GERONTOLOGIA POLSKA 2020; 28; 127-135 ARTYKUŁ ORYGINALNY / ORIGINAL PAPER
Zgłoszono 23.06.2020; zaakceptowano 2.07.2020

Structural and functional context of social support including elderly population

Strukturalny i funkcjonalny kontekst wsparcia społecznego z uwzględnieniem populacji seniorów

Paweł Chruściel

Department of Basic Nursing and Medical Teaching, Chair of Development in Nursing, Faculty of Health Sciences, Medical University of Lublin, Poland

Abstract

Introduction. *Old age is considered to be a period associated with the deterioration of the life situation, both in terms of health, social relations and financial situation. Therefore, elderly people tend to see social support as inferior in comparison to younger people. In addition, the number of available sources of support decreases with age.* ***Aim.*** *The aim of this study was an attempt to systematize knowledge about social support in terms of its structure and functions, taking into account the population of elderly people.* ***Brief description of the state of knowledge.*** *Social support as a multidimensional concept still does not have a precise definition and is assigned a meaning of an empirical nature. The semantic concepts of social support are usually descriptive and atheoretical. Despite the semantic variety and interpretations of social support given to it by researchers of the phenomenon – towards a structure or function, or a quantitative or qualitative approach – most definitions have a common denominator in the form of actions between the donor and the recipient of the support.* ***Conclusions.*** *Social support is a resource indispensable at any age, and it is especially crucial for the elderly, including dependent people. Definitional heterogeneity, ambiguity and imprecise theoretical foundations of social support lead to discrepancies in the comprehension and construction of measurement tools as well as the subsequent interpretation of the obtained results. (Gerontol Pol 2020; 28; 127-135)*

Keywords: *social support, functional support, structural support, support networks, elderly*

Streszczenie

Wstęp. *Starość uznawana jest za okres związany z pogorszeniem się sytuacji życiowej, zarówno w aspekcie stanu zdrowia, relacji społecznych czy sytuacji finansowej. Dlatego też, osoby w podeszłym wieku postrzegają wsparcie społeczne zwykle jako gorsze w porównaniu z osobami młodszymi. Poza tym, wraz z wiekiem zmniejsza się ilość dostępnych źródeł wsparcia.* ***Cel pracy.*** *Celem pracy była próba usystematyzowania wiedzy o wsparciu społecznym w zakresie jego struktury i funkcji, z uwzględnieniem populacji osób starszych.* ***Skrócony opis stanu wiedzy.*** *Wsparcie społeczne jako pojęcie o charakterze wielowymiarowym, nadal nie posiada dokładnej definicji i przypisuje się mu znaczenie o charakterze empirycznym. Koncepcje znaczeniowe wsparcia społecznego mają zazwyczaj charakter opisowy i ateoretyczny. Pomimo różnorodności znaczeniowej i interpretacyjnej wsparcia społecznego nadawanej mu przez badaczy zjawiska – w kierunku struktury lub funkcji bądź też ujęcia ilościowego lub jakościowego – większość definicji posiada wspólny mianownik w postaci podejmowania działań pomocowych zachodzących pomiędzy dawcą a biorcą wsparcia.* ***Wnioski.*** *Wsparcie społeczne jest zasobem niezbędnym w każdym wieku, szczególnie istotne jest ono dla osób starszych, w tym niesamodzielnych. Niejednorodność definicyjna, wieloznaczność oraz nieprecyzyjne podstawy teoretyczne wsparcia społecznego prowadzą do rozbieżności w rozumieniu oraz konstruowaniu narzędzi pomiarowych jak i późniejszej interpretacji otrzymanych wyników. (Gerontol Pol 2020; 28; 127-135)*

Słowa kluczowe: *wsparcie społeczne, wsparcie funkcjonalne, wsparcie strukturalne, sieci wsparcia, osoby starsze*

Introduction

Until recently, the subject of research related to the measurement of social support did not enjoy particular interest among Polish researchers. Currently, the increase in the number of scientific publications about the discussed variable proves the constant need to measure it. There is also a noticeable growing tendency to measure

Adres do korespondencji / Correspondence address: ✉ Paweł Chruściel; Department of Basic Nursing and Medical Teaching, Chair of Development in Nursing, Faculty of Health Sciences, Medical University of Lublin 4/6 Staszica St.; 20-081 Lublin ☎ (+48 81) 448 68 00 💻 pawelchrusciel1@o2.pl

social support in relation to the elderly population. It is the needs of this heterogeneous demographic group that become a priority and, at the same time, a challenge for modern society in the context of therapy and care, including environmental and institutional care.

On the basis of national literature, the subject of social support is usually considered in the context of its structural dimension, ignoring the type of available assistance. This is due to the limited availability of tools used for measuring functions. Additionally, the existence of social networks is often identified with the support itself, which may result from the heterogeneous ways of defining it. The discussed construct does not usually constitute an independent variable under evaluation and is measured in comparison with other positive or negative personal resources, such as optimism, a sense of loneliness, a sense of coherence.

Old age is considered to be a period related to the deterioration of the life situation, both in terms of health, social relations and financial situation [1]. Therefore, elderly people tend to see social support as inferior in comparison to younger people. The physiological consequences of old age lead to disability and dependence of the elderly on help from other people, while the dependence on the environment is permanent and deepens over time [1, 2]. In addition, the number of sources of support available decreases with age. The increased demand for long-term care in this period of life requires the involvement of non-professional caregivers - members of the immediate family. In Poland, it is still common to take care of a sick and dependent person by taking nursing and support actions by a spouse / partner and / or by children. The immediate family members are responsible for providing the required assistance. Additionally, non-professional care is considered the most valuable form of assistance to an elderly person, as it creates a sense of stability and security. However, due to the weakening of the caring function of the family, there are more and more situations in which it becomes necessary to help in the form of institutional support in everyday functioning – adequately to the degree of disability and state of health. Covering an older person with 24-hour institutional care is associated with a change in their current living environment, which in turn leads to deterioration of social support. Moreover, isolating the elderly from natural support networks may have a negative effect on their health, including mental fitness [2].

Support is a subjective perception of satisfaction with interpersonal contacts. Strong and positive relationships with significant others are especially important in coping with stressful events. Events such as, for example, changing the current living environment or being in a new environment reduce personal internal resources such as: sense of control, self-esteem or sense of meaning in life. On the other hand, the support shown allows, at least partially, to compensate for the resulting deficiencies [3]. Due to the increasing number of elderly people, including chronically ill and dependent people, who require round-the-clock care from institutions, it was considered justified to formulate the following research aim: determining the relationship between the quality of life and social support for elderly people covered by institutional care.

Aim

The aim of this study was an attempt to systematize knowledge about social support in terms of its structure and functions, taking into account the population of elderly people.

Material and methods

The method of critical analysis of the available literature on the subject was used to develop this study. The analysis was carried out in the theoretical context serving to indicate the scientific substantiation of the discussed variable and its interpretation, and was based on sources in the form of Polish and English language reviewed scientific papers.

In order to select it correctly, full-text and bibliographic-abstract databases available on-line through the EBSCOhost server were analyzed. The following subject terms were used in the search: *social support*, *social network*, *social relationships*, *structural support*, *functional* support, *older people*, *older adults*, *elderly*.

A significant number of the returned search results were not adequate and directly related to the desired scope, so the found references were subjected to two-stage content verification.

First, the abstract content of a given publication was read, and then the analysis of the theory of social support presented by various authors in relation to the ways of defining social support, description of structural and functional support, and the relationship between support and health were focused on. The most valuable publications have been qualified for use in this study, regardless of the year of their publication.

Description of the state of knowledge

Defining social suport

Social support as a multidimensional concept still does not have a precise definition and is assigned a more empirical than theoretical meaning. The beginnings of the development of the concept date back to the 1970s. However, it has recently been treated as an independent research subject. It has aroused considerable interest especially in relation to social and psychological sciences in the context of stress and ways of dealing with its consequences. The semantic concepts of social support are usually of a descriptive and atheoretical nature.

According to H. Sęk's proposal, social support is an interaction initiated by the person offering and/or the person anticipating support in a stressful, problematic or difficult situation [4]. J. Terelak, on the other hand, identifies support with asymmetric relationships of humanitarian and moral values between a person anticipating help and a person ready to provide it, in relation to the difficult situation of one of these people [5]. I. Sarason's definition treats support in terms of help that is available to people in difficult situations [6]. J. Kirenko understands the commonly expected help in critical situations that cannot be dealt with by the individual through social support [7]. According to J. House, social support is a specific type of interpersonal transaction, during which emotions, information, values or instruments may be exchanged [8] In the comprehensive concept of support according to Ch. H. Tardy, specific areas in which support should be considered, that is direction, disposition, content, evaluation and support networks were taken into account [9].

Despite the variety of meanings and interpretations of social support given to it by researchers of a phenomenon – towards a structure or function, or a quantitative or qualitative approach – most definitions have a common denominator in the form of helping activities taking place between the *donor* and the *recipient* of the support. It is other people as well as the willingness and type of help they provide that are of key importance in the proper functioning of a person in the environment. There are several dimensions of social support, also called categories of support, which can be distinguished depending on the adopted criterion (figure 1). With regard to the subjective and objective criteria, the following can be distinguished:

a. structural support and
b. functional support [10].

Structural support

Structural support refers to the existence and availability of support networks characterized by, in addition to emotional affiliation and relationships closeness, a real willingness to provide support activities to the person expecting support.

Support networks are usually described by such indicators as: network availability, its size, homogeneity, density, frequency of contacts, network coherence, network age, network gender, network location, network structure or its activity [8,11,12].

It is vital to make a distinction between the terms social network and support network (Figure 2). The term social network is not synonymous with the concept of support network and should not be used interchangeably with it. The social network is a broader concept than the support network and refers to the system of general interpersonal relations in a given social community, including relations devoid of altruism and mutuality traits. However, a constant feature of the support network is the presence of the so-called significant people who act in favour of their members and are ready to offer help whenever it is needed.

The support network usually consists of family members and often unrelated people. These people are important (significant) to the individual and are a source of stimuli primarily positive ones. One of the advantages of being part of a support network is having sources of support. The source of support should be understood as a person or group of people creating a given category (level) of the support network. Hence, very often the so-

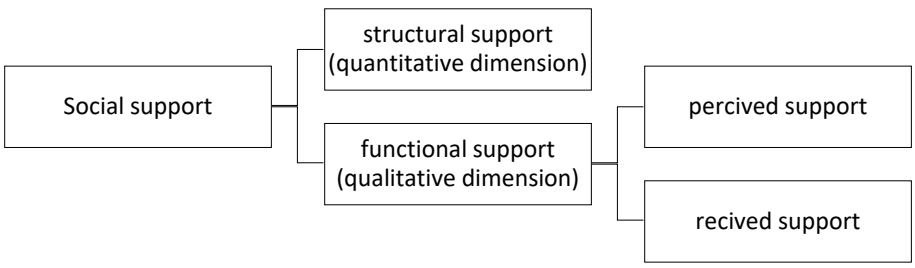

Figure 1. Dimensions of social support

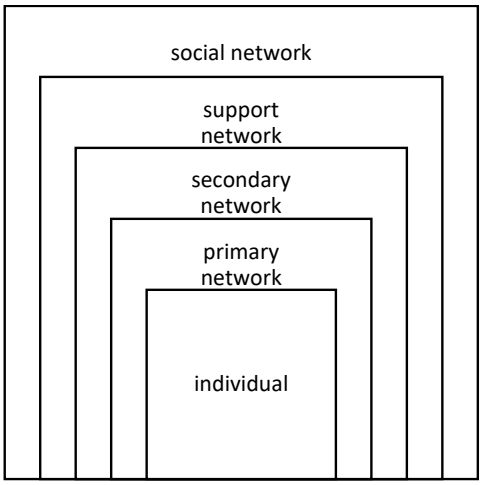

Figure 2. Hierarchisation of the support structure

urces of support are identified with objectively existing support networks. However, each source of support has a specific direction of the *donor → recipient* support interactions and the permanent nature of the interactions. According to the general division, two categories of sources of support are distinguished:

a. informal (*non-professional, natural*) creating the so-called *primary network* that lists family members, friends, neighbours and associates;
b. formal (*professional, formalized*) constituting the basis for the existence of a *secondary network*, that is people professionally involved in providing help, institutions of support and care, religious unions or associations [4, 13].

In accordance with the division of sources of support according to K. Hebel [14], three groups of people providing support can be distinguished:

a. the first circle formed by the closest people, most often it is an intimate partner, children and friends. These people are considered a basic and permanent support network, available anytime, and providing ongoing support;
b. the second circle, which includes the extended family, neighbours and colleagues. People from this circle can provide support at a significant level, but it is usually weaker than that provided by the first circle. Additionally, the rotation of these people and bonds with them are subject to changes throughout their lives, which means that the help they provide may be occasional;
c. the third circle consists of associates, attendants, employees of the institutions or casual acquaintances. The relationships between these people and the support *recipient* are characterized by high volatility and instability. The support from people within the third circle is considered the least significant, but very useful in the absence of people from the first and second circles.

Support received from people from particular circles mobilizes the individual's personal resources in order to cope with a difficult situation and is conditioned by:

– the number of people ready to provide support;
– real possibilities and willingness to help by people from the environment;
– resources owned by the individual and the possibility of their activation [13].

Individual sources of support perform different and at the same time complementary functions towards the *recipient* of support – depending on the situational context and the current needs of the individual, the consequences of their impact may be cumulative and may overlap. Each of the support sources can provide a different kind of aid. It seems justified that the simultaneous receipt of several types of support from different sources is the most optimal situation, as it equips the individual with better resistance to difficult situations, reduces the risk of health complications, and even reduces the risk of premature death. The existence of a support network, i.e. people ready to provide help and support, constitutes the essence and foundation of social support.

A person without a support network (structural dimension) cannot experience the benefits of its functional aspect – support is impossible without the participation of other people. Despite this, support resources exist regardless of the occurrence or nono-occurrence of difficult and crisis situations. Man as a being of a social nature lives in a given community and is usually surrounded by family and friends. As a result of disorders in performing social roles caused by an illness or other difficult situation, support from the environment enables an individual to find themselves in a new, changed role [14]. The most valuable, voluntary and often reliable source

of support for a sick person is their family, an intimate partner and other people emotionally connected with them (e.g. friends and neighbours) [13, 15-17]. The supporting function in the absence of a family can be taken over by neighbours, especially of similar age, offering closeness and understanding. They often constitute an even stronger resource of support than family members. Natural sources of support have a more beneficial effect on an individual and do not lead to their stigmatization due to the existing intra-group trust [18].

Functional support

Another dimension of support is functional support, which is expressed in its relational nature – between the *donor* and the *recipient* of the support. Instruments, emotions, information or values are transferred (exchanged) in relations between these entities in order to control a difficult situation. This exchange is intended to build a sense of security and belonging or to eliminate stressful experiences. Functional relationships are influenced by the support network and the individual characteristics of the *recipient*. Within functional support, several types of it can be distinguished (depending on the content of social exchange):

a. emotional support related to the transmission of emotions that are supportive and reassuring, emotions that build a sense of care and trust. Emotional support is used to free oneself from negative thoughts and relieve stress. Emotional support is considered the most common and expected because it increases self-esteem and improves the well-being of the support *recipient*;
b. information support (*cognitive support)* is related to the exchange and provision of information aimed at facilitating the *recipient* to overcome difficulties by understanding their own situation and nature of the problem. This type of support also includes counseling on obtaining professional help from a given institution and sharing similar experiences, e.g. in self-help groups;
c. instrumental (*tangible support*) support, that is, providing direct and real help in the form of services or activities (e.g. feeding, medication and shelter provision, purchasing of specific products). It may also take the form of instructions on how to act, including the ways of dealing with specific situations. A common form of instrumental support is financial aid. Moreover, this type of support is most desirable in situations of natural disasters. Sometimes one can encounter an additional kind of purely material support (tanglible/material suport) which, due to its similarity to instrumental support, is often identified with it;
d. esteem support (*appraisal support*) refers to ensuring that the individual is in the posession of such resources, opportunities or abilities that are important to a given support network and helpful for the proper functioning of its individual members. Moreover, this type of support is related to expressing an opinion on the behavior, work, statements or appearance of the support *recipient* in order to mobilize them to correct the above ranges [4, 8, 9, 19].

In addition to the above-mentioned types of support, there is also a spiritual type associated with the occurrence of a life crisis, which is accompanied by suffering and fear of death (e.g. diseases that cannot be treated or terminal conditions). This support includes activities focused on maintaining faith in recovery or the meaning of life, assistance in developing an internal coping strategy or accompanying in experiences [4].

Taking into account the temporal criterion, i.e. considering social support from a time perspective, it can be divided into:

a. perceived support (*potential, anticipated*) – is prospective in nature and is equated with the individual's belief in the availability of people ready to provide help. It is assumed that this aspect of support constitutes a stronger indicator of state of health and coping with stressful situations compared to the support received.;
b. received (*real*) support – concerns real aid received in various forms, in the past, and thus is of a retrospective nature. Moreover, the received support determines the perceived support, which is justified by negative experiences from the past and consequently shapes the belief that its availability will be low in the future [20, 21].

Both perceived and received support are derivatives of the functional dimension of support. On the other hand, considering social suport in empirical terms, we can distinguish:

a. quantitative support, referring to its objective determinants in the form of a support network and being synonymous with structural support;
b. qualitative support as a subjectively perceived support taking into account its type, availability or adequacy. It is identified with functional support.

It is assumed that the division of support into quantitative and qualitative is particularly important in research related to health [22]. It should be added that the division of support depending on the theoretical (structural and functional support) and empirical context is a conventional one, and the distinguished categories are

arbitrary and do not form a common ground for the description of this phenomenon. Their semantic ranges complement each other or are treated as synonyms, and potential differences concern the way of presenting a given category depending on the researcher's preferences and the formulation of the research problem.

Social support and the health of seniors

Nowadays, apart from population changes, one can also observe epidemiological changes related to the increase in the incidence of non-communicable diseases, including chronic diseases manifested by the prolongation of life. Chronic diseases are a factor that strongly determines the quality of life, leading to dependence, including deficits in the field of self-care and psychophysical fitness. According to the guidelines of the National Commission on Chronic Illness, disorders with at least one of the following characteristics should be considered a chronic disease:

a. persistence;
b. milder course than in acute conditions;
c. being caused by irreversible pathological changes;
d. leading to a disability;
e. requiring specialized remedial procedures or long-term supervision, observation or care [2].

Old age is conducive to the increase in the number of concomittant chronic diseases, which may be related to many years of exposure to environmental and behavioral factors. The most common and cost bearing chronic diseases are: cardiovascular diseases, including stroke, cancer, respiratory diseases, diabetes, joint dysfunction and mental illnesses. Chronic disease disturbs the functioning of many aspects of the patient's life, becomes a prism through which the patient perceives themselves, notices their own limitations of a somatic, psychological or social nature [19]. Chronic disease is often accompanied by the necessity to modify the current lifestyle and undergo a long-term therapy, which in turn results in a loss of the sense of control over its course as well as disorganization of family life and existing relationships [12].

Structural and functional support are among the factors positively influencing the maintenance of health. It has been proved that the lack or a scant number of sources of support in a condition of loneliness may disturb the physical and mental well-being [23-25]. In addition, social support has a health-promoting function by building a sense of belonging. For this reason, people who support their relatives and experience help can be considered healthier than people who are deprived of those [26]. A positive role of support has been observed in alleviating post-traumatic stress, in the fight against addictions and somatic diseases, in convalescents after cardiac surgery or with breast cancer [13, 27-31]. According to P. Salmon, the benefits of emotional support provided to a sick person show a therapeutic effect [32]. Support plays a significant role in the process of adapting to a disease, such as breast cancer or coronary artery disease [27-30]. Owing to the presence of relatives who form the primary support network, it is possible to deal with negative feelings accompanying the disease. In addition, patients convinced of the support that can be obtained and actually receiving it, recover at a faster pace and live longer. Patients receiving social support adequate to their needs are more likely to follow medical recommendations and are characterized by a lower drug level, which positively affects their health [32,33]. People experiencing low-level social support, making use of it in an unskilful way or with a low sense of coherence, more often struggle with health problems (e.g. gastrointestinal ulcers, rheumatic diseases, ischemic heart disease, depression or personality disorders) [30-35].

Social support can also have an adverse or even destructive effect on an individual. The situation takes place when th support is provided in excess – in the long run – and when it is inadequate to the situation and needs of the *recipient*. Such activities may result in the recipient becoming dependent on help from other people, and, consequently, in the development of a sense of helplessness, dependency or reduced self-esteem. Despite many scientific reports confirming the strong correlation between social support and state of health, difficulties are still encountered when describing the mechanisms of the impact of support. It can be assumed that each type and form of support is desirable in unfavorable situations, especially emotional support [22].

The relationship between social support and health seems obvious, although scientific research shows that it is not a simple relationship and certain variables may weaken its directness. Such variables include the level of perceived stress. The literature describes two independent models (hypotheses) of social support relating to its association with state of health in the context of stressful experiences (Figure 3):

a. main effect model (*direct*) and
b. buffering model (*indirect*).

The first model addresses the structural context of social support and focuses on the beneficial role of having a support network and social relationships in which people are anchored. This model describes the direct impact of the support on the perceived stress or on health. According to the assumptions of this model, belonging to a given

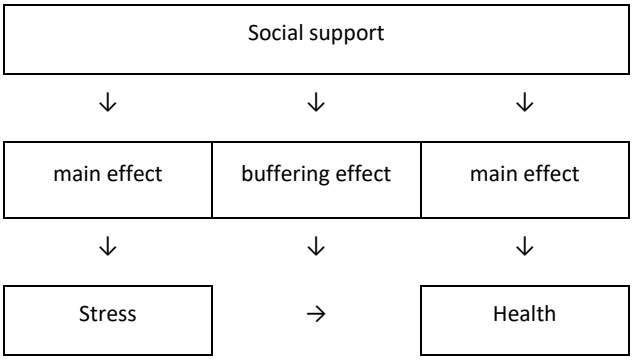

Figure 3. Impact of social support on stress and health

social group, organisation or having a partner has a positive and protective effect on health, regardless of the level of experienced stress. Social relations, including their intensity, increase the sense of stability, life predictability and a sense of security. In this model, support acts as a mediator and has prophylactic and protective properties against future stressful situations [36].

On the other hand, the buffer model assumes the existence of certain properties attributed to social support, which can play a buffer (shock-absorbing) role and have a protective effect in contact with the negative consequences of a stressful situation, including diseases. A stressful situation is associated with the occurrence of a specific physiological response of the body. The stress factor acts here as a trigger that releases the mobilization of personal health-sustaining resources. The support acts as a moderator, modifying the relationship between stress and health, e.g. by enhancing one's own abilities and increasing the sense of self-efficacy and resourcefulness. It should be noted that the effect of the buffer effect of support depends on the size and scope of the support and the *donor's* competences – the shortage or excess of support may result in the opposite effect to the intended one. It has been observed that experiencing support in unfavorable situations reduces the stress experiences, and thus affects the occurrence of a smaller number of disease symptoms [37-40]. Both the model of the direct and indirect influence of support on the health condtion are characterized by the phenomenon of mutual permeability and coexistence [4].

Conclusions

Social support is a necessary resource at any age, and it is especially important for the elderly, including dependent people. The state of health is a fundamental determinant of the activity of seniors, the possibility of independent functioning or using the help of other people in everyday activities. Definitional heterogeneity, ambiguity and imprecise theoretical foundations of social support lead to discrepancies in the understanding and construction of measurement tools as well as the subsequent interpretation of the obtained results. Measurement of social support usually concerns its two dimensions: quantitative and qualitative, however, it is support networks rather than their functions that are measured much more often. This study is a kind of incentive for people planning research based on the topic of social support, for a comprehensive measurement of the phenomenon as well as further and more narrow analyses of social support, constituting the background for international or population comparisons.

Conflict of interest
None

References

1. Jurek Ł. Sektory opieki długoterminowej – analiza kosztów. Gerontol Pol. 2007;15(4):111-5.
2. Kucyper E, Kucyper K. Wybrane zagadnienia polityki społecznej wobec osób starych. W: Fabiś A (red.). Seniorzy w rodzinie, instytucji i społeczeństwie. Wybrane zagadnienia z gerontologii społecznej. Sosnowiec: Wydawnictwo Wyższej Szkoły Zarządzania i Marketingu; 2005. ss. 133-142.

3. Niezabitowski M. Relacje społeczne ludzi starszych w środowisku zamieszkania – aspekty teoretyczne i empiryczne. Folia Sociologica. 2011;38:13-31.
4. Sęk H, Cieślak R. Wsparcie społeczne – sposoby definiowania, rodzaje i źródła wsparcia, wybrane koncepcje teoretyczne. W: Sęk H, Cieślak R (red.). Wsparcie społeczne, stres i zdrowie. Warszawa: Wydawnictwo PWN; 2006. ss. 14-20.
5. Terelak JF (red.). Człowiek i stres. Bydgoszcz-Warszawa: Oficyna Wydawnicza Branta; 2008. ss. 325-330.
6. Sarason IG, Levine HM, Basham RB, et al. Assessing social support: The Social Support Questionnaire. J Pers Soc Psychol. 1983;44(1):127-39.
7. Kirenko J, Byra S (red.). Zasoby osobiste w chorobach psychosomatycznych. Lublin: Wydawnictwo UMCS; 2008. ss. 103-106.
8. House JS. Social support and social structure. Sociological Forum. 1987;2(1):135-46.
9. Tardy ChH. Social support measurment. Am J Community Psychol. 1985;13(2):187-202.
10. Hogan BE, Linden W, Najarian B. Social support interventions: do they work? Clin Psychol Rev. 2002;22(3):383-442.
11. Agneessens F, Waege H, Lievens J. Diversity in social support by role relations: a typology. Soc Networks. 2006;28(4):427-41.
12. Tobiasz-Adamczyk B. Wsparcie społeczne, sieci a nierówności w stanie zdrowia w wieku starszym na przykładzie umieralności i jakości życia uwarunkowanej stanem zdrowia. Zesz Nauk Ochr Zdr Publ Zarz. 2011;9(2):119-26.
13. Kawczyńska-Butrym Z. Społeczne konsekwencje choroby i niepełnosprawności. W: Taranowicz I, Mjchrowska A, Kawczyńska-Butrym Z (red.). Elementy socjologii dla pielęgniarek. Lublin: Wydawnictwo Czelej; 2000. ss. 235-56.
14. Hebel K, Bieniaszewski L. Wsparcie społeczne i pomoc instytucjonalna dla osób niepełnosprawnych po udarze mózgu. For Med Rodz. 2008;2(1):76-83.
15. Michałowska-Wieczorek I. Rola wsparcia w zmaganiu się z chorobą nowotworową. Psychoonkologia. 2010;10(2):51-56.
16. Dudek M, Murat M. Wsparcie osób starszych w Polsce – wybrane problemy. W: Balogová B (red.). Pęd życiowy w relacjach międzypokoleniowych. Preszów: Wydawnictwo Uniwersytetu Preszowskiego; 2010. ss. 230-5.
17. Olejniczak P. Wsparcie społeczne i jego znaczenie dla osób starszych. Piel Zdr Publ. 2013;3(2):183-8.
18. Mirczak A. Determinanty wsparcia społecznego wśród starszych mieszkańców wsi. Labor et Educatio. 2014;2:189-203.
19. Glazer S. Social support across cultures. Int J Intercult Rel. 2006;30(5):605-22.
20. Łuszczyńska A, Cieślak R. Protective, promotive, and buffering effects of perceived social support in managerial stress: the moderating role of personality. Anxiety Stress Coping. 2005;18(3):227-244.
21. Schwarzer R, Knoll N. Functional roles of social support within the stress and coping process: A theoretical and empirical overview. Int J Psychol. 2007;42(4):243-52.
22. Kózka M. Wsparcie społeczne w chorobie. W: Kózka M, Płaszewska-Żywko L (red.). Modele opieki pielęgniarskiej nad chorym dorosłym. Warszawa: Wydawnictwo PZWL; 2010. ss. 45-49.
23. Uchino BN, Carlisle M, Birmingham W, et al. Social support and the reactivity hypothesis: conceptual issues in examining the efficacy of received support during acute psychological stress. Biol Psychol. 2011;86(2):137-42.
24. Uchino BN, Bowen K, Carlisle M, et al. Psychological pathways linking social support to health outcomes: a visit with the „ghosts" of research past, present, and future. Soc Sci Med. 2012;74(7):949-57.
25. Wang HH, Wu SZ, Liu YY. Association between social support and health outcomes: a meta-analysis. Kaohsiung J Med Sci. 2003;19(7):345-51.
26. Łuszczyńska A, Cieślak R, Maśliński W, et al. Stres i wsparcie społeczne: zależności z obszaru psychoneuroimmunologii. Psychologia-Etologia-Genetyka. 2001;3-4:13-32.
27. Wang W, Lau Y, Chow A, et al. Health-related quality of life and social support among Chinese patients with coronary heart disease in mainland China. Eur J Cardiovasc Nurs. 2014;13(1):48-54.
28. Barth J, Schneider S, von Känel R. Lack of social support in the etiology and the prognosis of coronary heart disease: a systematic review and meta-analysis. Psychosom Medicine. 2010;72(3):229-38.

29. Nabi H, Hall M, Koskenvuo M, et al. Psychological and somatic symptoms of anxiety and risk of coronary heart disease: the health and social support prospective cohort study. Biol Psychiatry. 2010;67(4):378-85.
30. Spatuzzi R, Vespa A, Lorenzi P, et al. Evaluation of social support, quality of life, and body image in women with breast cancer. Breast Care. 2016;11(1):28-32.
31. Thompson T, Rodebaugh TL, Pérez M, et al. Influence of neighborhood-level factors on social support in early-stage breast cancer patients and controls. Soc Sci Med. 2016;156:55-63.
32. Salmon P. Psychologia w medycynie wspomaga współpracę z pacjentem i proces leczenia. Gdańsk: Wydawnictwo GWP; 2000. ss. 364-80.
33. Reblin M, Uchino BN. Social and emotional support and its implication for health. Curr Opin Psychiatry. 2008;21(2):201-5.
34. Fiori KL, Denckla ChA. Social support and mental health in middle-aged men and women: a multidimensional approach. J Aging Health. 2012;24(3):407-38.
35. Yang Y. How does functional disability affect depressive symptoms in late life? The role of perceived social support and psychological resources. J Health Soc Behav. 2006;47(4):355-72.
36. Uchino BN. Social support and health: a review of physiological processes potentially underlying links to disease outcomes. J Behav Med. 2006;29(4):377-87.
37. Schawrzer R, Knoll N. Functional roles of social support within the stress and coping process: a theoretical and empirical overview. Int J Psychol. 2007;42(4):243-52.
38. de Longis A, Holtzman S. Coping in context: the role of stress, social support, and personality in coping. J Pers. 2005;73(6):1633-56.
39. Szymańska J, Sienkiewicz E. Wsparcie społeczne. Curr Probl Psychiatry. 2011;12(4):550-3.
40. Dudek B, Koniarek J. Wsparcie społeczne jako modyfikator procesu stresu – wybrane problemy teoretyczne i narzędzie pomiaru. Med Pr. 2003;54(5):427-35.