Seeking Social Support in Old Age as Reasoned Action: Structural and Volitional Determinants in a Middle-Aged Sample of Argentinean Women[1]

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Given that the availability of social support influences physical and psychological well-being, the provision of positive contacts is often crucial for older women. The purpose of the present study was to test the utility of both structural and volitional factors as determinants of support-seeking intentions. Two intentions to seek social support were studied in a group of 106 middle-aged women: (a) the intention to go to a doctor at least once a year after 55; and (b) the intention to visit a family member at least once a week after 55. The structural variables of interest were age, educational level, presence of partner, number of children, and number of grandchildren. The volitional factors assessed were intentions, beliefs, attitudes, and norms. There was little evidence that structural factors influenced support seeking. In contrast, as predicted from the theory of reasoned action (Ajzen & Fishbein, 1980; Fishbein & Ajzen, 1975), intentions to go to the doctor and to visit a family member could be successfully predicted from attitudes and norms.

Both informal and formal social support are crucial to well-being (for literature reviews, see Albarracin & Muchinik, 1994; Antonucci, 1985; and Lowenthal & Haven, 1968). Individuals are happier and healthier when there is a friend or a relative they can count on for company and help. Furthermore, if this friend or relative is not available, or does not satisfy a given need, a nurse, a doctor, or a priest invested by some formal role can take his or her place. In the first case, the benefits are a result of an informal social support

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interaction; in the second case, the support provider is a member of a formal social support network.

The positive effects of both formal and informal social support exchanges become evident from the data showing that transactions which involve help or affection are associated with improved physical and psychological health, as well as with lower mortality. Psychologically, the availability of social support has been consistently linked to lower levels of depression (Decker & Schultz, 1985; Murphy, 1983; Phifer & Murrel, 1986), and to greater life satisfaction in old age (Antonucci, 1982; Dorfman, Heckert, Hill, & Kohout, 1988; Vlassof, 1990). Furthermore, among older women, the extent to which one is depressed is more strongly related to social support than to physical health (Hale, 1982).

Physically, weak social support networks are directly related to poorer immune function in older women (McNaughton, Smith, Patterson, & Grant, 1990) and to higher mortality rates at every age. Two classic epidemiological studies conducted on the general population showed compelling effects. The first study was conducted in Alameda County, California, and led to the conclusion that individuals with scarce social networks had twice the probability of dying, compared to those involved in supportive relationships (Berkman & Syme, 1979). In the second study, House, Robbins, and Metzner (1982) found that male residents of Tecumseh, Michigan, who were married, went to church, and participated in community activities had 10 times less probability of dying than more isolated men. Similar conclusions have been reached in studies that observed the same phenomenon among the elderly. Blazer (1982), Haug, Breslau, and Folmar (1989), as well as Bryant and Rakowski (1992) observed that the elderly had higher mortality rates if they lacked social support.

Due to the relevance of social contacts to older women's well-being, the general goal of the present study was to understand some aspects of older women's support-seeking behaviors. Generally speaking, we wished to explore the extent to which a number of structural and volitional variables underlie older Argentinean women's support-seeking behaviors with respect to both informal and formal networks.

The interest in support seeking of older women originates in two factors. First, because the survival rate of women is greater than that of men, women are more likely to experience loneliness and to ultimately become dependent upon others (Antonucci, 1985). Second, stereotypic gender roles may make it difficult for women to actively reach out for support when it involves leaving their own home (Albarracin & Muchinik, 1994).

These problems may be exacerbated in Argentina—the only country in South America that can be classified as "aging"—where the above two factors combine with severe impoverishment among the elderly. This means that

proper access to formal and informal networks may be crucial to obtain basic goods and services. Consider, for example, the current situation in which the minimum post-retirement salary is three times less than the minimum rent of a one-room apartment. In such cases, the availability of social resources may be the key for both survival and general well-being because material resources may only become available through formal and informal support networks.

Structural Determinants

Traditionally, social support has been studied as a phenomenon in which individuals play a passive role. Most investigations on the topic have focused on structural variables that moderate the amount of social support one receives (e.g., Lopata, 1978, 1979). Some of the structural factors that impact on the reception of support are age, education, social status, presence of children, characteristics of the family, and community type. Thus, for example, with respect to informal support, compared to less educated women, more educated women more frequently live alone (Wolf & Pinelli, 1989). Moreover, because of the increased needs of the elderly, help and informal support are typically more available for older than for younger groups (Depner & Ingersoll Dayton, 1988; Kaye & Monk, 1991). Older persons also use the formal support network more often than do younger ones (Bowling, Farquar, & Browne, 1991).

The company of children has protective effects on individuals. That is, as might be expected, widows with children have more social support than do childless widows (Johnson & Catalano, 1981). Marital status seems to play a dual role: It protects people against loneliness during the life of the spouse, but it increases risk upon the death of the spouse; widows have less social support than do women of the same age who have never married (Essex & Nam, 1987; Jamuna, 1990; Lopata, 1978, 1979). The existence of other relatives is also a good predictor of the amount of social support one receives. Since other persons in a community do not generally provide as much support as do relatives (Peters, Hoyt, Babchuk, & Kaiser, 1987), it is important to consider the extent to which an extended family may be present. While many relatives are included in the extended family in collectivistic communities, individualistic cultures often have a family restricted to the nuclear family.

Given the attention structural factors have received in attempts to understand the passive acceptance or reception of social support, one purpose of the present study was to assess the extent to which these same factors influenced the active seeking of social support. More specifically, this paper will examine the contribution of educational level, age, marital status, and the existence of children and grandchildren to intentions to actively seek support.

Volitional Determinants

Other factors that may be important to analyze social support seeking are under people's volitional control. In this regard, Fishbein and Ajzen (1975; see also Ajzen & Fishbein, 1980) assert that to understand volitional behaviors, one should study behavioral intentions. These intentions are, in turn, influenced by the attitude toward the behavior and the subjective norm. The attitude is the evaluation of the behavior of concern as favorable or unfavorable. The subjective norm is the perception that important others think one should perform the behavior. Specifically:

$$I = (Ab)_{w1} + (SN)_{w2} \quad (1)$$

where I is the Intention to perform behavior B, Ab is the attitude toward performing behavior B, and SN is the subjective norm regarding performing behavior B.

The attitude toward performing a given behavior is conceptualized as a function of the person's beliefs that performing the behavior will lead to certain outcomes and their evaluations. Similarly, the subjective norm is a function of the beliefs that specific referents think one should perform the behavior in question and the motivation to comply with them. These relations are represented in Equations 2 and 3.

$$Ab = \Sigma b_i e_i \quad (2)$$

where Ab is the attitude toward performing behavior B, b_i is the strength of the belief that performing behavior B leads to certain outcome I, and e_i is the evaluation of outcome I.

$$SN = \Sigma b_i m_i \quad (3)$$

where SN is the subjective norm, b_i is the normative belief or the belief that a given referent thinks the respondent should (or should not) perform the behavior in question, and m_i is motivation to comply with referent I.

To summarize briefly, according to the theory of reasoned action (TRA), the volitional factors that may influence a person's support-seeking behavior include intentions, attitudes, norms, and beliefs. Consistent with this view, the TRA has successfully explained several behaviors that are indirectly related to support-seeking interactions, such as attending church (Brinberg, 1979), participating in the community (Jeffres, Dobos, & Sweeney, 1987), demanding dental care (Hoogstraten, De Haan, & Horst, 1985), or performing several leisure activities

(Ajzen & Fishbein, 1969; Godin, Valois, Shephard, & Desharnais, 1987; Young & Kent, 1985). Another purpose of the present paper is to investigate whether the theory applies in the domain of specific support-seeking behaviors.

Method

Subjects

In 1991, 106 middle-aged women from Buenos Aires, Argentina, responded to a TRA questionnaire on support-seeking behaviors.[3] The women's mean age was 47.48 (SD = 4.52) and 55.0% had finished primary school and had at least some secondary education. Although, most of the women were Argentinean, 5.8% had been born in a foreign country. After being contacted and giving informed consent, the women answered the questionnaire in individual sessions in their own homes. The assessment was conducted by trained female interviewers recruited from an advanced psychology course.

TRA Measures

From a pilot consultation with five experts in social psychology, clinical medicine, and gerontology, two behaviors were selected as a sample of social-support-seeking actions in old age. Visiting a family member at least once a week after 55 was chosen to measure informal social support-seeking behavior. Going to the doctor at least once a year after 55 was selected as the formal social-support-seeking behavior. (Although this latter behavior is not as frequent as the former, it is often the way by which women gain access to other formal support services, such as other health care services, social workers, and recreational activities.)

By focusing on middle-aged women's intentions to engage in these behaviors after they turn 55, it should be possible to gain some insight into what these women believe about their futures. It seems reasonable to assume that support-seeking intentions and behaviors are shaped early in life and are modified throughout the life cycle. Thus, support-seeking intentions should be well-formed and relatively stable by middle age, and may reflect women's behavior during old age.

Following the guidelines outlined in Ajzen and Fishbein (1980), a fixed-item questionnaire was constructed based on an elicitation study performed in a comparable sample of middle-aged women. For each behavior, measures included an intention item, a measure of attitude, a set of behavioral belief items, a set of

[3]In the paper we refer to both "older" and "middle-aged" women. This is due to the fact that, although we are concerned with the behaviors that occur in old age, we use a sample of "middle-aged" women to study their current intentions about the future.

outcome evaluation items, a subjective norm item, a set of normative belief items, and a set of items measuring motivation to comply. The measures are described below.

Intentions. Participants reported their intentions by responding to the items: (a) "I intend to go to the doctor at least once a year after 55," and (b) "I intend to visit a family member at least once a week after 55." Responses were provided along a scale ranging from -3 (*unlikely*) to +3 (*likely*).

Attitudes. Attitudes toward the behavior were measured by means of semantic differential scales (i.e., *bad-good*, *useless-useful*, *unimportant-important*, *unpleasant-pleasant*, and *boring-fun*). Both attitude scales were internally consistent as shown by Cronbach's alphas. The attitude toward going to the doctor had an alpha of .73; the attitude toward visiting a family member had an alpha of .81. Therefore, items were summed to construct overall indexes.

Outcome beliefs. Responses to two sets of items were used as measures of outcome beliefs. Beliefs about the consequences of going to the doctor were as follows: (a) preventing diseases, (b) detecting diseases, (c) avoiding deterioration, (d) keeping calm, (e) preventing high blood pressure, (f) avoiding uterine cancer, (g) feeling old or sick, (h) not getting answers, (i) finding out one is sick, (j) worrying about one's own health, and (k) having to keep attending.

Beliefs about visiting a family member regarded the following consequences: (a) having company, (b) maintaining affective links, (c) making an effort to talk, (d) being surrounded by insincere people, (e) not getting along well with the family, (f) becoming dependent on the family, (g) getting help, (h) not being isolated, and (i) finding that the relative is sick.

Evaluations. The favorableness of each outcome was evaluated by participants along a -3 (*bad*) to +3 (*good*) scale.

Outcome beliefs weighted by evaluations. Belief-based measures of attitudes were computed by summing the products of each belief multiplied by the corresponding evaluation.[4]

Normative beliefs. Normative beliefs concerned the following referents: (a) my partner, (b) my family, (c) the older members of my family, (d) my friends, and (e) my children. In addition, for going to the doctor, the belief that the doctor would support the behavior was also assessed. Responses were again provided along -3 (*unlikely*) to +3 (*likely*) scales.

[4]Although some readers may wish to see internal consistency coefficients, we follow Fishbein's (Fishbein & Ajzen, 1975) criterion for belief scales. He argues that high internal consistency indices indicate poor discriminant validity across different belief contents. In this regard, coefficients such as Cronbach's alpha may provide inadequate indications of construct validity. In contrast, researchers should rely on the appropriate elicitation procedures, and ultimately validate their constructs by comparing actual results with theoretical expectations. Both of these conditions were satisfied in this study.

Motivation to comply. The motivation to comply with each referent in each behavioral domain was assessed by participants' answers along a 1 to 7 probability scale. A sample item is "When it comes to going to the doctor, I want to do what my husband thinks I should do."

Normative beliefs weighted by motivations to comply. Belief-based measures of attitudes were computed by summing the products of each belief multiplied by the corresponding evaluation (see Footnote 4).

Structural Measures

Several structural variables were measured. Presence of partner was measured dichotomously, with absence being coded as 0, and presence as 1. Age, number of children, and number of grandchildren were represented by absolute scales.

Results

Most women in the sample did not intend, once they were 55, to either go to a doctor at least once a year or to visit a family member once a week. Only 8% intended to annually visit a doctor, and only 22% had intentions to make a visit to a family member at least once a week.

In order to understand the determinants of these two intentions, correlational analyses were conducted (Table 1). Further, the applicability of the TRA was tested through multiple regression equations (Table 2). In addition, the contribution of structural variables to the TRA was studied through hierarchical multiple regression analysis. Finally, to study how beliefs were related to attitudes and norms, simple correlations were used.

Structural Versus TRA Determinants

Intention to visit a doctor annually. Regarding structural determinants, only educational level tended to be positively associated with the intention to visit a doctor ($r = .24$, $p < .05$). Age ($r = .13$, *ns*), presence of a partner ($r = .08$, *ns*), number of children ($r = .06$, *ns*), mean age of children ($r = .09$, *ns*), and number of grandchildren were all unrelated to this intention to seek formal support. In contrast, attitudes ($r = .47$, $p < .01$) and subjective norms ($r = .40$, $p < .01$) were significantly associated with intentions to visit a doctor once a year (Equation 1). Taken together, the two variables explained 29% of the variance in the women's intentions ($R^2 = .29$, $R = .54$). Adding education produced a nonsignificant 1% increase in the explained variance. Nor did any of the other structural predictors improve prediction over and above TRA variables.

Table 1

Correlations of Intentions With Structural and Volitional Determinants

	Intentions to go to the doctor	Intentions to visit a family member
Structural factors		
Age	.13	.08
Number of children	.06	.02
Age of children	.09	.15
Number of grandchildren	.09	.04
Education	.24*	.09
Presence of partner	.08	-.11
Volitional factors		
Attitude	.47**	.60**
Norm	.40**	.40**

*$p < .05$. **$p < .01$.

Intention to visit a family member weekly. None of the structural variables were significantly related to the intention to seek informal support. More specifically, the intention to visit a family member at least once a week was not significantly related to age ($r = .08$, *ns*), education ($r = .09$, *ns*), presence of partner ($r = -.11$, *ns*), number of children ($r = -.02$, *ns*), age of the children ($r = .15$, *ns*), or number of grandchildren ($r = .04$, *ns*). In contrast, attitude ($r = .60$, $p < .01$) and subjective norm ($r = .40$, $p < .01$) were strongly related to the women's intentions to visit with a family member. Taken together, attitude toward performing the behavior and the subjective norm explained 40% of the variance in the intention ($R^2 = .40$, $R = .63$), with attitude and norm carrying beta weights of .53 ($p < .01$) and .20 ($p < .05$), respectively. As before, adding the structural variables to the regression equation did not significantly improve prediction over and above TRA determinants. For example, although education and presence of partner increased the prediction by 1%, the changes were not significant.

The Underlying Cognitive Structure

To identify the beliefs that influenced attitudes and norms, each belief multiplied by its evaluation or motivation to comply was correlated with

Table 2

Multiple Regressions

Variable	Standard β	*T*	*p*	*R*	R^2
Intention to go to the doctor					
Subjective norm	0.27	3.03	.003		
Attitude	0.37	4.16	.001	.54	.29
Intention to visit a family member					
Subjective norm	0.20	2.34	.021		
Attitude	0.53	6.24	.001	.63	.40

attitudes and norms, respectively (Equations 2 and 3). The correlations between belief-based measures of attitudes and attitudes are presented in Table 3.

Going to a doctor at least once a year. Consistent with expectations based on the TRA, the women's attitudes toward going to the doctor at least once a year after 55 were significantly correlated with the sum of the products of behavioral beliefs and outcome evaluations ($r = .53, p < .01$). Similarly, the subjective norm was significantly correlated with the sum of the product of normative beliefs and motivations to comply ($r = .61, p < .01$).

At the individual belief level, the women's attitudes toward going to a doctor once a year were significantly correlated with their weighted beliefs that performing this behavior would lead to: (a) detecting diseases on time ($r = .55, p < .01$); (b) avoiding deterioration ($r = 41, p < .01$); (c) keeping calm ($r = .50, p < .01$); and (d) preventing high blood pressure, high cholesterol levels, and heart problems ($r = .45, p < .01$). In addition, attitude toward the behavior was positively correlated with the weighted belief that going to the doctor would not cause one to feel old or sick ($r = .30, p < .01$). Finally, there was a tendency for attitude to be more positive when the respondent believed that performing the behavior did not lead to being worried about health ($r = .20, p < .05$), when one believed that this behavior would enable one to avoid uterine cancer ($r = .20, p < .05$).

The subjective norm was influenced by all six salient referents. More specifically, all correlations between the subjective norm and weighted normative beliefs were significant (husband, $r = .48, p < .01$; family, $r = .42, p < .01$; older members of the family, $r = .38, p < .01$; friends, $r = .58, p < .01$; children, $r = .50, p < .01$; and medical doctor, $r = .57, p < .01$).

Visiting a family member every week. The women's attitudes toward visiting a family member every week was successfully predicted from the sum of

Table 3

Correlations Between Belief-Based Measures and Attitudes

Going to the doctor		Visiting a family member	
1. To prevent diseases	-.14	1. To have company	.42**
2. To detect diseases	.55**	2. To maintain affective links	.41**
3. To avoid deterioration	.41**	3. To make an effort to talk	.36**
4. To keep calm	.50**	4. To be surrounded by insincere people	.12
5. To prevent a high BP	.45**	5. To not get along well with the family	.21*
6. To avoid uterine cancer	.20*	6. To be dependent on family	.16
7. To feel old or sick	.30**	7. To get help	.00
8. To not get answers	.03	8. To not be isolated	.24*
9. To find out one is sick	.03	9. To find that the relative is sick	-.07

Note. Belief-based measures are sums of beliefs weighted by evaluations.
*$p < .05$. **$p < .01$.

beliefs weighted by evaluations ($r = .42, p < .01$). Attitude toward the behavior was positively correlated with the weighted beliefs that visiting a family member once a week after 55 will lead to: (a) having company ($r = .42, p < .01$), (b) maintaining affective links ($r = .41, p < .01$), and (c) making an effort to talk to people ($r = .36, p < .01$). Similarly, women who believed that visiting a family member would prevent isolation were more likely to hold a positive attitude toward performing this behavior, although the correlation was only marginally significant ($r = .24, p < .05$). Finally, those who did not believe that frequent family visits would lead to interpersonal difficulties were also somewhat more likely to have positive attitudes toward such visits ($r = .21, p < .05$).

Turning to the normative aspects of intentions to visit a family member, subjective norm was significantly correlated with the sum of normative beliefs by motivations to comply ($r = .62, p < .01$). Considering normative beliefs individually, the subjective norm was significantly correlated with the weighted normative beliefs of all four salient referents: (a) husband ($r = .57, p < .01$), (b) older members of the family ($r = .60, p < .01$), (c) friends ($r = .40, p < .01$), and (d) children ($r = .49, p < .01$).

Discussion

Although structural variables have often been found to be important correlates of the amount of social support received by a given individual, it appears that these variables have little, if any, impact on intentions to actively seek social support. Among the demographic variables, only educational level showed a tendency to be associated with intention to go to the doctor at least once a year after 55. The other structural variables had no relation to either the intention to go to the doctor or the intention to visit a family member. The low relation between these factors and social support seeking seems to indicate that reception and seeking of support may be slightly different phenomena.

Consistent with expectations, volitional determinants accounted for considerable variance in women's intentions to engage in both formal and informal active support seeking. Attitudes and norms were important in both cases, and adding demographic variables to the prediction models did not significantly increase the amount of explained variance.

Although neither actual behavior nor perceptions of support were available in this study, there is evidence that people's behavior influences the type of support they receive. Thus, for example, increasing social attitudes and interpersonal skills has been shown to increase the size of the support network and the frequency of contacts (Lovel & Richey, 1995). In this regard, it is important to consider the determinants of support-seeking behaviors as they influence the social support that becomes available. In this case, the analysis of the cognitive structures underlying attitudes and subjective norms helped to identify some of the beliefs that appear to influence at least some types of support-seeking behavior. These findings have important implications for the design of interventions to increase support-seeking behavior in older women.

For example, the more the women perceived that specific referents (e.g., husbands, older members of the family, friends, children) thought they should actively seek support, the stronger were their intentions to go to a doctor at least once a year and to visit a family member at least once a week. In this regard, an intervention designed to increase active seeking of informal support could use normative messages designed to increase women's beliefs that specific referents (e.g., friends, family, children) thought they should keep regular contact with family members. Alternatively, persuasive messages could target the referents themselves in order to get them to explicitly encourage women to visit them on a regular basis.

While such a normative approach should impact upon support-seeking intentions, the data obtained from this sample of Argentinean women suggest that an attitudinal campaign might be somewhat more effective, particularly with respect to actively seeking informal support. This suggests that a behavior

change intervention should also focus on some of the behavioral beliefs underlying support-seeking attitudes.

For example, with respect to formal support seeking, the women were more likely to form intentions to go to a doctor on an annual basis the more they believed that this behavior would lead to improved health (e.g., early detection, preventing high blood pressure and high cholesterol levels) without making them feel old or sick or worried about their health. Similarly, the women were more likely to form intentions to visit a family member at least once a week the more they believed that this behavior would provide company, maintain affective links, and avoid isolation without increasing the likelihood that one would not get along well with her family.

These findings suggest that an attitudinal campaign designed to increase the likelihood that older women will visit a doctor at least once a year should try to strengthen beliefs about the health benefits of annual visits and, at the same time, try to counter the belief that annual visits make one feel old and sick. There is growing evidence that such theory- and data-based campaigns can successfully increase the likelihood that members of a given population will engage in behaviors that are beneficial to their health and well-being (Winett, 1995).

Finally, some limitations of this study should be noted. Given the use of two specific support seeking behaviors, the current data may not be generalizable to other actions in this domain. In fact, Ajzen and Fishbein (1980) have indicated that changes in the action, the target, the context, and the time need to be consistent if one wishes to make inferences from one variable to another. Thus, beliefs about going to the doctor (which is a restricted operationalization of social support) are unlikely to be useful to predict church attendance or participation in social recreational activities. A broader generalizability of these results can only be achieved by multiple operations of social support seeking.

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