chapter 13

Dilemmas of Social Support: Parallels between Victimization and Aging[1]

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> They don't know that I am here imprisoned in old age, trying to make contact with the world [Maclay 1977].

There is considerable research suggesting that close supportive relationships can play an important role in preserving mental and physical health. Though many questions about the impact of social support remain unresolved, we believe that this research may have powerful implications for the elderly. As social psychologists, we became interested in the topic of social support while studying how people cope with uncontrollable, aversive life events. Those who have experienced misfortune appear to benefit greatly from the support of family, friends, and professionals. Ironically, however, there is evidence to indicate that sufficient support is often not available. Research suggests that because people feel discomfort in the presence of suffering and distress, they are often unable to provide the help and attention that victims need. Thus, the very nature of victims' unfortunate circumstances prohibits others from extending the help and attention that are required.

This paradox was sufficiently intriguing that we examined it among

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individuals suffering from a number of different problems including cancer and depression. In this chapter, we explore the possible relevance of our perspective to the elderly. First, our analysis concerning the social support needs and dilemmas of those victimized by life crises is described in some detail. In the second section of the chapter, we consider the applicability of this victimization perspective to the elderly by addressing several specific questions: In what ways might the elderly benefit from social support? What are their specific support needs? Do they receive adequate support? Or like victims of life crises, might the elderly elicit reactions in others that reduce the probability that support will be extended? In the concluding section of the chapter, we explore both research and policy implications of our analysis.

SOCIAL SUPPORT AND COPING WITH VICTIMIZATION

The Adaptiveness of Social Support

An examination of the available research on coping with serious life crises reveals a consistent relationship between the support people receive and their psychological adjustment. Individuals suffering from malignant disease (Bloom and Ross 1977, Carey 1974, Ferlic *et al.* 1979, Jamison *et al.* 1978, Sheldon *et al.* 1970, Vachon 1979, Weidman Gibbs and Achterberg-Lawlis 1978, Weisman 1976), physical disability (Kelman *et al.* 1966, Kemp and Vash 1971, Litman 1962), the death of a family member (Bornstein *et al.* 1973, Clayton *et al.* 1972, Gerber *et al.* 1975, Parkes 1975, Raphael 1977, Vachon 1979), rape (Burgess and Holmstrum 1978), job loss (Cobb and Kasl 1977) and other misfortunes (Davidson *et al.* 1979, Findlayson 1976) appear to adjust more successfully when social support is available to them than when it is not (and see review papers by Cobb 1976, Dean and Lin 1977, DiMatteo and Hays, in press, Heller 1979, House, in press, and Silver and Wortman 1980). Among those coping with stress, there also appears to be a positive relationship between social support and indices of physical health status (Cobb and Kasl 1977, deAraujo *et al.* 1973, Dudley *et al.* 1969, Gerger *et al.* 1975, Gore 1978, Holmes *et al.* 1961, Kimball 1969, Lynch *et al.* 1974, Maddison and Walker 1967, Nuckolls *et al.* 1972, Weisman and Worden 1975). For example, widows who do not receive support from others are more likely to experience symptoms of illness and to have poor health than those who do (Maddison and Walker 1967, Porritt 1979, Raphael 1977).

The mechanisms through which perceived support affects coping and health status have not yet been clearly delineated (see Cobb 1976, 1979, Kahn 1979, and Silver and Wortman 1980, for a more detailed discussion of this issue). Moreover, there are alternative explanations for the findings in many of the individual studies showing a relationship between perceived support and adjustment to life crises. Since most of these studies are correlational, for example, it is not clear whether support facilitates coping or whether one's coping or prognosis determines the amount of support available. However, it is noteworthy that social support has also been found to facilitate adjustment to crises in studies where participants have been assigned to a supportive treatment or a control condition (e.g., Bloom and Ross 1977, Raphael 1977). There is also evidence to suggest that the benefits of social support are not limited to those undergoing a particular life stressor (e.g., Brown *et al.* 1975, Hinkle 1974, Lynch 1977). For example, Berkman and Syme (1979) conducted a large-scale survey on a population that was very heterogeneous with respect to the types and levels of stressors experienced. They found that people who were lacking in social ties (i.e., marital status, close friends and relatives, participation in groups) were from 3 to 300 times more likely to die within several years of follow-up than those who had such ties. Taken together, the consistent findings regarding the benefits of social support are remarkable given the wide variety of disciplines, methodologies, and populations involved.

Converging evidence regarding the advantages of social support have aroused widespread interest in this construct and have fostered attempts to specify conceptually distinct components or types of support (e.g., Caplan 1974, Caplan 1979, Caplan and Killilea 1976, Cobb 1976, 1979, Heller 1979, House, in press, Kahn 1979, Pinneau 1975). Emotional support—the attempt to communicate positive regard (i.e., love, concern, or respect)—is one frequently mentioned type (Cobb 1976, 1979, House in press, Kahn 1979, Kahn and Antonucci, in this volume). Another is instrumental or tangible support; for example, material aid or help with tasks (Dean and Lin 1977, Caplan 1974, House in press, Kahn 1979, Kahn and Antonucci, in this volume).

A third type, appraisal support, involves providing information to others that they can use to evaluate themselves or their experiences. This includes expressing agreement with or acknowledgment of a person's beliefs or feelings (Caplan 1974, Caplan and Killilea 1976, Dunkel-Schetter and Wortman in press, House in press, Kahn 1979, Kahn and Antonucci, in this volume, Walker *et al.* 1977, Wortman and Dunkel-Schetter 1979). These components of support are not entirely independent of one another. A given behavior may provide two or more types of

support simultaneously (see House in press); for example, gift-giving, which usually conveys affection (i.e., emotional support), can also be a way of helping meet material needs (i.e., instrumental support). Further theoretical and empirical work on the components of social support may highlight the process through which support influences physical and mental well-being.

Ventilation and Validation: Types of Support Especially Valuable for Those Victimized by Life Crises

In our previous work with victims, we became especially interested in emotional and appraisal support. A careful examination of prior research, clinical experience, and our ongoing research with cancer patients, spinal cord injured persons, and rape victims have helped us to identify two specific support needs often experienced by these populations. These are the need to express one's feelings (*ventilation*) and the need to know that one's feelings are normal given the circumstances (*validation*). Actions that encourage ventilation are a specific kind of emotional support, while those providing validation are a form of appraisal support.

In previous papers, we have argued that people who are confronted with undesirable life events usually experience considerable uncertainty and anxiety. Such events may challenge one's assumptions about the world and create feelings of fear and confusion. Many victims of life crises experience an intense need to clarify what is happening and to receive support. For these reasons, they may wish to talk with others about their feelings (Coates *et al.* 1979, Dunkel-Schetter and Wortman in press, Silver and Wortman 1980, Wortman and Dunkel-Schetter 1979). Verbalizing personal concerns during a time of stress can help people to clarify their feelings, to manage them more effectively, and to begin active problem-solving. A person's need to ventilate can best be met by supportive others who encourage open communication and who listen attentively to expressions of feelings, especially negative ones, without judging the person or feeling compelled to provide a solution. Silver and Wortman (1980) review considerable evidence that people appreciate and benefit from the opportunity to express their feelings and that lack of such opportunities can intensify their distress.

The second support need that we have emphasized is validation (Coates and Wortman 1980, Dunkel-Schetter and Wortman in press, Silver and Wortman 1980, Wortman and Dunkel-Schetter 1979). It is common, we have argued, for those who suffer from undesirable life events to worry that their uncertainty, confusion, and anxiety are abnormal. The intensity of these feelings leads many victims to believe that they are coping poorly or are losing their sanity. Learning that their reactions are prevalent among others in similar situations can reduce some of this secondary anxiety. Such knowledge can be gained by acquiring relevant information about others' reactions and then comparing one's own responses to theirs (see Festinger 1954, Schachter 1959). For example, a cancer patient can learn that it is normal to become angry or depressed following diagnosis or to be plagued by fears of recurrence.

In principle, comparison information is available from educational materials (e.g., pamphlets, films), from media accounts and books about others, from professionals who work closely with the specific populations, and from direct contact with others who have had similar experiences. We believe that the last of these—interactions with similar others—is particularly effective in obtaining validation and is beneficial for other reasons as well. Interacting with peers provides a chance to gain direct and vivid comparison information. It also offers excellent opportunities to ventilate and may allow for exchange of valuable practical information and useful suggestions about methods of coping.

The Adequacy of Social Support Available to Those Victimized by Life Crises

While we have argued that the need for ventilation and validation are particularly acute for many victims of undesirable life events, there is also evidence that opportunities to fulfill these needs are frequently unavailable. In a study of cancer patients undergoing radiation therapy, for example, less than half of the sample could identify a person with whom they could discuss emotional difficulties. Moreover, 86% of the respondents indicated that they wished they were able "to discuss the situation more fully" with someone (Mitchell and Glicksman 1977). Similarly, in several studies on bereavement reactions, respondents have reported that they are encouraged to be "strong" and to avoid open expression of their grief (see, e.g., Glick *et al.* 1974, Helmrath and Steinitz 1978, Schwab *et al.* 1975). In each of these investigations, respondents reported that such advice from others was not helpful. Those who allowed or encouraged the expression of their feelings were more likely to be regarded as supportive (see also Schoenberg *et al.* 1975).

The Victimization Perspective: Reactions to Victims and Their Impact

If victims desire support from others and profit when it is forthcoming, why are these needs so infrequently met? In past papers, we have devoted

considerable attention to analyzing the interpersonal difficulties that often seem to accompany a victimized status (Coates *et al.* 1979, Coates and Wortman 1980, Dunkel-Schetter and Wortman, in press, Silver and Wortman 1980, Wortman and Dunkel-Schetter 1979). We have argued that while others are usually motivated to help, the victim's plight is a powerful stimulus in its ability to arouse negative feelings in others. One reason why victims may elicit such feelings is that they unwittingly make others feel vulnerable to a similar fate. Second, victims may arouse feelings of helplessness and inadequacy if there is little that one can say or do to alleviate the victim's problems. In short, interactions with people who are suffering are distressing because they may force us to think about things we would rather not contemplate and confront us with problems that we are unable to solve.

In addition, there is evidence that many people hold erroneous assumptions about how victims should respond to the crisis and how they should be treated to facilitate good coping. These assumptions may interfere with the provision of effective support. Past work has indicated that people feel victims should not discuss their negative feelings, and that they should attempt to be optimistic and cheerful (Dunkel-Schetter and Wortman in press, Silver and Wortman 1980, Wortman and Dunkel-Schetter 1979). In reviewing research on widows, for example, Walker, MacBride, and Vachon (1977) concluded that "even intimates do not support the need to mourn the loss beyond the first few days after the death [p. 38]." Similarly, Helmrath and Steinitz (1978) report that although mothers who have lost an infant experience a strong desire to talk about the child, "friends and family steadfastly avoided mentioning the infant or the death [pp. 787–788]." Conversely, victims who do ventilate their negative feelings may be seen as coping poorly. In one study, rape victims who indicated, 6 months after the assault, that they were having some difficulty in getting over the incident were judged as less attractive and more maladjusted than rape victims who did not indicate difficulties (Coates *et al.* 1979).

As a result of prevailing assumptions and negative feelings, people often behave toward victims in a variety of ways that are detrimental to them. Some of these actions are meant to help, while others may be unintentional or unthinking. People frequently avoid victims and may discourage or even prevent open communication. In addition, they typically attempt to be cheerful while concealing their negative feelings. This can result in negative nonverbal behavior and other signs of insincerity that confuse victims and, over time, can undermine their self-esteem.

In examining the needs of victims and the reactions of others to them,

we have advocated an interactional approach (Coates and Wortman 1980, Dunkel-Schetter and Wortman in press, Wortman and Dunkel-Schetter 1979). Coates *et al.* (1979), for example, state: "In victims' relationships and interactions with others, all the participants provide input and influence outcomes [p. 23]." We feel it is extremely important to analyze how the behaviors of victimized individuals and those in their social environment influence one another over time, and ultimately, affect adaptation or well-being. This general approach as well as the preceding specific points are considered with regard to the elderly in the remainder of this chapter.

PARALLELS TO THE ELDERLY AND THE PROCESS OF AGING

To what extent might our previous work on victims be useful in understanding the elderly? Do the elderly, like victims of life stress, arouse negative feelings in others and thereby decrease the likelihood of obtaining social support? Clearly, our perspective applies to the elderly who are suffering, the disabled, the chronically ill, the bereaved, and those who have experienced other undesirable life events or life circumstances. Butler and Lewis (1977) have indicated that individuals generally face a large number of negative outcomes during the later years of life: "The elderly are confronted by multiple losses, which may occur simultaneously: death of a partner, older friends, colleagues, relatives; decline of physical health and coming to personal terms with death; loss of status, prestige, and participation in society; and for large numbers of the older population, additional burdens of marginal living standards [p. 34]." Concerning physical decline alone, 85% of the noninstitutionalized population over 65 report at least one chronic disease, and 50% report limitations in activity due to chronic health conditions (Shanas and Maddox 1976). The subgroup of those over 65 years of age who experience suffering of various types is referred to as the "frail," "vulnerable," or "at risk" elderly (Federal Council on Aging 1978). These individuals may experience compound problems including financial, health, and social difficulties that categorize them as victims similar to people in any other age group.

Distinguishing this subgroup should not imply that the remainder of the elderly population is without stress. The process of aging, even if unaccompanied by disability or loss, may be significantly distressing for many people. The feelings of confusion and uncertainty that occur among victims are likely to occur among large segments of the elderly population

as they attempt to cope with the multiple changes associated with the aging process. These changes do not fall within a single domain but may include concurrent physical, social, emotional, and mental changes. Some of these can occur gradually, such as alterations in appearance and the loss of physical strength, stamina, and function; others, such as a heart attack or a stroke, relocation or retirement, are instantaneous. Thus, the process of aging may be visualized as a continuous stream of gradual changes punctuated by sudden, dramatic discontinuities. These accelerating changes may arouse considerable anxiety and may shatter an older person's illusions of personal invulnerability and immortality. The increased unpredictability and loss of control accompanying aging (see Schulz 1976), and the salient inevitability of deterioration, loss, and death contribute to making this time of life potentially difficult. Considering all of these factors, it may be useful to think of the elderly as victims of the aging process.

The elderly have often been thought in the past to be the victims of negative beliefs, attitudes, and perceptions on the part of other age groups. Evidence on this has been conflicting, but reviews indicate the negative views of the elderly are generally slight, and vary as a function of the perceiver's and target person's characteristics (Lutsky 1980, McTavish 1971). The focus of this chapter is on suffering that results from undesirable life events and the transition to late life. However, if the elderly as a group are viewed in negative or inaccurate stereotypical ways as some research suggests (Brewer 1979, Eisdorfer and Altrocchi 1961, Lutsky 1978, Richman 1977), this probably compounds other problems they may have.

In summary, available evidence suggests that a significant portion of the elderly population is likely to experience undesirable life events similar to those we have studied in the general population. Even among those elderly whose lives are not disrupted by major crises, the many other changes associated with aging may result in confusion and distress. For these reasons, we believe that our analysis of victims' support needs and dilemmas is generally applicable to the experiences of large segments of the elderly population. In the subsections to follow, we (*a*) consider whether the elderly, like other victims of life crises, appear to benefit from social support; (*b*) examine the specific support needs of the elderly, especially the possible significance of ventilation and validation; (*c*) analyze the adequacy of the social support available to the elderly and attempt to identify specific problems that the elderly may encounter in meeting their support needs; (*d*) discuss possible reactions to the elderly that may interfere with the provision of effective social support.

The Adaptiveness of Social Support for the Elderly

A number of gerontological studies reviewed by Larson (1978) have suggested that social activity and interaction may be related to life satisfaction among the elderly. Larson reports that across diverse populations, investigators have found a significant association between the frequency of social activity and subjective indices of well-being. Although most of the research discussed in Larson's review is correlational, two more recent studies suggest that social interaction may be a causal determinant of life satisfaction among the elderly. Using a path analytic approach, Markides and Martin (1979) found that general activities such as organizational involvement or going to the movies increased satisfaction with life among 141 persons who were over 60 years of age. Similarly, Palmore and Kivett (1977) conducted an extensive longitudinal investigation involving 378 community residents between 46 and 70 years of age. They found that the amount of social activity was a strong indicator of satisfaction with life 6 years later (see also Sauer 1977).

In order to explore the relationship between social activity and other variables, investigators typically employ measures such as frequency of interaction, number of relationships, or attendance at social events. As others have noted (see Conner *et al.* 1979, Lowenthal and Haven 1968, Lowenthal and Robinson 1976), these measures do not permit an examination of the relationship between the qualitative aspects of social interaction and life satisfaction. An exception to this rule is a frequently cited longitudinal panel study of 280 community-resident aged conducted by Lowenthal and Haven (1968). They found that a stable relationship with a close confidant was associated with several indices of successful adaptation (i.e., positive morale, perceptions of self, and psychiatrist ratings). Furthermore, the presence of a confidant influenced the relationship between number of social activities and subsequent depression. Among individuals with a confidant, social activities or roles could be decreased with little effect on depression. For those without a confidant, however, these changes were associated with significant increases in depression.

In summary, social support appears to be important to the well-being of the elderly in the same way it is to the adjustment of victims. Further investigation of the specific dimensions of social activity that are helpful or supportive might strengthen this conclusion and clarify the issues (see Kahn 1979 for a general discussion of social support and aging as well as suggested research directions).

The Specific Social Support Needs of the Elderly

Knowing that social support is generally beneficial to the elderly does not indicate much about the specific support needs of the elderly. Our impression from the gerontology literature is that more is known about the needs of the elderly for instrumental support (e.g., money, health care, housing, food) than for other types of support (i.e., emotional support, appraisal support). These other support needs of the elderly seem to have been neglected. The following questions are intriguing: Do the elderly feel misunderstood by their families or unaccepted by younger generations? Would they like more information about various aspects of their experience—how to handle the stress of retiring or losing a spouse? Do they feel unattractive, abnormal, useless, bored? Would they like more opportunities to talk openly with others about negative feelings? (See Gaitz and Scott 1975 for data and Waters *et al.* 1976 for discussion relevant to these issues.)

It is proposed that the need to ventilate one's feelings and to validate them through comparison with similar others may be present for large segments of the elderly population, particularly those who are suffering. When an elderly person is uncertain, confused, or nervous for any of the reasons previously considered, discussing these emotions may be very beneficial. This expression may help to diffuse the intensity of these concerns and to clarify them. For example, an older woman who feels neglected by her children may be able to relieve some of her resentment and anger by expressing her feelings openly to a sympathetic friend. Or an older man who feels worthless in retirement may recognize some of the reasons for his feelings by exploring them with his wife. These verbalizations create opportunities for feedback that may indicate one's experience is understood and perhaps shared by others.

The Lowenthal and Haven study (1968) previously mentioned provides evidence that communicating with others is beneficial to the aged. The results indicate that a confidant protects an elderly person from adjustment problems that might result from loss of social roles, decreased social interaction, widowhood, and retirement. Similarly, in a study of self-disclosure patterns of older adults, Henkin (1979) has written: "Sharing one's concern with others often facilitates the adjustment process that follows a major role change and affords people the opportunity to validate their altered self-image [p. 8]." An experimental study by Raphael (1977) supports this conjecture. Widows and widowers who were randomly assigned to participate in a supportive treatment that encouraged expression of grief did not show the health deterioration over a year's time that was characteristic of control group subjects.

Validation is also highly beneficial to the elderly as they attempt to cope with the many changes inherent in aging. By interacting with other elderly persons, an individual may realize that it is common to have alarming or distressing thoughts and feelings. Moreover, these can be seen as normal consequences of aging rather than reflections of personal inadequacy or insanity. For example, the bereaved often believe that their tendency to hear or see their dead spouse is a sign of psychological disturbance. Learning that this is a common occurrence during the early stages of grieving may be extremely reassuring. Comparison information can be provided in many ways, but, as in the case of victims, interaction with similar others may be optimal. For the elderly, age peers can provide unique opportunities for social support (Rosow 1967, 1970).

Several qualities of the elderly discussed by Butler and Lewis (1977) are consistent with the claim that they need opportunities for ventilation and validation. Not unlike victims, the elderly are often motivated to clarify their experiences and to achieve a meaningful perspective on the changes they are undergoing and on their lives as a whole. Thus, it is common for an elderly person to sift through past experiences and relationships (e.g., childhood, marriage, career, friendships) and to examine unresolved conflicts. This process of life review may be facilitated by providing the elderly with opportunities to ventilate or express their concerns. By listening to such expressions, we can enable the elderly to see their past lives as more significant, and thereby, to complete their life review more successfully. In fact, Butler and Lewis (1977) state that the elderly are often motivated to share their experiences and accumulated knowledge with younger people. Feedback or acknowledgment that their reminiscing is regarded as interesting and their advice as valuable may enhance their self-esteem and reduce anxiety.

In addition, most people wish to believe that when they die they will leave behind something important, such as children or possessions, or be remembered by others (Butler and Lewis 1977). For this reason, they may have a strong desire to discuss the past contributions they have made, to explore their impact on the lives of others, and to consider the value of material possessions they will leave. Others' willingness to listen reassures the older person that his or her contributions are appreciated. Each of these tendencies of the elderly—to review their lives and attempt to see them as meaningful, to share their experiences and feel they are appreciated, and to know that they have left a legacy—are consistent with the notion that the elderly need to talk openly with others and to receive reassurance that they are normal, are understood, and are accepted by others.

Our analysis of victims suggests that ventilation and validation are

prevalent support needs and that promoting them is beneficial. However, there is not enough accumulated evidence to draw unqualified conclusions. There may be many conditions in which they are ill advised. For example, expressing feelings about one's problems in moderation is likely to be adaptive whereas dwelling on the negative aspects of one's situation, overindulgent complaining, and pervasive self-pity are probably maladaptive. Similarly, social comparison information is not always beneficial (see Brickman and Bulman 1977, for review and discussion). If the comparison reveals a dissimilarity, validation is not provided. Furthermore, if the dissimilarity reflects unfavorably on one of the parties, it may evoke additional distress and a more acute need for validation.

In summary, perhaps too little is known about the emotional and appraisal support needs of the elderly. A first step in more thoroughly describing and conceptualizing these needs might be to investigate the social–psychological processes of ventilation and validation previously described. Although more research is needed to uncover the boundaries of their adaptiveness, there is some preliminary evidence that these factors may be significant among the elderly.

The Adequacy of the Social Support Available to the Elderly

In this section, we consider whether the elderly receive effective social support or whether, like victims of crises, they are unlikely to be helped by others. The available evidence indicates that the majority of the elderly population have family networks and see family members on a regular basis (see reviews by Rosow 1970, Shanas 1975, 1979, Troll 1971). Shanas (1979), for example, reports that among the noninstitutionalized elderly (95% of all elderly over 65 years of age), approximately three-quarters see their children on a weekly basis. About the same proportion of those who never married see a brother or sister weekly. Evidence also suggests that the elderly have extensive ties with friends (see Babchuk 1978–1979, Cantor 1975, Rosow 1967). Although this body of research indicates that the majority of the elderly have the basic ingredients for social support, several additional issues are worth considering.

First, the elderly who are vulnerable to social support deprivation may be the remaining 25% of the noninstitutionalized who do *not* have frequent contact with family members and the 5% who are institutionalized. These individuals are likely to be an important and sizable target population in which to investigate socioemotional needs. A related point is that the elderly who are victimized (e.g., ill, disabled, dying, bereaved)

deserve special attention because they may be the most likely to be isolated. As we have mentioned, work with victims suggests that those who are suffering are frequently avoided by others (see Dunkel-Schetter and Wortman in press, Wortman and Dunkel-Schetter 1979). If this holds true for the victimized elderly, they would be a group especially in need of social support services.

Third, although the majority of older people appear to have some intact relationships, changes in one's social support network over time may take their toll (see Bengtson 1973, Kahn 1979). A reality of aging is that as one grows older, there is a high likelihood of being widowed, particularly for women. The elderly must also contend with the gradual diminishing of their former peer group (Butler and Lewis 1977). Rosow (1970) calls this phenomenon a "contracting social world." Consistent with the point, Bultena (1968) found that older retirees had less interaction with age peers than did younger retirees. He notes that the increased likelihood of death of one's spouse and friends can sever the individual from an important source of contact within his or her age group. The loss of relatives and lifelong friends necessarily creates instability or gaps in the social network of an older person. Although it may be possible to fill these gaps with other relationships, these shifts in patterns of support may cause stress, while simultaneously reducing the resources the individual has to manage it. Thus, substantial changes in the nature of one's network over time may not be reflected in measures of the sheer number of relationships or frequency of interaction.

Finally, intact social relationships and frequent interaction with others do not ensure that support needs are being met effectively. It is conceivable that some social relationships can contribute to rather than solve one's problems (see Caplan 1979, Heller 1979, House in press). For example, some spouses or children are habitual recipients, not sources, of support; they are a burden in both their demands for help and in their failure to reciprocate. Therefore, it is extremely important to examine the content of interactions or the quality of support received by the elderly (see Conner *et al.* 1979, Henkin 1979, Longino and Lippman 1979, Troll 1971, who also make this point). A recent study by Connor *et al.* (1979) underscores this problem. In this study, 22 quantitative aspects of social interaction (e.g., frequency of interaction, number of social relationships) were measured among 218 noninstitutionalized respondents over 70 years of age, but only four variables were significantly associated with life satisfaction. Moreover, these four measures accounted for only a small portion of the variance (3%). The authors conclude that quantity of interaction is not crucial to understanding ad-

aptation to old age and they add: "It is in the quality of interactional experience that a broader understanding of adjustment to the process of aging will ultimately be found [p. 121]."

The few studies that have probed the quality of support available to the elderly raise some doubts about whether they receive the socio-emotional support they need. In one study (Lopata 1978), over 1000 Chicago widows were interviewed about the extent to which families and friends provided 52 types of support organized into four categories (financial, service, social, emotional). With the exception of children, Lopata found that family members provided little support of any kind to respondents. In fact, less than 12% could indicate any relative who would supply each of 13 specific types of emotional support. Although some family members reportedly spent time with their elderly relatives, Lopata states that this "does not translate into real emotional supports. Such relatives are particularly ineffective as comforters, confidants, or suppliers of the self-feelings of usefulness, independence or self-sufficiency [p. 361]."

Two other investigations also raise doubts about the adequacy of support available to the elderly, despite their conclusions to the contrary (Babchuk 1978–1979, Seelbach and Hansen 1980). Seelbach and Hansen (1980) examined satisfaction with family relations among institutionalized and community-dwelling elderly persons. Although they conclude that the elderly are generally satisfied with their families, sizable minorities indicated support problems. For instance, 32% of the respondents wished their families would pay more attention to them, 16% felt their families did not care, and 15% indicated their families tried to boss them. Furthermore, these results may be biased in a favorable direction because of the probable tendency toward socially desirable responses, which the authors point out.

Using a different approach to studying social support from that of Lopata (1978) or Seelbach and Hansen (1980), Babchuk (1978–1979) asked middle-aged and elderly persons to identify relatives and friends with whom they felt very close and then to determine which of these were confidants. The overall pattern of results suggests that few were without close ties of any kind. However, on closer examination, 15% of the sample had no relatives in whom they could confide, and 37% had no friends who were confidants. Many questions are left unanswered by this investigation; for example, how many respondents had neither a relative nor a friend in whom to confide? How many felt a need for more confidants? Is having a confidant a good indication of the receipt of emotional support? Is it better to confide in someone who is unsupportive or who responds negatively than not to confide in anyone at all?

These questions are only a few of those not yet answered by the research on the quality of support available to the elderly.

Reactions to the Elderly That May Interfere with the Provision of Effective Social Support

We suspect that for many reasons, the elderly, like victims, are unlikely to receive as much effective or high-quality support as they need. Some of these reasons are inherent aspects of the elderly person's situation (e.g., the death of friends, discussed above, or impaired hearing or speech); others involve the specific feelings people have toward the elderly and the ways in which they are likely to behave toward them. As previously discussed, a complete understanding of support requires analyzing both the perspective of the elderly individual and that of others in the social environment. Up to this point, we have considered support only from the perspective of the elderly. In the following section, the viewpoint of others toward the elderly will be examined in light of what is known about peoples' reactions to victims of life crises.

As we have discussed, there is a strong and consistent body of research in the field of social psychology suggesting that people often hold negative feelings about those who are suffering, unhappy, or in need of help. Although most of us would agree that the elderly should be treated with compassion and respect, actual encounters with suffering elderly people may be very threatening and upsetting to us, especially if they have serious problems. Like other victimized populations, the elderly may generate negative affect because they threaten our assumptions about the world, shatter our illusions of invulnerability, and engender strong feelings of helplessness. These possibilities are explored further.

Feelings Possibly Elicited by the Elderly

Vulnerability. One consequence of being confronted with individuals who are suffering, disadvantaged, or treated unfairly is that it can make us feel vulnerable to a similar fate. Such encounters can threaten our perception of our ability to influence and control our future and our assumptions about the world in general. The theorist who has provided the most cogent discussion of this issue is Lerner (1975, Lerner *et al.* 1976), who has argued that we are motivated to believe that the world is a just place in which people are rewarded for their efforts. (See also Walster 1966, for a similar theoretical statement and Wortman 1976, for a comparative analysis of these theoretical perspectives.) The belief in

a just world begins with early socialization. People implicitly agree to give up certain immediate gratifications, to work, and to invest their efforts in return for greater fulfillment in the future. Lerner (1975) has maintained that people want to believe that such sacrifices will pay off: "If the person becomes aware that someone else—who lives in and is 'vulnerable' to the same environment—has received undeserved suffering or failed to get what he deserved, the issue must arise as to whether the person himself can trust his environment [p. 8]."

Considering the need to believe in a just world, it is not hard to understand why encounters with the elderly may sometimes be threatening. People believe that this is a time of life when rewards for one's earlier sacrifices should be realized. Encounters with an elderly person whose existence is characterized by loneliness, disability, or inadequate financial resources can make us feel apprehensive about our own future and doubtful about whether our sacrifices and efforts will be rewarded.

Both Lerner and Walster have pointed out a number of ways in which people can reduce the distress that exposure to suffering can cause. People may look for weaknesses in the victim's behavior to explain the incident or outcome. For example, if we learn that an acquaintance has been hurt in an automobile accident, we may sift through the available information in search of some shortcomings on her part. Was she driving too fast? Under bad conditions? In an unsafe car? Under the influence of alcohol? Alternatively, we may attempt to identify weaknesses in the victim's character that would help account for her fate. Lerner and his colleagues have conducted a number of laboratory experiments that provide support for these theories (e.g., Lerner and Matthews 1967).

The implications of the above for attitudes toward the elderly are straightforward (see Perloff 1980). Following the logic of Lerner and Walster, we may often derogate or blame the elderly for their fate. For example, we may attempt to cope with the abject financial condition of an elderly person by attributing it to past laziness, poor planning, or other personal characteristics. Similarly, we may conclude that an elderly person deserves to be lonely because he or she is self-centered, cantankerous, and difficult. By convincing ourselves that we are different, we can feel protected from these predicaments.

Suffering that is specific to the aging process (e.g., the physical changes and growing limitations that occur) may be especially likely to arouse feelings of vulnerability. Interactions with elderly individuals who maintain a good physical appearance and much of their vigor may not be especially troubling. In contrast, a confrontation with a frail elderly person who has trembling hands, wrinkled skin, a stooped back, and failing eyesight or hearing may be very threatening. This makes it difficult

to deny that the deterioration and physical decline that accompany aging will happen to us. Because the elderly are like a mirror of our future, they force us to face the potentially fearsome prospects of our own aging and death. For this reason, we believe that many people may find contact with the elderly to be aversive and upsetting.

Helplessness. We believe that the elderly may also be very likely to produce feelings of helplessness among many of the people with whom they interact. There is clearly nothing that can be done to alter the progressive physical deterioration or prevent the death of an elderly person. Moreover, there are often no actions that can be taken to alleviate many of the problems that are typically encountered, including the loss of a spouse, the inability to find meaningful work, or inadequate financial resources. Finally, it is possible to become overwhelmed by the sheer number of problems facing many elderly people. How does one respond to an elderly man, for example, who is depressed by the recent death of his wife or who is unable to find work because he is immobilized by pain from arthritis? Or an elderly divorced woman who is extremely lonely, who is unable to care for herself because her eyesight is failing, and whose resources are not adequate to cope with rising housing and food costs?

There is evidence from the literature that people feel more positive about helping others when they believe that such help leads to concrete improvements in the target person's situation. Conversely, efforts to help that result in no noticeable change are likely to be frustrating and upsetting (see Brickman *et al.* in press for a review). This is most convincingly documented in research on "burnout," a series of attitudinal changes that occur among helping professionals as a result of job stress (see, for example, Cherniss *et al.* 1976, Doherty 1971, Edelwich and Brodsky 1980, Maslach 1976 and 1978, Pines and Aronson 1980, Pines and Maslach 1978, Segel 1970, Wasserman 1971, and see Wills 1978 for a review). Maslach (1976, 1978) has suggested that it occurs because providers feel overwhelmed by the magnitude and complexity of their clients' problems. Over time, burnout can lead to withdrawal either physically (e.g., quitting or avoiding difficult clients) or psychologically (e.g., treating clients in detached or dehumanized ways, or even derogating or blaming them for their problems). Interactions with the elderly and exposure to their difficulties may result in feelings of helplessness and inadequacy among service providers and others similar to burnout (see Hughes *et al.* 1979 for empirical results on negative attitudes toward patients of nursing home personnel of varying tenures).

In summary, contacts with the elderly may generate considerable

negative affect for people. In light of this, how do they behave when they encounter an elderly person who is having difficulties? In general, people's feelings of distress may lead them to minimize the frequency of interaction with the elderly and may markedly alter the nature of those interactions that do occur. Thus, the elderly may find that as their health declines and their problems increase, their social relationships become more and more strained. In discussing the interpersonal dynamics of cancer, we have proposed that feelings of discomfort are often displayed in a pattern of negative behavioral reactions. These may include avoidance, reluctance to have open discussions about the suffering person's situation, and verbal as well as nonverbal signs of rejection (Wortman and Dunkel-Schetter 1979). Each of these behaviors will be considered.

Resultant Behaviors

Avoidance. There is considerable evidence that nurses and doctors avoid patients who are dying or who are seriously ill (see Schulz 1978 for a review). When the elderly are institutionalized, hospitalized, or dying, there is good reason to suspect that they are also avoided by staff and family. As we have discussed, interacting with a suffering person forces people to confront their own negative feelings about the situation; indeed it may heighten these feelings since the person's suffering and deterioration are usually more evident in face-to-face interaction. Often the easiest solution is to minimize contact.

To our knowledge, little research has been done on actual behavioral avoidance of the elderly. A few studies on attitudes toward them suggests that the elderly may be avoided by health care professionals (e.g., Campbell 1971, Troll and Schlossberg 1970) and younger people (e.g., Kidwell and Booth 1977, Kogan and Shelton 1962). Anecdotal reports also indicate that avoidance is common among therapists (Kastenbaum 1963, LeShan and LeShan 1961). Although attitudinal findings may suggest behavioral tendencies, it is important to distinguish negative perceptions of the aged from avoidance of them. People may not report negative attitudes toward the elderly as a group yet avoid actual encounters with specific older people. Thus, attitudinal findings taken alone may be misleading. Future research on this topic might combine attitudinal and behavioral measures in order to get a broader picture of reactions to the elderly.

Preventing Open Communication. When interactions occur between suffering individuals and those in their social environment, many empirical studies suggest that open communication is avoided (Jamison *et*

al. 1978, Sanders and Kardinal 1977, Vachon *et al.* 1977). In most of these studies, it is unclear whether this reluctance to discuss the person's problems was initiated by the victim or by others. However, the available evidence suggests that it is common for family members, friends, and medical staff to discourage open communication with the seriously ill or dying and that patients see this as a problem (see Bard 1952, Gordon *et al.* 1977, Kastenbaum and Aisenberg 1972, Mitchell and Glicksman 1977, Pearlman *et al.* 1969). For example, Kastenbaum and Aisenberg (1972) asked nurses and orderlies how they responded when elderly geriatric patients attempted to discuss their feelings about death. Approximately 80% of the time, nurses and orderlies reported that they avoided the subject, denied the implications of the patient's remark, or ended the discussion. A comment like "I think I'm going to die soon," for example, was often met with replies such as "That's silly, you'll probably live to be 100."

There is also research that family, friends, and medical personnel try to influence distressed individuals to conceal negative feelings (see Binger *et al.* 1969, Dyk and Sutherland 1956, Glaser and Strauss 1965, Klein 1971, Maddison and Walker 1967, Quint 1965). For example, Glick *et al.* (1974) have reported data suggesting that widows perceive others to be very intolerant of their expressions of grief. Respondents reported that they were continually admonished to focus on the positive, on all they had to live for, and to avoid displays of sadness. Moreover, the widows indicated that such statements from others were not helpful in coming to terms with their loss.

The avoidance of open communication with other distressed populations raises a number of intriguing questions about the elderly. How do others react when older people describe their problems, talk about their past, or attempt to give others advice? Do others exert pressure on the elderly to keep their feelings and opinions to themselves? Lack of open communication may result from false assumptions by others (e.g., assumptions that the older people do not want or need to talk [see Garfinkel 1975], or that they have speech and hearing problems [see Bettinghaus and Bettinghaus 1976, Oyer and Oyer 1976, Oyer *et al.* 1976]). However, avoidance of open communication may also result from lack of interest. Butler and Lewis (1977) have stated that "one of the greatest difficulties for younger persons . . . (including mental health personnel) is to listen thoughtfully to the reminiscence of older people [p. 50]." They go on to say that we believe reminiscence represents living in the past and self-centeredness, that it is "boring, meaningless, and time consuming." If these statements are well founded, it seems probable that the elderly do encounter barriers to open communication that interfere with meeting important social needs.

Negative Nonverbal Behavior. Although others may often attempt to cope with their own distress by avoiding contact with the elderly or their problems, this is not always possible. Many people have some obligation to visit the elderly, see them on a regular basis, and therefore must show some attentiveness to their problems. Among family members, in fact, obligation may be a primary motive for interacting with an elderly relative (cf. Adams 1967, Arling 1976) and it is an obvious factor for service providers. In all likelihood, these individuals may try to hide negative feelings and be as supportive as possible when in the presence of the older person. However, any negative affect experienced during the interaction is likely to be communicated to the elderly person in subtle and insidious ways.

One way in which negative feelings may be communicated is through discrepancies between the person's verbal and nonverbal behaviors. A family member or health care professional may be verbally reassuring but simultaneously show nonverbal signs of distress. Although nonverbal behaviors between the elderly and others have not been carefully studied, research on interactions between able-bodied and handicapped individuals suggests that such discrepancies often occur (see, e.g., Farina *et al.* 1966, Kleck 1968, Kleck *et al.* 1968, Kleck *et al.* 1966). This is another potentially fruitful area of study for enhancing our understanding of social interactions between the elderly and others (see Dunkel-Schetter and Wortman in press, Wortman and Dunkel-Schetter 1979).

Impact of Others' Reactions on the Elderly

The model we have proposed in this chapter suggests that the support needs of the elderly may be met with reactions from others that only magnify their feelings of anxiety, confusion, and isolation. If this reasoning is carried to its logical conclusion, the implications are both paradoxical and distressing. One unfortunate aspect of social encounters between the elderly and others is that the topics that are most beneficial for an elderly person to discuss may be the very topics most likely to threaten and upset others. For example, the elderly may be especially interested in focusing on past conflicts or present distresses in order to view them from a meaningful perspective and resolve them. However, listening to accounts of these problems may heighten others' feelings of vulnerability and helplessness.

A second, equally problematic aspect of the portrait we have been painting is that the more unfortunate an elderly person's situation is, the more negatively others are likely to feel and behave. Most people would probably not find it particularly upsetting to interact with an elderly

person who has few serious problems and who is in relatively good health. In fact, such conversations can make one feel optimistic about the later stages of life. In contrast, it may be threatening and upsetting to interact with an elderly person who has many problems and who is coping unsuccessfully with them. As both Lerner and Walster have suggested, the more serious another's problems are, the more threatened we feel and the more likely we are to derogate or blame them. Thus, the elderly who most need support from others may be the least likely to get it, and at the times when they especially need it, they may be particularly likely to alienate others. Some implications of the ideas previously presented for future research and policy on the elderly are explored in the following section.

IMPLICATIONS

Since social support has been demonstrated to be an important mediating variable of physical and mental health across life stages and circumstances, it is incumbent upon us to enhance the opportunities for support available to the elderly of the future. Pursuant to this, research strategies and interventions that may be derived from the foregoing analysis are now discussed.

Research Implications

The gerontological research on social support has some notable gaps. As emphasized earlier, past research has rarely examined the content of the interactions taking place between the elderly and others. When interactions have been studied, the methodologies were usually descriptive and nonempirical (e.g.,Hochschild 1978). In our judgment, rigorous, empirical studies on the actual exchanges between the elderly and others are needed.

In this chapter, we have argued that the elderly may be most likely to receive effective social support from similarly aged peers. We maintained that such peers may be more likely to permit and encourage ventilation and validation of the elderly person's experiences. These ideas could be examined empirically by a systematic study of the interactions between the elderly and various others (e.g., children, siblings, spouse, age peer acquaintances, age peer friends, etc.). How do such interactions differ? Is an elderly person more likely to bring up problems

with one type of target person than another? What types of social support are most likely to be offered by particular target individuals? How do the various target persons respond when problems are brought up? To what extent do the elderly and particular targets agree that the interaction went well or that particular behaviors were helpful? In order to conduct this type of research, it would be necessary to conceptualize and quantify many dimensions of the interaction (e.g., types of social support offered, nonverbal signs of rejection). It would also be important to examine the feelings and attitudes of both participants after the interaction had terminated.

These hypotheses could be studied both by monitoring naturally occurring conversations (e.g., those that occur between the institutionalized elderly and their visitors), or by arranging conversations between the elderly and others in which certain factors are manipulated experimentally (see, e.g., Coates *et al.* 1979, Coyne 1976, Perloff 1980, Schulz 1976). For example, one could experimentally vary the number, type, or severity of problems discussed by elderly stimulus persons, or their ability to cope with these problems, and examine the feelings and behaviors of those with whom they interact. Such a design should make it possible to determine whether elderly persons who have many problems, or who are coping poorly, are especially likely to elicit negative feelings in others. In order to determine whether elderly people profit from opportunities to ventilate their feelings, one could experimentally vary the listener's response to the elderly. For example, some listeners could be instructed to permit ventilation, while others could be instructed to try to offer solutions for the elderly person's problems. The elderly person's reaction to the conversation and subsequent feelings could then be behavior assessed.

The reason why we have advocated interactions between the elderly and similarly aged peers is because, generally speaking, such peers are more likely to have similar problems and concerns than other targets. Interactions with such peers not only provide an opportunity for ventilation about these problems, but also enable the person to receive validation information. During such an interaction, an elderly person can compare his or her behavioral reactions to those of the peer and judge the appropriateness of these reactions. An elderly widow, for example, can learn that it is normal to have hallucinations about her dead spouse.

The argument we have advanced in this chapter about the benefits of receiving validation information raises a number of issues that could be studied empirically. Similarly aged peers are clearly not a homogeneous group. While some peers are likely to have similar problems (e.g., financial concerns or having lost a spouse), others are not. Some will

be doing better or worse, physically or psychologically, than the elderly person. What is the psychological impact of interacting with a similarly aged peer who has many more problems, and/or who is coping poorly with these problems? Under what conditions is an elderly person likely to feel fortunate in comparison with the other, and under what conditions is he or she likely to feel threatened and vulnerable to the other's fate?

It follows from our analysis that an elderly person with a particular problem should be most likely to receive effective support from a similarly aged peer with similar problems. For example, an elderly widow should be especially likely to benefit from interactions with other elderly widows. But persons with highly similar problems may not always be available. Will an elderly widow receive more effective support from a similarly aged peer who has not lost her husband, or from a younger friend or family member? Is the elderly peer more likely to be emphatic and supportive, since a similar fate may happen to her? Or is the elderly peer more likely to feel vulnerable and threatened, and therefore derogate or blame the widow for her problems? Clearly, these issues are in need of more empirical research.

Policy and Intervention Implications

On the basis of our analysis of the parallels between victimization and aging, we would propose two general types of interventions that may be support-enhancing. First, treatment programs with the objective of improving communication can be designed to alleviate problems that often occur between the elderly and their families. Second, interventions can aim to encourage meaningful interactions among elderly peers.

Since the families of older people seem to be an important source of support, it might be advisable to target some interventions at improving the effectiveness of the support that they are able to offer. We believe that families of older people are very susceptible to feelings of helplessness and vulnerability and are likely to prevent open communication, partly due to lack of understanding of the elderly person's need to talk. When an elderly family member is suffering, families are likely to experience stress (see Egerman 1966), intense negative feelings, and the desire to avoid the person. They may also exhibit negative nonverbal signals that convey rejection to the elderly person. In light of this, interventions are probably often needed by families of older people.

Hausman has recently developed a program for troubled adult children of the aged and has emphasized that communication is one of the primary concerns they mention: "Communication—with parents, other relatives,

parents' doctors, nursing home personnel—was another major problem. The need to communicate without complaining, to be assertive, to state needs without accusations, was expressed at nearly every session [1979, p. 105]." Therapeutic interventions that improve communication within the family and that diffuse negative feelings may have important benefits. They can help relatives learn about some of the usual concerns and problems associated with aging. For example, family members may learn that the tendency to review one's life is very common and probably therapeutic among the elderly. The knowledge that merely listening is helpful and that they need not offer a solution may partially alleviate feelings of helplessness. Family members can also learn from discussions with other families that the negative feelings they are experiencing are frequently felt by others who are in similar situations. By providing families with a setting in which to ventilate and validate their feelings and to learn about aging, family interventions can increase the chances that the elderly will receive satisfying emotional support. Thus, it is our contention that making the families of the elderly aware of the complicated social environment in which they exist can improve the quality of support extended to the elderly.

Rosow (1967) has suggested that the best opportunities for socially integrating the elderly are with age peers. Similarly, we previously asserted that contact with others who are facing similar experiences and problems may be helpful to the elderly. We suspect that because elderly persons share common experiences, they are much more capable of meeting one another's support needs than are family or younger friends. A first step in providing peer support is to increase the likelihood that elderly people will meet and get to know others of their own age. To this end, it might be worthwhile to consider various living arrangements that offer proximity to other older people (e.g., communal households, retirement communities, public housing for senior citizens). Another setting in which elderly people congregate are local community centers or senior centers. Contrary to some opinions that the elderly should not be segregated in this way, there may be some important psychological advantages to age-segregated housing and recreational facilities because they provide primary access to age peers.

However, just as quantity of social support need not imply quality, proximity to age peers does not imply meaningful exchanges. Troll, in a paper on kin relationships late in life, agrees: "Residential proximity does not guarantee interaction. Presumably people who live near each other see each other frequently, but they may not be in any kind of intimate or meaningful contact [1971, p. 278]." It is therefore important to determine how different age-segregated environments vary in the extent to which they foster or inhibit interaction and communication among

the elderly. Moreover, it is important to develop interventions that aim to facilitate the formation of friendships and communication among older people.

One promising intervention is the peer support group. These groups have multiplied rapidly across the country in recent years and now exist for cancer patients, diabetics, widowed persons, single parents, bereaved parents, and rape victims (for an overview, see Lieberman and Borman 1979, and Levy 1976). They are usually founded on the principle that open and honest communication among people with similar previous experiences (or similar present circumstances) is valuable and therapeutic.

There are a number of outcomes of peer support that could be helpful to the elderly. Foremost among them are the valuable opportunities for ventilation and validation, previously discussed. Similar others are generally more interested in hearing one's concerns, can more easily empathize or share one's perspective, and can provide feedback from firsthand experience that one's concerns are also prevalent in others. Since such groups include a number of individuals with particular problems or concerns, it is usually possible to obtain comparison information that is personally relevant. For example, a widow who cannot sleep or who is afraid to go out at night may compare herself with other widows experiencing these problems. In addition to sharing one's feelings and learning that they are shared by others, peer support groups can provide a source of advice regarding how to cope with common problems (e.g., arthritis, social security benefits, or conflict with one's children). Finally, access to age peers may allow the elderly person to feel less dependent on family members for support, thereby reducing the strain placed on the family.

One example of a peer counseling program for older people has been in operation at the Continuum Center at Oakland University in Michigan (Waters *et al.* 1976). In this program, older people learn communication skills and have small group discussions led by peer paraprofessionals. Informal and formal evaluations conducted on the program suggest that it increases confidence, warmth, and positive feelings among the elderly who participate. Learning to communicate positive and negative feelings enables them to be more direct with their families, to hold fewer resentments, and to improve their interpersonal relationships. In addition to the evident positive effects for participants in the program, peer leaders appear to benefit greatly from their training and involvement.

A similar type of intervention for the institutionalized aged is described in a publication entitled *Old Is Part of the Whole* by Miller *et al.* This program involves a group experience with structured activities that focus discussion and interaction on the participants' feelings about themselves, their lives, and their current condition. One of the authors describes the

inferred positive effects of this program: "I have seen many group participants . . . become more positive about themselves and more tolerant of others. . . . I have seen them share losses and comfort each other. In the group, I have watched them mull over out loud what consequences the changes in their lives have brought about, explore a variety of alternatives, describe to each other what works and what no longer works for them, and make choices [1978, p. 3]." Although peer interaction programs like these must be empirically tested to ensure their beneficial effects, we believe that they provide unique opportunities for meeting social support needs.

CONCLUSIONS

In this chapter, several parallels have been examined between the experiences of victims of undesirable life events and those of the elderly. This process yielded several major themes: (1) The elderly can be seen as "victimized" in many different ways; (2) social support is beneficial to the elderly as it is to victims, although more research is needed; (3) the elderly may need more opportunities both to express their feelings (ventilation) and to receive feedback that they are normal given the circumstances (validation); (4) significant segments of the elderly population may experience deficiencies in the quality of support available to them at times when they especially need it; (5) the causes of ineffective support may include feelings of helplessness and vulnerability among others and resultant tendencies to avoid the elderly, prevent open communication with them, and convey nonverbal rejection. We believe that theory and research on victims of life crises offers a unique perspective for understanding the elderly, and are hopeful this analysis will be useful in stimulating further research.

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