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ABSTRACT

Since 1972 ,when the city of Miami Beach, Florida initiated redevelopment plans for South Miami Beach, the elderly residents have been besieged by a series of events beyond their control that have left them at risk emotionally and physically. To examine the relative impact of health, personal control, and social support as predictors of affect and life satisfaction, personal interviews were conducted with 92 South Beach residents. Eighty-seven respondents (50 females, 37 males) provided relatively complete information. Support measures incorporated in the interviews included a support diagram, the Desired and Expected Control Scale, a health checklist, the Affect Balance Scale, and a life satisfaction scale. An analysis of the results showed that health status was a strong predictor of affect balance, but the support and control variables were significant as well, and accounted for independent portions of the variance. Quantity of support was not related to life satisfaction, but was related to health. Support was related to satisfaction in specific areas such as geographic location, housing, standard of living and income, and family life satisfaction. Individuals with no close support figures were more likely to be depressed and less likely to desire control. These findings suggest that social support can mediate depression, and that attachment relationships are important to well being throughout the life span. (BL)

Social Support and Well-Being in an At-Risk Elderly Population

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Social Support and Well-Being in an At-Risk Elderly Population

The elderly population of South Miami Beach is clearly a population at-risk. This community of elderly retirees has been besieged by a series of events beyond their control. In 1972 the city of Miami Beach declared a moratorium on construction and renovation in anticipation of a massive redevelopment effort in which almost the entire South Beach area was to be razed and replaced by a hotel-condominium complex. As part of the redevelopment plan, more than 3000 individuals, most of them elderly, were to be temporarily or permanently relocated. Opposition to the plan, economic problems and other considerations inherent in a program of such massive proportions, led to repeated delays in the project and ultimately to its demise, as of this year, 1983. In its wake, city authorities, professionals, and reporters have been conducting an unofficial post mortem on the impact of the ten year moratorium on the South Beach area. The consensus is generally that the effect has been disastrous (Kranish, 1982). With low rental rates, buildings needing repair, and property values uncertain, the area became a magnet for low-income transients. This situation intensified dramatically as a result of an influx of refugees from Mariel, Cuba, a proportion of whom were criminals deported from Cuban prisons. The crime rate soared, many elderly residents fled the area, and, in 1978, the last year in which municipal statistics were obtained for national comparison, Miami Beach was reported to have the

highest suicide rate in the country (Bass, 1982). Of course controversy exists over whether the latter statistic can be linked directly to the effects of the moratorium and threatened relocation. It is apparent, however, that crime and deteriorating conditions accelerated by the prolonged moratorium and the ambiguity of redevelopment plans, have exerted an atypical degree of stress on the South Beach elderly.

We initiated a study of this population in January of 1981, supported by a grant from a bi-university center for environmental and urban problems. A primary objective of the investigation was the examination of interrulationships among variables thought to mediate risk. Previous analyses comparing this sample with a national probability sample (Levitt, Antonucci, Clark, Rotton, & Finley, In press) confirm the high risk character of the South Beach elderly population, particularly with respect to the availability of social support. The South Beach sample evidenced generally impoverished support networks, and a far greater proportion of individuals indicating no support figures than is found in the general population.

The focus of this report is on the moderating effects of social support on affect and life satisfaction in relation to other primary predictors of well-being, including health status, and desired and expected control. Previous studies have suggested links between social support and health and between support and life satisfaction (Antonucci, in press). Evidence for the presumed buffering effect of support has been somewhat

elusive, however—emerging more clearly in some samples than in others. It is likely that the role of social ties as mediators of personal satisfaction and well-being gains in importance with increasing levels of stress. Clear relationships have been found between support and well-being in populations of unemployed men, women experiencing stress during pregnancy, and persons diagnosed as schizophrenic (Cobb & Kasl, 1977; Nuckolls, Cassell, & Kaplan, 1972; Beels, 1981). In our own comparison of South Beach residents with the national sample, (Levitt, et al., in press), we found the relationship between social support and affective well-being to be markedly stronger for the South Beach sample. Furthermore, contrary to previous findings (Duff & Hong, 1982), it was the quantity, rather than the qualitative aspects of support, that predicted affect. The two samples were discrepant as well in terms of the relationship between health status and the support measures. The number of persons with whom the respondents reported discussing health problems was positively correlated to the actual number of health problems reported in the national sample, but these variables were negatively correlated in the South Beach sample. Thus, those on South Beach reporting more health problems also reported fewer individuals whom they could talk to about their health. Also, life satisfaction was found to be related to the talking about health variable only in the South Beach sample. So, although the South Beach respondents did not evidence more depressed affect, or a greater number of health problems than the national

average, the availability of social support seemed to be more important for the well-being of this group.

The relationship revealed in the foregoing analyses between quantity of support and well-being illustrates an unresolved issue in research on social support; that is, how much support makes a difference? Is it the demarcation, for example, between social isolation, and the presence of at least one close support provider that makes a difference? This question has been difficult to answer since social isolates in the general population are small in number and difficult to locate (Shanas, 1979). While research with single room occupancy hotel residents has provided some insight into the functioning of elderly isolates (Cohen & Sokolovsky, 1980) these studies have not involved comparisons of isolated and non-isolated persons from the same population. The availability of both support and well-being measures for the South Beach sample afforded a unique opportunity to explore this issue empirically.

An integral facet of our research was the assessment of the extent to which respondents both expected and desired control over environmental circumstances. Based on Seligman's (1975) model of learned helplessness as an antecedent of depression, we anticipated that affect and life satisfaction would be strongly related to perceived control, particularly in this distressed population anticipating forced relocation.

Previous associations have been found for elderly populations between control beliefs and various indices of

well-being. (Reid & Ziegler, 1980), and between health and well-being and control enhancing interventions in institutional settings (Shulz & Hanusa, 1980). In general, gerontological researchers have confirmed that a belief in one's own ability to affect the environment is related positively to life satisfaction, excepting a study by Felton and Hahana (1974) with an institutionalized population.

While social support, personal control, and health are thought to be interrelated (Cicirelli, 1980; Ried & Ziegler, 1980; White & Pappas, 1982) and each of these variables has been associated with indices of well-being, the effects of these variables have rarely been considered simultaneously, although conceivably there might be considerable overlap in these effects. A noted exception is a study by Mancini (1980-81), in which health and control were found to be independent predictors of life satisfaction. A primary objective of the current study was to assess the relative impact of health, personal control, and social support as predictors of affect and life satisfaction. We anticipated that each of these variables would contribute to well-being in this distressed sample, and that the presence of at least one close support figure would act as a buffer against depressed affect and reduced life satisfaction.

Personal interviews were conducted with 92 South Beach residents. A modified random sampling procedure was used to obtain a list of potential respondents from redevelopment agency data obtained on all residents of the area in 1977. Names were

drawn randomly from agency files, with the constraint that potential respondents be age 60 or over, and had lived in the area for at least five years. Individuals from this pool were contacted and offered $5.00 for participation in the study. Our first apprisement of the remarkable changes that had occurred in the area came as a result of these initial attempts to contact respondents. The 1977 redevelopment survey indicated that the bulk of elderly South Beach residents lived in rental apartments or hotels. By 1981, almost all of these individuals had left the area, despite promises of relocation assistance and remuneration to those who remained. Our sample consists then primarily of condominium owners (77%), many of whom might have wanted to leave but were constrained by the threat of financial loss stemming from the moratorium.

Of the 92 respondents who were interviewed, 87 provided relatively complete information. Of those, 50 were women and 37 were men. Respondents ranged in age from 61 to 87 with a mean age of 77. Almost all were retired. Thirty-seven percent of the respondents were married; 33% reported no living children, and 64% lived alone. Fifty-seven percent were born outside the United States, mostly in Europe and Russia; 78% of the respondents were Jewish. The mean level of education was 11.2 years, and 61% of the sample reported incomes below $5,000. One out of every five respondents indicated that they had been crime victims.

Interviews were conducted by trained interviewers in the respondent's home. The support measures incorporated into the interviews were adopted from Kahn & Antonucci (1983). For the current report, the measure employed was a diagram consisting of a series of concentric circles, in which respondents are asked to place those individuals who are close to them, with the most important individuals in the inner circle.

The index of personal control was an abbreviated version of the Ried and Ziegler (1980) Desired and Expected Control Scale. This scale, developed specifically for use with gerontological populations, has parallel items assessing first the degree to which respondents believe that various events are under their control and secondly the extent to which those events are important to or desired by the individual. As the full scale was too lengthy for our purpose, we extracted six items indexing expected control and the six matching desired control items, on the basis that these items were found by Reid and his colleagues, (Reid, Ziegler, Sangster, Haas-Hawkings, & Rivsech, 1979) to load highly on a primary control factor emerging from a factor analysis of the scale.

The measure of health status included in the present analyses was a checklist of health problems, also used in the national supports of the elderly study (Kahn & Antonucci, 1983). Indices of well-being included the Bradburn (1969) Affect Balance Scale, measuring both positive and negtative affect, and a life satisfaction scale employed in the Campbell, Converse, &

Rogers (1976) Quality of American Life study and in the Kahn & Antonucci (1983) project. This measure assesses satisfaction with respect to a number of specific domains, including the respondent's city of residence, neighborhood, police protection, housing, standard of living, income, health, friends, and family. The final item is a question indexing general life satisfaction, "How satisfied are you with your life as a whole these days?"

The predictor variables, including the number of support figures, the number of health problems, and the desired and expected control scores were entered into nonhierarchical multiple regression analyses, with affect balance, domain satisfaction, and the general life satisfaction index (satisfaction with "life as a whole") as the criteria. Intercorrelations of the variables and the results of the regression analyses are presented in Tables 1 and 2. All of the regressions were significant, but a somewhat different pattern of results emerged depending on the particular criterion. Health status was a strong predictor of affect balance, but the support and the control variables were significant as well, and accounted for independent proportions of the variance.

For the regression to the general life satisfaction index, the health measure, again, accounted for much of the variance, along with the desired control measure. Quantity of support was not related significantly to "satisfaction with life as a

whole", but was related, along with the health measure, to domain satisfaction.

Separate regressions for each of the domain satisfaction items suggest that support is related to satisfaction in a number of areas, including geographic location, housing, standard of living and income, and, not surprisingly, to satisfaction with family life. These results are presented in Table 3.

In the final set of analyses performed on these data, we compared, for each of the outcome measures, persons who reported no support figures in their inner circles, those who reported only one person in the inner circle, and those who reported more than one close figure. The results of this analysis are presented in Table 4.

Note that the three groups do not differ in number of reported health problems, but do differ with respect to affect balance, desired control, and, marginally, general life satisfaction. In particular, individuals reporting no close support figures are more likely to be depressed, and less likely to express a desire for control than those individuals in either of the two remaining groups. Only in general life satisfaction was there a difference in terms of one versus more than one support figure.

Although we must exercise some caution in interpreting these results, given the relatively small size and select nature of this sample, some tentative conclusions are warranted. First,

the pattern of these results supports the model of depression proposed by Seligman (1975), in which depression is seen as an outcome of perceived lack of control over the circumstances of one's life. Negative affect was related significantly to low expected and desired control and, while loss of health can be viewed as a primary contributor to both loss of perceived control and reduced affect, control emerged as a significant predictor apart from the health-affect relationship.

Secondly, confirmation of the role of social support as a buffer can be inferred from the data indicating that persons lacking a close personal relationship evidence significantly more depressed affect than individuals with close support, despite the fact that the groups are equivalent in terms of both expected control and number of health problems. Note that the isolated group also differs from the supported groups in desired control, with isolates desiring less control than nonisolates. This result is also consistent with Seligman's (1975) proposal that depression is the affective concomitant of helplessness. Depressed individuals are those who have abandoned the struggle to maintain control.

The present data suggest as well that, while life satisfaction may increase as a function of the number of support figures available to the person, it is the presence of one close relationship that is crucial to warding off depression.

The consistency between the present findings and the infant attachment literature should not go unrecognized. While infants

may become attached to a number of individuals, infants deprived of contact with at least one responsive caretaker often develop severe depressive sympotomatology and fail to thrive (Wenar, 1982). We are in agreement with our colleagues at this symposium that it is important to distinguish among the various structural and functional components of social support convoys. Friendship, kinship, and attachment relationships may all be supportive, but may differ markedly in terms of their significance to the individual. The present results are consistent with the view that attachment relationships are important to the maintenance of affective well-being throughout the life span, particularly in times of stress.

Table 1

Intercorrelations of Predictor and Outcome Variables.

Variable	Variable 1	2	3	4	5	6	7
1. Health[a]	-	-.36	-.01	.17	-.38	-.34	-.24
2. Expected Control		-	.33	.00	.47	.38	.24
3. Desired Control			-	.46	.49	.37	.27
4. Support[b]				-	.33	.12	.35
5. Affect Balance					-		
6. Life Satisfaction[c]						-	.57
7. Domain Satisfaction[d]							-

[a]Number of health problems; [b]Number of support figures in diagram; [c]General index, "How satisfied are you with life as a whole these days:"; [d]Sum of the domain satisfaction indices excluding the satisfaction with health item.

Table 2

Regressions of Predictor Variables to Indices of Well-Being

Criteria/ Predictors	Statistics			
	R	R^2	R^2_Δ	F
Affect Balance				13.2*
Health	.38	.15	.15	10.3*
Desired Control	.55	.30	.15	6.0*
Expected Control	.65	.43	.13	5.6*
Support	.69	.48	.05	5.5*
Life Satisfaction[a]				5.3*
Health	.34	.12	.12	5.4*
Desired Control	.50	.25	.13	4.3*
Expected Control	.53	.28	.03	2.1
Support	.53	.28	.00	0.1
Domain Satisfaction[b]				4.2*
Health	.24	.06	.06	4.0*
Desired Control	.36	.13	.07	0.1
Expected Control	.37	.13	.01	1.0
Support	.48	.23	.10	7.2*

[a]General index, "How satisfied are you with life as a whole these days?"; [b]Sum of domain satisfaction items excluding the satisfaction with health item.

*$p<.01$

Table 3

Regressions of predictor variables to Domain Satisfaction Items.

Domain	R^2 Total	R^2 Predictors			
		Health	Desired Control	Expected Control	Support
City	.18	.02	.01	0	.09*
Neighborhood	.08	.04	.04	0	0
Police	.03	0	0	.02	.01
Housing	.14	0	.02	0	.10*
Standard of living	.25*	.06*	.08	.01	.10*
Income	.13	.06*	0	0	.07*
Health	.29*	.22*	.04	.01	.01
Friends	.24*	.01	.18	.03	.03
Family	.17	.08*	.05	.00	.04*

*$p<.05$

Table 4

Means for Health, Control, and Well-Being Indices for Respondents Differing in Availability of Close Support

Index	Number of Close Support Figures				
	0	1	>1	F	p
Health	2.8	1.9	2.5	.54	ns
Expected Control	3.0	3.1	3.3	1.06	ns
Desired Control	3.7	4.2	4.2	2.80	.067
Affect Balance	4.8	6.1	6.4	3.64	.031
Life Satisfaction	3.8	3.3	2.7	2.29	.108
Domain Satisfaction	3.8	3.3	3.0	2.06	.135

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