.³

Much of the social support literature focuses on coping. When we use this frame of reference, it may be important to keep in mind what we are asking women to cope with. Is our coping strategy a healthy one, or is it asking people to submit to social codes of their culture?⁴ Condeluci (1994), for example, recommends systemic change for people with disabilities, rather than asking individuals to learn how to cope with the system.

Batt (1994) recommends treating people individually, and moving away from research on biomedical analysis and treatment to models that include psycho-social and physical environments that value prevention instead of treatment. She adds that patients who volunteer for a study need to be the first to hear the results. Last, she states, “the profession must learn not to be dismissive and patronizing of the patients’ views of research” (p. 397).

DeMarco (1993) states that “a representation of reality for women must emanate from all women’s lived experience” and that we need to have many representatives for our “knowing” to be more complete (p.1246). She suggests several ways to use traditional research to open more feminist ways of knowing (for example, when using a questionnaire, do researchers share anything of themselves to decrease “hierarchical/-power researcher/researched participant dyad?” (p. 1247). It is not that this method should not be used; rather it needs to encompass feminist ideology that women should not be “reported on” but seen to share their experiences. She sug-

¹Stanton and Gallant, 1997.

²Stanton and Gallant, 1997.

³Stanton and Gallant, 1997.

⁴Shaffer, 1978.

gests additional, increased participation of those responding to a questionnaire by sharing information about findings with participants personally or by mail; and creating opportunities to discuss and interpret responses and experiences. Otherwise, she asks, is “meaning” reciprocally shared? Does a trade take place?

Patti Lather (1991) believes research needs to “change as well understand the world” (p. 3). She describes one of the goals of feminist research is *empowerment*. To her, empowerment is “analyzing ideas about the causes of powerlessness, recognizing systemic oppressive forces, and acting both collectively and individually to change the conditions of our lives empowerment is a process one undertakes for oneself; it is not something that is done ‘to’ or ‘for’ someone” (p. 4). She argues the challenge is “how to bring scholarship and advocacy together in order to generate new ways of knowing that interrupt power imbalances” (p.110). Tudiver and Hall (1996) note that empowerment in health care can be encouraged by offering more consumer choice and allowing individuals to be involved in identifying their needs and making decisions about their solutions. Lown (1998) remarks that many patients are not well enough informed to make quality health care decisions. He states that “sick people do not know what ails them, which doctor to seek out, what tests are required for diagnosis, or how their condition should be treated” (p.5). As well, he notes that with limited medical care, the patient has little bargaining power and little choice but to buy. Thus, empowerment may be difficult to achieve when the client has few choices. Researchers need to ask how empowerment relates to the issue of social support and the current medical tradition. How can a woman be empowered when she needs to ask for help? How does empowerment occur when she is restricted to receiving help from a limited selection, none of which are supportive of women’s needs?

Tudiver and Hall (1996) recommend a better understanding of health determinants. They state “providing a woman with basic health information is unlikely to change her behaviour if the emotional barriers she faces are not addressed” (p. 21). They describe one health care practitioner who notes that her clients do not breast-feed due to the shame they feel when they look at their bodies, after years of sexual and physical abuse. Erickson (1994) comments that campaigns to promote breast-feeding will be ineffective unless emotions are acknowledged and space is made for healing.⁵ These are the types of issues that research on social support need to address.

DeMarco (1993) questions research that limits participants to white, middle and upper class women. She asks “where are the disenfranchised people’s voices and voices of ethnic minorities?” (p. 1248). Without descriptors, she says, we must make assumptions about the faces behind the voices speaking in the study. In only one study she reviewed were the participants described as “white” women. She adds that researcher-developed tools need to be reviewed for bias, language barriers, reading levels, and content congruence. Cook (1994), for example, used a questionnaire for Anglo-Celtic and Chinese participants. The questionnaire was translated from English to Chinese with three goals: to convey the same meaning; to be clear, concise and coherent; and to use phrasing that sounded natural to a Chinese person. It was then translated back to English and the two English versions were compared. Discrepancies were discussed and revisions were made to either the Chinese or English version. Cook describes this as an example of attempts to make the instrument “more culturally sensitive while retaining a core theoretical model” (p. 457).

⁵Cited in Tudiver and Hall, 1996.

DeMarco (1993) has other recommendations. She warns of researchers who are consciously or unconsciously still being directed by patriarchal systems. The use of artificial dichotomous categories for data collection such as “married/unmarried,” reflect androcentric ways of looking at the human experience. These descriptors “do not support a feminist approach to the benefits of a lived experience” (p. 1245). By placing women into categories of married/unmarried we are making certain assumptions. We can, for example, ask: Where do women who are lesbian fit into this category, or women who live with their partners, but choose not to marry? Does this type of category leave out women and/or slot them into artificial categories?

Stanton and Gallant (1995) describe health as a multi-variate phenomenon that is a “function of the complex interplay of economic, socio-political, environmental, psychological, and biological determinants, the formula for which varies over the life course and across diverse groups of women (p. 579). They note it requires multi-variate models and methods as well as broadened interdisciplinary collaboration in research and application. Some of these research methods are:

Grounded Theory. The goal is to develop theory (Morse and Field, 1995).

Phenomenology. A description of behaviour, with a purpose of promoting human understanding (Morse and Field, 1995).

Narrative. Personal stories are used to make sense of an experience, and to construct and communicate meaning (Chase, 1995).

Ethnography. Studies the values, beliefs and practices of a culture (Morse and Field, 1995).

Ethology. The goal is to systematically observe, analyze and describe behaviour in the context they occur (Morse and Field, 1995).

Focus Groups. Used to obtain a variety of opinions based on the premise that attitudes are not developed in isolation, but through interactions with others (Morse and Field, 1995).

Needs Assessment. Identifies the context and unmet needs of a particular group, which can lead to a program established to attain certain results (McMillan and Schumacher, 1997).

Participatory Action Research (PAR). The goal is to improve practice rather than gain knowledge (Elliot, 1991). PAR is based on a philosophy of egalitarian collaboration between researchers and participants (Richer, 1998).

Participatory Action Research is a distinct form of research, described as a form of resistance as it transforms rather than preserves. It is used by those who are interested in initiating change.⁶ Carson and Sumara (1997) state that action research is concerned with studying process, producer and product. They believe each of these components can be studied individually. However, the interpretation is much deeper when the relationship between each is studied. PAR also is described as “communal” research because it requires the active participation of both the researcher and those whose lives are impacted by the research question.⁷ It attempts to democratize the research process by eliminating the research power hierarchy of researcher at the top (who holds all the power), and the subjects of the research at the bottom (who have little or no power in the research process).⁸

⁶Elliot, 1991.

⁷Richer, 1998.

⁸Richer, 1998.

To truly fit the PAR criteria, Heron and Reason (1997) state that PAR needs to become a collaborative effort, where all individuals act cooperatively to develop the research question and methodology. They note that most research only invites participation by informed consent and/or requesting modifications to a plan already laid out by the researcher. The authors believe subjects have a basic right to participate fully in research that is designed to gather knowledge about them, and that research is conducted by people *with* each other, not by researchers on or about an individual or a group.

The goal of PAR not only is to improve outcomes, but to improve process.⁹ There are many problems that need to be resolved for research to be truly participatory. Richer (1998) describes current roadblocks:

Funding application demands. Many funding agencies demand the active involvement of university-based researchers as principal investigators. This is in direct opposition to the equality principle of participatory research, bringing into question the right of those who do not hold a Ph.D. to conduct research.

Deadlines. Research often is not given a legitimate place in the day-to-day activities of participants. As a result, they are unable to work according to deadlines as easily as academic researchers.

Experience and recognized legitimacy. Academic researchers are often the only members who have the experience and skills for many aspects of research, including writing proposals. If work is distributed according to knowledge and skills, this places the academic researcher in a privileged position.

Who participates and who the researchers are. For research to be truly participatory, it requires the collaboration of all who are or will be affected, not just a select few. In reality, however, most participants do not have the time, means or inclination to be actively involved. As a result, a small group acts on behalf of that community. As well, the identity of the researchers from the academic community who are involved in the research is important—most researchers are well-established white males. This is an area ignored in academic literature.

Credit for work produced. Authorship is important for academic researchers. However, individual recognition is not in the spirit of participatory research. One solution is to list alphabetically all who participated regardless of relevant contribution.

Barriers to participating in out-of-town seminars to disseminate results. Academic researchers often have budgets that allow them to attend out-of-town conferences to discuss results. Community participants often have neither the time nor money to attend and participate in these events. One solution is to budget a percentage of the research funding to allow participants to travel to these events and to cover loss of income during time away.

There are many ways that researchers attempt to democratize and dismantle the power hierarchy in research. One method is called “reflexivity,” the honest exploration of the researcher’s bias and its impact on the research process.¹⁰ Race and social class are two obvious categories that create differences between women. Diane Reay (1996), for example, found that class differences between herself and the research participants influenced the research process and her report-

⁹Elliott, 1991.

¹⁰Jones, 1997.

ing. She notes that academic achievement moves one beyond the working class, and that the social advantage and privilege of academia is seldom addressed in the research literature.

Feminist participatory research involves the principles of PAR as well as concentrating on women's issues. Janice Thompson writes, "feminist participatory research, then, is not just neutral on the topic of women. It is instead openly committed to a diverse range of women's experiences and women's struggles. It is guided by the feminist critiques of science and employs methods that preserve women's experience in context" (p. 31).

In summary, there are many ways research can be undertaken. Who we are as researchers can and does influence the research process, including what questions are asked and how the answers are collected. Feminist research attempts to uncover androcentric or male-centred bias, and attempts to include many factors. Participatory research attempts to eliminate power differentials in the research process, by including all people affected by the research at all stages. Feminist participatory research attempts to include feminist principles in research.

CONCLUSION

Much of the traditional research conducted on women and social support has an androcentric bias and does not take into account the context of women's lives.

This often results in a lack of differentiation between women's and men's experiences and needs, and the experiences and needs of diverse groups of women. There is an inherent assumption that what is learned from research on men is applicable to women, and that the needs and experiences of all groups of women are the same.

Research needs to be conducted from a feminist perspective that acknowledges the impact of gender roles on women, as well as the diverse needs of a wide variety of women's groups.

There is some disagreement over the value of research on gender differences. One author concludes that if gender research is not undertaken, then unequal treatment between men and women may not be acknowledged.

Research on gender differences needs to take into account possible bias of reporting (i.e., biological explanations) as well as the possibility that research findings may be used for social policy in a way that is harmful to women.

Most of the research on social support has been done in a traditional manner where factors are isolated and studied in depth. This has provided a base for understanding what variables are involved in the social support process. Little research has been done from a holistic viewpoint that invites women to be active participants in the research process.

More research is needed that is qualitative in nature and explores the meaning of support in women's lives to expand understanding of their day-to-day experiences, including exposure to violence, poverty, discrimination and cultural expectations.

These studies need to invite women to be active members of the research process. This may require more community education about how this approach to research is different from traditional methods.

Research that has focused on social support and specific women's groups has left gaps in the literature. Certain groups have had little or no research conducted with them. Care needs to be taken so that women are not categorized solely on the basis of one category. Defining a woman based on a single category, when there is much overlap between categories, may exclude impor-

tant factors that affect her life and can limit how a woman is seen and treated. While it is important to group women to understand the influence of a particular factor, it is always important to see women as whole individuals.

Researchers need to target under-represented groups. These groups include disabled women, minority women, Aboriginal women, lesbians, older women, adolescents, and women who live in poverty.

Much of the research and resulting discussion on social support is based on a philosophy of individual choice and responsibility. This has led to a considerable amount of research that implies that support is determined by the individual involving her personality characteristics, ability to cope with stress and anger, and/or her state of mental health. One of the positive outcomes of this research is that it may aid in the identification of persons who have less support. One of the dangers of this approach is that an individual may be blamed for their own lack of support, placing responsibility on an individual to change. While change can be positive, this approach can ignore external conditions over which an individual has no or little control.

More research is required on external or environmental factors that inhibit/encourage the support processes to take place, including social structures within a community or organization that inhibit support and that may value certain individuals over others.

More studies are needed on organizations that are described as supportive by those who are involved or have access to explore what is working and why (What does a supportive health centre for women look like? What are the characteristics of a work environment that is supportive to the women who work there?)

Research has shown that for many reasons, women are the primary caregivers. But women also need support.

Research needs to explore the relationship between a woman as a caregiver and as a care receiver. Learning how these roles inter-relate is of value.

There is much research on the personality and individual characteristics of the person receiving support, yet few studies exist on the person who gives support. While it is documented that women give more support than men, there is little research on which women give what kinds of support, how much and when.

Studies can explore the characteristics of the support person. Are there some women more likely to give quality support?

Research indicates that education and promotion of healthy behaviours is not enough for some groups of women. Support interventions may be ineffective if we do not fully understand why certain choices are being made.

More research is needed on negative coping. What does a woman have to cope with and why? What resources does she have? Which does she use? What is offered that she does not use? Why?

Some researchers are promoting the idea that support needs to be identified as a process rather than as only a single event.

Support needs to be measured at various stages of an event, rather than only once.

The inter-relationships between a series of support events needs to be examined. (For example, tracking the amount of support received over the course of an illness—when do inter-relationships with support givers wane and why? How does this affect the individual who is ill?)

Researchers tend to focus on a specific area such as “support needs of women with breast cancer.” There is little research that explores the concept of support and the meaning of support from a woman’s perspective. There is little understanding of social and economic influences on women’s lives, particularly on a day-to-day basis.

Research which explores women’s daily lives is required.

Studies have indicated that perceived support is often more beneficial than support actually received. Studies also indicate that for many, the informal support of family and close friends is used more frequently than formal agency support.

For those who do not have large or strong support systems, how can the community provide support to those with limited access to informal support? Why do individuals choose informal support over formal support? What implications does this have for women’s health? Can we change this trend? Should we change this trend? Is there a way to allow women to be supportive and receive more support themselves?

Reciprocity can be seen as one barrier to support if individuals feel that they are unable to give back, yet support is often needed by those who

are unable to reciprocate. Besides reciprocity, there is little research on the barriers preventing women asking for and/or receiving support.

Research needs to explore barriers to support from a woman’s perspective to understand what stops a woman from asking or giving support.

The literature reveals that there are cultural reasons why women are the main givers of support (i.e., social expectations). Most research on being a support-giver focusses on how it is detrimental. However, some researchers suggest that women may enjoy giving support.

Are there any health benefits to giving support? If so, then what are those benefits? Under what conditions? When is giving support not a benefit?

New technology has opened a new door for social support. Chat lines and on-line support groups can offer emotional support. Up-to-date informational support is also available.

Studies can explore how technology can be a useful support system, especially for individuals who may be isolated. How do communities provide easy access to those who may wish to use this technology but cannot afford to be on-line? What are the detriments of the Internet? Will it enlarge the gap between those who have access to support and those who do not?

In summary, social support research needs to encompass methods that move beyond traditional ways of studying a phenomenon to include a more holistic approach that acknowledges the influence of values in the research process. Feminist participatory research is one

method that not only acknowledges bias that can influence research results, but follows a process that can empower participants by giving them ownership of the research process and results. Participatory research is interested not only in understanding, but is dedicated to making changes that will improve the lives of the participants.

There are currently many groups of women who have not had an opportunity to share their experiences. Many of these women are marginalized and do not have strong support networks. We need to provide opportunities to invite these voices to be heard, and support women through this process. We need to have a better understanding of social, economic influences on women's lives, particularly on a day-to-day basis. When we look at health policy, we can ask: how much influence do women have on health policy? Whose voices are being heard with regard to health policy? How does health policy affect a woman's health choices? How does it support her choices?

Social support is about connection. It is about having needs recognized and acknowledged. It is about interdependence, accepting help when it is needed, and giving help when we are in a position to do so. It is about feeling connected to a community, so that as we go about our daily business, or face a crisis, we feel there are people who care about us, who value us, to be there when we need help and feel alone.

Through research, we can create opportunities to connect with women. We can create a space for others to hear our voices, and for us to hear our own voices being heard—a space where we share our stories. In listening to each other, touching each other, we will be able to work together so that one day, no woman will ever have to stand alone.

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