Throughout our lives, we rely on others and are relied on in turn. This is especially apparent in times of need, but also in ordinary daily goal pursuit. Granted, we also do things on our own, and some have argued that we try things on our own before turning to others (Bodenmann, Randall, & Falconier, 2016). At the same time, many interactions we have with others contain supportive acts—whether we asked for them or not. Among the people with whom we interact supportively, family members feature prominently (e.g., Antonucci, Akiyama, & Takahashi, 2004). Because the extent to which we are embedded in social networks and can rely on their help are consistent predictors of better health and longevity (e.g., Holt-Lunstad, Smith, & Layton, 2010; Uchino, Bowen, Carlisle, & Birmingham, 2012), it is not surprising that of the many forms of social exchange we can practice with others, social support has received the most research attention in health psychology.

This chapter provides a conceptual overview of social support and related constructs, discusses theoretical perspectives of how social support is associated with health outcomes, and reviews social support interventions in the area of coping with stress and disease. To account for the role of family processes, the choice of social support theories reviewed here was guided not only by their impact on the field of health psychology, but also by their assumptions on the role of specific support providers, including family members.

Social Support—Conceptual Overview and Assessment

The term social support has been used to describe a wide range of social interaction phenomena. Relying on a classification widely used in the literature (e.g., Barrera, 1986; Berkman, Glass, Brisette, & Seeman, 2000; Gottlieb & Bergen, 2010; Schwarzer & Knoll, 2007), we distinguish between structural/formal aspects and functional/qualitative processes connected with social relationships.

Structural or formal aspects of relationships are often referred to as “social networks” or as the closely related concept of “social integration”. They describe the structure of people’s social environments and the degree to which people interact with network members (Gottlieb & Bergen, 2010). Researchers can count the total number of people that a person has regular contact with, differentiate network members by their closeness or importance to the focal person, assess the number of different groups existing within a social network (e.g., family, friends, neighbors,
colleagues, church; as well as the groups’ diversity or homogeneity), and measure the degree to which members of one’s social network interact (e.g., Antonucci et al., 2004; Berkman et al., 2000; Cohen & Janicki Deverts, 2009).

Functional or qualitative aspects of social relationships, in contrast, include social exchange processes within interpersonal interactions that are used to achieve certain ends, such as solving problems, achieving goals, or regulating emotions. Social support is the most frequently studied form of social exchange in health psychology research.

**Definition of Support**

There are many definitions of the construct. Cohen, Gottlieb, and Underwood (2001) defined social support as the “social resources that persons perceive to be available or that are actually provided to them by nonprofessionals in the context of both formal support groups and informal helping relationships” (p. 129). This definition distinguishes between perceived (available) support and (actual) received support. Perceived support describes the degree of support a person feels he or she can count on should the need arise; it is often assessed prospectively and is fairly consistently associated with indicators of better mental and physical health (Cohen, 2004; Holt-Lunstad et al., 2010; Uchino et al., 2012). In contrast, received support refers to the retrospective and subjective report of support that was obtained. Together with its counterpart, provided support, received support is also called enacted support (Barrera, 1986). The relations between received support and health indicators are more complex (e.g., Finch, Okun, Pool, & Ruehlman, 1999; Holt-Lunstad et al., 2010), highlighting the need to investigate moderators of the relationship.

Associations between perceived and received support are at times surprisingly small in magnitude (Dunkel-Schetter & Bennett, 1990; Melrose, Brown, & Wood, 2015). Although perceived support is often assumed to produce its effects through received support, reciprocal effects between the two should be considered; for example, support received may feed back into the perception of the general availability of support. The support deterioration deterrence model (Kaniasty, 2012; Norris & Kaniasty, 1996) predicts that under severely stressful circumstances, perceived support is likely to deteriorate over time, but that this process can be slowed by received support.

Both perceived and received support serve a variety of functions for which a number of taxonomies exist (Barrera, 1986; Berkman et al., 2000; Gottlieb & Bergen, 2010). Two very commonly demarcated functions are emotional and instrumental support. Emotional support refers to soothing, consoling, and/or the communication of warmth and care. Instrumental, or practical, support entails hands-on help with problem solving, the provision of resources, or taking over chores and activities. Other support functions focus on the transfer of information to solve a problem (i.e., informational support) or provide self-relevant feedback and decision aid to the recipient (i.e., appraisal support; Berkman et al., 2000). Although the benefits of highly differentiated support functions that meet different specific needs of recipients are straightforward, the drawback to their use in research are high interrelations often found among these support functions, making it difficult to investigate their unique associations with health indicators in a given context (Cutrona & Russell, 1990; Cutrona, Shaffer, Wesner, & Gardner, 2007).

Social support is most often assessed with self-report questionnaires (e.g., Gottlieb & Bergen, 2010); direct observation of enacted support has been used less often (e.g., Suhr, Cutrona, Krebs, & Jensen, 2004; Verhofstadt, Buyse, & Ickes, 2007). In self-report measures, respondents are often asked to indicate the extent to which they perceive or have received specific types of support; the provider (or source) of support is either directly specified or is left undefined. When defined, types of providers are often identified as “most important other”, partner, family, friends, neighbors, and co-workers (Barrera, 1986; Gottlieb & Bergen, 2010; Schulz & Schwarzer, 2003).
Social Support, Family Processes, and Health

How Social Support Affects Health

A comprehensive model delineating the assumed pathways between social integration and health was proposed by Berkman et al. (2000). Social integration is linked to the perceived or actual availability of several social exchange processes (i.e., psychosocial mechanisms), including social support. Health outcomes occur through interconnected psychological, physiological, and health-behavioral pathways. Following this framework, we review theories and empirical findings with an emphasis on the first two pathways. Theory and research on the third, the health-behavioral pathway, will only briefly be addressed in the outlook as investigated theoretical mechanisms typically go beyond social support.

Social Support and Psychological Pathways to Health

Proposed proximal psychological outcomes of social support often entail indicators of emotional well-being, but may also include beliefs or expectancies (Banik et al., 2017; Benight & Bandura, 2004; Hohl et al., 2016), which are assumed to translate into overall better health (Berkman et al., 2000). In accordance with the stress-buffering model (Cohen & Wills, 1985), social support unfolds its beneficial effects primarily under conditions of stress. As a result, many authors have examined support as a predictor of emotional well-being either during potentially stressful situations or in interaction with the presence and absence of hassles and life events (e.g., Cohen, 2004; Ditzen & Heinrichs, 2014). The model does not make assumptions about specific sources or providers of support, but maintains that there is a protective effect of social support when it meets an individual's needs. Similar provider-unspecific propositions are also made by other theories that attach higher importance to the psychological functions of support than to who provided that support (Cutrona & Russell, 1990; Lakey & Orehek, 2011).

Perceived Support and Health

Although support providers are rarely named in measures of perceived support, an exception is the understanding of perceived support as a stabilized form of childhood attachment in adult life. Sarason, Pierce, and Sarason (1990) maintain that a secure childhood attachment to mother, father, or other primary caregiver translates into a high level of perceived support in later years. Early anxious and avoidant attachment to caregivers, however, is likely to result not only in developmental problems (Bowlby, 1988), but also in a relatively stable, lowered perception of available support in times of need (Sarason et al., 1990). These effects are assumed to be driven by internal working models of what is to be expected of others. The resulting belief, availability of perceived support, is characterized as a general sense of being accepted, valued, or loved. It is assumed to have consequences for one’s overall expectations of others’ supportive behaviors, for seeking and developing intimate relationships in adulthood, for one’s level of coping self-efficacy, and for regulating emotions and behaviors at times of stress (Sarason et al., 1990).

A more recent theory of perceived support fully disposes of the relevance of particular sources of perceived support, but holds that perceived support may even be enriched by symbolic supporters (e.g., TV characters) provided they conform with the support perceiver’s preferences. In their relational regulation theory (RRT), Lakey and Orehek (2011) observe that in addition to its buffering functions, perceived support also produces consistent direct effects on (better) mental health. These outcomes evolve from ordinary, yet affectively consequential, but not necessarily stress- or coping-related conversations or interactions with others: “Simply put, dyads do things together that elicit favorable affect. When a provider has a history of successfully regulating a recipient’s affect in
these ways, the recipient sees the provider as supportive” (Lakey, Cooper, Cronin, & Whitaker, 2014, p. 405). Whereas positive affect and perceived support are assumed to be proximal outcomes of social interactions, a more distal consequence should be better mental health (Lakey & Orehek, 2011). Extending assumptions of the RRT to symbolic providers, Lakey et al. (2014) found evidence that viewing symbolic providers’ social interactions and activities on TV improved the emotional state of the focal person in a similar manner as interactions with real people can. In addition to its consistent associations with mental health, perceived support has been related to longer survival (Cohen, 2004; Holt-Lunstad et al., 2010).

Received Support and Health

In contrast to research on perceived support, research on received support reveals far less consistent ties with either emotional well-being (Finch et al., 1999) or physical health outcomes (Holt-Lunstad et al., 2010). As received support is the outcome of an interaction with another person, it is easy to identify potential methodological and interpersonal pitfalls responsible for the inconsistent findings. First, stress may be both a predictor and an outcome of social support and causal direction is often elusive, particularly in cross-sectional studies (Seidman, Shrout, & Bolger, 2006). Second, a number of moderating dimensions of support have been proposed to understand its effects. As reviewed earlier, there is the question of whether the type of support fits the problem at hand (the matching hypothesis; Cohen, 2004; Cutrona et al., 2007). Overprotection (Coyne & Smith, 1994; Hagedoorn et al., 2000) or support that does not match the recipient’s independence goals (Knoll et al., 2015) has been related to worse emotional and cognitive adaptation.

Although social support from a partner or spouse is often helpful (Revenson & DeLongis, 2011), co-occurring spousal strain may render received spousal support ineffective for stress relief in couples (DeLongis, Capreol, Holtzman, O’Brien, & Campbell, 2004). Moreover, although attachment may, in part, represent how much support is expected in close relationships (Sarason et al., 1990), it was also shown to modulate how much individuals benefit from received support (Ditzen et al., 2008; Meuwly et al., 2012). Furthermore, there is a danger that support may damage the recipient’s self-esteem, because help was needed in the first place or because provision of support was less than skillful (e.g. Bolger & Amarel, 2007; Rook, 2015). All these moderating effects may cancel out the positive effects of receiving support.

Another important moderator is the degree of fairness or reciprocity in support interactions. Based on equity theory (e.g. Walster, Berscheid, & Walster, 1973), received support is likely to induce further stress if the recipient does not or cannot reciprocate support (i.e. an overbenefit), or if support received does not “pay back” one’s own prior investments in support exchange (i.e., an underbenefit). Equity in support, defined as the fair distribution of support exchange, predominantly lies in the eye of the beholder, because it depends on how much a person values specified supportive inputs and outcomes (Zhang & Epley, 2009). This is further complicated by diverse possibilities of what constitutes adequate supportive payback at different stages of the lifespan (e.g., Lang, Wagner, Wrzus, & Neyer, 2013) or in different cultures (Shen, Wan, & Wyer, 2011).

Clark and Mills (2012) proposed the distinction between communal and exchange relationships. Within communal relationships, characterized by showing general concern (e.g., parents–children, other close familial relations, couples, best friends), the norm is that support is given when it is needed, without an expectation of benefits returned. In contrast, exchange relationships that are more distant and formal (e.g., work relationships, acquaintances) rely on equity principles in their distribution of rewards, such as support provision.

Antonucci and Jackson (1990) use the metaphor of a “support bank” to illustrate how individuals keep track of their supportive exchanges over time and that the immediacy of give and take varies as a function of the expected longevity of the relationship. Superficial or short-term relationships may
be a form of exchange relationship and need short-term payback, or else they might dissolve before debts are repaid. Support accounts in close and expectedly lasting (more communal) relationships can be balanced over a longer period of time.

In their convoy model of support, Kahn and Antonucci (1980) characterized in more detail the degrees of closeness in supportive relationships. All individuals are assumed to have a personal network or convoy of important confidants around them throughout their lives. Convoy members are sorted into three concentric layers of closeness around the individual (e.g., Antonucci et al., 2014). Cross-culturally, overall network size and especially inner circle convoy composition seem fairly similar when comparing, for example, Japan and the U.S. (e.g., Antonucci et al., 2004). But whereas in Lebanon and Mexico increases of overall convoy size with age were observed (Antonucci, Ajrouch, & Abdulrahim, 2014; Fuller-Iglesias & Antonucci, 2016), decreases in convoy size were found in the US and Japan (Antonucci et al., 2004). Note that whereas a re-composition of networks and a reduction of potential support providers can have detrimental effects on health and well-being in old age (Rook & Charles, 2017), smaller networks in older age do not automatically imply less support or less satisfying contact with other people (Carstensen, 2006; Gurung, Taylor, & Seeman, 2003; Rook & Charles, 2017).

Social Support and Physiological Pathways to Health

Hypotheses on how social support affects physiological parameters are most often derived from the stress-buffering model (Cohen, 2004; Ditzen & Heinrichs, 2014). It is assumed that through its stress protective effects, support is not only associated with greater self-reported well-being, but also with diverse biomarkers and associated organ responses implicated in the stress process. Empirical findings on the effect of social support on physiological responses are often derived from carefully controlled laboratory experiments (Kamarck, Manuck, & Jennings, 1990) or correlational designs using ambulatory assessment (Bajaj et al., 2016; Steptoe, 2000). In laboratory studies, an experimental manipulation of non-evaluative received support was consistently associated with decreased physiological stress responses (Ditzen & Heinrichs, 2007). However, some manipulations raise the question of whether the conscious support perception is actually the active ingredient for the effects of social support. That is, more immediate perceptions of safety through affective touch or even the presence of a pet might modulate the beneficial effects of social support on biological stress responses (Ditzen & Heinrichs, 2014).

The most investigated biomarkers in relation to social support can be grouped along two dominant stress axes, the fast reacting sympathetic-adrenal-medullary system and the slower-reacting hypothalamus-pituitary-adrenal axis. Physiological stress responses on these axes interact with each other and with the immune system (DeVries, Craft, Glesper, Neigh, & Alexander, 2007). Central nervous-system responses to stress and social support also have been studied, including prominent stress modulators such as endogenous opioids (Eisenberger & Cole, 2012) and oxytocin (Heinrichs, Baumgartner, Kirschbaum, & Ehlert, 2003).

In the “tend-and befriend” model, Taylor and colleagues (2000) imply the neuropeptide oxytocin as one explanatory mechanism of the often reported gender differences in social behavior under stress, including the use and effects of social support. They propose that one mechanism behind women’s more extensive use of affiliative behaviors under stress, including social support, is the higher availability of oxytocin. The evidence for this assumption is equivocal, however, with gender differences in support behaviors more consistently found in self-report than in observational studies (Verhoffstadt et al., 2007).

Some physiological pathway findings are remarkably similar to the ones reviewed in the psychological pathway section. In correlational field research, perceived support is more closely associated with physiological responses than received support. In addition, effects of received social support
on physiological outcomes are often inconclusive, likely for the same reasons as reviewed earlier (Ditzen & Heinrichs, 2014).

Social Support Interventions in Health Psychology

A number of social support interventions have been designed to alleviate psychosocial stress or facilitate coping among adults living with a chronic illness (Badr & Krebs, 2013; Hogan, Linden, & Najaran, 2002; Martire, Schulz, Helgeson, Small, & Saghafi, 2010). Enhancing the quantity or quality of enacted support in patients and informal caregivers, mostly partners or other family members, is one prominent focus. Typically, through these interventions, informal caregivers are trained how to support the persons they care for (Martire, Schulz, Keefe, Rudy, & Starz, 2008), helped to acquire more support from their networks (e.g., Dam, de Vugt, Klinkenberg, Verhey, & van Boxtel, 2016), or patient-caregiver dyads are trained how to support each other (Kuijer, Buunk, Majella De Jong, Ybema, & Sanderman, 2004).

Much of this intervention research has focused on couples coping with cancer (e.g., Kayser & Scott, 2008; Manne, Kashy, Siegel, & Heckman, 2017), where small beneficial effects on psychological and physical quality of life outcomes have been found (see review by Badr & Krebs, 2013). A meta-analysis of couple-oriented interventions for chronic illness management also found small effects on patient-reported outcomes including well-being, marital functioning, and pain indicators across a number of illnesses (Martire et al., 2010).

As a potentially chronic stressor, marital problems are another obvious intervention target for couples (Bodenmann, 2016), but treatments often address more than just partners’ social support interactions. One approach in which support-related interactions are given a prominent role is based on Bodenmann’s dyadic stress and coping model (Bodenmann et al., 2016). In addition to delineating how stress emerges in dyads, Bodenmann describes three dyadic coping modes that couples use to solve problems and that all involve support and communication. Using this theoretical backdrop, Bodenmann developed the couple coping enhancement training (CCET), finding moderate to strong effects on key relationship outcomes in distressed but otherwise healthy couples (e.g., Bodenmann, 2016).

Generally, there is a large heterogeneity in intervention approaches regarding their theoretical foundations, intervention techniques (e.g., cognitive behavior therapy, marital therapy), formats (formal support group, professional support, family, dyadic or individual delivery), intervention targets (individuals, couples, family members, peers), dosage, and degree of “purity” of social support as an active ingredient in the intervention components (Badr & Krebs, 2013; Hogan et al., 2002). As many intervention studies do not actually test whether the intervention increased support and whether that increase was related to an improvement in physical or mental health, it is still difficult to make a confident statement about the efficacy of support interventions. Intervention research needs to become more precise and explanatory.

Current Issues and Outlook

Correlational and intervention research seems to place the concept of received or enacted support at an impasse as direct effects on health outcomes appear to be small. Strategies to overcome this impasse, however, continue to emerge from the literature.

One of these strategies aims at broadening concepts while differentiating them at the same time. A number of theories on dyadic adaptation to stress, coping with illness, or illness management share the idea that social interactions are vital, but that support is not the only form of health-relevant dyadic interaction (Berg & Upchurch, 2007; Martire & Helgeson, 2017). For example, the construct of coping congruence (Revenson, 1994, 2003) investigates varying degrees of similarity and complementarity of different coping strategies used by partners in dyads. Dyadic coping (Bodenmann
et al., 2016; Berg & Upchurch, 2007; Kayser, Feldman, Borstelmann, & Daniels, 2010; Revenson & Lepore, 2012) and communal coping (Lyons, Mickelson, Sullivan, & Coyne, 1998) theories stress the dyad as a system and differentiate support from collaboration, common stress appraisals, common goal setting and goal-engagement, and other related interaction types. Beyond social support, further adaptation-related social exchange processes have been suggested, for example, companionship (Rook, August, & Sorkin, 2011) or capitalization (Gable, Reis, Impett, & Asher, 2004).

Another strategy entails taking a new look at social support’s etiology and active ingredients. Lakey and Orehek (2011) propose that perceived support and mental health emerge not only from dyadic problem solving interactions but also from pleasant social interactions. Beckes and Coan (2011) argue that it is the more basic energy saving and risk-distributing processes emerging from social integration, social support, and other exchange processes that may be responsible for survival advantages. Both assumptions are in line with the immediate beneficial effects of the presence of others, affective touch, or intimacy on physiological stress responses (Debrot, Schoebi, Perrez, & Horn, 2013; Ditzen & Heinrichs, 2014). However, there is a need for empirical research supporting these theories and showing their superiority to other ones.

A third strategy is re-locating emphasis from the psychological to the health-behavioral pathway connecting social integration with better health (Arden-Close & McGrath, 2017; Hoppmann & Gerstorf, 2014; Martire & Helgeson, 2017; Richards, Franks, McDonough, & Porter, 2017; Scholz et al., 2016). These theoretical approaches, however, often go beyond social support and use broader explanatory frameworks such as communal coping (Lewis et al., 2006) or dyadic collaboration (Sorkin et al., 2014). Others propose to broaden the array of social exchange processes by including social control (Lewis & Rook, 1999) or dyadic forms of self-regulatory strategies (Berli, Stadler, Inauen, & Scholz, 2016; Fitzsimons, Finkel, & van Dellen, 2015; Knoll et al., 2017) as mechanisms of health-behavior change, or to embed social support in individual health-behavior change theories (e.g., Luszczynska & Cieslak, 2009; Scholz, Ochsner, Hornung, & Knoll, 2013; Scholz et al., 2016). Whether or not these broadened and focused approaches will reliably explain the beneficial effects of social integration on health beyond the contributions of social support remains to be seen.

**Conclusion**

This chapter provided an overview of social support components, theories, mediating pathways to health, and intervention efforts. Although much of contemporary research on social support in health psychology has been conducted with couples or other close relationships, it was noted that the role of specific support sources, including family members, is not regularly addressed in theories or research. Instead, psychological functions of support are emphasized. Returning to the question that was integral to many parts of this chapter, whether social support is a mediator for the effects of social integration on health, we, like many before, conclude with “it depends”. The observation that perceived support may be a much more promising mediator candidate than received support is dated (e.g., Barrera, 1986), but continues to be reinforced by newer evidence (e.g., Holt-Lunstad et al., 2010; Uchino et al., 2012). Continuing to disentangle protective and harmful effects of support will nevertheless be of note, because we perceive, receive, provide, and use it frequently.

**References**


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